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Personality and Mental Health

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1. Introduction

The importance of personality to mental health entails accurate definition of both personality and mental health. According to World Health Organization (WHO) health is defined as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 2001b, p.1). Mental health and mental well-being are included in the foregoing definition of health which emphasizes on considering mental health as a construct interconnecting with other variables in a unified context. In addition of, this definition, psychologists deal with mental health in some terms. looking at the realm of mental health, we meet terms such as mental health (WHO, 2001), “psychological health” (Rosenthal & Hooley, 2010), well-being (Josefsson et al., 2011), “subjective well-being” or “happiness” (Lucas & Diener, 2008; Ryan and Deci, 2001), “Psychological well-being” or “eudaimonia” (Cloninger & Zohar 2011; Wood, Joseph, & Maltby, 2011) “mental hygiene” (Barenbaum & Winter, 2008) and “psychological wealth” (Diener & Biswas-Diener, 2008) that need to be explained in order to illustrate a correct definition and understanding of mental health. Thus, it is clear that, mental Health cannot be considered separately, and in order to have a better understanding of mental health, its major components such as physical, mental, and spiritual well-being should be considered together (Cloninger & Zohar, 2011).

Personality, which is the main concentration of this chapter, is defined as **an individual's characteristic style of behaving, thinking, and feeling**” (Schacter, Gilbert, & Wegner, 2009). Although there has been much debate about the definition of personality, two major themes have pervaded nearly all efforts at domain of personality theorizing: human nature and individual differences (Buss, 2008). The way we think, feel and behave and our unique individuality have significant contribution in our mental health as in our psychopathology. Some individuals are more prone to mental illness and psychopathology because of their characteristics and personality traits (Hampson & Friedman, 2008), whereas some others experience higher level of mental health because of their personality traits and characters (Cloninger, 1999, 2004; Seligman et al., 2005; Wood & Tarrier, 2010). Therefore, it seems that some individuals are more susceptible to mental illness, thereby threatening their mental health.

Another controversy in personality psychology addresses the nature and domain of personality. Do personality traits locate as some separate constructs that are either present or absent in individuals? Or they should be considered in a continuum? The answer to this question has grave theoretical and practical implications not only in personality psychology,

but also in mental health. The purpose of this chapter is to explain and debate important role of personality in mental health in a comprehensive context and finally accentuate and propose prospective areas of personality regarding to both mental health and mental illness.

2. Domain of personality

Personality psychology seems to be the broadest and most integrative branch of the psychological sciences (Buss, 2008). The recent calls for integration in psychology, entails us to have a more unified and integrative approach toward behavior and psychological process of individuals. This integration has also addressed personality psychology (e.g., Mayer, 2005; Mischel & Shoda, 2008). Integration in personality psychology is depicted in new frame work in personality suggested by Mayer (2005). In the field of personality, there used to be a perspective-by-perspective framework that causes personality psychology get fragmented by theories; however, Mayer (2005) suggests the systems framework for personality which leads to the integration of personality that can naturally promote integration as well as a vision of the whole person.

While, Mayer (2005) proposes integration of personality in a broad scale, encompassing all psychology, Mischel and Shoda (2008) on the other hand, argue about unification within personality theories and concepts. They point to the two main approaches in personality: dispositional approach and processing approach. Mischel and Shoda (2008), reconcile these two approaches within a unifying framework at least in the abstract. They analyze both the distinctive behavior patterns that characterize the exemplars of a disposition and the psychological processes and mediating units that underlie those.

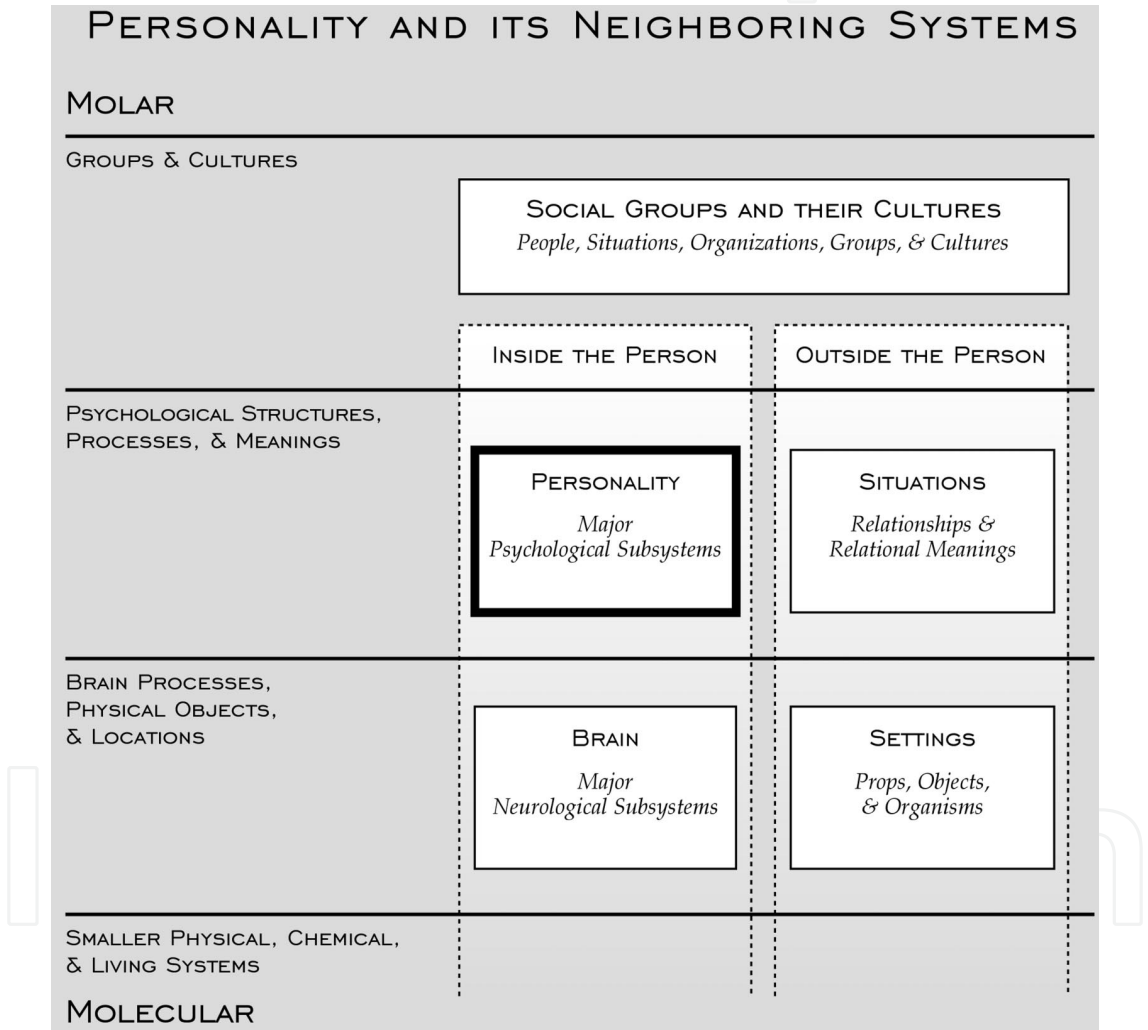
On balance, Mayer's new frame work in personality (2005) seems more successful in regard to mental health because of its broad inclusion of biological, psychological, and social systems. Understanding that personality connects the biological and social helps identify its location. The biological, psychological, and social systems are connected, in part, along a continuum called the molecular-molar dimension (Mayer, 2005). In the figure 1 Mayer, illustrates the integration of personality psychology. The molecular end of the dimension refers to smaller systems of interest—at its extremes, subatomic particles. The molar end refers to larger systems—at its extremes, the entire universe as a system (Henriques, 2003; Levy-Bruhl, 1903). The middle range of this dimension separates psychology from its biological neighbors below and its larger sociological and ecological systems above.

