informa
healthcare

State and Trait in Personality Disorders

JAMES REICH, MD, MPH

Department of Psychiatry and Behavioral Science, Stanford Univerity and Department of Psychiatry,
University of California Medical Center at San Francisco, CA, USA

Background. *The current definitions of personality disorder indicate early onset, long duration and disorders of relatively stable severity. It has been noticed by a number of authors and researchers that at times personality pathology can be quite variable and not fit that model.*

Methods. *This report examines the possibility that there is a valid psychiatric disorder whose key feature is episodic personality dysfunction. The disorder would be designated State personality disorder (State PD) to separate it from Trait personality disorder (Trait PD), which is the non episodic form, and from no personality disorder (No PD). This report examines what criteria might be necessary to validate such a diagnosis.*

Results. *It finds that State personality disorder has been identified in two distinct populations and in both it can be distinguished from its near neighbor disorders of Trait PD and No PD. The family history method of personality clusters distinguishes State PD from its near neighbors and provides a possible biological marker for the disorder. In two separate populations the disorder is related to an independent measure of the hypothesized underlying personality construct. Although the two populations in which the phenomenon has been clinically identified are very different and cannot be directly compared, in both it appears that clinical variables may distinguish State PD from its near neighbor diagnoses. State PD appears to have a negative relationship to suicidal ideation and might affect the course of treatment of comorbid Axis I disorders.*

Conclusions. *It is concluded that State PD represents a valid diagnostic entity.*

Keywords Personality, Personality disorders, Diagnosis, Course

INTRODUCTION

Personality has in the past been considered to be stable, or at the very least, something that changes slowly over time. However, all clinicians can think of a case where there was personality change on a seemingly more rapid basis. Sometimes this is in relation to treatment, sometimes not. It is to this phenomenon that this report addresses itself. I propose the concept of a State Personality Disorder (State PD). A State PD would be analogous to the concept of State Anxiety, a set of symptoms that appear under certain circumstances and which may remit, perhaps in rapid fashion. In State Anxiety these are anxiety symptoms whereas in State Personality these would be symptoms we usually think of as being personality symptoms.

Address correspondence to Dr. James Reich, 2255 North Point St., Suite 102, San Francisco, CA 94123. E-mail: jhreich@ix.netcom.com

Current Status of the Definition of Personality Disorders

Personality disorders have been conceptualized in different ways by different schools of thought. There is not space here to review all the different conceptualizations of personality disorder, but I will mention two of the current major definitions. The current DSM-IV diagnosis of personality disorder is "An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture." (1,2) The pattern is manifested in two or more of the following areas: cognition, affectivity, interpersonal functioning, and impulse control. The pattern is inflexible and pervasive across a broad range of situations, has an early onset, is stable, and leads to significant distress or impairment.

Personality disorders, according to the ICD-10 diagnostic guidelines (3), "… comprise deeply ingrained and enduring behaviour patterns, manifesting themselves in inflexible responses to a broad range of personal and social situations. They represent either extreme or significant deviations from the way the average individual in a given culture perceives, thinks,

feels, and, particularly, relates to others. Such behavior patterns tend to be stable and to encompass multiple domains of behavior and psychological functioning. They are frequently, but not always, associated with various degrees of subjective distress and problems in social functioning and performance."

The DSM-IV does not allow for the possibility of a State PD. The ICD-10 allows for a personality disorder to be created by stress. This is called an enduring personality change and is defined as "a disorder of adult personality and behavior that has developed following catastrophic or excessive prolonged stress, or following a severe psychiatric illness, in an individual with no previous personality disorder. There is a definite and enduring change in the individual's pattern of perceiving, relating to, or thinking about the environment and the self. The personality change is associated with inflexible and maladaptive behavior that was not present before the pathogenic experience and is not a manifestation of another mental disorder or a residual symptom of any antecedent mental disorder" (3,4). The ICD-10 definition does not allow for a stress created personality disorder to reverse itself.

It is clear that much of the current nomenclature does not have a place for the concept or State and Trait personality. (Trait personality or Trait PD would be the form of personality dysfunction that is stable over time.)

