Handbook of Personality Disorders

Theory and Practice

Edited by

Jeffrey J. Magnavita

John Wiley & Sons, Inc.

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This volume is dedicated to my wife, Anne Gardner Magnavita,
and children, Elizabeth, Emily, and Caroline.

Foreword

It is critical that mental health professionals have a detailed, working knowledge of the personality of the individual patient, whether the patient is presenting with symptoms, problems in relating to others, or difficulties coping with stressors and life events. The clinical community has a growing awareness of personality, its deviations, and the impact on psychotherapy (see chapter 3).

Over the years, there have been developments in the understanding and specification of the relationship between therapist and patient that fosters or hinders treatment and its outcome. The impact of patient characteristics on psychotherapy process and outcome is considerable. Long-standing patient characteristics related to personality such as attachment style, repetitive interpersonal behavior, reactance, and coping styles all significantly influence the therapeutic endeavor. Every clinician must develop a therapeutic alliance with the patient, and the nature of this alliance depends on the personality of the patient in interaction with the personality of the therapist. Relating to patients with personality difficulties is not a specialty of a few, but a clinical skill needed by all.

In academic psychology, there is a rich history of the study of personality. Enduring issues in that academic tradition that are relevant to the pursuit of such issues in clinical psychology and psychiatry are the conceptualization and definition of personality, the relative influence on personality of nature and nurture, persistence and change in personality features, and emphasis on conscious versus unconscious processes. The mutual contact and fertilization between this academic tradition and clinical work has been variable and sporadic. There is an obvious parallel between the major theories of personality and the dominant theories of personality disorder These theories need further development as the research unfolds.

With the introduction of *DSM-III* in 1980, it has become commonplace in clinical work and psychotherapy research to distinguish between patients with and without personality disorders. This "official" recognition of the difference between symptom conditions and abnormality in the personality itself has given legitimacy to the investigation of personality disorders in their own right, and has alerted clinicians to the need to assess both symptom conditions and personality dysfunction. Armed with this helpful but somewhat arbitrary and oversimplified distinction, clinicians have been aware that they are treating symptomatic patients with and without co-existing personality disorders, and researchers have gathered empirical outcome data on these treatments. It has become evident in the empirical literature that the treatment of symptoms in the context of personality disorders is more complicated, slower, and less effective than the treatment of symptomatic patients without personality disorders (see chapter 23).

Our current diagnostic system—*DSM-IV*—is better at describing the indicators of the presence of a personality disorder than it is in describing the different constellations of personality disorder or dysfunction. In the diagnostic system, the overall description of a personality disorder is the presence of serious and chronic interference in cognition and emotion regulation that affects functioning in the domains of work and interpersonal relationships. Thus, chronic dysfunction in relationships and work is the hallmark and final common pathway of the personality disorders. These deficits must be clear before the clinician considers the specific type or constellation of personality disorder category.

Clinicians are attuned to deficits and dysfunction in work and relationships, but often find the specific types of personality disorder as described currently in *DSM-IV* as a mixture of feelings, attitudes, behaviors and symptoms, insufficient for describing the patients' personalities and for treatment planning. This dissatisfaction and alternative ways of describing personality difficulties for intervention are grappled with in this volume, especially in chapters 2 and 5 in section 1.

The identification of individuals with personality difficulties begins with the assessment of work functioning and the nuances of interpersonal relations. However, that is a somewhat gross indication, and the task for the therapist is to arrive at a conceptualization of the current functional characteristics of the patient that, if changed, would lead to improvement in the individual's life. The conceptualization of mechanisms of personality dysfunction orient the clinician directly to the target of treatment. This is the leading edge of clinical work. How does the therapist assess and conceptualize the active and repetitive functions of the individual that are directly related to dysfunctional personality and personality organization? Does the clinician assess personality traits (chapter 4), the social cultural context (chapters 6 and 7), and/or how the personality itself is organized (chapter 5)? Indeed, without theory we are in a sea of observations and facts that do not adequately guide the clinician (chapter 3), either in assessment or in the choice of focus of treatment. The much touted atheoretical orientation of *DSM-IV* has lead to some of the serious difficulties with *DSM-IV* Axis II.

This volume rightfully assumes that targeted and thorough assessment logically leads to planned interventions (section 2). The treatment of personality disorders specifically is difficult and fraught with problems. Progress on the treatment of symptom conditions depends upon the personality and personality traits of the patient; cooperativeness with the therapist, and focus and persistence on the work of the therapy are major considerations. This therapeutic work becomes even more complex and difficult when the patient has the characteristics of those designated as having a personality disorder. What are the mechanisms of change, and, related to that, what are the foci of the therapists' interventions when treating patients with personality difficulties/disorders?

Should the primary focus be on working models of relationships (chapter 8), automatic thoughts and cognitive distortions (chapter 9), developing skills (chapter 11), and/or problematic relationship patterns (chapter 12)? Of course, these foci of therapeutic intervention are not mutually exclusive, and some of them seem to be touching on the same reality but with different metaphors and terminology. There is a growing consensus toward a focus on the patients' characteristic ways of attending to and processing information on the interaction between self and others. Thus, this volume is informative on the foci of interventions in general (section 2) and with special populations and settings (section 3).

Related to the focus of therapist intervention, is the question of treatment goals. Is the goal of treatment the amelioration of symptoms (e.g., reduction of situational depression in an individual with narcissistic personality disorder) or change in behaviors (e.g., reduction of parasuicidal behavior in borderlines) of those with personality disorders, or is it more directly to change the organization of the personality itself? This is an unresolved issue, and each author in this volume addresses the goal of treatment. The way in which each theoretician and clinician answers this question relates to a whole complex of issues, involving managed care and the clinician's conception of the existence and nature of personality, and whether or not personality can be changed. In a very practical way, the answer to this question relates to the duration of treatment.

There is much written today about evidence based treatment planning, and matching patient diagnosis with treatment packages that have been empirically investigated as compared to treatment as usual. Evidence based approaches to treatment planning are presented as definitive, but leave many details unaccounted for: the uniqueness of the patients who are more than their diagnosis, the aspects of the patients unrelated to diagnosis that affect the therapeutic relationship, the unique relationship qualities of the therapist, the social milieu of the patient, to name a few. The data on the treatment of personality disorders is too meager to approach evidence based treatment planning, which makes the value of this volume of even greater value to the practicing clinician.

The practitioner needs an expert guide through the winding paths and thickets of a new and developing field such as personality disorders. Jeffrey Magnavita is both a theoretician and clinician with many years of experience with this patient population. He has skillfully constructed and edited this volume, bringing together a number of thoughtful experts who highlight the unique aspects of treatment planning with patients with personality disorders. Each of the authors expands our horizon in thinking about personality and personality dysfunction, combining clinical experience with empirical data. These authors are pioneers, as the development of assessment and treatment of personality disorders is in its infancy compared to comparable efforts in the treatment of symptom conditions.

