What do all personality disorders have in common?  
Ineffectiveness and uncooperativeness

Fernando Gutiérreza, Ricard Navinésb, Puri Navarroc, Luisa García-Estevec, Susana Subirád, Marta Torrensb, Rocío Martín-Santosb,e,⁎

⁎Corresponding author.
E-mail address: rmsantos@imim.es (R. Martín-Santos).

Psychology Service, Neurosciences Institute, Hospital Clinic Barcelona, and IDIBAPS, Barcelona, Spain

Pharmacology Research Unit (URF), Municipal Institute of Medical Research (IMIM) and Drug Abuse and Psychiatry Department, Hospital del Mar 08003-Barcelona, Spain

Perinatal Psychiatric Unit and Gender Research, Neurosciences Institute, Hospital Clinic Barcelona, Barcelona, Spain

Department of Adult, Adolescent and Child Psychopathology, Faculty of Psychology, Autonomous University of Barcelona, Barcelona, Spain

Psychiatry Department, Neurosciences Institute, Hospital Clinic Barcelona, Barcelona, Spain

Abstract

We still lack operative and theoretically founded definitions of what a personality disorder (PD) is, as well as empirically validated and feasible instruments to measure the disorder construct. The Temperament and Character Inventory (TCI) is the only personality instrument that explicitly distinguishes personality style and disordered functioning. Here, we seek to (1) confirm in a clinical sample that the character dimensions of the TCI capture a general construct of PD across all specific PD subtypes, (2) determine whether such core features can be used to detect the presence of PD, and (3) analyze whether such detection is affected by the presence and severity of Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) Axis I symptoms. Two hundred five anxious/depressed outpatients were evaluated with the Structural Clinical Interview for DSM-IV Axis I and II Disorders. Assessment also included the TCI, the Hamilton rating scales for depression and anxiety, and the Panic and Agoraphobia Scale. Sixty-one patients (29.8%) were diagnosed as having a DSM-IV PD. Self-directedness and Cooperativeness, but no other TCI dimensions, predicted the presence of PD (Nagelkerke R² = 0.35-0.45) and had a moderate diagnostic utility (κ = 0.47-0.58) when Axis I symptoms were absent or mild. However, accuracy decreased in anxious or depressed patients. Our study supports the hypothesis of a disorder construct that is not related to the intensity of any specific PD subtype but which is common to all PDs. This construct relies largely on internal representations of the self revealing ineffectiveness and uncooperativeness.

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1. Introduction

The difficulty in defining disorder is one faced throughout psychopathology [1-3], but it has proved to be a particular hindrance to the study of personality disorders (PDs). Unlike most illnesses, PDs do not occur to the subject but rather are part of his/her nature and are continuous with normal personality variation. Furthermore, PDs come without biographical breaks or identifiable lesions, they do not form a homogeneous category, and their harmfulness is often judgmental, such as being functionally ineffective or socially annoying. Thus, although the PD field is undergoing rapid changes in how personality traits are measured and organized [4], no equivalent attention has been devoted to how to discern whether a subject has a personality disorder.

The most widespread criterion for the existence of a disorder is the presence of a statistically deviant trait, which is equated with dysfunction in both the Diagnostic and Statistical Manual of Mental Disorders (DSM) and most dimensional models. Indeed, extreme traits may be more
inflexible and pervasive, causing inadequacy to the changing environment and, ultimately, dysfunction. Nevertheless, it is also the case that many traits are only maladaptive above a singularly high threshold (e.g., obsessiveness), in one of its extremes (e.g., neuroticism), or under certain conditions (e.g., intimate relationships). Hence, extremity is not a sufficient criterion for diagnosing a disorder, and some additional construct is needed [5-7].

