The Patient's Personality, Personality Types, Traits, and Disorders in the CL Setting

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25.1 Vignettes

1. A 34-year-old woman was admitted to the hospital after cutting her abdomen with a steak knife. She had methodically cut her skin, abdominal muscles, fasciae, peritoneum, and omentum, and pulled out her small intestine. She was in a pool of blood when her roommate came home and called the ambulance. Upon admission to the hospital, the patient denied suicidal intent; rather, she said she just had to cut herself and see blood to relieve the tension. She had seen visions of herself cutting before she actually cut herself. She felt no pain. Her abdomen was covered with scars from previous lacerations. This was her 18th hospitalization for cutting herself. The CL psychiatrist called a multidisciplinary conference concerning this patient. During the meeting, the surgical staff expressed considerable consternation and puzzlement over this patient. The CL psychiatrist empathized with the surgical staff about the frustration of having to deal with repeated self-mutilation. He then explained to the staff the nature of Borderline Personality Disorder, that the cutting behavior seems to have occurred in a dissociative state, and cutting often relieves unbearable tension in these patients. The staff's anger was visibly lessened following this conference, and they were able to treat the patient as another very sick patient.

H. Leigh and J. Streltzer (eds.), *Handbook of Consultation-Liaison Psychiatry*,
DOI 10.1007/978-3-319-11005-9_25, © Hoyle Leigh & Jon Streltzer 2015

2. A psychiatric consultation was requested on a patient who was admitted to the hospital with back pain. A spinal mass was discovered on imaging and further diagnostic workup was in progress. The patient seemed to the staff to be depressed, just staring at the ceiling, and not sleeping or eating. The patient was an accountant, and was concerned about his business while he was in the hospital. The consultant was impressed with the detailed, exacting description he gave of his symptoms and signs, as well as descriptions of his job and other concerns. When asked, the patient admitted that what made him most anxious was not knowing what was going on in the hospital, what each procedure was, and what the diagnosis and prognosis were. The consultant arranged a meeting among the patient, the resident responsible for the patient, and, at his request, the patient's wife. During the meeting, the resident explained in detail the diagnostic and therapeutic plans for the patient utilizing printouts of web pages. The patient's seeming depression immediately lifted, and he began to cooperate with the treatment plans.

25.2 Concepts of Personality

Personality refers to the totality of attributes of a person including intelligence; cognitive, perceptual, and behavioral traits; and habitual coping styles. *Character*, in the psychodynamic sense, refers to an individual's typical ways of dealing with reality and stress determined by unconscious defense mechanisms such as denial and projection.

25.3 What Contributes to Personality?

Personality is formed by the interaction of genetic predisposition with early environment and the accumulation of experiences and learning, much of which is influenced by cultural and socioeconomic factors.

25.3.1 Genetic Contributions

Obviously, temperament and disposition of individuals are largely genetically determined. Some examples of genetic contribution to personality traits follow.

The short allele of the serotonin transporter promoter gene *5HTTLPR* may underlie an anxious trait that in interaction with experience may give rise to increased neuroticism and anxious or borderline personality traits (see Chap. 7).

Some personality traits, including novelty seeking, are good predictors of vulnerability to stress-related mood and personality disorders in both humans and rodents. High-novelty-seeking rats [high responders (HRs)] are vulnerable to the induction of depressive-like symptoms by social defeat stress, low-novelty-seeking rats [low responders (LRs)] are not. While LR animals exhibited an increase in hippocampal BDNF levels following social defeat, HR individuals did not. This difference in hippocampal BDNF expression promoted the vulnerability of HR and the resilience of LR rats. Preventing activation of BDNF signaling by infusing the BDNF scavenger TrkB-Fc into the dentate gyrus of the hippocampus of LR rats led to social defeat-induced social avoidance, whereas its activation in HR rats by the TrkB agonist 7,8-dihydroxyflavone promoted social approach. Along with the changes in BDNF expression following defeat, there was in LR animals a downregulation of the inactive BDNF receptor but not in HR animals. The BDNF upregulation in LR involved an epigenetically controlled transcription of a specific area of BDNF (bdnf exon VI). Thus, hippocampal BDNF regulation seems to be a critical regulator of stress resilience, and underscores the importance of epigenetic factors in mediating stress-induced adaptive and maladaptive responses in different individuals (Duclot and Kabbaj 2013).

Mounting evidence from animal studies show that the mesolimbic dopaminergic pathways are modulated by the brain-derived neurotrophic factor (BDNF). The personality traits of Novelty Seeking and Harm Avoidance, are mediated, in

part, through dopaminergic mesolimbic circuitry. In one human study, carriers of the 66Met+/A1+ BDNF gene variant scored lowest on Novelty Seeking and highest on Harm Avoidance, compared to all other genotype groups. These participants are characterized by a relatively low D(2) receptor density in the striatum and an impaired activity-dependent secretion of BDNF (Montag et al. 2010). The long allele of the dopamine DRD4 genes has also been implicated in the Novelty Seeking personality trait (Okuyama et al. 2000; Ono et al. 1997).

A "risk halotype" of tryptophan-hydroxylase 2 (TPH2) gene has been identified for borderline personality diagnosis, impulsive aggression, affective lability, and suicidal/parasuicidal behaviors (Perez-Rodriguez et al. 2010).

Monoamine oxidase A gene, in interaction with childhood abuse, has been implicated in the development of the antisocial personality disorder. The stress of medical illness and hospitalization often causes a regression in the patient's personality; that is, the patient retreats to a more immature, child-like state with an exaggeration of the personality traits. By understanding a patient's personality, the physician can then determine how it influences the patient's ways of perceiving the world. This understanding leads to an approach to the patient that would result in better a physician–patient relationship and increased patient cooperation.

These are only some of the known genetic influences in certain personality traits and possibly disorders.

25.3.2 Experiential Factors

It is well known that normal development involves psychosexual (e.g., Freudian) and psychosocial development (e.g., Erikson's stages), and that each developmental stage may contribute to individual differences in personality.

Of particular importance in the development of psychiatric, and personality *disorders*, is the experience of childhood trauma and abuse.

In one study, there were independent relationships between: physical abuse and antisocial personality disorder traits; emotional abuse and anxious and fearful (Cluster C) personality disorder traits; and maternal neglect and odd, eccentric (Cluster A) personality disorder traits. Furthermore, physical abuse was independently and positively associated with narcissistic and paranoid traits and negatively associated with Cluster C traits (Cohen et al. 2013).

Childhood maltreatment and temperamental traits play a role in the development of Borderline Personality Disorder (BPD). In one recent study, approximately 70 % of borderline personality disorder reported some form of abuse or neglect. Childhood maltreatment inversely correlated with sociability. The regression model showed that neuroticism-anxiety and aggression-hostility traits, as well as emotional abuse, were risk factors independently associated with the severity of BPD. Sexual abuse was not associated with the severity of the disorder. The interaction between high neuroticism-anxiety traits and the presence of severe emotional abuse was associated with BPD severity. Thus, the interaction between temperamental traits and childhood emotional abuse may have an influence not only on the development but also on the severity of BPD (Martin-Blanco et al. 2013; Newnham and Janca 2014).