John F. Clarkin, PhD

Preface

The inspiration for this volume emerged from my work over the past 20 years conducting psychodiagnostic assessments and practicing psychotherapy with children, adolescents, adults, and the elderly, first in an inpatient and then outpatient settings. What struck me was that across the spectrum of individuals and families that I encountered presenting with complex clinical syndromes was how many struggled with self-defeating and self-destructive personality patterns that were so difficult to impact with standard methods and techniques. With most clinicians, as it is with me, the compelling force that drives us is to reduce human suffering, and we often gain an understanding of our own suffering and developmental challenges. During a crisis or a major life transition, many have experienced personality "dysfunction," but for most, this is short lived. Yet, for many others, as addressed in this volume, these patterns or systems are often entrenched, enduring, and chronically dysfunctioning. These dysfunctioning systems cause much disruption to the individual, family, and society. Attempting to understand this complex phenomenon that clinicians are faced with daily is challenging, fascinating, and often daunting. It is my hope that this volume clarifies some of these challenges and adds to our hope. It seems clear that the phenomenon we are dealing with, whether symptoms of clinical syndromes or relational disturbance, rests on the integrity of the personality system. If the personality system is not functioning especially well, trouble looms, symptom complexes emerge, and relationships falter. Clinical syndromes and symptom complexes are expressed sometimes somatically or psychologically but always in the relational matrix. In my diverse clinical work with individuals, couples, families, and groups, it has been clear to me that there is one central system that informs the way in which we conceptualize psychopathology; understand intrapsychic, interpersonal, and family functioning; and formulate our psychotherapeutic strategies. This central organizing system is personality. Although personality has been primarily conceptualized as housed in the individual or *self-system,* theoretical advances over the past century have underscored the necessity of expanding our conceptual field to other domains such as the interpersonal (dyadic), triadic (threesomes), and larger family and social systems that form the entire ecological system or biosphere.

When the personality system is vulnerable or not operating effectively at any of the biopsychosocial domains, the system becomes *dys*functional. When the level of adaptive functioning meets appropriate diagnostic criteria, a personality *disorder* is diagnosed. The diagnostic category and label personality *disorder* is not necessarily the best way to classify what we experience in relationships and observe clinically, as it is necessarily reductionistic. It is, however, what we have at this phase in the development of the field and some consider the state of the art. I

prefer the term *personality dysfunction,* but many others represented in this volume may not agree. For some individuals, personality dysfunction is something that affects their lives but that they suffer in silence and may go undetected, except by those in immediate proximity such as spouses, partners, children, and coworkers. These individuals have been termed *neurotic* characters in the past. Yet others show more dramatic signs and may be stuck in chronic maladaptive patterns that cause severe suffering as well as having major impact on the family and society. These patterns are often referred to as the *severe* personality disorders. Couples and families may have faltering personality systems that can result in what I have termed *dysfunctional personologic systems* that can transmit this dysfunction from one generation to another, often downward spiraling, unless intervention takes place.

Personality has been an interest to humankind since we became conscious and able to "observe" ourselves. Over the past century of modern behavioral science, personality and its disorders has been a subject of interest to many disciplines including anthropologists, primatologists, academic psychologists, psychopathologists, clinical psychiatrists, and psychologists, and, more recently, neuroscientists. We are entering a new phase of the field where interdisciplinary collaboration and advances in fields such as neuroscience may help us map human consciousness and develop efficient, effective, and accelerated treatments for even the most refractory of these dysfunctional systems.

Theories, methods, and techniques have been developed to address these faltering or dysfunctioning personality systems. Many of these models presented in this volume offer a rich array of conceptual systems, approaches, and therapeutic stances. In spite of all these remarkable developments, we should not forget about the importance of the therapeutic relationship, which tends to be given a back seat as we head toward an era of *empirically validated treatments* (EVTs) and the concomitant pressure to produce treatment manuals. Although they can be useful, we should not forget that our endeavor is complex and human to human, requiring clinical intuition and a genuine desire to alleviate human suffering.

PURPOSE OF THIS VOLUME

This volume provides the latest information to clinicians who are treating personality dysfunction or disorders of personality, students who are interested in the topic, and others such as theorists and researchers. A goal was for each contributor to provide as much in the way of clinical utility as possible. Therefore, the book focuses primarily on theory, which is essential, and methods and techniques of practice. *The approaches, methods, and techniques presented in this volume are for professional purposes and should be used only by qualified mental health clinicians and, in some cases, require additional training and supervision.* For those primarily interested in research, other excellent volumes are available on the topic and may be used in conjunction with this one. In rapidly advancing fields such as personality, personality disorders, psychotherapy, and psychopathology, it is impossible to present a comprehensive overview of these interrelated areas in a single volume. However, the reader will appreciate the selective and in-depth treatment of the topic with special emphasis on theory and practice. Another goal of this volume is to present the spectrum of approaches that remain contemporaneous in that they continue to evolve and have clinical utility as well as many newer ones that hold promise. There are

many similarities in the approaches presented in this volume, yet there are some approaches that remain highly divergent and offer the reader contrasting viewpoints with which to consider the clinical phenomenon. Another goal is to provide a sample of some of the cutting edge applications of treatment approaches using various methods, techniques, and modalities creatively and apply these to other populations not previously considered as a focus of intervention.

OUTLINE OF VOLUME

This volume is divided into five sections. The first section, Etiology, Theory, Psychopathology, and Assessment, begins with some of the fundamental conceptual theoretical bulwark for the topic and exposes the reader to some of the challenges and controversies around conceptualizing, diagnosing-labeling, and assessing personality.

The next section, Contemporary Psychotherapeutic Treatment Models, presents a number of current approaches to treating personality dysfunction. It is interesting that the majority of these models are primarily used individually. The modality of individual psychotherapy has been the mainstay for treatment delivery, but newer models delivered in couples, family, and group treatment modalities are beginning to emerge.

The third section, Broadening the Scope of Treatment: Special Populations and Settings, offers readers a sample of some of the groundbreaking work being done by contemporary workers who are applying technological and theoretical innovations to those populations with co-occurring personality dysfunction who are underserved and difficult to treat, such as substance abusers, medical patients, and the severely disturbed, who often require day treatment and inpatient hospitalization. This cutting edge work represents a growing interest in modifying and discovering methods that can assist clinicians as well as ways of conceptualizing the role of memory and trauma in the development and maintenance of these dysfunctioning personality systems.

The fourth section, Expanding the Range of Treatment: Child, Adolescent, and Elderly Models, presents the extension of treatment paradigms to children and adolescents as well as the elderly. In this section, leading figures explore the edges of diagnostic knowledge and add substantially to our understanding of these often difficult-to-reach developmental phases that have been virtually overlooked in the past. Often because of the controversy surrounding labeling, these phases have not received the consideration of theorists, practitioners, and researchers, although this is beginning to slowly change as these topics are opened for discussion.

The final section, Research Findings and Future Challenges, presents a cogent summary of the extant, albeit limited, research findings on personality disorders and then explores an emerging theoretical movement toward unified treatment. The model for this treatment, which I consider the next wave of development in personality and psychotherapy—beyond integration—should stir some polemics.

