CHAPTER 24

Dissociative, Somatoform, and Personality Disorders

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With the system for multiaxial diagnosis specified by the revised Diagnostic and Statistical Manual (DSM-III; APA, 1980), interest has renewed in classifying operationally defined behaviors described as deviant and maladjusted. It has been said that the DSM-III implies a medical model explanation for aberrant response styles, and the system has been criticized for other problems (Adams & Haber, 1984; Schacht & Nathan, 1977). Yet the five-axial format allows for description of behaviors in terms of class and multivariate models. Its advantages are important for attempting to specify the common responses, etiology, natural history, and prognosis of individuals who may be labeled in the dissociative, somatoform, and personality disorder groups. Whatever the theoretical assumptions about the causes of normal or aberrant behaviors, it is possible to assess the basic response patterns suggested by the DSM-III for these disorders. This chapter presents an overview of the dissociative, somatoform, and personality disorders, with primary focus on research attempting to identify common responses which exist over time and with specificity in given situations. For each disorder we shall explore subsets of characteristics which covary uniquely within a classification set and discuss briefly hypothesized etiologies contributing to the disorders. Where possible, progression and prognosis for symptom remission will be considered.

DISSOCIATIVE DISORDERS

The DSM-III classification of "dissociative phenomena" is used to refer to sudden, temporary alterations in the normally integrative functions of consciousness, identity, or motor behavior that remain unobserved by the individual and dissociated from ongoing cognitions and events. Within this context, even

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dramatic episodes are assumed to be of psychogenic rather than organic etiology. Dissociative disorders are rare among psychiatric samples, especially in light of the sensationalism generated by several celebrated cases. Further, a high occurrence of malingering has been documented in dissociative cases. Kiesch (1962), for example, used both hypnotic and sodium amytal approaches to assess the claims of 98 military patients who reportedly suffered from various amnesic symptoms. In this sample, roughly 42% were determined to be malingering. Unfortunately, similar statistics are not available for other forms of dissociative disorders. For the present then, general descriptions are essentially all that can be gleaned from the body of available literature.

Historically, clinicians have suggested that the key feature of dissociative disorders is memory loss or disruptions in acquisition, retention, and retrieval functions. The severity of dissociative disorders is defined in terms of the course and degree of recoverability. It is assumed that the extent to which dissociated memory subpatterns are accessible and the degree to which identity, cognitions, and motor behaviors have been altered during the dissociative episode are important in predicting treatment outcome. For example, individuals who are amnesic for events preceding a traumatic incident but recognize a memory lapse have occurred tend to be characterized by better prognosis than those in a fugue state, who suffer from disrupted identity and motor behaviors and leave the home environment with no knowledge of their "normal" psychosocial, psychomotor state. Even upon recovery in such cases, patients may be unable to recall the events that were experienced during the fugue. Unfortunately, systematic evaluation of the varied symptoms, disorder progression, and effective resolution is essentially nonexistent despite a long history of clinical accounts dating to Janet (1889). However, Aalpoel and Lewis (1984) noted a welcome resurgence of scientific interest in dissociative phenomena.

Writers of the DSM-III subdivided dissociative disorders into five categories, which include psychogenic amnesia, psychogenic fugue state, multiple personality, and depersonalization disorder, as well as a residual atypical category for patients who appear to be experiencing dissociative symptoms but cannot easily be classified into one of the other subtypes. Examples of atypical disorders include trancelike states, such as those associated with hypnosis and somnambulism, derealization (where unreality applies to the external rather than internal world) unaccompanied by depersonalization, and states of prolonged dissociation similar to those seen in intense persuasive efforts such as brainwashing. Researchers and clinicians do not unanimously support this classification system, and future nosological efforts will be required to isolate salient differentiating features of dissociative phenomena and to ensure the basic integrity of the scheme.

Psychogenic Amnesia

"Amnesia" is a term commonly used to refer to acute memory loss for important previously learned/stored information. The potential role of physical trauma in
producing such memory loss is discussed extensively in the literature (Lewis, 1979; Russell, 1981). However, DSM-III specified that a diagnosis of psychogenic amnesia implies absence of organic etiological factors. This differentiation tends to have initial appeal, but determination of the relative contributions of organic and functional variables presents diagnostic challenges. Some researchers have reasoned that all authentic memory phenomena must inevitably be mediated by specific neurochemical or physiological substrates (Lewis, 1979). Others, such as Stengel (1966), emphasized that psychological factors play a crucial role in memory functioning even when cerebral damage is obviously apparent. Precise isolation and delineation of physical versus psychogenic influences are difficult if not impossible tasks for practicing clinicians.

The course of the amnesic episode generally follows a sudden, often dramatic onset with gradual and usually complete remission over a period of hours, days, or months. Specific physical and psychological traumatic events typically precipitate amnesic episodes (Sargent & Slater, 1941), and the literature is replete with speculations that ineffective coping skills and potent secondary gains often predispose and maintain their occurrence (Aalpoel & Lewis, 1984). Memory losses may be for isolated events (selective amnesia) or all events (localized amnesia) occurring during a specified period of time, and patient awareness of the lapses frequently results in help-seeking behaviors. In some rare amnesic cases, patients are unable to recall all previous life events (generalized amnesia). In others, the memory lapse is equally complete but restricted to information acquired subsequent to the precipitating traumatic episode (continuous amnesia). Most common are instances of memory failure for isolated information surrounding a traumatic event in which the information is recovered gradually over time. Amnesic patients may forget critical information involving a previous traumatic event or in some cases may forget name, home address, or other identifying data. Despite distress about the memory difficulties, patient behavior is often within normal limits. Hence masking of the cognitive deficit is often complete. Although Nemiah (1975) found that memory deficits may also be associated with temporary confusion or clouding of consciousness, basic learned abilities and motor skills are almost never influenced.

Most critical for assessment of psychogenic amnesia is an accurate description of the phenomena, the precipitating circumstances, and the consequences of the episode to the patient. This information will assist the clinician in generating hypotheses regarding the etiology of the memory lapse and treatment methods for its alleviation. Adams (1981) offered four guidelines to facilitate diagnosis: (1) Psychogenic amnesia tends to appear and disappear rapidly. (2) It is commonly selective for events surrounding a traumatic emotional event. (3) In certain unique situations, such as hypnosis, the memories can be recovered. (4) There is an absence of evidence implicating organic brain disease or physical trauma. Aalpoel and Lewis (1984) noted additional cues to detect amnesic malingering, such as episode duration and presence of secondary gains. Nevertheless, the state of the art in assessing and treating dissociative disorders is limited by a number of factors, including our ability to measure memory functioning in its various
facets. Russell (1981), for example, presented an impressive integration of our understanding of memory dysfunctions with known organic etiologies. Equal sophistication has not been attained with psychogenic amnesia cases, and clinicians must await research advances with these interesting phenomena.

**Psychogenic Fugue**

The origin of the word *fugue* has been traced to the Latin term meaning to “run away” or “flee.” Patients suffering from psychogenic fugue abruptly assume a different personal identity, travel to a new locale, and typically cannot recall previous life events. Numerous accounts have described a precipitating emotional conflict situation (Laughlin, 1967). Nevertheless, the behaviors of an individual in a fugue state may not appear blatantly aberrant. Aalpoel and Lewis (1984) isolated sporadic accounts of “trancelike states,” perplexity, and disorientation in some cases, but they concluded that patients in dissociative fugue states experience minimal psychological distress and concern about the memory loss. Instead, cognitive activity in these patients may be restricted to goal-oriented thoughts about travel or other seemingly minor details. The DSM-III indicated that social interactions, although minimal and typically avoided, may be surprisingly well integrated in some cases.

Patients may remain in fugue states for durations up to years. They may undertake completely new occupations, remarry, or undergo other dramatic life-style changes. Yet clinicians have noted that the new identities tend to be similar to those of the prefugue state. Although spontaneous recovery of the previous identity is common, memory upon recovery for occurrences during the fugue state is rare. Aalpoel and Lewis (1984), however, reviewed a range of responses among those patients who did become aware of their memory disturbances. Some individuals displayed obvious concern and made appreciable attempts at recall. Others evidenced “la belle indifférence,” or “sweet indifference,” and resisted efforts toward memory restoration. Denial of reality appears to be central to the disorder, particularly in cases of the latter type. Diagnosis by DSM-III rules out an organic etiology to these disturbances.

**Multiple Personality**

Multiple personality is said to be characterized by the existence of two or more distinct “personalities,” with one dominant at a given time. Each personality represents a complex entity integrated with memories, behavior patterns, and social associations. In terms of prevalence, Abse (1966) found less than 200 documented cases in the psychiatric and psychological literature. More recently, Aalpoel and Lewis (1984) pointed to a resurgence of reports over the past decade. Documented cases are typically dramatic in their description of extreme psychopathological manifestations and sudden changes. In fact, many of these accounts have been widely circulated for their literary rather than scientific value. As a result, skepticism has been generated among behavioral scientists.
about the validity of clinician-writer claims. Aalpoel and Lewis (1984) noted, however, that psychiatrists, clinical psychologists, and other direct observers of multiple personality have typically been convinced of its reality.

