Iran J Psychiatry Behav Sci. 2018 September; 12(3):e9318. doi: 10.5812/ijpbs.9318.

Published online 2018 July 21. **Original Article**

Experience of Living With Patients With Obsessive-Compulsive Personality Disorder: A Qualitative Study

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Received 2016 October 10; **Revised** 2017 August 01; **Accepted** 2017 August 15.

Abstract

Background: Obsessive-compulsive personality disorder (OCPD) is the most common personality disorder in the general population, with prominent features of inflexibility, excessive attention to details, extreme perfectionism, and excessive self-control and interpersonal control.
Objectives: This study aimed at assessing the experiences of daughters living with OCPD fathers.
Methods: Fifteen daughters of fathers with obsessive-compulsive personality disorder were selected by purposive sampling method and were subjected to semi-structured in-depth interviews. Interviews were analyzed using qualitative content analysis.
Results: Analysis led to emergence of 17 subcategories and three main categories, which included experiences of negative emotions, disorientation, and fear.
Conclusions: Children of these patients were found to be under severe mental pressure, requiring serious attention, and interventions as preventive measures.

Keywords: Children, Experience, Obsessive Compulsive, Personality Disorder, Qualitative

1. Background

Obsessive-compulsive personality disorder (OCPD) is the most common personality disorder in the general population (1), with the prominent features of inflexibility, excessive attention to details, extreme perfectionism, and excessive self-control and interpersonal control (2, 3). These features cause a significant dysfunction in the long-term (4). Generally, all personality disorders adversely affect family members, notably, preoccupation with the present and future illness of a family member. In addition, most families are dissatisfied with treatment (5). Some studies have reported a greater burden on the family of various personality disorders, compared to other severe psychiatric disorders (6). Despite their limited number, studies have emphasized on the need for attending to the adverse effects of parents' personality disorders, especially OCPD, on the family and particularly on the children (7). However, the question of whether any specific personality disorder in parents may affect children with a special pattern, and form particular experiences or lead to personality disorders in children has received little attention in studies.

2. Objectives

The present study was an attempt to demonstrate the adverse effects of parents' personality disorders, especially OCPD, on the family and particularly on children.

3. Materials and Methods

3.1. Participants

This qualitative study was conducted on 15 daughters of 13 patients with OCPD, with a mean age of 22 years (rang of 15 to 35), who were selected using the purposive sampling method at Iran psychiatrist hospital, from April 2015 to March 2016, Tehran, Iran. This study was approved by the ethics committee of Iran University of Medical Sciences; it was performed in accordance with the declaration of helsinki. informed consent was given to all subjects; they were notified that their information remained confidential, and would be used only for scientific research.

Five participants were married and the rest were single. In two patients, two daughters were selected, and in

others, only one daughter participated. Study exclusion criteria included unwillingness to take part and the lack of cognitive ability to establish communication and conduct interviews. None of the participants met such criteria.

In this study, to more accurately diagnose OCPD, the patients were interviewed based on the SCID-II exam and their daughters through semi-structured interviews; the structured clinical interview (SCID-II) is a diagnostic tool used to determine and investigate patterns of Axis II disorders (personality disorders) (8). There are modified versions of SCID-II: DSM-III editions of SCID-I and SCID-II; DSM-IV editions of SCID-I and SCID-II; and DSM-IV-TR (APA, 2000). Reliability and validity of the Persian version of SCID have been investigated by Hafizi et al. (9). Two psychiatrists, who were university faculty members and had an extensive experience with the study population were selected, and were trained to use the SCID-II and the interview. Semi-structured interview is defined as a qualitative method of inquiry, in which a pre-determined set of open questions is asked. Fathers and then daughters were interviewed based on the mentioned methods. All of these patients had referred to a university psychiatric clinic. Sampling continued until data saturation (extraction of no new codes or theme in the last three consecutive interviews). None of the interviewees refused participation, which may be attributed to the therapist's lasting therapeutic relationship with the patients, and also their desire to share a difficult life experience. None of the fathers with OCPD were referred to the clinic and had attended later to receive any counseling about their daughters. In other words, the daughters had come for counseling for various reasons: In seven cases, daughters had sought advice because their fathers frequently rejected their suitors.

