Personality Disorders in Modern Life

SECOND EDITION

THEODORE MILLON

and

Seth Grossman
Carrie Millon
Sarah Meagher
Rowena Ramnath

JOHN WILEY & SONS, INC.

Personality Disorders in Modern Life

Personality Disorders in Modern Life

SECOND EDITION

THEODORE MILLON

and

Seth Grossman
Carrie Millon
Sarah Meagher
Rowena Ramnath

JOHN WILEY & SONS, INC.

This book is printed on acid-free paper. ♾

Copyright © 2000, 2004 by John Wiley & Sons, Inc. All rights reserved.

Published by John Wiley & Sons, Inc., Hoboken, New Jersey.
Published simultaneously in Canada.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording, scanning, or otherwise, except as permitted under Section 107 or 108 of the 1976 United States Copyright Act, without either the prior written permission of the Publisher, or authorization through payment of the appropriate per-copy fee to the Copyright Clearance Center, Inc., 222 Rosewood Drive, Danvers, MA 01923, (978) 750-8400, fax (978) 646-8600, or on the web at www.copyright.com. Requests to the Publisher for permission should be addressed to the Permissions Department, John Wiley & Sons, Inc., 111 River Street, Hoboken, NJ 07030, (201) 748-6011, fax (201) 748-6008.

Limit of Liability/Disclaimer of Warranty: While the publisher and author have used their best efforts in preparing this book, they make no representations or warranties with respect to the accuracy or completeness of the contents of this book and specifically disclaim any implied warranties of merchantability or fitness for a particular purpose. No warranty may be created or extended by sales representatives or written sales materials. The advice and strategies contained herein may not be suitable for your situation. You should consult with a professional where appropriate. Neither the publisher nor author shall be liable for any loss of profit or any other commercial damages, including but not limited to special, incidental, consequential, or other damages.

This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is sold with the understanding that the publisher is not engaged in rendering professional services. If legal, accounting, medical, psychological or any other expert assistance is required, the services of a competent professional person should be sought.

Designations used by companies to distinguish their products are often claimed as trademarks. In all instances where John Wiley & Sons, Inc. is aware of a claim, the product names appear in initial capital or all capital letters. Readers, however, should contact the appropriate companies for more complete information regarding trademarks and registration.

For general information on our other products and services please contact our Customer Care Department within the United States at (800) 762-2974, outside the United States at (317) 572-3993 or fax (317) 572-4002.

Wiley also publishes its books in a variety of electronic formats. Some content that appears in print may not be available in electronic books. For more information about Wiley products, visit our web site at www.wiley.com.

Library of Congress Cataloging-in-Publication Data:

Personality disorders in modern life.—2nd ed. / Theodore Millon . . . [et al.].
p. cm.
Rev. ed. of: Personality disorders in modern life / Theodore Millon and Roger D. Davis. c2000.
Includes bibliographical references (p.).
ISBN 0-471-23734-5
1. Personality disorders. I. Millon, Theodore. II. Millon, Theodore. Personality disorders in modern life.
RC554.M537 2004
616.85′81—dc22

2004043374

Printed in the United States of America.

10 9 8 7 6 5 4 3 2 1

Foreword

It is a pleasure to introduce the reader to the second edition of this highly acclaimed volume, *Personality Disorders in Modern Life.* The first edition, which I had the honor to review for *Contemporary Psychology: APA Review of Books,* was excellent, and the second edition by Theodore Millon and his team of coauthors—Seth Grossman, Carrie Millon, Sarah Meagher, and Rowena Ramnath—expands and updates the first. The senior author of this volume has reached the status of icon in the psychological sciences and has inspired a generation of workers in the field of personality theory, assessment, psychotherapy, and nosology. He is almost single-handedly responsible for the resurgence of a nearly moribund area in psychology—personology, the study of the human personality system, of interest to humankind since the dawn of consciousness—and the concomitant development of language, cognition, and culture—only a recent development. Personality theory nearly became extinct during the latter half of the past century, dismissed as a useless artifact of "prescientific psychology." However, the advances of clinical sciences, such as diagnosis, classification, and psychotherapy, spearheaded by Millon, beckoned leaders in the field to prevent this clinically and socially useful area of discourse and science from going the way of other prescientific precursors of our field, such as phrenology—the study of the contours of the head and their relationships to various neuropsychological functions.

As I described in my review of the original edition, published at the turn of the century, this volume represented significant advances over the first 100 years of modern psychology. Advances in the fields of psychotherapy, psychopathology, and personality theory have been substantial. Over a century ago, William James (1890) published his two-volume work, *Principles of Psychology,* which many consider a landmark in psychology and which ushered in the birth of modern psychology. Certainly, there were other groundbreaking works that had similar impact on the clinical sciences, such as Freud's (1900) *Interpretation of Dreams,* which during the same time span, gave birth to psychoanalysis and what many consider to be the beginning of modern psychotherapy. Over the course of the first century of modern psychology, many have attempted to elaborate the realm of the personality system; but few have been as comprehensive in this endeavor as Millon. This volume represents the accumulated wisdom and theoretical, clinical, and empirical findings over the past century. It affords us the opportunity to be introduced or reawakened by one of the most interesting subjects of our time: personality and its disorders. The insight offered in this volume allows all of us to understand the complexities of the plethora of converging forces that leads to alterations in personality and how they are represented, conceptualized, and treated.

The audience for this text is advanced undergraduate and graduate students, but it will serve as an introduction to all interested readers and excite even the most hesitant reader. Its broad coverage introduces undergraduate students to the fascinating world of clinical sciences with easy-to-follow case illustrations through the eyes of a student struggling to understand how these constructs and theories apply to clinical reality. For advanced students, this text serves as a consolidation of Millon's other works and introduces his conceptual system, which, for many, will lead to the reading of his other groundbreaking volumes on the topic. As a practicing clinician and personality theorist, I share Millon's view that personality is the main organizing system of humankind,

and any understanding or attempt at altering the suffering encountered in clinical practice requires a deep appreciation of the domains of human personality.

For those pursuing careers in the social or clinical sciences, this volume is one for your library of reference books. I guarantee that you will refer to it often. The systematic theoretical modeling and self-other awareness that this volume engenders will enrich those students who are attracted to other disciplines. All of us at one time will encounter individuals similar to those described in this volume. It is important that we not use personality labels pejoratively or stigmatize those who suffer from personality dysfunction but, rather, that we develop a deeper appreciation for the variety of personality types profiled in this volume. This appreciation will enable those in various careers to be more effective when assigned a narcissistic boss or when reading about a psychopathic individual who preys on society, such as some of the infamous figures presented in this text. Those in the medical professions will gain a keener appreciation for their patients and for how their psychological immune system, as Millon has termed it, functions and dysfunctions under stressful conditions.

