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Basic Personality Model

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Abstract

The personality structure of persons within clinical populations may not be fundamentally different from the personality structure of persons who have not sought treatment for their maladaptive personality traits. Indeed, there has long been an interest in understanding personality disorders as maladaptive variants of general personality structure. Presented herein is an understanding of personality disorder from the perspective of basic personality research; more specifically, the five factor model (FFM) of general personality structure. Potential advantages of understanding personality disorders from the perspective of the FFM are provided.

Keywords

five-factor model; trait; personality; personality disorder; DSM-IV; DSM-5

The personality disorders provided within the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM-5; 1) and the World Health Organization's (WHO) International Classification of Diseases (ICD-10; 2) trace their origins to research within psychiatric, clinical populations. Perhaps though the personality structure of persons within clinical populations is not fundamentally different from the personality structure of persons who have not sought treatment for their maladaptive personality traits. Indeed, there has long been an interest in understanding personality disorders as maladaptive variants of general personality structure (3–5).

The five-factor model (FFM) is the predominant dimensional model of general personality structure (6,7), consisting of the five broad domains of neuroticism (or negative affectivity), extraversion (versus introversion), openness (or unconventionality), agreeableness (versus antagonism), and conscientiousness (or constraint). Each domain includes both adaptive and maladaptive personality traits (8,9). Consider, for example, the domain of agreeableness versus antagonism. Most of the traits of agreeableness are adaptive (e.g., trusting, honest, generous, cooperative, and humble) but there are also maladaptive variants of these traits (e.g., gullible, guileless, selflessly sacrificial, subservient, and self-denigrating, respectively). Most of the traits of antagonism are maladaptive (e.g., cynical-suspicious, manipulative, boastful, and callous) but there are also adaptive variants of these traits (e.g., cautious-skeptical, savvy, confident, and tough-minded).

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The FFM traces its roots to the lexical paradigm: what is of most importance, interest, or meaning to persons is encoded within the language. The most important domains of personality are those with the greatest number of terms to describe and differentiate their various manifestations and nuances, and the structure of personality is provided by the empirical relationship among these trait terms. The lexical research of the English language, and all other languages considered, have converged well onto the Big Five or FFM, albeit the convergence has been less strong for the last two domains typically extracted: neuroticism and openness (10).

One of the compelling attributes of the FFM is its robustness, which is a natural consequence of accounting for virtually every trait term within the language. Other dimensional models of general personality are well understood in terms of the domains and facets of the FFM (11). For example, O'Connor (12) conducted integrative factor analyses of previously published findings from approximately 75 studies involving FFM scales, along with the scales of 28 commonly used self-report inventories of personality. He concluded that "the basic dimensions that exist in other personality inventories can thus be considered 'well captured' by the FFM" (p. 198). Markon, Krueger, and Watson (13) conducted meta-analytic and exploratory hierarchical factor analyses of numerous measures of normal and abnormal personality, consistently obtaining a five factor solution that they indicated "strongly resembles the Big Five factor structure commonly described in the literature, including neuroticism, agreeableness, extraversion, conscientiousness, and openness factors" (p. 144). Psychodynamic measures and models of personality structure are also well understood within the FFM, including the Shedler-Westen Assessment Procedure (see 14), the California Q-Set (see 15), and the General Assessment of Personality Disorder (see 18).

Personality Disorders and the Five Factor Model of General Personality Structure

There is a considerable body of research to indicate that all of the personality disorders of DSM-5 and ICD-10 can be readily understood as maladaptive variants of general personality structure. The volume of FFM-personality disorder research is substantial and can not really be summarized within this limited space. Widiger, Gore, Crego, Rojas, and Oltmanns (8) provide a reasonably comprehensive summary of all of the FFM-personality disorder studies. Reviews concerning individual personality disorders have been provided for the borderline (17), the schizotypal (18), the antisocial or psychopathic (19), the dependent (20), and the narcissistic (21). Livesley (22) concluded on the basis of his review of this research that "all categorical diagnoses of DSM can be accommodated within the five-factor framework" (p. 24). Clark (6) similarly concluded that "the five-factor model of personality is widely accepted as representing the higher-order structure of both normal and abnormal personality traits" (p. 246).

