

CHAPTER 10

PERSONALITY AND PERSONALITY DISORDER



Can you spot the difference? These two individuals are both holding a toy bear above their heads in their right hands. One picture is taken outside in daylight and the other is taken indoors at night. One individual is young and female, the other is old and male. Can you make a guess at possible personality differences? The female looks more extraverted and fun loving, the male looks more conservative and grumpy. Like some chemical pathology tests, visual appearance gives potentially useful information about the individual, but further information is required before conclusions can be reached. Does either or both have a personality disorder? Bad question. A diagnosis of personality disorder cannot be made on limited information. The female is a former porn actress who made a successful transition into the Italian parliament. The male is the current author (who wanted to be a porn star). They are probably both “different” or “eccentric”, but probably neither has a diagnosable personality disorder.

Alert, Alert, Alert

Over recent years there had been a revolution in the way personality disorder has been conceptualized.

Until recent times, personality disorders have been conceptualized as a bunch of separate ‘conditions’ (this was called the “categorical” approach) – examples include ‘Narcissistic personality disorder’ (in which noticeable features included narcissism and a sense of entitlement) and ‘Dependent personality disorder’ (in which noticeable features included the seeking of excessive amounts of advice and support).

The categorical approach is being replaced by a “dimensional” approach.

It was expected that the latest version of the DSM [DSM-5 (2013)] would provide a new dimensional system. This did not happen, due to lack of time and conflicting views (Zachar et al, 2016).

The DSM-5 chapter is currently very confusing. It provides 2 separate diagnostic systems – one categorical and one dimensional. It is expected the DSM will eventually move to an exclusively dimensional system.

The other diagnostic system – International Classification of Disease, has a new edition about to be released [ICD-11] – this presents a dimensional approach.

This Download of Psychiatry attempts to present straightforward information.

Thus, after some introductory remarks, a dimensional approach is presented, which will be similar to the anticipated ICD-11 entry.

In the second half of this chapter, some cases will be discussed which were written with the categorical approach in mind – this is case based material and is retained as it illustrates personality disorder.

Introduction

Personality disorders are highly prevalent and carry serious consequence. A recent estimate of general population prevalence of 17% (Tyrer, 2018).

15% of psychiatric outpatients, and 10% of psychiatric inpatients are believed to have personality disorder as the primary diagnosis. However, an additional 30% of psychiatric inpatients are believed to have a personality disorder in addition to the primary disorder for which they have been admitted (Tyrer, 2018).

Students encounter people with personality disorder quite frequently. People with personality disorders are frequent attendees at hospital Emergency Departments, because of social crises, injuries from fights, alcohol or drug intoxication, or with self-injuries. People with personality disorders are often encountered in general medical wards following over-doses and because of they have difficulty managing any other chronic disorder they may suffer.

Personality

There are many definitions - a good example - personality is those features which determine that individual's unique response to the environment (human and non-human).

Expanded descriptions add that personality is "lifelong and persistent" (although personality changes somewhat over time, through the natural maturation process, and can be changed through sustained psychotherapy), and that personality features influence the individual's ways of thinking, feeling and behaving.

Normal versus abnormal

It is impossible to know exactly what and how another person thinks and feels. What may be adaptive in Beirut may be maladaptive in Sydney, what is humorous in Melbourne may be insulting in Kuala Lumpur. Next-door neighbours may fanatically support opposing football team, or one may have no interest in sport whatsoever. Thus, the concept of “normal” must be approached with caution.

Normal is sometimes taken to mean with no impediment, whatsoever.

It may also mean average. Personality features (i.e., warmth, perfectionism, impulsivity) obey the normal distribution curve, with most of the population in the middle of the graph and a few at the extremes.



Illustration. This person, who has long fingernails, appears to have different values, at least in some regards, to the majority of readers.

Dimensional model of personality

This paragraph is not required for examination purposes – (unless you are studying Ancient Civilizations). It lists earlier attempts to measure personality using a dimensional approach. Thus, the use of dimensions in the field has a long and proud history.