Patients characterized as multiple personality commonly present with complaints of depression, severe headache, dizzy spells, periodic blackouts, amnesic episodes, and even hallucinations. Alarm is often expressed with regard to these manifestations. After obtaining an unusually bizarre developmental history, the clinician may mistake the disorder for schizophrenia or some other form of psychosis. Correct diagnosis may await a dramatic transition occurring in the therapist's office. The presenting personality may remain briefly or for periods of up to years. Usually, one personality is dominant over the course of the disorder, but the dominant expression may not necessarily represent the most capable or adaptive personality constellation present within the individual. Ellenberger (1970) noted that with the mutually cognizant multiple personality, amnesia is virtually absent. Both personalities are aware of one another and the events that transpire in both states; yet each maintains a separate identity and an autonomous state of functioning. It is also possible to identify a mutually amnesic case, in which neither personality is aware of the other's thoughts and experiences. One-way amnesic situations also exist, in which one personality is aware of the other(s), but this state of awareness is not reciprocal.

Secondary personalities are usually aware of the dominant entity, yet reciprocal recognition is often absent or indirect, even when videotapes are used to stimulate the memory of the primary personality. The ascendancy of secondary personalities to permanent positions of dominance has been reported. Transitions from one personality to another are sudden and may not be predictable. Increased stress, fatigue, and/or emotional responses have been implicated as possible precursors for transitions. Personalities may differ on a multitude of dimensions, including age, sex, marital status, body image, physical health, creative abilities, and such personality traits as introversion–extraversion, gregariousness, impulsivity, egocentrism, and capacity for violence. Differences have been found between personalities on projective and objective psychological tests, but no discrepancies have been found in intellectual functioning (Larmore, Ludwig, & Caia, 1977; Ludwig, Brandsma, Wilbur, Bendfeldt, & Jameson, 1972; Thigpen & Cleckley, 1954).

The etiology of multiple personality is incompletely understood. Some clinicians have suggested that patients raised in highly restrictive environments may resort to diametrically opposite behaviors as an escape from the intolerable stress associated with their upbringing. This postulation is inadequate for explaining the memory peculiarities which are central to the disorder. Other hypothesized precursors to multiple personality include such childhood problems as violent and rigidly repressive parental styles, confusing identification with parents, sexual molestation, conflicts between desires and restrictions, and repressed anger. Our knowledge is limited largely to data offered in single case reports, and the rarity of the disorder makes it unlikely that systematic research studies will proliferate.
Depersonalization Disorder

Extreme accounts of depersonalization have been reported (Schilder, 1914), but most writers describe the phenomena in less dramatic terms. In any event, a vast range of symptomatology is suggested. The DSM-III diagnostic criteria specify one or more episodes of depersonalization sufficient to produce significant impairment in social or occupational functioning, with the symptom not due to any other disorder. The process of depersonalization refers to perceptual alterations by which the experience of self and reality are temporarily lost or changed. Sensations of self-estrangement or unreality may include feelings that extremities have changed in size or perceptions of self seen from a distance. Having identified over 50 patients with such features, Ackner (1954) described depersonalized patients as characterized by unpleasant feelings of change from baseline states, perceptions of self and body feeling unreal and dreamlike despite grossly intact reality-testing ability, and affective unresponsiveness. These experiences were said to be ego-dystonic in nature and without evidence of delusional thinking.

Controversy exists as to whether depersonalization satisfies the criteria for classification under the rubric of dissociative phenomena. A critical problem in diagnosis of depersonalization is that the disorder refers exclusively to private, unobservable cognitive events; nevertheless, widespread prevalence of depersonalization symptoms necessitates classificatory efforts of some sort. For example, mild depersonalization occurs at some time in 30–70% of young adults (APA, 1980). Roberts (1960) found symptoms in 40% of his student population, and Dixon (1963) reported a similar estimate (46%). A higher prevalence has been observed in women (Roth, 1959; Shorvon, 1946). Onset is typically characteristic of adolescence, but symptoms emerge in rare cases after the age of 40 years. The course of the disorder is variable, generally chronic, and punctuated by recurrences and exacerbations. Among the factors thought to precipitate depersonalization are physical and emotional trauma, medical illness and concomitant stress, and exhaustion and anesthesia associated with childbirth (Mayer-Gross, 1935; Roth, 1959; Shorvon, 1946). Interestingly, sensory deprivation has been found to induce feelings of depersonalization (Weckowicz, 1970), as has ingestion of LSD (Hofmann, 1970).

SOMATOFORM DISORDERS

The past decade has been a time for increased interest in exploring interactions between psychological processes and physical illness. Lowy (1979) estimated that 30–80% of patients seeking medical assistance do so for somatic problems that may be related to functional rather than organic etiologies. Categories which may be considered for differential diagnosis when patients present with somatic complaints include: somatoform, factitious, psychophysiological, malingering, and medical illness. An understanding of the conceptual system incorporating
these entities is essential for medical health professionals, especially psychologists working in hospital and outpatient medical settings. Patients falling under the rubric of somatoform disorders represent difficulties—both in terms of assessment and management. Although there may be absence of diagnosed physical dysfunction, repetitive and unnecessary reliance on physicians places patients at risk for physical harm associated with potentially damaging medical procedures, for example, repeated X-rays and exploratory surgery. Differential diagnosis is problematic yet essential for appropriate case assessment and treatment (see Table 24.1).

Unlike patients characterized as somatoform disorder, those diagnosed as factitious or malingering express or exude feelings of voluntary symptom control. In both malingering and factitious cases, no actual tissue damage can be detected; however, personal motives for the fabricated distress differ sharply. Among malingers, the purpose of the complaints is said to be recognizable, given knowledge of current environmental circumstances. With factitious patients, there seems to be no apparent goal other than to assume the patient role. Reinforcers for the deception are often nonspecific and difficult to determine. The factitious category is subdivided into two types: factitious disorder with physical symptoms, known as Munchausen syndrome, and factitious disorder with psychological symptoms, known as Ganser syndrome. Patients described by the former category are vulnerable for negative consequences, such as

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Tissue Damage</th>
<th>Feelings of Symptom Control</th>
<th>Primarily Medical or Psychological Disorder</th>
<th>Patient Motivation</th>
</tr>
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<tbody>
<tr>
<td>Somatoform disorders</td>
<td>Absent</td>
<td>No control</td>
<td>Psychological</td>
<td>Reduce somatic distress</td>
</tr>
<tr>
<td>Factitious disorders</td>
<td>Absent</td>
<td>Complete control</td>
<td>Psychological</td>
<td>Varied, nonspecific, and complex; usually to receive reinforcement from health care professionals in the form of emotional support, etc.</td>
</tr>
<tr>
<td>Psychophysiological disorders</td>
<td>Present</td>
<td>Minimal control</td>
<td>Both</td>
<td>Reduce somatic distress</td>
</tr>
<tr>
<td>Malingering</td>
<td>Absent</td>
<td>Complete control</td>
<td>Neither</td>
<td>Specific and identifiable personal gain; avoidance of negative consequences, etc.</td>
</tr>
<tr>
<td>Medical illness</td>
<td>Present</td>
<td>No control</td>
<td>Medical</td>
<td>Reduce somatic distress</td>
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needless surgeries, extended hospitalizations, and unwarranted drug taking. Indeed, their "doctor shopping" may result in permanent disability.

In psychophysiological disorders, there is evidence of tissue damage and/or physical dysfunction. Unfortunate misconceptions are the terms "psychophysiological" or "psychosomatic" imply unreal medical complaints or that illness is a manifestation of disordered " psyche." Henneker (1982) demonstrated that such notions do exist, as 74% of patient, 12% of general physician, and 7% of psychiatrist samples surveyed endorsed the view that psychophysiological disorder represented " imaginary illnesses." In contrast to what may be believed among patients and some physicians, fundamental to the concept of psychophysiological disorder is medical illness which is generated and/or exacerbated by psychological influences, such as chronic anxiety. Classic examples are ulcerative colitis, asthma, and peptic and duodenal ulcers. Although their presence does not necessarily imply psychological causes, in many cases it is clear that such processes influence generation and/or exacerbation of disease.

Somatization Disorder

The label "somatization" represents DSM-III nosology, but the concept is closely tied to the traditional notion of hysteria with its rich psychoanalytic history. Hysteria has been viewed as illustrative of the process by which deep-seated neurotic conflicts become manifested in physical disorders. Briquet (1871) early described hysterical disorders, and other writers have elaborated on his concept (Putt, Reins, & Cohen, 1951). Guze (1975) coined the label "Briquet's syndrome," and the term persists as a synonym of somatization disorder. A number of studies have been designed to refine diagnostic criteria in somatization disorder (Putt et al., 1951; Woodruff, Clayton, & Guze, 1971). Cloninger, Reich, and Guze (1975) concluded that data from a variety of sources confirm the reliability and validity of the diagnosis, and Woodrup et al. (1971) reported that patients meeting the criteria for hysteria showed chances of 90% in remaining clinically stable over time.

