



Personality disorder

Personality disorders (PD) are a class of mental disorders characterized by enduring maladaptive patterns of behavior, cognition, and inner experience, exhibited across many contexts and deviating from those accepted by the individual's culture.^[1] These patterns develop early, are inflexible, and are associated with significant distress or disability. The definitions vary by source and remain a matter of controversy.^{[2][3][4]} Official criteria for diagnosing personality disorders are listed in the sixth chapter of the *International Classification of Diseases* (ICD) and in the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders* (DSM).

Personality, defined psychologically, is the set of enduring behavioral and mental traits that distinguish individual humans. Hence, personality disorders are defined by experiences and behaviors that deviate from social norms and expectations. Those diagnosed with a personality disorder may experience difficulties in cognition, emotiveness, interpersonal functioning, or impulse control. For psychiatric patients, the prevalence of personality disorders is estimated between 40 and 60%.^{[5][6][7]} The behavior patterns of personality disorders are typically recognized by adolescence, the beginning of adulthood or sometimes even childhood and often have a pervasive negative impact on the quality of life.^{[1][8][9]}

Treatment for personality disorders is primarily psychotherapeutic. Evidence-based psychotherapies for personality disorders include cognitive behavioral therapy, and dialectical behavior therapy especially for borderline personality disorder.^{[10][11]} A variety of psychoanalytic approaches are also used.^[12] Personality disorders are associated with considerable stigma in popular and clinical discourse alike.^[13] Despite various methodological schemas designed to categorize personality disorders, many issues occur with classifying a personality disorder because the theory and diagnosis of such disorders occur within prevailing cultural expectations; thus, their validity is contested by some experts on the basis of inevitable subjectivity. They argue that the theory and diagnosis of personality disorders are based strictly on social, or even sociopolitical and economic considerations.^[14]

Classification and symptoms

The two latest editions of the major systems of classification are:

- the International Classification of Diseases (11th revision, ICD-11) published by the World Health Organization
- the Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition, DSM-5) by the American Psychiatric Association.

The ICD is a collection of alpha-numerical codes which have been assigned to all known clinical states, and provides uniform terminology for medical records, billing, statistics and research. The DSM defines psychiatric diagnoses based on research and expert consensus. Both have deliberately aligned their diagnoses to some extent, but some differences remain. For example, the ICD-10 included *narcissistic personality disorder* in the group of *other specific personality disorders*, while DSM-5 does not include *enduring personality change after catastrophic experience*. The ICD-10 classified the DSM-5 *schizotypal personality disorder* as a form of schizophrenia rather than as a personality disorder. There are accepted diagnostic issues and controversies with regard to distinguishing particular personality disorder categories from each other.^[15] Dissociative identity disorder, previously known as *multiple personality* as well as *multiple personality disorder*, has always been classified as a dissociative disorder and never was regarded as a personality disorder.^[16]

DSM-5

The most recent fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* stresses that a personality disorder is an enduring and inflexible pattern of long duration leading to significant distress or impairment and is not due to use of substances or another medical condition. The DSM-5 lists personality disorders in the same way as other mental disorders, rather than on a separate 'axis', as previously.^[17] DSM-5 lists ten specific personality disorders: paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, avoidant, dependent and obsessive–compulsive personality disorder. The DSM-5 also contains three diagnoses for personality patterns not matching these ten disorders, which nevertheless exhibit characteristics of a personality disorder.^[18]

- Personality change due to another medical condition – personality disturbance due to the direct effects of a medical condition
- Other specified personality disorder – disorder which meets the general criteria for a personality disorder but fails to meet the criteria for a specific disorder, with the reason given
- Unspecified personality disorder – disorder which meets the general criteria for a personality disorder but is not included in the DSM-5 classification

These specific personality disorders are grouped into the following three clusters based on descriptive similarities:

Cluster A (odd or eccentric disorders)

Cluster A personality disorders are often associated with schizophrenia. People with these disorders can be paranoid and have difficulty being understood by others, as they often have odd or eccentric modes of speaking and an unwillingness and inability to form and maintain close relationships.^[19]

- Paranoid personality disorder – pattern of irrational suspicion and mistrust of others, interpreting motivations as malevolent
- Schizoid personality disorder – cold affect and detachment from social relationships, apathy, and restricted emotional expression
- Schizotypal personality disorder – pattern of extreme discomfort interacting socially, and distorted cognition and perceptions

Significant evidence suggests a small proportion of people with Cluster A personality disorders, especially schizotypal personality disorder, have the potential to develop schizophrenia and other psychotic disorders. These disorders also have a higher probability of occurring among individuals whose first-degree relatives have either schizophrenia or a Cluster A personality disorder.^[20]

Cluster B (emotional or erratic disorders)

Cluster B personality disorders are characterized by dramatic, impulsive, self-destructive, emotional behavior and sometimes incomprehensible interactions with others.^[19]

- Antisocial personality disorder – pervasive pattern of disregard for and violation of the rights of others, lack of empathy, lack of remorse, callousness, bloated self-image, and manipulative and impulsive behavior
- Borderline personality disorder – pervasive pattern of abrupt emotional outbursts, fear of abandonment, unhealthy attachment, altered empathy,^[21] and instability in relationships, self-image, identity, behavior and affect, often leading to self-harm and impulsivity
- Histrionic personality disorder – pervasive pattern of attention-seeking behavior, including excessive emotions, an impressionistic style of speech, inappropriate seduction, exhibitionism, and egocentrism
- Narcissistic personality disorder – pervasive pattern of superior grandiosity, haughtiness, need for admiration, deceiving others, and lack of empathy (and, in more severe expressions, criminal behavior *with* remorse)^[22]

Cluster C (anxious or fearful disorders)

Group C personality disorders are characterised by a consistent pattern of anxious thinking or behavior.^[19]

- Avoidant personality disorder – pervasive feelings of social inhibition and inadequacy, and extreme sensitivity to negative evaluation
- Dependent personality disorder – pervasive psychological need to be cared for by other people
- Obsessive–compulsive personality disorder – rigid conformity to rules, perfectionism, and control to the point of exclusion of leisurely activities and friendships (distinct from obsessive–compulsive disorder)

DSM-5 general criteria

Both the DSM-5 and the ICD-11 diagnostic systems provide a definition and six criteria for a general personality disorder. These criteria should be met by all personality disorder cases before a more specific diagnosis can be made. The DSM-5 indicates that any personality disorder diagnosis must meet the following criteria:^[18]

- There is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:

- Cognition (i.e., ways of perceiving and interpreting self, other people, and events)
- Affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response)
- Interpersonal functioning
- Impulse control
- The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.
- The enduring pattern leads to clinically significant distress, or impairment in functioning, in social, occupational, or other important areas.
- The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.
- The enduring pattern is not better explained as a manifestation or consequence of another mental disorder.
- The enduring pattern is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., head trauma).

ICD-11

The ICD-11 personality disorder section differs substantially from the previous edition, ICD-10. All distinct PDs have been merged into one: *personality disorder* (6D10 (<https://icd.who.int/browse/latest-release/mms/en#941859884>)), which can be coded as *mild* (6D10.0 (<https://icd.who.int/browse/latest-release/mms/en#263226710>)), *moderate* (6D10.1 (<https://icd.who.int/browse/latest-release/mms/en#758339377>)), *severe* (6D10.2 (<https://icd.who.int/browse/latest-release/mms/en#40156192>)), or *severity unspecified* (6D10.Z (<https://icd.who.int/browse/latest-release/mms/en#941859884%2FUnspecified>)). There is also an additional category called personality difficulty (QE50.7 (<https://icd.who.int/browse/latest-release/mms/en#853711607>)), which can be used to describe personality traits that are problematic, but do not meet the diagnostic criteria for a PD. A personality disorder or difficulty can be specified by one or more *prominent personality traits or patterns* (6D11 (<https://icd.who.int/browse/latest-release/mms/en#1128733473>)). The ICD-11 uses five trait domains:

1. Negative affectivity (6D11.0 (<https://icd.who.int/browse/latest-release/mms/en#953246526>)) – including anxiety, separation insecurity, distrustfulness, worthlessness and emotional instability
2. Detachment (6D11.1 (<https://icd.who.int/browse/latest-release/mms/en#919081088>)) – including social detachment and emotional coldness
3. Dissociality (6D11.2 (<https://icd.who.int/browse/latest-release/mms/en#1913158855>)) – including grandiosity, egocentricity, deception, exploitativeness and aggression
4. Disinhibition (6D11.3 (<https://icd.who.int/browse/latest-release/mms/en#387934990>)) – including risk-taking, impulsivity, irresponsibility and distractibility
5. Anankastia (6D11.4 (<https://icd.who.int/browse/latest-release/mms/en#848330288>)) – including rigid control over behaviour and affect and rigid perfectionism

Listed directly underneath is *borderline pattern* (6D11.5 (<https://icd.who.int/browse/latest-release/mms/en#2006821354>)), a category similar to *borderline personality disorder*. This is not a trait in itself, but a combination of the five traits in certain severity. In the ICD-11, any personality disorder must meet all of the following criteria:^[23]

- There is an enduring disturbance characterized by problems in functioning of aspects of the self (e.g., identity, self-worth, accuracy of self-view, self-direction), and/or interpersonal dysfunction (e.g., ability to develop and maintain close and mutually satisfying relationships, ability to understand others' perspectives and to manage conflict in relationships).
- The disturbance has persisted over an extended period of time (e.g., lasting 2 years or more).
- The disturbance is manifest in patterns of cognition, emotional experience, emotional expression, and behaviour that are maladaptive (e.g., inflexible or poorly regulated).
- The disturbance is manifest across a range of personal and social situations (i.e., is not limited to specific relationships or social roles), though it may be consistently evoked by particular types of circumstances and not others.
- The symptoms are not due to the direct effects of a medication or substance, including withdrawal effects, and are not better accounted for by another mental disorder, a disease of the nervous system, or another medical condition.
- The disturbance is associated with substantial distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

- Personality disorder should not be diagnosed if the patterns of behaviour characterizing the personality disturbance are developmentally appropriate (e.g., problems related to establishing an independent self-identity during adolescence) or can be explained primarily by social or cultural factors, including socio-political conflict.

ICD-10

The ICD-10 lists these general guideline criteria:^[24]

- Markedly disharmonious attitudes and behavior, generally involving several areas of functioning, e.g. affectivity, arousal, impulse control, ways of perceiving and thinking, and style of relating to others;
- The abnormal behavior pattern is enduring, of long standing, and not limited to episodes of mental illness;
- The abnormal behavior pattern is pervasive and clearly maladaptive to a broad range of personal and social situations;
- The above manifestations always appear during childhood or adolescence and continue into adulthood;
- The disorder leads to considerable personal distress but this may only become apparent late in its course;
- The disorder is usually, but not invariably, associated with significant problems in occupational and social performance.

The ICD adds: "For different cultures it may be necessary to develop specific sets of criteria with regard to social norms, rules and obligations."^[24] Chapter V in the ICD-10 contains the mental and behavioral disorders and includes categories of personality disorder and enduring personality changes. They are defined as ingrained patterns indicated by inflexible and disabling responses that significantly differ from how the average person in the culture perceives, thinks, and feels, particularly in relating to others.^[25]

The specific personality disorders are: paranoid, schizoid, schizotypal, dissocial, emotionally unstable (borderline type and impulsive type), histrionic, narcissistic, anankastic, anxious (avoidant) and dependent.^[26] Besides the ten specific PD, there are the following categories:

- *Other specific personality disorders* (involves PD characterized as eccentric, haltlose, immature, narcissistic, passive-aggressive, or psychoneurotic.)
- *Personality disorder, unspecified* (includes "character neurosis" and "pathological personality").
- *Mixed and other personality disorders* (defined as conditions that are often troublesome but do not demonstrate the specific pattern of symptoms in the named disorders).
- *Enduring personality changes, not attributable to brain damage and disease* (this is for conditions that seem to arise in adults without a diagnosis of personality disorder, following catastrophic or prolonged stress or other psychiatric illness).

