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Personality Mapping: A Conceptual Framework for Surveying Personality Based on the Psychological Domains of Temperament, Attachment, World View, Mood Pattern and Coping Style

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Abstract

The subject of personality has long been recognized as a central aspect of psychiatry. And yet, despite volumes of research, the field remains lacking in a conceptual framework jointly embraced by researchers and clinicians, the former mostly concerned with dimensional constructs of personality and the latter favouring prototype based systems.

This article presents a conceptual framework as the basis for the systematic surveying of personality, whether in an academic or clinical context. It is necessarily theoretical in nature at this initial stage and, as such, modest in scope. It is primarily concerned with articulating an idea: a conceptual framework of personality comprising the five psychological domains of temperament, attachment, world view, mood pattern and coping style, which are familiar to researchers and clinicians alike. The distinctive feature and theoretical coherence of this model is due to the framework following the same sequence of steps as those on the path of personality development in the ordinary course of life.

Keywords: Personality mapping; Personality domains; Temperament; Attachment; World view; Mood pattern; Coping style

Introduction

'There is nothing so practical as a good theory' [1].

If we imagine someone's personality as represented by an individually fashioned crystal prism, and a life event or psychiatric disturbance as a ray of light beamed into that prism, then the resulting pattern of light that emerges from the other side will have been uniquely shaped by that particular prism's refractive qualities. So for any given patient, and whatever the primary diagnosis, personality is always a key consideration because of its inevitable bearing on clinical presentation, not to mention treatment and prognosis.

And yet, despite volumes of academic work spanning decades, we still don't have a widely adopted and practical model of personality that has been jointly embraced by researchers and clinicians [2-5]. Further, and perhaps because of this unsettled state of affairs, the evaluation and communication about an individual's personality seems often to receive only modest attention in everyday clinical practice. Seldom does pertinent information about the individual's personality appear to be put into productive service such as informing case formulation, forecasting the clinical course and planning treatment.

This paper presents a theoretically accessible framework for mapping personality with particular emphases on conceptual coherence and potential for clinical applicability. The central thesis concerns the basic modular structure of the framework itself which is then linked into, and fleshed out with, some familiar concepts drawn from the already established psychiatric literature.

Nosological Aspects of Personality: Prototype and Dimensional Models

Personality disorder prototypes, such as have been provided by the World Health Organisation's International Classification of Diseases (ICD) and the American Psychiatric Association's Diagnostic and Statistical Manual (DSM), have been widely used though with a few limitations that may perhaps not have been broadly appreciated. First, they haven't recognised some clinically meaningful diagnostic entities such as the depressive personality [6,7]. Second is the problem of heterogeneity within diagnostic categories [5,8]. And third, many patients present with either a sub-threshold picture or a medley of features from two or more personality types [2,5,8,9]. And so, whilst 'textbook' prototypes have represented significant reference points in the study of personality, they have been limited in applicability for those individuals presenting with sub-threshold presentations or with mixed features, accounting for between 17-70% of research cohorts [10,11].

Dimensional approaches have been numerous and varied in the research literature, many having been built on statistical processes and, inferring from the minimal migration into clinical practice, possibly tending to appear abstract. With regard to substantial texts, the DSM-5 has introduced a supplementary dimensional alternative to its traditional typology of personality disorders although, as mentioned above, it might also appear abstract in quality. Indeed, these parallel systems being offered in the one pre-eminent publication may be emblematic of the ongoing schism in this field. Another text, the Psychodynamic Diagnostic Manual [7] utilises a set of domains comparable to the one presented here though isn't predicated on this conceptual rationale, doesn't include the crucial domain of attachment, and employs the domains mainly in the service of deconstructing traditional diagnostic prototypes.

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So, our attention could instead be turned to considering a framework of personality based on the mapping of a set of psychological domains which are not only conceptually meaningful but also familiar to researchers and clinicians alike.

Before going further, however, some preliminary points need to be established. First, personality can be defined as the enduring, characteristic manner in which a person thinks, feels, behaves and relates to others [12]. Second, that interpersonal attachment constitutes a principal psychological dimension [13-16]. And third, that personality evolves from the interweaving of constitutionally inherent temperamental factors and acquired characterological features [17].