In line with this view, the DSM-IV [8] has attempted to define the core features of all PDs irrespective of the intensity of specific traits or categories: To be maladaptive, an extreme trait should also be inflexible, pervasive, long lasting, and culturally decontextualized and it should lead to clinically significant distress or functional impairment. Earlier influential proposals have further posited that a dysfunctional trait should cause self-defeating circles, ineffectiveness, fragility under stress, personal and interpersonal discomfort, or reduction of opportunities (for review, see Parker et al [9]). Despite the relevance of the disorder construct, these proposals have not been properly tested hitherto, and we still lack consensual, operative, and theoretically founded definitions of disorder, as well as empirically validated and feasible instruments to measure it.

The only personality instrument that explicitly distinguishes personality style from disordered functioning is the Temperament and Character Inventory (TCI), which is grounded in Cloninger’s biosocial model [10]. The TCI encompasses 4 dimensions of temperament (Novelty Seeking, Harm Avoidance, Reward Dependence, and Persistence) that are purported to measure heritable differences in automatic emotional responses to stimuli and to define personality style; and 3 dimensions of character (Self-directedness, Cooperativeness, and Self-transcendence), said to capture learned self-concepts and values that reflect adaptation and then differentiate normal from disordered personalities [11]. Existing evidence has not confirmed a smaller heritability for character. However, it has been reported that Self-directedness and Cooperativeness score lower in PD patients across subtypes and correlate negatively with continuous measures of all PDs [12-15]. Hence, character, but not temperament, seems to behave as a general indicator of disordered functioning. If this point is confirmed, character dimensions may advance our understanding of what PDs are beyond the extremity of specific PD subtypes. Furthermore, character would provide us with a useful clinical tool for detecting personality pathology that is less expensive and time-consuming than structured interviews. Indeed, clinicians do not know whether the presence of personality pathology can really be detected from the TCI scores or how accurate this detection is. Finally, because Axis I disorders—notably mood and anxiety disorders—are frequent in PD subjects and distort personality measures, clinicians need to know whether psychopathological state affects the diagnostic ability of the TCI.

The aims of this study were to (1) confirm that the TCI character dimensions capture a general construct of PD across specific subtypes in a clinical sample of anxious/depressed DSM-IV patients, (2) determine whether these core features can be used to detect the presence of PD, and (3) analyze whether the presence and severity of Axis I symptoms affect this detection.

2. Method

2.1. Sample

The sample consisted of 224 psychiatric outpatients consecutively attended for anxious and/or depressive symptoms in the Psychiatry Service of a general teaching hospital. Exclusion criteria were psychosis, cognitive disorders, mental retardation, or severe concomitant medical illness. Participants were diagnosed by 2 senior psychiatrists with the Spanish version of the Structural Clinical Interview for DSM-IV Axis I Disorders (SCID-I [16]) and by 2 clinical psychologists with the Structured Clinical Interview for DSM-IV Axis II Disorders (SCID-II [17]). Patients were also assessed with the TCI [10], the Hamilton Rating Scale for Depression (HAM-D [18,19]), the Hamilton Rating Scale for Anxiety (HAM-A [20,21]), and the Panic and Agoraphobia Scale (P&A [22]). SCID-II examiners were blind to the results in Axis I, and both SCID-I and SCID-II examiners were blind to the TCI results. The κ indexes of agreement were 0.65 to 1.00 for SCID-I and 0.49 to 0.95 for SCID-II. The study was approved by the institutional review board. Written informed consent was obtained from all participants before enrollment in the study.

2.2. Instruments

The TCI [10] is a 240-item, true/false self-report questionnaire measuring 7 personality dimensions. Four of these are temperamental dimensions: Novelty Seeking reflects the reward system activity and, hence, a tendency to impulsiveness, disinhibition, monotony avoidance, and exploratory behavior in response to novelty; Harm Avoidance reflects the punishment system activity, so it refers to a tendency to shyness, anxiety, pessimism, and anticipatory worry; Reward Dependence expresses variation in social attachment, affiliation, and dependence on approval of others; and Persistence reflects ambitious overachieving and a tendency to maintain behavior despite frustration. The other 3 are character dimensions: Self-directedness reflects the ability to cope effectively and to regulate and adapt behavior in accord with individual goals and values; Cooperativeness reveals the presence of ethics, social tolerance, and good interpersonal adjustment; and Self-transcendence is related to imagination, creativity, and religious and magical thought.