1. The Eysenck Personality Inventory (EPI) measures two separate dimensions: extraversion-introversion (which measures reserved, versus outgoing attitude) and neuroticism (which measures tendency to distress).
2. The Cattell 16 Personality factor Test (16PF) measures 16 different dimensions, and the Minnesota Multiphasic Personality Inventory (MMPI)

(probably the most widely used personality test) measures 10 different dimensions.

3. Cloninger et al (1993) described four temperamental dimensions, 1) novelty-seeking, 2) harm avoidance, 3) reward dependence, and 4) persistence), which are present from birth and are essentially stable. In addition, this group described three-character dimensions (1, self-direction, 2) co-operation, and 3) self-transcendancy) which are variable and modified by experience. He believed that while the temperamental dimensions strongly influence behaviour, it is the character dimensions which determine the presence or absence of personality disorder.]
4. McCrae & John (1992) developed a five-factor model (FFM) of personality which was widely accepted. It employs the personality dimensions of 1) openness, 2) conscientiousness, 3) extraversion, 4) agreeableness, and 5) neuroticism, known by the acronym OCEAN.

Since McCrae & John (1992) described their FFM of personality, there have been numerous others, each employing slightly different personality dimensions.

Personality disorder

The clinical interview with the patient (and those who know the patient) is currently the most useful method of obtaining diagnostic material. A detailed life history provides extensive information regarding previous and likely future responses to the environment and is central to personality assessment.

The clinical interview itself, is a test situation, which provides practical examples of the patient's manner of self-presentation and response. The skilled interviewer will also make observations regarding her/his own response to the patient, which is likely to be similar to the responses of others.

ICD-11 diagnostic criteria:

- A pervasive disturbance in how an individual experiences and thinks about the self, others, and the world, manifested in maladaptive patterns of cognition, emotional experience, emotional expression and behaviour.
- The maladaptive patterns are relatively inflexible and are associated with significant problems in psychosocial functioning that are particularly evident in interpersonal relationships.
- The disturbance is manifest across a range of personal and social situations (i.e., is not limited to specific relationships or situations).
- The disturbance is relatively stable over time and is of long duration. Most commonly, personality disorder has its first manifestations in childhood and is clearly evident in adolescence.

For further details see (Tyrer et al, 2015; Skodol, 2018)

ICD-11 severity – assessed using “**domain traits**”:

- **Negative affect features**
Characterized primarily by the tendency to manifest a broad range of distressing emotions including anxiety, anger self-loathing, irritability, vulnerability, depression and other negative emotional states, often in response to even relatively minor actual or perceived stressors.
- **Dissocial features**
Disregard for social obligations and conventions and the rights and feelings of others. Traits in this domain include callousness, lack of empathy, hostility and aggression, ruthlessness, and inability or unwillingness to maintain prosocial behaviour, often manifested in an overly positive view of self, entitlement, and a tendency to be manipulative and exploitative of others.
- **Features of disinhibition**
Persistent tendency to act impulsively in response to immediate internal or environmental stimuli without consideration of longer term consequences. Traits in this domain include irresponsibility, impulsivity without regard for risks or consequences, distractibility and recklessness.
- **Anankastic features**
A narrow focus on the control and regulation of one’s own and others’ behaviour to ensure that things conform to the individuals’ particularistic ideal. Traits in this domain include perfectionism, perseveration, emotional and behavioural constraints, stubbornness, deliberativeness, orderliness, and concern with following rules and meeting obligations.
- **Features of detachment**
Emotional and interpersonal distance, manifested in marked social withdrawal and /or indifference to people, isolation with very few or no attachment figures, including avoidance of not only intimate relationships but also close friendships. Traits in the detachment domain include aloofness or coldness in relation to other people, reserve, passivity and lack of assertiveness, and reduced experience and expression of emotion, especially positive emotions, to the point of a diminished capacity to experience pleasure.