Considering this approach to personality, the biological, psychological and social and cultural factors with regard to mental health are appreciated. Thus I believe that when we address mental health issues, personality as described above, can provide a broader as well as a more realistic view toward mental health. Each perspective may address mental health problems with more emphasize on a specific set of variables, rather than in a multivariable context. Thus, personality should be considered as an integral part whenever we tackle either mental health or mental illness. The role of personality in determining mental health and mental illness is quite prominent and can lead to theoretical implications in the realm of research toward mental health and practical implications in community level.

2.1 Personality traits vs personality processes

I like to point briefly to a new developed approach in personality psychology that bring about new implications for issues in models of personality structure, methods of personality

assessment, and identifying targets for personality interventions. As we know Reviews of studies documenting associations between personality traits and important life outcomes amply confirm the predictive power of personality. Personality traits predict consequential Outcomes for individuals (e.g., happiness, longevity), couples (e.g., relationship quality), groups, and society (e.g., volunteerism, criminality). These reviews provide an extensive catalogue of *what* personality predicts but do not examine *how* personality gives rise to these associations (Hampson, 2012). According to Hampson (2012) Understanding personality processes or “*how*” of personality, goes beyond describing individual differences by explaining the expression of Individual differences. Adopting this approach in personality researches allows us understanding the predictive power of personality in our life and how personality can mediate or moderate our mental states.



Note. The horizontal lines represent levels of the molecular–molar continuum. The “Inside the Person” box shows personality and its emergence from major psychological subsystems and from the brain. The “Outside the Person” box shows the psychological situation and the setting from which it emerges. Both personality and the situation are incorporated within larger social systems (shown above them). Adapted from Figure 1 in “Classifying Change Techniques According to the Areas of Personality They Influence: A Systems Framework Integration,” by J. D. Mayer, 2004, *Journal of Clinical Psychology*, 60, p. 1296.

Fig. 1. Personality and its Neighboring Systems.

3. Relationship between personality and mental health: unidirectional or bidirectional?

What is the nature of relationship between personality and mental health? It is clear that personality traits and characters of individuals affect their mental health (Josefsson et al., 2011; Cloninger & Zohar, 2011). But the question is that how these personality traits and characters affect individuals in a way that promote mental health and wholesome behaviours. Is this relationship unidirectional, in a way that personality as an independent structure, determines mental states of individuals? Or personality can be affected by the presence or absence of mental health too? To answer this question we should primarily define both personality and mental health.

3.1 Definition of personality

Your intuitive understanding of personality is probably very similar to the way that psychologists define the concept. **Personality is an individual's characteristic style of behaving, thinking, and feeling** (Schacter, Gilbert, & Wegner, 2009). Consider this definition regarding the figure 1 in order to draw a more accurate concept of personality in your mind. Besides of personality, personality disorders are notable with regard to mental illness. The conceptualization of personality disorders in DSM-IV-TR represents the categorical perspective that personality disorders are qualitatively distinct clinical syndromes (American Psychiatric Association, 2000, p. 689), which are distinct from each other and from general personality structures (Shedler & Westen, 2004; Skodol et al., 2006). This categorical classification is problematic from both theoretical and practical points of view. It has been argued that the current personality disorder classification in DSM is neither theoretically sound nor empirically validated (Aboaja, Duggan, & Park, 2011). The categorical model of classification has become so problematic that a Research Planning Work Group for DSM-V concluded that it will be "important that consideration be given to advantages and disadvantages of basing part or all of DSM-V on dimensions rather than categories" (Rounsaville et al., 2002).

In contrast to DSM-IV-TR, Psychodynamic Diagnostic Manual (PDM) and recent evidences (Rounsaville et al., 2002) suggest a dimensional model for personality disorders and personality traits. Dimensional model for personality suggest a spectrum relationship in regard to personality and personality disorders (Widiger & Smith, 2008). It would appear more likely that personality disorders are on a spectrum with general personality structure. This spectrum relationship may also exist for personality disorders and Axis I mental disorders. (Widiger & Smith, 2008). Adopting this view toward personality has some important implications with regard to mental health; Personality traits which affect mental health can be found in each individual. The intensity or weakness of these traits is different in individuals and these differences are responsible for mental states to be healthy or unhealthy. In what follows, I will discuss more about the consequences of spectrum relationship in mental health.

3.2 Definition of mental health

The term 'mental health literacy' was first coined by Jorm et al. (1997) meaning 'knowledge and beliefs about mental disorders which aid their recognition, management or prevention' (p.182). As it is said earlier, WHO has included mental well-being in the definition of health.

WHO famously defines health as: a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 2001b, p.1). Three ideas central to the improvement of health follow from this definition: mental health is an integral part of health, mental health is more than the absence of mental illness, and mental health is intimately connected with physical health and behavior (WHO, 2001a). WHO has recently proposed that mental health is: a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO, 2001b, p.1).

Realizing abilities, coping with stresses, and working productivity are some behaviors and according to definition of personality, these style of behaving are determined by personality. When we notice to definition of other related terms to mental health, we find the relationship between personality and mental health more vivid. "Subjective well-being" has been defined as an individual's evaluation of his/her life as a whole (Diener, 1984;) this individual evaluation can be affected by the way of thinking or feeling in which personality account for this. Well-being is the other term in the realm of health and mental health. Well-being is a multidimensional concept that includes Various aspects of mental and physical health, supporting social relationships, and ability to cope with stressful situations (McDowell, 2010; Stokes, et al., 1982). Subjective well-being and subjective health are more highly correlated with each other than subjective health and objective physician assessed health (Josefsson et al, 2011). Subjective well-being which is an integral component of well-being thus, is related with personality.

