18

The Patient's Personality

1. A 67-year-old man was admitted to the hospital for evaluation of fainting episodes. On admission, he started complaining about the "sloppy service," wanted to have food specially brought in from a restaurant every day, and called the office of the president of the hospital to complain about the delay in the nurses' responding to his calls. History revealed that he was a self-made man who was still active as the chairman of the board of a large corporation. Soon the patient was considered by the doctors and nurses to be a "pain in the neck" and a "crank," and they tried to avoid dealing with him as much as possible. This resulted in further delays in medications and responses to his calls.

2. The doctor asked, "Do you have any pains in your chest?" The patient replied, "Yes, doctor, I have so much pain in my chest—like constant pressure and pins and needles, and then I have these terrible aches and pains in my stomach, I have indigestion and constipation, and pains in my spine. My head hurts, too, and all my joints."

"It sounds like you are suffering a lot."

"I suffer all the time, what with my pain and my luck . . . you know, when I had my operation for my back, the wound would not heal, then I had an abscess which was treated with penicillin—then I had this reaction to penicillin so they had to stop it. My husband left me while I was still in bed from the operation, and the house burned down. That's when my arthritis flared up, and my headaches started. My old doctor gave me aspirin for it, which caused my stomach ulcers . . . when they started bleeding and I had to have an emergency operation. . . ."

PERSONALITY AND CHARACTER

How an individual reacts to illness, and the willingness with which he assumes the sick role, are determined in large measure by his personality. *Personality* is a broad general term that refers to a person's *characteristic patterns of thought, behavior, and feelings.* It includes, among other things, cognitive style, temperament, tolerance for anxiety, and patterns of defense and coping. In its broadest sense, personality includes the concepts of character and "neurotic styles," the latter referring to habitual symptomatic ways in which a person perceives and thinks (Shapiro, 1965). The term "character" is often incorrectly used as a synonym for personality.

Character was used in a special sense by Wilhelm Reich (1949), who regarded it as a "defensive armor," an aggregate of characteristic psychological defenses (see Chapter 5) utilized so often by the person that it functioned as a "structure" always in a state of readiness, in preparation to react to anxiety-provoking situations. Seen in this special light, character has a primarily defensive function and can be regarded as one component of personality.

CONCEPT OF PERSONALITY TYPES IN PATIENTS

Although each person has his or her own unique personality, it is sometimes useful in the context of medical care to classify patients according to arbitrary but loosely defined "personality types." Identification of the personality type or style of a patient does not necessarily imply a need for changing it through treatment. Its value lies rather in the fact that assessment of the personality type helps us to understand the meaning of illness for the given patient and, in turn, its influence on sick-role performance. This understanding can then provide the rationale for developing optimal ways of interacting with the patient. Without it, an impasse can develop between a "difficult" patient and health-care personnel.

Habitual ways (e.g., neurotic styles) of dealing with stressful situations often become exaggerated when a person is ill, particularly when he finds himself in the strange environment of the hospital (see Chapter 19). Thus, a person who has a tendency to be precise and controlling may become even more precise and controlling in the hospital, even to the extent that his personality may come into conflict with the sick-role

expectation of allowing himself to become dependent on the hospital personnel.

The meanings of illness, of hospitalization, and of medical procedures to a patient are congruent with his personality type, and the ways in which patients and physicians relate to one another are influenced by the interaction of their personalities. Kahana and Bibring (1964) described seven personality types often encountered in the general hospital and discussed how illnesses might have differential meaning according to differences in personality styles and how different management approaches might be used depending on the personality style of the patient. The ten personality types we present here are modifications and expansions based on their work.

PERSONALITY TYPES AND THE SICK ROLE

Patients may be categorized by personality type as follows*:

1. Dependent, demanding patients
2. Orderly, controlling (obsessive-compulsive) patients
3. Dramatizing, emotional (histrionic) patients
4. Long-suffering, self-sacrificing (masochistic) patients
5. Guarded, suspicious (paranoid) patients
6. Superior and special (narcissistic) patients
7. Seclusive, aloof (schizoid) patients
8. Impulsive patients with a tendency to act out
9. Patients with mood swings (cyclothymic)
10. Patients with intense, unstable relationships (borderline personality)

Dependent, Demanding Patients

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 patient who comes into the hospital as though he 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 in-

*The terms in parentheses are "psychiatric" terms denoting extreme forms of the personality characteristics (patterns).

volved 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, nurturant 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. This *regressive, dependent behavior* is congruent with some aspects of Parsons's description of the sick role except for the third and fourth elements, that is, considering the sick role as an undesirable state of being and cooperating with the doctor in becoming well again (Chapter 2).

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. Hostile behavior, when excessive demands for attention are not met, provokes 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 an opposite 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.

Orderly, Controlling Patients

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. (Isolation is often used as a defense mechanism by these patients [see Chapter 5].)

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—of being helpless.*

The *sick role* is obviously a difficult pill for patients with these personality characteristics to swallow. 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 bodies in order to administer necessary medical care.

In response to these threats, they may become contentious, complaining, and accusatory. Usually quite conscious of time and details, for example, 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 him to feel that the physician respects his autonomy enough to ask him 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. 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 volume of water drunk and urine voided.