People with “neurotic disorders” (old fashioned term, an example is anxiety disorder) have “autoplastic defences” meaning they react to stress by attempting to change their own internal psychological process and perceive their disorder as “ego-dystonic”, meaning they find their symptoms unacceptable and in need of change.

People with personality disorders, by contrast, have “alloplastic defences” meaning they react to stress by attempting to change the external environment (rather than themselves), and perceive their symptoms to be “ego-syntonic”, meaning they find these aspects of themselves to be acceptable, and not in need of change.

People with personality disorder believe the world should change to accommodate them/their wishes (rather than they should adjust themselves to the world) and view their own features to be acceptable and not in need of change. They often experience less distress as a direct result of their personality disorder than might be expected.

However, the world does not change to suit them, and they experience indirect distress - their maladaptive responses lead to failed relationships (with lovers, family and employers), losses, disappointments and distress. (Thus, there are consequential losses and distress).

Because of reduced ability to co-operate with others, people with borderline personality disorder (BPD) show enduring lowered economic functioning (Niesten et al, 2016).

People with personality disorder are inflexible. They have a limited repertoire, or number of ways, of responding to the world. Faced with opposition the normal/average individual has a range of responses: to think of a new approach, work harder and try again when better prepared, to use humour, to be more assertive, to reassess whether the goal is worth further effort or not, etc. The individual with a personality disorder has a limited number of ways of responding (for example, responses may be limited to seduction or aggression). These are applied in all situations, and because of inflexibility, they are applied repeatedly, even when they have already proved unsuccessful. In these circumstances loss and disappointment, and direct and indirect distress are inevitable.

Possible clinical examples

You be the judge:

US man charged for shooting mower

A 56-year-old man from the Midwestern US state of Wisconsin has been arrested after shooting his lawn mower in his garden because it would not start.

Keith W was charged by police in Milwaukee with disorderly conduct and possession of a sawn-off shotgun.

He could face a fine of up to \$11,000 and a maximum prison sentence of six-and-a-half years if convicted.

Police officers said Mr W had told them: "It's my lawn mower and my yard, so I can shoot it if I want."



Witnesses told police Mr W appeared to have been drinking

BBC: 26, July, 2008

Illustration. This man may not have a personality disorder. It does appear that he has low impulse control. On the other hand, his impulse control may simply have been temporarily lowered by alcohol intoxication.