Early parent–child relationships moderate the future developmental trajectory. In one study, diminished tense discomfort predicted more antisocial outcomes, but only in insecure or unresponsive relationships. That risk was defused in secure or responsive relationships. The links between diminished tense discomfort and future antisocial behavior in insecure parent–child dyads were mediated by stronger discipline pressure from parents (Kim et al. 2013).

Children with conduct disorder often have psychopathic traits. Psychopathic traits consist of a callous-unemotional component and an impulsive-antisocial component, which are associated with two core impairments. The first is a reduced empathic response to the distress of other individuals, which primarily reflects reduced amygdala responsiveness to distress cues; the second is deficits in decision making and in reinforcement learning, which reflects dysfunction in the ventromedial prefrontal cortex

and striatum. Genetic and prenatal factors contribute to the abnormal development of these neural systems, and social-environmental variables that affect motivation influence the probability that antisocial behavior will be subsequently displayed (Blair 2013).

25.4 Brain Mechanisms of Personality Disorder

In a study of emotional habituation, unlike normal population, neither borderline nor avoidant personality disorder patients showed increased activity in the dorsal anterior cingulate cortex when viewing repeated versus novel pictures. This lack of an increase in dorsal anterior cingulate activity was associated with greater affective instability in borderline patients. In addition, borderline and avoidant patients exhibited smaller increases in insula-amygdala functional connectivity than healthy subjects and, unlike healthy subjects, did not show habituation in ratings of the emotional intensity of the images. Borderline patients differed from avoidant patients in insula-ventral anterior cingulate functional connectivity during habituation. Unlike healthy subjects, borderline patients fail to habituate to negative pictures, and they differ from both healthy subjects and avoidant patients in neural activity during habituation. A failure to effectively engage emotional habituation processes may contribute to affective instability in borderline patients (Koenigsberg et al. 2013).

Borderline patients tend to attribute resentment and aggression to others (Barnow et al. 2009) and are more likely to ascribe anger to ambiguous facial expressions (Domes et al. 2008). A bias toward negative or threatening information in borderline patients is also reflected in brain imaging data of increased and prolonged amygdala responses (Bertsch et al. 2013a; Hazlett et al. 2012).

The neuropeptide oxytocin is involved in social behavior across species. In healthy individuals, the intranasal administration of oxytocin reduces anxiety and stress in social situations, enhances the recognition of facial expressions, and shifts attention from negative to positive information, although individual differences and situational factors seem to play an important role (Bartz et al. 2011; Olff et al. 2013). Neuroimaging and animal studies indicate that oxytocinergic modulation of social behavior is related to its effects on the amygdala (Knobloch et al. 2012).

Bertsch and colleagues found, in a facial emotion classification experiment, borderline patients exhibited more and faster initial fixation to the eyes of angry faces combined with increased amygdala activation in response to angry faces compared with the control group. These abnormal behavioral and neural patterns were normalized after intranasal oxytocin administration. They conclude that borderline patients exhibit a hypersensitivity to social threat in early, reflexive stages of information processing.

Oxytocin may decrease social threat hypersensitivity and thus reduce anger and aggressive behavior in borderline personality disorder or other psychiatric disorders with enhanced threat-driven reactive aggression (Bertsch et al. 2013a). Reduced oxytocin levels have also been found in female borderline patients (Bertsch et al. 2013b).

25.5 DSM Personality Disorders (PD)

DSM I and II defined personality disorders by narrative paragraphs providing a general description and clinical conceptualization for each disorder. If a person fits the description, that person could be diagnosed with the disorder regardless of the impact of symptoms on daily life. While these were descriptions, these diagnoses were based on prevailing psychodynamic theory of personality development.

Beginning with DSM–III (1980) and the adoption of the multiaxial system, pesonality disorders, together with developmental disorders, became Axis II and explicit criteria were specified for each. This categorical model continued to be used for diagnosing PDs, but the distinction between normal and abnormal personality traits

appeared for the first time—a person must surpass a certain number of identified personality symptoms that define a specific disorder in order to meet the necessary conditions for a diagnosis.

In the planning stages of DSM-5, major changes were proposed in personality diagnosis including the elimination of Axis II, elimination of the three clusters, and reducing the number of personality disorders from 10 to 6. Above all, a more dimensional approach was to be incorporated.

It also proposed replacing the 79 *DSM–IV* personality disorder criteria with 25 personality trait facets (from five higher-order trait domains: negative affect, detachment, antagonism, disinhibition, and psychoticism), with each of the personality disorder types defined by different combinations of these traits; assessing five severity levels of personality functioning based on impairment in core self-personal and interpersonal capacities; new criteria for the general personality disorder diagnosis based on a combination of core deficits and specified pathological traits. These changes were not adopted, however, and DSM_IV criteria have remained unchanged.

Behavior genetics tend to favor dimensional conceptualizations of personality pathology. Biometric modeling generally assumes multiple gene systems, or quantitative trait loci, underlying complex behavioral phenotypes (Butcher et al. 2008; Butcher and Plomin 2008; Larsson et al. 2008; Meaburn et al. 2008; Ronald et al. 2008; Viding et al. 2008; Wardle et al. 2008) Risk alleles for personality pathology are distributed throughout the population, with some people having very few, some have a moderate amount, and some having many, thus creating a dimension of risk.

Most behavior genetic modeling of personality disorder assumes a dimensional, spectrum model of disorder (South and DeYoung 2013a, b).

There is considerable evidence that all personality disorders have some heritable biological basis (Torgersen 2005; Torgersen et al. 2008; Torgersen et al. 2012). In a national Norwegian sample of adult twins, Torgersen et al., reported heritability estimates from 28 % (paranoid, avoidant) to 77 % (narcissistic, obsessive–compulsive). A twin study using parental ratings in a sample of children and adolescents found relatively high-heritability estimates: from .50 (paranoid) to .81 (dependent, schizotypal), with a median heritability of .75 (Coolidge et al. 2001).

In the NIPHTP community twin sample, schizotypal personality disorder had the strongest loading on the genetic and environmental factors and appeared to be the strongest marker of the genetic and nonshared environmental liability to Cluster A pathology (Kendler et al. 2006) Among Cluster B disorders, one genetic factor influenced all four disorders, but a second genetic and nonshared environmental factor was also needed to account for influence on antisocial and borderline PDs (Torgersen et al. 2008). A common factor accounted for 83 % and 48 % of the variance in avoidant and dependent personality disorders, respectively, but most of the genetic influence on obsessive-compulsive personality was disorder-specific (Reichborn-Kjennerud et al. 2007a; Reichborn-Kjennerud et al. 2007b). Thus, obsessive-compulsive personality disorder appears to be etiologically distinct from avoidant and dependent personality disorder; in fact the clusters did not appear to hold up genetically and was proposed to be disbanded in DSM-5 (Kendler et al. 2008).

