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# EVOLUTION OF PERSONALITY DISORDER DIAGNOSIS IN THE *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS*

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**ABSTRACT.** *This article reviews the history and evolution of the diagnosis of personality disorders according to the Diagnostic and Statistical Manual of Mental Disorders (DSM) from its first edition in 1952 through its fourth edition in 1994. The article also traces the earliest origins of personality disorders (e.g., Hippocrates) through the modern foundational works of Pritchard, Schneider, and Horney. Analysis of the changes across the editions of the DSM suggest slow but steady progress in the clarification and classification of personality disorders, although formidable challenges remain. A call for future research as to reliability and validity of personality disorders is made, and suggestions for research are offered. © 1998 Elsevier Science Ltd*

PERSONALITY DISORDERS HAVE been defined as longstanding and long-lasting maladaptive patterns of inner experiences and behaviors that seriously impair an individual's ability to perform adequately in a variety of settings. The key features of personality disorders appear to be their early onset (typically by adolescence or early adulthood), stability and chronicity (although individual symptoms and the overall severity may wax and wane), pervasiveness (relationships, occupational, and educational settings), intrapsychic and interpersonal focus, and impairment (the disorder must disrupt social or occupational functioning; Hirschfeld, 1993).

The history of personality disorders can be traced to Hippocrates (1952), who, in about 400 BC, described four fundamental body fluids associated with specific personality patterns (e.g., black bile is indicative of melancholia). His theory, however, was physiologically based, yet he also associated environmental features like climate and temperature with the exacerbation or even creation of essential personality traits, such as aggression or gentleness (e.g., mild climates produce gentle races, and climatic extremes arouse strong emotions and passions). The modern history of personality disorders has been frequently attributed to Pritchard (1835). In 1835 he insightfully described what is now the antisocial personality disorder as a condition of “moral

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insanity” whereby there was a perversion of feelings, habits, morals, and impulses yet without any defects of intellect or reasoning and without the presence of hallucinations.

Even more influential on the overall structure and nature of current personality disorders has been the work of Schneider (1950), who first published his taxonomy in 1923. He heralded the present Axis II disorders in many respects. First, he did not view “psychopathic personalities” (his term for personality disorders) as necessary precursors to other or more severe mental disturbances but saw them as coexistent entities. Second, he saw them as developing in childhood and continuing into adulthood. Third, he described 10 different psychopathic personalities commonly seen in psychiatric settings, some of which have greatly influenced current personality disorder diagnoses such as his depressive personality (depressive personality disorder), anankastic personality (obsessive compulsive personality disorder), attention-seeking personality (histrionic personality disorder), labile personality (borderline personality disorder), and the affectionless personality (antisocial and schizoid personality disorders).

It is the purpose of the present article to examine the evolution of the diagnosis of modern personality disorders in the five versions of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, first published in 1952 (for a more complete historical overview of the European origins of personality disorders, see Berrios, 1993). Contrary to some observers, personality disorder diagnoses did not begin in 1980 with publication of the innovative multiaxial *DSM-III*. It is our intention that elucidation of the evolution of the diagnosis of personality disorders may be helpful in the continued research and validation of the past, present, and future of personality disorders. Our historical overview may also help clarify the genesis of the current personality disorder typography so that clinicians and researchers can have a greater appreciation for the broader context of this important diagnostic category. Further, we hope that increased awareness of the evolution of *DSM*-based personality disorders will prevent the current classification from becoming a mere palimpsest, such that the long and rich history of personality disorders is lost.

Personality disorders are debilitating and fairly common, and most practicing mental health professionals will undoubtedly have clients in their caseloads with severe personality dysfunction. According to Turkat (1990), approximately 50% of clients seeking psychotherapy services suffer from personality disorders. Even higher rates have been reported in diverse settings: 67% in a state hospital population (Jackson et al., 1991) and 63% in a depressed elderly mixed inpatient and outpatient sample (Molinari & Marmion, 1995). Weissman (1993) estimated the overall lifetime rate of personality disorders to be between 10% and 13%. These estimates were based on community surveys and large samples of relatives and through various methods including self-report inventories and clinical interviews. In our recent study, we assessed personality disorders in young (mean age = 39 years) and old (mean age = 63 years) chronically mentally ill inpatients and found high prevalence rates for both groups: 66% for the younger sample and 58% for the older sample (Coolidge, Segal, Pointer, Knaus, & Yamazaki, in press). In all, it is clear that many clients receiving psychiatric services for diverse Axis I conditions (e.g., depression, anxiety, substance abuse, schizophrenia) also have comorbid personality disorders (e.g., Coolidge, Janitell, & Griego, 1994). Moreover, many of these patients have several personality disorder diagnoses, as overlap among these illnesses is typical.