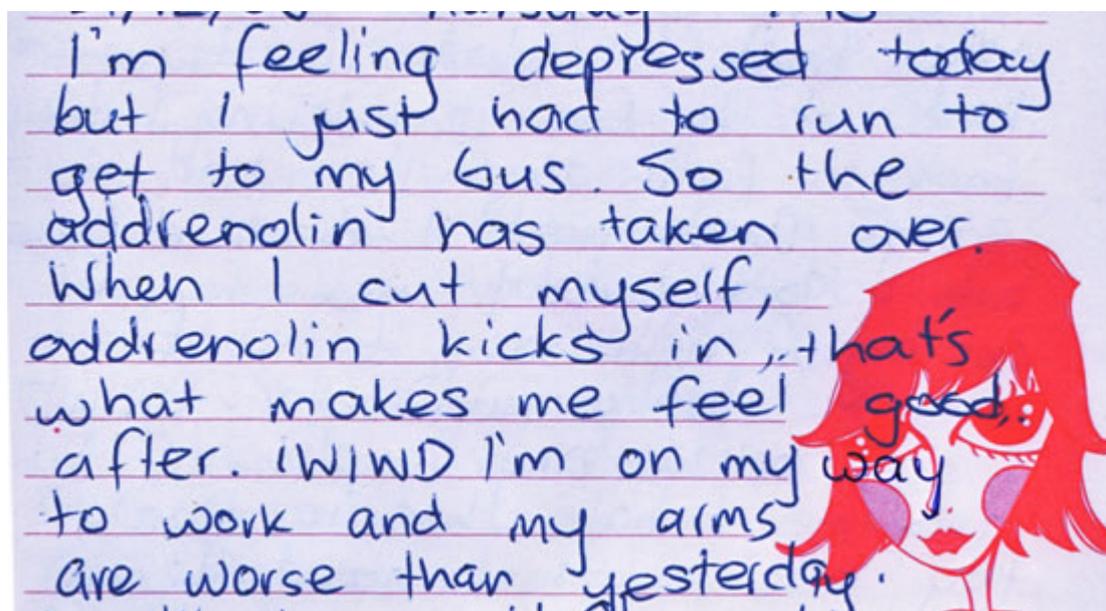


Illustration. This is an entry from a note book maintained by an 18 year old female. She states she is feeling “depressed”. She is referring to feelings of distress, rather than the experience of major depressive disorder – although the two are frequently confused by patients, their parents and some doctors. She makes mention that when she cuts herself she feels “good”. Self cutting is very common in some people with personality disorder – it serves as a means of releasing tension/distress. She uses a code IWIWD (I wish I was dead). She makes this statement without apparent conviction – some people personality disorder frequently engage in suicidal behaviour (this is in addition to the cutting, most of which has little to do with suicide, and as mentioned, is a means of releasing tension/distress).

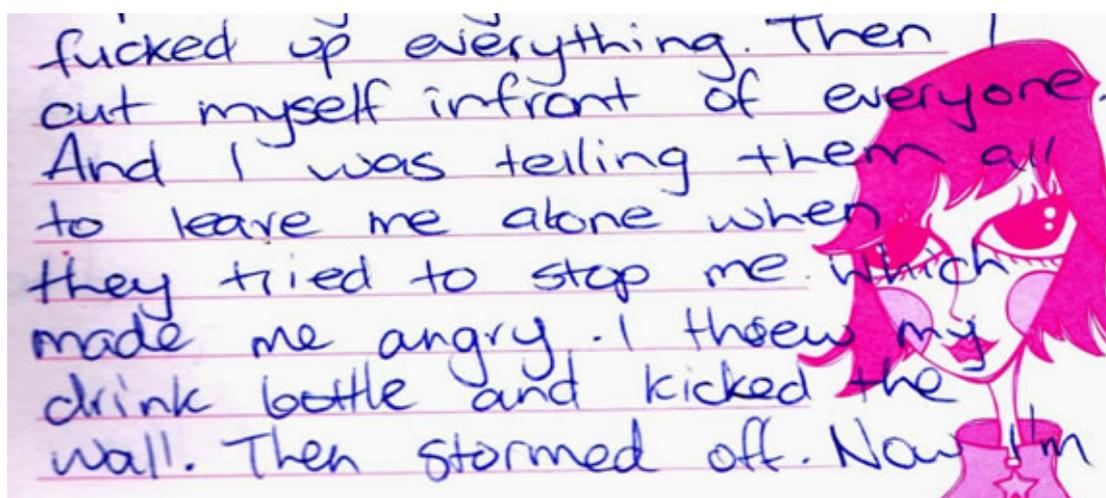


Illustration. A further abstract from the note book mentioned above. The patient was waiting at a bus stop with some people she knew when (she cannot remember why) she began to have negative thoughts. “Then I cut myself in front of everyone.”

Naturally people tried to stop her – this made her angry and threw things around and kicked things. Dramatic, care eliciting, manipulative behaviour and unreasonable anger are common features in personality disorder.



Illustration. The arm of a man with a history of 'cutting' himself when he was stressed.





Illustration. The arms, hands and abdomen of a man with a history of cutting. This man kept the large lesion on his left arm permanently open. The edges and even the base of the lesion were scarred and indurated. He burnt the dorsum of his right hand and there was muscle tissue loss from the extensors of his right forearm. There were less obvious (in these photographs) scars on the upper chest. In the past he had swallowed razor blades, which had perforated his bowel, leading to abdominal surgery. This man then repeatedly removed the stitches and recut his abdominal scar leading to a large incisional hernia. (The bulge in the middle of his abdomen is abdominal organs pushing out against the skin, the muscle wall of his abdomen having been damaged through the repeated self cutting.)



