Personality and psychopathology

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Personality and psychopathology can relate to one another in three different ways: personality and psychopathology can influence the presentation or appearance of one another (pathoplastic relationships); they can share a common, underlying etiology (spectrum relationships); and they can have a causal role in the development or etiology of one another. Each of these possible forms of interrelationship is considered in this paper.

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Personality and psychopathology can relate to one another in three different ways (1). Personality and psychopathology can influence the presentation or appearance of one another, commonly referred to as a pathoplastic relationship. They can share a common, underlying etiology, referred to as a spectrum relationship. And, finally, they can have a causal role in the development or etiology of one another. Each of these relationships has significant theoretical and clinical implications, and each will be considered in turn.

PATHOPLASTIC RELATIONSHIPS

The influence of personality and psychopathology on the presentation, appearance, or expression of one another is typically characterized as a pathoplastic relationship. This relationship is bidirectional, as psychopathology can vary in its appearance depending upon a person's premorbid personality traits, and the appearance of personality can similarly be affected by the presence of a comorbid psychopathology.

Pathoplastic effects of personality on psychopathology

Personality is the characteristic manner in which one thinks, feels, behaves, and relates to others. Mental disorders are clinically significant impairments in one or more areas of psychological functioning. It would be surprising for the presentation, course, or treatment of a dysfunction in thinking or feeling not to be significantly affected by a person's *a priori* characteristic manner of thinking and feeling. For example, anorexia and bulimia tend to emerge during adolescence (driven in part perhaps by high levels of neuroticism). Persons with a preoccupation with weight loss who go on to develop anorexia are most likely characterized in part by high premorbid conscientiousness, one of the fundamental individual differences included within the well validated five-factor model (FFM) of general personality structure (2). Persons high in conscientiousness have high levels of self-discipline, competence, and achievement-striving, precisely the attributes that would be necessary to be so successful in weight loss. In contrast, persons low in conscientiousness would be prone to the impulsive dyscontrol characteristic of binge eating and bulimia. Empirical support for this hypothesis is provided by studies indicating the presence of perfectionistic and compulsive personality traits in persons with anorexia, particularly the restrained subtype, as well as personality traits of impulsivity with bulimic symptomatology (3).

Pathoplastic effects of psychopathology on personality

One of the most well-documented relationships between personality and psychopathology is the pathoplastic effect of psychopathology on the appearance, presentation, or perception of personality (4,5). Clinicians (and at times researchers) will typically assess a patient's personality during an initial intake procedure, yet this is perhaps the worst time to do so (6). Persons who are very anxious, depressed, angry, or distraught will often fail to provide an accurate description of their usual way of thinking, feeling, behaving, and relating to others. Once their mood, anxiety, or other mental disorder is successfully treated, their self-description changes accordingly.

Consider, for example, temporal stability findings reported in the highly published, multi-site Collaborative Longitudinal Study of Personality Disorders (CLPS). Twenty-three of 160 persons (14%) who met diagnostic criteria for borderline personality disorder (BPD) at baseline had no more than two diagnostic criteria just six months later (7). Eighteen sustained this reduction from six months to one year. For five of the 18 cases, a "remission of the Axis I disorder was judged to be the most likely cause for the sudden BPD improvement" (7). For eight cases, "the changes involved gaining relief from severely stressful situations they were in at or before the baseline assessment" (7). For one of the participants, the "personality disorder" symptoms were even secondary to the use of a stimulant for weight reduction during the year prior to the beginning of the study: "the most dramatic improvement following a treatment intervention occurred when a subject discontinued a psychostimulant she had used the year prior to baseline for purposes of weight loss. Discontinuation was followed by a dramatic reduction of her depression,

panic, abandonment fears, and self-destructiveness" (7). Nevertheless, all 18 cases have been considered to be true cases of remission from a personality disorder (7). An alternative view is that the initial assessments of personality disorder were inaccurate due to the presence of emotional distress at baseline.

Costa et al (8) though argue that change in self-description secondary to a mood disorder can represent an actual change in personality. One of the fundamental traits of personality is neuroticism, which is a disposition to experience and express negative affects (3). Persons high in neuroticism will respond to stress with clinically significant levels of depression, and this depression could then be understood as a direct expression of the neuroticism. "Rather than regard these depression-caused changes in assessed personality trait levels as a distortion, we interpret them as accurate reflections of the current [personality] of the individual" (8).