Some Arguments for the Possibility of a State Personality Disorder

The two official definitions of personality cited above emphasize the concept of the level of personality functioning being stable over time. However, there is no question that measures of personality characteristics can be elevated if measured when the patient is acutely ill with an Axis I disorder. These measures then return to baseline after resolution of the Axis I disorder. (5–11). Although these studies vary in their details, the findings are remarkably similar over several decades and in different populations. That is that patients who are acutely depressed and patients who are acutely anxious score higher on the same measures of personality than when they are not acutely depressed and not acutely anxious. This would represent one possible model for a State PD. That would be symptoms of personality dysfunction which increase or remit in relatively short periods of time. It certainly demonstrates that clinicians can see more rapid changes in personality than would be expected by current definitions of personality disorder.

An example of this can be seen in Figure 1. Here the prevalence of personality disorders in depressed and recovered patients is used (9,10). Personality measures in patients were taken when they were acutely ill and from this was subtracted the prevalence when they were in remission from depression. This results in a picture of the personality disorders that have "disappeared." As can be seen in the figure for three different personality instruments, The Personality
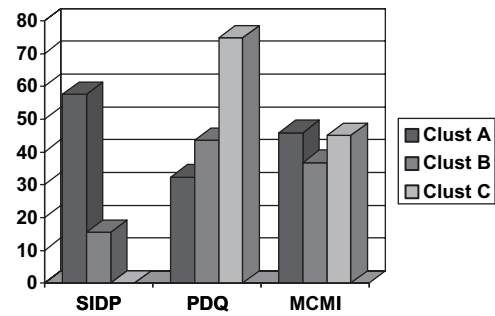

● % of PDs disappearing upon recovery.

Figure 1 In the figure Cluster A, B and C refer to personality disorders in the DSM Personality A, B and C clusters. The first cluster, cluster A or the Schizoid cluster includes the Schizoid, Schizotypal and Paranoid personality disorders. The second cluster, cluster B or Impulsive cluster includes Borderline, Histrionic, Antisocial and Narcissistic PDs. The third cluster, cluster C or the Anxious cluster, consists of the Avoidant, Dependent, and compulsive PDs. MCMI, PDQ and SIDP refer to three different personality instruments, The Personality Diagnostic Questionnaire (PDQ), the Millon Clinical Multiaxial Personality Inventory (MCMI) and the Structured Clinical Interview for DSM Personality Disorders (SIDP) (Reich 1987, 1989).

Diagnostic Questionnaire (PDQ), the Millon Clinical Multiaxial Personality Inventory (MCMI), and the Structured Clinical Interview for DSM Personality Disorders (SIDP) (12,13) the amount of personality pathology that disappears is large.

One must consider the possibility that this seeming remission of Axis II symptoms with the treatment of an Axis I disorder is a measurement artifact. If this were the case, traits distorted by the presence of an Axis I disorder would have no clinical value (i.e., they would just be "noise" confusing the clinical picture). However, if the evidence was that State PD can be reliably distinguished from its near neighbors and has important clinical implications, it would clearly be more than noise in the system. The evidence does seem to indicate distinction form near neighbor disorders and clinical relevance.

Numerous research reports indicate the phenomena of personality pathology being less than lifelong. Zanarini et al. (14) reported a follow-up of Patients diagnosed with borderline personality disorder. Thirty-four and a half percent met criteria for remission at 2 years, 44.9% at four years, 68.6% at six years, and 73.5% over the entire follow-up. Paris and Zweig-Frank (15) in a long term follow-up of 64 borderline patients found that in a 15-year follow-up only 5 met the criteria for Borderline personality disorder. In a seven-year follow-up of borderline patients, Links et al. (16) found that only 47.4% still met the criteria for borderline at the end of the study. In a longitudinal study of Schizotypal, Borderline, Avoidant, and Obsessive Compulsive personality disorders, the majority did not remain at the diagnostic threshold after 12 months (17). Seivewright et al. (18) in a 12-year follow-up of 202 personality disorder patients also came to the conclusion

that the assumption that personality characteristics do not change over time is incorrect. The weight of the empirical evidence is that what we have traditionally diagnosed as personality disorders are clearly not as stable as was once thought.

Other Literature Relevant to the State Personality Concept

Other researchers have speculated about the possibility of State induced personality disorders. As far back as 1968 Leonhard (19) theorized about this concept. Mischel (20) examined the issue and found that while high levels of personality traits could predict behavioral response much of the time, as the personality trait was present at lower levels there was more variability in response. Some of this variability was presumed to be environmental. This conceptualization would fit the concept of stress induced personality disorders. The high trait (Trait PD) would be more predictable in their dysfunctional responses, the very low trait (No PD) would have the greatest adaptive flexibility and the intermediate group (State PD) would be in between.