"Psychological health" (Rosenthal & Hooley, 2010), well-being (Josefsson et al., 2011), "subjective well-being" or "happiness" (Lucas & Diener, 2008; Ryan and Deci, 2001; Luhmann et al., 2012), "Psychological well-being" or "eudaimonia" (Cloninger & Zohar 2011; Wood, Joseph, & Maltby, 2011) "mental hygiene" (Barenbaum & Winter, 2008) and "psychological wealth" (Diener & Biswas-Diener, 2008) are terms and concepts in the realm of mental health each one points to psychological functioning and determines styles of behaving leading to healthy state. Therefore, personality which directs our ways of thinking, feeling and behaving is an undeniable construct in determining these healthy states. Finally we should appreciate the role of culture with its given values which can affect directly or indirectly health and mental health through beliefs, expectations, values and ingroup concepts (Bagherian, Rocca, Thorngate, & Salehinezhad, 2011)

3.3 Relationship between personality and mental health

We realized definition of personality and mental health. The question is that how their relationship is shaped? Many studies have shown the effect of personality, personality traits, and personality dimensions in mental health (e.g., Josefsson et al., 2011; Cloninger & Zohar, 2011; Cloninger, 1999; Cloninger, 2004; Cloninger, 2006; Diener & Biswas-Diener, 2008; Aboaja, Duggan, & Park, 2011; Chan & Joseph, 2000; Herero & Extremera, 2010; Wood & Tarrier, 2010; Joseph & Wood, 2010). A cumulating body of research suggests that there are variables such as personality traits that predispose individuals to experience specific life events (Luhmann et al., 2012). However, as we know, personality is conceptualised as an unchanging aspect of the person (Chan & Joseph, 2000) at least according to dispositional approach (Mischel & Shoda, 2008). According to Widiger and Smith (2008) an Axis I disorder can alter the appearance or expression of premorbid personality traits. Persons who are very anxious, depressed, angry, or distraught will often fail to provide an accurate description of their general personality traits

(i.e., their usual way of thinking, feeling, behaving, and relating to others). Presence of a mental disorder negatively affect individuals in realizing their abilities and coping with stress as well as making them dysfunctional in important areas of life and this is in opposition with mental health. Thus presence and absence of mental health can alter the appearance and expression of personality traits. Finally recent evidence even suggest that the relation between life events and subjective well-being may be bidirectional (Luhman et al., 2012)

4. Personality and mental illness

Mental illness or, in other word, “psychopathology” is a term that can facilitate our conceptualization of mental health. This is more intelligible when we consider that mental illness (MI) and mental health (MH) have been recently considered to be bipolar extremes of the same underlying dimension (Insel & Scolnick, 2006; Keyes, 2007; Pressman & Cohen, 2005). By measuring psychopathology symptoms in mental health studies, we can set the findings in a broader perspective of well-being and ill-health (Josefsson et al., 2011). The concept of mental health requires an understanding of abnormal behavior leading to mental illness. Normality and abnormality cannot be differentiated objectively. They reside on a continuum and slowly fade into the other (Millon et al. 2004). Mental health and mental illness are the same. They cannot be considered separately. An individual with mental illness does not experience the state of mental health. By recognizing and examining the personality factors related to psychopathology, the relationship between personality and mental health would be clear in turn.

It is notable that we consider, although mental illness (MI) and mental health (MH) have been considered to be bipolar extremes of the same underlying dimension, this viewpoint has begun to be questioned. There are now some indications that positive and negative aspects of psychological experience are mediated by different psychological systems (Keyes, 2007, 2009; MacLeod & Moore, 2000; Pressman & Cohen, 2005). Thus, low levels of a mental illness characteristic such as depression does not guarantee high levels of mental health characteristic such as optimism. What we can claim with more certainty is that various combinations of both MI and MH are possible (Keyes, 2007). Thus, with regard to psychological treatment of clients and considering researches in the realm of mental health we need to take into account the level and characteristics of MH as well as those of MI (Alterman et al., 2010).

Understanding the role of personality can help us understand mental health and that's why in this part, the relationship between personality and psychopathology is discussed. The importance of personality to psychopathology has been recognized since the beginnings of medicine (Widiger & Smith, 2008). Hippocrates (in the fourth century b.c.) distinguished between four fundamental dispositions (i.e., sanguine, melancholic, phlegmatic, and choleric) that were thought to provide a vulnerability to a variety of physical and psychological disorders (Maher & Maher, 1994). Moreover, in recent years personality and mental health have been studied in large amount of researches (e.g., Akiskal, Hirschfeld, & Yerevanian, 1983; Clark, Watson, & Mineka, 1994; Eysenck, 1987; Krueger, McGue, & Iacono, 2001). Contemporary theoretical models directly link personality with psychopathology (Pincus, Lukowitsky, & Wright, 2010; Widiger & Smith, 2008), and cross sectional research finds links between personality and psychopathology of most types and Personality disorders in particular (Wright, Pincus, & Lenzenweger, 2011).

Krueger, McGue, and Iacono (2001) provided interesting findings about relationship between personality and psychopathology. They found a connection between the higher-order structure of common DSM mental disorders and personality. This higher order structure includes internalization and externalization. These two fundamental dimensions of child psychopathology map well also onto the adult psychopathology and fundamental personality temperaments (Widiger & Smith, 2008). Krueger et al (2001) point to personality as a covariance, meaningfully account for comorbidity among mental disorders. They found that internalization was linked with higher negative emotionality and lower positive emotionality and externalization was linked with lower constraint. In general, they found that comorbidity could be modelled by hypothesizing the existence of broad, continuous variables underlying observed patterns of correlation among DSM constructs. These broad variables, in turn were linked to broad variables from the personality literature. This refers to a vulnerability model of the relationship between personality and mental disorder; a model in which personality contributes to the risk of experiencing mental disorder (Krueger et al, 2001).

It is notable that in relationship between personality and psychopathology, we should include both maladaptive personality functioning - as described within the American Psychiatric Association's (2000) Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) - as well as normal personality traits, as described within dimensional models of general personality structure such as Big Five theory. In respect to this relationship there are three important potential forms of interplay between personality and psychopathology: first, Personality and psychopathology can influence the presentation or appearance of one another (pathoplastic relationships); second, they can share a common, underlying etiology (spectrum relationships); and third, they can have a causal role in the development or etiology of one another (Widiger & Smith, 2008).

4.1 Pathoplastic relationship

The influence of personality and psychopathology on the presentation, appearance, or expression of each is typically characterized as a "pathoplastic relationship" (Widiger & Smith, 2008). As it was pointed earlier about bidirectional the relationship between personality and mental health, the relationship between personality and psychopathology is bidirectional too. Consequently, personality traits can affect on appearance of psychopathology and the appearance or presentation of personality can similarly be affected by the presence of a psychopathology.