In three cases, daughters had attended because of their fathers' opposition to their selection of academic discipline; and in three cases, daughters accompanied their mothers for family problems, especially their parents' relationship problems, and their fathers had been requested to attend for resolving the problems. Thus, the fathers attended counseling separately; two of them attended only once, yet others showed better cooperation. In case of the daughters, the main diagnosis was a parent-child communication problem. Only three sons attended, who were not included in the study due to their small number. Out of fifteen daughters participating in the study, two were students, six graduates, three postgraduates, and four medical students. All fathers were older than 50 years old, and in two cases, older than 70 years, with the mean age of 56 to 57 years old.

3.2. Data Collection

Data were collected and recorded through semi-structured in-depth interviews. Interviews were conducted by one of two psychiatrists, who were a university faculty member. The questions included demographic questions as follows:

1- Explain your feelings and experience of living with your father.

2- What did you do to cope with your father's control on your behavior and inflexibility?

3- How did you experience your father's extreme perfectionism?

4- What concerns did you experience by your father's side?

Regarding previous studies on this subject, the first interview was used to help design further questions and answer the above questions. Participants were also allowed to raise issues and change the course of interviews (10). Themes derived from analysis of the first interview were used to design clarifying questions in the later interviews. A one-by-one analysis process was continued to the end of study until reaching data saturation. The mean duration of the interviews was about 90 minutes (60 to 120 minutes). Supplementary interviews were also performed in five cases, of which, three were conducted over one 45- to 60-minute session, and over two 45- to 50-minute sessions due to the lack of consensus on the meaning of statements made in interviews. The study lasted for two months, in total.

3.3. Analysis of Data

Data were analyzed according to a qualitative content (thematic) analysis method proposed by Graneheim and Lundman in (11). First, the interview recordings were transcribed verbatim, and reviewed individually twice by two psychiatrists, who were university faculty members. In the first review, sentences in response to previous interview questions were identified and coded with a word. In the second review, other sentences were matched with the coded words, and emerging new themes were coded with new words. Next, in a joint meeting, if the new codes were agreed upon, they were added to the list of questions for later interviews. In the first four interviews, one new category and about eight new subcategories emerged, which were added to the initial questions of the study for subsequent interviews. If two faculty members did not agree on a code, the opinion of a third faculty member, who was also the coauthor was asked as an external observer. If two of the three faculty members reached a consensus on the code, they were selected and the related questions were

added to the next interview. This occurred in five subcategories. Regarding the codes that did not receive the consensus of three faculty members, two other faculty members were asked to read and discuss the codes. Then, their comments were discussed in a joint session with three faculty members, the authors of the paper. The consensus was reached for two subcategories. Eventually, codes were classified to 17 subcategories and three main categories, according to similarities and differences. Since every interviewee answered questions derived from the previous interviews, all previous codes were validated in later interviews. The final report comprised of data from more than 50% of participants. This is how the validity and reliability of the study were confirmed as much as possible.

4. Results

The categories and subcategories are shown in Table 1.

Table 1. Categories and Subcategories

Category	Subcategories
Negative emotions	
	Frequent judgments
	Under pressure
	Feeling guilty
	Being caged up
	Feeling depressed
	Feeling angry
	Social isolation
Disorientation	
	Low self-esteem
	Failing to achieve personal aspirations
	Lack of confidence to recognize the right time
	Lack of creativity
Fears	
	Fear of unexpected future events
	Fearing people
	Fear of death
	Fear of illness
	Fear of marriage
	Fear of responsibility

4.1. Category 1: Negative Emotions

This category consists of seven subcategories that deal with negative emotions and experience of participants (Table 1).

4.1.1. Frequent Judgments

Eighty percent of participants reported being frequently judged, reproached, and valued according to the judgments made, and also a variety of negative emotions. “I think my father would make a good judge (said sneeringly)”, or “sometimes, when my father picks on me; I feel as if I am in a court room and everybody is listening to the accusations made against me (said angrily)”.

4.1.2. Under Pressure

Participants frequently reported being pressured and forced, and felt the need for commitment to obligations, and keeping up appearances. Nearly all participants complained about being constantly pressurized to maintain their father’s standards in full. Participant 9 asserted: “I constantly feel a heavy burden on my shoulders. My life is so full of musts; it’s choking me”.