Patient accounts of physical symptoms are commonly dramatic, vague, and overemphasized, with a course that is characteristically prolonged, fluctuating, and unlikely to remit (Guze, 1975). Age of onset is usually before 30 years and most often during adolescence or the early twenties. Early onset has significance, because later development may be tied to actual physical dysfunction (APA, 1980). Somatization patients are convinced of the authenticity of their complaints and may solicit attention from multiple medical sources. Symptoms cover a range of neurological, gastrointestinal, psychosomatic, cardiopulmonary, reproductive, and pain-related areas. Psychosomatic traits suggested by diagnosis of histrionic personality. Pointing to depression as a complication, Morrison (1981) reported that 64% of 39 identified histrionic patients admitted at least one unsuccessful suicide attempt. However, Morrison (1981) found only one convincing case of a Briquet's suicide among 29 29.
suicides, and Woodruff et al. (1971) noted that successful suicides are rare. Brioquet's patients have also been seen as exhibiting such histrionic features as emotional lability, self-dramatization, manipulation, attention seeking, and sexual maladjustment. This constellation has traditionally suggested a functional basis to complaints. Hyler and Spitzer (1978) observed that somatization disorder and histrionic personality disorder are separate entities and that one does not necessarily indicate the other.

The estimated prevalence of somatization is 1–2% in women and extremely rare among men (APA, 1980; Guze, 1975; Woodruff et al., 1971). Pitman and Moffett (1981) reviewed the literature on occurrence of Brioquet's syndrome in men and found only two single case reports in the modern English literature other than their own and Brioquet's (1859) seven documented male cases. While the prevalence may be considered low, somatic complaints are observed with high frequency in the general population. Lowy (1979) found that about 60% of the general population periodically report somatic complaints of some type. Similarly, White, Williams, and Greenberg (1961) concluded that 75% of normal people experience some illness or injury each month which requires alterations in behavior, such as absenteeism, diminished activity, or medication. It is widely recognized that only a small subset of such persons satisfy criteria for Brioquet's syndrome.

The etiology of somatization disorder is unclear, but several factors have been suggested. Cultural influences have been shown to predispose some groups, such as those of lower socioeconomic status and limited education, to respond to psychological stress with somatization (Crandell & Dohrowend, 1967; Langner & Michael, 1963). Differences may also be apparent across ethnic (Mechanic, 1972) and urban versus rural populations (Gordon & Gordon, 1959). Lowy (1979) suggested that early life experiences operating through mechanisms of modeling, identification, and incorporation may be predisposing factors for somatization. For an interesting conceptualization of chronic illness behavior as a function of social learning, see Woolley, Blackwell, and Winget (1978).

Woodruff et al. (1971) noted that the first-degree relatives of women with hysteria were 10 times more likely to develop the disorder than were women in the general population, and these authors cited supportive evidence for the role of genetic influences in the disorder etiology.

Conversion Disorder

Conversion disorders have a rich psychoanalytic history dating to the writings of Charcot (1877) and Breuer and Freud (1895/1950). Conversion patients suffer from specific, acute, and usually dramatic losses or alterations of voluntary bodily functioning which are determined to result from psychological rather than physiological processes. The symptomatology usually suggests neurological disease with involvement of any sensory or motor modality. Common presenting problems include anesthesia (total loss of sensation), hypoesthesia (reduced sensitivity), paresthesia (unusual sensation), and psychomotor disability.
ness, aphonia, paralysis, and unconsciousness are among the classical symptoms. Autonomic and endocrine system responses, such as vomiting and false pregnancy, are rare.

Conversion disorder frequently develops in a setting of extreme psychological stress and is usually characterized by acute onset, particularly in adolescents and young adults (APA, 1980). Disabilities that result are usually marked and inevitably interfere with daily activities. Support for an association between hysterical personality characteristics and conversion disorder has been equivocal. Traditionally, there have been recurrent analytic claims for a high incidence of hysterical features in these patients, but Jones (1980) argued that this assumption is unjustified. Incidences as low as 8% (Chodoff & Lyons, 1958) are apparently more common than previously believed. There is also disagreement regarding the diagnostic significance of "la belle indifference." Mucha and Reinhardt (1970), for example, found that la belle indifference characterized 100% of a group of conversion cases, while other researchers reported this attitude in about one-third of cases (Stephens & Kamp, 1962). Buss (1966) contended that only a minority of conversion patients exhibit minimal concern about their complaints.

Diagnosis of conversion disorder, as with all somatoform disorders, suggests that patients have no voluntary control over the symptom(s). Because the range of distress could indicate serious CNS impairment, misdiagnosis may have disastrous consequences. Slater and Glithero (1965) completed a 7- to 11-year follow-up study of diagnosed conversion cases and found that 60% had either died from or developed evidence of authentic organic disease. Whitlock (1967) also argued that organic factors should not be dismissed lightly in conversion disorders. Jones (1980) pointed to increased numbers of hospitalizations and unnecessary surgical interventions in this population. This incidence of needless surgery has probably diminished over the years with increased diagnostic sophistication; however, to arrive upon differential diagnoses among patients with physical complaints is difficult. Such factors as selectivity of dysfunction, pattern of symptoms, presence of symptoms during sleep, and others are important to consider.

The prevalence and distribution by sex of conversion disorders are still poorly understood. Engel (1970) and Jones (1980) concluded that conversion symptoms are 2 to 3 times more common in women. Coleman, Butcher, and Carson (1980) suggested that the disorder may have declined in incidence during recent years. Certainly, cultural-environmental factors influence its expression (Weinstein, Eck, & Leyerly, 1969). It has been assumed that conversion disorders result from ignorance and lack of psychological sophistication, but Engel (1970) contended that the disorder is not restricted to uneducated, unsophisticated persons or members of culturally more primitive groups but instead is expressed in terms of prevailing medical notions popular for the time and place. Thus cultures with commonplace advanced neurological knowledge would predictably foster alternative, more socially acceptable forms of conflict resolution than conversion.
The etiology of conversion disorder is unknown, but most writers suggest a significant role for primary and secondary reinforcers. Traditionally, primary reinforcement has been thought to result from minimization of psychological conflicts, but potent, tangible reinforcers, such as attention and concern from an audience, probably act in a more direct manner and largely circumvent the need for implication of unconscious influences. Secondary gains are described in the DSM-III as avoidance of noxious activities or support derived from the environment which otherwise might not be forthcoming. The differentiation between primary and secondary influences, however, is largely a semantic issue, with the central point being that potent cognitive and environmental factors are thought to influence the occurrence of conversion reactions.

**Psychogenic Pain Disorder**

DSM-III diagnostic criteria include reports of prolonged, severe pain in the absence of observable organic pathology and/or grossly exaggerated pain descriptions beyond those expected from physical examination. It is said that chronic pain syndrome may develop at any time in life but that the periods of adolescence and early adulthood represent those of greatest vulnerability. The disorder is diagnosed more frequently among women and individuals with relatives who have had more painful injuries and illnesses than occur in the general population. Impairments of social and occupational functioning are dependent upon pain severity and duration, and the primary medical risks are development of drug dependence and physical trauma subsequent to medical interventions. La belle indifférence is typically absent, although patients may state concern with less exaggeration than expected given reports of pain intensity (APA, 1980).

Significant gains have been achieved over the past two decades in understanding and treating chronic pain. It has been argued that subjective and behavioral pain components are not necessarily directly related to injury extent and suggested that situational/perceptual influences play obvious roles in determining levels of subjective discomfort that result from tissue damage. Barber (1959) and Kolb (1962) set the stage for behavioral models of chronic pain. Sternbach (1978) and Fordyce and his colleagues (Fordyce, 1976; Fordyce, Fowler, & DeLateur, 1968) proposed that a major component of chronic pain is overt, publically observable pain behavior. In his review of the literature, Sanders (1979) defined "pain" as a label to describe an interacting cluster of individualized overt, covert, and physiological responses that may be produced by tissue damage or other antecedent and consequent stimulus conditions. In acute cases where physiological and overt-subjective response components are highly correlated, relationships between stimulus and behavioral-subjective responses are predictable and relatively well understood through medical models; for example, the intensity of pain-related behaviors and subjective distress increases with extent of tissue damage.
When pain persists over time, there is enhanced opportunity for its behavioral components to be exacerbated by environmental contingencies. Individuals who receive social or other potent reinforcements for pain responses may maximize gains through increased frequency and intensity of somatic complaining. Proponents of attribution theory (Janis & Rodin, 1980) have suggested that subjective feelings of pain, for example, emotional and cognitive correlates, may be altered by enhanced perceptions of pain intensity. Cognitive-perceptual processes, such as focusing attention on painful stimuli, serve to intensify subjective experiences of pain (Craig, 1979). This feature of pain perception has provided a rationale for extensive use of cognitive distraction treatment techniques (Turk & Genest, 1979). Janis and Rodin (1980) recently suggested that cognitions and labels applied to pain may well be more important in determining the level of distress experienced than the intrinsic physical properties of pain itself.

Experimental studies demonstrate the effects of modeling on pain tolerance and behavioral response. Subject exposure to models who respond to painful stimuli with exaggerated pain-related behaviors resulted in increased subject capability to detect intensity differences between varying magnitudes of electric shock (Craig, 1978). Exposure to seemingly pain-tolerant models in these same studies diminished subject discriminative ability, demonstrating that modeling influences can alter the sensory-perceptual capacity for subjects. Models can also alter behavioral, verbal, and subjective pain responses in experimental subjects (Craig & Prkachin, 1979), and Rosenthal, Rosenthal, and Chang (1977) showed that vicarious pain exposure can produce stronger physiological and behavioral reactions in subjects than direct experience of noxious stimuli. Craig (1978) also found that children who observed intense, affect-ridden, prolonged pain and illness in their families later exhibited pain-complaint patterns similar to those seen at home. Differences in pain tolerance and behavior have also been found among different cultural and racial groups (Weisenberg, 1977).