For example, from the perspective of the FFM, borderline personality disorder includes (in part) such traits as affective dysregulation, fragility (which includes self-harm), dysregulated anger, behavioral dysregulation, self-disturbance, despondence, and anxious uncertainty (23), all of which are considered to be within the FFM domain of neuroticism. The Five

Factor Borderline Inventory (FFBI) includes scales for the assessment of each of these traits, and multiple studies have documented large effect size relationships with FFM neuroticism (convergent validity), as well as weak relationships (discriminant validity) with the other domains of the FFM (23,24). Likewise, obsessive-compulsive personality disorder includes (in part) such traits as workaholism, ruminative deliberation, doggedness, punctiliousness, perfectionism, and fastidiousness (25), all of which are considered to be within the domain of conscientiousness. The Five Factor Obsessive-Compulsive Inventory includes scales for the assessment of these traits, and multiple studies have again documented large effect size relationships with conscientiousness, as well as weak relationships with the other domains of the FFM (25,26). There are also FFM self-report measures for the schizotypal, narcissistic, dependent, antisocial (psychopathic), histrionic, and avoidant personality disorders (27).

A major step toward a conceptualization of personality disorders from the perspective of the FFM occurred with DSM-5 (1). The dimensional trait model included within Section III of DSM-5, consisting of five broad domains of negative affectivity, detachment, psychoticism, antagonism, and disinhibition, are aligned with the FFM domains of neuroticism, introversion, openness, antagonism, and low conscientiousness, respectively. As expressed in DSM-5, “these five broad domains are maladaptive variants of the five domains of the extensively validated and replicated personality model known as the ‘Big Five’ or Five Factor Model of personality (FFM)” (1, p. 773). Similarly, proposed for ICD-11 is another five-domain dimensional trait model, consisting of the five domains of negative affective, detachment, dissocial, disinhibited, and anankastic, that are again aligned with the FFM: “Negative Affective with neuroticism, Detachment with low extraversion, Dissocial with low agreeableness, Disinhibited with low conscientiousness and Anankastic with high conscientiousness” (28, p. 85). Research has supported the alignment of the DSM-5 trait model with the FFM (29–31), albeit the alignment of DSM-5 psychoticism with FFM openness has been more inconsistent and complex (32). The strength of the relationship appears to depend on how both openness (29,33,34) and psychoticism (35) are conceptualized and/or assessed.

Another focus of future research would be the relationship of the FFM, DSM-5, and ICD-11 dimensional trait models with the self-other deficits of DSM-5 Criterion A (1). In DSM-5 Section III, the maladaptive traits (Criterion B) are coupled with deficits in the sense of self (identity and self-direction) and interpersonal relatedness (empathy and intimacy), as if Criterion A and B are independent of one another. The Criterion A deficits are also considered in theory to define the core of personality disorder (1).

However, from the perspective of the FFM, deficits in the sense of self and interpersonal relatedness are also expressions of maladaptive traits. For example, the empathy deficit specified for antisocial personality disorder in DSM-5 is said to involve a “lack of concern for feelings, needs, or suffering of others” and “lack of remorse after hurting or mistreating another” (1, p. 654). This deficit would appear to be essentially equivalent to the trait of callousness, which is also said to involve a “lack of concern for feelings or problems of others” and “lack of guilt or remorse about the negative or harmful effects of one’s actions on others” (1, p. 654). Research has suggested a substantial overlap of the self-interpersonal deficits with maladaptive personality traits (16,36,37). Indeed, one of the neuroticism scales

of the Five Factor Borderline Inventory (FFBI) is Self-Disturbance (sample items include “I can be so different with different people that I wonder who I am” and “I am often ashamed of my thoughts and feelings”), and research has consistently indicated a strong alignment of this scale with FFM neuroticism (23,24).

In the typical presentation of the FFM of personality disorder, one first assesses for the presence of an FFM trait, followed by an assessment of impairment (9). This can be misunderstood to imply a fundamental distinction between traits and impairment. It is certainly necessary to assess for impairments secondary to apparently adaptive traits (e.g., determining if a trusting person is in fact gullible, or if a cooperative person is in fact submissive). However, the assessment of a maladaptive trait will inevitably include as well an assessment of impairment (38). For example, as noted earlier, an assessment for the presence of callousness will include an assessment for the presence of deficits in empathy.