Using the NIPHTP sample, Kendler et al. (2008) found three genetic factors that did not directly correspond to the *DSM* cluster structure. The first genetic factor included loadings on paranoid, histrionic, borderline, narcissistic, dependent, and obsessive–compulsive PDs; the second had loadings on borderline and antisocial PDs; and the third had loadings on schizoid and avoidant PDs. These three genetic factors captured only a modest proportion of the total genetic variance, with 6 of the 10 PDs demonstrating substantial disorder-specific genetic effects. In contrast, the three unique environmental factors corresponded well to the *DSM* cluster structure, although as with genetic influences, all disorders (with the exception of schizotypal) demonstrated

substantial disorder-specific unique environmental influences. The authors concluded that the three genetic factors reflect (a) a broad tendency toward personality pathology or negative emotionality, (b) genetic risk for a factor of "impulsive aggression," and (c) a factor of low extraversion or inhibition. Further, they posited that the pattern of findings for genetic and environmental influences have implications for the comorbidities commonly found among personality disorders, i.e., antisocial and borderline PDs may be highly comorbid because they share the same genetic influences. Other Cluster B personality disorders may be comorbid because the same environmental influences (i.e., those not shared in common with other family members) lead to a "final common pathway" of Cluster B-type pathology (Kendler et al. 2008; South and DeYoung 2013a).

Neuroticism is a heritable common feature of both internalizing disorders and externalizing disorders, and that novelty seeking is a heritable broad-band specific factor that distinguishes anxiety disorders from externalizing disorders.

When broadly defined according to various measures of antisocial behavior, it appears to demonstrate substantial *shared* environmental effects (Hink et al. 2013; Rhee and Waldman 2002). Disregard for others in toddlerhood was a strong predictor of antisocial personality later (Rhee et al. 2013).

The proposal to radically change the personality disorders section of DSM-5 resulted in much controversy, finally resulting in maintaining all DSM-IV personality disorder diagnoses, but relegating future development as a research area in Section III. Emerging Models and Measures.

Definition DSM-5 defines personality disorder as an *enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment* (APA 2013).

DSM-5 presents two different models of personality disorders, a dimensional model that is presented in an unofficial Section III, and a categorical model that is a carry-over of DSM III/IV, in Section II, which is the official diagnosis.

25.5.1 General Personality Disorder

Nevertheless, a dimensional model is presented as General Personality Disorder, with the diagnostic criteria of: (1) An enduring pattern of inner experience or behavior that deviates markedly from the expectations of the individual's culture, which is manifested in at least two of the following: (a) cognition, (b) affectivity, (c) interpersonal functioning, and d) impulse control.

The enduring pattern must be inflexible and pervasive across a broad range of personal and social situations, and it leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning, and the pattern is stable and long duration, and its onset can be traced back to adolescence or childhood.

DSM-5 recognizes *personality traits* as enduring patterns of perceiving, relating to, and thinking about oneself. Only when the traits become inflexible and maladaptive enough to cause significant disruption would a personality disorder diagnosis be justified.

DSM-5 still maintains the three clusters of personality disorders which are based largely on phenomenology and not genetics or pathophysiology.

A listing of personality disorders in DSM-5 follows. Each personality disorder, when appropriate, will be discussed in Sect. 25.7.

25.5.2 Cluster A Personality Disorders

Paranoid PD, Schizoid PD, and Schizotypal PD.

25.5.3 Cluster B Personality Disorders

Antisocial PD, Borderline PD, Histrionic PD, and Narcissitic PD.

25.5.4 Cluster C Personality Disorders

Avoidant PD, Dependent PD, and Obsessive-Compulsive PD.

25.5.5 Other Personality Disorders

Personality Change due to Another Medical Condition, Other Specified and Unspecified Personality Disorder.

25.6 Classification of Personality Types

Prominent aspects of personality may be classified loosely into types. The Myers-Briggs Personality Inventory, based on Carl Jung's work, is an example that is used commonly. This typology contains the following dimensions: Introversion (I)–Extraversion (E), Sensing (S)–Intuition (N), Thinking (T)–Feeling (F), Judging (J)–Perceiving (P). Based on the predominance of these dimensions, a person's typology may be, for example, Introverted, Intuitive, Thinking, and Perceiving type (INTP). Eysenck's personality test measures three dimensions: *extroversion* as a measure of cortical activation (extroverts being underaroused, introverts being overaroused), *neuroticism* as a measure of activation thresholds of limbic or sympathetic system (minor stresses activate them in neurotics), and *psychoticism*, a tendency toward psychotic breaks and aggression (see Chap. 7 for a discussion of how personality traits may be predispositions for major psychiatric syndromes).

If everyone has a personality, and normal persons can be classified by personality type, what is a *personality disorder*? In our view, there is a continuum between normality and disorder. The only demarcation line is whether patients feel consistently distressed or their function is persistently impaired because of the personality characteristics.

Borderline personality disorder patients are often severely distressed and nonfunctional, and they often suffer from comorbid major psychiatric syndromes such as major depression and substance use.

The consultation-liaison (CL) psychiatrist must understand the interaction of personality types with the sick role that patients must assume in the general hospital setting (Bibring and Kahana 1968; Kahana and Bibring 1964; Leigh and Reiser 1980). Thus it is important for the CL psychiatrist to recognize the personality characteristics of the patient (i.e., personality type). We seldom, however, make the diagnosis of a personality disorder in the CL setting because such diagnoses in the medical record have little therapeutic value and often leads to stigma. The two exceptions are borderline personality disorder and antisocial personality disorder, which do have treatment implications.

25.7 Personality Types, the Sick Role, and Management Strategies

Many normal patients who are hospitalized will show transient exaggerations of their personality traits as a result of the stress of illness, hospitalization, and treatment. This section describes the types of traits, their interaction with the sick role (for further discussion of the sick role, see Chap. 10), and management strategies based on the personality needs.

We will here discuss the commonly encountered personality types in the CL setting. We will use the DSM-5 classification and nomenclature for personality disorders but we use the term personality types for those patients who do not meet the criteria for personality disorders (a majority of our patients), and some of the personality types discussed in this chapter are not DSM-5 personality disorders at all. Most patients discussed here are not candidates for treatment for their personality disorders per se in the medical setting—in fact, personality disorders are very difficult to treat even in long-term psychiatric outpatient therapy. As stated above, the goal of treatment in the general hospital and other medical settings is to take into account the personality needs of the patient in providing optimal medical care.

25.7.1 Cluster A: Odd and Eccentric Personalities

25.7.1.1 Guarded, Suspicious Patients (Paranoid Personality and Disorder)

Patients with this personality type are always watchful and concerned about the possibility that harm might be done to them, intentionally or unintentionally. They are quite fearful of being exploited or taken advantage of. They are quite sensitive to the possibility of criticism. They are prone to wonder about ulterior motives concerning any suggestions or remarks made by the health-care personnel, especially if they are ambiguous. These patients are also likely to misinterpret statements and actions and read something ominous or threatening into them. This is especially true in the presence of great anxiety, as in being hospitalized, and in states of reduced cerebral function that impair the integration of sensory input.

Such patients also tend to blame others for their illness. For example, a patient may claim that he developed a heart attack because his employer did not provide air conditioning for his work area and "poisoned the air" with carbon dioxide exhaled by so many others.

These patients, obviously, do not enjoy being in the sick role. The dependency on health care personnel increases their feelings of vulnerability, and with that comes the fear that persons in powerful positions will do harm to them or take advantage of them. Although they see the ill state as an undesirable one, they cannot trust the physician enough to cooperate fully.