Hypochondriasis

The concept of hypochondriasis has been the focus of nosological controversy over the years (Bishop, 1980; Kenyon, 1964). Arguments prevail as to whether hypochondriasis represents a primary disorder or is symptomatic of other psychopathological states, most commonly affective disorder (Bishop, 1980; Kenyon, 1964). Hypochondriasis is conceptualized by the DSM-III as a unitary disorder often associated with other conditions, such as depression and anxiety. As with other somatoform disorders, patients feel no persistent control over their symptomatology and are motivated to reduce their unpleasant somatic preoccupations. Essential features include (1) continuing preoccupations that physical signs or sensations are abnormal, (2) persistent beliefs and unrealistic fears of disease maintained in spite of negative physical findings and physician reassurance, and (3) resulting social and occupational impairment. Hypochondriacal preoccupations do not reach delusional proportions seen in psychosis, but they
or its behavioral individuals who may maximize complaining, suggested that correlates, may for. Cognitive-simul, serve to feature of pain subjective distraction (1980) recently more important intrinsic physical pain tolerance and to painful increased subjectudes of electric in these same that modeling Models can also mental subjects (1977) showed and behavioral thing (1978) also aged pain and similar to those also been found

of controversy as to whetheromatic of other Bishop, 1980; as a unitary m and anxiety. control over theiromatic preoccupations that physical unrealistic fears of physician reassurance-hypochondriacal hnosis, but they are exaggerated. Patients may regularly self-monitor bodily processes such as respiration, heart rate, muscle twitches, and urination frequency and misinterpret their significance.

Age of onset is typically during the adolescent years, although hypochondriasis has been observed to occur later among women (APA, 1980). The course is chronic and characterized by recurrent exacerbations. Impairment of social and occupational functioning is generally dependent on degree of preoccupation with illness. Literature on prevalence is equivocal, but estimates range from conclusions that it is common in general practice (APA, 1980) and found in approximately 1% of hospital inpatients and outpatients (Kenyon, 1964). DSM-III reported an equal incidence of hypochondriasis for sex groups, despite the predominance of women diagnosed as somatization disorder. Hypochondriasis and somatization disorder are similar in their diagnostic features. However, hypochondriasis is defined by preoccupations with unrealistic fears of well-defined diseases, whereas somatization disorders are characterized by rumination of multiple somatic complaints. In hypochondriasis, complaints tend to be more circumscribed, the center of greater time and energy expenditure, and more reflective of even minor alterations in bodily functioning than in conversion cases (Hyler & Spitzer, 1978).

Among the more popular measures for assessment of hypochondriasis are the Hypochondriasis Scale (Scale 1) of the MMPI, the Cornell Medical Index (Brodmann, Erdman, Lorge, & Wolff, 1949), and the McGill Pain Questionnaire (Melzack, 1975). The latter two instruments are primarily symptom inventories and fail to reflect patient attitudes toward illness or susceptibility to develop sick-role behaviors. Several other measures may satisfy these objectives, including Mechanic and Volkart's (1961) sick-role tendency scale, Pilowsky's (1967) hypochondriasis questionnaire, and the general hypochondriasis subscale of the Illness Behavior Questionnaire (Pilowsky & Spence, 1976). Assessment of relationships between somatic symptomatology and major life events has also been a target for exploration (Stone & Neale, 1981).

At present there is meager knowledge about the etiology of hypochondriasis. A history of physical illness and exposure to a sick model in the home environment have been cited as possible predisposing factors (APA, 1980). Learning and modeling influences have most often been implicated in development of tendencies toward preoccupation with diseases (Adams, 1981; Ullmann & Krasner, 1975), and Campbell (1975) found that typical children's views about illness had much in common with those of typical mothers. Zborowski (1952) showed that potent cultural influences impact on the elicitation of illness behavior. And, as sickness results in legitimate excuses for personal inadequacy or minimization of social responsibilities, so potent reinforcements are derived for development and maintenance of sick-role behaviors. Parental behavior patterns have also been discussed as influential in contributing to the development of hypochondriacal patterns.

Bianchi (1971) found support in a controlled study for the hypothesis that maternal overprotection and oversolicitude led to the genesis of hypochon-
driasis. Parker and Lipscombe (1980) also recently examined whether parental behavior patterns such as care and overprotection led children to manifest greater care-eliciting behaviors as adults. Subjects who scored high on the measure of hypochondriasis described their fathers as highly overprotective and their mothers as highly caring. In regard to when they were ill as children, these subjects remembered more sympathy being evidenced by both parents and a higher likelihood of their mother's calling the doctor than did subjects scoring low on hypochondriasis. Of course, there are problems with retrospective reports in such subject groups; however, the data described above do suggest important relationships for exploration between parental and patient behaviors.

PERSONALITY DISORDERS

Classification of behaviors that appear to be aberrant and maladjusted into categories of personality disorders has raised controversies for years. Apart from arguments that diagnosis is unnecessary and perhaps detrimental or unwise (Rogers, 1951), some clinicians contend that diagnoses of personality disorder represent only convenience for labeling problematic individuals who fail to meet criteria for more meaningful categories. Nevertheless, the personality disorders constitute a major option for classification in DSM-III, encompassing 50% of the psychiatric samples examined for the DSM-III field trials (Turkut & Levin, 1984). Among the most popular character-disorder diagnosis is that of the antisocial personality, cited as the most frequent diagnosis assigned to criminals (Guze, Goodwin, & Crane, 1969) and the third most common diagnosis among psychiatric emergency room patients (Robins, Gentry, Munoz, & Marten, 1977). As Robins (1978) observed, if the notion of the antisocial personality is a myth, it is one told over and over among different groups of people in different places at varying times—yet with surprising similarity.

The concept of personality disorders is itself suggestive of trait theoretical explanations for behavior. Many of the problems with trait theories have been discussed by Mischel (1968, 1973, 1977). He indicated that whether one uses the language of factors, habits, attitudes, or dynamics/character structure, the basic assumption of trait theories has been that personality comprises broad underlying dispositions which influence individual behavior across situations and with consistency. The assumption is also frequently made that identification of individual traits or global, generalized predispositions to respond to the environment in particular ways will allow accurate and reliable prediction of behaviors in a multiplicity of situations over time. The major assumption of trait-theory proponents is that personality traits are the substrate of normal or abnormal behavior; hence, aberrant behaviors are seen as reflections of aberrant "personalities."

This perspective of "trait" views is oversimplistic, if one assumes that labeling subsets of behaviors as traits is convenient for description and that common response patterns may be explained etiologically from genetic, psychodynamic,
Whether parental aggression to manifest red hots on the perceptive and as children, these parents and a subjects scoring respective reports suggest important behaviors.

Maladjusted into years. Apart from mental or unwise personality disorder who fail to meet personality disorders passing 50% of Turkat & Levin, is that of the need to criminals diagnosis among Marten, 1977). Personality is a myth, it different places at trait theoreticalories have been her one uses the picture, the basic broad understandings and with identification of respond to the el predication of assumption of rate of normal or ions of aberrant ones that labeling that common psychodynamic, social learning, ecological, and a host of other perspectives. The naive view of trait explanations has come under constructive criticism in the last 15 years with the emergence of the behavioral perspective in clinical psychology. Many important contributions to this ongoing dialogue have emerged from the social learning views expressed by Bandura (1977), the writings of Mischel (1968, 1973, 1977), and later discussions of cross-situational consistency of behaviors and personality of situations (Bem & Allen, 1974; Bem & Funder, 1978). The result of most of this accumulating literature has been to suggest minimization of person variables as primary behavior determinants and focus on situations and the interaction of persons and situations. Arguments around these topics can become convoluted, and the viewpoints of various theorists have been subject to distortion by their critics.

It is reasonable to conclude that normal and abnormal behaviors are multidetermined phenomena which are influenced by genetic/biological and other person factors, the environments in which they unfold, ongoing behaviors as they occur, and complex interactions among factors. Personality may be defined simplistically as those tendencies to respond to certain environmental situations in specific ways. Given this framework, personality disorders may be viewed in the context provided by the DSM-III. For example, Adams (1981) defined personality-disordered individuals as those who exhibit deficient social skills resulting in impaired interpersonal relationships. Individuals diagnosed as personality-disordered often experience negative consequences for their behaviors instead of or along with a paucity of positive reinforcers. Character-disordered individuals, simply put, exhibit grossly ineffective affective, cognitive, and behavioral response patterns which result in variable negative consequences in psychosocial and vocational functioning, depending on the environmental definitions of "problematic" responses. However, idiosyncratic types of reward also sustain their behaviors despite the punishments society affords.