> 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, their lack of punctuality in bringing him medications, etc. 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 urine tests for sugar. It means . . . " etc.) 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.

Dramatizing, Emotional Patients

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, of course, 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 life-styles. For example, a man who had been accustomed to a "Don Juan" life-style may find the restriction of sexual activity in the hospital most unbearable.

These patients respond best if the doctor responds, within set boundaries and limits, a certain amount to their needs to engage him. 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 the patient, at the same time indicating concern and willingness to continue to take care of the patient. *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, that is, discussion of objective findings and test results.

Long-Suffering, Self-Sacrificing Patients

Some experienced physicians say that this personality type can be diagnosed by the pitch and tone of the patient's first utterance in the doctor's office. 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" (vignette 2).

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 life-style, as a means of maintaining interpersonal relationships.* These are patients who might be *"addicted" to the sick role.* 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.

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 with reassurance, for example, that it should relieve pain, the patient is 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, he may have nausea and dizziness. He may even overtly blame the physician for the 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. The long-suffering, self-sacrificing patients, although asserting belief in Parsons's third and fourth sick-role expectations, actually refute them in their behavior. Those who become addicted to the sick role fail to fulfill the sick-role expectations of "considering the ill state as being undesirable" and "attempting to get well as soon as possible by cooperating with the physician."

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 will also help 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."

Attempts to mobilize altruistic tendencies may also be helpful. For example, a female 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."

Guarded, Suspicious Patients

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 or 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 the 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 the health-care personnel increases their feelings of vulnerability, and with that comes the fear that persons in positions will do things to them that might 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 strategy for *management* of 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, since patients like to feel that they are not "fools." Occasionally, agreeing with the patients about the inconveniences about which they are suspicious 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 information imparted. 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.

Superior and Special Patients

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 (vignette 1). 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 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 (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 caretaking persons 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 the patient to boast of his strengths. When this is done, the patient may feel secure enough to identify the caring persons with himself—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 patient's part that he might not be in the best hands, after all.

Seclusive, Aloof (Schizoid) Patients

This is the type of patient who seems to be remote, detached, and not in need of any interpersonal contact. They 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 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 the countercultures, such as health 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 find interpersonal relationships without true intimacy.

In *managing* such patients, it is important to recognize and respect the 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 members can then serve as "translators" for these aloof patients.

Impulsive Patients with a Tendency to Act Out

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 after the action. 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.

The patient with an impulsive personality style is likely to seek help for relatively minor symptoms based on the immediate pain or discomfort experienced, and he is likely to demand *immediate relief* from the discomfort. If immediate relief is not produced, the person is prone to act 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 swallowing a gastric tube. Although the patient may appear to have understood the necessity of such a procedure, he is 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 a difficult achievement 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. 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 making compensations for it when it is avoidable.

For example, tranquilizers may be utilized more freely for these patients as a partial preventive measure against outbursts of aggression. Pain should be treated especially vigorously. Firm limit-setting is also

necessary to establish some external control over their 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.

Patients with Mood Swings

These are patients who 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 depressive disorder may be made (see Chapter 6).

The importance in recognizing this personality trait lies in that depending on the period in which the person finds himself, the reaction to illness and to the medical treatment may be different. When an illness occurs during an up period, the patient may not even recognize the presence of the symptoms, or even if he recognizes them, he may brush them aside as being of no consequence. If he happens to be in a down phase, however, he may feel quite pessimistic about the symptoms and attach all kinds of grave implications to them. In fact, he may be convinced that he has a terminal illness for which there is no hope by the time he sees the physician. 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 develop 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, referral to a psychiatrist should be made for definitive treatment. This is also true for any other patients who show similar evidence of depression (see Chapter 6).

Patients with Intense, Unstable Relationships

These are patients who arouse very strong feelings among the hospital staff because they tend to see them as either all good or all bad. Consequently, some staff feel very positively about these patients while others feel exactly the opposite. In more severe cases, the patients are diagnosed as having the borderline personality disorder, which often also includes the features of manipulative suicide attempts, unstable sense of self, negative affects (anger, bitterness, demandingness, sadness, etc), brief psychotic experiences, impulsivity, and low achievement (Gunderson, 1984). 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 are accommodating. The basic difficulty with these patients is that almost all relationships become stormy, such that the doctor who was "perfect" may become a persecuting monster the next day because of a perceived mistreatment or imperfection.

In the severe form, this condition represents a serious psychiatric disorder that requires a long-term treatment by a trained professional (Gunderson, 1984; Meissner, 1988). 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.

From Types to Individuals

As should be clear from our discussion so far, 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 living 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.

SUMMARY

How an individual reacts to illness, and the willingness with which he assumes the sick role, are determined by his personality. Ten personality types often encountered in medical settings are discussed: (1) dependent, demanding; (2) orderly, controlling; (3) dramatizing, emotional; (4) long-suffering, self-sacrificing; (5) guarded, suspicious; (6) superior and special; (7) seclusive, aloof; (8) impulsive; (9) those with mood swings; and (10) those with intense, unstable relationships. *Illness* and *hospitalization* tend to have different *meanings* depending on the patient's personality type.