The HAM-D [18,19] is a 21-item, clinician-scored scale for measuring depressive symptoms, whereas the HAM-A [20,21] is a 14-item, clinician-scored scale of somatic and
psychic anxiety symptoms. Both are among the most widely used and validated symptom rating scales. The P&A [22] is a 13-item, clinician-rated scale measuring panic attacks, agoraphobia, anticipatory anxiety, disability, and worries about health.

2.3. Data analysis

First, the mean differences between patients with and without PD (PD and NPD subjects, respectively) in both the TCI dimensions and the measures of psychopathological state (HAM-D, HAM-A, and P&A) were analyzed using Student t tests. Mantel-Haenszel statistics were used to test for linear relationships between the TCI dimensions and the risk of a PD diagnosis. Second, the ability of the TCI to predict the presence/absence of PD was analyzed through logistic regressions and diagnostic indices: sensitivity, specificity, positive predictive value, negative predictive value, hit rate, and Cohen κ. Cutoffs were obtained based on receiver operating characteristic (ROC) curves and κ statistics. Finally, to control for Axis I symptoms, these analyses were repeated in different subgroups of Axis I severity. The possible biases caused by the differing prevalence of PD in each subgroup were controlled using bootstrap procedures. Fisher exact test was used to compare the proportion of specific disorders between correctly and incorrectly classified subjects. Raw scores for TCI were used for analyses, although they are reported as T scores for descriptive purposes (population norms in Cloninger [10]). Power was 0.90 for an α of .05 and effect sizes of 0.2 (mean differences) and 0.22 (Pearson r). SPSS v.12 was used for all analyses.

3. Results

3.1. Sociodemographic and clinical data

Two hundred five patients completed the whole protocol and were included in the study. Mean age was 37.1 years.

Table 1
Point biserial correlations (rpb) of the presence of PD (SCID-II) with age, TCI dimensions, and Axis I symptoms and mean differences between NPD and PD subjects

<table>
<thead>
<tr>
<th>TCI Dimension</th>
<th>NPD (n = 144)</th>
<th>PD (n = 61)</th>
<th>P*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>-0.09</td>
<td>37.7 (11.4)</td>
<td>35.6 (8.2)</td>
</tr>
<tr>
<td>Novelty Seeking</td>
<td>0.03</td>
<td>48.3 (9.1)</td>
<td>49.0 (10.9)</td>
</tr>
<tr>
<td>Harm Avoidance</td>
<td>0.26</td>
<td>62.9 (9.2)</td>
<td>68.3 (10.1)</td>
</tr>
<tr>
<td>Reward Dependence</td>
<td>-0.26</td>
<td>52.3 (9.2)</td>
<td>46.9 (9.6)</td>
</tr>
<tr>
<td>Persistence</td>
<td>-0.03</td>
<td>44.8 (9.7)</td>
<td>44.2 (8.7)</td>
</tr>
<tr>
<td>Self-directedness</td>
<td>-0.36</td>
<td>46.8 (9.6)</td>
<td>38.9 (9.2)</td>
</tr>
<tr>
<td>Cooperativeness</td>
<td>-0.34</td>
<td>48.6 (7.5)</td>
<td>42.5 (8.6)</td>
</tr>
<tr>
<td>Self-transcendence</td>
<td>0.08</td>
<td>38.6 (10.4)</td>
<td>40.3 (10.0)</td>
</tr>
<tr>
<td>Hamilton Depression</td>
<td>0.33</td>
<td>9.8 (6.7)</td>
<td>15.1 (7.5)</td>
</tr>
<tr>
<td>Hamilton Anxiety</td>
<td>0.33</td>
<td>12.0 (7.5)</td>
<td>17.8 (7.4)</td>
</tr>
<tr>
<td>Panic/Agoraphobia</td>
<td>0.25</td>
<td>12.0 (9.1)</td>
<td>17.9 (13.5)</td>
</tr>
</tbody>
</table>