Illustration. The leading story of a regional newspaper told that a state branch of the Royal Society for the Protection and Care of Animals had lost millions of dollars in donations due, in part, to the "repeated lying" of the CEO. In his response the CEO

wrote, "...I am a very moral and ethical person and feel incredible shame that this happened...I admit freely the lies I told..."

MUCH OF THE FOLLOWING ACADEMIC MATERIAL USES CATEGORICAL TERMINOLOGY

Neuroimaging in personality disorder

Neuroimaging in personality disorders is a relatively new field. It would not be surprising if the brains of people who thought and behaved differently to the average person had somewhat different brain operations. It is probable that your brain operates a little differently to the way Isaac Newton's brain operated, but that does not mean you have a brain lesion (so, relax).

It is unlikely that neuroimaging will produce anything of clinical significance in the foreseeable future – the following details are provided to give a sense of the activity in this research area.

Psychopathic personality

Neuroimaging in psychopathic personality disorder has been reviewed (Pridmore et al, 2005). There is evidence of psychopathy being associated with larger prefrontal sub-volumes (Korponay et al, 2017). Functional studies suggest reduced perfusion and metabolism in the frontal and temporal lobes.

Borderline personality disorder (BPD)

Imaging studies demonstrate differences between people with BPD and healthy controls (Ninomiya et al, 2018).

Kuhlmann et al (2012) found, in women with BPD, reduced grey matter in the hippocampus and increased grey matter in the hypothalamus.

Functional abnormalities have been detailed (Krause-Utz et al, 2014).

Schizotypal personality disorder

Schizotypal personality disorder (SPD) attracts research attention because of the clinical similarities and genetic links with schizophrenia. SPD is associated with significantly smaller grey matter volume of the left superior temporal gyrus and widespread frontal frontolimbic and parietal regions (Asami et al, 2013). These changes were proportional to symptoms. Also, these changes are similar to those found in schizophrenia, but do not appear to be progressive, as in schizophrenia.

SPD also features some white matter (thalamo-frontal tract) deficits (Hazlett et al, 2012). Again, these are similar to, but not as extensive as, those found in schizophrenia.

Traits

There has also been recent neuroimaging of individual traits – again, the clinical significance of this work is not immediate.

‘Novelty seeking’ and ‘harm avoidance’ are components described in the Temperament and Character Index (Cloninger et al, 1993). Laricchiuta et al, (2012) recently reported that novelty seeking scores were positively associated and harm avoidance was negatively associated with white matter and cerebellar cortex volumes.

Alexithymia (difficulty identifying and describing one’s feelings) is a personality trait which has been associated with various psychopathological states, particularly psychosomatic disorders. Kano and Fukudo (2013) have described alexithymia as being associated with lower reactivity in brain regions associated with emotion – limbic areas (cingulate cortex, anterior insula, amygdala) and the prefrontal cortex. Grabe et al (2014) found, in people with alexithymia, lower grey matter volume in the dorsal anterior cingulate cortex and various left temporal regions.

Neuroticism can be considered the tendency of the individual to experience distress. Terasawa et al (2012) have shown that right anterior insular activation is positively correlated with neuroticism, and negatively correlated with agreeableness and extraversion.

Genetics

The etiology of personality disorder is about half genetic and half are environmental (Livesley J, et al. 1993).

The genetics of personality is progressing very slowly (Sanchez-Roige et al, 2018) – the following is a taste of emerging research.

There appears to be a genetic component for the development of borderline personality disorder (Skodol et al, 2002).

Neuroticism is strongly influenced by genetic factors (Viken et al, 1994).

Impulsivity and aggressiveness are both influenced by genetics (Mann et al, 1999).

Epigenetics

Epigenetics is promising to provide unprecedented insight into the biology of personality disorder. Chapter 37 (Epigenetics) is recommended.