Millon and his team have carefully laid the groundwork for you to build a working model of human personality functioning and dysfunction. The framework is based on the dominant psychiatric model of diagnosing personality disorders but provides an even richer, more textured system, pioneered by Millon and based on evolutionary principles and clearly articulated domains of functioning. You will begin to acquire an appreciation for how clinical syndromes such as anxiety, depression, and eating disorders emanate from the unique configuration of the personality system, which will allow you to embark on an incomparable journey of self- and other understanding. You will be challenged with many of the constructs and terminology, but familiarization with Millon's system has both clinical utility and value in understanding the unique and shared characteristics of the human race. Dr. Millon is one of the most prominent personality theorists of contemporary times; his work will inspire successive generations, just as William James and Sigmund Freud did more than 100 years ago. Enjoy the journey!

JEFFREY J. MAGNAVITA, PHD, ABPP
Fellow, American Psychological Association
Adjunct Professor in Clinical Psychology, University of Hartford
Director, Connecticut Center for Short-Term Dynamic Psychotherapy

References

Freud, S. (1900). The interpretation of dreams. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vols. 4 & 5, pp. 1–715). London: Hogarth Press.

James, W. (1890). *The principles of psychology* (Vols. 1 & 2). New York: Henry Holt.

Magnavita, J. J. (2001). A century of the "scientific" study of personality: How far have we come? [Book Review: *Personality disorders in modern life*]. *Contemporary Psychology: APA Review of Books, 46*(5), 514–516.

Preface

The first edition of my *Disorders of Personality* text (1981) was widely regarded as the classic book in the field. Given its coordination with a theory of personality and psychopathology and with the then newly published *DSM-III,* it gained immediate acceptance among mental health professionals, the audience for which it was intended. As the years wore on, however, the readership of the book began to change. With the emergence of personality disorders as a distinct axis in the *DSM,* doctoral programs began to instruct their students on the role played by personality in creating and sustaining psychopathology. By the mid-1980s, my *Disorders of Personality* text gradually became required reading in most graduate programs, and even enjoyed some use at the undergraduate level.

With the publication of the *DSM-IV* in 1994, the *Disorders* text was ready for revision. Published in 1996, the second edition was greatly revised and expanded, its 800 pages of two-column text reflecting growing interest in personality disorders. Again, the book was an immediate success at the professional level. Unfortunately, with its increased length and complex writing style, the book was no longer appropriate for the limited background and experience of undergraduate students.

In mid-1998, a group at the Institute for Advanced Studies in Personology and Psychopathology began working in earnest on a revision for advanced undergraduate and beginning graduate students. About half of the material was simplified from the extensive *Disorders of Personality,* second edition, and about half the material was essentially new. This text was entitled *Personality Disorders in Modern Life,* published in 1999.

Students found the *Modern Life* text both informative and absorbing. Instructors found it well-organized and easy to teach. An optimal balance was struck between abstract concepts and concrete clinical case materials. Students appreciated the vivid examples that demonstrate personalities "in action." To that end, each of the clinical chapters began with a case vignette, which was then discussed in terms of the *DSM-IV.* The result was a cross-fertilization that brought the rather dry diagnostic criteria to life for the student and provided a concrete anchoring point to which student and instructor could refer again and again as the discussion of the personality was elaborated. The psychodynamic, cognitive, interpersonal, and evolutionary sections referred back to the cases as a means of providing a clearer understanding of otherwise abstract and difficult to understand concepts. This was true even where the text discussed the development of a particular personality disorder, which was then linked back to the concrete life history of the particular case. Students thus saw not only how psychological theory informs the study of the individual, but also how the individual came to his or her particular station and diagnosis in life. Each chapter included two or three cases interwoven in the body of the text.

This new second edition of *Modern Life* has added two important elements to strengthen the text. First, we added a full chapter on personality development (Chapter 3) so that the origins and course of personality pathology could be more fully and clearly articulated. And second, with the growth of empirical research in the field, considerable reference is now made throughout the book to spell out supporting data for ideas contained in the text.

While case studies provide continuity between concrete clinical phenomena and abstract concepts and theories, other sections of each chapter address continuity in different ways. Since there is no sharp division between normality and pathology, an entire section of each clinical chapter is devoted to their comparison and contrast. The introductory case receives a detailed discussion here, and it is shown exactly why he or she falls more toward the pathological end of the spectrum. Such examples help students understand that diagnostic thresholds are not discrete discontinuities, but instead are largely social conventions, and that each personality disorder has its parallels in a personality style that lies within the normal range. Each chapter invites students to find characteristics of such normal styles within themselves, thus opening up their interest for the material that follows. The hope is that students will learn something about their own personalities, and what strengths and weaknesses issue therefrom. Continuity between normality and abnormality in personality gives the text a "personal growth agenda" that most books in psychopathology lack.

In addition, the text also focuses on the continuity between the personality pathology of Axis II and the Axis I disorders, such as anxiety and depression. As practitioners have recognized, depression in a narcissist is very different from depression in an avoidant. While some sources present only comorbidity statistics for Axis II and Axis I, our contention is that the next generation of clinical scientists will be best prepared if it is understood why certain personalities experience the disorders they do. When a dependent personality becomes depressed, for example, what are the usual causes, and how do they feel to the person concerned? Once students understand how the cognitive, interpersonal, and psychodynamic workings of each personality lead them repeatedly into the same problems again and again, they are ready for the last section of each chapter, focused on psychotherapy.

We are pleased to report that an excellent 240-minute videotape entitled "*DSM-IV* Personality Disorders: The Subtypes" has been produced and is distributed by Insight Media (800-233-9910, www.Insight-Media.com), psychology's premier publisher of videos and CD-Roms. It is available for purchase by instructors and students who wish to view over 60 case vignettes that illustrate all *DSM-IV* personality prototypes and subtypes, as interviewed by psychologists and discussed by the senior author of this book.

Thanks and credit for this second edition are owed to each member of the team of young associates at the Institute, all co-authors of this text. In addition, the Institute's executive director, Donna Meagher, provided an organizing force throughout, drawing the various pieces together into a coherent whole. We would also like to thank the many hundreds of instructors and thousands of students who have offered constructive suggestions that have made this second edition even more useful and attractive than the first.