Such conditions are both fascinating and bedeviling, as they often negatively impact treatment efficacy. Therapeutic progress is often slower, treatment noncompliance

rates are higher, and difficulty forming collaborative therapeutic relationships is endemic. Personality disorders are also difficult to diagnose properly. In fact, agreement between diagnosticians (reliability) has been notoriously poor for personality disorders (Segal, 1997; Segal & Falk, 1998). Moreover, the fact that the diagnostic criteria and conceptualization of the personality disorders have changed so remarkably over the past 40 years has also contributed strongly to diagnostic difficulty. We hope that our discussion of the evolution of the diagnostic category of personality disorders from *DSM-I* to the current *DSM-IV* classification system will also shed some light on the changing nature of the taxonomy of this particular form of psychopathology.

### THE *DSM-I*

Although anecdotal and literary descriptions of individuals who may have had personality disorders are thousands of years old, official diagnosis of personality disorders as a unique and separate diagnostic entity did not formally appear until 1952, with publication of the *DSM* (American Psychiatric Association, 1952). As previously noted, however, Schneider's early work in 1923 and his later revisions profoundly influenced the modern *DSM* system. Earlier official (not the work of a single individual) diagnostic systems in this century, particularly from about 1915 to the 1940s, were dominated by various and numerous categories of psychoses, including organic (clear physiological etiology) and psychogenic (functional, psychologically caused, or of unknown etiology) and usually a single category of neurotic types. In some respects, however, this is not an entirely out-dated system, because psychoses and neuroses were viewed by many psychologists and psychiatrists at that time as existing on a continuum of functioning. Those patients whose behavior was severely incapacitated were diagnosed as psychotic, and lesser disturbances of behavioral functioning were viewed as neurotic. In fact, psychoneurotic reactions were actually diagnosed as "minor psychoses" as early as 1924, and even antisocial behavior was first termed a type of "psychosis with psychopathic personality" (Strecker & Ebaugh, 1940, p. 84).

The 1952 *DSM* arose from earlier work beginning in May 1917. The Committee on Statistics of the American Psychiatric Association (then called the American Medico-Psychological Association) adopted the first official classification system at that time. Along with the approval of the National Committee for Mental Hygiene (which became the National Association for Mental Health), the American Psychiatric Association assumed official responsibility for maintenance and publication of the national diagnostic system. The original purpose of the classification scheme was primarily to gather statistical data in mental hospitals, and this is why the word *statistical* still appears in the title of the *DSM*. Minor revisions of the 1917 nomenclature occurred in 1933 and 1942. With the beginning of World War II, the military was faced with a tremendous need for a more sophisticated diagnostic system. Indeed, the simple gathering of statistics was no longer prudent. Rather, the military needed a classification system that involved useful diagnostic terminology, particularly for placement and treatment. It was estimated that 90% of the psychiatric caseload of the military at that time did not fit within the standard diagnostic nomenclature. For example, even minor personality disturbances had to be classified as "psychopathic personality" (American Psychiatric Association, 1952).

Both the Navy and Army made their own changes to the standard system in the 1940s. Even the Veterans Administration independently adopted its own revised standard system. From about 1948 through 1951, the American Psychiatric Association

worked fervently on a single revised system, and the result of this monumental work appeared in the first publication of the *DSM* (American Psychiatric Association, 1952).

The 1952 *DSM* consisted of seven major diagnostic categories, including a category entitled "Personality Disorders." On the basis of the *DSM*, personality disorders were:

characterized by developmental defects or pathological trends in the personality structure, with minimal subjective anxiety, and little or no sense of distress. In most instances, the disorder is manifested by a lifelong pattern of action or behavior, rather than by mental or emotional symptoms. . . . The Personality pattern disturbances are considered deep seated disturbances, with little room for regression. (p. 34)

There were three separate sections in the 1952 *DSM* personality disorders classification. The first section listed four "cardinal personality types," which were said to be rarely if ever altered by any form of therapy. They were as follows:

1. *Inadequate personality*: characterized by inadequate responses to intellectual, social, emotional, and physical demands coupled with inflexibility, ineptness, poor judgment, lack of stamina, and social incompatibility.
2. *Schizoid personality*: depicted by avoidance of close relationships, inability to express anger, autistic thinking, coldness, detachment, and daydreams about omnipotence.
3. *Cyclothymic personality*: characterized by "extratensive" and outgoing adjustment to life with frequently alternating moods of elation and sadness as well as being either persistently euphoric or depressed.
4. *Paranoid personality*: characterized by traits of the schizoid personality plus "exquisite" sensitivity in relationships, suspiciousness, envy, jealousy, and stubbornness.