Other personality types and Millon's description

Some types of personality disorder were in previous versions of the diagnostic manuals but have been deleted. Examples include sadistic personality disorder (pervasive pattern of cruel, demeaning, and aggressive behavior) and self-defeating personality disorder or masochistic personality disorder (characterized by behavior consequently undermining the person's pleasure and goals). They were listed in the DSM-III-R appendix as "Proposed diagnostic categories needing further study" without specific criteria.^[27] Psychologist Theodore Millon, a researcher on personality disorders, and other researchers consider some relegated diagnoses to be equally valid disorders, and may also propose other personality disorders or subtypes, including mixtures of aspects of different categories of the officially accepted diagnoses.^[28] Millon proposed the following description of personality disorders:

Type of personality disorder	DSM-5 inclusion	Description
<u>Paranoid</u>	Yes	Guarded, defensive, distrustful and suspicious. Hypervigilant to the motives of others to undermine or do harm. Always seeking confirmatory evidence of hidden schemes. Feel righteous, but persecuted. Experience a pattern of pervasive distrust and suspicion of others that lasts a long time. They are generally difficult to work with and are very hard to form relationships with. They are also known to be argumentative and hypersensitive. ^[29]
<u>Schizoid</u>	Yes	Apathetic, indifferent, remote, solitary, distant, humorless, contempt, odd fantasies. Neither desire nor need human attachments. Withdrawn from relationships and prefer to be alone. Little interest in others, often seen as a loner. Minimal awareness of the feelings of themselves or others. Few drives or ambitions, if any. Is an uncommon condition in which people avoid social activities and consistently shy away from interaction with others. It affects more males than females. To others, they may appear somewhat dull or humorless. Because they do not tend to show emotion, they may appear as though they do not care about what's going on around them. ^[30]
<u>Schizotypal</u>	Yes	Eccentric, self-estranged, bizarre, absent. Exhibit peculiar mannerisms and behaviors. Think they can read thoughts of others. Preoccupied with odd daydreams and beliefs. Blur line between reality and fantasy. Magical thinking and strange beliefs. People with schizotypal personality disorder are often described as odd or eccentric and usually have few, if any, close relationships. They think others think negatively of them. ^[31]
<u>Antisocial</u>	Yes	Impulsive, irresponsible, deviant, unruly. Act without due consideration. Meet social obligations only when self-serving. Disrespect societal customs, rules, and standards. See themselves as free and independent. People with antisocial personality disorder depict a long pattern of disregard for other people's rights. They often cross the line and violate these rights. ^[32]
<u>Borderline</u>	Yes	Frantic efforts to avoid abandonment. Identity disturbance; unstable sense of self-image or sense of self. Impulsivity — spending, sex, substance abuse, binge eating. Unstable mood; fluctuation between highs and lows. Feelings of emptiness. Ideation and devaluation of interpersonal relationships. Intense or inappropriate anger. Suicidal-behaviour. ^[33]
<u>Histrionic</u>	Yes	Hysteria, dramatic, seductive, shallow, egocentric, attention-seeking, vain. Overreact to minor events. Exhibitionistic as a means of securing attention and favors. See themselves as attractive and charming. Constantly seeking others' attention. Disorder is characterized by constant attention-seeking, emotional overreaction, and suggestibility. Their tendency to over-dramatize may impair relationships and lead to depression, but they are often high-functioning. ^[34]
<u>Narcissistic</u>	Yes	Egotistical, arrogant, grandiose, insouciant. Preoccupied with fantasies of success, beauty, or achievement. See themselves as admirable and superior, and therefore entitled to special treatment. Is a mental disorder in which people have an inflated sense of their own importance and a deep need for admiration. Those with narcissistic personality disorder believe that they are superior to others and have little regard for other people's feelings.
<u>Avoidant</u>	Yes	Hesitant, self-conscious, embarrassed, anxious. Tense in social situations due to fear of rejection. Plagued by constant performance anxiety. See themselves as inept, inferior, or unappealing. They experience long-standing feelings of inadequacy and are very sensitive of what others think about them. ^[35]
<u>Dependent</u>	Yes	Helpless, incompetent, submissive, immature. Withdrawn from adult responsibilities. See themselves as weak or fragile. Seek constant reassurance from stronger figures. They have the need to be taken care of by others. They fear being abandoned or separated from important people in their life. ^[36]
<u>Obsessive–compulsive</u>	Yes	Restrained, conscientious, respectful, rigid. Maintain a rule-bound lifestyle. Adhere closely to social conventions. See the world in terms of regulations and hierarchies. See themselves as devoted, reliable, efficient, and productive.
<u>Depressive</u>	No	Somber, discouraged, pessimistic, brooding, fatalistic. Present themselves as vulnerable and abandoned. Feel valueless, guilty, and impotent. Judge themselves as worthy only of criticism and contempt. Hopeless, suicidal, restless. This disorder can lead to aggressive acts and hallucinations. ^[37]
<u>Passive–aggressive (Negativistic)</u>	No	Resentful, contrary, skeptical, discontented. Resist fulfilling others' expectations. Deliberately inefficient. Vent anger indirectly by undermining others' goals. Alternately moody and irritable, then sullen and withdrawn. Withhold emotions. Will not communicate when there is something problematic to discuss. ^[38]
<u>Sadistic</u>	No	Explosively hostile, abrasive, cruel, dogmatic. Liable to sudden outbursts of rage. Gain satisfaction through dominating, intimidating and humiliating others. They are opinionated and closed-minded. Enjoy performing brutal acts on others. Find pleasure in abusing others. Would likely engage in a sadomasochist relationship, but will not play the role of a masochist. ^[39]
<u>Self-defeating (Masochistic)</u>	No	Deferential, pleasure-phobic, servile, blameful, self-effacing. Encourage others to take advantage of them. Deliberately defeat own achievements. Seek condemning or mistreatful partners. They are suspicious of people who treat them well. Would likely engage in a sadomasochist relationship. ^[40]

Additional factors

In addition to classifying by category and cluster, it is possible to classify personality disorders using additional factors such as severity, impact on social functioning, and attribution.^[41]

Severity

This involves both the notion of personality difficulty as a measure of subthreshold scores for personality disorder using standard interviews and the evidence that those with the most severe personality disorders demonstrate a "ripple effect" of personality disturbance across the whole range of mental disorders. In addition to subthreshold (personality difficulty) and single cluster (simple personality disorder), this also derives complex or diffuse personality disorder (two or more clusters of personality disorder present) and can also derive severe personality disorder for those of greatest risk.

Dimensional system of classifying personality disorders^[42]

Level of severity	Description	Definition by categorical system
0	No personality disorder	Does not meet actual or subthreshold criteria for any personality disorder
1	Personality difficulty	Meets sub-threshold criteria for one or several personality disorders
2	Simple personality disorder	Meets actual criteria for one or more personality disorders within the same cluster
3	Complex (diffuse) personality disorder	Meets actual criteria for one or more personality disorders within more than one cluster
4	Severe personality disorder	Meets criteria for creation of severe disruption to both individual and to many in society

There are several advantages to classifying personality disorder by severity:^[41]

- It not only allows for but also takes advantage of the tendency for personality disorders to be comorbid with each other.
- It represents the influence of personality disorder on clinical outcome more satisfactorily than the simple dichotomous system of no personality disorder versus personality disorder.
- This system accommodates the new diagnosis of severe personality disorder, particularly "dangerous and severe personality disorder" (DSPD).

Effect on social functioning

Social function is affected by many other aspects of mental functioning apart from that of personality. However, whenever there is persistently impaired social functioning in conditions in which it would normally not be expected, the evidence suggests that this is more likely to be created by personality abnormality than by other clinical variables.^[43] The Personality Assessment Schedule^[44] gives social function priority in creating a hierarchy in which the personality disorder creating the greater social dysfunction is given primacy over others in a subsequent description of personality disorder.

Attribution

Many who have a personality disorder do not recognize any abnormality and defend valiantly their continued occupancy of their personality role. This group have been termed the Type R, or treatment-resisting personality disorders, as opposed to the Type S or treatment-seeking ones, who are keen on altering their personality disorders and sometimes clamor for treatment.^[41] The classification of 68 personality disordered patients on the caseload of an assertive community team using a simple scale showed a 3 to 1 ratio between Type R and Type S personality disorders with Cluster C personality disorders being significantly more likely to be Type S, and paranoid and schizoid (Cluster A) personality disorders significantly more likely to be Type R than others.^[45]

Psychoanalytic theory has been used to explain treatment-resistant tendencies as egosyntonic (i.e. the patterns are consistent with the ego integrity of the individual) and are therefore perceived to be appropriate by that individual. In addition, this behavior can result in maladaptive coping skills and may lead to personal problems that induce extreme anxiety, distress, or depression and result in impaired psychosocial functioning.^[46]

Presentation

Comorbidity

There is a considerable personality disorder diagnostic co-occurrence. Patients who meet the DSM-IV-TR diagnostic criteria for one personality disorder are likely to meet the diagnostic criteria for another.^[47] Diagnostic categories provide clear, vivid descriptions of discrete personality types but the personality structure of actual patients might be more accurately described by a constellation of maladaptive personality traits.

DSM-III-R personality disorder diagnostic co-occurrence aggregated across six research sites^{[47]:1721}

Type of Personality Disorder	PPD	SzPD	StPD	ASPD	BPD	HPD	NPD	AvPD	DPD	OCPD	PAPD
Paranoid (PPD)	—	8	19	15	41	28	26	44	23	21	30
Schizoid (SzPD)	38	—	39	8	22	8	22	55	11	20	9
Schizotypal (StPD)	43	32	—	19	4	17	26	68	34	19	18
Antisocial (ASPD)	30	8	15	—	59	39	40	25	19	9	29
Borderline (BPD)	31	6	16	23	—	30	19	39	36	12	21
Histrionic (HPD)	29	2	7	17	41	—	40	21	28	13	25
Narcissistic (NPD)	41	12	18	25	38	60	—	32	24	21	38
Avoidant (AvPD)	33	15	22	11	39	16	15	—	43	16	19
Dependent (DPD)	26	3	16	16	48	24	14	57	—	15	22
Obsessive–Compulsive (OCPD)	31	10	11	4	25	21	19	37	27	—	23
Passive–Aggressive (PAPD)	39	6	12	25	44	36	39	41	34	23	—

Sites used DSM-III-R criterion sets. Data obtained for purposes of informing the development of the DSM-IV-TR personality disorder diagnostic criteria.

Abbreviations used: PPD – Paranoid Personality Disorder, SzPD – Schizoid Personality Disorder, StPD – Schizotypal Personality Disorder, ASPD – Antisocial Personality Disorder, BPD – Borderline Personality Disorder, HPD – Histrionic Personality Disorder, NPD – Narcissistic Personality Disorder, AvPD – Avoidant Personality Disorder, DPD – Dependent Personality Disorder, OCPD – Obsessive–Compulsive Personality Disorder, PAPD – Passive–Aggressive Personality Disorder.

The disorders in each of the three clusters may share with each other underlying common vulnerability factors involving cognition, affect and impulse control, and behavioral maintenance or inhibition, respectively. But they may also have a spectrum relationship to certain syndromal mental disorders.^[47]

- Paranoid, schizoid or schizotypal personality disorders may be observed to be premorbid antecedents of delusional disorders or schizophrenia.
- Borderline personality disorder is seen in association with mood and anxiety disorders, with impulse-control disorders, eating disorders, ADHD, ASD, or a substance use disorder.
- Avoidant personality disorder is seen with social anxiety disorder.

Impact on functioning

It is generally assumed that all personality disorders are linked to impaired functioning and a reduced quality of life (QoL) because that is a basic diagnostic requirement. But research shows that this may be true only for some types of personality disorder. In several studies, higher levels of disability and lower QoL were predicted by avoidant, dependent, schizoid, paranoid, schizotypal and antisocial personality disorders. This link is particularly strong for avoidant, schizotypal and borderline PD.

However, obsessive–compulsive PD was not related to a reduced QoL or increased impairment. A prospective study reported that all PD were associated with significant impairment 15 years later, except for obsessive compulsive and narcissistic personality disorder.^[48]

One study investigated some aspects of "life success" (status, wealth and successful intimate relationships). It showed somewhat poor functioning for schizotypal, antisocial, borderline and dependent PD, schizoid PD had the lowest scores regarding these variables. Paranoid, histrionic and avoidant PD were average. Narcissistic and obsessive–compulsive PD, however, had high functioning and appeared to contribute rather positively to these aspects of life success.^[9] There is also a direct relationship between the number of diagnostic criteria and quality of life. For each additional personality disorder criterion that a person meets there is an even reduction in quality of life.^[49] Personality disorders – especially dependent, narcissistic, and sadistic personality disorders – also facilitate various forms of counterproductive work behavior, including knowledge hiding and knowledge sabotage.^[50]

Issues

In the workplace

Depending on the diagnosis, severity and individual, and the job itself, personality disorders can be associated with difficulty coping with work or the workplace—potentially leading to problems with others by interfering with interpersonal relationships. Indirect effects also play a role; for example, impaired educational progress or complications outside of work, such as substance abuse and co-morbid mental disorders, can be problematic. However, personality disorders can also bring about above-average work abilities by increasing competitive drive or causing the individual with the condition to exploit his or her co-workers.^{[51][52]}

In 2005 and again in 2009, psychologists Belinda Board and Katarina Fritzson at the University of Surrey, UK, interviewed and gave personality tests to high-level British executives and compared their profiles with those of criminal psychiatric patients at Broadmoor Hospital in the UK. They found that three out of eleven personality disorders were actually more common in executives than in the disturbed criminals:

- Histrionic personality disorder: including superficial charm, insincerity, egocentricity and manipulation
- Narcissistic personality disorder: including grandiosity, self-focused lack of empathy for others, exploitativeness and independence.
- Obsessive–compulsive personality disorder: including perfectionism, excessive devotion to work, rigidity, stubbornness and dictatorial tendencies.^[53]

According to leadership academic Manfred F.R. Kets de Vries, it seems almost inevitable that some personality disorders will be present in a senior management team.^[54]

In children

Early stages and preliminary forms of personality disorders need a multi-dimensional and early treatment approach. Personality development disorder is considered to be a childhood risk factor or early stage of a later personality disorder in adulthood.^[55] In addition, in Robert F. Krueger's review of their research indicates that some children and adolescents do experience clinically significant syndromes that resemble adult personality disorders, and that these syndromes have meaningful correlates and are consequential. Much of this research has been framed by the adult personality disorder constructs from Axis II of the Diagnostic and Statistical Manual. Hence, they are less likely to encounter the first risk they described at the outset of their review: clinicians and researchers are not simply avoiding use of the PD construct in youth. However, they may encounter the second risk they described: under-appreciation of the developmental context in which these syndromes occur. That is, although PD constructs show continuity over time, they are probabilistic predictors; not all youths who exhibit PD symptomatology become adult PD cases.^[55]

Versus normal personality

The issue of the relationship between normal personality and personality disorders is one of the important issues in personality and clinical psychology. The personality disorders classification (DSM-5 and ICD-10) follows a *categorical approach* that views personality disorders as discrete entities that are distinct from each other and from normal personality. In contrast, the dimensional

approach is an alternative approach that personality disorders represent maladaptive extensions of the same traits that describe normal personality.