THEODORE MILLON, PHD, DSC
Institute for Advanced Studies
in Personology and Psychopathology

Coral Gables, Florida
IASPP@aol.com

Contents

Personality Disorders in Modern Life

Chapter 1

Personality Disorders: Classical Foundations

Objectives

- What is *personality?*
- Distinguish among personality, character, and temperament.
- What makes a personality disordered?
- What is the *DSM?*
- Make a list of terms important in the study of personality and its disorders.
- Explain the *DSM*'s multiaxial model. What are the reasons for having a multiaxial classification system?
- Why is personality analogous to the body's immune system?
- What are the three criteria that distinguish normal from abnormal functioning?
- Why is eclecticism perforce a scientific norm in the social sciences?
- Explain how ideas progress in the social sciences.
- What are the different components of the biological perspective?
- Describe Freud's topographical and structural models of the mind.
- What is the function of defense mechanisms? How do they work?
- Describe the stages of psychosexual development.
- What are *character disorders?*
- Explain the significance of object relations theory.
- Explain Kernberg's use of the term *structural organization.*

What sort of a person are you? What do you see as distinctive about your personality? How well do you know yourself? Are there aspects of your personality of which you are unaware? Do others know you as you know yourself? What are the best and worst things about your personality? Questions such as these are easy to ask, but are often difficult to answer. Yet, they go directly to the essence of what we are as human beings. Personality is that which makes us what we are and that which makes us different from others. People who are especially different, for example, are said to have "personality" or be "quite a character." Other people have "no personality at all." Depending on how someone affects us, he or she may be viewed as having a "good personality" or a "bad personality."

In the past several decades, the study of personality and its disorders has become central to the study of abnormal psychology. In the course of clinical work, we encounter subjects with vastly different pathologies. Some are in the midst of a depressive episode, and some must cope with the lasting effects of traumas far beyond the range of normal human experience. Some are grossly out of contact with reality, and some have only minor problems in living rather than clinical disorders. Although the problems of patients vary, everyone has a personality. Personality disorders occupy a place of diagnostic prominence today and constitute a special area of scientific study. The issues involved are complex, certainly much more sophisticated than the everyday understanding of personality described in the previous questions. This chapter introduces the emergence of this new discipline by analyzing personality and personality disorders by comparing and contrasting the basic assumptions that underlie different approaches to these ideas and by presenting the fundamentals of the classical perspectives on personality, which are essential to the understanding of the clinical chapters that follow. The questions are: What is personality? How does our definition of personality inform our understanding of personality disorders? Do the assumptions underlying the concept of personality support the use of the term **disorder?** How can the content of different personality disorders best be described?

One way to investigate the definition of a term is to examine how its meanings and usage have evolved over time. The word **personality** is derived from the Latin term **persona,** originally representing the theatrical mask used by ancient dramatic players. As a mask assumed by an actor, persona suggests a pretense of appearance, that is, the possession of traits other than those that actually characterize the individual behind the mask. In time, the term persona lost its connotation of pretense and illusion and began to represent not the mask, but the real person's observable or explicit features. The third and final meaning personality has acquired delves beneath surface impression to turn the spotlight on the inner, less often revealed, and hidden psychological qualities of the individual. Thus, through history, the meaning of the term has shifted from external illusion to surface reality and finally to opaque or veiled inner traits. This last meaning comes closest to contemporary use. Today, personality is seen as a complex pattern of deeply embedded psychological characteristics that are expressed automatically in almost every area of psychological functioning. That is, personality is viewed as the patterning of characteristics across the entire matrix of the person.

Personality is often confused with two related terms, character and temperament. Although all three words have similar meanings in casual usage, **character** refers to characteristics acquired during our upbringing and connotes a degree of conformity to virtuous social standards. **Temperament,** in contrast, refers not to the forces of socialization, but to a basic biological disposition toward certain behaviors. One person may be said to be of "good character," whereas another person may have an "irritable

temperament." Character thus represents the crystallized influence of nurture, and temperament represents the physically coded influence of nature.

Abnormal Behavior and Personality

The concept of personality disorders requires an understanding of their role in the study of abnormal behavior. The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) is considered the bible of mental disorders by psychologists and psychiatrists. The first official edition, published in 1952, was heavily influenced by previous systems established by the Army and the Veterans Administration to assist in understanding the mental health problems of World War II servicemen. In time, the *DSM* evolved beyond its original military purpose, becoming the standard or compendium for all of abnormal behavior. Now in its fourth edition, the *DSM-IV* is widely considered the official classification system or taxonomy for use by mental health professionals. It describes all mental disorders widely believed to exist, as well as a variety of others provisionally put forward for further research. Twelve personality disorders are included in *DSM-IV,* 10 of which are officially accepted, and 2 of which are provisional. In addition, this text briefly discusses two others that appeared in the revised third edition of the *DSM*. Although deleted from the latest edition, their diagnostic labels remain in widespread clinical use. Table 1.1 gives brief descriptions of these 14 personality disorders, an overview to the later chapters of this book.

Basic Vocabulary

Abnormal psychology has its own special vocabulary, or jargon. Many terms used in the discussion of abnormal behavior appear repeatedly in this book. Learn them now, for you will see them again and again. **Diagnostic criteria** are the defining characteristics used by clinicians to classify individuals within a clinical category. Essentially, diagnostic criteria constitute a checklist of features that must be present before a diagnosis can be made. Each disorder has its own unique list. Some lists are short; others are longer. For example, seven criteria are used to diagnose the antisocial personality. One of these is "deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure" (*DSM-IV,* 1994, p. 650). Eight criteria are used to diagnose the histrionic personality. One of the most interesting is "interaction with others is often characterized by inappropriate sexually seductive or provocative behavior" (p. 657).

The criteria list for each personality disorder includes either seven, eight, or nine items, each of which details some characteristic trait, attitude, or behavior strongly related to that particular disorder. In the antisocial criteria, deceitfulness is considered a **personality trait,** a long-standing pattern of behavior expressed across time and in many different situations. The histrionic criteria can also be considered as tapping the personality trait of seductiveness, because histrionics are known for inappropriately sexualizing their communications. Where many such personality traits typically occur together, they may be said to constitute a **personality disorder.** Antisocials, for example, are much more than just deceitful; they are often manipulative, reckless, aggressive, irresponsible, exploitive, and lacking in empathy and remorse. When all of these characteristics are taken together, they constitute what is called a personality

TABLE 1.1 Brief Description of the Fourteen Personality Disorders of *DSM-III, DSM-III-R,* and *DSM-IV*