4.1.1 Pathoplastic effects of personality on psychopathology

Mental disorders occur within the context of a premorbid personality structure that often has a profound effect on their presentation, course, or treatment (Millon et al., 1996). This is better intelligible when we know that mental disorders are clinically significant impairments in one or more areas of psychological functioning including one's thinking, feeling and behaving (American Psychiatric Association, 2000). Thus, a person's characteristic manner of thinking, feeling and behaving that we call it as personality, can affect these significant impairments.

As an example it can be refer to anorexia nervosa and bulimia nervosa (Widiger & Smith, 2008). The primary distinction between persons with anorexia nervosa and those with

bulimia nervosa is perhaps simply that the former are pathologically successful in the effort to maintain a low body weight (i.e., are grossly underweight), whereas persons with bulimia nervosa are relatively unsuccessful, due partly to their binge eating and inadequate (but still excessive) compensatory behaviors. This fundamental distinction could be driven, in large part, by premorbid personality differences. It is possible that those who go on to develop anorexia are characterized in part by premorbid personality traits of very high conscientiousness (Widiger & Smith, 2008).

Another example in regard to this pathoplastic relationship of personality and psychopathology refers to depression. Studies about relationships between depression and Temperament and Character Inventory (TCI), usually show that depressed patients exhibit higher harm avoidance and self-transcendence scores as well as lower self-directedness and cooperativeness scores as compared to healthy controls (Hansenne et al, 1999; Marijnissen et al, 2002). Personality features may predispose an individual to depression; the personality can be modified after a depression; the personality can modify the clinical presentation of a depressive disorder; and finally the personality can be considered like a subclinical manifestation of a depressive disorder (e.g., Akiskal et al., 1983; Hirschfeld et al., 1997).

4.1.2 Pathoplastic effects of psychopathology on personality

Just as premorbid personality traits can alter the appearance or expression of an Axis I disorder, an Axis I disorder can alter the appearance or expression of premorbid personality traits (Widiger & Smith, 2008). Persons who are very anxious, depressed, angry, or distraught will often fail to provide an accurate description of their general personality traits (i.e., their usual way of thinking, feeling, behaving, and relating to others). Distortion in self-image is a well-established symptom of mood disorder (American Psychiatric Association, 2000), and it should not be surprising to find that persons who are depressed provide inaccurate descriptions of their usual way of thinking, feeling, and relating to others. Once their mood, anxiety, or other mental disorder is successfully treated, their self-description changes accordingly.

Some may argue that personality is a relatively stable structure and psychopathology cannot change or alter personality, however some well-documented studies reveal the existence of such a relationship (e.g., Clark & Harrison, 2001; Farmer, 2000; Vitousek & Stumpf, 2005; Widiger & Samuel, 2005). According to processing approach, personality is an organized system of mediating units (e.g., encodings, expectancies, goals, motives) and psychological processes or cognitive-affective dynamics, conscious and unconscious, that interact with the situation the individual experience (Mischel & Shoda, 2008). Personality in this approach is a dynamic construct which operates across social situations as well as it can be influence from social behaviour.

In sum, pathoplastic relationship between personality and psychopathology is a notion with practical implications, which should be considered in mental health research. An important theoretical and practical implication implies that psychological problems can predispose individuals to develop morbid personality traits which in turn can intensify the psychological problems. On the other hand there are some kinds of personality profiles which can promote mental health (e.g., Josefsson et al, 2011; Herero & Extremera, 2010; Chan & Joseph, 2000; Unterrainer et al, 2010) which will be discussed in this chapter.

4.2 Spectrum relationship

It used to be assumed that personality and psychopathology are distinct entities. Looking at Diagnostic and statistical manual of mental disorders, 4th edition (DSM-IV), show attempts in order to provide a more accurate diagnostic criteria in mental disorders, including personality disorders. The assumption of the diagnostic manual is that the categories refer to distinct clinical entities, each with its own distinguishable etiology, pathology, and treatment (Widiger & Mullins-Sweatt, 2007). However, personality and psychopathology may themselves fail, in some instances, to be distinct entities. They may instead exist along a common spectrum of functioning. For example, rather than contributing to the etiology of depression, neuroticism may itself be a form of a depression (Widiger & Smith, 2008). In contrast to DSM-IV-TR, Psychodynamic Diagnostic Manual (PDM) and recent evidences (Rounsaville et al., 2002) suggest a dimensional model for personality disorders and personality traits.

This spectrum relationship exists in some ways such as: Personality on a Spectrum with Personality Disorders, Personality Disorders on a Spectrum with Axis I Mental Disorders, and Axis I on a Spectrum with Personality (Widiger & Smith, 2008). This dimensional approach to personality, personality disorders and mental disorders accompanies with beneficial implication in the realm of mental health. The first and most important one involves our attitude toward mental health research; identification and differentiation of etiological relationships of personality and psychopathology cannot be considered with simplicity. Actually it is more complicated because of observable overlapping and comorbidity that exists among mental health problems specially. This approach affects the way clinicians meet mental disorders, as well as research guidelines we adopt toward psychopathology and mental illness problems. That is why the American Psychiatric Association (APA) subsequently cosponsored a series of international conferences devoted to further enriching the empirical database in preparation for the eventual development of DSM-V (Widiger & Smith, 2008).

The other important theoretical and practical implication refers to inclusion of mental health. Mental health is a pervasive issue which can be endangered and this can happen to everyone, rather than a specific group of afflicted people suffering from mental problems. In fact mental health issues can afflict each individual based on styles of thinking, feeling and behaving. By adopting this approach, community psychologist and researchers in the areas of mental health will have better conceptualization of mental health problems.

4.3 Causal relationship

The third form of interplay between personality and psychopathology refers that they can have a causal role in the development or etiology of one another. This causal relationship is again bidirectional: One's characteristic way of thinking, feeling, behaving, and relating to others can 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 in personality (Widiger & Smith, 2008). Personality can change for the better or worse. The ICD-10 (World Health Organization, 1992) contains a number of mental disorder diagnoses that concern maladaptive changes to personality functioning occurring within adulthood; however, this is not noticeable in DSM-IV. As it is noted earlier personality is conceptualised as an

unchanging aspect of the person (Chan & Joseph, 2000). This reluctance toward immutability of personality is because there is little empirical research to document the reliability or validity of such personality change (Chan & Joseph, 2000; Widiger & Smith, 2008).

The assertion that an individual's personality has changed or remained the same over time is ambiguous. 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 fundamental and lasting effect on one's characteristic manner of thinking, feeling, and relating to others (e.g., Caspi et al., 2005; Roberts & DelVecchio, 2000; Srivastava, John, Gosling, & Potter, 2003). Thus, severe mental problems and mental health problems can affect or even alter personality. Looking at other side of this relationship, the casual effects of personality on mental problems is well documented (e.g., Marijnissen. Et al., 2002; Furukawa et al., 1998; Krueger et al., 2001).