Thomas Widiger and his collaborators have contributed to this debate significantly.^[56] He discussed the constraints of the *categorical approach* and argued for the *dimensional approach* to the personality disorders. Specifically, he proposed the Five Factor Model of personality as an alternative to the classification of personality disorders. For example, this view specifies that Borderline Personality Disorder can be understood as a combination of emotional lability (i.e., high neuroticism), impulsivity (i.e., low conscientiousness), and hostility (i.e., low agreeableness). Many studies across cultures have explored the relationship between personality disorders and the Five Factor Model.^[57] This research has demonstrated that personality disorders largely correlate in expected ways with measures of the Five Factor Model^[58] and has set the stage for including the Five Factor Model within DSM-5.^[59]

In clinical practice, individuals are generally diagnosed by an interview with a psychiatrist based on a mental status examination, which may take into account observations by relatives and others. One tool of diagnosing personality disorders is a process involving interviews with scoring systems. The patient is asked to answer questions, and depending on their answers, the trained interviewer tries to code what their responses were. This process is fairly time-consuming.

DSM-IV-TR Personality disorders from the perspective of the five-factor model of general personality functioning^{[47]:1723} (including previous DSM revisions)

Factors	PPD	SzPD	StPD	ASPD	BPD	HPD	NPD	AvPD	DPD	OCPD	PAPD	DnPD	SDPD	SaPD
Neuroticism (vs. emotional stability)														
Anxiousness (vs. unconcerned)	—	—	High	Low	High	—	—	High	High	High	—	—	—	—
Angry hostility (vs. dispassionate)	High	—	—	High	High	—	High	—	—	—	High	—	—	—
Depressiveness (vs. optimistic)	—	—	—	—	High	—	—	—	—	—	—	High	—	—
Self-consciousness (vs. shameless)	—	—	High	Low	—	Low	Low	High	High	—	—	High	—	—
Impulsivity (vs. restrained)	—	—	—	High	High	High	—	Low	—	Low	—	—	—	—
Vulnerability (vs. fearless)	—	—	—	Low	High	—	—	High	High	—	—	—	—	—
Extraversion (vs. introversion)														
Warmth (vs. coldness)	Low	Low	Low	—	—	—	Low	—	High	—	Low	Low	—	High
Gregariousness (vs. withdrawal)	Low	Low	Low	—	—	High	—	Low	—	—	—	Low	—	High
Assertiveness (vs. submissiveness)	—	—	—	High	—	—	High	Low	Low	—	Low	—	—	—
Activity (vs. passivity)	—	Low	—	High	—	High	—	—	—	—	Low	—	High	—
Excitement seeking (vs. lifeless)	—	Low	—	High	—	High	High	Low	—	Low	—	Low	—	High
Positive emotionality (vs. anhedonia)	—	Low	Low	—	—	High	—	Low	—	—	—	—	—	High
Open-mindedness (vs. closed-minded)														
Fantasy (vs. concrete)	—	—	High	—	—	High	—	—	—	—	—	—	Low	High
Aesthetics (vs. disinterest)	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Feelings (vs. alexithymia)	—	Low	—	—	High	High	Low	—	—	Low	—	—	—	High
Actions (vs. predictable)	Low	Low	—	High	High	High	High	Low	—	Low	Low	—	Low	—
Ideas (vs. closed-minded)	Low	—	High	—	—	—	—	—	—	Low	Low	Low	Low	—
Values (vs. dogmatic)	Low	High	—	—	—	—	—	—	—	Low	—	—	High	—
Agreeableness (vs. antagonism)														
Trust (vs. mistrust)	Low	—	—	Low	—	High	Low	—	High	—	—	Low	High	Low
Straightforwardness (vs. deception)	Low	—	—	Low	—	—	Low	—	—	—	Low	—	High	Low
Altruism (vs. exploitative)	Low	—	—	Low	—	—	Low	—	High	—	—	—	High	Low
Compliance (vs. aggression)	Low	—	—	Low	—	—	Low	—	High	—	Low	—	High	Low

Modesty (vs. arrogance)	—	—	—	Low	—	—	Low	High	High	—	—	High	High	Low
Tender-mindedness (vs. tough-minded)	Low	—	—	Low	—	—	Low	—	High	—	—	—	—	Low
Conscientiousness (vs. disinhibition)														
Competence (vs. laxness)	—	—	—	—	—	—	—	—	—	High	Low	—	Low	High
Order (vs. disorderly)	—	—	Low	—	—	—	—	—	—	High	High	Low	—	—
Dutifulness (vs. irresponsibility)	—	—	—	Low	—	—	—	—	—	High	Low	High	High	—
Achievement striving (vs. lackadaisical)	—	Low	—	—	—	—	—	—	—	High	—	—	High	Low
Self-discipline (vs. negligence)	—	—	—	Low	—	Low	—	—	—	High	Low	—	High	Low
Deliberation (vs. rashness)	—	—	—	Low	Low	Low	—	—	—	High	—	High	High	Low

Abbreviations used: PPD – Paranoid Personality Disorder, SzPD – Schizoid Personality Disorder, StPD – Schizotypal Personality Disorder, ASPD – Antisocial Personality Disorder, BPD – Borderline Personality Disorder, HPD – Histrionic Personality Disorder, NPD – Narcissistic Personality Disorder, AvPD – Avoidant Personality Disorder, DPD – Dependent Personality Disorder, OCPD – Obsessive–Compulsive Personality Disorder, PAPD – Passive–Aggressive Personality Disorder, DpPD – Depressive Personality Disorder, SDPD – Self-Defeating Personality Disorder, SaPD – Sadistic Personality Disorder, and n/a – not available.

As of 2002, there were over fifty published studies relating the five factor model (FFM) to personality disorders.^[60] Since that time, quite a number of additional studies have expanded on this research base and provided further empirical support for understanding the DSM personality disorders in terms of the FFM domains.^[61] In her seminal review of the personality disorder literature published in 2007, Lee Anna Clark asserted that "the five-factor model of personality is widely accepted as representing the higher-order structure of both normal and abnormal personality traits".^[62] The five factor model has been shown to significantly predict all 10 personality disorder symptoms and outperform the Minnesota Multiphasic Personality Inventory (MMPI) in the prediction of borderline, avoidant, and dependent personality disorder symptoms.^[63]

Research results examining the relationships between the FFM and each of the ten DSM personality disorder diagnostic categories are widely available. For example, in a study published in 2003 titled "The five-factor model and personality disorder empirical literature: A meta-analytic review",^[64] the authors analyzed data from 15 other studies to determine how personality disorders are different and similar, respectively, with regard to underlying personality traits. In terms of how personality disorders differ, the results showed that each disorder displays a FFM profile that is meaningful and predictable given its unique diagnostic criteria. With regard to their similarities, the findings revealed that the most prominent and consistent personality dimensions underlying a large number of the personality disorders are positive associations with neuroticism and negative associations with agreeableness.

Openness to experience

At least three aspects of openness to experience are relevant to understanding personality disorders: cognitive distortions, lack of insight (means the ability to recognize one's own mental illness) and impulsivity. Problems related to high openness that can cause problems with social or professional functioning are excessive fantasising, peculiar thinking, diffuse identity, unstable goals and nonconformity with the demands of the society.^[65]

High openness is characteristic to schizotypal personality disorder (odd and fragmented thinking), narcissistic personality disorder (excessive self-valuation) and paranoid personality disorder (sensitivity to external hostility). Lack of insight (shows low openness) is characteristic to all personality disorders and could help explain the persistence of maladaptive behavioral patterns.^[66]

The problems associated with low openness are difficulties adapting to change, low tolerance for different worldviews or lifestyles, emotional flattening, alexithymia and a narrow range of interests.^[65] Rigidity is the most obvious aspect of (low) openness among personality disorders and that shows lack of knowledge of one's emotional experiences. It is most characteristic of obsessive–compulsive personality disorder; the opposite of it known as impulsivity (here: an aspect of openness that shows a tendency to behave unusually or autistically) is characteristic of schizotypal and borderline personality disorders.^[66]

Causes

Currently, there are no definitive proven causes for personality disorders. However, there are numerous possible causes and known risk factors supported by scientific research that vary depending on the disorder, the individual, and the circumstance. Overall, findings show that genetic disposition and life experiences, such as trauma and abuse, play a key role in the development of personality disorders.

Child abuse

Child abuse and neglect consistently show up as risk factors to the development of personality disorders in adulthood.^[67] A study looked at retrospective reports of abuse of participants that had demonstrated psychopathology throughout their life and were later found to have past experience with abuse. In a study of 793 mothers and children, researchers asked mothers if they had screamed at their children, and told them that they did not love them or threatened to send them away. Children who had experienced such verbal abuse were three times as likely as other children (who did not experience such verbal abuse) to have borderline, narcissistic, obsessive–compulsive or paranoid personality disorders in adulthood.^[68] The sexually abused group demonstrated the most consistently elevated patterns of psychopathology. Officially verified physical abuse showed an extremely strong correlation with the development of antisocial and impulsive behavior. On the other hand, cases of abuse of the neglectful type that created childhood pathology were found to be subject to partial remission in adulthood.^[67]

Socioeconomic status

Socioeconomic status has also been looked at as a potential cause for personality disorders. There is a strong association with low parental/neighborhood socioeconomic status and personality disorder symptoms.^[69] In a 2015 publication from Bonn, Germany, which compared parental socioeconomic status and a child's personality, it was seen that children who were from higher socioeconomic backgrounds were more altruistic, less risk seeking, and had overall higher IQs.^[70] These traits correlate with a low risk of developing personality disorders later on in life. In a study looking at female children who were detained for disciplinary actions found that psychological problems were most negatively associated with socioeconomic problems.^[71] Furthermore, social disorganization was found to be inversely correlated with personality disorder symptoms.^[72]

Parenting

Evidence shows personality disorders may begin with parental personality issues. These cause the child to have their own difficulties in adulthood, such as difficulties reaching higher education, obtaining jobs, and securing dependable relationships. By either genetic or modeling mechanisms, children can pick up these traits.^[69] Additionally, poor parenting appears to have symptom elevating effects on personality disorders.^[69] More specifically, lack of maternal bonding has also been correlated with personality disorders. In a study comparing 100 healthy individuals to 100 borderline personality disorder patients, analysis showed that BPD patients were significantly more likely not to have been breastfed as a baby (42.4% in BPD vs. 9.2% in healthy controls).^[73] These researchers suggested "Breastfeeding may act as an early indicator of the mother-infant relationship that seems to be relevant for bonding and attachment later in life". Additionally, findings suggest personality disorders show a negative correlation with two attachment variables: maternal availability and dependability. When left unfostered, other attachment and interpersonal problems occur later in life ultimately leading to development of personality disorders.^[74]

Genetics

Currently, genetic research for the understanding of the development of personality disorders is severely lacking. However, there are a few possible risk factors currently in discovery. Researchers are currently looking into genetic mechanisms for traits such as aggression, fear and anxiety, which are associated with diagnosed individuals. More research is being conducted into disorder specific mechanisms.^[75]

Neurobiological correlates – hippocampus, amygdala

Research shows that several brain regions are altered in personality disorders, particularly: hippocampus up to 18% smaller, a smaller amygdala, malfunctions in the striatum-nucleus accumbens and the cingulum neural pathways connecting them and taking care of the feedback loops on what to do with all the incoming information from the multiple senses; so what comes out is anti-social – not according to what is the social norm, socially acceptable and appropriate.^{[76][77]}

Management

Specific approaches

There are many different forms (modalities) of treatment used for personality disorders:^[78]

- Individual psychotherapy has been a mainstay of treatment. There are long-term and short-term (brief) forms.
- Family therapy, including couples therapy.
- Group therapy for personality dysfunction is probably the second most used.
- Psychological-education may be used as an addition.
- Self-help groups may provide resources for personality disorders.
- Psychiatric medications for treating symptoms of personality dysfunction or co-occurring conditions.
- Milieu therapy, a kind of group-based residential approach, has a history of use in treating personality disorders, including therapeutic communities.
- The practice of mindfulness that includes developing the ability to be nonjudgmentally aware of unpleasant emotions appears to be a promising clinical tool for managing different types of personality disorders.^{[79][80]}

There are different specific theories or schools of therapy within many of these modalities. They may, for example, emphasize psychodynamic techniques, or cognitive or behavioral techniques. In clinical practice, many therapists use an 'eclectic' approach, taking elements of different schools as and when they seem to fit to an individual client. There is also often a focus on common themes that seem to be beneficial regardless of techniques, including attributes of the therapist (e.g. trustworthiness, competence, caring), processes afforded to the client (e.g. ability to express and confide difficulties and emotions), and the match between the two (e.g. aiming for mutual respect, trust and boundaries).