4.1.3. Feeling Guilty

In this subcategory, 60% of participants cited a deep feeling of guilt about following religious and moral instructions correctly. “My whole life circles around guilt. Whatever I do or don’t do, I have to think about the guilt involved, and if I have properly observed moral instructions or not”.

4.1.4. Being Caged Up

Ninety percent of the participants complained about feelings of being imprisoned, in a cage, lack of freedom, and being stuck in a closed mental atmosphere; a feeling that was frequently displayed in tears. “You wouldn’t believe it when I say I feel like a bird in a half-meter wide cage, banging her head onto the bars (wiping off tears)”.

4.1.5. Feeling Depressed

About 30% of the participants expressed feelings of sadness, depression, despair and loneliness, yet matched adjustment disorder rather than full MDD diagnostic criteria. This feeling was associated with a loss of joy and worthlessness. “I feel the blues, and I’m weighing up to see if life is worth living. What kind of a life is this?”

4.1.6. Feeling Angry

In 50% of participants, anger, hatred, short verbal periods of spite, and aggression against the father, and sometimes even loud tantrums and leaving the house, feelings of revenge, happiness with being away from the father, and wishing he would stay at work for longer could be seen. This feeling was occasionally associated with a death wish for the father, which was immediately accompanied by a feeling of guilt and repentance and begging God’s forgiveness to remove such ideas out of their minds.

4.1.7. Social Isolation

More than 80% of the participants complained about experiencing poor family and social interactions, limited family gatherings, and social isolation beside their fathers. They considered their families as remote islands with limited interactions with others under specific conditions. "We've come to terms with our dad's belief that friendship strengthens when you are far. My dad doesn't get along with anyone".

4.2. Category 2: Disorientation

Four subcategories emerged in this category, and all shared the theme of loss of personal ability to understand oneself, time, and talents (Table 1).

4.2.1. Low Self-Esteem

Seventy percent of participants complained about feelings of inadequacy and incompetence in performing their responsibilities, and the feeling of inability to face major academic exams. They had such feeling since childhood and could not remember when it all started. "I think I'm a blundering person. My dad always told me I couldn't do anything properly, and I think perhaps he was right".

4.2.2. Failing to Achieve Personal Aspirations

Nearly 60% of the participants complained about disappointment in achieving personal aspirations and wishes. This feeling was accompanied by frequent regretful sighs when they talked about these emotions. "What a pity! How I could grow. Opportunity lost".

4.2.3. Lack of Confidence to Recognize the Right Time

Seventy percent of the participants complained about experiencing lack of control over time, father's frequent interference in scheduling tasks, the feeling of disorientation in scheduling, frequent procrastinations, leaving things to the last minute, and even inability to recognize an appropriate time for rest and recreation, and felt that it was the father that decided when to work and rest, and that they could not decide for themselves about such matters, and had to repeatedly seek guidance from their father about these things. "I feel I have no sense of time or timing. My father is always grumbling. So I prefer to leave timing of things to him. That way, he would grumble less".

4.2.4. Lack of Creativity

Almost 100% of participants complained about lack of creativity in their lives and a robot-like living. This experience was accompanied with comparing oneself to others. "I feel I'm living like a robot, with no creativity. There's nothing new in my life, and everything is repetitive".

4.3. Category 3: Fears

This category contains six subcategories, dealing with experiencing fear about living with a father with OCPD (Table 1).

4.3.1. Fear of Unexpected Future Events

More than 60% of participants reported fear of the future, poverty, famine, drought, unemployment, and possible war while living with their fathers. They revealed that for these fears, their fathers frequently encouraged them to make savings and plans for a rainy day. "My dad says that drought is very likely with this water shortage; marking my words he says. Well, really, I have my heart in my mouth with such words".

4.3.2. Fearing People

Fear of people, distrusting others, the constant feeling of espousing social risks, and disrespecting personal rights by others were among other children's experiences of fathers with OCPD. They frequently complained that their father considered no one good enough to trust 100%. A participant described: "When I'm with my dad, my stomach churns. I'm even scared to cross the street to go to school alone".

4.3.3. Fear of Death

Fifty percent of participants complained about experiencing fear of death, grave, judgment day, and fear of God, living with their fathers. "There are very few days for my father to watch something on TV and not to remark about the judgment day and pressure of the first day in the grave. My heart sinks when he says these things".