FINAL ACKNOWLEDGMENTS

I am very fortunate to have had the opportunity to collaborate on this volume with some of the leading figures in the fields of personality disorders, psychotherapy, research, and pharmacotherapy. The contributors to this volume represent some of

the most forward, innovative thinkers and courageous pioneers of approaches developed from their interest in alleviating human suffering and their commitment and passion for clinical work. All contributors toiled on their chapters to bring the material to the readers in a clinically relevant way. I thank them for their devotion to this task.

I would like to express my appreciation to Dr. John Clarkin, one of the leading figures in the field, whose work I have absorbed even though it has become a part of my procedural memory and thus is not adequately cited. Dr. Clarkin graciously agreed to read this volume and write the Foreword. This is a task that no one looks forward to after a tiring day of clinical practice, research, writing, and supervision. For his generosity, I am indebted and very grateful.

I also want to express my appreciation to all those at John Wiley & Sons who have supported this endeavor and for their belief in the value of a volume of this nature. Special thanks are due to Peggy Alexander and Isabel Pratt for shepherding this volume through the stages of development necessary to bring the final product to the reader.

Last, but most important to me, is my tremendous appreciation to my wife, Anne Gardner Magnavita, who edited the final drafts of my chapters and who always seems to understand and support the demands of my work and professional life and seemingly endless writing projects.

JEFFREY J. MAGNAVITA

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Jeffrey J. Magnavita, PhD, ABPP, FAPA, is a licensed psychologist and marriage and family therapist in active clinical practice. A Diplomate of the American Board of Professional Psychology and Fellow of the American Psychological Association, he is the nominee or recipient of many awards for his work in the practice and theory of psychotherapy and personality disorders, on which he speaks at the national level. He is the founder of Glastonbury Psychological Associates, PC, and the Connecticut Center for Short-Term Dynamic Psychotherapy and is an adjunct professor of clinical psychology at the University of Hartford and lecturer at Smith College of Social Work. He authored *Restructuring Personality Disorders: A Short-Term Dynamic Approach; Relational Therapy for Personality Disorders,* and a text; *Theories of Personality: Contemporary Approaches to the Science of Personality* and was the volume editor of the *Comprehensive Handbook of Psychotherapy: Psychodynamic/Object Relations: Volume 1* and has extensive publications in the field. He is affiliate medical staff at a number of Hartford, Connecticut, area hospitals, where he consults and conducts training. He is an active member of the International Society for the Study of Personality Disorders, Society for Psychotherapy Research, New York Academy of Science, and Society for the Exploration and Integration of Psychotherapy and a founding member of the International Institute of Experiential Short-Term Dynamic Psychotherapy.

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SECTION ONE

ETIOLOGY, THEORY, PSYCHOPATHOLOGY, AND ASSESSMENT

CHAPTER 1

Classification, Prevalence, and Etiology of Personality Disorders: Related Issues and Controversy

Jeffrey J. Magnavita

We stand poised at the edge of a remarkable new era in contemporary clinical psychology. Multiple related scientific disciplines intersect at a point of important mutual interest—*the effective treatment of personality systems*—especially for those systems that are poorly functioning and/or inefficiently adapting to the requirements of contemporary society. Such systems comprise what clinical scientists call *personality disorders.* Personality and its disordered or dysfunctional states have been of interest to humankind since the early stages of civilization probably coinciding with the birth of consciousness or the point at which we could reflect upon our "self." As soon as we became conscious of the existence of the "self" and aware of the "other," we wanted to know what made us tick and what was happening with those around us; adaptation and survival would have depended, in part, on this kind of insight. Evolutionary processes have certainly shaped our wide array of personality adaptations, styles, and disorders, and will continue to do so.

Evidence of an interest in personality and psychopathology can be seen in earliest documented history. The early Egyptians were fascinated by a possible link between the uterus and emotional disorders, which the Greeks later called *hysteria* (Alexander & Selesnick, 1966; Stone, 1997). This clinical syndrome became a major impetus in the development of Freud's system of psychoanalysis, which is considered by many to be one of the main intellectual milestones of the twentieth century (Magnavita, 2002a; Wepman & Heine, 1963). Earlier efforts in the late nineteenth century were made to understand the etiology of and treatment for hysteria, which posed a scientific and clinical challenge to the major pioneers in medicine, psychology, and psychiatry. Jean Charcot (1889) devoted much of his scientific career to documenting this disorder. Using the newly discovered art of photography, he captured haunting images of this often grotesque disturbance.

Charcot also experimented with various forms of treatment, most notable of which was hypnosis. His interest in psychopathology, along with that of others such as Emil Kraepelin (1904), the great classifier of mental disorders, initiated modern nosology, much of which is still in use in current day diagnostic systems.

The study of personality is fueled by our relentless interest in knowing ourselves and has resulted in various theoretical systems. The most familiar of these is the four humors of the Greeks (Magnavita, 2002b), elements of which are still seen in some contemporary biological and psychological theories (Davis & Millon, 1999). Our interest in self-understanding and the theories associated with it converged with a fascination in the pathological states of adaptation that have plagued humankind from the time of documented history. Humans have always shown a desire to alleviate the suffering of those who experience mental disorders. The early Egyptians developed a system of treatment based on soul-searching on the part of ill patients (Alexander & Selesnick, 1966). The use of the word *psychotherapy* was first seen in the writings of Hippolyte Bernheim (1891) in his work entitled, *Hypnotisme, Suggestion, Psychotherapie* (Jackson, 1999). There has been great progress in developing personality theory, in understanding and classifying psychopathology, and in pioneering new methods of treatment for those suffering with disorders of personality, but developing cost-efficient and effective forms of treatment remains a challenge. This chapter presents some of the basic background information on classification, etiology, and prevalence of personality disorders and reviews some constructs and useful theoretical developments to guide you through the remainder of this volume. We begin with the classification of personality. How we categorize and label the clinical phenomenon has major implications for researchers and clinicians; there are multiple perspectives and approaches to consider.

CLASSIFICATION OF PERSONALITY

The classification of personality is a problematic area that has not been sufficiently resolved at this stage in development of the science of personality. Classification is a topic that can result in heated debates about what is, and what is not, a personality disorder and what the optimal treatment should be and how it should be delivered. Once a diagnosis is established, decisions must be made concerning "differential therapeutics" (Frances, Clarkin, & Perry, 1984): (1) *treatment format*—long-term, intermittent, intensive short-term, supportive; (2) *type/model*—cognitive, behavioral, interpersonal, psychodynamic, integrative, pharmacological; (3) *modalities*—group, individual, family, couples, mixed, sequential and; (4) *setting*—hospital, outpatient, partial, residential. The permutations seem overwhelming!

During one recent seminar, a participant raised his hand and announced that the cases being presented were not "truly personality disordered." A heated disagreement ensued regarding the diagnosis that the patient had been given. Even well-trained and experienced clinicians often disagree about what constitutes a "genuine" personality disorder. We all long for clear, meaningful diagnostic guidelines, potent treatment alternatives, and positive and preferably rapid outcomes. What we have to contend with in clinical reality is not nearly so clear, is often confusing, and lacks simple algorithms to help us neatly plot our course. Thus, what we do remains more a clinical art than a science. The models that clinicians adopt to depict patient systems and communicate via metaphorical language are often

novel and flexible. Our models offer a way to organize the data, understand the phenomenology, and indicate the possibility of a "cure." Our primary concern is a way out for the patient who is suffering and the suffering of those others in his or her lives. Many of the dominant contemporary models are presented in this volume for you to study and possibly to incorporate into your clinical practice.