5. Personality and mental health

Much is known about the relationship of personality to psychopathology (Cloninger, 1999), but much less is known about the relationship of personality to health as a state of physical, mental, and social well-being (Cloninger, 2004). In recent decades, health-related researches and health care have focused on negative mental processes such as Psychological distress and dysfunction, while positive mental processes such as psychological well-being have been much less studied (Huber et al., 2008). Mental health professionals need to understand the relationship between personality, well-being and mental health in order to help motivate both the promotion of health and the reduction of distress and disability (Amering & Schmolke, 2009; Cloninger, 2006).

In contrast to previous studies of clinical psychologists who were interested in understanding distress (Wood & Tarrier, 2010) and alleviating human suffering (Joseph & Wood, 2010), positive psychology research can best impact on the scientific knowledge base of psychology, and be utilized to improve people's lives (Wood & Tarrier, 2010). Normal personality traits are described within the dimensional models of general personality structure. It has been proposed that most of the problems in treating personality disorders could be resolved based on normal personality (Aboaja, Duggan, & Park, 2011). By considering personality and personality disorders on a spectrum (Widiger & Smith, 2008), the contribution of personality in mental health and well-being would be more clear.

5.1 Models of personality

There are some prominent models of personality including: Eysenck's (1987) three dimensions of neuroticism, extraversion, and psychoticism; Harkness and McNulty's five factors of positive emotionality / extraversion, aggressiveness, constraint, negative emotionality / neuroticism, and psychoticism (Harkness, McNulty, & Ben-Porath, 1995); Tellegen's (1982) three dimensions of negative affectivity, positive affectivity, and constraint; Millon's six polarities of self, other, active, passive pleasure, and pain (Millon et al., 1996); the interpersonal circumplex dimensions of agency and communion (Pincus & Gurtman, 2006); Zuckerman's (2002) five dimensions of sociability, activity, aggression-hostility, impulsive sensation seeking, and neuroticism- anxiety; Cloninger's (2000) seven factors of novelty seeking, harm avoidance, reward dependence, persistence, self-

directedness, cooperativeness, and self-transcendence; and the FFM dimensions of neuroticism, extraversion, openness, conscientiousness, and agreeableness (Costa & McCrae, 1990). However, according to Markon, Krueger, and Watson's (2005) meta-analysis which has been done in order to assemble a matrix of correlations among the 44 scales derived from all of these inventories obtained from 52 prior studies, no more than five major factors underlie variation in the 44 scales. These five factors strongly resembled the domains of the Five Factor Model (Widiger & Smith, 2008).

5.1.1 Five Factor Model of personality

Previous research mostly leaned on the Five Factor Model (FFM), as a dominant one in personality psychology (Aboaja, Duggan, & Park, 2011; Garcia, 2011; Jovanovic, 2011). And agree that individual differences in personality are captured by the dimensions of the five-factor model or Big Five taxonomy (Hapmson, 2012). Much of what psychologists mean by the term "personality" is summarized by the FFM, and the model has been of great utility to the field by integrating and systematizing diverse conceptions and measures (McCrae & Costa, 2008). Additionally, each of the DSM-IV-TR personality disorders can, in fact, be readily understood as a maladaptive or extreme variant of the domains and facets of the FFM (Widiger & Trull, 2007; Aboaja, Duggan, & Park, 2011). Therefore, an investigation of Big Five model scales and subscales would have useful outcomes in considering personality traits in mental health. FFM involves some assumptions about human nature and about what people are like. Noting these assumptions, illustrate the natural functioning of individuals and helps us discriminating how normal functioning is.

The five personality factors—Neuroticism, Extraversion, Openness, Agreeableness, and Conscientiousness— form the substantive nucleus of FFM. According to McCrae & Costa (2008) each of these factors are related to some Characteristic adaptations which can either promote or mar mental health. They are characteristic because they reflect the enduring psychological core of the individual, and they are adaptations because they help. Neuroticism (a tendency to experience dysphoric affect, sadness, hopelessness, guilt) is related to Low self-esteem, irrational perfectionistic beliefs, and pessimistic attitudes. Extraversion (a preference for companionship and social stimulation) is related to social skills, numerous friendships, enterprising vocational interests, participation in team sports, club memberships. Openness to experience (a need for variety, novelty, and change) is related to interest in travel, many different hobbies, knowledge of foreign cuisine, diverse vocational interests, friends who share tastes. Agreeableness (a willingness to defer to others during interpersonal conflict) is related to forgiving attitudes, belief in cooperation, inoffensive language, and reputation as a pushover. And Conscientiousness (strong sense of purpose and high aspiration levels) is related to leadership skills, long-term plans, organized support network, technical expertise.

Among the five factors neuroticism is shown to be related to psychopathology. For example neuroticism is shown to be significantly correlated with half of the personality disorder (e.g., Aboaja, Duggan, & Park, 2011; Blais, 1997; Costa & McCrae, 1990; Duggan, 2004; Egan et al., 2002). Both neuroticism and extroversion contribute in the conceptualization of personality disorder while openness was the least notable factor in the conceptualization of personality disorder. (Aboaja, Duggan, & Park, 2011). During recent decades, special interest has developed in the positive rather than the negative aspects of mental health (Seligman et al.,

2005) such as subjective well-being (Quevedo & Abella, 2011). In regard to mental health and well-being, well-being variables such as gratitude are positively correlated with extraversion, agreeableness, openness, and conscientiousness, and negatively correlated with neuroticism (e.g., McCullough et al., 2004, Wood, Joseph, et al., 2008; Wood, Maltby, Gillett et al., 2008; Wood, Maltby, Stewart et al., 2008). In regard to subjective well-being in which a broad range of studies has compellingly shown that personality is an important precursor of SWB (e.g., McCrae & Costa, 1991; Myers, 1992; Myers & Diener, 1995) it is notable that there is a robust negative relationship between neuroticism and SWB, and a robust positive relationship between extraversion and SWB. Moreover, the association has consistently been shown to be stronger for neuroticism than for extraversion (Gomez et al., 2009).

Recently, Steel, Schmidt, and Shultz (2008) conducted a comprehensive meta-analysis and evaluated the associations between each personality factor and SWB. Their findings support a strong relationship between neuroticism, extraversion, agreeableness, conscientiousness and all components of SWB, whereas openness to experience shows close associations with the SWB facets of happiness, positive affects, and quality of life. In another meta-analysis by DeNeve and Cooper (1998), Neuroticism was most closely related with happiness, life satisfaction and negative affect, and Extraversion with positive affect. Quevedo & Abella (2011) examined whether the facets of the Big Five Model and other personality characteristics not included in this model, such as optimism, self-esteem, and social support, are better predictors of SWB than Big Five broad dimensions. They found that Neuroticism was negatively correlated with positive affect and Extraversion inversely related with negative affect. Neuroticism and Extraversion were associated to happiness; individuals with low Neuroticism and high Extraversion showed increased happiness. The findings also showed that Facets accounted for double the variance of SWB than the Big Five, although only 7 of 30 facets were relevant. More importantly, optimism, self-esteem and social support better explained the relationship between personality and SWB.