After a review of the literature on personality and the anxiety and depressive disorders Bronisch and Klerman (21) concluded that a state personality disorder was a reasonable concept. They referred to the concept as "personality change." They postulated five different areas where fluctuations in personality might occur: Mood and affect, Impulse control, Attitudes toward self, Attitudes toward the world, and Social and Interpersonal behavior.

Other researchers have approached the subject of personality from dimensional and genetic perspectives. Livesley et al. (22) examined the heritability of personality traits in twin pairs. They found personality traits had varying levels of heritability, some high and some low. They did not see discrete categories of personality, but rather personality traits behaving as dimensionally distributed attributes in the population. For most personality dimensions the best fitting model specified additive genetic and unique environmental effects. In this model the State personality group would be the middle rank in those who responded to environmental stress. They would be between those who responded maladaptively to minor environmental stress (Trait PD) and those who were relatively resilient to environmental stress (No PD). Although this model would not give clear categorical boundaries, the State personality group would still be of clinical interest. It is also an example of how the State PD concept could fit into a dimensional model.

Tyrer and associates in the United Kingdom (23,24) developed an empirically based personality disorder system measured by an instrument called the Personality Assessment Schedule. This system categorizes No personality disorder, sub-threshold personality disorder, complex personality disorder, and severe personality disorder. In this system the State personality group might be considered somewhere near the border of sub-threshold and the simple personality disorder (Tyrer, personal communication).

Requirements for Validating the Concept of State and Trait Personality Disorders

There are no completely accepted criteria for validating a new psychiatric disorder (25). However, the development of diagnostic criteria from other disorders can give us a rough guide. We should be able to distinguish it from near neighbor disorders. We would want it to be associated with an independent measure linking the disorder to its area of hypothesized content. It is useful to have biological, family study, or family history markers. Ideally, it should be empirically identified in two or more populations. It should also have clinical relevance.

The Disorder Should Be Distinguishable from Its Near Neighbor Disorders

No disorder can be considered separate unless it can be distinguished from other disorders with at least some degree of reliability. The ultimate test of this is whether it can be distinguished from its near neighbor disorders. This does not mean that it does not share symptoms with other disorders, merely that there can be a good differentiation. For example, bipolar disorder and major depression look identical when patients are in the depressed state; however, course can distinguish them. Many of the individual personality disorders diagnosed under the DSM system share criteria, but are still considered different constellations of symptoms.

For State PD to meet these criteria it would be necessary to identify groups of patients where there were relatively brief personality fluctuations and to distinguish this group from Trait PD and No PD.

Evidence This Criterion Is Met

I have now done two empirical studies on State personality disorder. The first (26) used two measures of personality to identify the groups. One was the Personality Diagnostic Exam (PDE) (27,28), which was designed to measure personality dysfunction of longer duration (29). The second instrument was the Personality Diagnostic Questionnaire (PDQ) (30,31). This instrument was designed in such a way that it would pick up current personality symptoms (12,13). Clearly, personality dysfunction and disorders picked up by the PDQ, but not the PDE, would represent a subgroup of patients with relatively brief personality dysfunction. The differences in the two instruments allowed me to identify three groups. These were: No PD (no personality pathology on either instrument); State PD (relatively brief fluctuations in personality pathology indicated by pathology on the PDQ but not the PDE); and Trait PD (enduring personality pathology as indicated by the PDE).

The second empirical study (32) used an updated PDQ and followed Social Phobics over a twelve-week course of behavioral treatment. By examining the PDQ-IV scores at baseline and post treatment we were able to identify three groups based on the course of their symptoms. There were those with high

levels of personality pathology that did not change (Trait PD), those with personality pathology that changed over the 12-week treatment (State PD group), and those with consistently low personality scores (No PD group). The State personality group was distinguishable from the other groups by Trait Anxiety as measured by the State Trait Anxiety scale (33) and by Harm Avoidance (34). This is shown in Table 1.

We now have identified State personality disorder empirically in two populations and in each distinguished it from its near neighbor disorders. This criterion seems to have been met.

There Should Be Some Independent Measure Linking the Identified Group to the Area of Hypothesized Content

Once a group representing a new disorder or category is found it should have an association with some other measure of a similar concept. This measure, ideally, should not have been used to initially identify to the disorder. For example, if a new anxiety disorder was proposed it would strengthen the concept of that disorder if it was associated with other measures of anxiety. In the case of a personality disorder we would want the new group, State PD, to be associated with other established measures of personality.