TCI scores are expressed as mean (SD) of T scores.
* P is the same for Student t and rpb.
directedness or Cooperativeness was associated with about an 18% increase in the probability of having a PD. Thus, taking as a reference those patients with Self-directedness scores in the medium range \((T = 40-60)\), patients scoring less than 40 were 2.5-fold more likely to have a PD, whereas patients scoring less than 30 were 3.8-fold more likely to have a PD. If both Self-directedness and Cooperativeness scores were less than 40, this probability multiplied by 4.3. Fig. 1 also shows (nonlined points) the emergence of a similar relationship when we reanalyzed 3 earlier studies in both drug-dependent patients [14] and psychiatric patients [11,23].

3.3. TCI as a diagnostic test

We next examined the accuracy of the TCI as a diagnostic test of the presence of PD, with SCID-II diagnoses as a gold standard. Self-directedness and Cooperativeness again showed a significant predictive power in logistic regression, with Nagelkerke \(R^2 = 0.27\) \((P < .001)\). Reward Dependence made an additional contribution to this prediction, but it was considered negligible \((\Delta R^2 = 0.03)\) and idiosyncratic to our study, as our NPD subjects had higher Reward Dependence than the general population did.

Different cutoffs were then assayed for Self-directedness and Cooperativeness, with the combined use of both dimensions always being superior to their individual use. The best solution (both cutoffs at \(T = 43\)), based on ROC curves and Cohen \(\kappa\)s, yielded a hit rate of 0.77, with sensitivity of 0.38, specificity of 0.94, and \(\kappa\) of 0.36 \((P < .001)\). At this and other cutoffs, diagnostic agreement largely relied on the ability of character to correctly classify NPD subjects (specificity). By contrast, the TCI underdetected PD subjects (sensitivity), presenting a considerable percentage of false-negatives. Attempts to improve sensitivity by boosting cutoffs or by applying a disjunctive algorithm—that is, subjects under the cutoff in either Self-directedness or Cooperativeness—led to unacceptably low agreements. In fact, 62% of subjects with a diagnosable PD did not exceed our cutoff in either Self-directedness or Cooperativeness, and 21% did not do so in either dimension. In addition, although the literature has reported that Self-directedness and Cooperativeness are less intensely related to certain disorders

Table 2

<table>
<thead>
<tr>
<th></th>
<th>With PD (%)</th>
<th>(R^2)</th>
<th>Diagnostic indices</th>
<th>Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>S</td>
<td>E</td>
</tr>
<tr>
<td>Whole sample</td>
<td>205</td>
<td>29.8</td>
<td>0.27</td>
<td>0.38</td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absent or mild</td>
<td>76</td>
<td>11.8</td>
<td>0.35</td>
<td>0.44</td>
</tr>
<tr>
<td>Moderate</td>
<td>65</td>
<td>32.3</td>
<td>0.15</td>
<td>0.29</td>
</tr>
<tr>
<td>Severe</td>
<td>64</td>
<td>48.4</td>
<td>0.20</td>
<td>0.42</td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absent or mild</td>
<td>68</td>
<td>11.8</td>
<td>0.45</td>
<td>0.50</td>
</tr>
<tr>
<td>Moderate</td>
<td>73</td>
<td>28.8</td>
<td>0.19</td>
<td>0.43</td>
</tr>
<tr>
<td>Severe</td>
<td>64</td>
<td>50.0</td>
<td>0.12</td>
<td>0.31</td>
</tr>
<tr>
<td>Panic/Agoraphobia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absent or mild</td>
<td>72</td>
<td>23.6</td>
<td>0.41</td>
<td>0.47</td>
</tr>
<tr>
<td>Moderate</td>
<td>65</td>
<td>24.6</td>
<td>0.00</td>
<td>0.31</td>
</tr>
<tr>
<td>Severe</td>
<td>68</td>
<td>41.2</td>
<td>0.33</td>
<td>0.36</td>
</tr>
</tbody>
</table>

\(R^2\) indicates Nagelkerke \(R^2\) of Self-directedness and Cooperativeness predicting PD; S, sensibility; E, specificity; PPV, positive predictive value; NPV, negative predictive value.
pathology produced a floor effect whereby PD subjects did not reduce their character scores if depressed or anxious.