The second section of the personality disorders category of the 1952 *DSM* listed four personality trait disturbances. They were defined as a category of personality disorders where the individuals were:

unable to maintain their emotional equilibrium and independence under minor and major stress because of disturbances in emotional development. . . . This classification will be applied only to cases of personality disorder in which the neurotic features (such as anxiety, conversion, phobia, etc.) are relatively insignificant, and the basic personality maldevelopment is the crucial distinguishing factor. (p. 36)

They were as follows:

1. *Emotionally unstable personality*: depicted by excitability and ineffectiveness in even minor stressful situations, poor judgment under stress, and fluctuating relationships due to poorly controlled anger, anxiety, and guilt.
2. *Passive-aggressive personality*: consisted of three subtypes—passive-dependent type who are helpless, overly dependent, and indecisive; passive-aggressive type who express their aggressiveness through passive means like pouting, procrastination, and intentional inefficiency; and the aggressive subtype who react to frustration with irritability, temper tantrums, and overt destructive behaviors.
3. *Compulsive personality*: characterized by chronic and excessive worries about conformity to internal standards of conscience or external conformity to societal

standards. Such individuals were also excessively inhibited, rigid, unable to relax, and overly involved in work.

4. *Personality trait disturbance, other*: this diagnosis was reserved for any exaggerated personality trait that was not classifiable elsewhere.

The third section of the 1952 *DSM* personality disorders category listed four types of “sociopathic personality disturbances.” This section was for individuals who “are ill primarily in terms of society and of conformity with the prevailing cultural milieu” (p. 38). They were as follows:

1. *Antisocial reaction*: individuals who are chronically in trouble and do not seem to change as a result of experience or punishment, with no loyalties to anyone.
2. *Dyssocial reaction*: individuals who disregard societal rules, although they are capable of strong loyalties to others or groups.
3. *Sexual deviation*: included diagnoses of homosexuality, transvestism, pedophilia, fetishism, and sexual sadism.
4. *Addictions*: two subtypes were listed—alcoholism and drug addiction. The latter was viewed as “usually symptomatic of a personality disorder” (p. 39), and the diagnosis of the additional personality disorders was encouraged.

The 1952 *DSM* descriptions for all 12 main types of personality disorders consisted of at most two paragraphs and most typically four or five sentences. Although it was a major evolution in the diagnosis of personality disorders, psychological tests for the assessment of personality disorders would lag for an additional 25 or more years. By any standards of success, however, the *DSM* was a hit. It was widely used and reprinted 20 times through 1967. No rival system existed in the United States. The international World Health Organization had produced the only world-wide alternative to the *DSM*, called the International Classification of Diseases (ICD), which included a section on mental disorders. The American Psychiatric Association’s Committee on Nomenclature and Statistics helped to revise the ICD for its eighth edition (ICD-8), which was approved in 1966 and published in 1968. At the same time, the American Psychiatric Association sent the first major revision of the 1952 *DSM* to 120 psychiatrists in February, 1967. As a result of this feedback, the second edition of the *DSM* (*DSM-II*) was published early in 1968, and it was then aligned with the ICD-8.

### **Comment**

Overall the *DSM-I* appears to have been an adequate starting point for the diagnosis of personality disorders. It began the tradition of the categorical diagnosis of personality disorders, although the diagnostic system employed was atheoretical. Furthermore, the diagnosis of the individual disorders lacked essential criteria, and the disorders themselves were proposed without substantial empirical support for reliability and construct validity. Subsequent research was hampered by these latter factors. Furthermore, a major guiding principle of change in the history of the *DSM* has always been improvements in reliability and validity of diagnoses. Ironically, changes in the *DSM* have not been made to make it more consonant with any particular theoretical orientation despite the fact that the history of psychology has been dominated by major theoretical paradigms (e.g., psychoanalytic, behavioral, humanistic).