Evidence This Criterion Is Met

We do have this evidence on our two empirically identified groups. In the Social Phobic group (32), the State PD group is separated from the Trait personality group by the personality measures Harm Avoidance (see Table 1).

In the other identified population drawn from veterans (26) we have an independent measure, the MCMI version 1, a validated personality instrument. It was available on only part of the subject sample. One scale from the MCMI-I felt most likely to be relevant was chosen for the comparison. This was the scale which measured cluster B personality pathology. Using this scale the results were Trait PD (75.4, SD = 11.7), State PD (70.6, SD = 6.4), and No PD (55.6, SD = 13.8). Even given the relatively small sample sizes (10, 3, and 5, respectively) Fisher's Exact test indicates a significant difference, p = .025. This finding adds an independent personality measure association to the second identified population (35).

Biological of Family Study or Family History Data to Support the Diagnosis

Biological markers that distinguish the diagnostic group of interest from near neighbor disorders are a useful validating tool. In most cases they are not available. However, they are present in this situation. The family study method is one such accepted technique. Here relatives of the identified group are diagnosed for psychiatric disorders and compared with relatives of comparison groups. Familial differences are considered as a useful tool in helping to validate a disorder. When the relatives cannot be directly interviewed, another method is used in which the patients are asked a structured interview about their relatives. This is a valid measure called the family history method (36,37).

Evidence This Criterion Is Met

In research on one population of State personality disorder (26) a validated family history measure of DSM anxiety and personality disorder clusters was used (38,39). The personality clusters referred to here are the DSM personality disorder clusters. When the No PD, State PD, and Trait PD relatives were compared we see significant differences between the groups in all three personality disorders as well as one measure of anxiety, Generalized Anxiety Disorder. These results can be seen in Table 2. The loading of psychopathology is what would be predicted from the model. Relative loading for each of the personality disorder clusters is Trait PD > State PD > No PD. The family history measures provide further evidence for the validity of State PD.

The Disorder Should Be Identified in at Least Two Populations

Identifying a potential disorder in a single population is an interesting first step, but as in many interesting first findings it gains weight with replication. Replicating a potential finding on a new population is a key step towards establishing its validity.

Evidence This Criterion Is Met

We now have identified a State PD group in two very different populations. The first was a population of veterans in

Table 1 Comparison of Personality Groups on Trait Anxiety and Harm Avoidance

Variable value	No PD (N = 32)	State PD (N = 33)	Trait PD (N = 28)	p
State trait AnxietyScale trait score	44.5 (SD = 10.1)	51.2 (SD = 12.6)	61.6 (SD = 7.1)	P = .0001[a]
Harm avoidance	19.8 (SD = 5.9)	23.3 (6.7)	26.3 (4.3)	P = .0002[a]

[a]Kruskal-Wallis test.

Table 2 Family History Measures for Relatives of the Different Groups in Percent

Diagnoses of Relatives	No PD N = 627	State PD n = 430	Trait PD n = 169
GAD	2.2	6.2	11.2[a]
Schizoid cluster PD	5.5	8.0	16.5[b]
Dramatic cluster PD	21.6	27.2	45.0[c]
Anxious cluster PD	11.3	15.6	32.0[d]

[a]Chi Square = 25.9, df = 2, p = .0001.
[b]Chi Square = 24.2, df = 2, p = .0001.
[c]Chi Square = 37.2, df = 2, p = .0001.
[d]Chi Square = 42.9, df = 2, p = .0001.

an outpatient clinic (26) and the second in a group of Social Phobic patients recruited by advertising in a college setting (32). These two groups were identified by different methods. The first was identified by the cross sectional use of two different personality instruments and the second by following personality symptoms over a period of time with one instrument. Although it would not be expected that the disorder be exactly the same in these two very different populations, that the State PD groups was identified in both contributes to the conclusion that this is a possibly valid disorder requiring further research.

The Concept Should Have Clinical Relevance

Although identifying a new disorder is an intellectually interesting step, of importance in the real world is whether the concept would inform clinical practice. In other words, does it make a difference in how we view a patient and potentially improve our understanding and outcomes?

Evidence This Criterion Is Met

There are two lines of evidence that State PD might have clinical significance.