A reanalysis conducted in each severity subgroup of the diagnostic ability of the TCI confirmed the confounding effect of depressive and anxious pathology. Indeed, the predictive power fell as symptom severity increased (Table 2). Some additional remarks should be made. First, confusion was more patent for depression and anxiety symptoms than it was for panic/agoraphobia symptoms. Second, although loss of accuracy concerned Self-directedness more than it did Cooperativeness, both dimensions continued to perform best when used together. Finally, at any level of Axis I pathology, we once again found poor sensitivity (0.44-0.50) and excellent specificity (0.95-0.98), suggesting that the TCI is better at identifying NPD than PD subjects. The remaining diagnostic indices were acceptable, especially in the absence of Axis I symptoms.

In addition, because diagnostic indices are known to be affected by the base rate of the disorder, we wanted to be sure that differences were really because of Axis I severity and not of the distinct prevalence of PD in each severity subgroup. We extracted from each subgroup 1000 random samples so that the mean PD prevalence was that of the whole sample (29.8%). The resulting mean ks did not differ noticeably from those reported in Table 2: They were 0.50, 0.26, and 0.28 for depression; 0.56, 0.37, and 0.24 for anxiety; and 0.47, 0.27, and 0.36 for panic/agoraphobia. Results were also unchanged when we sought the best cutoff for each severity subgroup instead of using a uniform cutoff of 43.

### 4. Discussion

#### 4.1. Character and PD

As previously proposed [24], in our study, Self-directedness and Cooperativeness, but no other stable characteristics, were related to the presence of personality pathology. Thus, many DSM-IV PD subjects have an internal representation of themselves as faulty, ineffective, unresourceful, powerless, lacking a guiding principle, and unable to control desired outcomes. Furthermore, PD patients characteristically are more intolerant, self-serving, merciless, revengeful, and morally lax than NPD patients. The quantitative review of 10 published studies confirms that this association is true—although dissimilar in size—for both interviews and questionnaires and across all DSM PDs (Fig. 3). Overall, Self-directedness and Cooperativeness have median correlations with continuous measures of PD of −0.36 and −0.27, respectively, whereas respective medians are −0.30 and −0.24 for structured interviews and −0.47 and −0.32 for questionnaires. As for specific disorders, median correlations range between −0.14 (schizoid) and −0.58 (borderline) for Self-directedness and between −0.14 (dependent) and −0.49 (paranoid) for Cooperativeness. Thus, the TCI character dimensions outperform the Neo Five-Factors Personality

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**Fig. 3.** Median correlations (Pearson $r$) of DSM PD scores with Self-directedness (SD) and Cooperativeness (C) in 10 published studies. The studies reviewed were the following: TCI and Structured Interview for DSM Personality Disorders (SIDP-R) in 136 psychiatric patients [11]; TCI and SCID-Screen in 36 obsessive-compulsive patients [12]; TCI and SCID-II in 74 drug-dependent patients [14]; TCI and SCID-II in 256 bulimic or depressed patients [23]; TCI and SCID-II in 370 drug users [25]; TCI and Million Clinical Multiaxial Inventory (MCMI-II) in 103 psychiatric patients [26]; TCI (short) and SCID-II in 91 psychogeriatric patients [27]; TCI and Questionnaire on Personality Traits (VKP) in 148 general population subjects [28]; TCI and Coolidge II Inventory (CATI) in 163 college students [29]; and TCI and Personality Disorder Questionnaire–Revised (PDQ-R) in 103 psychiatric patients [30]. PAR indicates paranoid; SZD, schizoid; SQT, schizotypal; HIS, histrionic; NAR, narcissistic; BOR, borderline; ANT, antisocial; AVD, avoidant; DEP, dependent; OBS, obsessive-compulsive.
Evidence other than the TCI substantiates the relevance of these 2 dimensions in defining the PD construct. When Parker et al. [33] factorized 17 markers of disordered functioning gathered from the literature, they obtained 2 dimensions of “Non-coping” and “Non-cooperativeness.” The former was chiefly loaded by “Lacking self-direction,” “Self-defeating,” and “Ineffectiveness,” and the latter was composed of “Disagreeableness,” “Non-empathic,” and “Uncaring.” The authors concluded that “despite starting with a very wide set of indicative constructs, our final two-construct model is strikingly similar to that emerging from Cloninger’s studies” (p 236).