### THE DSM-II

The *DSM-II* (American Psychiatric Association, 1968) contained 10 major categories of mental disorders (up from seven in *DSM-I*). Section V was entitled "Personality Disorders and Certain Other Nonpsychotic Mental Disorders." Code number 301 was given to the 10 specific types of personality disorders. Sexual deviations now had its own code number (302), as did alcoholism (303), and drug dependence (304). The general description of personality disorders in *DSM-II* was brief (two sentences): "This group of disorders is characterized by deeply ingrained maladaptive patterns of behavior that are perceptibly different in quality from psychotic and neurotic symptoms. Generally, these are life-long patterns, often recognizable by the time of adolescence or earlier" (p. 41). The 10 specific *DSM-II* personality disorders were as follows:

1. *Paranoid personality*: characterized by hypersensitivity, suspicion, jealousy, and envy as well as the tendency to blame others and perceive evil intentions in others.
2. *Cyclothymic personality*: shown by alternating periods of depression and elation, which were not attributable to external factors.
3. *Schizoid personality*: manifested by shyness, seclusiveness, avoidance of close or competitive relationships, and eccentricity. Other features included autistic thinking, daydreaming, and an inability to express ordinary aggressive feelings.
4. *Explosive personality*: typified by outbursts of rage atypical of the individual's normal personality.
5. *Obsessive compulsive personality*: demonstrated by excessive concern with conformity. Such individuals also appeared rigid, overinhibited, duty- and work-bound, and unable to relax.
6. *Hysterical personality*: characterized by excitability, emotional instability, self-dramatization, and attention-seeking behavior as well as a tendency to be seductive, vain, and self-centered.
7. *Asthenic personality*: manifested by being easily fatigued, having low energy, an inability to enjoy life, and oversensitivity to stress.
8. *Antisocial personality*: for individuals who are unsocialized, in repeated conflicts with society, incapable of loyalty, selfish, irresponsible, and unable to learn from prior experiences.
9. *Passive-aggressive personality*: characterized by passivity and aggression through obstinate behavior, procrastination, stubbornness, and intentional inefficiency.
10. *Inadequate personality*: as shown by ineffectual responses to emotional, intellectual, social, and physical demands despite apparent capabilities to perform in these areas.

*DSM-II* also included two additional categories of personality disorders: an "other" type and an "unspecified" type. However, these disorders were in title only, as they did not have accompanying definitions. It is also interesting to note one subtle change from *DSM-I* to *DSM-II*, and that is the simple addition that personality disorders are recognizable by adolescence or earlier. *DSM-I* mentioned that they tended to be life-long, but there was no mention of onset. Both *DSM-I* and *DSM-II* noted the chronicity of personality disorders, but neither described any changes in the disorders as a differential function of life span or type of personality disorders.

### Comment

From the *DSM-I* to the *DSM-II*, seven personality disorders essentially remained the same, four disorders were dropped, and three new ones were added. The categorical diagnosis of personality disorders persisted despite the lack of specific criteria for each diagnosis. Only brief descriptions were presented, generally consisting of one or two sentences. Thus, the problems of poor reliability and validity of the diagnoses of the personality disorders also continued.

### THE *DSM-III*

Diagnosis of personality disorders took the equivalent of a quantum leap with publication of the *DSM-III* in 1980 (American Psychiatric Association, 1980). Indeed, the entire manual nearly tripled in pages from 134 in *DSM-II* to 494 in *DSM-III*. The diagnostic paradigm also shifted from a psychoanalytic perspective to a behavioral one. However, the major evolution in the *DSM-III* came in the form of an innovative multiaxial approach, in which psychiatric diagnosis was divided into five separate "axes" or domains on which information about several important areas of functioning is recorded. Major clinical syndromes (e.g., depression, panic disorder, schizophrenia, etc.) were to be coded on Axis I, and Axis II was reserved for personality disorders and some types of childhood problems. Axis III was used for the notation of physical problems or disorders. Interestingly, this axis represented the actual demise of the *DSM-II* section VI: "Psychophysiological Disorders." The *DSM-III* officially recognized that an individual's psychological state could affect and aggravate any physical system. Thus, rather than the previous *DSM-II* comprehensive list of all possible organs and organ systems that could be influenced by one's mental state, the entire section of psychophysiological disorders was dropped. The *DSM-III* stated that Axis III be used to code any physical disorder relevant to the patient's psychological state that is pertinent to the understanding or management of the case. Axis IV was provided to code the severity of psychosocial stressors in the patient's life, and Axis V was used to code the patient's highest level of adaptive functioning in the past year.

Placement of personality disorders on Axis II had a profound effect. Clinicians were now more than subtly forced to evaluate each of their patients for a personality disorder. It was estimated that 40% to 50% of all patients with an Axis I diagnosis might also have an Axis II personality disorder. The need for personality tests to assess personality disorders also became obvious. In the *DSM-III*, there was also a revolutionary development in the descriptions and diagnosis of personality disorders. For the first time in the history of diagnostic nomenclature, a specific list of numbered criteria was presented for each personality disorder. For a patient to receive a personality disorder diagnosis, the patient had to meet a specified minimum number of criteria. The set of criteria was considered to be "polythetic," indicating that no single criterion was considered to be essential or sine qua non.