4.3.4. Fear of Illness

Sixty percent of the participants complained about experiencing fear of illness, screening tests, visiting the doctor for screening, and fear of side-effects of medicines prescribed by doctors. They believe that their fathers were constantly entangled with such fears, and prohibited them from such things, or medical follow-up. "My father scares us of taking medicine and becoming sick. He tells us to eat this and not to eat the other, otherwise, we would be sick and then you know what will happen".

4.3.5. Fear of Marriage

Fear of getting married, choosing a husband, place of residence, childbearing, and mothering were among the experiences of daughters about to marry or already married, reported by 80%. "Even though I'm sure my fiancé is a good boy; it worries me when my father tells me to be careful in my choice of a husband, and that marriage is not a child's game".

4.3.6. Fear of Responsibility

More than 70% of the participants talked about their fear of responsibilities at work, university, and high school. Almost none of them was a member of an organization or a group at work, and felt worried about people's expectations of them, and feared failure, or thought that people may cheat them. "My father always tells me that I should let other people take responsibilities because they only cause headaches, so I'm scared of such things".

5. Discussion

In this study, three main categories were identified, which included negative emotions, disorientation, and fears. Although this is a study for describing experiences and cannot provide a causal explanation for them, the following assumptions can be used to justify the distressful and pathological nature of such experiences in children.

Regarding the relationship between personality disorders and psychopathology in parent-child relationships, the following can be used as the most common theories:

5.1. Pathoplastic Relationship

This means that personality disorders and psychopathology in parent-child relationships affect the form and pattern of each other; in other words, this is a mutual relationship. For example, Young's cognitive theory can be used to justify this point.

Cognitive conceptualization and Young's model can be used to explain experiences of participants in dealing with a patient with OCPD (12). This model has been developed according to the traditional cognitive-behavioral therapy model and is based on conceptualization of schema models, which are patterns of dominant emotions and coping strategies arisen from situations that individuals are oversensitive to (13). The schema proposed for patients with OCPD include detached self-soother, self-aggrandizer, bully and attack, and demanding parent (14).

The demanding parent model indicates high standards, which these people seek to attain (15). Self-aggrandizer indicates that they think they can do everything correctly and properly, and consider others incompetent and irresponsible, because they cannot meet their high standards (16). Detached self-soother is probably related to this disorder because it includes workaholism, which is probably the self-soothing function in these patients (14). The following can explain the connection between these features and participants' fathers:

5.1.1. Demanding Parent

Various studies have shown its relationship with peer bullying (17), reduced creativity (18), and children's dissatisfaction with life (19). In other words, the authoritarian form of this model is associated with a variety of the negative emotions in children (20), and can explain negative emotions in daughters of fathers with OCPD.

Self-aggrandizing in fathers has been shown to be associated with anxiety and depression in children (21), which can explain negative emotions and feeling of disorientation.

Self-soother and aggressive and bullying behaviors indicate the lack of appropriate response according to the authoritarian model (20), which explains daughters' fears. Studies have shown that parents with anxious personalities are less involved in children's problems and less sensitive to their needs (22). Generally, personality disorders in parents are associated with psychological damage in children (7).

On the other hand, the presence of psychopathology in children can affect the effectiveness and the type of interference in a father with OCPD. In other words, some of the experiences of children, such as their anxieties and concerns, can exist independently from the father's behavior and cause the father to develop an impaired interaction with children to control and manage them and this vicious cycle continues. As shown in studies, the presence of psychopathology in children affects conflicts and the pattern of parenting (23, 24). Based on this theory, the experiences of negative emotions and fears can partly be justified, yet the experiences of disorientation are hard to explain, as disorientation in time and place, and talents is in contrary to common definitions of OCPD; the definitions emphasize on accuracy, careful attention to time and place in this disorder (25), unless we assume that there is a serious disorientation that shows itself in the relationship with children beyond discipline and perfectionism of patients with OCPD.