Personality disorder is first and foremost a *construct* that social and clinical scientists use in an attempt to deal with the complex phenomenon that results when the personality system is not functioning optimally. Some believe the construct should be jettisoned altogether and does more harm than good (Jordan, this volume, chapter 6). Is there any such thing as a personality disorder in reality? Those practitioners who have been in clinical practice can attest that there are certain individuals who demonstrate a capacity to engage in behavior that is clearly self-destructive, self-defeating, and self-sabotaging. Even when we *can* identify an inadequately functioning personality system, the challenges of measuring its severity and choosing a treatment approach must be tackled. We must account for the clinical reality that patients cut and mutilate themselves, use excessive amounts of substances to numb them, create chaos in their communities and families, and so forth. Personality remains a useful coherent construct to understand these and other disturbing phenomenon.

We find that, even with the best intentions on all sides, certain types of personality "dysfunction" are very difficult to modify or transform. So the term *personality disorder,* in spite of the stigma associated with conferring this label on another, does have clinical utility. This construct has remained a focus of attention for modern psychology for over a century, even though it had fallen in and out of vogue in some circles. It does seem to account for a clinical phenomenon that has not been replaced by a more useful construct. As this volume attests, most of the leading clinicians and theorists in the field choose to use the construct, with all its limitations. There are exceptions, such as Jean Baker Miller and Judith Jordan (Frager & Fadiman, 1998) from the Stone Center, who eschew pathological labeling as pejorative and demeaning. We return to this important issue later in this chapter.

What is a personality disorder? Before we try to answer this important question, we should first explore a related question, *What is personality?* As clinicians, theorists, and researchers, we are treating and studying people with unique personalities, although possibly poorly functioning, or functioning at any of the various levels of adaptive capacity. One definition of personality is "an individual's habitual way of thinking, feeling, perceiving, and reacting to the world" (Magnavita, 2002b, p. 16). There are problems with this classic textbook perspective drawn from academic psychology of the last century: with the focus on personology, which primarily investigates individual differences (Murray, 1938), it leaves the rest of the ecological matrix in the hands of sociologists, anthropologists, and social psychologists. This *individualistic* definition of personality is one whose primary focus is clearly on the individual personality system. As such, this definition is limiting and antiquated, especially if we, as we must, acknowledge that human personality is expressed within a context, an intrapsychic, dyadic, triadic, familial, sociopolitical, cultural, and ecological matrix. The components of this matrix are in an ongoing interaction, shaping and influencing the various subsystems, in multiple and complex feedback loops. To prepare ourselves for the challenges we are facing at the beginning of the new millennium, such as developing effective treatment

for underserved minority groups, the elderly, substance abusers, severe personality dysfunction, and many others, we need to expand our perspective of personality from the individual system to the subsystems that operate within the total ecological system (Magnavita, in press). This requires an interdisciplinary collaboration among related scientific disciplines concerned with the study of human nature, relational science, neuroscience, affective science, the study of consciousness and personality (Magnavita, 2002b).

Does a personality disorder exist? The answer to this question depends on whom you ask. If you ask a clinical researcher who is trained to use empirical measures, a personality disorder represents a score on an objective measure that exceeds a statistically significant cut-off point or a designated score on a structured interview. With a score above the point, the clinician would say a personality disorder exists, and below it a disorder is not present. A psychopathologist might define the presence or absence of a personality disorder based on whether there exists a "harmful dysfunction" (Wakefield, 1999) or, in their terms, is the patient demonstrating signs of an *evolutionary maladaptive behavioral repertoire?* A clinician might look for whether there are long-standing, self-defeating aspects to the individual's interpersonal patterns, and whether there is an over-reliance on primitive defenses (Magnavita, 1997; McWilliams, 1994). A family clinician might be more interested in deciding how the individual or family's organization and function influences maladaptive or dysfunctional processes. A psychopharmacologist might investigate the response to various psychotropic medications. A forensic psychologist or psychiatrist would be interested in the results of a battery of objective and standardized tests, in-depth clinical interviews, and history that would support a diagnosis likely to be held to legal standards of evidence. The answer depends on the orientation of the professional answering the question, as well as the system or systems of classification that he or she employs, and has the most utility for the task on which they embark, such as producing academic papers, conducting epidemiological research or a forensic evaluation, planning clinical treatment, engaging in psychopathological research, and so forth.

There are various systems of classification that include (1) *categorical,* (2) *dimensional,* (3) *structural,* (4) *prototypal,* and (5) *relational.* They each have strengths and certain limitations. Each has a perspective and offers one view of reality.

1. Categorical Classification

The categorical classification is used predominantly by psychotherapists in research. For many clinicians, it is required to complete insurance forms for reimbursement of clinical services. The predominant categorical system for classification of personality disorders and other clinical syndromes is the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*) published by the American Psychiatric Association (APA, 1994). The *DSM* defines personality disorder 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 lead to distress or impairment" (APA, 1994, p. 629). The multiaxial *DSM* has been a major development in the classification of personality disorders, particularly in its emphasis on placing personality disorders on their own axis—the second axis. The categorical system relies on establishing the presence of behaviorally observable

and atheoretical criteria that indicate the presence of a diagnosable personality disorder. *DSM* categorizes personality disorders into three clusters, A, B, and C, as follows:

1. *Cluster A* is characterized by odd or eccentric behavior and includes paranoid, schizoid, and schizotypal personalities. This cluster tends to be the most treatment refractory and is probably the most likely to have underlying biogenetic factors.
2. *Cluster B* is characterized by erratic, emotional, and dramatic presentations and includes antisocial, borderline, histrionic, and narcissistic personalities. This cluster includes personality disorders often considered to be severe and that have mixed treatment results.
3. *Cluster C* is characterized by anxiety and fearfulness and includes avoidant, dependent, and obsessive-compulsive personalities. These are generally viewed as the most treatment responsive and have shown the best results with shorter duration treatment protocols (Beck, Freeman, et al., 1990; Winston et al., 1994).

There are several problems with *DSM.* One is the degree of overlap among the categories—many patients are diagnosed with more than one. In addition, many clinicians find *DSM* to be a very rough diagnostic schema that does not take into consideration the finer distinctions among those who are given the same diagnosis. For example, two patients diagnosed with an obsessive-compulsive personality disorder may be functioning at very different levels of adaptive functioning and thus treatment and prognosis might be very different. The usefulness for treatment planning is questionable and rightly so; how could the presence of six or seven criteria truly inform the complex treatment intervention that is most often required for the personality disordered patient?

2. Dimensional Classification

The dimensional classification of personality takes a different approach from the categorical. This system is based on the premise that personality does not exist in categories but rather along dimensions. Dimensional classification grew out of the study of normal personality using the trait approach developed by Gordon Allport (Allport & Odbert, 1936) that used factor analysis to reduce the over 17,000 words they identified in the dictionary to describe personality. Personality disorders are an example of normal traits amplified to an extreme, to the point of being maladaptive, and so they are well suited to the dimensional system. This system has been primarily used to investigate the construct of personality in both normal and disordered populations. The most dominant of the dimensional models is the five-factor model which has identified five empirically derived dimensions of personality that include: neuroticism, extraversion, openness, agreeableness, and conscientiousness (Costa & McCrae, 1992).