A good management strategy for these patients is to assume a relatively neutral attitude concerning their suspicions, criticisms, and other manifestations of hostility without becoming provoked by them or arguing with them. A helpful statement is, "I understand how you feel under the circumstances." Identifying their suspiciousness as "sensitivity" is also helpful. Occasionally, agreeing with the patients about the inconveniences that they are suspicious about and then putting the blame on impersonal things like hospital regulations can diffuse their feelings of anger from being directed toward the health care personnel.

Above all, it is important to provide as little cause for suspicion as possible. This involves consistency on the part of health care personnel in terms of the information imparted to the patient. It is also necessary to explain, in as much detail as feasible, the nature of the patient's illness and plans for treatment. This will tend not only to minimize the suspiciousness but also to reduce the likelihood of litigation in case of complications, since this type of patient is likely to be litigious as well. When a procedure is recommended to the patient, it is best to present it as objectively as possible, so as not to arouse the suspicion that the doctor is trying to "manipulate" the patient for ulterior motives.

In severe cases, small doses of antipsychotic medications may help to reduce the degree of suspiciousness and accompanying anxiety during the hospitalization, for example, quetiapine 25 mg hs or risperidone 0.5 mg hs or b.i.d. po.

25.7.1.2 Seclusive, Aloof Patients (Schizoid Personality and Disorder)

This is the type of patient who seems to be remote, detached, and not in need of interpersonal contact. These patients usually prefer to be in private rooms and seldom speak or relate to other patients or staff. They like to be involved in solitary activities, such as reading or listening to music. They appear shy and uninvolved. Nurses are sometimes so disturbed by the aloofness and lack of personal response that they suspect depression, and thus bring the patient to the attention of the physician. Some patients with this personality might also appear to be eccentric, with affinities for activities associated with countercultures, such as unusual foods and quasi-religious sects.

The main concern of these patients is a desire not to be intruded on by others; they wish to maintain a sense of tranquility by being absorbed in themselves and things familiar to them. Any attempt at socialization by others may be seen as an intrusion threatening their fragile tranquility.

Illness is seen as a threat to this self-absorption and tranquility. These patients, therefore, have difficulty in adjusting to the sick role, with its

expectation of dependency on and cooperation with health care personnel. The patients come to terms with the role expectations through noninvolvement at a personal level while allowing the medical process to go on. Thus, a patient with this personality may appear to be strikingly unconcerned about illnesses and procedures that would normally be expected to arouse much anxiety. Of course, many patients with this personality delay seeking help because of their aversion to the intrusion into their privacy that is necessary in receiving medical care. On the other hand, some patients with this personality may use the sick role as an excuse to develop interpersonal relationships but without true intimacy. In managing such patients, it is important to recognize and respect their need for privacy. Although socialization and sharing are important to most people, these patients need to protect their privacy and tranquility. Some of these patients, however, may be able to form some relationship with one or two members of the hospital staff. These staff members can then serve as "translators" for these aloof patients.

25.7.1.3 Odd, Eccentric Patients with Schizophrenia-Like Tendencies (Schizotypal Personality and Disorder)

These are patients who seem odd and eccentric, have limited interpersonal contact, and have unusual experiences such as derealization and depersonalization, and they may manifest magical thinking, odd beliefs, paranoia, and other tendencies that approximate schizophrenia. Such patients may have peculiar beliefs and perceptions concerning illness that may conflict with the views of the medical profession. Health care professionals may be alarmed or turned off by the odd and eccentric behavior of such patients. Sick role expectations are often not shared by such patients. Managing patients who are odd and eccentric requires an understanding that the attributes are of long standing, and that the patient cannot really help being odd. Accepting and respecting such patients' individuality will allow a reduction of anxiety and perhaps paranoia so that medical treatment can be optimal. If the patient has a psychosis-like experience, perhaps precipitated by the stress of hospitalization and medical illness, small doses of antipsychotic medication may be helpful, for example, quetiapine 25 mg hs, risperidone 0.5 mg hs, b.i.d. po., or perphenazine 2 mg hs or b.i.d.

25.7.2 Cluster B: Colorful, Dramatic, Emotional, or Erratic Personalities

25.7.2.1 Patients with Repeated Legal Difficulties and Behavioral Problems (Antisocial Personality Traits)

Antisocial traits consist of a pattern of failure to conform to social norms, repeated lying, and deceiving others for profit or pleasure. Patients with these traits are often impulsive and aggressive, resulting in repeated fights. They tend to show personal and financial irresponsibility and to lack remorse, showing indifference to others' feelings. There is often a history of conduct difficulty before the age of 15, and these patients are unable to learn from experience, especially from punishment. It is therefore unrealistic to expect such patients to adhere without difficulty to the sick role expectations. These patients are often unreliable, demanding, uncooperative, impulsive, and aggressive. Managing such patients requires a firm and nonjudgmental attitude and explicit explanations as to how cooperation can result in specific benefit for the patient. Unreasonable demands should be declined based on explicit reasons or rules. Breach of rules and unlawful activity, if present, should be reported to the appropriate authorities. It is important for the health care personnel to realize that such patients naturally evoke angry feelings in others but that such provocations are part of their personality deficit.

25.7.2.1.1 Antisocial Personality Disorder

DSM-5 states the essential feature of this disorder is a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues

into adulthood. For this diagnosis to be given, the person must be at least age 18 and must have had some symptoms of conduct disorder before age 15 years. Conduct disorder involves a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, i.e., aggression to people or animals, destruction of property, deceitfulness or theft, or serious violation or rules (APA 2013).

The prevalence is considered to be 0.2–3.3 %. Higher prevalence is among males with alcohol use disorder and from substance use clinics or prisons.

There is no conclusively successful treatment for antisocial personality disorder at this time (Gibbon et al. 2010; Khalifa et al. 2010).

25.7.2.2 Patients with Intense, Unstable Relationships (Borderline Personality and Traits)

Borderline traits consist of a pattern of unstable and intense interpersonal relationships, unstable self-image, and marked impulsivity that are self-damaging, such as substance abuse, compulsive sexual activity, and binge eating. Patients with these traits often suffer from chronic feelings of emptiness, and may have transient stress-related dissociative symptoms. These patients arouse very strong feelings among the hospital staff members, because such patients tend to see them as either all good or all bad (splitting). Consequently, some staff members feel very positively about these patients while others feel exactly the opposite. Such patients regress easily, and may act out impulsively if they feel uncared for. Their demands for care, affection, and, often, special treatment may escalate if they feel that the staff is accommodating. The basic difficulty with these patients is that almost all relationships become stormy, such that the doctor who was "perfect" 1 day may become a persecuting monster the next day because of a perceived mistreatment or imperfection.

25.7.2.2.1 Management in the CL Setting

Patients who attempted suicide (which may be the reason for psychiatric consultation) or demonstrated serious suicidal ideation may require psychiatric hospitalization. In the general medical setting, the approach should be caring but, above all, consistent, with explicit expectations on the part of both the patient and the staff. The caregiver must recognize that these patients invariably produce intense feelings as a part of their personality makeup, but that he or she must provide a consistent, evenhanded, and caring approach to them. Sometimes, a multidisciplinary conference about a borderline patient may help (See Vignette 1). In such meetings, staff's feelings about the patient may be expressed and empathized with. At times, splitting may be evident in such a meeting, which can be discussed as a part of the patient's personality pathology. Such a meeting can facilitate the staff being able to assume a more objective, caring approach toward such patients.