In sum, the five personality factors—Neuroticism, Extraversion, Openness, Agreeableness, and Conscientiousness— form the substantive nucleus of the system; FFT traces their ramifications throughout the personality system. It also provides a framework in which to understand the development and operation of psychological mechanisms (such as need for closure) and the behavior and experience of individual men and women.

5.1.2 Temperament and Character Inventory (TCI)

Cloninger's theory of personality is based on a synthesis of information from family studies, studies of longitudinal development, and psychometric studies of personality structure, as well as neuropharmacologic and neuroanatomical studies of behavioral conditioning and learning in man and animals (Cloninger, 1987). His revised biosocial model of personality posits seven domains of personality as measured by the Temperament and Character Inventory (TCI) (Cloninger, 1994): four temperament (Harm Avoidance, Novelty Seeking, Reward Dependence and Persistence) and three character domains (Self-Directedness, Cooperativeness, and Self- Transcendence) (Cloninger, 1994). TCI has been extensively used in many studies in regard to health, mental health, mental illness, genetic and environmental relationship, mood states, brain regions, well-being and happiness (e.g.,

Cloninger, 1999; Cloninger, 2006; Gillespie, Cloninger, Heath, & Martin, 2003; Constantino et al., 2002; Svrakic, Przybeck, & Cloninger, 1992; Gardini, Cloninger, & Venneri, 2009; Josefsson et al., 2011; Cloninger & Zohar, 2011).

The TCI personality dimensions have been shown to be antecedent causes of individual differences in psychopathology and personality (Calvo et al., 2009; Ettelt et al., 2008; Smith et al., 2008; Zohar, Ebstein, & Pauls, 2005) showing a beneficial application of TCI in examining mental health and having predictive validity in prospective studies in the general population and with specific disorders that have extensive effects on all aspects of health (Cloninger & Zohar, 2011). Additionally, within the seven factor model of personality, by conceptualizing personality as a combination of several components rather than single dimensions examined separately, it is possible to understand processes within individuals and not just differences among individuals facing the biopsychosocial reality (Josefsson et al., 2011). In Temperament and Character Inventory (TCI), 8 different character profiles can be determined by combining only three character dimensions (Cloninger & Zohar, 2011; Josefsson et al., 2011); associations of these character profiles with well-being and mental health need to be explained. By characterizing temperament and character we can understand the natural course of personality development (Constantino, Cloninger, Clarke, Hashemi, & Przybeck, 2002). Character dimensions aim at depicting maturity and integration of personality (Josefsson et al., 2011); thus character traits have strong effects on the perception of well-being (Cloninger & Zohar, 2011). Regarding the dimensions of character such as Self-directedness, Cooperativeness and Self-transcendence (Cloninger, 1994) individuals with mature and immature, or normal and abnormal personalities are differentiable (Gillespie, Cloninger, Heath, & Martin, 2003).

In the Temperament and Character Inventory (TCI) character has been found to be strongly related to well-being whereas temperament traits are only weakly associated (Cloninger & Zohar, 2011; Cloninger, 2004; Ruini et al., 2003). Among the character dimensions, Self-directedness, Cooperativeness and Self-transcendence aim at depicting maturity and integration of personality and 8 character profiles are assumed base on these three character profiles (Josefsson et al., 2011; Cloninger & Zohar, 2011). Cloninger and Zohar (2011) studied the relation between personality and health and happiness based on 8 character profiles including: creative (SCT), organized (SCt), fanatical (ScT), autocratic (Sct), moody (sCT), dependent (sCt), disorganized (scT) and depressive (Sct). They found that character has a strong impact on the perception of all aspects of health, including social, emotional, and physical well-being. Creative (SCT) profile was significantly higher than all others with the exception of organized (SCt) profile in positive affect while depressive (sct) profile was significantly lower than all others. Individuals who with creative (SCT) or organized (SCt) profiles are frequently in the best of health, whereas those who are depressive (sct) or disorganized (scT) are frequently in the worst of ill-health. Thus Character profiles have a strong association with individual differences in health, including both its non-affective aspect (i.e., "wellness") and its affective aspect (i.e., happiness).

Among the dimensions of character, three dimensions of character measured by the TCI contribute to individual differences in health. TCI Self-directedness clearly has the strongest impact as a foundation for the regulation of a person's hopes and desires, which influences all aspects of both wellness and happiness (Cloninger & Zohar, 2011), consistent with theories of self-efficacy and self-determination (Cervone, 2005; Ryan and Deci, 2000).

Cooperativeness has a strong impact on perceptions of social support, which also makes a substantial impact to increase wellness and reduce negative emotions, consistent with attachment and social engagement theories (Bowlby, 1983; Ryan and Deci, 2001). Self-transcendence has a strong impact on awareness of participation in what is beyond the individual self, which increases the experience of positive emotions, but has little or no impact on wellness or negative emotions, consistent with humanistic and existential theories (Cloninger, 2004; Jaspers, 1968; Rogers, 1995).

5.2 Personality and physical health

As we noticed, in the integrative definition of health and mental health, mental health is intimately connected with physical health and behavior (WHO, 2001a). One way personality can influence mental health is through physical health. In a broader view, mental health is a crucial component of health (Cloninger & Zohar, 2011); thus, considering the likelihood of disease regarding personality traits is notable. The effects of type A behavior pattern (e.g., Houston & Snyder, 1988;) and type D personality (Mols et al, 2010) in disease, and the influence of personality traits on other physical problems have been studied significantly (e.g., Olson & Dahli, 2009; Mols et al., 2010; Carver & Miller, 2006 & Goodwin & Friedman, 2006). These studies indicate the undeniable role of personality in determining mental health based on physical health. It is also notable that the relationship between physical and mental health is mutual according to the definition of health and mental health (WHO, 2001,a).

6. Personality related variables in mental health

The Broad literature in personality studies has demonstrated some particular variables contributing to mental health which might not be categorized in a personality model. In what follows I point to some of these variables based on previous studies.