3. Structural-Dynamic Classification

The structural-dynamic classification of personality is based on a psychodynamic understanding of personality structure and organization (McWilliams, 1994).

This system evolved from the character types developed by psychoanalytic pioneers of the last century and to a certain extent they are still present in many of the current *DSM* categories. In this system, personality organization is placed on a continuum from psychotic, borderline, neurotic to normal with each point representing a varying degree of structural integrity—how well the system can handle anxiety, conflict, and emotional experience before becoming overloaded and symptomatic—called *ego-adaptive capacity.* Thus, someone functioning at the right of the borderline position would be able to handle more anxiety and conflict than someone on the left side, toward the psychotic range whose tolerance is much lower. Each type or mixture of personality types can be organized at any position along the continuum. If you could overlay *DSM* on top of the structural continuum, you would see that the Cluster C disorders are equivalent to those at the neurotic level, Cluster B at the borderline level, and Cluster A at the psychotic level. A crucial part of personality in the structural-dynamic classification is the organization and use of defense mechanisms. Those at higher levels of organization and adaptation generally use more mature and neurotic defenses, those in the borderline range use more primitive defenses and those in the psychotic spectrum tend to use more primitive and psychotic mixes. O. Kernberg (1984) has advanced the structural-dynamic system in his work focusing primarily on the severe personality disorders.

4. Prototypal Classification

The prototypal classification of personality combines the categorical with the dimensional and lends itself to finer distinctions among various personality types and disorders. The most notable of the prototypal systems is Millon's (Millon & Davis, 1996) that retains categories of personality disorder but assesses them on three primary dimensions: self/other, active/passive, and pleasure/pain. Millon has developed highly valid and reliable instruments that can be used to assess the personality with standardized objective tests.

5. Relational Classification

The relational classification of personality has two main branches, the interpersonal model of Harry Stack Sullivan (1953) who dealt with *dyadic configurations* and the systemic model of Murray Bowen (1976) who dealt with *triadic configurations.* The interpersonal model has evolved in various forms from Leary's (1957) circumplex model to Benjamin's (1993) Structural Analysis of Social Behavior (SASB), and a systemically based relational model (Magnavita, 2000) of dysfunctional personologic systems. Most recently, there has been a movement to develop and codify a comprehensive relational model (Kaslow, 1996) and another to expand the use of relational diagnoses in *DSM* (Beach, 2002). Relational diagnosis looks at patterns of communication, themes, multigenerational processes, feedback loops, and interpersonal processes such as complimentarity.

Pathological Labels—Useful or Pejorative?

As mentioned earlier in this chapter, the label "personality disorder" can be pejorative and some clinicians eschew its use. In the worst case, labeling can be used to marginalize and control those who society finds unacceptable. We have seen

evidence of this in the use of psychiatric labeling of dissidents in the communist Soviet Union. Most of us have had a representative from a managed care company deny a request for treatment of a patient who has been diagnosed with personality disorder. This is done on the grounds that these patients are not treatment responsive and that Axis II disorders are not covered under their policy. Most of us have been conditioned to report the secondary symptom complexes such as depression, anxiety, and substance abuse, which are generally more acceptable and covered by the policy. When we confer a label on a patient regardless of our intent it can be demoralizing or experienced as an act of devaluing that person, or even felt as a deeply wounding and moralistic attack. Language is indeed powerful and the way in which we use it can be constraining or freeing. Clinicians and diagnosticians must be aware of the effect of sloppy or inconsiderate use of diagnostic labeling. The term *personality disorder* is probably not the best one for the field to have adopted, but for now we have no choice as it has been codified in *DSM-IV.* It seems more acceptable to many to use the alternative label *personality dysfunction,* that occurs when a personality system is not adapting optimally or is overwhelmed or flooded with trauma or overwhelming stress. Personality dysfunction is a more fluid construct that allows for changes in the manner in which a person's personality functions. During times of trauma, war, or economic or political adversity, a person's personality may be reorganized to cope with the events. At these times, the person's personality may indeed be dysfunctional as it has become overwhelmed, but it seems a stretch to say that this is a personality disorder, which implies a long-standing dysfunction. If someone's personality is not functioning effectively, we can help them by enhancing defensive organization, restructuring cognitive schema and beliefs, metabolizing affect over traumatic experience, teaching interpersonal skills, offering alternative attachment experiences, increasing adaptive strategies, and so on.

Science likes labels and needs tools to organize and categorize that which it studies. The construct of personality disorder has indeed allowed researchers interested in personality to study the subject and get research funding. There has been a major increase in research interest and development of new models to treat personality disorders as can be seen by many of the contributions in this volume. Identifying a condition such as borderline personality disorder has drawn attention to those who suffer from affective dysregulation, identity confusion, and interpersonal instability that characterizes this disorder. It allows those who have these symptoms to educate themselves and seek the best treatment available. Identifying and labeling also allows clinicians to understand the commonalties among patients that might suggest a particular method or approach for treatment.

PREVALENCE OF PERSONALITY DISORDERS IN CONTEMPORARY SOCIETY

The prevalence of personality disorders in contemporary society depends on the validity of the classification system and diagnostic instruments used to establish the presence of a disorder. As we have discussed, there are problems with classification and nosology that make estimates of prevalence only approximate. Millon and Davis (1996) write: "No other area in the study of psychopathology is fraught with more controversy than the personality disorders" (p. 485). Nevertheless, epidemiological surveys do shed some light and provide some empirical evidence about the prevalence of personality disorders in the population. The most often

cited study on the prevalence of personality disorders in the United States is by Weissman (1993) who found that approximately one out of 10 people fulfill the criteria for a personality disorder. Merikangas and Weissman (1986) found that approximately half of those receiving mental health treatment also suffered from a personality disorder. The Weissman study remains the most comprehensive report on the prevalence of personality disorders but was based on *DSM-III* and as Mattia and Zimmerman point out: "No epidemiological survey of the full range of personality disorders has been conducted in the post *DSM-III* era" (2001, p. 107). Further studies are warranted; the Merikangas and Weissman studies have illuminated the problem of quantifying the extent of personality disorders in the general and clinical population and will guide future research.

The finding that about half of those receiving mental health treatment are compromised in their personality functioning, enough to warrant a personality disorder diagnosis, underscores the importance of acknowledging the contribution of personality to relational disturbances such as marital dysfunction, spousal abuse, domestic violence, child abuse, as well as the most common clinical syndromes such as anxiety, depression, eating disorders, and addictions. The prevalence rates for personality disorders vary greatly. In a review of six studies, Mattia and Zimmerman (2001) found that the rates documented ranged from as low as 6.7% to as high as 33.3%. These findings are suggestive of a greater problem than is being acknowledged. There are few epidemiological studies that have investigated the prevalence of childhood and adolescent personality disorders. Bernstein et al. (1993) indicate that the rate of personality disorders between the ages of 9 and 19 is "high." They found that approximately 31% suffer from moderate personality disturbance and 17% can be classified as severe. In contrast, Lewinsohn, Rohde, Seeley, and Klein (1997), using a different methodology, only report 3.3% rate of prevalence in young adults; the discrepancy seems to be due to methodological and measurement issues but is useful in pointing the way for further studies.