Development of aberrant behavior patterns may be traced clearly to similar response styles in childhood and early adolescence. Robins (1978) and Nylander (1979) emphasized that obstreperous childhood behaviors are highly predictive of later antisocial expression. Behavior patterns among character-disordered individuals are also distinguished by relative inflexibility across time and situations. The characteristics that usually make up subsets of character-disorder constellations may be seen as inflexibly deviant and maladaptive in terms of generating adequate personal reinforcements. Although our data base describing so-called normal behavior is scanty and yet would appear to be fundamental to understanding that which is "abnormal," it is assumed that adaptive persons consider the complex situations which life offers and alter their responses accordingly. This implies adaptive responsiveness to the environment and flexibility in managing unexpected events and change. Individuals falling under the rubric of character disorders are seen to lack sufficient adaptive skills for social/vocational success as well as needed flexibility to cope effectively with problems of daily living.
Curiously, some clinicians have viewed character-disordered individuals as minimally troubled by feelings of subjective discomfort. For example, it has been assumed that those called antisocial personality are invulnerable to depression and anxiety (Cleckley, 1976). In part, such reasoning derives from observation of their behaviors as inflexible to changing reward systems and as repetitious regardless of seeming punishment. Simply because behavior is not altered subsequent to negative consequences which have presumably led to negative affect states is not tantamount to concluding that the feelings of discomfort are absent. It often appears that individuals labeled as character-disordered seem to experience little subjective distress but, in fact, create significantly more discomfort for those who are close to them in their lives. Yet it is interesting to note that the DSM-III emphasized at least two important criteria for their classification: (1) impaired social or occupational functioning and/or (2) subjective distress as a consequence of the disorder. Given this scheme, it becomes critical to refer to estimates of population parameters for these attributes or criterion variables, in that judgments specifying limits of normalcy can be seen as arbitrary.

The DSM-III lists 11 types of character disorders and a residual atypical, or mixed, category. Our discussion will include most of these disorders, with focus on those most frequently employed diagnostically. Characteristics defining each category are described in terms of response patterns that are thought to covary uniquely for the given subset as opposed to the other subsets and the normal population. The term "syndrome" implies that features are associated in particular constellations rather than independently arranged. It is also recognized that disordered behaviors are not easily and neatly classified into subsets. Despite major improvements in the operationalization of the response patterns described for the character disorders in DSM-III over DSM-II (APA, 1968), Axis II diagnoses have not been found to be as reliable as those for Axis I in field tests of the new taxonomic system (Spitzer, Forman, & Nee, 1979).

Each disorder is perhaps best conceptualized on a continuum of severity, with recognition that behaviors can differ in quality and quantity. Everyone at one time or another exhibits cognitive, emotional, physiological, and/or behavioral responses similar to those said to be critical for the diagnosis of paranoid personality. However, the number and patterns of the different symptoms as well as their consequences influence judgments of the severity of paranoid tendencies for a given person. When these responses are seen in a given constellation and certain of them are sufficiently unusual, rare, distressing, or maladaptive, the label of paranoid personality disorder can be applied. From this perspective, individuals are seen as exhibiting in high frequency a large number of the designated responses associated with a specific characterological subset. Individuals can therefore be diagnosed in terms of more than one disorder at a time. This presents no theoretical problem, since identification of specific problematic response components rather than a descriptive label for the individual is the goal of classification.
Antisocial Personality Disorder

Diagnosis of antisocial personality disorder is perhaps the most frequent classification among the 11 labels listed by the DSM-III. The DSM-III suggested the prevalence of antisocial personality for American men to be about 3%, with less than 1% of American women so affected. Prevalence rates are thought to be higher in lower socioeconomic groups, however, perhaps the manifestations of the disorder differ such that they are more easily detected among male and lower income groups. In any event, it is clear that the constellation of features known as "antisocial" flies in the face of social convention if not legal restraint and frequently leads to relatively severe, punitive consequences. The diagnosis of sociopathy or antisocial personality disorder has been found to be strongly associated with socially deviant groups including criminals (Lidberg, Levander, Schalling, & Lidberg, 1978; Widom, 1976), institutionalized juvenile delinquents (Rime, Bouvy, Leborgne, & Rouillon, 1978; Skrzypek, 1969), and alcohol- and drug-dependent individuals (Hill, Haertzen, & Davis, 1962; Suttner, 1971).

Antisocial personality disorder is the most popularly discussed and widely researched of the character disorders. The concept of the antisocial personality may be traced to the early nineteenth century. Pinel (1801), cited by Cleckley (1971), described a condition he labeled "mania sans delire" to characterize individuals who demonstrated defective affective abilities and capacities for instinctual rage combined with apparently undisturbed reasoning. Hence he linked capacity for violent outbursts with cognitive integrity, a notion that has persisted in the literature. That is, antisocial individuals are often thought to be of a violent bent, but research has not yet substantiated this view. Through the years, other labels were applied to individuals whose behaviors were aberrant, nonconforming, resistant to change, and even socially outrageous. Clinicians evoked such terms as "moral depravity," "moral derangement," "psychopathic inferiority," and "moral insanity"—all of which imply negative views toward this disorder and its prognosis (Cleckley, 1971; Whiteley, 1975). Writers may use the terms "sociopath," "antisocial personality," and "psychopath" interchangeably.

Descriptions of antisocial behaviors and attempts at explaining related response patterns have proliferated over the last three decades. Cleckley (1976) provided the most comprehensive characterization of the disorder. Although his views were based on clinical observations and intuitive logic, Cleckley laid a strong foundation for research efforts to define psychopathic response patterns. Cleckley's descriptions were compatible with characteristics listed in the DSM-II, and studies have shown surprising agreement among clinicians regarding the essential features of the antisocial personality (Albert, Briggs, & Chase, 1959; Gray & Hutchinson, 1964). Typically, clinicians referred to such features as inability to profit from experience, early onset, irresponsibility, inability to form meaningful relationships, and lack of impulse control and moral sense. On a more positive note, Vaillant (1975) reasoned that such conceptualizations may represent a "mythical beast," described his view of the "human" underlying
dynamics associated with sociopathy, and emphasized problems in immaturity and affective states as critical.

A trend away from postulating underlying personality dynamics cast in such negative descriptors as "selfish," "callous," "irresponsible," "impulsive," "guiltless," and "basically unsocialized and incapable of loyalty" is obvious in DSM-III. Based largely on research criteria developed by Spitzer, Endicott, and Robins (Note 1), characteristics of the antisocial personality were operationalized in behavior. With the exception of age requirements, criteria for adult diagnosis make reference to erratic work performance, parental irresponsibility, unlawful acts, inability to maintain long-term sexual attachments, repeated physical fights or assaults, failure to honor financial commitments or plan ahead, disregard for the truth, and driving recklessness. Emphasis is on a history of continuous, chronic antisocial behavior in which the rights of others are violated. The DSM-III also listed at least 12 signs of emerging antisocial symptoms among adolescents, including truancy, thefts, persistent lying, fights, substance abuse, and poor school grades. Comments included in DSM-III also suggest that presenting problems of personal distress, tension, depression, guilt, and fears are often common, clearly reflecting the influence of Vaillant's (1975) reasonings.

Recent reviews of the literature on the antisocial personality have described attempts by researchers to identify common response patterns among individuals so diagnosed (Brantley & Sutker, 1984; Sutker, Archer, & Kilpatrick, 1981). These reviews focused on investigations of learning-conditioning parameters, psychophysiological response patterns, interpersonal interaction styles, cognitive construct systems, situation-specific performance variables, and possible genetic and environmental etiological contributions. Brantley & Sutker (1984) concluded that antisocial behavior patterns reflect the influence of person (including biological/genetic) and environment systems working in interaction. It was noted that data from clinical reports and research studies complement each other in yielding similar descriptions of the behavioral patterns suggesting antisocial personality or sociopathy. What emerges from studies to date is the notion that sociopaths are seemingly socially facile individuals who as a group tend toward nonconformity, rule breaking, and disregard for ethical and legal restraints, particularly when significant personal gain is anticipated. There is consensus that reward-seeking behaviors are greatly exaggerated among sociopaths and that they respond to threats of punishment with minimal anxiety. Whether they are unafraid or less demonstrably resolved to negative consequences has yet to be explored. Current research fails to support the hypothesis that sociopaths display an inability to delay gratification or plan ahead across situations. Rather, the relationship between impulsivity and sociopathy appears to be influenced by such factors as intelligence, employment history, severity of antisocial traits, and individual learning histories.

Although sociopaths may be motivated powerfully by positive reinforcers, threats of negative consequences often prove ineffective in changing plans or behaviors, particularly once cognitive-behavioral sequences have been set purposively into motion. Sociopaths' persistence and resistance to change have
been interpreted to suggest learning deficits or incapacity to profit from experience (Cleckley, 1971). Nevertheless, sociopaths may not necessarily be deficient in acquiring learned responses or in performing tasks for reward. However, they may be observed to behave idiosyncratically or differently than do most "normals" in learning situations. Brantley and Sutker (1984) concluded that the quality of their performance appears to be more variable than that of normals and more influenced by salient or subtle differences in the learning context, for example, type of reward, delay of reinforcement, probability of punishment or reward, closeness in time of discriminative or signaling stimuli, perceptions of tasks and surrounding conditions, content of experimental tasks or instructions, and characteristics of the experience. These reviewers suggested that antisocial behavior, ranging from idiosyncratic to highly maladaptive, is subject to the principles of acquisition and modification as is any set of behaviors. Though the contingencies for controlling antisocial expression may be infrequently apparent, this is not tantamount to their being nonexistent or inexplicable.