Schizoid	Apathetic, indifferent, remote, solitary. Neither desires nor need human attachments. Minimal awareness of feelings of self or others. Few drives or ambitions, if any.
Avoidant	Hesitant, self-conscious, embarrassed, anxious. Tense in social situations due to fear of rejection. Plagued by constant performance anxiety. Sees self as inept, inferior, or unappealing. Feels alone and empty.
Depressive[1]	Somber, discouraged, pessimistic, brooding, fatalistic. Presents self as vulnerable and abandoned. Feels valueless, guilty, and impotent. Judges self as worthy only of criticism and contempt.
Dependent	Helpless, incompetent, submissive, immature. Withdraws from adult responsibilities. Sees self as weak or fragile. Seeks constant reassurance from stronger figures.
Histrionic	Dramatic, seductive, shallow, stimulus-seeking, vain. Overreacts to minor events. Exhibitionistic as a means of securing attention and favors. Sees self as attractive and charming.
Narcissistic	Egotistical, arrogant, grandiose, insouciant. Preoccupied with fantasies of success, beauty, or achievement. Sees self as admirable and superior, and therefore entitled to special treatment.
Antisocial	Impulsive, irresponsible, deviant, unruly. Acts without due consideration. Meets social obligations only when self-serving. Disrespects societal customs, rules, and standards. Sees self as free and independent.
Sadistic[2]	Explosively hostile, abrasive, cruel, dogmatic. Liable to sudden outbursts of rage. Feels self-satisfied through dominating, intimidating and humiling others. Is opinionated and close-minded.
Compulsive	Restrained, conscientious, respectful, rigid. Maintains a rule-bound lifestyle. Adheres closely to social conventions. Sees the world in terms of regulations and hierarchies. Sees self as devoted, reliable, efficient, and productive.
Negativistic[1]	Resentful, contrary, skeptical, discontented. Resist fulfilling others' expectations. Deliberately inefficient. Vents anger indirectly by undermining others' goals. Alternately moody and irritable, then sullen and withdrawn.
Masochistic[3]	Deferential, pleasure-phobic, servile, blameful, self-effacing. Encourages others to take advantage. Deliberately defeats own achievements. Seeks condemning or mistreatful partners.
Paranoid	Guarded, defensive, distrustful and suspiciousness. Hypervigilant to the motives of others to undermine or do harm. Always seeking confirmatory evidence of hidden schemes. Feels righteous, but persecuted.
Schizotypal	Eccentric, self-estranged, bizarre, absent. Exhibits peculiar mannerisms and behaviors. Thinks can read thoughts of others. Preoccupied with odd daydreams and beliefs. Blurs line between reality and fantasy.
Borderline	Unpredictable, manipulative, unstable. Frantically fears abandonment and isolation. Experiences rapidly fluctuating moods. Shifts rapidly between loving and hating. Sees self and others alternatively as all-good and all-bad.

[1] Listed as a provisional disorder in *DSM-IV.*
[2] From the Appendix of *DSM-III-R.*
[3] Called Self-Defeating in *DSM-III-R* appendix.

prototype, a psychological ideal found only rarely in nature. The disorder is the prototype, put forward in terms of its purest expression.

Real persons, however, seldom are seen as "pure types." The *DSM* does not require that subjects possess each and every characteristic of a personality disorder before a diagnosis can be made. Typically, some majority of criteria will suffice. For example, five of eight criteria are required for a diagnosis of histrionic personality disorder, and five of nine are required for a diagnosis of narcissistic personality disorder. Many different combinations of diagnostic criteria are possible, a fact that recognizes that no two people are exactly alike, even when both share the same personality disorder diagnosis. Although Charles Manson and Jeffrey Dahmer might both be considered antisocial personalities, for example, their personalities are nevertheless substantially different. Determining exactly what separates individuals such as Dahmer and Manson from the rest of us requires a great deal of biographical information. Each chapter in this text, therefore, focuses on factors important in the development of a personality disorder. For example, a chummy relationship between father and daughter is one of the major pathways in the development of an adult histrionic personality disorder.

Categorical typologies are advantageous because of their ease of use by clinicians who must make relatively rapid diagnoses with large numbers of patients whom they see briefly. Although clinical attention in these cases is drawn to only the most salient features of the patient, a broad range of traits that have not been directly observed is often strongly suggested. Categories assume the existence of discrete boundaries both between separate personality styles and between normality and abnormality, a feature felicitous to the medical model, but not so for personality functioning, which exists on a continuum. The arguments of those who favor the adoption of dimensional models enter mainly around one theme: The categorical model, because it entails discrete boundaries between the various disorders and between normality and abnormality, is simply inappropriate for the personality disorders. Although trait dimensions have a number of desirable properties, there is little agreement among their proponents concerning either the nature or number of traits necessary to represent personality adequately. Theorists may "invent" dimensions in accord with their expectations rather than "discovering" them as if they were intrinsic to nature, merely awaiting scientific detection. Apparently, the number of traits required to assess personality is not determined by the ability of our research to disclose some inherent truth but rather by our predilections for conceiving and organizing our observations. Describing personality with more than a few such trait dimensions produces schemas so complex and intricate that they require geometric or algebraic representation. Although there is nothing intrinsically wrong with such quantitative formats, they pose considerable difficulty both in comprehension and in communication among clinicians.

THE *DSM* MULTIAXIAL MODEL

The disorders in the *DSM* are grouped in terms of a multiaxial model. **Multiaxial** literally means multiple axes. Each axis represents a different kind or source of information. Later, we concentrate on exactly what these sources are; now, we just explain their purpose. The multiaxial model exists because some means is required whereby the various symptoms and personality characteristics of a given patient can be brought together to paint a picture that reflects the functioning of the whole person. For example, depression in a narcissistic personality is different from depression in a dependent

personality. Because narcissists consider themselves superior to everyone else, they usually become depressed when confronted with objective evidence of failure or inadequacy too profound to ignore. Their usually puffed-up self-esteem deflates, leaving feelings of depression in its wake. In contrast, dependent personalities seek powerful others to take care of them, instrumental surrogates who confront a cruel world. Here, depression usually follows the loss of a significant caretaker. The point of the multiaxial model is that each patient is more than the sum of his or her diagnoses: Both are depressed, but for very different reasons. In each case, what differentiates them is not their surface symptoms, but rather the meaning of their symptoms in the context of their underlying personalities. By considering symptoms in relation to deeper characteristics, an understanding of the person is gained that transcends either symptoms or traits considered separately. To say that someone is a depressed narcissist, for example, conveys much more than does the label of depression or narcissism alone.