Potential Strengths of Basic Personality Conceptualization

There are a number of advantages in conceptualizing personality disorders as maladaptive variants of general personality structure. First, the dimensional personality structure would address the many limitations inherent to the existing categorical model (6,39,40). Rather than lump patients into categories that fail to describe all of the person’s traits and includes traits that do not apply to a respective patient, a dimensional trait model would provide a more precise, individualized description. Insurance, disability, and other social, clinical decisions would be easier and more informative because more relevant and specific cutoff points could be placed along the trait dimensions that would be optimal and specific to each particular decision.

The homogeneous and distinct trait constructs also have more specific treatment implications (41). In 1992, the American Psychiatric Association began publishing empirically-based practice guidelines, some of which are now in their third edition. However, to date, guidelines have been provided for only one personality disorder: borderline. None have been developed for the other nine personality disorders. Note as well that the treatment section of this issue of *Current Opinion in Psychology* is devoted largely to one personality disorder: borderline.

One potential reason for the absence of treatment manuals might be the complex heterogeneity of the DSM-5 Section II personality disorders (41). Each personality disorder is a syndromal assortment of different maladaptive personality traits (6,40) for which it would be quite difficult to develop a uniform treatment program. This is a limitation that is not present for the FFM domains and facets, nor for the DSM-5 and ICD-11 trait models. Indeed, treatment guidelines have been developed for neuroticism (42,43).

The inclusion of normal, adaptive FFM personality traits (along with the maladaptive) would also provide a richer, fuller, and more appreciative description of each patient (41). Personality disorders are among the more stigmatizing labels within the diagnostic manual, suggesting that who the person is, and perhaps always will be, is itself a mental disorder. The FFM of personality disorder recognizes that the person is more than just the disorder

and that other aspects of the self can be adaptive, even commendable. “Some of these strengths may also be quite relevant to treatment, such as openness to experience indicating an interest in exploratory psychotherapy, agreeableness indicating an engagement in group therapy, and conscientiousness indicating a willingness and ability to adhere to the demands and rigor of dialectical behavior therapy” (44, p. 203).

Finally, to the extent that the DSM-5 Section II personality disorders are understood as maladaptive variants of the domains and facets of the FFM, all that has become known about the FFM (7) would be applicable to an understanding of the personality disorders. Indeed, some of the more problematic findings for the personality disorders are well addressed when they are understood within the FFM. For instance, diagnostic co-occurrence has been highly problematic, even providing a primary rationale for the proposal to delete half of the personality disorder diagnoses in DSM-5. However, this co-occurrence is largely explained by the extent of shared FFM traits (45). Gender differences have also been very controversial (46) but the differential sex prevalence rates are consistent with the sex differences that would be predicted if the personality disorders are understood to be maladaptive variants of the FFM (46).

Very little is known on the childhood antecedents for most of the personality disorders. In contrast, there is a considerable body of research on the childhood antecedents of the FFM (48). De Clercq, De Fruyt, Van Leeuwen and Mervielde (49) have even developed an instrument for the assessment of the maladaptive FFM traits within childhood. Tyrer (50), Chair of the WHO ICD-11 Personality Disorders Work Group, lamented the reluctance of childhood clinicians and researchers to recognize childhood antecedents of adult personality disorders. However, as indicated by De Fruyt and De Clerq (48), “an integrative model of personality pathology precipitants for childhood and adolescence is available now” (p. 469).

Conclusions

It would appear to be self-evident that it would be useful to seek an integration of the clinical understanding of personality disorder with general personality research, as the personality of persons with personality disorder does not appear to be fundamentally different from general personality structure. (5,6,39,40). This integration would improve the validity of personality disorder diagnosis and conceptualization, as well as increase its clinical utility, allowing clinicians to provide more individualized, accurate, and precise descriptions of their clients with respect to homogeneous and distinct traits that will have more specific treatment implications.

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