sonality disorder. Thus, substance abusers are divided into two groups: primary antisocial addicts, whose antisocial behavior is independent of the need to obtain drugs, and secondary antisocial addicts, whose antisocial behavior is directly related to drug use.

Psychotic episodes or disorders often co-occur with schizotypal, borderline, and dependent personality disorders. Mood disorders co-occur more often with avoidant and borderline personality disorders; and anxiety, eating, and somatoform disorders co-occur with avoidant, dependent, and borderline personality disorders. The presence of personality disorders impedes the recovery from Axis I disorders (Zanarini, Frankenburg, Hennen, Reich, & Silk, 2004).

Recurrent suicidal behavior is characteristic of borderline personality disorder. Suicides are often associated with anger and often the result of impulsive behavior in the context of interpersonal relationship problems. Other factors contributing to suicide in persons with personality disorders include depression and substance abuse. A history of prior attempts is the strongest predictors of future attempts and suicide completion (Yen et al., 2004).

Some studies indicate a comorbidity of borderline personality disorder and posttraumatic stress disorder (PTSD) in combat veterans. There are two possible explanations for this co-occurrence. First, individuals with BPD have limited ability to cope with traumatic events, which makes them more vulnerable to PTSD. Secondly, the trauma of war causes long-lasting changes in personality leading to a diagnosis of BPD (Axelrod, Morgan, & Southwick, 2005).

**Etiologies**

As with other psychiatric disorders, a number of theories have been offered to identify the causes of personality disorders. With continuing refinement of diagnostic criteria for each cluster of disorders, it will become possible to conduct useful research on specific populations that have been accurately diagnosed. In the past, wide differences in the application of specific diagnostic labels precluded the gathering of reliable data. Since there was so little agreement about whether a person should be included in the category at the outset, it is easy to understand why the search for any common factors—in genetics, early experiences, family patterns, or any other variable—failed to yield results from which general conclusions could be drawn.

Remaining obstacles are the refusal to seek treatment on the part of the client and the relatively infrequent need for psychiatric hospitalization. Thus, research has usually focused on those individuals who seek therapy or those who are referred through the criminal system (most often with antisocial personality disorder).

There is no single cause of the personality disorders. Most likely, they arise from an interaction between biological factors and the environment. Just as one’s biology or constitution can alter experiences in life, so, too, can many experiences alter one’s basic biology. The brain constantly changes to absorb new experiences.

**Genetics**

Studies suggest a common genetic factor in schizotypal personality disorder and schizophrenia. Individuals in both groups have an equal probability of having a sibling with schizophrenia. This shared genetic vulnerability has led many people to consider schizotypal personality disorder as one of the schizophrenia spectrum disorders (Keshavan et al., 2005).

Extreme shyness beginning in infancy may be associated with Cluster C disorders. Overanxious children are more likely to be overprotected and vulnerable to developing dependent traits. It is critical, however, that labels not be attached to behavior that is developmentally appropriate (American Psychiatric Association, 2000).

A strong predictor of the development of antisocial behavior is antisocial personality disorder in one or both parents. This seems to be due to both genetic and environmental factors. There also appears to be a genetic link between antisocial

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**TABLE 16.1 Characteristics of Personality Disorders**

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Behavioral</th>
<th>Affective</th>
<th>Cognitive</th>
<th>Sociocultural</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Eccentric, craves solitude, argumentative, odd speech</td>
<td>Quick anger, social anxiety, blunted affect</td>
<td>Unable to trust, indecisive, poverty of thoughts</td>
<td>Impaired or nonexistent relationships, occupational difficulties</td>
</tr>
<tr>
<td>B</td>
<td>Dramatic, craves excitement, wants immediate gratification, self-mutilates</td>
<td>Intense, labile affect; no sense of guilt; anxious; depressed</td>
<td>Considers self special and unique, egocentric, identity disturbances, no long-range plans</td>
<td>Manipulates and exploits others; stormy relationships</td>
</tr>
<tr>
<td>C</td>
<td>Tense, rigid routines, submissive, inflexible</td>
<td>Anxious; fearful, depressed</td>
<td>Moralist, low self-confidence</td>
<td>Dependent on others, avoids overt conflict, seeks constant unconditional love</td>
</tr>
</tbody>
</table>

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