Nevertheless, although Self-directedness and Cooperativeness are undoubtedly at the very core of PD, our results qualify the statement that they “can be used to determine the presence or absence of personality disorder” [11, p 992], at least as diagnosed in the DSM-IV. In the present study, the TCI provides an excellent approximation to the PD diagnosis only in the absence of Axis I symptoms. For example, a subject who is not depressed or not anxious has an 80% probability of having a diagnosable PD if he/she scores less than 43 in both Self-directedness and Cooperativeness (positive predictive value) and a 93% to 94% probability of not having a PD if he/she scores more than 43 in either Self-directedness or Cooperativeness (negative predictive value). Our global probability of making a correct classification (hit rate) is 92% to 93%. However, the hit rate (0.77) and the κ (0.36) decrease markedly when the sample is unfiltered for depressive and anxious symptoms. Our accuracy then equals that reported by previous studies using the TCI, in which character dimensions correctly classify three quarters of patients [14,29], and it is also similar to both the median hit rate (0.76; range, 0.53-0.94) and the median κ (0.40; range, 0.14-0.86) of 26 previously published studies using other screenings [34]. Hence, it is advisable to administer the TCI when the subjects are euthymic [35]. Data are lacking as to whether other screenings are affected by the presence of Axis I symptoms.

Moreover, the TCI seems to be better at ruling out (85-99%) than it is at detecting DSM-IV PDs (29%-50%) across all levels of severity. Inferring that the TCI fails to detect half of all personality pathology is, however, conceptually questionable and does not take the peculiarities of our gold standard into account. Indeed, DSM diagnoses are based on the intensity of traits, not on dysfunction, and use problematic categories with arbitrary cutoffs. In the absence of a cogent standard for dysfunction, a more balanced conclusion is that the TCI captures the gist of DSM PDs but differs in its threshold levels and makes substantially fewer diagnoses than SCID-II does (15.6% vs 29.8%). This conceptual disarray is illustrated by our “undetected” subjects, who receive a PD diagnosis but nonetheless are able to effectively attain their goals, cope with difficulties, and establish pleasant, harmonious, and supportive relationships. Further research and reflection seem advisable on this point.

4.2. Ineffectiveness and uncooperativeness

The theoretical question that needs to be addressed is why completely different, or even opposite, styles of functioning (eg, avoidant, antisocial, or schizotypal) share the same features of low Self-directedness and low Cooperativeness. In our view, these dimensions reflect the operation of higher-order evaluative devices appraising 2 related domains: the individual’s chances of achieving motivated, relevant goals and his/her ability to maintain a supportive social network. Although these domains are central to fitness, they also seem to be easily impaired by almost any extreme trait.

On the one hand, Self-directedness is rooted in evaluative constructs such as self-esteem, self-efficacy, and locus of control that form, in fact, a unitary entity [24,36-38]. Self-directedness signals competitive advantage or disadvantage in a number of fitness-relevant parameters, such as physical strength, intelligence, power, prestige, or attractiveness. It also attests the individual’s ability to cope with difficulties resourcefully and to exert control over both their own behavior and the circumstances and, hence, to achieve desired, relevant life goals. Although Self-directedness has been conceived as a high-minded human faculty [39], homologous devices regulating goal-directed behavior and gauging effectiveness, control, or competitive advantage are widespread throughout the animal kingdom and have been assigned an ancestral adaptive value [40-43]. Self-assessment purportedly contributes to calibrate behavioral choices on the basis of past outcomes and to attend aspiration levels to the individual’s own abilities and flaws, often making the best of a bad job. For instance, it may limit losses by preventing vain, even detrimental, attempts, such as trying to attract unattainable mates, competing against superior opponents, or investing in other unduly expensive enterprises [44-47]. Although Self-directedness may afford, like any appraisal, a biased assessment of the individual’s talents and abilities, it probably indicates a true adaptive disadvantage in the case of PDs. Indeed, previous research suggests that overly pronounced traits, such as those collected by the DSM-IV, lead to suboptimal functioning in essential life areas, including self-preservation, accessing resources, independent functioning, group inclusion, gaining status, mating, or reproducing [48-53]. Thus, our contention is that PD subjects repeatedly implement inapt, inflexible strategies that lead to pervasive fitness failure and then to an enduringly biased self-concept. Although borderline, avoidant, and dependent disorders are the ones most characterized by low Self-directedness, all of them present a significant degree of perceived ineffectiveness [Fig. 3].