On the other hand, to the extent that one considers self-report levels of neuroticism secondary to a mood disorder to reflect actual personality functioning, it becomes difficult to conduct research on the etiological contribution of these same personality traits to the mood disorder. They are no longer distinguished constructs. One should at least not attempt to infer premorbid personality traits on the basis of an assessment when the person is suffering from a mood disorder (or other comparable disorder or condition).

SPECTRUM RELATIONSHIPS

The identification of pathoplastic (and etiological) relationships of personality and psychopathology is complicated by the possibility that personality and psychopathology may themselves fail in some instances to be distinct entities. They may instead exist along a common spectrum of functioning. All personality disorders may in fact be maladaptive variants of general personality traits, and some personality disorders could be early onset, chronic, and pervasive variants of other mental disorders. These two possibilities will be discussed in turn.

Personality disorders on a spectrum with personality

There is a considerable body of research on how general personality traits (e.g., neuroticism and low conscientiousness) can contribute to the etiology of anxiety, mood, substance, and other mental disorders (1), but little to no research on how these traits could contribute to the etiology of personality disorders. This may reflect an implicit acceptance that personality and personality disorders lie along a common spectrum of functioning. In fact, there is now a considerable body of research to indicate that personality disorders are readily understood as maladaptive and/or extreme variants of the FFM personality structure (9,10).

For example, obsessive-compulsive personality disorder (OCPD, 11) can be understood as largely a maladaptive variant of FFM conscientiousness. FFM conscientiousness includes such facets as order (i.e., OCPD preoccupation with details, rules, lists, and order), achievement striving (i.e., OCPD excessive devotion to work and productivity), dutifulness (i.e., OCPD overconscientiousness and scrupulousness about matters of ethics and morality), competence (i.e., OCPD perfectionism), and deliberation (i.e., OCPD rumination). Empirical support for this conceptualization is extensive (12-14).

The fifth edition of the American Psychiatric Association (APA)'s diagnostic nomenclature is likely to include a dimensional classification that will serve as an ancillary supplement to the traditional categorical diagnoses (15). The proposal for this model currently consists of six domains: negative emotionality (aligning with FFM neuroticism), introversion (FFM introversion), antagonism (FFM antagonism), compulsivity (FFM conscientiousness), disinhibition (low FFM conscientiousness), and schizotypy (low FFM openness). The authors of this model, however, argue that compulsivity is not in fact a maladaptive variant of conscientiousness and schizotypyal is not a maladaptive variant of openness (15). No normal variants for the dimensions of compulsivity and schizotypy are in fact proposed, suggesting that these maladaptive personality traits are somehow qualitatively distinct from general personality structure.

Personality disorders on a spectrum with other mental disorders

A spectrum relationship may also exist for personality disorders with other mental disorders. In fact, a proposal for DSM-5 has been to abandon the classification of personality disorder altogether, subsuming personality disorders within other mental disorder diagnoses (16). Schizotypal personality disorder is already classified as a variant of schizophrenia rather than as a personality disorder in the ICD-10 (17). Support for this alternative classification is that schizotypal personality disorder is genetically related to schizophrenia, many of its neurobiological risk factors and psychophysiological correlates are shared with schizophrenia (e.g., eye tracking, orienting, startle blink, and neurodevelopmental abnormalities), and the treatments that are effective in ameliorating schizotypal symptoms overlap with treatments used for persons with schizophrenia (18).

One can similarly convert avoidant personality disorder into generalized social phobia, OCPD into an early onset, pervasive, and chronic variant of obsessive-compulsive disorder, antisocial into an adult variant of disruptive behavior disorder, and borderline into a mood dysregulation disorder (1). The narcissistic, histrionic, and dependent personality disorders are not well integrated into any existing mental disorder, but it might be no coincidence that these diagnoses are slated for deletion in DSM-5 (14).

A concern with reformulating personality disorders as early onset and chronic Axis I disorders, beyond the fundamental consideration that the diagnostic manual would no longer recognize the existence of maladaptive personality functioning, is that it might create more problems than it solves. Persons have constellations of maladaptive personality traits that are not well described by just one or even multiple personality disorder diagnoses

(19). These constellations of maladaptive personality traits would be even less well described by a collection of anxiety, mood, disruptive behavior, and schizophrenic diagnoses. In addition, simply because a personality disorder (or trait) shares some genetic foundation with another mental disorder does not then indicate that it is a form of that disorder. For example, inconsistent with the ICD-10 classification of schizotypal personality disorder as a form of schizophrenia is that this disorder is far more comorbid with other personality disorders than it is with psychotic disorders. Furthermore, persons with schizotypal personality disorder almost never go on to develop schizophrenia, and schizotypal symptomatology is seen in quite a number of persons who appear to lack a genetic association with schizophrenia and would not be at all well described as being schizophrenic (18).