Individuals diagnosed as antisocial personality may be seen to pursue self-determined goals in a reckless manner and with little regard for social consequences. They have been shown to be ineffective in passive-avoidance learning paradigms, to take inordinate risks to secure reinforcement, and to generate often brilliant strategies to achieve desired outcomes. In terms of interpersonal performance, Gough (1948) hypothesized that they are unable to view their actions from the perspective of another and characterized them as basically inadequate in assuming interpersonal roles. Findings from a conglomerate of studies (Rime et al., 1978; Sutker, Gil, & Sutker, 1971; Sutker, Moan, & Allan, 1974; Widom, 1976) indicate that sociopaths tend to be keen observers of social behavior, respond emotionally in conversations with nonverbal enthusiasm, find themselves stimulated by socially relevant stimuli, and participate in various types of games with regard for the rules of cooperation. Although they may find difficulty in understanding what others are thinking and feeling because of their own peculiar or idiosyncratic mentation, they have learned to compensate by demonstrating more than adequate social skills on the tasks administered in experimental situations. To what extent and/or why they may be unable to participate successfully in long-term interpersonal relationships is undetermined. Certainly, mediating variables such as intelligence, socioeconomic status, and other person factors such as gender are important in influencing behavioral manifestations of the disorder.

Despite general agreement about the characteristics associated with antisocial personality disorder, researchers and clinicians are by no means unanimous in specifying its underlying causes or genetic-environmental precursors. Explanations vary from those heavily slanted toward biological factors and genetic or constitutional influences to those focusing on the principles of social learning. Certainly, no single set of factors can account fully for the disorder. Cloninger, Reich, and Guze (1978) cautioned that a plausible model of the transmission and pathogenesis of antisocial behavior disorder must allow for genetic and
environmental factors without making unwarranted assumptions about their relative contributions. Reich, Cloninger, and Guze (1975) also proposed the multifactorial model of disease transmission, which assumes that pathogenetic factors relevant to specific disorders are multiple and additive and together constitute a single, continuous, underlying variable which is normally distributed and termed the "liability to develop the disorder." The work summarized briefly below illustrates the notion that nothing but a complex etiology, yet poorly understood, can explain antisocial behaviors.

Environmental factors peculiar to family situations, subculture sets, and the society influence expression of antisocial behaviors. Parental modeling, peer influences, assortative mating, other person and environmental variables, and behavior–behavior interactions must be considered. A family history of sociopathy and/or criminality places a man or woman at greater risk for developing antisocial behaviors; yet childhood antisocial expression seems to be the most potent predictor of later nonconforming and illegal behaviors. Whether family factors identified as critical for fostering these types of behaviors, for example, affectionless mothers (Bowlby, 1951) and parental coldness and inconsistency in reward/punishment (Buss, 1966), can be demonstrated to be influential has yet to be determined. Nevertheless, it appears that family variables play a role in setting the stage for social deviance and its extent, and peer and subcultural contributions are important in influencing such behaviors.

Cloninger et al. (1978) accentuated the significance of family, learning, and environmental variables and noted that criminality occurred among siblings more frequently than could be predicted by genetic factors alone. Kandel, Kessler, and Margulies (1978) also found a positive association between parental use of psychoactives and alcohol and adolescent use, particularly for illicit drugs other than marijuana and alcohol. Parental attitudes conveying approval or ambivalence toward drinking and drug use have also been shown to be associated with higher adolescent use rates (Kandel et al., 1978). Robins (1978), however, found that severely antisocial children were at high risk, despite the environment in which they were raised. Robins (1978) reported that moderately antisocial children with antisocial fathers were more likely to be highly antisocial adults than were others. Other writers have produced evidence implicating peer-group involvement (Jessor & Jessor, 1978) and subculture reward and support (Preble & Casey, 1969) in the development of antisocial proclivities, and these deviant behaviors have been shown to form a highly interrelated pattern of response (Robins, 1978).

Probably the best attempts at integrating biological and psychosocial theories of antisocial behavior have involved the concepts of arousal and behavioral hyperresponsiveness. Quay (1965) suggested that autonomic underarousal, which leads to attenuated sensory inputs, heightened demand for stimulation, diminished emotionality, and decreased awareness of aversive stimuli, was a primary problem among antisocial individuals. Later researchers have attempted to identify neurobiological substrates which account for hypothesized
cortical and/or autonomic underarousal and hyporesponsiveness to aversive stimulation or conversely to exaggerated stimuli or sensation seeking. As yet, the only consensus which has been conceded is that antisocial individuals do not experience anticipatory anxiety to normally threatening stimuli and fail to inhibit their behaviors when faced with punishment or negative consequences. Since much individual learning involves avoidance of punishment or extinction, antisocial persons may not achieve normal socialization.

One of the more interesting recent arousal hypotheses is that of Fowles (1984), who proposed that antisocial individuals are characterized by deficits in behavioral inhibition which lead to reduced sensitivity to threatening stimuli and attenuated anxiety under conditions of normal stress. Reward-seeking behaviors are disinhibited by virtue of the inability of aversive consequences to inhibit approach propensities. Fowles (1984) pointed to the hippocampal structure as critical for mediation of behavioral inhibition. This suggestion complements a growing body of literature implicating the limbic system as important for regulation of behavioral and emotional states. Gorenstein and Newman (1980), for example, argued that animals with septal lesions often present behavioral deficits comparable to those evidenced among antisocial individuals.

Accounts are typically pessimistic as to the potential for constructive change among sociopaths, and current thinking does not offer promise of their “burning out” with middle and old age (Robins et al., 1977; Vaillant, 1966). Diagnostically, they represent a group of patients who are difficult to manage because they do not show the typical signs of mental illness. Further, their psychopathology is defined almost exclusively by reference to societal rules for appropriate behavior. It should be noted that although contingencies for controlling antisocial expressions may be infrequently apparent, they may be discovered with continual research in the area. It cannot be assumed that sociopaths represent a unitary or homogeneous group. The extent to which such symptoms as depression, violence, and anxiety are present should be determined. In addition, there are individuals who share characteristics with sociopaths and yet maintain their behaviors within the bounds of social propriety or function effectively (Sutker & Allain, 1983). What sets them apart from their more maladaptive peers is worthy of investigation.

Avoidant, Schizoid, and Schizotypal Personality Disorders

While individuals diagnosed as antisocial personality lack shyness and throw themselves into myriad relationships, those classified as avoidant, schizoid, or schizotypal do not. Social isolation and interpersonal withdrawal are common to the latter disorders, but a number of key features differentiate the presenting problems of individuals affected. Diagnosis of avoidant personality as defined by the DSM-III requires observation of the following: hypersensitivity to rejection, unwillingness to enter into relationships without strong guarantees of uncritical acceptance, social withdrawal, exaggerated desires for affection and acceptance,
and low self-esteem. Behaviorally, avoidant people may be observed to be interpersonally shy, reticent, and timid despite what are assumed to be paradoxical cravings for attention and interaction.

When social avoidance is impossible, the avoidant person shows inhibition, an inability to respond in an engaging way, and hesitancy to talk, smile, gesture, or make eye contact in interactions with others (Pilkonis, 1984). In addition to withdrawal or nonresponsiveness, cognitive distortions have been described as common among avoidant individuals (Aiden & Safran, 1978; Clark & Arkowitz, 1975; Smith & Sarason, 1975). Typically, this involves unrealistic or rigid expectations about performance in social interactions, negative self-appraisals and self-absorption, and continued self-devaluation despite strong desires for acceptance. Pilkonis (1984) noted that avoidant persons must be distinguished from “true introverts,” who are satisfied with their limited social contacts and approach others for social needs if desired or necessary.

Both shyness and anxiety have been described as important features in the constellation of avoidant characteristics. However, not all socially anxious individuals are socially withdrawn, and shyness may be a component of several disorders. Pilkonis (1977a, 1977b) distinguished between privately and publicly shy persons in describing interpersonal anxieties. Private shyness was linked to focus on internal events, such as subjective stress or physiological arousal as a component to a given situation; whereas, public shyness was described as having specific reference to behavioral expressions of shyness, such as awkward remarks or social faux pas. Much of this work is closely associated with introversion–extraversion theory and research focusing on differences in arousal, conditionability, and social anxiety.

The avoidant personality disorder probably occurs more often than either schizoid or schizotypal disorder. The DSM-III suggested that avoidant symptomatology is common within the adult psychiatric population, although most of our knowledge derives from research directed toward shyness and social anxiety. As many as 40% of late adolescents and young adults consider themselves to be dispositionally shy (Pilkonis, 1977b). Other studies have documented that undergraduates commonly complain of social anxiety (Glass, Gottman, & Shmurak, 1976). Pilkonis, Feldman, Himmelhoch, and Cornes (1980) found that 31% of an older sample of untreated adults described themselves as “shy persons.” As might be expected, social anxiety and shyness are prevalent among psychiatric samples. Pilkonis et al. (1980) found that 41% of a group of patients with mixed diagnoses saw themselves as dispositionally shy.