The *DSM-III* also revised the formal definition of personality disorders:

Personality *traits* are enduring patterns of perceiving, relating to, and thinking about the environment and oneself, and are exhibited in a wide range of important social and personal contexts. It is only when *personality traits* are inflexible and maladaptive and cause either significant impairment in social or occupational functioning or subjective distress that they constitute *Personality Disorders*. The manifestations of Personality Disorders are generally recognizable by adolescence or earlier and continue throughout most of adult life, though they often become less obvious in middle or old age. (p. 305)

This description of traits and their relationship to disorders is an important one to the conceptual issue of whether personality disorders should be viewed as discrete categories (apart from normalcy) or whether it is more useful to view them as dimensionally and continuously related to the behaviors of normal individuals (except that the behaviors are at an extreme position on a continuum). It should be noted here that the *DSM* has always approached diagnosis (for personality disorders and all other mental disorders) from a categorical (present/absent) perspective, despite the fact that, for the personality disorders, pure types are rarely seen in clinical practice. Moreover, most empirical personality research of abnormal behavior has involved the use of dimensional models, which typically have ranged from 3 to 16 core factors or personality traits. For further discussion of dimensional approaches to personality, see Cloninger (1987), Eysenck (1978), and McCrae and Costa (1986, 1989).

Another interesting aspect of personality disorder diagnoses in *DSM-III* was that they were grouped into three clusters. The odd or eccentric cluster consisted of the paranoid, schizoid, and schizotypal personality disorders. The dramatic, emotional, or erratic cluster consisted of the histrionic, narcissistic, antisocial, and borderline personality disorders. The anxious or fearful cluster consisted of the avoidant, dependent, compulsive, and passive-aggressive personality disorders.

The *DSM-III* revised definition of personality disorders also contained another important element, notably, the hypothesis that personality disorders may become less prominent in middle and old age. Although conventional thought and wisdom anecdotally support the idea that the elderly appear to be less violent and antisocial as a group, conventional thinking just as well supports the hypothesis that the elderly as a group may withdraw and become more schizoid (for full review of diagnostic issues regarding personality disorders in older adults, see Segal, Hersen, Van Hasselt, Silberman, & Roth, 1996). Thus, although this novel aspect of the *DSM-III* definition was interesting and compelling, it was also provocative.

There were at least two other revolutionary aspects of the personality disorders section in *DSM-III*. First, unlike previous editions, *DSM-III* specifically noted that personality disorders may be a preexisting condition in psychotic Axis I disorders (e.g., schizophrenia) and that such preexisting personality disorders should be coded on Axis II. Second, the *DSM-III* reported that traditionally clinicians have sought a single, specific personality disorder to describe a patient, yet more frequently patients are not limited to a single personality disorder. The *DSM-III*, therefore, officially encouraged multiple diagnoses of personality disorders provided that the patient met full criteria for each disorder coded.

Overall, the *DSM-III* listed 11 specific personality disorders (compared to 12 in *DSM-I* and 10 in *DSM-II*). Only four personality disorders remained essentially unchanged from *DSM-I* through *DSM-III*: paranoid, schizoid, antisocial, and passive-aggressive types. Two had name changes, each containing a touch of irony: The new *DSM-III* histrionic personality disorder was formerly the hysterical personality disorder in *DSM-II*, although the name histrionic personality disorder appeared in parentheses in *DSM-II*. Also, the *DSM-I* compulsive personality disorder, which changed to obsessive compulsive personality disorder in *DSM-II*, changed backed to its original name in *DSM-III*, compulsive personality disorder.

Four specific personality disorders were eliminated: the cyclothymic and inadequate personality disorders, which had persisted from *DSM-I*, and the explosive and asthenic personality disorders, which made their only appearance in *DSM-II*. Five new personality disorders were also added to *DSM-III*: schizotypal, narcissistic, borderline, avoidant, and dependent. There was also a final single category: atypical, mixed, or other person-

ality disorders. This designation was applied where there was insufficient information to make a specific diagnosis but a personality disorder was suspected, when an individual did not meet the full criteria for a specific personality disorder but they had significant features of several personality disorders, or when the clinician felt that the individual fit the diagnosis for a personality disorder that was not listed in *DSM-III*.