The multiaxial model is divided into five separate axes (see Figure 1.1), each of which gets at a different source or level of influence in human behavior. Axis I, *clinical syndromes,* consists of the classical mental disorders that have preoccupied clinical psychology and psychiatry for most of the history of these disciplines. Axis I is structured hierarchically. Each family of disorders branches into still finer distinctions, which compose actual diagnoses. For example, the anxiety disorders include obsessive-compulsive disorder, posttraumatic stress disorder, and generalized anxiety disorder. The mood

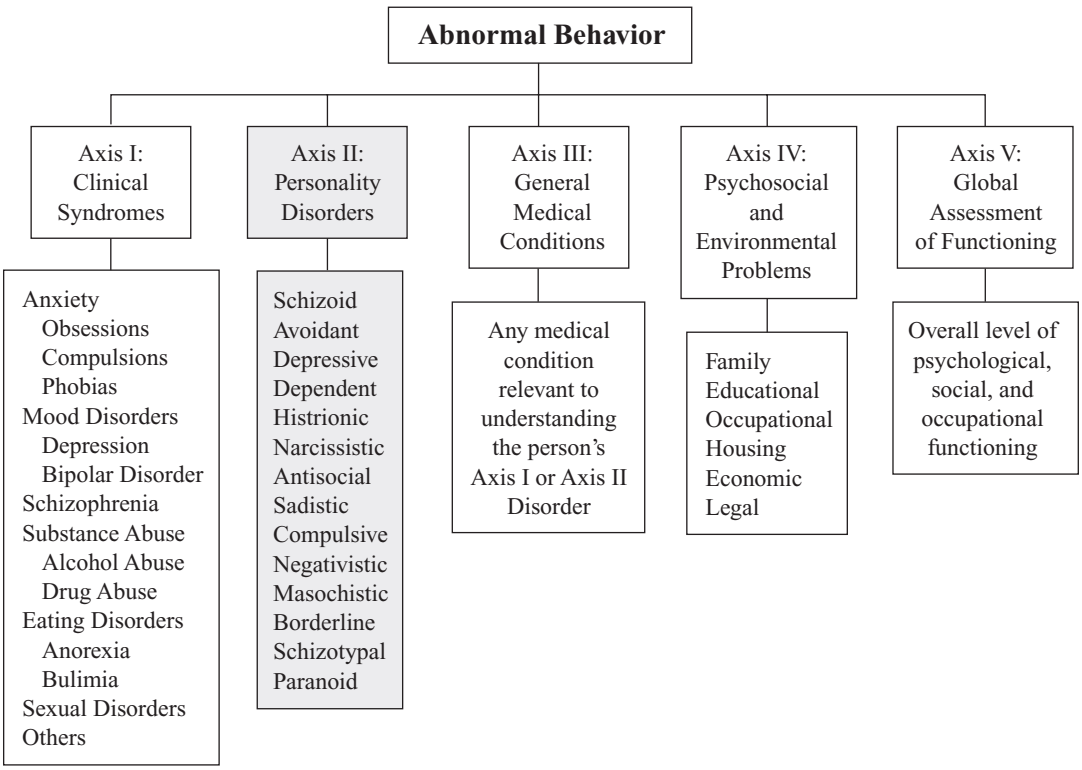

FIGURE 1.1 Abnormal Behavior and the Multiaxial Model.

disorders include depression and bipolar disorder. Other branches recognize sexual disorders, eating disorders, substance abuse disorders, and so on. Finally, each disorder is broken down into diagnostic criteria, a list of symptoms that must typically be present for the diagnosis to be given. Axis II, *personality disorders,* is the subject of this text.

Axis III consists of any *physical or medical conditions* relevant to understanding the individual patient. Some influences are dramatic, and others are more subtle. Examples of dramatic influences include head injury, the effects of drug abuse or prescribed medications, known genetic syndromes, and any other disease of the nervous, respiratory, digestive, or genitourinary system, brain structure, or other bodily system that impacts psychological functioning. Examples of subtle influence include temperament as the pattern of activity and emotionality to which an individual is genetically disposed, as well as constitutional and hormonal patterns. Essentially, Axis III recognizes that the body is not just the vessel of the soul. Instead, we are all integrated physical and psychological beings. A computer metaphor illustrates the concept: Software always requires hardware, and, depending on the hardware, different software functions may be either enhanced or disabled or just run in a different way. Some individuals have a central processing unit that keeps crunching busily, for example, whereas others run hot and have a great-looking case, but not much more. Physical factors always impact psychological functioning, if only because the body is the physical matrix from which mind emerges. Anyone who has had a lobotomy undoubtedly knows this already, but probably doesn't much care.

Axis IV consists of all *psychosocial and environmental factors* relevant to psychological functioning. Included are problems related to the family or primary support group, such as the death of a family member, marital separation or divorce, sexual or physical abuse, family conflict, or inappropriate or inadequate discipline at home. Also included are problems in the social environments outside the family. Educational problems include poor reading skills, lack of sufficient instruction, and conflict with teachers. Occupational problems include threats to employment, actual job loss, and conflict with authority figures and coworkers. Finally, Axis IV includes miscellaneous issues such as *general economic* and *legal problems,* for example, a pending criminal trial.

Axis IV recognizes that each person exists and functions in a variety of contexts and, in turn, these contexts often have profound effects on the individual. For example, if a narcissistic person is fired from employment, odds are that the firing has something to do with the person's intolerable attitude of superiority. Narcissists are above it all, to the point of not bowing to the boss. Some even view themselves as being above the law, as if the rules of ordinary living could not possibly apply to them. By putting all the pieces together—current symptoms, personality characteristics, and psychosocial stressors—a complex, but logical, picture of the total person is obtained. When considered in relation to specific biographical details, the result is an understanding that links the developmental past with the pathological present to explain how particular personality characteristics and current symptoms were formed, how they are perpetuated, and how they might be treated. This complex integration of all available information is known as the **case conceptualization.**

In contrast to the other axes, Axis V contains no specific content of its own. Once the case has been conceptualized, the next question is the level of severity: How pathological is this total picture? To make this determination, problems across all other axes are collapsed into a global rating of level of psychological, social, and occupational functioning, the **Global Assessment of Functioning (GAF)** Scale, which ranges from 0 to

100. Ratings may be made at any particular moment in time, perhaps admission to the hospital emergency room, at intake, or at discharge. Alternatively, ratings can sum up functioning across entire time periods, perhaps the past week or the past year. Limitations due to physical handicaps are excluded. In general, Axis V functions as an overall index of psychological health and pathology. Such measurements are often useful in tracking total progress over time.

Although you could memorize the five axes of the multiaxial model, it is much better to understand the purpose for which the model was constructed—why it exists as it does. The most fundamental reason is that the model increases clinical understanding by ensuring that all possible inputs to the psychopathology of the given subject receive attention. If you went to the doctor for a physical, you would want him or her to check your lungs, heart, kidneys, stomach, and all other major organs and systems. A doctor who pronounced you healthy after taking only your blood pressure would not be much of a doctor at all.

