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How temperament and character affect our career, relationships, and mental health

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Abstract

Background: On the way toward an agreed dimensional taxonomy for personality disorders (PD), several pivotal questions remain unresolved. We need to know which dimensions produce problems and in what domains of life; whether impairment can be found at one or both extremes of each dimension; and whether, as is increasingly advocated, some dimensions measure personality functioning whereas others reflect style.
Method: To gain this understanding, we administered the Temperament and Character Inventory to a sample of 862 consecutively attended outpatients, mainly with PDs (61.2%). Using regression analysis, we examined the ability of personality to predict 39 variables from the Life Outcome Questionnaire concerning career, relationships, and mental health.
Results: Persistence stood out as the most important dimension regarding career success, with 24.2% of explained variance on average. Self-directedness was the best predictor of social functioning (21.1%), and harm avoidance regarding clinical problems (34.2%). Interpersonal dimensions such as reward dependence and cooperativeness were mostly inconsequential. In general, dimensions were detrimental only in one of their poles.
Conclusions: Although personality explains 9.4% of life problems overall, dimensions believed to measure functioning (character) were not better predictors than those measuring style (temperament). The notion that PD diagnoses can be built upon the concept of "personality functioning" is unsupported.

1. Introduction

Dimensional models are seen as the next stage in the assessment of personality disorders (PDs), and a considerable consensus has been reached on which, and how many, personality traits a dimensional taxonomy should measure [1–4]. However, traits alone are not enough, as a separate assessment of dysfunction is a necessary condition for diagnosis [5–7]. In this regard, we still do not know how much distress and impairment is caused by each of these basic dimensions, or in which life domains – and therefore which dimensions merit inclusion in a PD classification. We need to determine whether harmfulness is likely to occur at one or both extremes of each dimension [8,9], and we have to establish whether – as is being increasingly advocated – certain personality dimensions measure impairment, and are then able to determine by themselves the presence and severity of PD, while other dimensions are stylistic and allow subtyping [10–16]. These questions raise doubts about the very concept of PD itself.

To gain this understanding, we need to examine the structure of relationships that personality traits maintain with a wide array of external correlates. Most existing studies have focused on one sole domain of functioning or on a few

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outcomes, and thus provide a fragmented picture [17–19]. When a broader scope has been adopted, it has usually been through instruments such as the Global Assessment of Functioning (GAF) or the Social Adjustment Scale (SAS) [6,20,21]. Despite their interest, global measures of functioning cannot replace the study of particular real-life outcomes and may obscure the existing heterogeneity between and within domains. Indeed, academic failure, financial difficulties, conflict with family or mate, violence, drug abuse, psychiatric admissions, and suicide are important consequences of PDs in their own right [7,9,22,23], but do not necessarily correlate or form a homogeneous construct of disordered functioning. Studies measuring a broad array of concrete real-life problems are rare, and with the relative exception of neuroticism [24], our knowledge of which personality dimensions place us at risk of which particular predicaments is embryonic [7,9,17,18].

On the other hand, in the task of upgrading our diagnostic system we should not limit ourselves prematurely to one sole personality model. Although the Five Factor Model (FFM) has been widely adopted as the standard for normal and abnormal personality, Cloninger's Psychobiological Model fits our goals better, for a number of reasons. First, the Temperament and Character Inventory (TCI) [25] detects the presence of PDs quite accurately [26] and predicts some functional and clinical outcomes as well as, or better than, the FFM [27]. Second, its four temperament dimensions offer an alternative perspective to the FFM [28,29] that fits well with the main personality axes underlying the personality pathology landscape: harm avoidance aligns with anxiety-neuroticism, novelty seeking with dissociality, low reward dependence with asociality, and persistence with conscientiousness-compulsivity [1,2,4,29]. Finally, Cloninger's model includes three character dimensions — self-directedness, cooperativeness, and self-transcendence — which measure key aspects of personality functioning such as self-esteem, self-efficacy, personality integration, empathy, conciliation, creativity, and spirituality [25]. This two-tiered organization that separates style and functioning is absent from other models, it has gained progressive acceptance despite criticism [30], and has ultimately paved the way for the current conceptions of PD [12,14,21,23]. In spite of having very different theoretical foundations, the DSM-5 alternative model has also adopted a two-layered structure, and the very concept of PD as an adaptive failure encompassing self and interpersonal dysfunctions bears some resemblance to the TCI's character dimensions [3,15,16,31,32]. Given that the TCI remains the only widely validated instrument that assesses style and functioning at one and the same time, it offers a unique opportunity to test the value of this proposal.

Lastly, some previously overlooked issues are essential to the development of a clinically congruous model. For instance, we need to know whether life problems exist at one or the two poles of each dimension. Like other normal-range traits, TCI dimensions are "defined by a bipolar continuum from low to high expression, capturing both normalcy and extreme presentations" (p. 158) [29]. Therefore, both poles are theoretically expected to cause disadvantages [8,9,22]. By contrast, the evidence tends to pinpoint only one of the extremes — high neuroticism and antagonism, low conscientiousness — as maladaptive [17–19,24]. On the other hand, we must establish whether any combination of dimensions (e.g. being anxious *and* impulsive) is particularly noxious, beyond the effect of each dimension on its own. Temperament × character interactions are of particular interest in this regard, because of the suggestion that the combination of extreme temperament (reflecting style) and low character (reflecting dysfunction) is both necessary and sufficient for PD diagnosis [13,15,31].

In sum, a comprehensive, empirically sound, and clinically useful taxonomy of PDs requires a greater knowledge of which personality traits are associated with life problems and are therefore relevant for PD nosologies. In a clinical sample with high prevalence of PDs, we seek to study which personality dimensions impact, and how severely, on 39 variables pertaining to three life domains: career, relationships, and mental health. Secondarily, we want to examine whether one or both extremes of the dimensions are harmful, and whether certain combinations of traits are particularly noxious.

2. Method

2.1. Subjects

The sample was made up of 862 outpatients (53.2% female) with mean age 34.5 years (SD 10.8; range 16–67) consecutively referred for personality assessment to the psychology service of a general university hospital over a 5-year period. This sample covered the entire range from normal to severely disordered personalities. From a random subsample of 327 (37.7%) subjects, 61.2% received a categorical PD diagnosis in the Personality Disorder Questionnaire (PDQ-4+) [33] Clinical Significance Interview, with all disorders being represented. This ensured a sufficient representation of both extreme personality variants and life problems [21]. Sixty-five percent of the patients also presented an Axis I disorder, mainly mild to moderate affective disorders (29.5%), anxiety disorders (7.6%), or mixed anxious-depressive disorders (14.7%), which were diagnosed according to DSM-IV by the referring staff, and again by two experienced clinical psychologists (FG, JMP). Patients with psychosis, severe affective disorder, or dementia were excluded. The study was approved by the ethics committee of the hospital, and all subjects gave informed consent prior to participating.

2.2. Measures

The Temperament and Character Inventory–Revised (TCI-R) [34] is a 240-item self-report using a 5-point Likert scale ranging from 1 ("*definitely false*") to 5 ("*definitely true*").