Management strategy should take into account the patient's personality since an effective approach with one type of patient may induce noncooperation in another type. For example, detailed explanation of contemplated procedures may win the confidence and cooperation of an orderly, controlling type of patient but may frighten a patient who has the dramatizing, emotional personality. Because of the heightened anxiety, such a patient may not be able to understand the explanation, and a general reassuring attitude with a general, undetailed explanation may be more helpful for him. An orderly, controlling person often has difficulty in accepting the *sick-role* expectations of dependency, while a long-suffering, self-sacrificing type of person may be "addicted" to certain aspects of the sick role.

Although an understanding of the prominent features of a patient's personality can help health-care personnel in planning effective approaches, most patients do not fall into one or the other personality "type." Familiarity with the commonly encountered personality types and the meaning of illness to them should help health-care personnel *individualize* their approach to individual patients.

IMPLICATIONS

For the Patient

Illness interacts with the individual's personality system and determines his help-seeking behavior (including whether or not he will seek medical advice), adaptation to the expectations of being a patient (sick role), and performance as a patient. Depending on the personality characteristics, *illness, hospitalization, and medical care have different meanings to patients.* A patient is usually unaware of his personality characteristics and of the relationship of these characteristics to his feelings about being

a patient. Thus, any conflict or contradiction arising between the personality needs and the sick-role expectations has a tendency to be seen by both the patient and the physician as a specific conflict arising from specific situations; that is, the patients have a tendency to blame a specific doctor or nurse for not understanding them or not caring for them (or for being incompetent, neglecting, or otherwise inadequate).

For the Physician

Understanding the patient's personality style can help the physician formulate an *optimal approach* to the patient. Physicians should also be aware that their own personalities influence how they treat their patients, and a particular mix of the physician's and patient's personalities may bring about a *conflict* in the medical setting. For example, an orderly, controlling type of physician may find himself feeling challenged and unrespected while treating a patient who also has an extremely orderly, controlling personality. Taking some distance from the situation emotionally when such conflicts arise and understanding the personality needs of patients can help the physician avoid becoming entangled in unnecessary personality conflicts (e.g., "power struggle") and meet patients' needs. Physicians should also be aware that conflicts arising between patients and other health-care personnel may reflect a lack of understanding on the part of the health-care personnel about the personality needs of the patients. The physician can then educate others in how to approach patients while taking into account their personality characteristics.

For the Community and the Health-Care System

Training for physicians and health-care personnel should include the skills for assessing patients' personality types and their interaction with illness and sick-role behavior. The health-care system should recognize that a patient brings into the medical setting an exaggeration of his premorbid personality characteristics in addition to being a person defined by the presence of the particular illness that made him a patient.

For preventive medicine to be effective, methods should be devised to induce persons with personality types that tend to avoid assuming the sick role to seek help when needed. Health-care personnel should be educated to recognize those patients whose main motivation for being patients is perpetuation of certain aspects of the sick role. The treatment for them can then be made more effective by avoiding the pitfalls of

premature removal of the legitimacy of the sick role or unnecessary laboratory tests or surgical procedures.

REFERENCES

Gunderson JG: *Borderline Personality Disorder.* Washington, DC, American Psychiatric Press, 1984.

Kahana R, Bibring G: Personality types in medical management, in Zinberg N (ed): *Psychiatry and Medical Practice in a General Hospital.* New York, International Universities Press, 1964, pp 108–123.

Little CJ: The athlete's neurosis: A deprivation crisis. *Acta Psychiatr Scand* 45:197, 1969.

Meissner WW: *Treatment of Patients in the Borderline Spectrum.* Northvale, New Jersey, Jason Aronson, 1988.

Reich W: *Character Analysis.* New York, Orgone Institute Press, 1949.

Shapiro D: *Neurotic Styles.* New York, Basic Books, 1965.

RECOMMENDED READING

Goldberg RJ: Personality types and personality disorders, in Leigh H (ed): *Psychiatry in the Practice of Medicine.* Menlo Park, California, Addison Wesley Publishing Co, 1983, pp 33–56. This article complements this chapter in extending the discussion of personality types to personality disorders, including a discussion of the borderline personality disorder.

Groves JE: Taking care of the hateful patient. *N Engl J Med* 298:883–887, 1978. Using a somewhat different typology, this article describes some of the most troublesome types of patients seen in medical practice and suggests ways of dealing with them.

Kahana R, Bibring G: Personality types in medical management, in Zinberg N (ed): *Psychiatry and Medical Practice in a General Hospital.* New York, International Universities Press, 1964, pp 108–123. This is the classic description of the personality types often seen in medical settings. The reader will find somewhat more detailed discussion of the psychodynamics and possible evolution of the personality types, as well as management approaches with examples.

Shapiro D: *Neurotic Styles.* New York, Basic Books, 1965. (Also available in paperback.) The author describes the cognitive characteristics of the major "neurotic" (or "personality," in less exaggerated form) styles, such as hysterical, obsessive-compulsive, and paranoid styles. An important book for understanding the influence of personality styles on how individuals perceive the world and how they think.