Empirical data on the possible etiologies of avoidant characteristics are as rare as those estimating its prevalence. Some researchers have argued strongly for a biological basis to these characteristics (Eaves & Eysenck, 1975). Others have suggested personality dispositions or “temperaments” as explanatory concepts. For example, Thomas and Chess (1977) identified consistent temperament patterns among groups of children who were studied from infancy to early adulthood and speculated about the interaction of temperaments with environ-
mental events in contributing to interpersonal styles. Buss and Plomin (1975) proposed a temperament model of personality which specified significant interactions between inherited temperaments and environmental forces as influencing behavior. Focusing on the social environment, Bowlby (1980) described the nature of the childhood attachments as well as the consequences of what he called "anxious attachment," which was thought to develop from patterns of pathogenic parenting. A number of hypotheses regarding the development of avoidant behaviors may also be derived from social learning studies (Bandura, 1977; Hersen & Bellack, 1976; Wolpe, 1969).

Similar to the avoidant-personality-disordered, individuals assigned the schizoid label may appear withdrawn and distant. DSM-III criteria specify that these behaviors are motivated by emotional coldness rather than fearfulness of rejection. It is said that schizoid persons are isolated because they find relationships and interpersonal interchange nonreinforcing—a hypothesized underlying dynamic which differs from that proposed for the avoidant disorder. More specifically, individuals diagnosed as schizoid are viewed as bereft of warm, tender feelings for others, indifferent to praise or criticism, unlikely to have more than one or two friends, unable to express strong emotions, and detached from the environment—perhaps lost in daydreams or fantasy. In contrast to avoidant persons, who are thought to be disabled by chronic social anxiety, the schizoid personality as defined by DSM-III appears to exhibit anhedonia and hyporesponsiveness to environmental stimuli, particularly those of an interpersonal nature. Impairment of productive work involvements is thought to be dependent upon such factors as type of occupation, work demands, and intelligence. Incidentally, an early report by Jenkins (1950) indicated that schizoid children may be intellectually superior but underachieving.

The concept of schizoid personality has been traced historically by Nannarelli (1953) and Wolff and Chich (1980). The term "schizoid" as incorporated into the DSM-III differs from earlier descriptions of schizoid personality. The revised nosology has caused confusion in assignment of diagnostic labels and in tracing the development of the disorder. Pilkonis (1984) pointed out that the authors of the DSM-III justified their differentiation of schizoid and schizotypal individuals on the basis of evidence suggesting a link between schizotypal symptomatology and a family history of schizophrenia. However, this differentiation has not been universally accepted, and critics have pointed to its arbitrary nature. Nevertheless, one of the key distinctions between the two disorders is the eccentricities of speech, behavior, and/or thinking said to be characteristic of schizotypal rather than schizoid individuals. Additionally, it is noted that schizoid persons do not wish or desire to pursue relationships.

There is question in the literature as to whether schizoid features are associated with schizophrenic disorders and in fact represent premorbid signs of later decompensation. Estimates of the proportion of schizophrenics exhibiting premorbid schizoid functioning prior to the emergence of psychotic symptomatology range from 50–60% (Winokur & Crowe, 1975) to 9% (Wolff &
Chick, 1980). Wolff and Chick's (1980) 10-year follow-up study, however, showed that schizoid children almost inevitably were classified as schizoid rather than schizophrenic as adults. Nevertheless, there are those who postulated a strong genetic link between schizophrenia and schizoid and schizotypal personalities (Kendler, Gruneberg, & Strauss, 1981a; Kety, Rosenthal, Wender, Schulzingr, & Jacobsen, 1975). The work of Meehl (1962; Golden & Meehl, 1979), identifying schizotypic or schizoid individuals and their range of symptomatology, has also been directed in part toward this question. Although relevant to the labeling of schizotypal disorders under the new diagnostic system, Meehl's postulates of the characteristics of the schizotypal personality structure and relationships with schizophrenia are worth careful study. Given the changes in nosology and contradictions in research findings, continuing investigation is required before the complex relationships among schizoid, schizotypal, and schizophrenic symptoms are well understood.

As noted above, the DSM-III distinction between schizoid and schizotypal disorders departs from previous nomenclature. The concept of schizotypal personality is now used to describe individuals who exhibit eccentricities of thought and unusual styles of communication in addition to difficulties in establishing interpersonal relationships. For example, peculiarities of thought, perception, speech, and behavior must be observed, including at least four of the following: magical thinking, ideas of reference, social isolation, recurrent illusions, odd speech, inadequate rapport in face-to-face interaction due to constricted or inappropriate affect, suspiciousness or paranoid ideation, and undue social anxiety or hypersensitivity to real or imagined criticism.

**Histrionic, Narcissistic, and Paranoid Personality Disorders**

Although these disorders are distinguished across several critical dimensions, it can be observed that individuals so labeled share a penchant for drawing attention to themselves. Histrionic behavior is characterized by overly dramatic, reactive, and intense emotional behaviors and disturbances in interpersonal functioning. Requirements for DSM-III diagnosis include at least three of the following symptoms: self-dramatization or exaggerated affective expression; incessant attention seeking; craving for activity and excitement; overreaction to insignificant events; and irrational, angry outbursts or tantrums. At least two disturbances in interpersonal relationships are needed, and histrionic persons are often described as insincere, shallow, egocentric, self-indulgent, inconsiderate, vain, demanding, dependent, helpless, manipulative, and/or constantly seeking reassurance. If these characteristics are present and stable across situations in constellation, it is not difficult to imagine that interpersonal styles are aversive and detrimental to forming lasting emotional bonds among adults.

Histrionic behaviors or inclinations have been observed among men, but diagnosticians consider this disorder to be more closely associated with the feminine gender. Cloninger et al. (1975) suggested that women whose behavior is
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antisocial are often labeled hysterical as opposed to sociopathic. It has been questioned whether hysteria is a milder, feminine manifestation of sociopathy and whether women are less likely to be diagnosed in the extreme category of antisocial personality. That is, whether this is a diagnostic bias among clinicians or whether, in fact, hysteria represents sex-specific behavior is not known. Nevertheless, women who are classified as histronic are often said to be physically attractive and seductive in their sexual behavior. They are described as generating high initial interpersonal appeal, but their interpersonal relationships are said to be intense and short-lived. The histronic person is characterized as one who attempts to control others through interpersonal manipulation. Further, as has been said of women collectively, histronic persons typically show little interest in intellectual pursuits and are easily influenced, particularly by authority figures. Somatic complaints are also cited as common.

The history of narcissistic personality disorder can be traced to Freud's early writings (Freud, 1914/1957). Recent descriptions, however, differ substantially from Freud's original formulations. According to the DSM-III conceptualization, the narcissistic personality disorder is characterized by grandiose notions of self-importance or uniqueness; fantasies of unlimited success, power, or ideal love; exhibitionism and need for constant attention and admiration; and cool indifference or rage, shame, and humiliation in response to criticism, indifference of others, or failure. The DSM-III also requires at least two of the following features: feelings of entitlement or expectation of special favors without assuming reciprocal responsibilities; exploitativeness; fluctuations between extreme feelings of overidealization and devaluation; and, absence of empathic regard. Narcissistic individuals are said to be more concerned with appearance than substance and to engage in activities for the benefit of impression rather than self-satisfaction. Commonly associated features include depression, somatic complaints, deception, and transient psychotic symptomatology.

There is a meager body of research or clinical case studies that describes the behaviors, etiology, and progression of paranoid symptomatology in the absence of psychotic severity. Disputes characterize the literature regarding the nosological status of paranoid or delusional psychosis, and questions remain about the distinctiveness of paranoid psychosis from that subsumed under the label of schizophrenia (Kendler, 1980; Winokur, 1977). Relationships among the types of paranoid disorders outlined in the DSM-III are also unclear; however, it is noted that paranoid personality disorder may predispose to the development of other paranoid disorders or perhaps schizophrenia, paranoid type. In any event, individuals who are labeled paranoid personality disorder are described as unlikely to come to clinical attention because they are thought to seek assistance rarely and to require hospitalization infrequently. It can be assumed then that paranoid-personality-disordered persons might occasionally surface, perhaps in drug/alcohol treatment programs, prisons, or outpatient psychotherapy clinics. However, they may not be expected to appear with sufficient frequency to be studied systematically.
The essential features of the paranoid personality disorder are pervasive and unwarranted suspiciousness, hypersensitivity, and restricted affectivity. The DSM-III described such individuals as guarded, secretive, argumentative, stubborn, defensive, and hypercritical as well as energetic, serious, ambitious, and capable. They avoid intimacy, exhibit excessive needs for self-sufficiency, and appear keenly aware of power and rank. It is suggested that paranoid personalities might be found with greater frequency among highly religious or quasi-political groups. While women are thought more likely to exhibit histrionic traits, men are hypothesized to be more vulnerable to paranoid features. Authors of the DSM-III predicted that like the antisocial personality, the paranoid personality will have difficulty in forming and sustaining close relationships and will exhibit poor occupational performance. The latter would seem, however, to be highly dependent on type of occupation and level of intelligence as well as on degree and type of social interactions required by work. Indeed, paranoid personalities may be highly successful vocationally—being able to subjugate needs for affiliation and warmth for tangible and predictable rewards, for example, money and recognition.