5.2. Spectrum Relationships

In this theory, psychopathology in "parent-child relationship" is seen in a spectrum, which starts from a healthy relationship and continues to its non-adaptive and inefficient form. In other words, this psychopathology is the extreme and inflexible continuance of a healthy relationship (26). In support of this theory in OCPD, studies consider it as the extreme form of personality conscientiousness. This trait justifies features, such as order, achievement striving, dutifulness, competence, and deliberation (27) that can justify the experiences of negative emotions and fears in females to some extent, yet cannot explain the

experiences of disorientation and does not explain the extreme attention of females with OCPD to time, place and how to justify the disorientation, unless we assume that the extreme excess in the natural spectrum of order will lead to chaos and disorientation at the end. The interesting point is that this disorientation has not been reported in patients with OCPD and this phenomenon may be better explained by one cycle than a spectrum, i.e. the end of the order loop and extreme structure goes back to the beginning of the loop i.e. disorder and disorientation.

5.3. Etiological (Causal) Relationships

Based on this theory, personality disorder can cause these experiences in female patients. In other words, these negative experiences are the result of pathological behaviors of fathers (26). As studies have shown, neuroticism can lead to a variety of mental and communication problems and patients with OCPD respond to stresses and bad life events with much anxiety and concern due to extreme neuroticism, which can lead to mood and anxiety disorders in patients and their children (28). This causal relationship can justify the experiences of negative emotions and fears in females and may justify disorientation in females due to the ability to create psychopathology in children, yet since psychopathology was considered a factor of exclusion during the initial interview, this phenomenon is a little hard to justify. It can be assumed that the experience of disorientation in children is manifested from this experience in fathers. In other words, it appears that children, who live with their fathers are involved in their world and find similar experiences, without necessarily having developed psychopathology.

It seems that disorientation is an important finding that should be addressed in studies. Time disorientation can be seen in all four subcategories in the concept of disorientation, either in the form of not understanding the right time for activities, manifesting abilities and talents, or in the form of incomplete understanding of the right time to deal with stresses, academic exams and studying, or in the form of regretting to have missed the right time, a feeling that is finally manifested in the form of being passive and being a robot. Although several studies in the recent decades have been conducted on the effects of emotions on individual's perception of time (29), no study was found on the effects of parents' feelings on children's understanding of time and the results of this disorientation in the formation of the psychological structure of children. However, studies have shown that the internal clock of each person can be specific and affect his psychological function (30) and several neural systems are involved in regulating this internal clock, including globus pallidus external, globus pallidus internal, supplementary motor area, substantial nigra pars compacta, ventral tegmental area, hippocampal, cortex (30). However, the following questions still remain unanswered: What is the relationship between parents' personality disorder and time perception disorder in children? How is this relationship? What is the relationship between the concept of time and the formation of personality? Does it have a causal relationship with other psychological phenomena or is it an effect. All these questions require further studies.

The pressure imposed on daughters of fathers with OCPD requires clinical attention and further studies. It must be reiterated that only daughters with some kind of problem with their fathers were interviewed and other children were not, which may have caused an error in sampling, and requires further investigation in future studies. Moreover, personality of daughters was not specifically assessed; for instance, using SCID-II could have affected reporting of their experiences, and should be investigated. Since only three sons had the same problem; they were excluded, which could have affected the results.

5.4. Conclusions

Children of these patients were found to be under severe mental pressure, such as depression, the feeling of guilty, anxiety and fears, low self-esteem and self-confidence, lack of creativity, social withdrawal, etc. requiring serious attention and interventions as preventive measures. As known, because of the over controlling trait of their father, it is not easy for them to discuss about their feelings in a single visit; so it is wise to spend some more time to evaluate these people's children separately.

Acknowledgments

The authors wish to thank Rasoul Akram Hospital Clinical Research Development Center for technically supporting the implementation of the project.

Footnotes

Authors' Contribution: Amir Abbas Keshavarz Akhlaghi and Ruohollah Seddigh conducted the study concept and design. Amir Abbas Keshavarz Akhlaghi and Somayeh Azarnik performed the acquisition of data. Somayeh Azarnik and Ruohollah Seddigh performed the data analysis and interpreted the data. Somayeh Azarnik and Ruohollah Seddigh drafted the manuscript. Behnam Shariati performed the critical revision of the manuscript for important intellectual content. Behnam Shariati and Zahra Torabi Goodarzi also conducted the statistical analysis.

Zahra Torabi Goodarzi performed the administrative, technical and material support. Ruohollah Seddigh was the supervisor of the study.

Declaration of Interests: The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding/Support: The authors received no financial support for the research, authorship, and publication of this article.

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