ETIOLOGICAL (CAUSAL) RELATIONSHIPS

Of primary concern to many personality, personality disorder, and psychopathology researchers is the etiological relationship between personality and psychopathology. This causal relationship is again bidirectional, as one's characteristic way of thinking, feeling, behaving, and relating to others can at times result in or contribute to the development of a mental disorder, just as a severe or chronic mental disorder can itself contribute to fundamental changes to personality.

Causal effects of psychopathology on personality

Psychopathology can fundamentally alter personality, for the better or for the worse. For example, it is conceivable that the experience of having suffered from a severe mental disorder, such as a psychosis or a major depression, might have a lasting effect on one's characteristic manner of thinking, feeling, and relating to others. This alteration to personality functioning, often referred to as a "scar" of a mental disorder, need not represent simply a continuing subthreshold manifestation of the psychopathology (e.g., a residual phase of schizophrenia appearing to be schizotypal personality traits) but may even represent the development of new personality traits due to the occurrence or experience of the psychopathology (e.g., dependent personality traits resulting from an experience of recurrent panic attacks or psychotic episodes).

The ICD-10 does include a diagnosis for personality change secondary to a mental disorder, as well as secondary to catastrophic experience (17). The APA nomenclature though provides no recognition to either possibility (11). An example of the latter condition would be "complex post-traumatic stress disorder" (complex PTSD), a reaction to severe (often sustained) interpersonal stress (e.g., abuse, battering, or torture), that includes "impaired affect modulation; self-destructive and impulsive behavior; dissociative symptoms; feeling permanently damaged; a loss of previously sustained beliefs; hostility; social withdrawal; feeling constantly threatened; impaired relationships with others; or a change from the individual's previous personality characteristics" (11). Complex PTSD could be conceptualized as an adult-onset borderline personality disorder. However, most advocates for the inclusion of this diagnosis in a future edition of the diagnostic manual prefer that it be classified as an anxiety disorder rather than as a disorder of personality change (20).

Causal effects of personality on psychopathology

Much of the vast literature on the relationship of personality or personality disorder with psychopathology is concerned with the contribution of personality to the onset or etiology of mental disorder. Premorbid personality traits can provide a vulnerability (or a resilience) to stress, helping to explain why some people collapse under life stresses while others remain unscathed by severely traumatic circumstances.

Neuroticism is a particularly robust predictor of future psychopathology in response to life stress (21,22), including mood, eating, substance use, anxiety, and other forms of psychopathology (23). Neuroticism can contribute both diathesis and stress, providing a vulnerability through both reactive and evocative person-environment interactions. Persons high in neuroticism react to events with high levels of distress, anxiety, and worry, providing an explicit risk for various forms of psychopathology, particularly mood and anxiety disorders (which perhaps can also be understood then as a spectrum rather than a causal relationship). The evocative interaction occurs when one's frequent expressions of upset, worry, and vulnerability produce negative reactions from others or contribute to poor decision-making, thus reinforcing and increasing the original distress (i.e., personality as causing stress). The contribution of neuroticism to the development of physical health problems, financial difficulties, and dissolution of relationships and other negative life outcomes (21) will result in a considerable amount of stress, with which persons high in neuroticism would have an inherent difficulty emotionally surmounting.

Dependent personality traits have also been shown to have an important role in the etiology of depression. Multiple prospective, longitudinal studies have confirmed that dependent cognitions and behaviors result in increased feelings of depression in reaction to interpersonal loss or rejection (24). This relationship can again be both reactive and evocative. Dependent persons will react to interpersonal loss and rejection with intense feelings of despair, hopelessness, and sadness. The dependent traits of neediness, clinging, preoccupation with fears of loss, and excessive reassurance-seeking can also evoke a disengagement and rejection by others (25). However, despite the importance of dependent traits for the development of psychopathology, dependent personality disorder is slated for deletion in DSM-5 (26).

CONCLUSIONS

One basic observation of the research

on the relationship of personality and psychopathology is its vibrancy. All aspects of the various relationships between personality and psychopathology (pathoplastic, spectrum, and causal) are the focus of a number of highly productive, sophisticated, and informed research programs. Disentangling the forms of relationship from one another, however, is a formidable task. However, it will be through the dismantling of this complexity that continued progress will be made in understanding the relationship of personality and psychopathology.

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