If we accept these points, we can then integrate them and rationally derive a mapping framework specifically comprising the psychological domains of temperament, attachment, world view, mood pattern and coping style. Moreover, and crucially, these domains are allied by virtue of their representing each of the sequential steps on the path of personality development in the ordinary course of life (see below), in effect 'carving nature at the joints' and in so doing providing this framework with its specific theoretically coherence.

Conceptual Rationale

So, the domains of temperament, attachment, world view, mood and coping pattern re-trace the naturally evolving, sequential process of personality development as follows: first, the child's temperament has a bearing on the 'goodness of fit' with the particular sensibilities of the primary parental figure(s) [15,18]. Next, the quality of this relational fit, whether favourable or otherwise, substantially impacts on the child's subjective quality of attachment. The subjective experience of the attachment, in turn, goes on to shape and colour his/her world view, be it broadly positive or negative, including an emerging, inner representational picture and narrative of him/herself and significant others, along with a matching set of emotional concomitants [14]. Given that attachment experiences can hardly all be favourable, the child is bound to come across adversities involving either under-exposure to benign experiences (such as interpersonal warmth, approval and security) or exposure to negative ones (such as domestic instability, neglect or traumas). So, in response to whatever unsettling notions and emotions that have begun to take form in his/her psyche, the child will then necessarily adopt some psychological or behavioural manoeuvres to, in one way or another, cope with that discomfort. And however 'dysfunctional', i.e. flawed or personally costly such coping manoeuvres may be, they are at least partially effective and generally the best that the person can manage at the time, and therefore tenaciously clung to. Hence the relatively enduring nature of personality.

The conceptual model presented below applies equally to personality in disordered and sub-clinical forms, with the designation of 'disorder' being determined by the presence of dysfunction, as evidenced by substantial suffering or adverse consequences for the person or others in his/her life. And so, if dysfunction is deemed to be both a necessary and sufficient criterion for designating clinical caseness, this then dispenses with problematic polythetic and prototype diagnostic requirements in the currently prevailing classification systems.

Temperament

Temperament refers to relatively characteristic inherent patterns of responding to circumstances, evident from childhood and considered mainly constitutional i.e. genetic in nature. These tendencies may be manifested in various forms such as through autonomic, emotional or behavioural patterns.

Numerous categorisations of temperament have been described, some of which include: Thomas and Chess's typology comprising 'easy', 'difficult' and 'slow-to-warm' children [18], Cloninger's set of 'novelty seeking', 'harm avoidance', and 'reward dependence' traits [17], and Kagan's 'high-reactive' and 'low-reactive' infants with differential tendencies regarding behavioural inhibition [19].

Zentner and Bates reviewed and rationalized the various typologies into an integrated set comprising behavioural inhibition, irritability/frustration, positive emotionality, activity level, attention/persistence and sensory sensitivity [20]. As has generally tended to be the case with dimensional models, and as previously mentioned above, these terms likely have greater resonance for researchers than clinicians. The latter would possibly relate better to established, familiar and useful constructs such as introversion/extraversion.

With regard to the conceptual model presented in this paper, the intention here is simply to recognise temperament as (i) a relatively enduring constitutional tendency and (ii) the first stepping stone on the path of the evolving personality.

Attachment style

Researchers have outlined various informative perspectives on attachment [13,14,21,22]. Bartholomew examined attachment patterns in adults involving the dual axes of positive/negative model of self and positive/negative model of others, which define four quadrants of clinically pertinent attachment patterns, namely secure, preoccupied, fearful and dismissing [23]. Birtchnell's octagonal model of interpersonal patterns [24] incorporated the dimensions of closeness/nearness and upper/neutral/lower relational position. This model was presented in two parts: one illustrating positive attachment patterns, the other, and negative. The architecture of the latter was used as an octagonal grid within which the ICD or DSM personality disorder types could be positioned.

In its most essential distillation, however, attachment can be conceptualised in terms of the dual aspects of being able to feel secure in oneself, and in others. The former correlates with an individual's sense of confidence/autonomy, and the latter with the capacity for intimacy/trust. Individuals who don't feel secure on their own, and tend to be needy of interpersonal proximity, are described as having an anxious attachment. Those who feel uneasy with interpersonal closeness and trust, have an avoidant attachment [16].