6.1 Self-related variables

“Self-” related variables such as self-esteem (Rosenberg, 1979), self-monitoring (Snyder, 1987), and self- Regulation (Gailliot, Mead, & Baumeister, 2008) have strong effects on mental health. Self-esteem is shown to be associated with psychological health (e.g., Rosenthal & Hooley, 2010; Ni et al., 2010; Baumeister, Campbell, Krueger, & Vohs, 2003). Furthermore, self-regulation as an underlying structure of personality characterizes the structure and processes of everyday behavior especially the experience of stressor events (Carver, Scheier, & Fulford, 2008) and dependence on its level would be accounted for risky behaviors which are harmful for health (Arnaut, 2006). In what follows, I discuss about these variables in brief.

6.1.1 Self esteem

Self esteem is regarded as a positive personality feature, contribute in healthy functioning. High self esteem has elicited considerable interest in recent years (Zeigler-Hill, Chadha, & Osterman, 2008). Despite the association of high self esteem with markers of psychological adjustment such as subjective well-being (e.g., Baumeister, Campbell, Krueger, & Vohs,

2003; Diener, 1984; Robins, Hendin, & Trzesniewski, 2001; Tennen & Affleck, 1993), there also appears to be a dark side to high self-esteem. That is, high self-esteem has been linked to a variety of negative outcomes including prejudice, aggression and various strategies to maintain or enhance self-esteem (Zeigler-Hill, Chadha, & Osterman, 2008).

In an effort to better understand how high self-esteem can be associated with both positive and negative outcomes, contemporary theorists (e.g., Deci & Ryan, 1995; Kernis, 2003) have proposed that there are actually two forms of high self-esteem: secure high self-esteem and fragile high self-esteem. Secure high self-esteem reflects positive attitudes toward the self that are realistic, well-anchored, and resistant to threat. Individuals with secure high self-esteem have a solid foundation for their feelings of self-worth that does not require constant validation. In contrast, fragile high self-esteem refers to feelings of self-worth that are vulnerable to challenge, require constant validation, and rely upon some degree of self-deception (Zeigler-Hill, Chadha, & Osterman, 2008). The model of self-esteem instability developed by Kernis and his colleagues (Kernis, 2005) is often used to distinguish between secure and fragile self-esteem. According to the model of self-esteem instability, individuals with stable high self-esteem are believed to possess a solid basis for their positive feelings of self-worth. As a result, the self-esteem of these individuals is relatively unaffected by events that may have an evaluative component. That is, the solid foundation for their feelings of self-worth protects individuals with stable high self-esteem from the variety of adversities that individuals frequently encounter in their day-to-day lives. In contrast, individuals with unstable high self-esteem are thought to possess positive feelings about the self that are highly vulnerable to challenge which leads these individuals to behave as if their self-esteem is constantly at stake (Greenier et al., 1999; Kernis, Brown, & Brody, 2000; Kernis et al., 1993; Kernis, Greenier, Herlocker, Whisenhunt, & Abend, 1997; Waschull & Kernis, 1996).

6.1.2 Self regulation

Self-regulation is a prominent component of personality. Early on, Freud (1962) theorized that personality consisted of three components: the id, ego, and superego (Gailliot, Mead, & Baumeister, 2008). Self-regulation allows the individual to resist behaviors such as engaging in unsafe or promiscuous sex, abusing drugs and alcohol, overeating, overspending, fighting or acting violently, procrastinating, and making lewd or negative remarks toward others. In one sense, self-regulation can be seen as a process that allows the influence of personality to outshine the influence of the situation and other factors (Gailliot, Mead, & Baumeister, 2008).

Self-regulation influences many of the major problems faced by people individually and by society collectively and contribute in both negative and positive consequence based on its intensity. Poor self-regulation can increase the spread of sexually transmitted diseases, contributes to crime and indeed is regarded as one of its most important causes (Gottfredson & Hirschi, 1990; Pratt & Cullen, 2000), undermines drinking restraint, thereby possibly contributing to alcoholism and other harmful effects, such as drunk driving. In contrast benefits of self-regulation include controlling monetary spending, performing well in school, and refraining from aggressive or violent behavior, preventing unhealthy or disordered eating. It is also beneficial to social interactions. Contextually appropriate self-regulation promotes harmonious interactions with others and the other important benefit of

self regulation involves emotion regulation and control of emotions (Gailliot, Mead, & Baumeister, 2008). The latter one has a mutual relationship with self regulation in a way that controlling one's emotions can also deplete self-regulatory resources. With regard to mental health, we see that in most of mental disorders, there are problems with self regulation process such as substance use (Donohue, Farley, & French, 2006), borderline and antisocial personality disorder (Trull, Steep, & Solhan, 2006), eating disorders and sexual deviation (Murphy & Page, 2006), and externalizing problems (Whilmshurst, 2005).

6.2 Resilience, hardiness and mental toughness

The recent resurgence of an emphasis on positive psychology (e.g., Seligman & Csikszentmihalyi, 2000) is welcome and has spurred relevant theorizing and research (Maddi, 2006). During recent decades, special interest has developed in the positive rather than the negative aspects of mental health (Seligman et al., 2005). Resilience, hardiness and mental toughness are factors which act as protective ones and improve as well as promote well being and mental health. In contrast to pathological factors which their absence is not beneficial, presence of these protective factors affect our mental state in a healthy way and thus, must be considered in mental health issues.

6.2.1 Resilience

Resilience is a construct that has flourished across many disciplines of psychology and health like positive psychology (Yi-Frazier, Smith, Vitalino, Yi, Mai, Hillman, & Weinger, 2009). Because of ambiguities of resilience in both definitions and terminology, it has often been criticized (Davydov et al., 2010). Resilience has had numerous meanings in prior research as a dynamic process of adaptation to adverse and unpleasant experiences (Luthar & Cicchetti, 2000; Masten, 2001) but generally refers to an individual capacity in the face of stressful events (Yi-Frazier et al., 2009) and a pattern of functioning indicative of positive adaptation in context of risk or adversity, underlying two conditions: (a) exposure to risk and (b) positive adaptation (Ong, Bergeman, & Boker, 2009). In other definitions it is called stress resistance (Garmzy, 1985) or post traumatic growth (Tedeschi, Park, & Calhoun, 1998). According to Bonanno (2004), resilience is more than surviving from life stresses and is not synonymous with invulnerability (Philippe, Lecours, & Beaulieu-Pelletier, 2009) but corresponds to successful adjustment (Donnellan, Conger, McAdams, & Neppl, 2009), behavioral adjustment (Leve, Fisher, & Chamberlain, 2009) and hanging to balance after prior disequilibrium (Richardson, 2002).