Response of patients with personality disorders to biological and psychosocial treatments^{[47]:36}

Cluster	Evidence for <u>brain dysfunction</u>	Response to biological treatments	Response to psychosocial treatments
A	Evidence for relationship of schizotypal personality to <u>schizophrenia</u> ; otherwise none known.	Schizotypal patients may improve on <u>antipsychotic</u> medication; otherwise not indicated.	Poor. <u>Supportive psychotherapy</u> may help.
B	Evidence suggestive for antisocial and borderline personalities; otherwise none known.	<u>Antidepressants</u> , <u>antipsychotics</u> , or <u>mood stabilizers</u> may help for borderline personality; otherwise not indicated.	Poor in antisocial personality. Variable in borderline, narcissistic, and histrionic personalities.
C	None known.	No direct response. Medications may help with comorbid <u>anxiety</u> and <u>depression</u> .	Most common treatment for these disorders. Response variable.

Despite the lack of evidence supporting the benefit of antipsychotics in people with personality disorders, 1 in 4 who do not have a serious mental illness are prescribed them in UK primary care. Many people receive these medication for over a year, contrary to NICE guidelines.^{[81][82]}

Challenges

The management and treatment of personality disorders can be a challenging and controversial area, for by definition the difficulties have been enduring and affect multiple areas of functioning. This often involves interpersonal issues, and there can be difficulties in seeking and obtaining help from organizations in the first place, as well as with establishing and maintaining a specific therapeutic relationship. On the one hand, an individual may not consider themselves to have a mental health problem, while on the other, community mental health services may view individuals with personality disorders as too complex or difficult, and may directly or indirectly exclude individuals with such diagnoses or associated behaviors.^[83] The disruptiveness that people with personality disorders can create in an organisation makes these, arguably, the most challenging conditions to manage.

Apart from all these issues, an individual may not consider their personality to be disordered or the cause of problems. This perspective may be caused by the patient's ignorance or lack of insight into their own condition, an ego-syntonic perception of the problems with their personality that prevents them from experiencing it as being in conflict with their goals and self-image, or by the simple fact that there is no distinct or objective boundary between 'normal' and 'abnormal' personalities. There is substantial social stigma and discrimination related to the diagnosis.

The term 'personality disorder' encompasses a wide range of issues, each with a different level of severity or impairment; thus, personality disorders can require fundamentally different approaches and understandings. To illustrate the scope of the matter, consider that while some disorders or individuals are characterized by continual social withdrawal and the shunning of relationships, others may cause fluctuations in forwardness. The extremes are worse still: at one extreme lie self-harm and self-neglect, while at another extreme some individuals may commit violence and crime. There can be other factors such as problematic substance use or dependency or behavioral addictions.

Therapists in this area can become disheartened by lack of initial progress, or by apparent progress that then leads to setbacks. Clients may be perceived as negative, rejecting, demanding, aggressive or manipulative. This has been looked at in terms of both therapist and client; in terms of social skills, coping efforts, defense mechanisms, or deliberate strategies; and in terms of moral judgments or the need to consider underlying motivations for specific behaviors or conflicts. The vulnerabilities of a client, and indeed a therapist, may become lost behind actual or apparent strength and resilience. It is commonly stated that there is always a need to maintain appropriate professional personal boundaries, while allowing for emotional expression and therapeutic relationships. However, there can be difficulty acknowledging the different worlds and views that both the client and therapist may live with. A therapist may assume that the kinds of relationships and ways of interacting that make them feel safe and comfortable have the same effect on clients. As an example of one extreme, people who may have been exposed to hostility, deceptiveness, rejection, aggression or abuse in their lives, may in some cases be made confused, intimidated or suspicious by presentations of warmth, intimacy or positivity. On the other hand, reassurance, openness and clear communication are usually helpful and needed. It can take several months of sessions, and perhaps several stops and starts, to begin to develop a trusting relationship that can meaningfully address a client's issues.^[84]

Epidemiology

The prevalence of personality disorder in the general community was largely unknown until surveys starting from the 1990s. In 2008 the median rate of diagnosable PD was estimated at 10.6%, based on six major studies across three nations. This rate of around one in ten, especially as associated with high use of cocaine, is described as a major public health concern requiring attention by researchers and clinicians.^[85] The prevalence of individual personality disorders ranges from about 2% to 8% for the more common varieties, such as obsessive-compulsive, schizotypal, antisocial, borderline, and histrionic, to 0.5–1% for the least common, such as narcissistic and avoidant.^{[86][47]}

A screening survey across 13 countries by the World Health Organization using DSM-IV criteria, reported in 2009 a prevalence estimate of around 6% for personality disorders. The rate sometimes varied with demographic and socioeconomic factors, and functional impairment was partly explained by co-occurring mental disorders.^[87] In the US, screening data from the National Comorbidity Survey Replication between 2001 and 2003, combined with interviews of a subset of respondents, indicated a population prevalence of around 9% for personality disorders in total. Functional disability associated with the diagnoses appeared to be largely due to co-occurring mental disorders (Axis I in the DSM).^[88] This statistic has been supported by other studies in the US, with overall global prevalence statistics ranging from 9% to 11%.^{[89][90]}

A UK national epidemiological study (based on DSM-IV screening criteria), reclassified into levels of severity rather than just diagnosis, reported in 2010 that the majority of people show some personality difficulties in one way or another (short of threshold for diagnosis), while the prevalence of the most complex and severe cases (including meeting criteria for multiple

diagnoses in different clusters) was estimated at 1.3%. Even low levels of personality symptoms were associated with functional problems, but the most severely in need of services was a much smaller group.^[91] Personality disorders (especially Cluster A) are found more commonly among homeless people.^[92]

There are some sex differences in the frequency of personality disorders which are shown in the table below.^{[93]:206} The known prevalence of some personality disorders, especially borderline PD and antisocial PD are affected by diagnostic bias. This is due to many factors including disproportionately high research towards borderline PD and antisocial PD, alongside social and gender stereotypes, and the relationship between diagnosis rates and prevalence rates.^[86] Since the removal of depressive PD, self-defeating PD, sadistic PD and passive-aggressive PD from the DSM-5, studies analysing their prevalence and demographics have been limited.

Sex differences in the frequency of personality disorders

Type of personality disorder	Predominant sex	Notes
<u>Paranoid personality disorder</u>	Inconclusive	In clinical samples men have higher rates, whereas epidemiologically there is a reported higher rate of women ^[94] although due to the controversy of paranoid personality disorder the usefulness of these results is disputed ^{[86][95]}
<u>Schizoid personality disorder</u>	Male	About 10% more common in males ^[96]
<u>Schizotypal personality disorder</u>	Inconclusive	The DSM-5 reports it is slightly more common in males, although other results suggest a prevalence of 4.2% in women and 3.7% in men ^{[1][97]}
<u>Antisocial personality disorder</u>	Male	About three times more common in men, ^[98] with rates substantially higher in prison populations, up to almost 50% in some prison populations ^[98]
<u>Borderline personality disorder</u>	Female	Diagnosis rates vary from about three times more common in women, to only a minor predominance of women over men. This is partially attributable to increased rates of treatment-seeking in women, although disputed ^{[86][94]}
<u>Histrionic personality disorder</u>	Equal	Prevalence rates are equal, although diagnostic rates can favour women ^{[99][94][86]}
<u>Narcissistic personality disorder</u>	Male	7.7% for men, 4.8% for women ^{[100][101]}
<u>Avoidant personality disorder</u>	Equal ^[86]	
<u>Dependent personality disorder</u>	Female	0.6% in women, 0.4% in men ^{[94][86]}
<u>Depressive personality disorder</u>	N/A	No longer present in the DSM-5 and no longer widely used ^[1]
<u>Passive-aggressive personality disorder</u>	N/A	No longer present in the DSM-5 and no longer widely used ^{[1][102]}
<u>Obsessive-compulsive personality disorder</u>	Inconclusive	The DSM-5 lists a male-to-female ratio of 2:1, however other studies have found equal rates ^[103]
<u>Self-defeating personality disorder</u>	Female ^[104]	Removed since the DSM-IV, not present in the DSM-5 ^[1]
<u>Sadistic personality disorder</u>	Male ^[105]	Removed since the DSM-IV, not present in the DSM-5 ^[1]

History

Diagnostic and Statistical Manual history

Personality disorder diagnoses in each edition of the Diagnostic and Statistical Manual^{[18][93]: 17}

DSM-I	DSM-II	DSM-III	DSM-III-R	DSM-IV(-TR)	DSM-5
Inadequate ^[a]	Inadequate	Deleted ^{[93]: 19}	—	—	—
Schizoid ^[a]	Schizoid	Schizoid	Schizoid	Schizoid	Schizoid
Cyclothymic ^[a]	Cyclothymic	Reclassified ^{[93]: 16, 19}	—	—	—
Paranoid ^[a]	Paranoid	Paranoid	Paranoid	Paranoid	Paranoid
—	—	Schizotypal	Schizotypal	Schizotypal	Schizotypal ^[b]
Emotionally unstable ^[c]	Hysterical ^{[93]: 18}	Histrionic	Histrionic	Histrionic	Histrionic
—	—	Borderline ^{[93]: 19}	Borderline	Borderline	Borderline
Compulsive ^[c]	Obsessive-compulsive	Compulsive	Obsessive-compulsive	Obsessive-compulsive	Obsessive-compulsive
Passive-aggressive,	Deleted ^{[93]: 18}	Dependent ^{[93]: 19}	Dependent	Dependent	Dependent

Passive–dependent subtype ^[c]					
Passive–aggressive, Passive–aggressive subtype ^[c]	Passive–aggressive	Passive–aggressive	Passive–aggressive	Deleted ^{[d][106]: 629}	—
Passive–aggressive, Aggressive subtype ^[c]	—	—	—	—	—
—	Explosive ^{[93]: 18}	Deleted ^{[93]: 19}	—	—	—
—	Asthenic ^{[93]: 18}	Deleted ^{[93]: 19}	—	—	—
—	—	Avoidant ^{[93]: 19}	Avoidant	Avoidant	Avoidant
—	—	Narcissistic ^{[93]: 19}	Narcissistic	Narcissistic	Narcissistic
Antisocial reaction ^[e]	Antisocial	Antisocial	Antisocial	Antisocial	Antisocial
Dyssocial reaction ^[e]	—	—	—	—	—
Sexual deviation ^[e]	Reclassified ^{[93]: 16, 18}	—	—	—	—
Addiction ^[e]	Reclassified ^{[93]: 16, 18}	—	—	—	—
Appendix					
			Self-defeating	Passive-aggressive (Negativistic) ^{[106]: 733}	Personality disorder - Trait specified
			Sadistic	Depressive	

 Introduced Deleted

- a. DSM-I Personality Pattern disturbance subsection.^{[93]: 16}
- b. Also classified as a schizophrenia-spectrum disorder in addition to personality disorder.
- c. DSM-I Personality Trait disturbance subsection.^{[93]: 16}
- d. Excluded from formal diagnoses and moved to Appendix.
- e. DSM-I Sociopathic personality disturbance subsection.^{[93]: 16}

Before the 20th century

Personality disorder is a term with a distinctly modern meaning, owing in part to its clinical usage and the institutional character of modern psychiatry. The currently accepted meaning must be understood in the context of historical changing classification systems such as DSM-IV and its predecessors. Although highly anachronistic, and ignoring radical differences in the character of subjectivity and social relations, some have suggested similarities to other concepts going back to at least the ancient Greeks.^{[3]: 35} For example, the Greek philosopher Theophrastus described 29 'character' types that he saw as deviations from the norm, and similar views have been found in Asian, Arabic and Celtic cultures. A long-standing influence in the Western world was Galen's concept of personality types, which he linked to the four humours proposed by Hippocrates.

Such views lasted into the eighteenth century, when experiments began to question the supposed biologically based humours and 'temperaments'. Psychological concepts of character and 'self' became widespread. In the nineteenth century, 'personality' referred to a person's conscious awareness of their behavior, a disorder of which could be linked to altered states such as dissociation. This sense of the term has been compared to the use of the term 'multiple personality disorder' in the first versions of the DSM.^[107]

Physicians in the early nineteenth century started to diagnose forms of insanity involving disturbed emotions and behaviors but seemingly without significant intellectual impairment or delusions or hallucinations. Philippe Pinel referred to this as ' *manie sans délire* ' – mania without delusions – and described a number of cases mainly involving excessive or inexplicable anger or rage.

James Cowles Prichard advanced a similar concept he called moral insanity, which would be used to diagnose patients for some decades. 'Moral' in this sense referred to affect (emotion or mood) rather than ethics, but it was arguably based in part on religious, social and moral beliefs, with a pessimism about medical intervention so social control should take precedence.^[108] These categories were much different and broader than later definitions of personality disorder, while also being developed by some into a more specific meaning of moral degeneracy akin to later ideas about 'psychopaths'. Separately, Richard von Krafft-Ebing popularized the terms sadism and masochism, as well as homosexuality, as psychiatric issues.