In the interest of exploring this more, we could go one step further and cluster the familiar personality prototypes on a grid of four quadrants defined by the two intersecting axes of high/low autonomy and high/low intimacy. As an illustration**:** in clinical practice, one not infrequently encounters the sort of person who is habitually suspicious, aloof, oversensitive, querulous and pedantic. Such an individual can be formulated in terms of suffering fundamentally from a sense of inter-personal insecurity i.e. a low capacity for intimacy/trust and associated features such as heightened sensitivity to criticism, rejection or feeling diminished and reacting accordingly, whereas according to DSM he/she would be considered to have features from all three personality clusters A, B and C, a less parsimonious perspective.

And so, whilst recognising the over-generalisations involved in the following exercise, and therefore presented here only for the purpose of conceptual illustration:

- People with schizotypal, schizoid, paranoid, psychopathic, narcissistic, obsessional and avoidant personalities generally tend to

have greater difficulty with intimacy/trust

- Those with dependent, histrionic and somatising personalities [25] would likely have a greater struggle with confidence/autonomy
- People with a borderline personality structure, including those considered 'high-functioning', are more psychologically complicated and vulnerable because of their difficulties with both autonomy and intimacy, and
- Those with depressive and sub-clinical personalities wouldn't necessarily be significantly troubled in either of these two regards.

World view

This section, which could alternatively be termed 'inner representational model', 'core belief set' or 'life narrative', refers to the way in which people think about themselves, their world and life in general. Some aspects of this, which could be considered sub-domains, include

- A view on the world underpinned by a recursive central theme
- A sense of personal identity comprising one's life narrative, personal values, strengths and weaknesses, and self-worth/esteem
- Attributional style: the tendency to view one's past, current or future as contingent on the person him/herself or others
- A general tendency to holding either integrated or split perspectives on various matters
- The capacity for mentalisation: 'the ability to see ourselves from the outside (as others see us) and others from the inside' [26]
- A set of enduring, deep-seated wishes and fears

Mood pattern

Though many researchers have attempted to identify and catalogue the 'basic emotions', there has been universal consensus on only three: fear, anger and sadness [27].

There are certain aspects to be considered when evaluating mood patterns. First, people often find it difficult to put their emotional experiences into words for the reason that feelings are innately more ineffable in comparison to thoughts and behaviours [27]. Consequently, and second, in assessing personality, clinicians find themselves necessarily more heavily reliant on impressionistic, non-verbal cues from the patient, which introduces an element of clinician subjectivity which, though unavoidable, nevertheless sits uneasily with the traditional emphasis on objectivity in clinical assessment.

Third: emotions are located at different depths in the psyche such that those that are closer to the surface tend to overshadow those below. The differential layering i.e. degree of overtness of various emotions, comes about, in part, from people being more inclined to talk in terms of those feelings, such as 'depression' or 'anxiety', which might tend to elicit a relatively supportive response, than reporting unseemly sentiments such as anger, disgust, mistrust or envy. Patients are also less inclined to mention emotions that stir within them deeper forms of anguish such as grief, guilt or shame.

Fourth: discourse on coping patterns or ego defences is usually focused around cognitive and behavioural manoeuvres for mitigating distress. Rarely is there mention of the phenomenon whereby one affect, though of itself unwelcome, has a net benefit by defending the person from another even more distressing affect. To illustrate**:** someone who for much of the time feels 'depressed' may suffer an intervening psychological insult that exacerbates his/her habitual sense of inadequacy or demoralisation to beyond a tolerable level. This triggers the emergence of anger which serves to fortify the individual and restore morale. Afterwards, however, remorse about the anger sets in which then ushers the now unwelcome anger backstage once again, thus priming the scene for the next re-activation. Clinicians would be familiar with this oscillating pattern of affects, often seen in people with an oversensitive and vulnerable personality structure for whom either of the 'deflated' or 'inflated' positions mentioned above may represent the default position [28].

Coping style

The numerous ways in which people cope with psychological discomfort and stressful situations have already been well described in the literature, mostly in either behavioural or psychodynamic terms of 'ego defences'. Some common examples would include avoidance, denial, rationalising, blaming others, anger, exerting control (on self or another), capitulating, regressing, overcompensating, self-medicating and distraction through various means. There are however a few general points to be mentioned.