25.7.2.2.2 Borderline Personality Disorder (BPD)

In more severe cases, the patients are diagnosed as having the borderline personality disorder, which often also includes the features of suicide attempts, unstable sense of self, negative affect (anger, bitterness, demandingness, sadness), brief psychotic experiences, impulsivity, and low achievement (Gunderson and Singer 1975). They often engage in substance abuse and demonstrate eating disorders. Borderline personality disorder requires psychotherapy combined with pharmacotherapy for depression, anxiety, or psychosis if present—see next section (Gunderson 1986; Koerner and Linehan 2000; Linehan et al. 2008). Borderline personality disorder patients often engage in cutting behaviors for tension relief rather than with suicidal intent (as in Vignette 1 at the beginning of the chapter).

The term, borderline, derives from "borderline schizophrenia" and "borderline state," the notion that patients with this disorder were at one time considered to have been on the border between schizophrenia and neurosis. Other old terms referring to this disorder or subsets of its patients include pseudoneurotic schizophrenia, psychotic character, and "as if" personality (Gunderson 2009). Now it is generally recognized that BPD is a syndrome independent of schizophrenia, though it can be comorbid with it. Many of the

clinical features of BPD are shared with bipolar disorder as well as with posttraumatic stress disorder, with which BPD has a 30 % comorbidity (Gunderson 2009).

According to DSM-5, the essential feature of borderline personality disorder is a pervasive pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in various contexts.

Persons with this disorder make frantic efforts to avoid real or imagined abandonment. The individuals are exquisitely sensitive to environmental circumstances. They have a pattern of intense and unstable relationships. There is often identity disturbance—unstable self-image or sense of self. They display impulsivity in at least two areas that are potentially self-damaging; gambling, spending money irresponsibly, binging, substance abuse, unsafe sex, or reckless driving. They engage in recurrent suicidal behavior, gestures, or threats, as well as attempts. Completed suicide occurs in 8–10 % of these patients. Self-mutilation such as cutting and burning are common, and may occur during a dissociative episode. Such behavior is often accompanied with relief.

Many patients experience marked reactivity in mood such as intense episodic dysphoria, irritability, and anxiety. They often experience chronic feelings of emptiness, as well as episodes of intense anger, panic, or despair. They are often easily bored. During periods of extreme stress, transient paranoid ideation or dissociative symptoms may occur.

Prevalence in the general population is 1.6–5.9 %, about 6 % in primary care settings, and about 10 % in outpatient mental clinics, and about 20 % among psychiatric inpatients (DSM-5).

25.7.2.2.3 Treatment of Borderline Personality Disorder

BPD is the only major psychiatric syndrome for which psychosocial interventions remain the primary treatment (Gunderson 2009). There are two specific psychotherapeutic modalities specifically developed for BPD—*Dialectical Behavioral Therapy and Mentalization Therapy. Schema Therapy* has recently been shown to be cost effective and more effective than transference-based psychotherapy, clarification-oriented psychotherapy, and treatment as usual, in BPD as well as in cluster C, paranoid, histrionic, or narcissistic personality disorders (Bamelis et al. 2013; Bamelis et al. 2011).

25.7.2.2.3.1 Dialectical Behavioral Therapy (DBT)

DBT was developed by Marsha Linehan at University of Washington in Seattle. It was introduced as a carefully manualized 1-year outpatient therapy consisting of integrated group and individual-therapy components (Linehan 1993a, b). It specifically targets the parasuicidal behaviors of BPD by outpatient therapists through emotional validation, constant availability, and not reinforcing self-harm through hospitalization, and utilizes social skills training and mindfulness training. The basic tenet of DBT is as follows:

BPD patients exhibit emotional vulnerability to stimuli, i.e., excessive arousal of negative emotions, and tend to blame others for the distress. On the other hand, they have internalized the invalidating environment and show self-invalidation, i.e., have unrealistic and excessive expectations of themselves and develop self-blame and guilt when they are not met. Emotional vulnerability and self-invalidation are the first pair of "dialectical dilemmas." Borderline patients frequently experience a series of relentless crises, often contributed to by their own dysfunctional lifestyle and tendency for emotional overreaction. Because of their inability to modulate emotions, such patients have difficulty in facing the emotions associated with loss and grief, and thus suppress negative emotions. The unrelenting crises and inhibited grieving represent the second set of dialectical dilemmas. The final set of dilemmas consist of "active passivity," i.e., they are active in finding others to help them solve problems but are passive in helping themselves and "apparent competence," i.e., they have developed the appearance of competence in the face of invalidating environment without actually achieving a generalizable competence. A pattern of self-destructive behavior often results due to the excessive painful emotions and helplessness.

DBT uses the dialectical use of acceptance on the one hand and change on the other. The philosophical concept of dialectics involves the juxtaposition of thesis and antithesis, resulting in a resolution of the opposites through synthesis. In DBT, there are individual and group sessions that consist of four training modules—*mindfulness*, *interpersonal effectiveness*, *distress tolerance*, *and emotion regulation*. Through mindfulness training derived from Buddhist meditation, the patients learn to accept the here and now free from worries and thoughts. Through interpersonal effectiveness training that incorporates assertiveness training, patients learn to develop more satisfying ways of dealing with others. DBT identifies the triggers for distress and regulates the reaction to them and uses behavioral principles in reinforcing healthful behavior and not reinforcing self-destructive behaviors (Chen et al. 2008; Crowell et al. 2009; Linehan 1993b; Linehan 1987, 1993c, 1995; Shearin and Linehan 1994).

The therapist in DBT assumes the role of a "coach" for the patient (Rizvi et al. 2011).

DBT has been shown to be particularly effective for parasuicidal behaviors in general, as well as for a variety of conditions including BPD, PTSD, binge eating, etc. (Bohus et al. 2004; Chen et al. 2008; Crowell et al. 2009; Harned et al. 2012; Linehan et al. 2006; Linehan et al. 2008; Neacsiu et al. 2010).

25.7.2.2.3.2 Mentalization-Based Treatment

Mentalization-based treatment was developed by Fonagy in England specifically for BPD, and has been shown to be effective (Bateman and Fonagy 2009, 2010; Higgitt and Fonagy 1992; Sharp et al. 2011). Fonagy postulated that caretakers' failure to accurately mirror (validate) a child's mental states was responsible for difficulties in knowing one's self and in empathizing with others—an inability to mentalize, a concept similar to *theory of mind* (*TOM*) in psychological literature. It was designed to correct the borderline patient's underlying handicaps in mentalizing by adopting a noninterpretive, "not-knowing," inquisitive stance intended to facilitate the accurate recognition and acceptance of one's own and others' mental states (including the therapist's).

25.7.2.2.3.3 Schema Therapy

Schema therapy integrates elements of cognitive therapy, behavior therapy, object relations, and gestalt therapy into one unified, systematic approach to treatment.

Schema Therapy, developed by Jeffrey Young, is based on identification and management of Early Maladaptive Schemas (or just "schemas"), Coping Styles, Modes, and basic emotional needs (Young 1990; Young et al. 2003).