The German psychiatrist Koch sought to make the moral insanity concept more scientific, and in 1891 suggested the phrase 'psychopathic inferiority', theorized to be a congenital disorder. This referred to continual and rigid patterns of misconduct or dysfunction in the absence of apparent "mental retardation" or illness, supposedly without a moral judgment. Described as deeply rooted in his Christian faith, his work established the concept of personality disorder as used today.^[109]

20th century

In the early 20th century, another German psychiatrist, Emil Kraepelin, included a chapter on psychopathic inferiority in his influential work on clinical psychiatry for students and physicians. He suggested six types – excitable, unstable, eccentric, liar, swindler and quarrelsome. The categories were essentially defined by the most disordered criminal offenders observed, distinguished between criminals by impulse, professional criminals, and morbid vagabonds who wandered through life. Kraepelin also described three paranoid (meaning then delusional) disorders, resembling later concepts of schizophrenia, delusional disorder and paranoid personality disorder. A diagnostic term for the latter concept would be included in the DSM from 1952, and from 1980 the DSM would also include schizoid, schizotypal; interpretations of earlier (1921) theories of Ernst Kretschmer led to a distinction between these and another type later included in the DSM, avoidant personality disorder.

In 1933 Russian psychiatrist Pyotr Borisovich Gannushkin published his book *Manifestations of Psychopathies: Statics, Dynamics, Systematic Aspects*, which was one of the first attempts to develop a detailed typology of psychopathies. Regarding maladaptation, ubiquity, and stability as the three main symptoms of behavioral pathology, he distinguished nine clusters of psychopaths: cycloids (including constitutionally depressive, constitutionally excitable, cyclothymics, and emotionally labile), asthenics (including psychasthenics), schizoids (including dreamers), paranoiacs (including fanatics), epileptoids, hysterical personalities (including pathological liars), unstable psychopaths, antisocial psychopaths, and constitutionally stupid.^[110] Some elements of Gannushkin's typology were later incorporated into the theory developed by a Russian adolescent psychiatrist, Andrey Yevgenyevich Lichko, who was also interested in psychopathies along with their milder forms, the so-called accentuations of character.^[111]

In 1939, psychiatrist David Henderson published a theory of 'psychopathic states' that contributed to popularly linking the term to anti-social behavior. Hervey M. Cleckley's 1941 text, *The Mask of Sanity*, based on his personal categorization of similarities he noted in some prisoners, marked the start of the modern clinical conception of psychopathy and its popularist usage.^[112]

Towards the mid 20th century, psychoanalytic theories were coming to the fore based on work from the turn of the century being popularized by Sigmund Freud and others. This included the concept of *character disorders*, which were seen as enduring problems linked not to specific symptoms but to pervasive internal conflicts or derailments of normal childhood development. These were often understood as weaknesses of character or willful deviance, and were distinguished from neurosis or psychosis. The term 'borderline' stems from a belief some individuals were functioning on the edge of those two categories, and a number of the other personality disorder categories were also heavily influenced by this approach, including dependent, obsessive–compulsive and histrionic,^[113] the latter starting off as a conversion symptom of hysteria particularly associated with women, then a hysterical personality, then renamed histrionic personality disorder in later versions of the DSM. A passive aggressive style was defined clinically by Colonel William Menninger during World War II in the context of men's reactions to military compliance, which would later be referenced as a personality disorder in the DSM.^[114] Otto Kernberg was influential with regard to the concepts of borderline and narcissistic personalities later incorporated in 1980 as disorders into the DSM.

Meanwhile, a more general personality psychology had been developing in academia and to some extent clinically. Gordon Allport published theories of personality traits from the 1920s—and Henry Murray advanced a theory called *personology*, which influenced a later key advocate of personality disorders, Theodore Millon. Tests were developing or being applied for personality evaluation, including projective tests such as the Rorschach test, as well as questionnaires such as the Minnesota Multiphasic Personality Inventory. Around mid-century, Hans Eysenck was analysing traits and personality types, and psychiatrist Kurt Schneider was popularising a clinical use in place of the previously more usual terms 'character', 'temperament' or 'constitution'.

American psychiatrists officially recognized concepts of enduring personality disturbances in the first Diagnostic and Statistical Manual of Mental Disorders in the 1950s, which relied heavily on psychoanalytic concepts. Somewhat more neutral language was employed in the DSM-II in 1968, though the terms and descriptions had only a slight resemblance to current definitions. The DSM-III published in 1980 made some major changes, notably putting all personality disorders onto a second separate 'axis' along with "mental retardation", intended to signify more enduring patterns, distinct from what were considered axis one mental disorders. 'Inadequate' and 'asthenic' personality disorder' categories were deleted, and others were expanded into more types, or changed from being personality disorders to regular disorders. Sociopathic personality disorder, which had been the term for psychopathy, was renamed Antisocial Personality Disorder. Most categories were given more specific 'operationalized' definitions, with standard criteria psychiatrists could agree on to conduct research and diagnose patients.^[115] In the DSM-III revision, self-defeating personality disorder and sadistic personality disorder were included as provisional diagnoses requiring further study. They were dropped in the DSM-IV, though a proposed 'depressive personality disorder' was added; in addition, the official diagnosis of passive-aggressive personality disorder was dropped, tentatively renamed 'negativistic personality disorder'.^[116]

International differences have been noted in how attitudes have developed towards the diagnosis of personality disorder. Kurt Schneider argued they were 'abnormal varieties of psychic life' and therefore not necessarily the domain of psychiatry, a view said to still have influence in Germany today. British psychiatrists have also been reluctant to address such disorders or consider them on par with other mental disorders, which has been attributed partly to resource pressures within the National Health Service, as well as to negative medical attitudes towards behaviors associated with personality disorders. In the US, the prevailing healthcare system and psychoanalytic tradition has been said to provide a rationale for private therapists to diagnose some personality disorders more broadly and provide ongoing treatment for them.^[117]

See also



- Paranoid personality disorder
- Schizoid personality disorder
- Schizotypal personality disorder
- Antisocial personality disorder
- Borderline personality disorder
- Histrionic personality disorder
- Narcissistic personality disorder
- Avoidant personality disorder
- Dependent personality disorder
- Obsessive-compulsive personality disorder
- Depressive personality disorder
- Passive-aggressive personality disorder
- Sadistic personality disorder
- Self-defeating personality disorder

References

1. American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders* (<https://books.google.com/books?id=-JivBAAAQBAJ>) (Fifth ed.). Arlington, VA: American Psychiatric Publishing. pp. 646–49. ISBN 978-0-89042-555-8.
2. Magnavita JJ (2004). "Chapter 1: Classification, prevalence, and etiology of personality disorders: Related issues and controversy". *Handbook of personality disorders : theory and practice* (<http://worldcat.org/oclc/52429596>). Wiley. ISBN 0-471-20116-2. OCLC 52429596 (<https://www.worldcat.org/oclc/52429596>).
3. Millon T, Davis RD (1996). *Disorders of Personality: DSM-IV and Beyond*. New York: John Wiley & Sons, Inc. p. 226. ISBN 978-0-471-01186-6.
4. Berrios GE (1993). "European views on personality disorders: a conceptual history". *Comprehensive Psychiatry*. **34** (1): 14–30. doi:10.1016/0010-440X(93)90031-X (<https://doi.org/10.1016%2F0010-440X%2893%2990031-X>). PMID 8425387 (<https://pubmed.ncbi.nlm.nih.gov/8425387>).

5. Beckwith H, Moran PF, Reilly J (May 2014). "Personality disorder prevalence in psychiatric outpatients: a systematic literature review". *Personality and Mental Health*. **8** (2): 91–101. doi:10.1002/pmh.1252 (<https://doi.org/10.1002%2Fpmh.1252>). PMID 24431304 (<https://pubmed.ncbi.nlm.nih.gov/24431304>).
6. Tyrer P, Reed GM, Crawford MJ (February 2015). "Classification, assessment, prevalence, and effect of personality disorder". *Lancet*. **385** (9969): 717–726. doi:10.1016/s0140-6736(14)61995-4 (<https://doi.org/10.1016%2Fs0140-6736%2814%2961995-4>). PMID 25706217 (<https://pubmed.ncbi.nlm.nih.gov/25706217>). S2CID 25755526 (<https://api.semanticscholar.org/CorpusID:25755526>).
7. Saß H (2001). "Personality Disorders". *International Encyclopedia of the Social & Behavioral Sciences*: 11301–11308. doi:10.1016/B0-08-043076-7/03763-3 (<https://doi.org/10.1016%2FB0-08-043076-7%2F03763-3>). ISBN 978-0-08-043076-8.
8. Kernberg OF (1984). *Severe personality disorders : psychotherapeutic strategies*. New Haven: Yale University Press. ISBN 978-0-300-05349-4.
9. Ullrich S, Farrington DP, Coid JW (December 2007). "Dimensions of DSM-IV personality disorders and life-success". *Journal of Personality Disorders*. **21** (6): 657–663. doi:10.1521/pedi.2007.21.6.657 (<https://doi.org/10.1521%2Fpedi.2007.21.6.657>). PMID 18072866 (<https://pubmed.ncbi.nlm.nih.gov/18072866>). S2CID 30040457 (<https://api.semanticscholar.org/CorpusID:30040457>).
10. Panos PT, Jackson JW, Hasan O, Panos A (March 2014). "Meta-Analysis and Systematic Review Assessing the Efficacy of Dialectical Behavior Therapy (DBT)" (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6405261>). *Research on Social Work Practice*. **24** (2): 213–223. doi:10.1177/1049731513503047 (<https://doi.org/10.1177%2F1049731513503047>). PMC 6405261 (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6405261>). PMID 30853773 (<https://pubmed.ncbi.nlm.nih.gov/30853773>).
11. Kliem S, Kröger C, Kosfelder J (December 2010). "Dialectical behavior therapy for borderline personality disorder: a meta-analysis using mixed-effects modeling". *Journal of Consulting and Clinical Psychology*. **78** (6): 936–951. doi:10.1037/a0021015 (<https://doi.org/10.1037%2Fa0021015>). PMID 21114345 (<https://pubmed.ncbi.nlm.nih.gov/21114345>).
12. Budge SL, Moore JT, Del Re AC, Wampold BE, Baardseth TP, Nienhuis JB (December 2013). "The effectiveness of evidence-based treatments for personality disorders when comparing treatment-as-usual and bona fide treatments". *Clinical Psychology Review*. **33** (8): 1057–1066. doi:10.1016/j.cpr.2013.08.003 (<https://doi.org/10.1016%2Fj.cpr.2013.08.003>). PMID 24060812 (<https://pubmed.ncbi.nlm.nih.gov/24060812>).
13. "There are few disorders that carry such a stigma as personality disorders" (<https://web.archive.org/web/20231027075635/https://www.helpseeker.net/Personality-disorders/there-are-few-disorders-that-carry-such-a-stigma-as-personality-disorders>). *Helpseeker.net*. Archived from the original (<https://www.helpseeker.net/Personality-disorders/there-are-few-disorders-that-carry-such-a-stigma-as-personality-disorders>) on 27 October 2023. Retrieved 6 December 2020.
14. McWilliams N (29 July 2011). *Psychoanalytic Diagnosis, Second Edition: Understanding Personality Structure in the Clinical Process* (<https://books.google.com/books?id=BzPOAWB2DncC&pg=PA196>). Guilford Press. pp. 196–. ISBN 978-1-60918-494-0.
15. Widiger TA (October 2003). "Personality disorder diagnosis" (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1525106>). *World Psychiatry*. **2** (3): 131–135. PMC 1525106 (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1525106>). PMID 16946918 (<https://pubmed.ncbi.nlm.nih.gov/16946918>).
16. "The ICD-10 Classification of Mental and Behavioural Disorders" (<http://www.who.int/classifications/icd/en/GRNBOOK.pdf>) (PDF). World Health Organization. *The ICD-10 classification of mental and behavioural disorders: diagnostic criteria for research* (<https://apps.who.int/iris/bitstream/handle/10665/37108/9241544554.pdf>) (PDF). Geneva: World Health Organization. 1993. p. 104. ISBN 92-4-154455-4. OCLC 29457599 (<https://www.worldcat.org/oclc/29457599>). *The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines* (https://apps.who.int/iris/bitstream/handle/10665/37958/9241544228_eng.pdf) (PDF). Geneva: World Health Organization. 1992. p. 160. ISBN 92-4-154422-8. OCLC 28294867 (<https://www.worldcat.org/oclc/28294867>). *Diagnostic and Statistical Manual of Mental Disorders: DSM-III-R*. Washington, D.C.: American Psychiatric Association. 1987. pp. 269–272. ISBN 0-89042-018-1.
17. A Guide to DSM-5: Personality Disorders (http://www.medscape.com/viewarticle/803884_8) Medscape Psychiatry, Bret S. Stetka, MD, Christoph U. Correll, 21 May 2013
18. "Alternative DSM-5 Model for Personality Disorders" (<https://books.google.com/books?id=-JivBAAQBAJ>). *Diagnostic and Statistical Manual of Mental Disorders* (<https://archive.org/details/diagnosticstatis0005unse/page/234>) (Fifth ed.). American Psychiatric Association. 2013. pp. 234–236 (<https://archive.org/details/diagnosticstatis0005unse/page/234>). doi:10.1176/appi.books.9780890425596.156852 (<https://doi.org/10.1176%2Fappi.books.9780890425596.156852>). ISBN 978-0-89042-555-8.
19. "Personality disorders - Symptoms and causes" (<https://www.mayoclinic.org/diseases-conditions/personality-disorders/symptoms-causes/syc-20354463>). *Mayo Clinic*. Retrieved 26 January 2019.