The same is true of the mental disorders. Psychopathology is much more complex, but nothing of importance should be neglected. Each of the axes in the multiaxial model corresponds to a different level of organization, so that each axis contextualizes the one immediately below it, changing its meaning and altering its significance. Axis I is the presenting problem, the reason the patient is currently being held in psychiatric emergency or sits chatting with a psychotherapist. In turn, Axis II, the personality disorders, provides both a substrate and context for understanding the symptoms of Axis I. As a substrate, personality inclines us toward the development of certain clinical disorders rather than others. For example, avoidant personalities typically shun contact with others, even though intimacy, approval, and self-esteem are what they most desperately seek. In contrast, narcissistic personalities, who are frequently indulged as children, grow up with a sense of superior self-worth that others often see as prideful and grandiose. Of the two, the avoidant is much more likely to develop a fear of public speaking, and the narcissist is much more likely to be fired from a job for being arrogant to everyone. The kinds of problems that a particular individual might develop can, in many cases, be predicted once his or her personality characteristics are known. In turn, personality rides on top of biology and rests within the psychosocial environment. We are both physical and social beings. When problems seem to be driven principally by personality factors, we speak of maladaptive personality traits or personality disorders. When difficulties concern primarily environmental or social factors, an Axis I adjustment disorder may be diagnosed or Axis IV problems in living may be noted. Personality is the level of organization in which these influences are synthesized (see Figure 1.2).

The multiaxial model draws attention to all relevant factors that feed into and perpetuate particular symptoms, and it also guides our understanding of how psychopathology develops. In most cases, the interaction of psychosocial stressors and personality characteristics leads to the expression of psychological symptoms; that is, Axis II and Axis IV interact to produce Axis I (see Figure 1.3). When personality includes many adaptive traits and relatively few maladaptive ones, the capacity to cope with psychosocial calamities such as death and divorce is increased. However, when personality includes many maladaptive traits and few adaptive ones, even minor stressors may precipitate an Axis I disorder.

In this sense, personality may be seen as the psychological equivalent of the body's immune system. Each of us lives in an environment of potentially infectious bacteria, and the strength of our defenses determines whether these microbes take hold, spread,

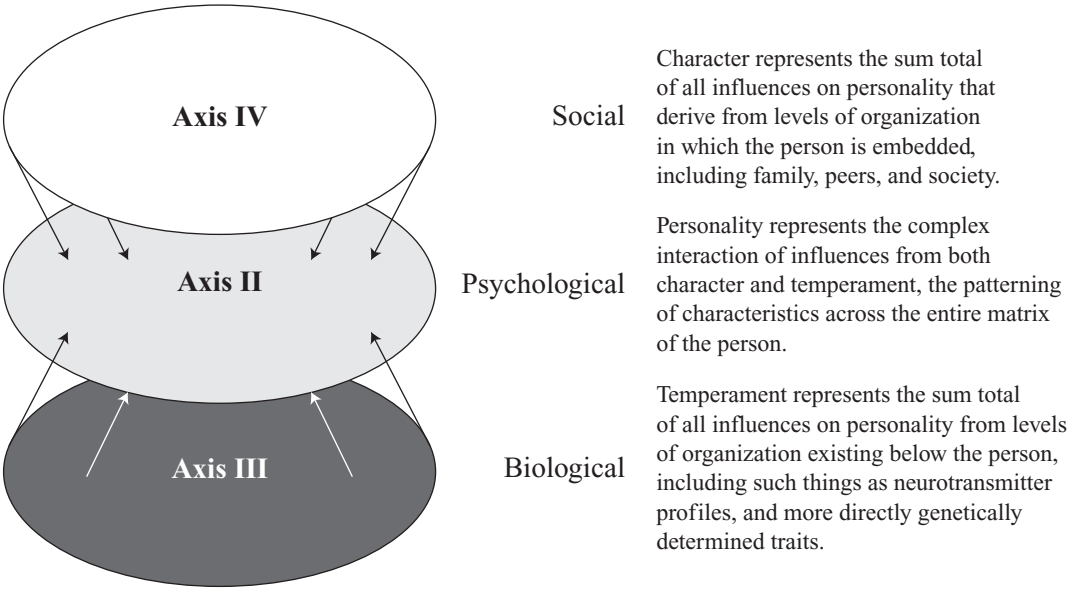

FIGURE 1.2 Levels of Organization and Their Relationship to the Multiaxial Model.

and ultimately are experienced as illness. Robust immune activity easily counteracts most infectious organisms, whereas weakened immune activity leads to illness. Psychopathology should be conceived as reflecting the same interactive pattern. Here, however, it is not our immunological defenses, but our overall personality pattern—that is, coping skills and adaptive flexibilities—that determine whether we respond constructively or succumb to the psychosocial environment. Viewed this way, the structure and characteristics of personality become the foundation for the individual's capacity to function in a mentally healthy or ill way. Every personality style is thus also a coping style, and personality becomes a cardinal organizing principle through which psychopathology should be understood.

PERSONALITY AND THE MEDICAL MODEL: A MISCONCEPTION

By describing the personality disorders as distinct entities that can be diagnosed, the *DSM* encourages the view that they are discrete medical diseases. They are not. The causal assumptions underlying Axis I and Axis II are simply different. Personality is the patterning of characteristics across the entire matrix of the person. Rather than being limited to a single trait, personality regards the total configuration of the person's characteristics: interpersonal, cognitive, psychodynamic, and biological. Each trait reinforces the others in perpetuating the stability and behavioral consistency of the total personality structure (see Figure 1.4). For the personality disorders, then, causality is literally everywhere. Each domain interacts to influence the others, and together, they maintain the integrity of the whole structure. In contrast, the causes of the Axis I clinical syndromes are assumed to be localizable. The cause of an adjustment disorder, for example, lies in a recent change in life circumstances that requires considerable getting used to. Here, causes and consequences are distinguishable, with discrete distinction