Are we underestimating the prevalence of personality disorders? What does seem evident from clinical practice, although undocumented by empirical findings, is the increasing number of children, adolescents, and adults who are entering treatment with signs of personality dysfunction. This may be disguised because of a tendency for clinicians to use diagnostic nomenclature that is less pathology oriented and "more hopeful" in terms of prognosis. Many clinicians still believe that personality dysfunction is beyond the realm of treatment and will avoid it in favor of a less stigmatizing Axis I disorder. The presence of multiple co-occurring clinical syndromes is often a sign that personality dysfunction is at the root of the problem but may be obscured by the complex interrelationship of these clinical and relational disorders, and an unwillingness to address the personality component. With regards to childhood and adolescent personality disorders, P. F. Kernberg, Weiner, and Bardenstein (2000) write: "when PDs are looked for in children and adolescents, their prevalence can be considerable" (p. 4). Further, they state in their book *Personality Disorders in Children and Adolescents:* "Our purpose is to present the mounting and compelling evidence for the presence of PDs in children and adolescents so that they will be more readily recognized and treated" (p. ix).

Are we witnessing signs of an epidemic in process? If clinical, sociocultural, and political indices are accurate, we may be entering an unprecedented era for

individual and social pathology caused by economic pressure, racism, and cultural fragmentation (West, 2001), which might be a harbinger for an epidemic in personality dysfunction. Cultural, political, and economic factors are putting undue strain on family and social institutions that were once able to mitigate some of the impact of increased anxiety from rapid cultural change and fragmentation that spawn social pathologies and promote personality dysfunction in individuals and families. In clinical settings, we see more and more severe cases of personality disorder at younger ages, along with fewer resources from the community with which to handle these, magnified by destabilization of the family. More and more, families are left without the necessary support to deal with disturbances in their family members. This is particularly evident to clinicians who have tried to find an appropriate hospital for a personality disturbed patient that will keep the patient more than a few days before returning the patient to the community and to a family ill-equipped to deal with the burden of acute episodes and chronic care. As more and more families are being forced into harsher economic conditions and poverty, the likelihood that there will be an epidemic in personality disorders is not far fetched. This may be especially true for groups that have already been marginalized by racism and economic disadvantage (West, 2001). West writes:

> The collapse of meaning in life—the eclipse of hope and absence of love of self and others, the breakdown of family and neighborhood bonds—leads to the social deracination and cultural denudement of urban dwellers, especially children. We have created rootless, dangling people with little link to the supportive networks—family, friends, school—that sustain some sense of purpose in life. We have witnessed the collapse of the spiritual communities that in the past helped Americans face despair, disease, and death that transmit through the generations dignity and decency, excellence and elegance. (p. 10)

West (2001) is concerned that unless there is significant attention paid to the problems of racism, sociocultural marginalization, and downward mobility of many groups in American society, the foundation of democracy will be threatened. There is no research that has investigated the presence of personality dysfunction in minority populations but it is clear that African American males as a group are experiencing severe stress to their personality systems.

Impact of Personality Disorders

The total impact of personality disorders (PDs) on the individual, family, and society is substantial. Ruegg and Francis (1995) nicely summarized the impact:

> PDs are associated with crime, substance abuse, disability, increased need for medical care, suicide attempts, self-injurious behavior, assaults, delayed recovery from Axis I and medical illness, institutionalization, underachievement, underemployment, family disruption, child abuse and neglect, homelessness, illegitimacy, poverty, STDs, misdiagnosis and mistreatment of medical and psychiatric disorder, malpractice suits, medical and judicial recidivism, dissatisfaction with and disruption of psychiatric treatment settings, and dependency on public support. (pp. 16–17)

"As economic conditions worsen and the trend toward family breakdown continues, we can predict an increase in the incidence of personality disorder" (Magnavita, 1997). This development underscores the urgency of developing the science of personality, obtaining epidemiological findings concerning the prevalence, developing cogent theoretical models, and effective treatment interventions for this under served population. According to P. F. Kernberg et al. (2000): "Personality disorders (PDs) historically have received less attention from clinicians and researchers than other psychiatric disorders such as depression and schizophrenia" (p. 3).

Prevalence of Co-Occurring Conditions

Along with a discussion of the prevalence of personality disorders, we should also consider the associated topic of *comorbidity:* the co-occurrence of more than one clinical disorder. Dolan-Sewell, Krueger, and Shea (2001) believe there are inherent problems with the concept of comorbidity when applied to mental disorders. "Although the use of the term 'comorbidity' to refer to covariation among disorders is common, our understanding of mental disorders has not yet reached the level described as truly 'distinct' " (p. 85). Comorbidity reflects the use of the dominant medical model to conceptualize mental disorders and may not be as useful as it is with medical illness where two or more separate disease entities often co-exist. The relationship among personality disorders and clinical syndromes is not so clear and might not be separable. Personality disorders represent a dysfunction of the individual and family personality system and thus lead to the expression of clinical disturbances and relational dysfunction (Magnavita, 1997, 2000, in press). Dissecting psychopathological conditions into various syndromes may mean losing sight of the goal of treating the personality system of the individual, the family, and the broader ecosystem in which they function.

Regardless of the controversy, using the current dominant diagnostic system of classification (*DSM*), there is increasing empirical evidence of the likelihood that a personality disorder diagnosis suggests that another clinical disorder will also be present and that it will likely be the reason for treatment. Tyrer, Gunderson, Lyons, and Tohen (1997) in their review of the literature found some of the following associated comorbid conditions: Borderline PD and Depression; Depressive PD and Depression; Avoidant PD and Generalized Social Phobia: Cluster B PDs and Psychoactive Substance Abuse; Cluster B and C PDs and Eating Disorders, and Somatoform Disorders; Cluster C PDs and Anxiety Disorders and Hypochondriasis; and finally Cluster A PDs and Schizophrenia. Looking at this phenomenon of co-occurring disorders from another perspective suggests that 79% of those diagnosed with a personality disorder will also fulfill criteria for an Axis I disorder (Fabrega, Ulrich, Pilkonis, & Messich, 1992).

Relevance of Identifying Co-Occurring Disorders for Clinical Practice

Co-occurring disorders are not exhibited by chance but emerge out of the personality configuration of the patient's total ecological system from the microscopic level to the macroscopic level of analysis. The clinical syndrome, relational dysfunction, and personality characteristics and organization of each patient cannot

be viewed separately. For example, we know that marital dissatisfaction is a cause of depression in women and that the personality characteristics and organization of a woman will influence how this complex constellation is handled. A woman with histrionic features may act out by having an affair and causing a marital showdown; a woman with obsessive features may become more perfectionistic and drive her spouse away; a woman with borderline features may become more self-destructive, increasing parasuicidal behavior such as cutting her arms; a dependent woman might triangulate a child by encouraging school phobia as she herself becomes increasingly agoraphobic. Millon (1999) has termed his model of treatment *personality-guided therapy,* which is an apt and useful description for how all therapy, regardless of the presenting complaint or treatment focus, should be conducted. The personality system, the central organizing system of a person, should be the cornerstone of treatment. Much of psychotherapy is concerned with pattern recognition, so that using personality as the central organizing system allows us to see patterns that are interconnected and, once discovered, are more readily restructured or modified. We next focus our attention on the causes of personality disorders.