Schemas are defined as self-defeating life patterns of perception, emotion, and physical sensation. For instance, a person with an Abandonment schema could be hypersensitive to their perceived value to others, which in turn could make them feel fearful in relationships. Coping styles are our behavioral responses to the schemas in hopes of making things better, but in fact they very often wind up reinforcing the schema. For example, someone with an avoidance coping style might behave in ways to limit the closeness in the relationship in order to try to protect themselves from being abandoned. The resulting loneliness or even actual loss of the relationship could reinforce the person's Abandonment schema.

Modes are mind states that one can shift into that combine schemas and coping styles into a temporary "way of being." (Young et al. 2003) For example, a Vulnerable Child Mode might be a state of mind encompassing schemas of Abandonment, Defectiveness, Mistrust/Abuse and a coping style of Surrendering (to the schemas).

If basic emotional needs are not met in childhood, schemas, coping styles, and modes can result. Some basic needs that have been identified are: connection, mutuality, reciprocity, flow, and autonomy.

The goal of Schema Therapy is to help patients get their core emotional needs met. Schema therapy utilizes various techniques including limited reparenting, imagery, rescripting, flashcards, diaries, etc.(Bamelis et al. 2012; Bamelis et al. 2013; Rafaeli et al. 2010; Young et al. 2003) Mindfulness meditation may also be blended into schema therapy (Amaro et al. 2010; Ball 1998).

Medications may be used to treat symptoms of depression, anxiety, and micropsychotic episodes. For micropsychotic episodes and for very

strong urges to self-mutilate, small doses of antipsychotics may be indicated on an as needed basis, e.g., perphenazine 2 mg or quetiapine 25 mg, up to three times a day PO PRN.

Medications should be used in conjunction with psychotherapy for comorbid conditions such as PTSD, bipolar disorder, major depression, and schizophrenia.

25.7.2.3 Dramatizing, Emotional Patients (Histrionic Personality and Disorder)

Patients with this personality type tend to come across as being rather charming and fun to talk with. They have a certain dramatic flair when giving accounts of their lives and are often quite amusing. Their histories tend to be more impressionistic and diffuse than precise. They may be overtly seductive: female patients wearing provocative negligees and "parading around" in the hospital; male patients making sexually seductive comments to nurses and female physicians. There is a tendency for these patients to consider their relationship with the doctor as special, with sexual overtones. The medical staff often finds itself split around these patients, some liking them very much and others feeling angry with them. The patients themselves have usually unwittingly provoked these split reactions.

A major concern underlying such behavior is the need to be attractive and desirable to others, to prove their masculinity or femininity over and over again and to gain care and support. An underlying fear that they might not be found attractive and desirable is accentuated by illness, with its threat to the integrity of the body. As patients, persons of this type have an exaggerated need to be reassured that they are still attractive and will not be deserted.

The sick role may or may not be compatible with this type of personality. On the one hand, the dependency and social perquisites inherent in the sick role afford some of these patients an acceptable opportunity to exhibit and "flirt" with authority figures in a situation that sets limits. Patients with extreme forms of this personality, despite their overtly sexually provocative behavior, tend to be rather inhibited in actual sexual encounters. For them, the hospital and medical treatment may be exactly the type of setting they find most comfortable for seductive behavior without danger of actual sexual activity. On the other hand, some patients become extremely frustrated by the confinement and limitations of the sick role, especially if they had been accustomed to active, exhibitionistic, and gratifying lifestyles. For example, a man who had been accustomed to a "Don Juan" lifestyle may find the restriction of sexual activity in the hospital most unbearable.

These patients do best when the doctor responds amiably and engages them within set boundaries and limits. However, this should not be overdone, since these patients also tend to be frightened if their characterological seductiveness seems to lead to unexpected intimacy. Showing some warmth and personal concern is usually all that is needed. When there seems to be a split in staff feelings, these should be openly discussed and resolved in staff meetings. It may also be necessary to set firm limits with these patients, at the same time indicating concern and willingness to continue to take care of them. Repeated reassurances are often necessary. With this group of patients, unlike the orderly, controlling personalities, the doctor's personal manner and attitudes are relatively more important in providing reassurance than factual content, such as discussion of objective findings and test results.

25.7.2.4 Superior and Special Patients (Narcissistic Personality and Disorder)

These are patients who behave like VIPs, whether or not they are. Such patients have a tendency to appear snobbish, self-confident, and sometimes grandiose. They are often quite proud of their bodies and their physical abilities. This basic style might be partially covered up by exaggerated, artificial humility. There is a sense of arrogance and disdain when they are in contact with other people. Though these patients may seek the most prestigious medical centers and the most eminent physicians when ill, there is often an air of tentativeness in their responses when the physician explains anything to them. They may display an arrogant attitude, especially toward persons on the lower strata of the hospital hierarchy, such as

house officers, student clerks, and nurse's aides. They are likely to threaten to notify the chief of service or the director of the hospital of any inconveniences they suffer. They also use "name-dropping" to try to impress health care personnel.

Many patients with this personality style have idealized body images, and illness represents a threat to the maintenance of this body image. Many neurotic patients with overvaluation of physical prowess, stamina, and fitness were found to have developed the neurosis after illness or injury, often of a minor nature, e.g., the "athlete's neurosis" (Little 1969).

The patients with superiority feelings naturally do not find the sick role agreeable. Their need to see themselves as being perfect and invulnerable is contradictory to the notion that they "cannot help themselves" and are in need of more competent help. Although they may submit to this unpleasant situation, they often attempt to find weaknesses and faults in the physicians, as though to cut them down to size in order to still feel superior to them.

Needless to say, health care personnel often resent this type of attitude. The result is often a battle between the care giving staff and the patient, each attempting to cut the other down!

Successful management of these patients involves a certain degree of magnanimity on the part of health care personnel, allowing these patients to boast of their strengths. When this is done, the patients may feel secure enough to identify the caring persons with the self as being almost perfect. It is, however, a mistake to be unnecessarily humble in relation to these patients. An attitude of security about one's professional competence, while recognizing the worth of the patient, is important to ward off insecure feelings on the patients' part that they might not be in the best hands after all.

25.7.2.5 Impulsive Patients with a Tendency to Act Out (Impulsive Personality—Not a DSM-5 Diagnosis)

These are the patients who keep on doing things they did not "mean" to do, usually on the basis of some impulse. These patients may appear to be rational and well controlled, until an impulsive action occurs. Usually, however, they have a history of being involved in interpersonal or legal difficulties because of some maladaptive acting-out behavior. The characteristic feature is a lack of deliberation, with decisions being reached on the spur of the moment. Patients with this character style seem to lack tolerance for sustained thinking and for frustration. They often say that they acted "without thinking" or "could not help" what they did and often are quite remorseful afterward. In the health care system, these impulsive actions usually involve some aggressive acts against health care personnel or ill-advised decisions such as signing out against medical advice despite having a serious illness.

These patients seem to feel an overwhelming sense of impotence in the presence of relatively minor frustrations and appear to be unable to delay gratification or to feel gratified by anticipatory cognitive processes such as planning.