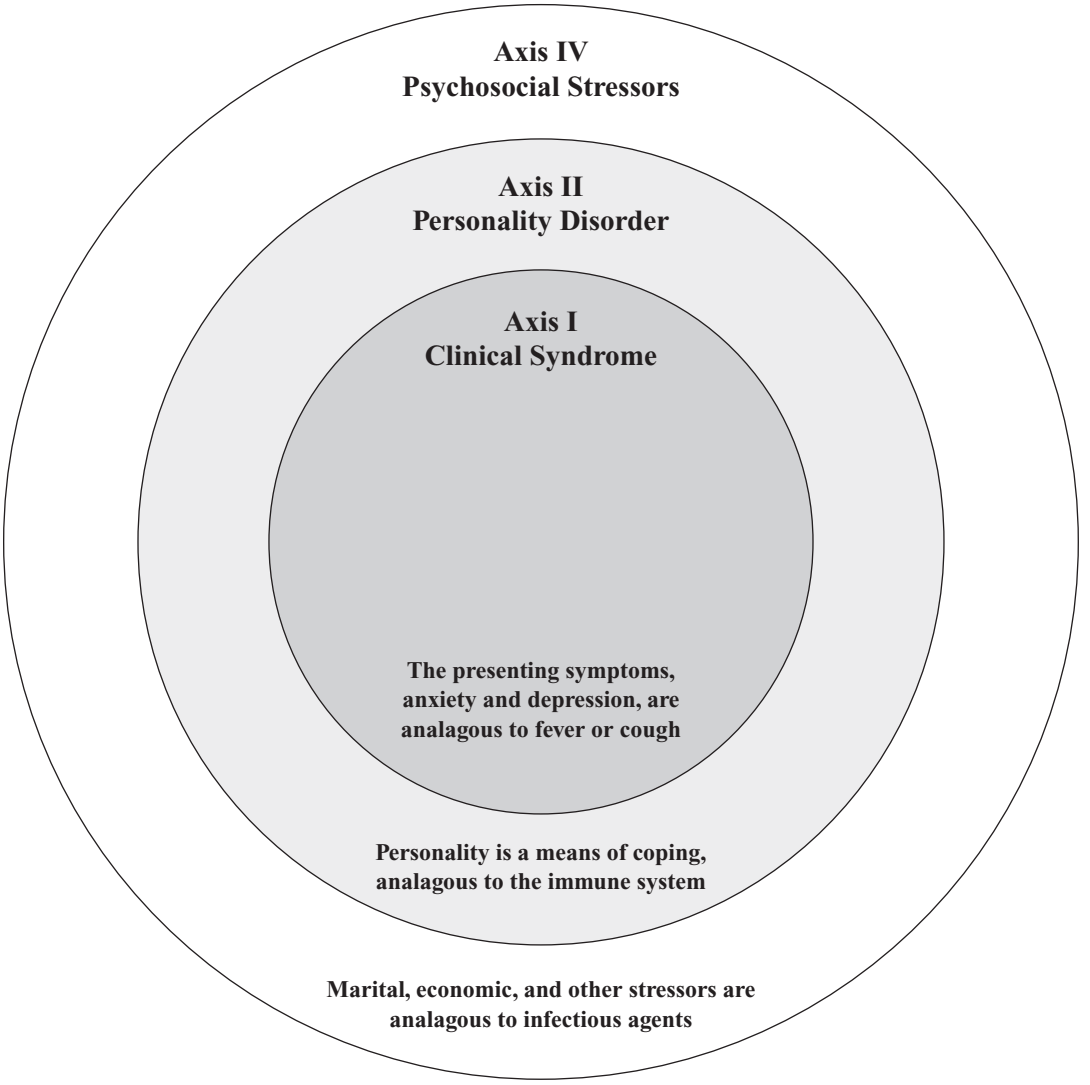

FIGURE 1.3 Axis IV and Axis II Interact to Produce Axis I.

between the underlying "disease" and its symptom expression. Difficulty making an adjustment might result in feelings of depression, for example. For the personality disorders, however, the distinction between disease and symptom is lost. Instead, causality issues from every domain of functioning. Each element in the whole structure sustains the others. This explains why personality disorders are notoriously resistant to psychotherapy.

Personality disorders are not diseases; thus, we must be very careful in our casual usage of the term. To imagine that a disorder, of any kind, could be anything other than a medical illness is very difficult. The idea that personality constitutes the immunological matrix that determines our overall psychological fitness is intended to break the

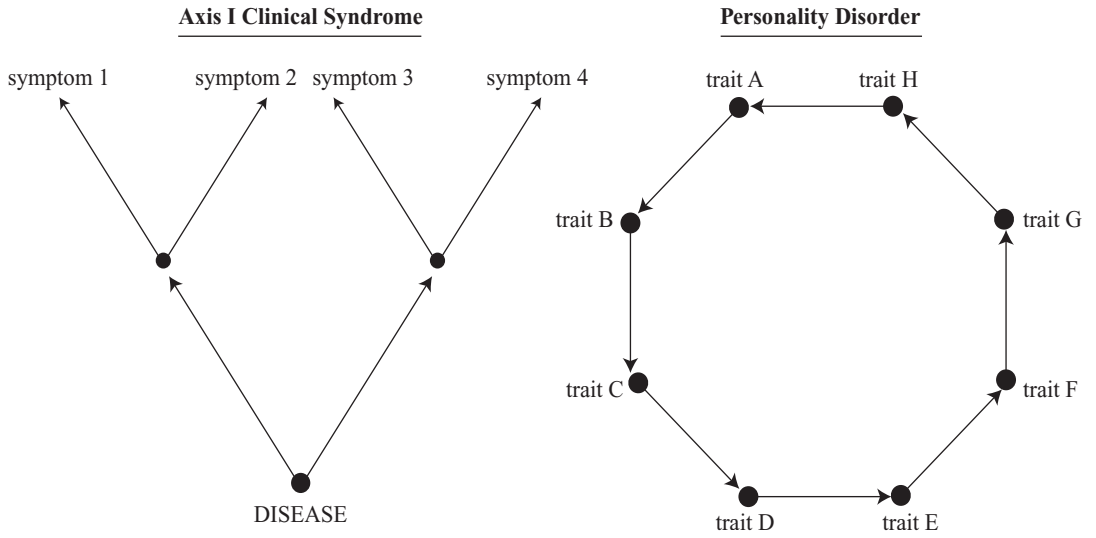

FIGURE 1.4 A Comparison of the Causal Pattern for Idealized Axis I and Axis II Disorders.

long-entrenched habit of conceiving syndromes of psychopathology as one or another variant of a disease, that is, as some "foreign" entity or lesion that intrudes insidiously within the person to undermine his or her so-called normal functions. The archaic notion that all mental disorders represent external intrusions or internal disease processes is an offshoot of prescientific ideas, such as demons or spirits that possess or hex the person. The role of infectious agents and anatomical lesions in physical medicine has reawakened this view. Demons are almost ancient history, but personality disorders are still seen as involving some external entity that invades and unsettles an otherwise healthy status. Although we are forced to use such terminology by linguistic habit, it is impossible for anyone to *have* a personality disorder. Rather, it is the total matrix of the person that constitutes the potential for psychological adaptation or illness.

Normality versus Pathology

Normality and abnormality cannot be differentiated objectively. All such distinctions, including the diagnostic categories of the *DSM-IV,* are in part social constructions and cultural artifacts. Although persons may be segregated into groups according to explicit criteria, ostensibly lending such classifications the respectability of science, the desire to segregate and the act of segregating persons into diagnostic groups are uniquely social. All definitions of pathology, ailment, malady, sickness, illness, or disorder are ultimately value-laden and circular (Feinstein, 1977). Disorders are what doctors treat, and what doctors treat is defined by implicit social standards. Given its social basis, **normality** is probably best defined as conformity to the behaviors and customs typical for an individual's reference group or culture. **Pathology** would then be defined by behaviors that are uncommon, irrelevant, or alien to the individual's reference group. Not surprisingly, American writers have often thought of normality as the ability to function independently and competently to obtain a personal sense of contentment and satisfaction.