Suicide attempts and ideation. The first area of clinical significance is in the area of suicide impulses or acts. This is a key clinical concern. In both studies of State PD there was evidence that separating the diagnosis of State PD from Trait PD increased the ability to predict suicidal ideation.

In the Reich (26) study the subjects were military veterans. The information regarding suicide attempts and impulses was from a structured clinical interview. Here the frequency of making a suicide attempt in their lifetime was for the No PD, State PD, and Trait PD, respectively, 5.3, 7.9, and 58.0. This is a significant difference (Chi Square = 45.2, df = 2, p = .001) that indicates that suicide attempts appear much more frequently in the Trait PD group than the No PD and State PD groups. The frequency for the No PD and State PD groups appear about the same.

In the second study (32) there is evidence in the same direction. Here a self report method was used, the PDQ. PDQ item 39 states, "I have tried to hurt or kill myself." We used this item for the comparisons in this population. Here we compared the Trait group to the combined No PD and State PD groups. This was due to there being no difference between the State PD and No PD groups on this variable, When all PDQ scores are taken at their highest clinical levels, the Trait group had 5 of 28 endorsing this item while the combined State and No PD group had 0 of 50 (p = .005, Fisher's exact test). Once again, there is an indication that there is less suicidal ideation and/or behavior in the State PD than the Trait PD group.

In these two studies we did not find other factors to explain this difference in suicide ideation. Although there are limitations (the second study only used a single variable as a measurement), both studies report similar results. If this finding

was further replicated it might enable clinicians to differentiate State PD from Trait PD and help them make a better assessment of which patients are more likely to make a suicide gesture or attempt. This would be clearly an aid to an important clinical decision.

Effect of State PD on the Course of Axis I Illnesses

A second line of evidence is the literature on the effect of personality pathology on the outcome of the treatment of Axis I disorders. Reviews on this subject (40–42) are extensive. Although there is not complete agreement among all investigators, the weight of the evidence is that personality pathology tends to produce a poorer clinical outcome in these cases. This effect appears to be present whether the personality pathology was measured by a self report instrument (which would be expected to be measuring more State PD) or by semistructured personality inventories (which would be expected not to be measuring State PD). Although not definitive, it appears that State PD may share with Trait PD the ability to be a predictor of poorer outcome for the treatment of Axis I disorders. This would of course be of clinical importance.

Clinical Characteristics of State Personality

Empirical Evidence for Describing Clinical Characteristics of State PD

There is very little empirical evidence on the clinical characteristics of State PD. I have examined this in two different data sets in widely differing populations. One of these was a Social Phobic college population (32) and the other was a veterans population with fairly severe psychopathology (26). These two populations are different enough that it is unlikely that the results can be combined. This is because the Social Phobic State PDs demonstrated Cluster C pathology while the veterans State PDs demonstrated Cluster B pathology.

In the Social Phobic population the State PD group differed from the No PD group and the Trait PD groups by having intermediate levels of trait anxiety, Harm Avoidance and the prevalence of the generalized form of Social Phobia. Numerous variables distinguished the State PD from the Trait PD group. Although these varied somewhat, an exploratory logistic regression seemed to indicate that the basic differences might have to do with some aspects of feeling not understood by others (due to paranoia or other reasons) combined with a tendency toward rapid mood shifts and impulsivity. These traits were higher in the Trait PD group (32). Although these characteristics do not define a set of clinical criteria, they might be somewhat of a guide for those searching for them.

I have more information on the veterans population with its predominantly Cluster B pathology (43). Here using candidate items from the personality measures (the PDQ and PDE), a logistic regression was able to distinguish State PD from Trait

PD with a fairly high degree of the variance accounted for. The maximum R squared was .63. The most powerful predictors for the presence of Trait PD were Suicide, Reacts Criticism, and Needs Approval. The specific results of the analysis are shown in Table 3 and the full wording of the criteria can be seen in Table 4. Although this is only a single sample, the results are intriguing. Clinical variables distinguishing State and Trait PD were clearly found, and it appears that shame may be a component of State PD in those with Cluster B traits.

Of course it is also of interest to know the clinical characteristics that separate State PD from No PD. This is also found in the Reich (43) report. A logistic regression distinguished the clinical questions that differentiated State PD and No PD in this population. The R squared for this analysis was .53 and the maximum R square was .71, showing that a good amount of the variance was accounted for. The question whose positive answer showed the greatest predilection for State PD was, "If I don't get my way I get angry and behave childishly." This question was from the self report, the PDQ, and had an odds ratio of 166. The questions whose negative answer showed the greatest predilection for No PD was, "Some people rarely show affection or talk about it. Are you like that? Have people told you that you are not affectionate?" This was from the PDE and had an odds ratio of 0.06.