Patients with an impulsive personality style are likely to seek help for relatively minor symptoms based on the immediate pain or discomfort experienced, and they are likely to demand immediate relief from the discomfort. If immediate relief is not produced, they are prone to acting out by such aggressive acts as cursing at the physician or kicking an article of equipment in the treatment room. Such patients, although wanting immediate relief from symptoms, often have difficulty in tolerating the treatment process, especially when it also involves some discomfort, such as a nasogastric tube. Although these patients may appear to have understood the necessity of such a procedure, they are as likely to curse and attempt to sign out in the midst of the procedure when discomfort occurs. Thus, cooperation with the physician (a sick-role expectation) is difficult for these patients.

Medical professionals, trained to be always deliberate and objective, tend to dislike patients with this personality type. They see these patients as being defective and childish. In fact, this style may be a manifestation of a defect in the integrative functions of the brain rather than a primarily developmental personality style. In fact, it is well known that brain-damaged patients frequently exhibit impulsive behavior. It is important, therefore, for

health care personnel to deal with it as a defect, just as they have to recognize and deal with a diabetic patient's metabolic defect. The management strategy, thus, would involve preventing situations in which the defect would be of major consequence and compensating for it when it is unavoidable.

For example, tranquilizers may be utilized more freely for these patients as a partial preventive measure against outbursts of aggression. Benzodiazepines such as lorazepam 1–2 mg may be used 30 min before a procedure. First generation antipsychotics (e.g., perphenazine 2–4 mg b.i.d. p.o.) may be used for their neuroleptic effect so as to decrease the patient's stimulus-bound immediate response to discomfort. Second-generation antipsychotics (e.g., risperidone, olanzapine, aripiprazole) and mood stabilizers (e.g., valproic acid) in small doses may also be considered.

Pain should be treated especially vigorously. Firm limit-setting is also necessary to establish some external control over these patients' acting-out behavior. In fact, these patients feel reassured by firm limit-setting, which also gives them a sense of external control and caring. Whenever possible, persons familiar to the patient, such as friends and relatives, should be mobilized to support and control the patient.

25.7.2.6 Patients with Mood Swings (Cyclothymia and Cyclothymic Disorder)

These patients characteristically have "ups and downs," that is, periods of relative euphoria and hyperactivity followed by periods of depressed feelings and lack of energy. Although most people have some periods characterized by euphoric or depressive moods, persons who have this personality trait exhibit such mood swings consistently. During the "up" periods, they feel optimistic, ambitious, and usually physically well. During the "down" periods, feelings of pessimism and a sense of malaise predominate. If these changes are exaggerated so as to cause major problems in function, the psychiatric diagnosis of bipolar disorder or cyclothymic disorder should be considered (see Chap. 15).

The importance of recognizing this personality trait lies in that, depending on the mood in which these patients find themselves, the reaction to illness and to the medical treatment may vary. When an illness occurs during an up period, patients may not even recognize the presence of the symptoms, or even if the patients do recognize them, they may brush them aside as being of no consequence. If patients happen to be in a down phase, however, they may feel quite pessimistic about the symptoms and attach all kinds of grave implications to them. In fact, they may be convinced, even before they see a physician, that they have a terminal illness for which there is no hope. In addition, because of the feelings of malaise and lack of energy experienced during the down phase, these patients may experience exaggerated discomfort that may be caused by minor dysfunctions.

Patients with this personality trait might be more prone to developing severe depression in the presence of major stress such as a serious medical illness. If a patient who has this pattern develops evidence of serious depression, including feelings of hopelessness, guilt, and lowered self-esteem, coupled with weight loss, anorexia, sleep disturbances, and, perhaps, suicidal thoughts, the diagnosis of major depression should be made, and definitive treatment instituted (See Chap. 15).

25.7.2.6.1 Cyclothymic Disorder

This is the more serious form of cyclothymia, and DSM-5 includes this disorder in the section of *Bipolar and Related Disorders* rather than in the personality disorders section because of its proximity to the extreme form, *Bipolar Disorder*.

DSM-5 defines cyclothymic disorder as a chronic, fluctuating mood disturbance involving numerous episodes of hypomanic symptoms and periods of depressive symptoms that are distinct from each other. The hypomanic symptoms and depressive symptoms must be insufficient in number, severity, pervasiveness, or duration to meet the full criteria for the hypomanic episode and major depressive episode, respectively (See Chap. 15) (APA 2013).

25.7.3 Cluster C: Shy, Anxious, and Fearful Personalities

25.7.3.1 Shy, Anxious, Rejection-Sensitive Patients (Avoidant Personality and Disorder)

These patients do not reach out to people for fear of rejection—that they are not likable, socially inept, and likely to be criticized. Thus, they tend to avoid activities that are likely to involve interpersonal contact. Hospitalization would be especially stressful for these patients because of the necessity to deal with new sets of people, both health care professionals and other patients, who might all dislike them, criticize them, and reject them. Managing such patients involves understanding their fear of criticism and rejection. A good approach to these patients entails a friendly and caring attitude and patiently explaining the procedures and treatments, as these patients are very much in need of feeling accepted by others.

25.7.3.2 Dependent, Demanding Patients (Dependent Personality and Disorder)

It is said that one can detect this type of personality by noting the amount of luggage the patient brings to the hospital. An exaggerated caricature form of this personality is indeed seen in the patients who come into the hospital as though they were prepared to stay for months, if not years. Patients of this type have a need for a great deal of reassurance and often want special attention from health care personnel. They tend to become dependent on the doctor and others who are involved in their care and often make frequent, inappropriately urgent calls to nurses and doctors. When their (excessive) demands are not met fully, they tend to feel angry and rejected.

The underlying dynamic for this type of personality is considered to be a regressive wish to be cared for as though by an idealized, nurturing mother. The fear of being rejected, left out in the cold, and neglected tends to exaggerate the need for reassurance and care. The sick role may be considered to be a temptation for these patients to return to a state of infantile dependency, and they may consider the illness to be a result of a lack of protection and concern by others.

The incessant demands of a patient of this type, coupled with relative comfort in the dependent position, may be regarded by others, especially doctors and nurses, as "enjoying" being sick, counter to the sick role expectation that the patient should consider being ill an undesirable state and try to get better by seeking and cooperating with medical care.

When excessive demands for attention are not met, the patient may become hostile, in turn provoking anger and conflict. The nurses, for example, may feel that the patient wants too much attention, while the patient feels that the nurses are cold and uncaring.

There is a flip side to this coin as well. A patient of this type was referred to the psychiatrist by an alarmed surgeon because he too eagerly consented to an amputation the first time it was discussed as a possibility. In this instance, it was learned that the doctor had been overly indulgent with the patient, allowing special privileges and giving an inordinate amount of care and attention. The patient, before long, regarded the doctor as an omnipotent, mothering figure and wanted to go along with anything that the doctor suggested might be good for him.

25.7.3.3 Orderly, Controlling Patients (Obsessive-Compulsive Personality and Disorder)

Such patients tend not to show feelings and generally experience illness without outward signals of emotional reaction. Their descriptions of symptoms are complete, precise, and dispassionate.

This personality style is motivated by a desire to control external as well as internal states. Behind the desire to control may be fear of loss of control or being helpless.

The sick role is obviously difficult for patients with these personality characteristics. Removal from normal responsibilities and daily routine may be experienced as disruptive. Being unable or not permitted to help themselves may be an alien experience for them. Needing to seek advice and help from a professional may generate concerns about who will control whom, and they

may feel deeply threatened by the control that doctors and nurses must assume over their lives and their bodies in order to administer the necessary medical care.