Other cultures may have other standards; in Asian societies, for example, individualism is not valued as highly as respect for group norms.

Normality and pathology reside on a continuum. One slowly fades into the other. Because personality disorders are composed of maladaptive traits, there are two ways that personality pathology becomes more severe when moving along the continuum from health to pathology. First, single traits can become more intense in their expression; assertiveness can give way to aggression, for example, or deference can give way to

TABLE 1.2 The Compulsive Personality, from Adaptive to Severely Disordered

	Adaptive	*Subclinical*	*Disordered*	*Severely Disordered*
Perfectionistic	"I take pride in what I do."	"I feel I have to work on things until I get them right."	"I can't stop working on something until it's perfect, even if it already satisfies what I need it for."	"Because nothing is ever good enough, I never finish anything."
Hard-working	"I believe in the work ethic."	"I rarely take time off for leisure or family."	"It drives me crazy if something is unfinished. I have never taken a vacation."	"I panic if I leave the office with something left undone. I work so late that I usually end up sleeping there."
Planful	"I like to consider my choices before I act on something."	"I have to analyze all the alternatives before I make up my mind."	"I try to consider so many eventualities that it becomes very difficult to make a decision."	"I get so lost in trying to anticipate all the possibilities and details that I put things off and never commit to anything."
Morally scrupulous	"I like to do the right thing."	"I am sometimes intolerant of people whose moral standards are less than my own."	"I am disgusted by the moral laxity and indulgence I see in 99% of humanity."	"I think anyone who deviates from the straight and narrow should be punished swiftly for their sins."
Conscientious	"I like to take my time and do things right."	"Sometimes I think others will disapprove of me if they find even one small mistake."	"I find it hard to stop working until I know others will be satisfied with the job I've done."	"I check and recheck my work until I'm absolutely sure that no one can find a mistake in what I've done."
Emotionally constricted	"I rarely get excited about anything."	"I don't believe in expressing much emotion."	"There are only a few things I enjoy, and even with those, I can't let myself go."	"I have never found any use for emotion. I have never felt any enjoyment from life."

masochism. Second, the number of maladaptive traits attributed to the given subject may increase. By comparing the statements given in Table 1.2 for a subset of compulsive traits, we can easily see how normality gradually gives way to personality disorder.

Personality disorders may best be characterized by three pathological characteristics (Millon, 1969). The first follows directly from the conception that personality is the psychological analogue of the body's immune system: Personality disorders tend to exhibit a tenuous stability, or lack of resilience, under conditions of stress. The coping strategies of most individuals are diverse and flexible. When one strategy or behavior isn't working, normal persons shift to something else. Personality disorder subjects, however, tend to practice the same strategies repeatedly with only minor variations. As a result, they always seem to make matters worse. Consequently, the level of stress keeps increasing, amplifying their vulnerability, creating crisis situations, and producing increasingly distorted perceptions of social reality.

A second characteristic overlaps somewhat with the first: Personality-disordered subjects are adaptively inflexible. Normal personality functioning entails role flexibility, knowing when to take the initiative and change the environment, and knowing when to adapt to what the environment offers. Normal persons exhibit flexibility in their interactions, such that their initiatives or reactions are proportional and appropriate to circumstances. When constraints on behavior come from the situation, the behavior of normal individuals tends to converge, regardless of personality. If the boss wants something done a particular way, most people will follow directions. Such situations are highly scripted. Almost everyone knows what to do and behaves in nearly the same way.

By contrast, the alternative strategies and behaviors of personality-disordered subjects are few in number and rigidly imposed on conditions for which they are poorly suited. Personality-disordered subjects implicitly drive or control interpersonal

FOCUS ON CULTURE AND PERSONALITY

The Misunderstood Student

The Interplay of Culture

Jenna, a first-year graduate student in psychology, was required to write up her impressions of a videotaped therapy session featuring a beginning therapist and a female Asian student referred by her instructor for excessive shyness. Eventually, Jenna noticed that regardless of what the therapist said, the student always seemed to agree. At the end of the session, the therapist was interviewed and asked for his impressions. The therapist reinforced the instructor's opinion about the student's shyness and felt change would be fast because the student offered little resistance. As Jenna's instructor pointed out, this conclusion was incorrect. In fact, the much younger female student was prevented from disagreeing with the much older male therapist because of cultural norms. Once the student was empowered to disagree, it was discovered that conventions appropriate to her reference group largely accounted for her behavior with her instructor, not long-standing personality traits. Accordingly, therapy was refocused on adjustments to the expectations of American culture, not on personality change.

situations through the intensity and rigidity of their traits. In effect, the personality-disordered person provides the most powerful constraints on the course of the interaction. Because they cannot be flexible, the environment must become even more so. When the environment cannot be arranged to suit the person, a crisis ensues. Opportunities for learning new and more adaptive strategies are thereby even further reduced, and life becomes that much less enjoyable.

The third characteristic of personality-disordered subjects is a consequence of the second. Because the subjects fail to change, the pathological themes that dominate their lives tend to repeat as vicious circles. Pathological personalities are themselves pathogenic. In effect, life becomes a bad one-act play that repeats again and again. They waste opportunities for improvement, provoke new problems, and constantly create situations that replay their failures, often with only minor variations on a few related, self-defeating themes.

FOCUS ON PERSONALITY AND RELATIONSHIPS

The Compulsive Entrepreneur

How Do Personalities Interact?

Eager to learn about the characteristics of the different personality disorders, Jenna asked her clinical supervisor for materials that might bring the different personalities vividly to life. She received an audiotape of a husband-and-wife interview with consent of the subjects. During the session, the wife bitterly complained that her husband, married once previously, spent almost no time with the family. Asked why his first wife had divorced him, the man stated solemnly that she was incapable of taking life seriously and refused to help while he toiled hour after hour checking and rechecking the operational details of their new business. Further probing revealed that although both women acknowledged his ability to stay focused on task, both also complained that the marriage had no intimacy, spontaneity, or romance. As additional data came to light, the husband was diagnosed as an obsessive-compulsive personality. His rigid work ethic and unending earnestness created almost identical problems across two relationships.

Early Perspectives on the Personality Disorders

The history of every science may be said to include a prescientific "natural history" phase, where the main questions are, "What are the essential phenomena of the field?" and "How can we know them?" Ideally, as more and more data are gathered through increasingly sophisticated methodologies, common sense begins to give way to theoretical accounts that not only integrate and unify disparate observations, but also actively suggest directions for future research. The existence of black holes, for example, is predicted by the theory of relativity, and the accumulated evidence of several decades now suggests that one or more black holes exist at the center of every galaxy. No one will ever smell, taste, touch, hear, or see an actual black hole. Because