Assessment of the presence of persistent symptoms of delusions and perhaps hallucinations is essential for differential diagnosis among the paranoid disorders. Delusions, hallucinations, or other symptoms suggesting severe psychopathology are never associated with the label of paranoid personality, unless paranoid disorders or paranoid schizophrenia are superimposed on what is thought to be an already-defined paranoid personality. The predominant feature of all the paranoid disorders is delusions; however, delusional phenomena may be associated with a variety of affective, neurological, and schizophrenic disorders. Maher and Ross (1984) recently provided a comprehensive description of delusional phenomena as well as the types of psychopathology which may be associated with delusions. Their interesting discussion of the etiology and nature of delusions may assist clinicians in making diagnostic decisions as well as in treating patients who are considered likely to develop delusions.

Questions regarding the etiology of paranoid disorders remain unresolved, and there is virtually no research defining the characteristics of individuals labeled paranoid personality disorder or exploring its etiology. Nevertheless, a literature of long-standing history exists on paranoid or delusional psychosis. Recent investigations have focused on attempts to differentiate between what has been called "delusional disorder" by Winokur (1977) and paranoid schizophrenia. One approach has been to determine whether a family link exists between schizophrenia and the paranoid disorders. Reporting results of an independent analysis of the Copenhagen sample of a Danish adoption study of schizophrenia, Kendler, Grunberg, and Strauss (1981b) found no evidence from a genetic perspective to suggest that delusional disorder is part of the schizophrenic spectrum. These researchers also included an interesting discussion of the criteria for diagnosis of paranoid disorders with special focus on symptoms of "delusional disorder" compared to DSM-III criteria for paranoid disorder.
Compulsive Personality Disorder

The criteria in DSM-III for labeling compulsive personality disorder require at least four of the following: restricted ability to express warm and tender emotions; perfectionism; insistence that others submit to specified ways of doing things; excessive devotion to work productivity at the exclusion of pleasure; and indecisiveness and procrastination. Compulsive persons are described as hypercritical, perfectionistic, hyperattentive to detail, and restricted in their ability to express genuine emotions. They are said to be excessively devoted to work at the exclusion of pleasurable activities and sufficiently preoccupied with insignificant details so as to fail frequently to understand the broad view of things. Order, perfectionism, and control are central to key compulsions, and work/productivity provides the primary source of self-esteem. Pleasurable activities, when they do occur, are said to be pursued much in the same manner as are occupational endeavors. Compulsive individuals remain cognizant of their relative status in power hierarchies and become angry, although it may not be openly expressed, when unable to control events and people around them.

It is important to differentiate compulsive personality disorders from those labeled obsessive-compulsive disorder. Obsessions are described by DSM-III as recurrent, persistent ideas, thoughts, images, or impulses that are ego-dystonic. They are said to be seen by the patient as senseless or repugnant; hence, patients attempt to ignore or suppress them. Compulsions are defined as repetitive, seemingly purposeful behaviors performed according to certain rules or in a stereotyped fashion. In this context, compulsions can be seen to represent behavioral responses elicited to diminish the intensity and frequency of recurrent cognitions and obsessional thoughts. Attempts to resist compulsive tendencies are said to lead to increased levels of tension associated with obsessions. In obsessive-compulsive cases, individuals typically view their symptoms as nonsensical and habitually resist, albeit unsuccessfully, their elucidation (Sturgis, 1984). As a result of these factors, obsessive-compulsive disorder has been classified under the heading of anxiety disorders, accentuating the anxiety-enhancing and -reducing properties of obsessions and compulsions, respectively.

Compulsive personality disorder is conceptually different from that described by obsessive-compulsive phenomena. Characteristic behavior patterns associated with diagnosis of compulsive personality disorder are neither thought to be ego-dystonic nor seen to be particularly problematic from the perspective of the patient. The anxiety-reducing properties of compulsive behavior patterns are minimal, because anxiety is not seen as integral to the trait constellation. Most important, the behaviors typical of compulsive personality are not specific, repetitive, ritualistic, or purposeless. They are easily distinguished from obsessive-compulsive rituals, such as hand washing, repetitive checking, and others. Obsessional patterns may well be absent in compulsive personalities, further distinguishing among these forms of psychopathology. Although little is known about predisposing factors to development of compulsive traits or their prevalence, the DSM-III indicated that they are more common among men and
family members. Black (1974), however, reported an absence of sex differences in expression and higher prevalence among the upper and middle classes.

**Borderline Personality Disorder**

The concept of borderline personality has achieved nosological recognition in the DSM-III; however, questions regarding its diagnostic validity, reliability, and usefulness have not been resolved. Turkat and Levin (1984) reviewed the literature on borderline personality and noted that widely divergent uses of the term have been in vogue over the past 40 years. The end result of this confusion has been tendencies on the part of clinicians to employ borderline diagnosis as a "wastebasket" classification for patients who exhibit a range of unstable personality traits. Some researchers indicated that the concept may be so overused that practically all nonschizophrenic, nonaffective-disordered, and nonclassically neurotic patients may be seen to fall somewhere on the narcissistic–borderline continuum, or that borderline disorder will be a nondiscriminatory synonym for personality disorder (Kroli, Sines, Martin, Lari, Pyle, & Zander, 1981). Spitzer, Endicott, and Gibbon (1979) also noted that writers of articles on borderline conditions traditionally used the concept despite an absence of diagnostic criteria other than for borderline schizophrenia in the first two DSM editions.

The term "borderline" has been employed primarily to describe two types of patients. In one sense, the label has been assigned to individuals who exhibit persistently unstable behavior patterns, intense affective and impulsive expressions, and marginal interpersonal adaptiveness. Kernberg (1967) discussed this use of the term as representing a basic personality disorder manifested in instability and psychological vulnerability. Spitzer, Endicott, and Gibbon (1979) suggested that the second major use of the term was as a label for a borderline condition in the sense of a subset of schizophrenia. This was perhaps best elaborated by Wender, Kety, Rosenthal, and their colleagues (Kety et al., 1975) who studied genetic influences contributing to development of tenuous reality contact and schizophrenic symptomatology in a subgroup of patients. However, there is some overlap between these two concepts, such as Gunderson and Singer's (1975) inclusion of paranoid ideation and mild but definite impairment in reality testing in their description of the former use of the concept.

After review of the literature and preliminary studies, the DSM-III Task Force concluded that the former use of the term refers to the distinction between normal and maladaptive personality functioning manifested in unusual affect, interpersonal and occupational disruptions, and identity confusion, whereas the other use most appropriately applies to the borderline functioning between normal and thought-disordered individuals. The diagnosis of borderline personality disorder was offered to represent the former phenomenon, and the schizotypal personality disorder was considered most appropriate for patients in the latter category. The DSM-III description of borderline personality includes chronic instability in several life areas specifically involving interpersonal
behavior, mood states, and self-concept. Relationships are described as characteristically intense and unstable, with evidence of extreme attitude shifts over time and feelings of emptiness, boredom, and intolerance of being alone. It is noted that transient psychotic symptomatology may be observed under extreme stress but is usually short-lived. Spitzer, Endicott and Gibbon (1979) noted that even the term “unstable” is a misnomer for describing borderline personality functioning, since the borderline personality is theoretically stable in terms of its instability. Kroll et al. (1981) cautioned clinicians to beware lest the borderline category be used to lump together disparate groups which happen to have similar superficial behavior.

SUMMARY AND CONCLUSIONS

This chapter has provided an overview of the clinical manifestations, suggested multidetermined etiologies, natural history, and implications for prognosis for the dissociative, somatoform, and personality disorders. Each of the disorders within these general categories is relatively well described in terms of behavioral patterns, which covary uniquely by disorder type and within individuals. However, discrepancies exist with regard to extent of agreement and validity for classification among and between disorder groups. For example, the behaviors, precipitating and causative factors, course, and potential outcome have been topics of clinical speculation and research for certain of the personality disorders. Among these, the antisocial personality has been the most well researched and most frequently used diagnostic classification. Follow-up studies of antisocial children exhibiting similarly deviant behavior as adults and those of antisocial adults into later life suggest validity for the antisocial personality classification. Yet much remains to be accomplished in identifying cognitive and affective correlates of this disorder, gender differences in its expression, and its multidetermined etiology. For many of the other personality disorders, such as paranoid, narcissistic, and borderline categories, little work has been done to trace the course, etiology, or outcome or even to test assumptions regarding their behavioral correlates.

Disorders classified by clinical symptoms present in many different forms and can be distinguished from one another in their behavioral expression, severity, physiological concomitants, response to treatment, and stability over time. Assessment of the types and range of clinical manifestations, including exploration of cognitive, affective, physiological, and behavioral components, is in itself an important area for careful elucidation. At this time, clinicians do not agree on issues of labeling, classification, and legitimacy of dissociative phenomena, and the rarity of their occurrence mitigates against systematic exploration. Confusion remains as to classification of somatoform disorders, and problems inherent in attempts to separate psychological and physiological components of chronic pain or conversion symptoms, for example, pose challenges for clinicians and researchers. Despite careful delineation of behav-
ioral and other symptom constellations required for DSM-III diagnoses for all three types of disorders, there is opportunity for controversy regarding their possible etiologies, natural course, prevalence, and progression. Considerably more research and clinical investigations are required to build upon the work reviewed such that the disorders discussed in this chapter are determined to be valid entities—useful for classification as well as prediction of response to treatment and outcome.

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