First, the degree of dysfunctionality of a coping response may be as much related to its intensity or frequency of deployment as the nature of the response itself although some, such as self-harm, are self evidently aberrant. Second, we sometimes lose sight of the obvious, namely (and notwithstanding the few who present to mental health services with ulterior motives) that people generally do the best that they can at the time, given their psychological and personal wherewithal, and that a notionally maladaptive way of coping necessarily contains an adaptive component as regards the person's primary drive toward mitigating discomfort, and which is therefore unlikely to be readily relinquished. In other words, the person's way of coping can represent both a solution and a problem: hence their enduring stuckness. And third, that coping responses can often be more lucidly described in clear, plain language than in overused and sometimes misconstrued psychological jargon.

Applicability to Clinical Practice

As an illustration of the complementary relationship between some of the different aspects of personality mentioned above, in clinical practice one sometimes sees patients referred with an apparently nondescript form of 'depression' who are troubled by an ill defined yet ever present unease with a vaguely existential flavour.

Such cases may have eluded a fitting formulation and diagnosis but can, actually, be understood in terms of a disturbance involving a gap in, or incongruence between, the interconnected characterological aspects of (i) what the person truly believes in (ii) what he/she desires (iii) how he/she actually conducts his/her life, and (iv) their sense of personal identity.

Such formulations can be facilitated by the use of a personality map. This may then help to inform treatment planning such as, in the case above, suggesting a specifically more existentially oriented approach to therapy instead of a generic one or one directly targeting the presenting symptoms.

And so, as outlined and illustrated above, this mapping framework may serve to provide

- A system to help organise the gathering, organising and presenting of clinical information

- Diagnostic precision resulting from the assemblage of individually evaluated parcels of information for each of the domains
- A framework for the various domains to be appraised against each other in order to test the internal coherence of the overall personality portrait, including sometimes seemingly contradictory information presented in clinical practice. This appraisal is made possible because the model is inclusive both of the person's underlying base psychological state and the superimposed layers of self-protective psychological responses
- A vantage point for identifying, and hypothesising about, as yet uncharted territories of the patient's psyche
- Assistance in navigating through the clinical tasks of case formulation, forecasting difficulties and tailoring treatment.

Conclusion

The traditional prototypal models of personality, whilst convenient and appealingly straightforward in concept, have had some limitations. In particular, because of within category heterogeneity and cases with mixed features or sub-threshold presentations, such diagnostic prototypes have not necessarily translated well into everyday clinical work with a substantial number of individual patients who don't conform to a specific prototype.

On the other hand, the dimensional approaches in circulation to date, as illustrated in DSM-5, have been perhaps more heavily constructed upon comparatively abstract theoretical rationales and advocated on the basis of statistical methodologies. But despite, or perhaps because of, this, dimensional approaches have just simply not been widely embraced by practicing clinicians in their everyday work.

The conceptual framework presented in this paper is centred on a set of five clinically familiar domains - temperament, attachment, world view, mood pattern and coping style - that re-trace the naturally evolving, sequential process of personality development. This gives this model a conceptual coherence and accessibility that might be sufficiently acceptable to researchers and clinicians alike for further consideration.

So to summarise, the domains and subcomponent aspects of personality comprise:

- Temperament aspects e.g. introversion/extraversion
- Attachment
- Feeling secure in self: capacity for personal autonomy, self-reliance and tolerance of aloneness
- Feeling secure in others: capacity for trust, intimacy and interdependence
- World view
- Recurring core theme about life and the world
- Sense of personal identity comprising: life narrative, personal values, strengths and weaknesses, and self-worth/esteem
- Attributional style
- Tendency to integrated or split perspectives
- Capacity for mentalisation
- Set of enduring core wishes and fears
- Prevailing mood pattern
- Coping style, including customary psychological defence mechanisms and behaviours

Limitations

The paper is theoretical in type and as such needs to be modest in scope at this first stage of the scientific process which, as always, begins humbly with just the spark of an idea. And so this paper has been firmly circumscribed to, and focussed on, just two principal objectives: describing the actual conceptual framework itself and articulating the underpinning theoretical rationale.

It is also recognised that an individually tailored personality map, though providing a degree of precision in the evaluation of the individual patient, obviously cannot compete with an incomparably succinct, one word ICD or DSM prototype label and is therefore not going to impact on the currently prevailing approach to diagnosis in clinical practice. Instead, the mapping approach is better suited to (i) the process of clinical assessment and case formulation (ii) psychotherapy patients (iii) reviewing complicated or treatment refractory cases and (iv) teaching and training purposes.

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