20. Esterberg ML, Goulding SM, Walker EF (December 2010). "Cluster A Personality Disorders: Schizotypal, Schizoid and Paranoid Personality Disorders in Childhood and Adolescence" (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2992453>). *Journal of Psychopathology and Behavioral Assessment*. **32** (4): 515–528. doi:10.1007/s10862-010-9183-8 (<https://doi.org/10.1007/s10862-010-9183-8>). PMC 2992453 (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2992453>). PMID 21116455 (<https://pubmed.ncbi.nlm.nih.gov/21116455>).
21. Niedtfeld I (July 2017). "Experimental investigation of cognitive and affective empathy in borderline personality disorder: Effects of ambiguity in multimodal social information processing". *Psychiatry Research*. **253**: 58–63. doi:10.1016/j.psychres.2017.03.037 (<https://doi.org/10.1016/j.psychres.2017.03.037>). PMID 28351003 (<https://pubmed.ncbi.nlm.nih.gov/28351003>). S2CID 13764666 (<https://api.semanticscholar.org/CorpusID:13764666>).
22. Lenzenweger MF, Clarkin JF, Caligor E, Cain NM, Kernberg OF (2018). "Malignant Narcissism in Relation to Clinical Change in Borderline Personality Disorder: An Exploratory Study". *Psychopathology*. **51** (5): 318–325. doi:10.1159/000492228 (<https://doi.org/10.1159/000492228>). PMID 30184541 (<https://pubmed.ncbi.nlm.nih.gov/30184541>). S2CID 52160230 (<https://api.semanticscholar.org/CorpusID:52160230>).
23. "ICD-11 for Mortality and Morbidity Statistics" (<https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/941859884>). *icd.who.int*. Retrieved 28 April 2022.
24. "Disorders of adult personality and behaviour (F60–F69)" (<https://www.who.int/classifications/icd/en/bluebook.pdf>) (PDF). *The ICD-10 Classification of Mental and Behavioural Disorders – Clinical descriptions and diagnostic guidelines*. WHO (2010). pp. 157–58.
25. WHO (2010) ICD-10: Specific Personality Disorders (<http://apps.who.int/classifications/icd10/browse/2010/en#/F60>)
26. "International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) Version for 2010 (Online Version)" (<https://web.archive.org/web/20181210205620/http://behaviouralsciences.net/classifications/icd10/browse/2010/en#/F60-F69>). Apps.who.int. Retrieved on 16 April 2013.
27. Fuller AK, Blashfield RK, Miller M, Hester T (November 1992). "Sadistic and self-defeating personality disorder criteria in a rural clinic sample". *Journal of Clinical Psychology*. **48** (6): 827–831. doi:10.1002/1097-4679(199211)48:6<827::AID-JCLP2270480618>3.0.CO;2-1 ([https://doi.org/10.1002/1097-4679\(199211\)48:6<827::AID-JCLP2270480618>3.0.CO;2-1](https://doi.org/10.1002/1097-4679(199211)48:6<827::AID-JCLP2270480618>3.0.CO;2-1)). PMID 1452772 (<https://pubmed.ncbi.nlm.nih.gov/1452772>).
28. Theodore Millon (2004). *Personality Disorders in Modern Life* (http://dlia.ir/Scientific/e_book/Medicine/Internal_Medicine/RC_435_571_Psychiatry_/017437.pdf) Archived (https://web.archive.org/web/20170207112700/http://dlia.ir/Scientific/e_book/Medicine/Internal_Medicine/RC_435_571_Psychiatry_/017437.pdf) 7 February 2017 at the Wayback Machine. Wiley, 2nd Edition. ISBN 0-471-23734-5. (GoogleBooks Preview (<https://books.google.com/books?id=BZjayfSEGyQC>)).
29. "Paranoid Personality Disorder (PPD): Symptoms & Treatment" (<https://my.clevelandclinic.org/health/diseases/9784-paranoid-personality-disorder>). *Cleveland Clinic*. Retrieved 29 December 2023.
30. "Overview – Schizoid personality disorder" (<http://www.mayoclinic.org/diseases-conditions/schizoid-personality-disorder/basics/definition/con-20029184>). Mayo Clinic. 12 July 2016. Retrieved 28 December 2016.
31. "Overview – Schizotypal personality disorder" (<http://www.mayoclinic.org/diseases-conditions/schizotypal-personality-disorder/basics/definition/con-20027949>). Mayo Clinic. 1 April 2016. Retrieved 28 December 2016.
32. Medline Plus. Antisocial personality disorder, 2018. <https://medlineplus.gov/ency/article/000921.htm>
33. *Diagnostic and statistical manual of mental disorders: DSM-5*. American Psychiatric Association. 2013.
34. French JH, Shrestha S (2023), "Histrionic Personality Disorder" (<http://www.ncbi.nlm.nih.gov/books/NBK542325/>), *StatPearls*, Treasure Island (FL): StatPearls Publishing, PMID 31194465 (<https://pubmed.ncbi.nlm.nih.gov/31194465>), retrieved 29 December 2023
35. "Avoidant Personality Disorder" (<https://my.clevelandclinic.org/health/diseases/9761-avoidant-personality-disorder>). *Cleveland Clinic*. Retrieved 29 December 2023.
36. "Dependent Personality Disorder" (<https://my.clevelandclinic.org/health/diseases/9783-dependent-personality-disorder>). *Cleveland Clinic*. Retrieved 29 December 2023.
37. Huprich SK (1 August 1998). "Depressive personality disorder: Theoretical issues, clinical findings, and future research questions" (<https://www.sciencedirect.com/science/article/pii/S0272735897001049>). *Clinical Psychology Review*. **18** (5): 477–500. doi:10.1016/S0272-7358(97)00104-9 ([https://doi.org/10.1016/S0272-7358\(97\)00104-9](https://doi.org/10.1016/S0272-7358(97)00104-9)). ISSN 0272-7358 (<https://www.worldcat.org/issn/0272-7358>). PMID 9740975 (<https://pubmed.ncbi.nlm.nih.gov/9740975>).
38. Hopwood CJ, Morey LC, Markowitz JC, Pinto A, Skodol AE, Gunderson JG, et al. (2009). "The Construct Validity of Passive-Aggressive Personality Disorder" (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2862968>). *Psychiatry*. **72** (3): 256–267. doi:10.1521/psyc.2009.72.3.256 (<https://doi.org/10.1521/psyc.2009.72.3.256>). ISSN 0033-2747 (<https://www.worldcat.org/issn/0033-2747>). PMC 2862968 (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2862968>). PMID 19821648 (<https://pubmed.ncbi.nlm.nih.gov/19821648>).

39. Myers WC, Burket RC, Husted DS (1 January 2006). "Sadistic Personality Disorder and Comorbid Mental Illness in Adolescent Psychiatric Inpatients" (<https://jaapl.org/content/34/1/61>). *Journal of the American Academy of Psychiatry and the Law Online*. **34** (1): 61–71. ISSN 1093-6793 (<https://www.worldcat.org/issn/1093-6793>). PMID 16585236 (<https://pubmed.ncbi.nlm.nih.gov/16585236>).
40. "APA Dictionary of Psychology: Masochistic personality disorder" (<https://dictionary.apa.org/masochistic-personality-disorder>). American Psychological Association. 19 March 2018. Retrieved 29 December 2023.
41. Murray, Robin M. et al (2008). *Psychiatry. Fourth Edition*. Cambridge University Press. ISBN 978-0-521-60408-6.
42. Tyrer, P. (2000) *Personality Disorders: Diagnosis, Management and Course. Second Edition*. London: Arnold Publishers Ltd., pp. 126–32. ISBN 9780723607366.
43. Nur U, Tyrer P, Merson S, Johnson T (March 2004). "Social function, clinical symptoms and personality disturbance". *Irish Journal of Psychological Medicine*. **21** (1): 18–21. doi:10.1017/S0790966700008090 (<https://doi.org/10.1017%2FS0790966700008090>). PMID 30308726 (<https://pubmed.ncbi.nlm.nih.gov/30308726>). S2CID 52962308 (<https://api.semanticscholar.org/CorpusID:52962308>).
44. Standage KF (September 1979). "The use of Schneider's typology for the diagnosis of personality disorders--an examination of reliability". *The British Journal of Psychiatry*. **135** (2): 238–242. doi:10.1192/bjp.135.2.163 (<http://doi.org/10.1192%2Fbjp.135.2.163>). PMID 486849 (<https://pubmed.ncbi.nlm.nih.gov/486849>). S2CID 3182563 (<https://api.semanticscholar.org/CorpusID:3182563>).
45. Tyrer P, Mitchard S, Methuen C, Ranger M (June 2003). "Treatment rejecting and treatment seeking personality disorders: Type R and Type S". *Journal of Personality Disorders*. **17** (3): 263–268. doi:10.1521/pedi.17.3.263.22152 (<https://doi.org/10.1521%2Fpedi.17.3.263.22152>). PMID 12839104 (<https://pubmed.ncbi.nlm.nih.gov/12839104>).
46. Blumenthal S (3 April 2014). "Psychoanalytic diagnosis: understanding personality structure in the clinical process". *Psychoanalytic Psychotherapy*. **28** (2) (2nd ed.): 233–234. doi:10.1080/02668734.2014.909673 (<http://doi.org/10.1080%2F02668734.2014.909673>). ISSN 0266-8734 (<https://www.worldcat.org/issn/0266-8734>). S2CID 144761197 (<https://api.semanticscholar.org/CorpusID:144761197>).
47. Tasman, Allan et al (2008). *Psychiatry. Third Edition*. John Wiley & Sons, Ltd. ISBN 978-0470-06571-6.
48. Emmelkamp PM (2013). *Personality Disorders* (<https://books.google.com/books?id=RwNmAgAAQBAJ&pg=PA54>). Psychology Press. pp. 54–56. ISBN 978-1-317-83477-9.
49. Torgersen S (2014). "Prevalence, Sociodemographics and Functional Impairment" (<https://books.google.com/books?id=TIKTAAwAAQBAJ&pg=PA126>). *The American Psychiatric Publishing textbook of personality disorders* (Second ed.). Washington, DC. pp. 122–26. ISBN 978-1-58562-456-0. OCLC 601366312 (<https://www.worldcat.org/oclc/601366312>).
50. Serenko A (2023). "Personality disorders as a predictor of counterproductive knowledge behavior: the application of the Millon Clinical Multiaxial Inventory-IV" (http://www.aserenko.com/papers/JKM_Personality_Disorders.pdf) (PDF). *Journal of Knowledge Management*. **27** (8): 2249–2282. doi:10.1108/JKM-10-2021-0796 (<https://doi.org/10.1108%2FJKM-10-2021-0796>). S2CID 256187160 (<https://api.semanticscholar.org/CorpusID:256187160>).
51. Ettner, Susan L. (2011). "Personality Disorders and Work." In *Work Accommodation and Retention in Mental Health* (https://books.google.com/books?id=g_HASArJsolC&q=personality+disorder), Chapter 9
52. Ettner SL, Maclean JC, French MT (January 2011). "Does Having a Dysfunctional Personality Hurt Your Career? Axis II Personality Disorders and Labor Market Outcomes" (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3204880>). *Industrial Relations*. **50** (1): 149–173. doi:10.1111/j.1468-232X.2010.00629.x (<https://doi.org/10.1111%2Fj.1468-232X.2010.00629.x>). PMC 3204880 (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3204880>). PMID 22053112 (<https://pubmed.ncbi.nlm.nih.gov/22053112>).
53. Board BJ, Fritzon K (2005). "Disordered personalities at work". *Psychology, Crime and Law*. **11**: 17–32. doi:10.1080/10683160310001634304 (<https://doi.org/10.1080%2F10683160310001634304>). S2CID 145582366 (<https://api.semanticscholar.org/CorpusID:145582366>).
54. Kets MF (2003). "Interview: Manfred Kets de Vries: The Dark Side of Leadership". *Business Strategy Review*. **14** (3): 26. doi:10.1111/1467-8616.00269 (<https://doi.org/10.1111%2F1467-8616.00269>).
55. Krueger RF, Carlson SR (February 2001). "Personality disorders in children and adolescents". *Current Psychiatry Reports*. **3** (1): 46–51. doi:10.1007/s11920-001-0072-4 (<https://doi.org/10.1007%2Fs11920-001-0072-4>). PMID 11177759 (<https://pubmed.ncbi.nlm.nih.gov/11177759>). S2CID 12532932 (<https://api.semanticscholar.org/CorpusID:12532932>).
56. Widiger TA (1993). "The DSM-III-R categorical personality disorder diagnoses: A critique and an alternative". *Psychological Inquiry*. **4** (2): 75–90. doi:10.1207/s15327965pli0402_1 (https://doi.org/10.1207%2Fs15327965pli0402_1).
57. Costa, P.T., & Widiger, T.A. (2001). *Personality disorders and the five-factor model of personality* (2nd ed.). Washington, DC: American Psychological Association.