### **Comment**

Development of the multiaxial diagnostic system was clearly a landmark in the history of psychiatric diagnosis, prompting a multifold evaluation of a patient's problems. Also highly notable was the placement of personality disorders on Axis II, the recognition that personality disorders are inherent personality traits that become disorders when they are inflexible and maladaptive, and the development of specific polythetic criteria for each personality disorder. From the *DSM-II* to the *DSM-III*, six personality disorders remained, three were eliminated, and four new personality disorders appeared, and one personality disorder reappeared from the *DSM-I*. Overall, the reliability and validity of the personality disorder diagnoses improved with the publication of the *DSM-III*; however, the reliabilities and validities still lagged behind more prominent Axis I diagnoses (see the classic report by Mellsop, Varghese, Joshua, & Hicks, 1982; also see Segal, 1997).

### **THE *DSM-III-R***

The revision of the *DSM-III* took only 7 years, and the *DSM-III-R* was published in 1987 (American Psychiatric Association, 1987). The 11 personality disorders remained, and they were again coded on Axis II. The odd or eccentric cluster of personality disorders from *DSM-III* officially became Cluster A in *DSM-III-R* and still consisted of the paranoid, schizoid, and schizotypal personality disorders. Although there were changes in the criteria for each personality disorder, each disorder still consisted of a group of polythetic criteria. The dramatic, emotional, or erratic cluster became Cluster B and still consisted of the histrionic, narcissistic, antisocial, and borderline personality disorders. The anxious or fearful cluster became Cluster C and still consisted of the avoidant, dependent, and passive-aggressive personality disorders. The compulsive personality disorder of the *DSM-III* remained in Cluster C but was renamed obsessive compulsive personality disorder. The latter change was highly ironic because in *DSM-I* it was compulsive personality disorder, in *DSM-II* it was obsessive compulsive personality disorder, in *DSM-III* it was back to compulsive personality disorder, and in *DSM-III-R* it reverted again to obsessive compulsive personality disorder.

There were also two new and potentially controversial personality disorders that were placed in Appendix A, which indicated that the disorders required further systematic investigation. These were the sadistic and the self-defeating personality disorders. Sadistic personality disorder was characterized by pervasive cruel, demeaning, humiliating, and aggressive behavior directed toward others, along with a basic lack of empathy and respect for others. In contrast, the self-defeating personality disorder was typified by ubiquitous self-defeating behavior such as repeatedly entering into unsatisfying and hurtful relationships, avoiding opportunities for pleasure, rejecting relationships with seemingly caring people, and repeatedly rendering ineffective reasonable efforts by others to help the person. Specific code numbers for these two proposed diagnoses were not provided, but official polythetic criteria were noted to encourage clinical research.

### Comment

Stability of the personality disorder diagnoses marked the *DSM-III-R*, in that all 11 personality disorders from *DSM-III* remained in the *DSM-III-R*. However, some of the criteria for the personality disorders were clarified and anchored to more objective, observable behaviors. These criteria changes resulted in substantially improved reliability and validity of the individual disorders. Also noteworthy was that the changes in criteria were at least partly based on systematic literature reviews and empirical research, a trend that continued into the *DSM-IV*. A final unique contribution of *DSM-III-R* was the use of the appendix to introduce proposed, questionable, or controversial personality disorders. The stated purpose of the appendix was to promote additional empirical research into these personality disorders.

### THE *DSM-IV*

The *DSM* was revised and published again in a 7-year interval. Notably, there are currently only 10 personality disorders in the *DSM-IV* (American Psychiatric Association, 1994) on Axis II. Due to poor reliability and questionable validity and usefulness, the passive-aggressive personality disorder was removed from Cluster C and was placed in Appendix B (for further study). The alternate name, negativistic personality disorder, also was given to the passive-aggressive personality disorder. A new personality disorder, the depressive personality disorder, also appeared in *DSM-IV* Appendix B. This condition is characterized by a pervasive pattern of depressive cognitions and behaviors, low self-esteem, brooding, and pessimism. Notably, the sadistic and self-defeating personality disorders described in *DSM-III-R* were dropped completely from the diagnostic manual. The current list of personality disorders in *DSM-IV* is as follows: Cluster A, odd or eccentric (paranoid, schizoid, and schizotypal); Cluster B, dramatic, emotional, or erratic (antisocial, borderline, histrionic, and narcissistic); Cluster C, anxious or fearful (avoidant, dependent, and obsessive-compulsive); Appendix B, criteria sets and axes provided for further study (depressive and passive-aggressive [negativistic]).