Epigenetics refers to environmental events causing the attachment to, or removal from, DNA (not altering the DNA sequence), molecules (such as methyl groups) which influence gene expression. This is the molecular mechanism by which environmental influence on DNA produces the phenotype.

Examples of epigenetics extending our understanding of personality disorder:

1. A series of studies (Weaver et al, 2004) demonstrate that the pups (offspring) of rat mothers who provided a particular type of (good) mothering, go on to be 1) 'good' mothers themselves, and 2) calm and well able to adapt to stress, and to demonstrate, 3) increased methylation of hippocampal glucocorticoid receptor (GR) genes.
2. People who are sexually abused as children have altered methylation of hippocampal GR gene (McGowan et al, 2009).
3. When people with borderline personality disorder are effectively treated with psychotherapy, there is a modification of the methylation of the brain derived neurotrophic factor (BDNF) gene (Perroud et al, 2013).
4. Child sex abuse leads to a) methylation of the promoter region of the serotonin gene, and b) female antisocial personality disorder – it is probable that methylation is the mechanism which links the abuse and the disorder (Beach et al, 2011; Nemeroff, 2016).
5. Correlations have been demonstrated (Martin-Blanco et al, 2014) between childhood maltreatment and GR gene methylation, and between the extent of GR methylation and clinical severity of borderline personality.

Aetiology

As stated above, one expert opinion states the etiology of personality disorder is about half genetic and half are environmental (Livesley J, et al. 1993).

Infants at 4 months can be separated by the personality characteristics – 'high reactors' and 'low reactors' (Kagan, 1997). This suggests but does not prove a genetic basis.

In common with other psychiatric disorders, the aetiology of personality disorders appears to be multifactorial, involving genetic, prenatal, early life experience, epigenetic and precipitating and perpetuating factors.

Prenatal factors including hormone and alcohol exposure, intrauterine nutrition, and birth complications such as hypoxia, can all impact on personality.

Temperament refers to aspects of personality which are considered innate, rather than learned, and can be observed in babies from birth. Temperament has an impact on the child's interaction with others (parents). A mismatch between the temperament of the child and the temperament of the parents makes for a difficult relationship, and this may predispose to the development of behavioural and personality disorders.

By definition personality disorders are long lasting. Contributing factors may include unhealthy early life experiences. However, personality disorder may only become apparent with the loss of an important support, such as caring parent, or when the individual is exposed to additional stress, such the responsibility for the care of a new baby.

Features of personality disorder may perpetuate the disorder – for example, illegal drug use, aggressive outbursts, and inappropriate sexual provocation damage relationships and lead to additional losses, distress and anger. The individual with a

personality disorder has limited ability to deal with stress in an adaptive manner, thus, limited ability to halt self-reinforcing, maladaptive cycles.

Prognosis

Prognosis depends on the nature and severity of the personality disorder. Disorders characterized by erratic and impulsive behaviour usually improve with age (after 35 years). Disorders characterized by anxious and fearfulness also tend to improve with age. Disorders characterized by eccentricity may not change markedly.

Borderline personality disorder is often thought of as a chronic, unremitting disorder. A recent report (Gunderson, et al. 2011), however, found that over 10 years, 85% remitted and only 12% relapsed. While remission of this disorder may occur, impaired social functioning commonly remains, and only about one third find employment.

The risk of suicide secondary to personality disorder decreases with maturation.

Management

Management begins with a full assessment and the exclusion of other psychiatric disorders, such as MDD. Comorbid conditions should be managed in the standard manner.

Treatment depends on the nature of the personality disorder, patient willingness to engage in treatment and the available resources (availability of specialist psychotherapists and treatment programs).

Prolonged treatment may be necessary and complete recovery is the exception rather than the rule. Individuals with antisocial personality disorder are usually unable to cooperate and maintain a therapeutic relationship and are generally regarded as untreatable in all but specialized (usually forensic) units.