On the other hand, humans and other group-living species pursue many tasks that are essentially interpersonal or require the collaboration or the acquiescence of the
social environment. In turn, conspecifics are also a major source of threat, and severe consequences can be derived from being harassed or ostracized. Adaptive success is then largely a function of the individual’s social effectiveness, that is, the ability to understand others, negotiate hierarchies, reciprocate, defend ground, help allies, and, in short, form and maintain supportive social networks [46,54,55]. By contrast, PD subjects display long-standing interpersonal styles that disable them for communal living. For example, they can be excessively self-centered, volatile, helpless, callous, manipulative, or demanding or display otherwise frictional features that frustrate their social goals, increase mutual distrust, and inflict costs on themselves and those surrounding them [56-58]. Whereas paranoid, antisocial, and narcissistic are expectedly the least cooperative disorders, all of them present a noticeable degree of interpersonal dysfunction.

Thus, although long-lasting extreme styles of functioning do not by themselves constitute disorder, they plausibly entail defeated goals, unsolved problems, and curtailed opportunities. All in all, they undermine the bearer’s chances of successfully thriving within their physical and social environment (see also Wakefield [2], Livesley [5], and Cosmides and Tooby [54]). This adaptive failure is captured by Self-directedness and Cooperativeness, which thus become the earmark of personality pathology. However, low character scores are not exclusive to PD: Abased Self-directedness leads to, results from, or underlies other conditions, notably depression [35,59,60]. Low character scores can rather be viewed as signaling unspecified, canalized psychobiological conditions that result from a wide range of dysfunctional styles involving thwarted goals or disturbed relationships.

4.3. Limitations and conclusions

Our findings are subject to several limitations. First, although earlier studies have pointed out that specific PDs relate differently to character, our limited sample size has precluded any attempt to predict each disorder individually. Thus, useful information concerning the diagnostic accuracy of the TCI has been lost. Second, the use of a clinical sample has limited the scope of our study to treatment-seeking (and thus unsuccessful) subjects with extreme personality styles, whereas nontreated, “wild” extreme styles may not present impaired character. Finally, we have used the current gold standard, that is, DSM-IV diagnoses, to judge the diagnostic accuracy of the TCI. We are aware that categorical taxonomies experience a considerable number of drawbacks and make debatable assumptions, which may lead to the predictive ability of the TCI dimensions being undervalued [61,62].

In short, we suggest that Cloninger’s biosocial model and other dimensional, theoretically driven and empirically founded personality taxonomies can be used to guide DSM toward a better arrangement and understanding of traits and their consequences. Our study supports the hypothesis of a disorder construct that is not related to the intensity of any specific PD subtype but which is common to all PDs. Incidentally, it also supports the proposal that diagnosing a PD should involve 2 separate stages: assessing personality style and evaluating whether this style is causing adaptive failure [6,63,64]. The disorder construct has been shown to rely largely on internal representations of the self revealing ineffectiveness and uncooperativeness. In our view, this reflects the operation of specialized evaluative mechanisms attesting that PD subjects are armed with inadequate equipment—their suboptimal personality style—to succeed in attaining many, if not most, adaptively significant human goals.

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References