### SUMMARY AND CONCLUDING COMMENTS

A summary comparison for the personality disorders for all five versions of the *DSM* appears in Table 1. A review of the table reveals that there have been 21 different personality disorders across the five *DSM* versions. It is also interesting to note that only three personality disorders have remained unchanged—paranoid, schizoid, and antisocial. Ironically, a fourth—the obsessive compulsive personality disorder—remained conceptually unchanged while its name changed three times. The irony is that the obsessive compulsive personality disorder has historically been described as a personality style characterized by having ambivalent features (Millon, 1981) and vacillating between obedience and defiance (Rado, 1969). Eight personality disorders appeared in only one version of the *DSM*, and they were dyssocial (*DSM-I*), sexual deviations (*DSM-I*), addictions (*DSM-I*), explosive (*DSM-II*), asthenic (*DSM-II*), self-defeating (*DSM-III-R*, Appendix A), sadistic (*DSM-III-R*, Appendix A), and depressive (*DSM-IV*). Stability, however, appears to be the hallmark of the last three versions of the *DSM*, in that 11 personality disorders have remained essentially unchanged across the last three versions.

As we look to the future evolution of personality disorders in the *DSM*, it is likely that changes will continue to occur. Poor diagnostic reliability has always been the

**TABLE 1. The Evolution of Personality Disorder Diagnoses in the Diagnostic and Statistical Manual of Mental Disorders (DSM)**

<i>DSM-I</i> (1952)	<i>DSM-II</i> (1968)	<i>DSM-III</i> (1980)	<i>DSM-III-R</i> (1987)	<i>DSM-IV</i> (1994)
Paranoid	Paranoid	Paranoid	Paranoid	Paranoid
Schizoid	Schizoid	Schizoid	Schizoid	Schizoid
Antisocial	Antisocial	Antisocial	Antisocial	Antisocial
Emotionally Unstable	—	Borderline	Borderline	Borderline
Compulsive	Obsessive Compulsive	Compulsive	Obsessive Compulsive	Obsessive Compulsive
Passive-Aggressive	Passive-Aggressive	Passive-Aggressive	Passive-Aggressive	— <sup>a</sup>
Cyclothymic	Cyclothymic	—	—	—
Inadequate	Inadequate	—	—	—
Dyssocial	—	—	—	—
Sexual Deviation	—	—	—	—
Addictions	—	—	—	—
—	Explosive	—	—	—
—	Hysterical	Histrionic	Histrionic	Histrionic
—	Asthenic	—	—	—
—	—	Schizotypal	Schizotypal	Schizotypal
—	—	Narcissistic	Narcissistic	Narcissistic
—	—	Avoidant	Avoidant	Avoidant
—	—	Dependent	Dependent	Dependent
		Appendix A	Appendix B	Appendix B
		Self-Defeating	Self-Defeating	—
		Sadistic	Sadistic	—
		—	—	Passive-Aggressive
		—	—	Depressive

<sup>a</sup>Placed in Appendix B.

bane of personality disorder assessment, and although agreement rates are as high as ever they are still modest at best. Refinements in the criteria for personality disorders (to increase reliability and reduce overlap among disorders) are more likely to continue than wholesale changes in the diagnostic categories, and this prediction is based on the recent versions of the *DSM*. However, use of the appendix ("Criteria Sets and Axes Provided for Further Study") of the *DSM* will likely announce the rise and fall of personality disorders in the future. For example, the appendix of the *DSM-III-R* announced two new personality disorders (i.e., self-defeating and sadistic), which were then eliminated from *DSM-IV*. The passive-aggressive personality disorder, which had been stable across the first four versions of the *DSM*, ended up in the appendix of *DSM-IV*, probably heralding its elimination. Rather than being capricious or dependent on the whims of a few influential clinicians, these changes are now based on empirical studies that show low coefficients of reliability and that question the diagnoses' validity. Indeed, empirical reports and data analyses (and some reanalyses) were heavily consulted to direct *DSM-IV* workshop members (Livesley, 1995). It is also possible that archaic personality disorders may come to life as new assessment methods and techniques are developed. For example, there have been recent calls to revive the dyssocial personality disorder from *DSM-I*, whose essential feature was antisocial behavior, although it was coupled with individual and group loyalties. This personality disorder may be particularly relevant with the increased awareness of and problems stemming from gang-related behavior.

Widiger (1993) noted that the ill-defined substantive validity of many personality disorders may, in part, be due to the lack of a theoretical model. He also noted that the consequence of a lack of theory has not resulted in an atheoretical taxonomic system but in a "theoretical stew," and thus some personality disorders are defined more in terms of a psychoanalytic model, some behavioral, and others by a physiological framework. He also argued that another consequence of this theoretical stew is that there is a lack of guidance as to whether personality disorders should be described by a particular domain of functioning (e.g., by emotional state, cognitive functioning, or intrapsychic vs. interpersonal features). However, it is interesting to note that personality trait and disorder research does not suffer from a paucity of theoretical models. Besides the traditional and still influential models like the psychoanalytic, behavioral, humanistic, and physiological theories, there are newly emerging paradigms such as the evolutionary psychology paradigm. Although the latter paradigm may never completely replace other models, it does preliminarily appear to make some important and heretofore unrecognized contributions to the ontogeny and phylogeny of personality disorders. For example, the theory postulates that personality disorders may arise evolutionarily because of their initial and continuing adaptive qualities. As a case in point, the antisocial personality disorder may owe its existence to the adaptive influence of predatory and remorseless behavior that subsequently results in increased reproductive opportunities and the accumulation of resources, and the paranoid personality disorder may result from the successful anticipation of the aggressive behavior of competitors (e.g., see Beck, 1992).