58. Samuel DB, Widiger TA (December 2008). "A meta-analytic review of the relationships between the five-factor model and DSM-IV-TR personality disorders: a facet level analysis" (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2614445>). *Clinical Psychology Review*. **28** (8): 1326–1342. doi:10.1016/j.cpr.2008.07.002 (<https://doi.org/10.1016%2Fj.cpr.2008.07.002>). PMC 2614445 (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2614445>). PMID 18708274 (<https://pubmed.ncbi.nlm.nih.gov/18708274>).
59. Widiger, Thomas A., Costa, Paul T. (2012). *Personality Disorders and the Five-Factor Model of Personality, Third Edition*. ISBN 978-1-4338-1166-1.
60. Widiger TA, Costa PT., Jr. (2002) "Five-Factor model personality disorder research", pp. 59–87 in Costa Paul T, Jr, Widiger Thomas A. (eds.) *Personality disorders and the five-factor model of personality*. 2nd ed. Washington, DC: American Psychological Association. ISBN 978-1-55798-826-3.
61. Mullins-Sweatt SN, Widiger TA (2006). "The five-factor model of personality disorder: A translation across science and practice", pp. 39–70 in Krueger R, Tackett J (eds.). *Personality and psychopathology: Building bridges*. New York: Guilford.
62. Clark LA (2007). "Assessment and diagnosis of personality disorder: perennial issues and an emerging reconceptualization" (<https://zenodo.org/record/1134186>). *Annual Review of Psychology*. **58**: 227–257. doi:10.1146/annurev.psych.57.102904.190200 (<https://doi.org/10.1146%2Fannurev.psych.57.102904.190200>). PMID 16903806 (<https://pubmed.ncbi.nlm.nih.gov/16903806>). S2CID 2728977 (<https://api.semanticscholar.org/CorpusID:2728977>).
63. Bagby RM, Sellbom M, Costa PT, Widiger TA (2008). "Predicting *Diagnostic and Statistical Manual of Mental Disorders-IV* personality disorders with the five-factor model of personality and the personality psychopathology five". *Personality and Mental Health*. **2** (2): 55–69. doi:10.1002/pmh.33 (<https://doi.org/10.1002%2Fpmh.33>).
64. Saulsman LM, Page AC (January 2004). "The five-factor model and personality disorder empirical literature: A meta-analytic review". *Clinical Psychology Review*. **23** (8): 1055–1085. doi:10.1016/j.cpr.2002.09.001 (<https://doi.org/10.1016%2Fj.cpr.2002.09.001>). PMID 14729423 (<https://pubmed.ncbi.nlm.nih.gov/14729423>).
65. Piedmont RL, Sherman MF, Sherman NC (December 2012). "Maladaptively high and low openness: the case for experiential permeability". *Journal of Personality*. **80** (6): 1641–1668. doi:10.1111/j.1467-6494.2012.00777.x (<https://doi.org/10.1111%2Fj.1467-6494.2012.00777.x>). PMID 22320184 (<https://pubmed.ncbi.nlm.nih.gov/22320184>).
66. Piedmont RL, Sherman MF, Sherman NC, Dy-Liacco GS, Williams JE (June 2009). "Using the five-factor model to identify a new personality disorder domain: the case for experiential permeability". *Journal of Personality and Social Psychology*. **96** (6): 1245–1258. doi:10.1037/a0015368 (<https://doi.org/10.1037%2Fa0015368>). PMID 19469599 (<https://pubmed.ncbi.nlm.nih.gov/19469599>).
67. Cohen P, Brown J, Smaile E (2001). "Child abuse and neglect and the development of mental disorders in the general population". *Development and Psychopathology*. **13** (4): 981–999. doi:10.1017/S0954579401004126 (<https://doi.org/10.1017%2FS0954579401004126>). PMID 11771917 (<https://pubmed.ncbi.nlm.nih.gov/11771917>). S2CID 24036702 (<https://api.semanticscholar.org/CorpusID:24036702>).
68. "What Causes Psychological Disorders?" (<https://web.archive.org/web/20101120002217/http://apa.org/topics/personality/disorders-causes.aspx>). American Psychological Association. 2010. Archived from the original (<http://apa.org/topics/personality/disorders-causes.aspx>) on 20 November 2010.
69. Cohen P, Chen H, Gordon K, Johnson J, Brook J, Kasen S (April 2008). "Socioeconomic background and the developmental course of schizotypal and borderline personality disorder symptoms" (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3857688>). *Development and Psychopathology*. **20** (2): 633–650. doi:10.1017/S095457940800031X (<https://doi.org/10.1017%2FS095457940800031X>). PMC 3857688 (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3857688>). PMID 18423098 (<https://pubmed.ncbi.nlm.nih.gov/18423098>).
70. Deckers T (February 2015). "How does Socio-Economic Status Shape a Child's Personality?" (https://web.archive.org/web/20181105062454/https://econresearch.uchicago.edu/sites/econresearch.uchicago.edu/files/Decker_s_Falk_etal_2016_SES-child-personality.pdf) (PDF). *Human Capital and Economic Opportunity Global Working Group*. Archived from the original (https://econresearch.uchicago.edu/sites/econresearch.uchicago.edu/files/Decker_s_Falk_etal_2016_SES-child-personality.pdf) (PDF) on 5 November 2018. Retrieved 9 August 2017.
71. Van Damme L, Colins O, De Maeyer J, Vermeiren R, Vanderplasschen W (June 2015). "Girls' quality of life prior to detention in relation to psychiatric disorders, trauma exposure and socioeconomic status". *Quality of Life Research*. **24** (6): 1419–1429. doi:10.1007/s11136-014-0878-2 (<https://doi.org/10.1007%2Fs11136-014-0878-2>). PMID 25429824 (<https://pubmed.ncbi.nlm.nih.gov/25429824>). S2CID 28876461 (<https://api.semanticscholar.org/CorpusID:28876461>).
72. Walsh Z, Shea MT, Yen S, Ansell EB, Grilo CM, McGlashan TH, et al. (December 2013). "Socioeconomic-status and mental health in a personality disorder sample: the importance of neighborhood factors" (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4628287>). *Journal of Personality Disorders*. **27** (6): 820–831. doi:10.1521/pedi_2012_26_061 (https://doi.org/10.1521%2Fpedi_2012_26_061). PMC 4628287 (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4628287>). PMID 22984860 (<https://pubmed.ncbi.nlm.nih.gov/22984860>).

73. Schwarze CE, Hellhammer DH, Stroehle V, Lieb K, Mobascher A (October 2015). "Lack of Breastfeeding: A Potential Risk Factor in the Multifactorial Genesis of Borderline Personality Disorder and Impaired Maternal Bonding". *Journal of Personality Disorders*. **29** (5): 610–626. doi:10.1521/pedi_2014_28_160 (https://doi.org/10.1521%2Fpedi_2014_28_160). PMID 25248013 (<https://pubmed.ncbi.nlm.nih.gov/25248013>).
74. Ball EM (20 October 2016). *The Moderating Role of Maternal Attachment on Borderline Personality Disorder Features and Dependent Life Stress* (<https://web.archive.org/web/20170809090626/https://shsu-ir.tdl.org/shsu-ir/handle/20.500.11875/44>) (Thesis). Archived from the original (<https://shsu-ir.tdl.org/shsu-ir/handle/20.500.11875/44>) on 9 August 2017. Retrieved 9 August 2017.
75. "What causes personality disorders?" (<https://web.archive.org/web/20100313134730/http://www.apa.org/topics/personality/disorders-causes.aspx>). *American Psychological Association*. Archived from the original (<http://www.apa.org/topics/personality/disorders-causes.aspx>) on 13 March 2010. Retrieved 9 August 2017.
76. Nunes PM, Wenzel A, Borges KT, Porto CR, Caminha RM, de Oliveira IR (August 2009). "Volumes of the hippocampus and amygdala in patients with borderline personality disorder: a meta-analysis". *Journal of Personality Disorders*. **23** (4): 333–345. doi:10.1521/pedi.2009.23.4.333 (<https://doi.org/10.1521%2Fpedi.2009.23.4.333>). PMID 19663654 (<https://pubmed.ncbi.nlm.nih.gov/19663654>).
77. Kaya S, Yildirim H, Atmaca M (May 2020). "Reduced hippocampus and amygdala volumes in antisocial personality disorder". *Journal of Clinical Neuroscience*. **75**: 199–203. doi:10.1016/j.jocn.2020.01.048 (<https://doi.org/10.1016%2Fj.jocn.2020.01.048>). PMID 32334739 (<https://pubmed.ncbi.nlm.nih.gov/32334739>). S2CID 210711736 (<https://api.semanticscholar.org/CorpusID:210711736>).
78. Magnavita, Jeffrey J. (2004) *Handbook of personality disorders: theory and practice* (<https://books.google.com/books?id=jhtvBV3i0rkC>), John Wiley and Sons, ISBN 978-0-471-48234-5.
79. Sng AA, Janca A (January 2016). "Mindfulness for personality disorders". *Current Opinion in Psychiatry*. **29** (1): 70–76. doi:10.1097/YCO.0000000000000213 (<https://doi.org/10.1097%2FYCO.0000000000000213>). PMID 26651010 (<https://pubmed.ncbi.nlm.nih.gov/26651010>). S2CID 235472 (<https://api.semanticscholar.org/CorpusID:235472>).
80. Creswell JD (January 2017). "Mindfulness Interventions" (<https://doi.org/10.1146%2Fannurev-psych-042716-051139>). *Annual Review of Psychology*. **68**: 491–516. doi:10.1146/annurev-psych-042716-051139 (<https://doi.org/10.1146%2Fannurev-psych-042716-051139>). PMID 27687118 (<https://pubmed.ncbi.nlm.nih.gov/27687118>).
81. "Antipsychotics are commonly prescribed to people with personality disorders, contrary to guidelines" (<https://evidence.nihr.ac.uk/alert/antipsychotics-commonly-prescribed-people-personality-disorders-contrary-guidelines/>). *NIHR Evidence*. 10 November 2022. doi:10.3310/nihrevidence_54520 (https://doi.org/10.3310%2Fnihrevidence_54520). S2CID 253467990 (<https://api.semanticscholar.org/CorpusID:253467990>).
82. Hardoon S, Hayes J, Viding E, McCrory E, Walters K, Osborn D (March 2022). "Prescribing of antipsychotics among people with recorded personality disorder in primary care: a retrospective nationwide cohort study using The Health Improvement Network primary care database" (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8968526>). *BMJ Open*. **12** (3): e053943. doi:10.1136/bmjopen-2021-053943 (<https://doi.org/10.1136%2Fbmjopen-2021-053943>). PMC 8968526 (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8968526>). PMID 35264346 (<https://pubmed.ncbi.nlm.nih.gov/35264346>).
83. Davison SE (2002). "Principles of managing patients with personality disorder" (<https://doi.org/10.1192%2Fapt.8.1.1>). *Advances in Psychiatric Treatment*. **8** (1): 1–9. doi:10.1192/apt.8.1.1 (<https://doi.org/10.1192%2Fapt.8.1.1>). S2CID 6874579 (<https://api.semanticscholar.org/CorpusID:6874579>).
84. McVey, D. & Murphy, N. (eds.) (2010) *Treating Personality Disorder: Creating Robust Services for People with Complex Mental Health Needs* (<http://www.routledge.com/books/details/9780415404808/>), ISBN 0-203-84115-8
85. Lenzenweger MF (September 2008). "Epidemiology of personality disorders". *The Psychiatric Clinics of North America*. **31** (3): 395–403, vi. doi:10.1016/j.psc.2008.03.003 (<https://doi.org/10.1016%2Fj.psc.2008.03.003>). PMID 18638642 (<https://pubmed.ncbi.nlm.nih.gov/18638642>).
86. Schulte Holthausen B, Habel U (October 2018). "Sex Differences in Personality Disorders". *Current Psychiatry Reports*. **20** (12): 107. doi:10.1007/s11920-018-0975-y (<https://doi.org/10.1007%2Fs11920-018-0975-y>). PMID 30306417 (<https://pubmed.ncbi.nlm.nih.gov/30306417>). S2CID 52959021 (<https://api.semanticscholar.org/CorpusID:52959021>).
87. Huang Y, Kotov R, de Girolamo G, Preti A, Angermeyer M, Benjet C, et al. (July 2009). "DSM-IV personality disorders in the WHO World Mental Health Surveys" (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2705873>). *The British Journal of Psychiatry*. **195** (1): 46–53. doi:10.1192/bjp.bp.108.058552 (<https://doi.org/10.1192%2Fbjp.bp.108.058552>). PMC 2705873 (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2705873>). PMID 19567896 (<https://pubmed.ncbi.nlm.nih.gov/19567896>).
88. Lenzenweger MF, Lane MC, Loranger AW, Kessler RC (September 2007). "DSM-IV personality disorders in the National Comorbidity Survey Replication" (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2044500>). *Biological Psychiatry*. **62** (6): 553–564. doi:10.1016/j.biopsych.2006.09.019 (<https://doi.org/10.1016%2Fj.biopsych.2006.09.019>). PMC 2044500 (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2044500>). PMID 17217923 (<https://pubmed.ncbi.nlm.nih.gov/17217923>).