Although the data available are limited, it does appear that diagnostic criteria for State PD might be developed, although it is possible they might vary somewhat based on the DSM clusters they were describing. It is possible, however, that the key criterion at the end of the day might be the fluctuating course of personality pathology.

Table 3 Logistic Regression Results Comparing Trait and State Groups in a Veterans Population[a,b]

Item	Chi Square	p value	Odds Ratio
Suicide (PDE)	10.2	.002	41.7
Reacts Criticism (PDE)	8.9	.003	37.0
Needs Approval (PDQ)	5.8	.02	37.0
Ashamed (PDQ)	4.8	.03	.006

[a]R squared for this analysis was .41, max R square .63.
[b]From Reich, 2002.

Table 4 Definition of Personality Items Used in the Logistic Regression

Item	Text
Suicide	Have you ever threatened to commit suicide? Have you actually made a suicide attempt or gesture?
Reacts criticism	Do you ever have a strong reaction to criticism, so that you feel ashamed or humiliated? Does criticism make you feel furious, even when you don't show it?
Fears embarrassment	Are you often afraid of being embarrassed by blushing, crying, or looking nervous when you are in front of other people?
Ashamed	Criticism makes me feel ashamed, inferior, or humiliated.

An Example of How State Personality Might Inform the Literature of Another Area of Psychiatry: Comorbid Anxiety and Depression

Another question that arises is whether this new conceptualization (State PD) will help inform the psychiatric literature in other areas. One possible way that this concept might have explanatory value is in the area of comorbid anxiety and depression. There is a review which puts forth the main points (44).

The review points out that there has been longstanding interest in whether comorbid anxiety and depression is qualitatively different from anxiety alone and depression alone. (This is as opposed to two disorders which, from time to time, happen to occur together.) Although there is agreement that this comorbid syndrome presents with a difficult course, nosologic, prospective, factor analytic, family history, and family studies have not definitively answered the question as to whether it is a distinct entity. However, by expanding the investigation of the phenomena between comorbid anxiety and depression to also include the personality disorders we may gain further insight. Clinical studies reveal a strong relationship between comorbid anxiety and depression and personality pathology. Family history studies taken from clinical populations indicate a strong association with personality pathology. Disorders combining anxiety, depression, and personality pathology have an especially virulent course.

It is likely that anxiety/depression/personality disorder represents a distinct clinical entity with its own course, pattern of morbidity, and etiology. If we consider the possibility that State PD is part of the phenomenon, the whole picture becomes clearer. The presence of State PD would likely reduce the odds of the disorder responding to standard treatment (see above). Due to increased personality pathology during times of exacerbation of affective and anxiety symptoms, exacerbations would be particularly nasty and difficult. It would also improve the odds for eventual successful treatment because it would point out the need for treatment or management of personality symptoms. Thus the concept of State PD might add explanatory power, possible new lines of investigation, and treatment to an existing difficult clinical phenomenon.

Future Directions

Clearly research into State personality disorder is at an early stage. The first order of business would seem to be to identify other populations of State PD. This could be done two ways. A cross sectional measure of personality pathology could be used over time to identify the different groups as was done in Reich and Hofmann (32). The second method would be to use an instrument that could assess probable Trait PD and to use a cross sectional personality measure to identify the remaining State PD (26). I would imagine that initially the most likely populations to study would be clinical psychiatric populations

with their presumed high level of personality morbidity. Eventually it would be of interest to examine other populations such as general medical and the general population.

Of course biological markers, either biochemical or of the family study sort, would be useful in further studies, as would research as to whether State PD would negatively affect the outcome of treatment of Axis I disorders.

SUMMARY AND CONCLUSIONS

In this report I have started by reviewing the current official nomenclature for personality pathology. This is a personality disorder characterized by being early onset, long duration, and relatively unchanging personality pathology. I then review the evidence that many patients have personality pathology that bears little resemblance to this picture. Patients may have personality pathology that appears to be mediated by depression or anxiety. Even those patients who appear to have a severe long-lasting Borderline personality disorder are often found to be in remission if careful follow-up is performed later. The current diagnostic nosology does not adequately reflect these latter cases.