There are also a host of relatively new (and older) paradigms that attempt to account for the specific number of factors required to describe the normal and abnormal personality. Horney (1945) described three neurotic trends that have recently found empirical support in the interpretation of personality disorders (Coolidge, Moor, & Yamazaki, in press). Her trends were the tendencies to moving toward others (compliance), moving against others (aggressive), and moving away from others (detachment). Eysenck (1978) also postulated a three-trait model with the dimensions of psychot-

icism, extraversion-introversion, and neuroticism. He further interpreted these dimensions in a multitheoretical framework involving learning styles and an interaction with the person's physiological substrate, thus reflecting his or her biological heritability. Cattell (1965) created a 16-source factor model of the normal (and ultimately the abnormal) personality by factor analyzing a plethora of previously identified personality traits. His work was the basis for the further refined, five-factor model of personality (Norman, 1963; Tupes & Christal, 1961), although the exact nature of the five factors is far from settled (Coolidge et al., 1994). The five factors were themselves factor analytically derived from Cattell's 16 source factors. Cloninger, Svrakic, and Przybeck (1993) proposed a seven-factor model consisting of four purportedly genetically based and independent trait dimensions (novelty seeking, harm avoidance, reward dependence, and persistence) and three character dimensions (self-directedness, cooperativeness, and self-transcendence). Livesley (1995) reported that early in the *DSM-IV* revision process attempts were made to gain a consensus on trait dimensions that might describe and underlie the personality disorders. There was a preliminary agreement on seven trait dimensions (introversion, neuroticism, constraint, antagonism, closedness, reward dependence, and cognitive disorganization); however, the proposal was abandoned to avoid the advocacy of a formal model without a solid empirical basis. This thinking, however, reflects an ironic yet nearly universal belief that personality disorders are best conceived of as dimensionalized traits and that it is only when the traits result in pervasive, inflexible, and maladaptive patterns of behavior may they be diagnosed as full-blown personality disorders. The irony is that the diagnosis of personality disorders remains categorical from *DSM-I* through *DSM-IV*.

It is perhaps better that the *DSM-IV* workshop members viewed their tasks conservatively. Thus, wholesale changes were not made, a formal dimensionalized underlying trait system was not endorsed, and ultimately the changes from *DSM-III-R* to *DSM-IV* were minimal. Although lack of change may disappoint clinicians who ask for greater clarity into the definitional basis of personality disorders, the *DSM-IV* task-force members accomplished a greater good: They relied on sound empirical investigations to make the changes that they did, and lacking this evidence they did not act. The latter behavior may be considered an advance in the diagnosis of personality disorders because personal agendas, individual opinions, and whimsy were largely avoided.

We agree with the calls for theoretical models for the interpretation and evolution of personality disorder diagnosis (e.g., Widiger, 1993), and we firmly support the contention that purely empirically based changes in the *DSM* may enhance reliability at the cost of construct validity. Strategies in the investigation of the construct validity of personality disorders may be to view each personality disorder as a separate hypothetical construct and to require evidence of construct validity for each specific criterion.

In conclusion, researchers of personality disorders must come to terms with one of the most basic dilemmas of the whole science of psychology. That is, are we preparadigmatic (on the verge of a unitary paradigm), or will we remain forever a multiparadigmatic science? It appears, then, that we walk a fine line between the dust bowl of atheoretical empiricism and the dogma associated with a single model. An advantage of development of theoretical models is that research is guided by a priori hypotheses generated from the theory. As a result, a theory can evolve based on empirical support (or lack of support) for these hypotheses. In contrast, disadvantages of the development of theoretical models are that a particular model may simplify complex relationships and may negatively narrow the scope of an investigation (e.g., important related factors that are not part of a theory may be ignored by proponents of a particular

theory). It also seems far too early in the history of personality disorder research to promote a single model as a guide to the interpretation of future *DSM* changes. However, the future of personality disorder research appears as exciting as ever if we also do not forget the value of viewing our past.

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