89. Collins A, Barnicot K, Sen P (June 2020). "A Systematic Review and Meta-Analysis of Personality Disorder Prevalence and Patient Outcomes in Emergency Departments". *Journal of Personality Disorders*. **34** (3): 324–347. doi:10.1521/pedi_2018_32_400 (https://doi.org/10.1521%2Fpedi_2018_32_400). PMID 30307832 (<https://pubmed.ncbi.nlm.nih.gov/30307832>). S2CID 52963562 (<https://api.semanticscholar.org/CorpusID:52963562>).
90. Sansone RA, Sansone LA (April 2011). "Personality disorders: a nation-based perspective on prevalence" (<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3105841>). *Innovations in Clinical Neuroscience*. **8** (4): 13–18. PMC 3105841 (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3105841>). PMID 21637629 (<https://pubmed.ncbi.nlm.nih.gov/21637629>).
91. Yang M, Coid J, Tyrer P (September 2010). "Personality pathology recorded by severity: national survey" (<http://doi.org/10.1192%2Fbjp.bp.110.078956>). *The British Journal of Psychiatry*. **197** (3): 193–199. doi:10.1192/bjp.bp.110.078956 (<https://doi.org/10.1192%2Fbjp.bp.110.078956>). PMID 20807963 (<https://pubmed.ncbi.nlm.nih.gov/20807963>). S2CID 14040222 (<https://api.semanticscholar.org/CorpusID:14040222>).
92. Connolly AJ, Cobb-Richardson P, Ball SA (December 2008). "Personality disorders in homeless drop-in center clients" (https://web.archive.org/web/20090617134208/http://www.ncsinc.org/images/pdfs/JPD_article_winter_2008.pdf) (PDF). *Journal of Personality Disorders*. **22** (6): 573–588. doi:10.1521/pedi.2008.22.6.573 (<https://doi.org/10.1521%2Fpedi.2008.22.6.573>). PMID 19072678 (<https://pubmed.ncbi.nlm.nih.gov/19072678>). Archived from the original (http://www.ncsinc.org/images/pdfs/JPD_article_winter_2008.pdf) (PDF) on 17 June 2009. Retrieved 31 January 2017. "With regard to Axis II, Cluster A personality disorders (paranoid, schizoid, schizotypal) were found in almost all participants (92% had at least one diagnosis), and Cluster B (83% had at least one of antisocial, borderline, histrionic, or narcissistic) and C (68% had at least one of avoidant, dependent, obsessive–compulsive) disorders also were highly prevalent"
93. Widiger T (2012). *The Oxford Handbook of Personality Disorders* (<https://books.google.com/books?id=CTVpAgAAQBAJ>). Oxford University Press. ISBN 978-0-19-973501-3.
94. Grant BF, Hasin DS, Stinson FS, Dawson DA, Chou SP, Ruan WJ, et al. (July 2004). "Prevalence, correlates, and disability of personality disorders in the United States: results from the national epidemiologic survey on alcohol and related conditions". *The Journal of Clinical Psychiatry*. **65** (7): 948–958. doi:10.4088/JCP.v65n0711 (<https://doi.org/10.4088%2FJCP.v65n0711>). PMID 15291684 (<https://pubmed.ncbi.nlm.nih.gov/15291684>).
95. Triebwasser J, Chemerinski E, Roussos P, Siever LJ (December 2013). "Paranoid personality disorder". *Journal of Personality Disorders*. **27** (6): 795–805. doi:10.1521/pedi_2012_26_055 (https://doi.org/10.1521%2Fpedi_2012_26_055). PMID 22928850 (<https://pubmed.ncbi.nlm.nih.gov/22928850>).
96. Coid J, Yang M, Tyrer P, Roberts A, Ullrich S (May 2006). "Prevalence and correlates of personality disorder in Great Britain" (<https://doi.org/10.1192%2Fbjp.188.5.423>). *The British Journal of Psychiatry*. **188** (5): 423–431. doi:10.1192/bjp.188.5.423 (<https://doi.org/10.1192%2Fbjp.188.5.423>). PMID 16648528 (<https://pubmed.ncbi.nlm.nih.gov/16648528>). S2CID 4881014 (<https://api.semanticscholar.org/CorpusID:4881014>).
97. Pulay AJ, Stinson FS, Dawson DA, Goldstein RB, Chou SP, Huang B, et al. (16 May 2009). "Prevalence, correlates, disability, and comorbidity of DSM-IV schizotypal personality disorder: results from the wave 2 national epidemiologic survey on alcohol and related conditions" (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2707116>). *Primary Care Companion to the Journal of Clinical Psychiatry*. **11** (2): 53–67. doi:10.4088/pcc.08m00679 (<https://doi.org/10.4088%2Fpcc.08m00679>). PMC 2707116 (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2707116>). PMID 19617934 (<https://pubmed.ncbi.nlm.nih.gov/19617934>).
98. Alegria AA, Blanco C, Petry NM, Skodol AE, Liu SM, Grant B, et al. (July 2013). "Sex differences in antisocial personality disorder: results from the National Epidemiological Survey on Alcohol and Related Conditions" (<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3767421>). *Personality Disorders*. **4** (3): 214–222. doi:10.1037/a0031681 (<https://doi.org/10.1037%2Fa0031681>). PMC 3767421 (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3767421>). PMID 23544428 (<https://pubmed.ncbi.nlm.nih.gov/23544428>).
99. Sprock J (2000). "Gender-Typed Behavioral Examples of Histrionic Personality Disorder". *Journal of Psychopathology and Behavioral Assessment*. **22** (2): 107–122. doi:10.1023/a:1007514522708 ([https://doi.org/10.1023/a:1007514522708](https://doi.org/10.1023%2Fa%3A1007514522708)). ISSN 0882-2689 (<https://www.worldcat.org/issn/0882-2689>). S2CID 141244223 (<https://api.semanticscholar.org/CorpusID:141244223>).
100. Stinson FS, Dawson DA, Goldstein RB, Chou SP, Huang B, Smith SM, et al. (July 2008). "Prevalence, correlates, disability, and comorbidity of DSM-IV narcissistic personality disorder: results from the wave 2 national epidemiologic survey on alcohol and related conditions" (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2669224>). *The Journal of Clinical Psychiatry*. **69** (7): 1033–1045. doi:10.4088/jcp.v69n0701 (<https://doi.org/10.4088%2Fjcp.v69n0701>). PMC 2669224 (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2669224>). PMID 18557663 (<https://pubmed.ncbi.nlm.nih.gov/18557663>).
101. Grijalva E, Newman DA, Tay L, Donnellan MB, Harms PD, Robins RW, et al. (March 2015). "Gender differences in narcissism: a meta-analytic review" (<http://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1004&context=pdharms>). *Psychological Bulletin*. **141** (2): 261–310. doi:10.1037/a0038231 (<https://doi.org/10.1037%2Fa0038231>). PMID 25546498 (<https://pubmed.ncbi.nlm.nih.gov/25546498>).
102. Rotenstein OH, McDermut W, Bergman A, Young D, Zimmerman M, Chelminski I (February 2007). "The validity of DSM-IV passive-aggressive (negativistic) personality disorder". *Journal of Personality Disorders*. **21** (1): 28–41. doi:10.1521/pedi.2007.21.1.28 (<https://doi.org/10.1521%2Fpedi.2007.21.1.28>). PMID 17373888 (<https://pubmed.ncbi.nlm.nih.gov/17373888>).

103. Grant JE, Mooney ME, Kushner MG (April 2012). "Prevalence, correlates, and comorbidity of DSM-IV obsessive-compulsive personality disorder: results from the National Epidemiologic Survey on Alcohol and Related Conditions". *Journal of Psychiatric Research*. **46** (4): 469–475. doi:10.1016/j.jpsychires.2012.01.009 (<https://doi.org/10.1016%2Fj.jpsychires.2012.01.009>). PMID 22257387 (<https://pubmed.ncbi.nlm.nih.gov/22257387/>).
104. *DSM-III-R*. p. 373.
105. *DSM-III-R*. p. 370.
106. *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.). 1994.
107. Suryanarayan, Geetha (2002) *The History of the Concept of Personality Disorder and its Classification* (http://www.asia.cmpmedica.com/cmpmedica_my/disppdf.cfm?fname=suryanHistory.pdf), The Medicine Publishing Company Ltd.
108. Augstein HF (July 1996). "J C Prichard's concept of moral insanity--a medical theory of the corruption of human nature" (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1037128>). *Medical History*. **40** (3): 311–343. doi:10.1017/S0025727300061329 (<https://doi.org/10.1017%2FS0025727300061329>). PMC 1037128 (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1037128>). PMID 8757717 (<https://pubmed.ncbi.nlm.nih.gov/8757717/>).
109. Gutmann P (June 2008). "Julius Ludwig August Koch (1841-1908): Christian, philosopher and psychiatrist" (https://hal.archives-ouvertes.fr/hal-00570903/file/PEER_stage2_10.1177%252F0957154X07080661.pdf) (PDF). *History of Psychiatry*. **19** (74 Pt 2): 202–214. doi:10.1177/0957154X07080661 (<https://doi.org/10.1177%2F0957154X07080661>). PMID 19127839 (<https://pubmed.ncbi.nlm.nih.gov/19127839/>). S2CID 2223023 (<https://api.semanticscholar.org/CorpusID:2223023>).
110. Ганнушкин П. Б. (2000). *Клиника психопатий, их статика, динамика, систематика*. Издательство Нижегородской государственной медицинской академии. ISBN 5-86093-015-1.
111. Личко А. Е. (2010) Психопатии и акцентуации характера у подростков. Речь, ISBN 978-5-9268-0828-2.
112. Arrigo BA (1 June 2001). "The Confusion Over Psychopathy (I): Historical Considerations". *International Journal of Offender Therapy and Comparative Criminology*. **45** (3): 325–44. doi:10.1177/0306624X01453005 (<https://doi.org/10.1177%2F0306624X01453005>). S2CID 145400985 (<https://api.semanticscholar.org/CorpusID:145400985>).
113. Amy Heim & Drew Westen (2004) *Theories of personality and personality disorders* (http://www.psychsystems.net/Publications/2005/17.%20theories%20of%20personality%20and%20personality%20disorders_Heim_textbook%20of%20pers%20disorders%202005.pdf) Archived (https://web.archive.org/web/20120111140930/http://www.psychsystems.net/Publications/2005/17.%20theories%20of%20personality%20and%20personality%20disorders_Heim_textbook%20of%20pers%20disorders%202005.pdf) 11 January 2012 at the Wayback Machine
114. Lane C (1 February 2009). "The Surprising History of Passive–Aggressive Personality Disorder" (<http://www.christopherlane.org/documents/Lane.PAPDisorder.pdf>) (PDF). *Theory & Psychology*. **19** (1): 55–70. CiteSeerX 10.1.1.532.5027 (<https://citeseerx.ist.psu.edu/viewdoc/summary?doi=10.1.1.532.5027>). doi:10.1177/0959354308101419 (<https://doi.org/10.1177%2F0959354308101419>). S2CID 147019317 (<https://api.semanticscholar.org/CorpusID:147019317>).
115. Hoermann, Simone; Zupanick, Corinne E. and Dombeck, Mark (January 2011) *The History of the Psychiatric Diagnostic System Continued* (http://www.mentalhelp.net/poc/view_doc.php?type=doc&id=560&cn=8). mentalhelp.net.
116. Oldham JM (2005). "Personality Disorders" (<http://focus.psychiatryonline.org/doi/abs/10.1176/foc.3.3.372>). *Focus*. **3**: 372–82. doi:10.1176/foc.3.3.372 (<https://doi.org/10.1176%2Ffoc.3.3.372>) (inactive 31 January 2024).
117. Kendell RE (February 2002). "The distinction between personality disorder and mental illness" (<https://doi.org/10.1192%2Fbjp.180.2.110>). *The British Journal of Psychiatry*. **180** (2): 110–115. doi:10.1192/bjp.180.2.110 (<https://doi.org/10.1192%2Fbjp.180.2.110>). PMID 11823318 (<https://pubmed.ncbi.nlm.nih.gov/11823318/>). S2CID 90434 (<https://api.semanticscholar.org/CorpusID:90434>).

Further reading

- Marshall WL, Serin R (1997). "Personality Disorders.". In Turner SM, Hersen R (eds.). *Adult Psychopathology and Diagnosis*. New York: Wiley. pp. 508–541.
- Murphy N, McVey D (2010). *Treating Severe Personality Disorder: Creating Robust Services for Clients with Complex Mental Health Needs* (<https://web.archive.org/web/20110715060200/http://www.pdmh-consultancy.com/publication-detail/4/>). London: Routledge. Archived from the original (<http://www.pdmh-consultancy.com/publication-detail/4/>) on 15 July 2011.
- Millon T, Davis RD (1996). *Disorders of personality : DSM-IV and beyond* (2nd ed.). New York: Wiley. ISBN 978-0-471-01186-6.

- Yudofsky SC (2005). *Fatal Flaws: Navigating Destructive Relationships With People With Disorders of Personality and Character* (1st ed.). Washington, DC. ISBN 978-1-58562-214-6.

External links

- [Personality Disorders Foundation \(http://counsellingresource.com/distress/personality-disorders/foundation/index.html\)](http://counsellingresource.com/distress/personality-disorders/foundation/index.html)
 - [National Mental Health Association personality disorder fact sheet \(http://www.nmha.org/go/information/get-info/personality-disorders\)](http://www.nmha.org/go/information/get-info/personality-disorders) [Archived \(https://web.archive.org/web/20101216172819/http://nmha.org/go/information/get-info/personality-disorders\)](https://web.archive.org/web/20101216172819/http://nmha.org/go/information/get-info/personality-disorders) 16 December 2010 at the [Wayback Machine](#)
 - [Personality Disorders information leaflet from The Royal College of Psychiatrists \(http://www.rcpsych.ac.uk/expertadvice/problemsdisorders/personalitydisorder.aspx\)](http://www.rcpsych.ac.uk/expertadvice/problemsdisorders/personalitydisorder.aspx)
-

Retrieved from "https://en.wikipedia.org/w/index.php?title=Personality_disorder&oldid=1235540903"

■