I have proposed that much of this phenomenon of fluctuating personality pathology might well be explained by creating a new addition to the nomenclature, the concept of a State PD, a personality disorder characterized by more transient personality pathology. The old definition of enduring personality disorder would now define Trait PD. This division is analogous to the concepts of State and Trait anxiety, an accepted concept. High trait subjects tend to display the symptoms on a regular basis; intermediated trait subjects have a fluctuating course while low trait subjects seldom evidence the symptoms.

Any new category needs to have some empirical evidence for its existence. Above I have reviewed how this disorder has been identified on two different populations using two different methods. In both cases it could be distinguished from its near neighbors No PD and Trait PD. In both cases an independent measure of personality was associated with the State PD group. In one sample there was a biological marker, a family history study of personality clusters which discriminated the State PD group from Trait PD and No PD. Although definite clinical criteria cannot yet be determined, it appears that this will be feasible in the future. In short, there is good preliminary evidence for the validity of State PD.

The clinical phenomenon of comorbid anxiety and depression is discussed to indicate how the concept of State PD might inform other areas of the psychiatric literature. Future work would require replications of identification of the State PD group in different populations. It would also require some longitudinal studies and the determination of other biological markers. I would also include studies to gauge the effect of State PD on the outcome of Axis I disorders.

REFERENCES

1. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition. Washington, D.C., American Psychiatric Association, 1994, p. 630
2. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition. Text Revision, Washington, D.C. American Psychiatric Association, 2000, p. 686
3. WHO: *The ICD-10 Classification of Mental and Behavioral Disorders. Clinical descriptions and diagnostic guidelines.* Geneva, World Health Organization, 1993
4. WHO: *The International Statistical Classification of Diseases and Related Health Problems, tenth revision. Volume I: Tabular list*, Geneva, World Health Organization, 1992
5. Kerr TA, Schapira K, Roth M, Garside RF: The relationship between the Maudsley Personality Inventory and the course of affective disorders. *Br J Psychiatry* 1970; 116:11–19
6. Ingham JG: Changes in MPI scores in neurotic patients; A three year follow-up. *Br J Psychiatry* 1966; 112:931–939
7. Reich J, Noyes R, Coryell W, O'Gorman T: The effect of state anxiety on personality measurement. *Am J Psychiatry* 1986; 143:760–763
8. Reich J, Noyes R, Hirschfeld RP, Coryell W, O'Gorman T: State effects on personality measures in depressed and panic patients. *Am J Psychiatry* 1987; 144:181–187
9. Reich J, Noyes R: A comparison of DSM-III personality disorders in acutely ill panic and depressed patients. *J Anxiety Disorders* 1987; 1:123–131.
10. Reich J, Troughton E: A comparison of DSMIII personality disorders in recovered depressed and panic disorder patients. *J Nerv Ment Dis* 1988; 176:300–304
11. Hirschfeld RMA, Klerman GL, Clayton PJ, Keller MB, McDonald-Scott P, Larkin BH: Assessing personality effects of the depressive state on trait measurement. *Am J Psychiatry* 1983; 40:695–699
12. Reich JH: Instruments measuring DSM-III and DSM-III-R personality disorders. *J Personality Disorders* 1987; 1:220–240
13. Reich JH: Update on instruments to measure DSM-III and DSM-III-R personality disorders. *J Nerv Men Disease* 1989; 177:366–370
14. Zanarini MC, Frankenburg FR, Hennen J, Silk KR: The longitudinal course of borderline psychopathology: 6-year prospective follow-up of the phenomenology of borderline personality disorder. *Am J Psychiatr* 2003; 160:274–283
15. Paris J, Zweig-Frank H: A 27-year follow-up of patients with borderline personality disorder. *Comprehensive Psychiatry* 2001; 42:482–487
16. Links PS, Heslegrave R, van Reekum R: Prospective follow-up study of borderline personality disorder: Prognosis, prediction of outcome, and Axis II comorbidity. *Can J Psychiatry* 1998; 43:265–270
17. Shea MT, Stout R, Gunderson J, Morey LC, Grilo CM, McGlashan T, Skodol AE, Dolan-Sewell R, Dyck I, Zanarini MC, Keller MB: *Am J Psychiatry* 2004; 161:926–927.
18. Seivewright H, Tyrer T, Johnson T: Change in personality status in neurotic disorders. *Lancet* 2002; 359:2253
19. Leonhard K: *Akzentuirerte Personlichkeiten*. Berlin: Verlag Volk und Gesundheit, 1968
20. Mischel W: *Introduction to personality: A new look, 4th edition*. New York: Holt Rinehart and Winston, 1986
21. Bronisch T, Klerman G: Personality functioning: Change and stability in relationship to symptoms and psychopathology. *J Personality Disorders* 1991; 5:307–317