ETIOLOGY OF PERSONALITY DISORDERS

The causes or etiology of personality disorders is a subject of great interest to clinical scientists and empirical researchers alike. There is no question that the etiology of personality disorders is multifactorial and complex, probably with multiple developmental pathways. Attempts to reduce the cause of a complex phenomenon to one level of abstraction such as trauma, biological, social, or interpersonal are likely to be fruitless. Most clinicians have faced the question posed by family members or patients with personality dysfunction: *What causes a personality disorder?* or, *How did I or my family member get it?* Aside from the clinical implications of knowing what the roots of a dysfunction are, being able to provide some reasonable psychoeducation to the family or individual is helpful. Useful models have been developed that can help us organize the etiological factors implicated in personality dysfunction. There are four models which, when blended, have extraordinary theoretical coherence and explanatory value when trying to understand the complex phenomenon of personality disorders. After reviewing these models, we will look at the most well-documented factors that have been empirically supported as etiological factors in the development or maintenance of personality dysfunction. These models are "atheoretical" in the sense that they cut across schools of theories of personality and psychotherapy and are building blocks for a unified personality-guided relational therapy (Magnavita, in press). We discuss some of the important advances in models that can guide the clinician regardless of his or her preferred treatment model.

Biopsychosocial Model

Engel (1980) reminded us of the importance of not ignoring any level of abstraction of the biopsychosocial model from the molecular to the ecological system. The biopsychosocial model views the individual holistically and does not ignore the potential contributing effects of various domains from the molecular to the ecological. This model reminds us of the fact that human functioning is complex

and any reductionistic model is likely to explain only a portion of the variance that accounts for a certain personality organization, style, or clinical condition.

Diathesis-Stress Model

The diathesis-stress model explains how we each have a certain threshold of biological and psychological vulnerability that when surpassed will result in symptom expression (Monroe & Simons, 1991). For example, when the level of stress in some individuals reaches a certain level they may develop lower back pain, while others may be subject to gastrointestinal disturbance. The most vulnerable biopsychological systems will be the channel for anxiety. These biopsychosocial systems are genetically determined to some degree. All people have a diathesis, or a genetically predisposed vulnerability, in one area or another. Some people have very hearty, euthymic temperaments, maintaining positive moods in bleak situations, while others tend more toward dysthymia. Some have a genetic predisposition to bipolar-affective or schizophrenic spectrum disorders. This model is very helpful in understanding and predicting how a schizophrenic illness may be precipitated in an individual, when stress and environmental conditions bring out the previously unexpressed phenotype. Paris (2001) applied this model to understanding personality functioning in a useful way. He suggested that temperamental vulnerabilities can be amplified by environmental challenges and trauma. The *diathesis* is the weak point where the organism "breaks down." Another way in which to apply the diathesis-stress model, which is of particular relevance for personality dysfunction, is to look at the overall personality system of an individual, dyad, or triadic configuration and to assess the impact of stress on the personality subsystems. For example, when viewing the individual personality at the intrapsychic system, we can observe that a patient with an obsessive compulsive personality configuration, when stressed by an external challenge, is likely to develop a symptom profile that is related to problems with anxiety suppression. Thus, it is common for these individuals to develop generalized anxiety disorder, sexual inhibition, and dysthymia.

General System Theory

A major development in social and biological sciences in the mid-twentieth century was the development of general system theory whose groundbreaking way of understanding complex systems was applied to communications theory, cybernetics, psychiatry, and was in part the impetus for the family therapy movement (von Bertalanffy, 1968). Von Bertalanffy's theoretical model has largely been incorporated into current psychological thought but remains of use. When we apply the tenets of general system theory to the elements of the biopsychosocial model, we have a powerful way of beginning to understand the interrelatedness of various elements and subsystems of the biopsychosocial model.

Chaos and Complexity Theory

Another very useful development in science in the latter part of the twentieth century was *chaos theory.* Chaos theory deals with complex systems and demonstrates that the universe has many properties of what are called chaotic systems,

which organize and re-organize in patterns (Gleick, 1987). If we can read the chaos, we see emergent patterns that reveal the self-organizing properties of the universe. The importance of chaos theory for our topic is in its ability to account for the interconnectedness of physical phenomenon. Early chaos theorists were very interested in studying and predicting weather patterns. This work revealed an important phenomenon known as the *Butterfly Effect,* which describes how a butterfly flapping her wings in China can create a violent weather pattern in North America. In other words, what they discovered was that small perturbations in parts of a system can have dramatic effects that can alter the system as a whole quite dramatically. Certain experiences are amplified in systems and create powerful effects.

Winter and Barenbaum (1999) write:

> In other fields of science, recognition of increased complexity has led to the development of "chaos theory" or "complexity theory," which is now being taken up by psychologists (e.g., Vallacher & Nowak, 1997). Because two basic postulates of personality psychology are (1) complexity of interaction among elements, and (2) that earlier experience affects later behavior in ways that are at least somewhat irreversible (or reversible with greater difficulty than acquisition), the field seems ideally situated to take advantage of these new theoretical and methodological tools. (p. 20)

Computer Modeling

The computer has been used by many cognitive psychologists and neuroscientists as a model for human cognition and, more currently, for emotional functioning. Personality has also been likened to a computer by Winter and Barenbaum (1999) who describe their analogy:

> Personality may come to be seen as a series of Windows computer applications. Over time, different personality "applications" are installed, opened, moved between foreground and background, modified, closed, even deleted. Although the sum total of available "personality" elements may have limits that are specifiable (perhaps unique for each person), the current "on-line" personality may be complex and fluid. (p. 20)

Computer Network Model

An analogy that is more contemporaneous and in keeping with the movement toward unified personality (see Magnavita, chapter 24) is the analogy of a network composed of interconnected computers capable of interaction and communication. A computer network seems to reflect the way personality systems function on an *intrapsychic* level (individual computer hardware—genetic and neurobiological, and software capability—attachment and relational experience); *dyadic level* (communication process among two computers); *triadic + N* (communication among three computers); and also in the larger *mesosystem* (interconnected computer networks). A more powerful computer with greater processing and expanded memory is capable of utilizing more powerful and faster programs. A

powerful computer will function at a high level with the proper software. If the software antiquated, poorly written, or has a virus (maladaptive personality patterns), the whole system will function poorly or may even crash. A system with limited hardware capacity will not do well even with the best available software; it will not be able to take advantage of its features and may become even slower or overwhelmed with demands. Interconnected computers may be arranged in networks that communicate to one another via hardware and software communication programs. An individual system with limited hardware and software can draw from the network. Any problem in the communication system could potentially cause a crash of the whole network.