In response to these threats, they may become contentious, complaining, and accusatory. Usually quite conscious of time and details, such as medication schedules, they may become incensed and critical if the nurse brings a pill a few minutes late.

Such patients do not respond favorably to blanket reassurances. They are likely to wonder if the physician is competent when reassurances are given without firm foundation in facts. The doctor's explanation of one hopeful laboratory finding may be far more reassuring to this type of patient than many impressionistic but unsupported optimistic statements.

A rule of thumb in dealing with this type of personality is to attempt to recruit the patient to be a part of a therapeutic team effort against the illness. This enables patients to feel that the physician respects their autonomy enough to ask them to cooperate in the common endeavor. Detailed explanations of the diagnosis, the physical and laboratory findings, and treatment plans are helpful, especially for more educated patients (as in Vignette 2 above). Sometimes it is useful to the patients to help the treatment team by keeping a diary of symptoms or by recording some of their clinical data, such as the volume of water drunk and urine voided.

Case History: A chemistry technician with diabetes mellitus was admitted for treatment of leg ulcers. Within days after admission, he complained of the "sloppiness" of the doctors and nurses, and their lack of punctuality in bringing his medications. Successful management involved the physician's acknowledging the patient as someone related to the medical profession ("As a chemist, you would understand the mechanism of diabetes mellitus. Now, we want to treat this with diet and insulin, and we will follow the course with blood glucose levels."). In addition to giving the patient credit for his knowledge of chemistry, the doctor taught him to change his own medicated dressings (he could do it "much better than any nurse") and to keep track of his medications to be sure that they were taken on time.

25.7.3.4 Long-Suffering, Self-Sacrificing Patients (Masochistic Personality—Not a DSM-5 Diagnosis)

Some experienced physicians say that this personality type can be diagnosed by the pitch and tone of the patient's first utterance at first contact with the doctor. Such patients often speak in a wailing, complaining voice, and usually the history involves a long list of hard luck and disasters: surgical operations followed by complications, trusted persons turning out to be untrustworthy, promised cures for a symptom bringing on more symptoms and side effects than relief, and other complaints. They almost always have endured protracted pain and suffering, and this "present illness" represents an additional suffering for a patient who seems to have been "born to suffer."

When listening to patients with this type of personality, one usually finds that they have taken care of someone else despite their own suffering and misery. They take much pride in relating how this feat was achieved in the presence of so much suffering and so many misfortunes. Often, that someone else is a child, a spouse, or a parent.

A major underlying dynamic in these patients is considered to involve strong feelings of guilt that do not allow them to enjoy life for themselves. With a "need" to suffer in order to expiate the guilt feelings, altruistic activities (such as caring for others) in the presence of physical or emotional pain may allow them some covert gratification (claim to happiness). Thus, these patients appear as though they are "exhibiting" their misfortunes, sufferings, and altruistic acts.

Another underlying dynamic in such patients is the use of pain and suffering as a lifestyle, as a means of maintaining interpersonal relationships. These are patients who might be "addicted" to the sick role (see Chap. 10). The sick role is taken on from time to time throughout their lifetimes, although they also feel proud of having taken care of others despite the sick-role restrictions. A closer

scrutiny reveals that the sick role is assumed as a way of meeting their needs indirectly through suffering and through ongoing contact with the physician. Many patients diagnosed as "hypochondriacs" have this personality type (see Chap. 23).

Patients with this type of personality often become severe problems for health care personnel. Typically, they tend to *react negatively to reassurances*, totally frustrating the doctors. When the physician prescribes a medication and offers the reassurance that it will relieve the pain, these patients are likely to return complaining of more rather than less pain, which may now be felt in areas that were previously free of pain! In addition, they may have nausea and dizziness. They may even overtly blame the physician for their added troubles, but most often this is attributed to bad luck. The physician, nevertheless, is often made to feel guilty by these patients. This frequently results in a rejection of the patient by the physician, which adds to the patient's feeling of being mistreated. Thus, these patients commonly have a history of repeated rejection or transfer from doctor to doctor.

If not quite reaching the degree of pathology of factitious disorder (Munchausen syndrome, See Chap. 21), the long-suffering personalities are often addicted to the sick role, and thus appear to the health care personnel not to consider being sick an undesirable state and pay only lip service to wanting to get well.

Patients with this personality type are best managed when the physician gives "credit" to their suffering and expresses appreciation for their courage and perseverance in the face of protracted pain and hardship. It is a mistake to promise such patients complete relief from pain and suffering. In fact, since they need to expiate guilt and maintain relationships, such a promise may provide a powerful reason for the patients' "refusal to improve." Taking away the symptoms and suffering would leave them exposed and helpless, without any means of relating to others.

Recognition of this pattern also helps the physician to recognize the necessity to accept and set limited goals for the treatment in order to avoid later frustration, feelings of helplessness, and reactive anger. This can prevent or postpone the development of disruptive tension in the relationship with the patient. It is often helpful for the physician to approach this type of patient with some degree of pessimism, such as, "Although we cannot take away the pain completely, this medication may take the edge off the pain somewhat," or "It is remarkable that you can tolerate this discomfort as much as you do!"

Attempts to mobilize altruistic tendencies may also be helpful. For example, a patient may be persuaded to seek proper treatment to alleviate crippling pain so that she might be better able to care for her children.

One has to differentiate this type of personality from patients who experience protracted suffering due to actual complications from treatment. Patients suffering from chronic illnesses without this character style do not show the self-sacrificing element, and although they may feel rather cynical about the prolonged illness, they do not show the tendency to "refuse to improve."

25.7.3.5 Other Personality Disorders

25.7.3.6 Personality Change Due to Another Medical Condition

Many medical conditions, particularly head trauma, neurodegenerative diseases, infections, metabolic/endocrine diseases, nutritional deficiencies, poisoning, can cause personality change. Exaggeration of preexisting personality characteristics with brain injury is well known (Gunter et al. 2013; Laborey et al. 2013; Sela-Kaufman et al. 2013; Sinha et al. 2013).

DSM-5 lists a number of types of personality change—labile, disinhibited, aggressive, apathetic, paranoid, other, combined, and unspecified types.

Personality change, especially lability, impulsivity and paranoia occur frequently as a symptom of delirium.

Recognition that the personality change is due to the underlying medical condition is usually reassuring both to the patient and the family. Treatment should be geared to the underlying medical condition, with symptomatic treatment if indicated, such as mood stabilizers or antipsychotics.

25.8 From Types to Individuals

As should be clear from our discussion, the various characteristics of personality types are not mutually exclusive but tend to coexist in varying combinations. One of our most gratifying experiences is to hear our students complain to us, after a discussion of personality types, that they could not actually categorize a single patient neatly into any single type. The personality types described here are like caricatures. In real life, it is the rule rather than the exception to see patients with characteristics belonging to several personality types. For example, one patient may be orderly and controlling *and* guarded and suspicious, or another may be dependent and demanding *and* also have mood swings. Once an individual is recognized as being unique, with certain characteristics from several different personality types, then the management of such a patient can be truly individualized.

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