22. Livesley J, Jang KL, Jackson DN, Vernon PA: Genetic and environmental contributions to dimensions of personality disorder. *Am J Psychiatry 1993;* 150:1826–1831

23. Tyrer P, Ferguson B: Chapter 2, Current classification of personality disorder, in Tyrer P and Johnson (Eds.) *Personality disorders: Diagnosis, management and course, Second Edition*, London, Arnold 2000

24. Tyrer P, Johnson T: Establishing the severity of personality disorder. *Am J Psychiatry* 1996; 153:1593–1597

25. Beals J, Novins DK, Spicer P, Orton HD, Mitchell CM, Baron AE, Spero MM, AI-SUPERPFP Team: Challenges in Operationalizing the DSM-IV Clinical Significance Criterion. *Arch Gen Psychiatry* 2004; 61:1197–1208

26. Reich J: An empirical examination of the concept of "stress induced" Personality Disorder. *Psychiatr Annals* 1999; 29:701–706

27. Loranger AW, Susman VL, Oldham JM & Russakoff LM: The Personality Disorder Examination: A preliminary report. *Journal of Personality Disorders* 1987: 1–14

28. Loranger AW: *Personality Disorder Exam (PDE) Manual.* Yonkers, NY, DV Communications, 1988

29. Loranger A, Lenzenweger MF, Gartner AF, Susman VL, Herzig J, Zammit GK, Gartner JD, Abrams RC, Young RC: Trait-State Artifacts and the diagnosis of Personality Disorders. *Arch Gen Psych* 1991: 48:720–728.

30. Hyler S: *Personality Diagnostic Questionnaire IV (PDQ-R).* New York, NY: New York State Psychiatric Institute, 1987

31. Hyler SE, Skodol AE, Oldham JM, Kellman HD, Doidge N: Validity of the personality diagnostic questionnaire—revised: A replication in an outpatient sample. *Comprehensive Psychiatry* 1992; 33:73–77

32. Reich J, Hofmann S: State personality disorder in social phobia. *Ann Clin Psychiatry* 2004; 16:130–144

33. Speilberger CD, Gorsuch RL, Lushene RE: *State Trait Anxiety Inventory*, Palo Alto, CA, Consulting Psychologists Press, 1970

34. Cloninger CR, Przybeck TR, Svrakic DM, Wetzel RD: *The Temperament and Character Inventory (TCI): A guide to its development and use.* St. Louis, MO: Center for Psychobiology of Personality, 1994

35. Reich J: Empirical evidence for a state personality group. *Ann Clin Psychiatry* 2005; 17:3

36. Andreasen NC, Endicott J, Spitzer RL, Winokur G: *Family History-Research Diagnostic Criteria (FH-RDC).* University of Iowa, Department of Psychiatry, Iowa City, IA, 1997

37. Andreasen NC, Endicott J, Spitzer RL, Winokur G: The family history method using diagnostic criteria: Reliability and validity. *Arch Gen Psychiatry* 1997; 34:1229–1235

38. Reich J: A family history method for DSM III anxiety and personality disorders. *Psychiatry Res* 1985; 26:131–139

39. Reich J, Crowe R, Noyes R, Andreasen N: *Family History for DSM III Anxiety and Personality Disorders (FHPD).* Stanford Medical School, San Francisco, CA, 1985

40. Reich J: The effect of Axis II disorders on the outcome of treatment of anxiety and unipolar depressive disorders. *J Personality Disorders* 2003; 17:387–405

41. Reich JH, Green AI: Effect of personality disorders on outcome of treatment. *J Nerv Ment Dis* 1991; 179:74–83

42. Reich J, Vasile R: The effect of personality disorders on the treatment outcome of Axis I conditions: An update. *J Nerv Ment Dis* 1993; 181:475–484

43. Reich J: Clinical correlated of stress-induced personality disorder. *Psychiatr Ann* 2002; 32:581–589

44. Reich J: Comorbid anxiety/depression/personality: Viewed as a possible stress induced personality disorder syndrome. *Psychiatr Ann* 1999; 29:707–712