Etiological Factors

We know with some degree of certainty the etiological factors that determine personality dysfunction. We are not, however, anywhere near having the ability to predict or pinpoint these with any degree of certainty. If we had the resources for a project comparable to the human genome project whereby we could focus many scientific resources on personality disorders, we could probably make advances in understanding similar to those we have made in understanding our genetic code. It is beyond the scope of this chapter to review in great detail the contributing factors to both functional and dysfunctional states of personality but it is critical for clinicians to have some familiarity with them. The broad categories include: (1) genetic predisposition, (2) attachment experience, (3) traumatic events, (4) family constellation, and (5) sociocultural and political forces. These factors are interactive, interrelated, and composed of complex biochemical/neuroanatomical-psychological-sociocultural feedback loops each evolutionarily shaping and being shaped by the others over the course of a lifetime and even across generations.

1. Genetic Predisposition Will a gene ever be found for personality disorders? It is unlikely, but there are certainly multiple genes that predispose our neurobiological system and that influence who we are and how we behave. It is estimated that anywhere between 30% to 50% of personality variation is inherited (Buss, 1999). In comparison, intelligence, another component system of personality, has an estimated heritability of 60%, which has been extensively documented (Herrnstein & Murray, 1994). Biological variables such as genetic endowments influencing temperamental dispositions set the parameters for personality development. Using the diathesis-stress model, we can loosely predict the symptom constellations and personality adaptations that will ensue. Neurobiological systems have bias in the way they are organized and function and may have a relationship to later personality development (Cloninger, 1986a, 1986b). Cloninger views personality predispositions as an artifact of neurotransmitter action that is genetically predetermined. Depue and Lenzenweger (2001) "conceive of personality disorders as emergent phenotypes arising for the interaction of the foregoing neurobehavioral systems underlying major personality traits" (p. 165). These neurobiological dispositions are also called *temperament;* there is robust evidence to suggest that these temperamental differences are observed quite early in development. Greenspan and Benderly (1997) describe these as sensitivity, reactivity, and motor preference potentials. Thomas and Chess

(1977) assessed temperament on an array of observable responses in infants that include approach or withdrawal, adaptability, threshold of responsiveness, intensity of reaction, quality of mood, distractibility, attention span, and persistence. It is certain that both nature and nurture influence personality, though the extent of the contribution of each remains unclear.

2. Attachment Experience One important developmental pathway to personality dysfunction is the quality and type of attachments that an individual forms as she progresses through her development. Bartholomew, Kwong, and Hart (2001) describe this process:

> From this perspective, personality disorder is viewed as a deviation from optimal development. Such deviation is presumed to have developed over an extended period and would be hypothesized to be associated with a number of interacting risk factors, which may defer across individuals and across disorders. Multiple pathways can lead to the same overt outcome—for instance, a particular form of personality disorder—and no specific risk factor would be expected to be necessary or sufficient for the development of a particular outcome. Attachment processes, in the past and present, may be one important factor affecting developmental pathways to personality disorder. (p. 211)

Thomas and Chess (1977) also realized that temperamental factors were not sufficient in explaining developmental shaping. They also believed that "goodness of fit" between the infant and child was crucial (Chess & Thomas, 1986). Winnicott believed that there is no such entity as an infant but only a mother-child dyad (Rayner, 1991).

3. Traumatic Events There is little question that traumatic events are strongly implicated in the development of personality dysfunction. This is especially apparent in the research on severe personality disorders. This is not to say that everyone who experiences a traumatic event will inevitably develop personality pathology but this does appear to be one common pathway. There are mitigating resiliency factors that seem to inoculate some who have been traumatized. Paris (2001) states: "whereas most individuals are resilient to adversity, people who develop clinical symptoms have an underlying vulnerability to the same risk factor" (p. 231). There is a point, however, where even the most resilient individual will be markedly affected by trauma and it will have an enduring impact on personality development. Herman (1992) and van der Kolk, McFarlane, and Weisaeth (1996) have made advances in our understanding of the impact of trauma on personality functioning. It seems that early and severe trauma is overwhelming to the neurobiological system and may in a sense "scar" the brain leading to future disturbance and developmental psychopathology. The over-excitation of certain brain centers, particularly the limbic system, may lead to a kindling effect that creates an easily triggered intense and disorganizing emotional response.

4. Family Constellation and Dysfunction Clinical observation and other evidence support the view that those who are raised in severely dysfunctional families are more likely to develop personality dysfunction (Magnavita & MacFarlane, in press; Magnavita, 2000). Although there is a paucity of empirical support for this

observation, in a review of the literature, Paris (2001) found that "parental psychopathology is associated with a variety of psychosocial adversities, such as trauma, family dysfunction, and family breakdown" (p. 234). Over the course of generations, a multigenerational transmission effect can continue to produce dysfunctional personologic systems, which, in some cases, worsen over time (Magnavita, 2000). The interaction between genetics and family environment is an interesting area of investigation. Plomin and Caspi (1999) studied nondisordered personality and found: "The surprise is that genetic research consistently shows that family resemblance for personality is almost entirely due to shared heredity rather than shared family environment" (p. 256). They report that family constellation such as birth order and sibling spacing seem to have an imprint on personality.

5. Sociocultural and Political Forces There is little in the way of documentation to assess the impact of sociocultural and political factors on personality dysfunction. Erickson's (1950) seminal work focusing on contemporary society's influence on identity remains relevant today. Paris (2001) posits that the disintegration of society may be an important factor implicated in the development of personality pathology and further suggests that the effect may be "amplified by rapid social change" (p. 237). Other contemporary social commentators such as West (2001) observe that strong political and sociocultural forces negatively impact the identity of many people, especially minority groups. Winter and Barenbaum (1999) write:

> First, we believe that personality psychology will need to pay increased attention to matters of context. Whatever the evolutionary origins, genetic basis, or physiological substrate of any aspect of personality, both its *level* and *channels of expression* will be strongly affected, in complex ways, by the multiple dimensions of social context: not only by the immediate situational context but also the larger contexts of age cohort, family institution, social class, nation/culture, history, and (perhaps supremely) gender. We suggest that varying the social macrocontext will "constellate," or completely change, all other variables of personality—much as in the classic demonstrations of gestalt principles of perception. (p. 19)

THE MUTABILITY OF PERSONALITY

An often-debated topic within the discipline of personality is whether personality is stable and how stable is it, and can it change, and whether it can be transformed slowly, rapidly, or at all (Heatherton & Weinberger, 1994; Magnavita, 1997). The mutability of personality is an academic research and clinical controversy that has yet to be adequately addressed. Standard measures of personality do support, to a degree, the consistency of personality over time and yet developmental processes entail continuous change. Whether or not personality is set and at what age it is consolidated has been the source of much speculation and controversy. The limited empirical work on this topic has been done in a naturalistic setting and suggests the possibility that "quantum change" or discontinuous transformational experiences do indeed occur at times (Miller & C'deBaca, 1994).

Why are some personality organizations so difficult to alter? It is unclear why certain manifestations of personality are so difficult to alter. The evidence seems to implicate the effect of interpersonal experience and trauma on the structuralization