Psychotherapy is the primary treatment. This may take many forms. Both dynamic psychotherapy (with roots in Freudian analysis) and cognitive behaviour therapy (which is focused more on thinking processes and behaviour) have much to offer. Supportive psychotherapy, in which the therapist mainly supports, educates and encourages the patient through the trials of life “buys time” (helps reduce self-destructive behaviour) and fosters the growing process. Psychotherapy may be conducted as individual or group sessions. In specialized practice the patient may attend both individual and group sessions.

Dialectical Behavior Therapy (DBT) is a form of psychological treatment designed specifically for individuals with self-harm behaviours, such as self-cutting, suicide thoughts, and suicide attempts (that is, common features of borderline personality disorder). While there is great enthusiasm for DBT in borderline personality disorder, it may not be superior to all other forms of treatment (Andreasson et al, 2016).

Medication has a place in the treatment of personality disorder. However, “Drug treatment should not be used specifically for borderline personality disorder or for the individual symptoms of behaviour associated with the disorder” (National Institute of Health and Clinical Excellence, 2009)

Avoidant personality disorder is indistinguishable from “social anxiety”, and anxiolytic medication may have a place.

In schizotypal personality disorder, psychotic-like symptoms and cognitive deficits may be assisted by use of low-dose anti-psychotics.

In antisocial personality disorder, impulsive aggression of incarcerated males has been reduced with lithium therapy.

In borderline personality disorder fluoxetine has been used to reduce impulsive aggression, and flupenthixol deconoate has reduced suicidal behaviour. Lithium and anticonvulsants have been used for affective instability. However, many of the central symptoms of the disorder, such as chronic emptiness and interpersonal dysfunction are unresponsive to medication.

Benzodiazepines are best avoided in the management of borderline personality disorder, due in part to the potential for abuse, but also because these medications may disinhibit and worsen symptoms (Cowdry & Gardner, 1988).

It is important to involve the family if possible (but frequently personality disorder has led to family disintegration and animosity). A clear explanation at an early stage, of the diagnosis, the difficulties experienced by the patient and the clinician, and the likely prognosis, will be of assistance to all involved.

The management of people with borderline personality presents special challenges. These people are usually angry much of the time and can move from happy to unhappy in response to minor events. They are particularly inclined to self-mutilation (cutting) and suicidal behaviour. Many people with borderline personality disorder have a limited ability to understand and describe the way they are feeling; they are limited to feeling good/happy or bad/distressed/tense/angry. They have limited ability to deal with their bad/distressed/tense/angry state. When they are in this unwelcome state they often get relief from cutting themselves. They report feeling a sense of relief when their blood flows. Such cutting can be distinguished from both attention seeking behaviour (although some subsequent attention may also be rewarding) and the intention to die. However, suicide may be attempted and may be successful.

People with personality disorders are best managed in the community with the help of an experienced psychotherapist/counsellor. It is better for them to live in the “real world” and learn to deal with the challenges which the “real world” presents. However, admission to hospital for a brief time (2-3 days) may be indicated when they are in the grip of the bad/distressed/tense/angry state. Such admissions are for safety purposes only. Being in hospital for long periods increases dependency and a sense of impotence and failure. Hospital is an artificial environment with little opportunity for the growth of a sense of autonomy and competence. The best outcome may be achieved where the patient, an out-patient psychotherapist and a psychiatric

inpatient unit cooperate in formulating a plan of regular out-patient psychotherapy and easy admission and rapid discharge (no inpatient psychotherapy) at times of crisis.

DSM-5 Alternative Model for Personality Disorder Diagnosis

The DSM-5 “Alternative” model of personality disorder - which is another dimensional approach.

It is complicated dividing “Personality functioning” into ‘self-identity’ and ‘self-direction’, and “Interpersonal functioning” into ‘empathy’ and ‘intimacy’. Then there are “Pathological personality trait” including, ‘negative affectivity’, ‘detachment’, ‘antagonism’, ‘disinhibition’, and ‘psychoticism’. And each has five levels.

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