Current theories of resilience regard it as a multidimensional construct including internal variables as temperament and personality and individual differences (Mancini & Bonanno, 2009; Campbell-sills, Cohan, & Stein, 2006) and external factors like social environment with a neurological functioning as mediating mechanism (Leve et al., 2009; Davis, Luecken, Lemery-Chalfant, 2009). Historically, resilience research has been largely the purview of developmental investigators dealing with early childhood and adulthood (Ong et al., 2009) and now has progressed to include early, middle, and late adulthood (Fava & Tomba, 2009). Clinical psychologists recently examined resilience in situations of economic hardship, social inequality and discrimination, psychological trauma, loss, bereavement, depression and pain (Davis et al., 2009; Donnellan et al., 2009; Keyes, 2009; Mancini & Bonanno, 2009; Southwick, Vythilingam, & Chamey, 2005; Zautra, Johnson, & Davis, 2005).

The consistent results approve positive and protective effects of resilience in stress resistance (Ong et al., 2009), successful adjustment (Donnellan et al., 2009), positive emotions (Philippe et al., 2009), better quality of relationships with others (Bonanno, Papa, Moskowitz, & Folkman, 2005), subjective well-being (Burns & Anstey, 2010), physical and psychological health and well-being (Davis et al., 2009; Fava & Tomba, 2009; Salehinezhad & Besharat, 2010), and even speedy recovery illness (Yi-Frazier et al., 2009). In opposite, low levels of resilience relates to vulnerability, low levels of well-being, psychological disorders, maladaptive coping behavior, and negative defenses (Campbell-sills et al., 2006; Fava & Tomba, 2009; Philippe et al., 2009; Yi-Frazier et al., 2009). Resilience has shown to be related not only to mental health but also to adapting performance and achievement in the field of sport, career and education (Salehinezhad & Besharat, 2010). This makes resilience not only a protective factor (Ong et al., 2009) but also an improving factor of emotions (Philippe et al., 2009), physical and psychological health and well-being (Davis et al., 2009; Fava & Tomba, 2009) and achievement (Salehinezhad & Besharat, 2010). Resilience has a particular feature in which turns it so applicable to mental health realm. This feature involves its extensive and broad application in different levels. People often show resilience in the face of adversity rather than ruminate over the bad things that happen in their lives (MacAdams, 2008). In a broader view, themes of resilience apply not only to individuals but to families and community (Zautra, 2009).

There is a significant theoretical and practical implication arising from resilience conceptualization which should be considered by researchers in the realm of mental health. Mono-causal models of psychopathology which is popular in clinical practice due to their simplicity in terms of theoretical, therapeutic and disorder prevention approaches, tends to ignore moderating, mediating and confounding effects of other biosocial variables, thereby undermining the multi-Causal nature of human health – from genes to cultures with developmental process mediating. However, construct of mental resilience can provide a means of integrating social and natural sciences taking into account both psychosocial and biological models of mental health pathways (Davydov et al., 2010). A guiding question in respect to resilience and mental health asks that while somatic disease, trauma and chronic stress are known to be common precedents of psychiatric disorder (Davydov et al., 2010) why majority of people who experience such stressful events do not develop psychopathology? And which resilience factors provide such mental ‘immunity’? (Collishaw et al., 2007; Jin et al., 2009; Patel & Goodman, 2007). These kinds of questions address protective factors of mental health rather than preventing pathological factors. Concepts of ‘mental immunity’, ‘mental hygiene’ or ‘mental resilience’ have in common the aim of broadening research concepts in mental health beyond risk factors for pathology to include wellness enhancement and health promoting factors, in the same way that it has been important to identify the characteristics of infection-resistant groups during epidemics (Davydov et al., 2010). Thus the importance of mental health in terms of protective factor and good mental health rather than absence of unhealthy states should be more considered in further studies.

6.2.2 Hardiness

The other psychological construct, prominent in domain of mental health and positive psychology is hardiness (Salehinezhad & Besharat, 2010). Over the past 20 years, personality

hardiness has emerged as a combination of attitudes that enhance performance, health, and mood despite stressful circumstances (e.g., Maddi, 1999, 2002; Maddi, Khoshaba, Harvey, Lu & Persico, 2001). It is also related to inspiring performance such as transformational leadership (Johnsen et al., 2009).

Hardiness is defined as the presence of three interrelated dispositions: commitment, control, and challenge (Kobasa, Maddi, & Kahn, 1982; Maddi et al., 2006). Control refers to the ability to feel and act as if one is in control of various life situations, commitment points, the tendency to involve rather than distance oneself from whatever one is doing; and challenge, addresses the ability to understand that change is normal (Horsburgh et al., 2009). Hardiness acts as a buffer to major life stressors (Maddi et al., 2006). High hardiness is associated with lower psychological distress, higher quality of life (Hoge, Austin, & Pollack, 2007) and high level of mental health (Salehinezhad & Besharat, 2010). The person high in hardiness is marked by increased commitment, sense of control, and challenge (Johnsen et al., 2009). Hardiness is a psychological style associated with resilience, good health, and good performance under a range of stressful conditions and is potentially a valuable personality style for highly demanding situations and occupations (Bartone, Roland, Picano, & Williams, 2008). Previous researches have established hardiness as a dispositional factor in preserving and enhancing performance and physical and mental health despite stressful circumstances (Maddi et al., 2006; Salehinezhad & Besharat, 2010).

In regard to mental health hardiness is indeed a measure of mental health and is not only negatively related to neuroticism, but also positively related to all four of the other factors in the Five Factor Model. Hardiness leads to beneficial health and performance effects by providing the courage and motivation needed to carry out coping, social support, and self-care efforts (Maddi et al., 2006; Maddi, 2002). Hardiness has emerged, over the years, as a positive dispositional force in encouraging an active, effective, healthy life (Maddi, 2002). A matter of interest, therefore, is its conceptual and empirical overlap with other proposed positive characteristics that also appear important in explaining effective functioning and health (Maddi et al., 2006).

6.2.3 Mental toughness

Mental toughness is newly defined construct (Horsburgh et al., 2009) and has recently been defined by Clough, Earl, and Sewell (2001). These researchers developed a definition of mental toughness based on the established psychological concept known as the 'hardy personality' that was first proposed by Kobasa (1979) (Horsburgh et al., 2009; Golby & Sheard, 2004) which consists of control, commitment and challenge. Mental toughness model requires a fourth category: confidence (Horsburgh et al., 2009). Thus Clough et al. (2001) created what they call the '4Cs model of mental toughness': control, commitment, challenge, and confidence and defined mental toughness as: Mentally tough individuals tend to be sociable and outgoing; as they are able to remain calm and relaxed, they are competitive in many situations and have lower anxiety levels than others. With a high sense of self-belief and an unshakeable faith that they control their own destiny, these individuals can remain relatively unaffected by competition or adversity (p. 38).

With regard to mental health, it is expected that mental toughness will be positively correlated with extraversion. Also from Clough et al's (2001) definition, it is expected that a

positive correlation will be found between mental toughness and agreeableness and conscientiousness: people who are “relatively unaffected by competition or adversity” may also be viewed as being agreeable; and those who believe they “control their own destiny” or who score high on Commitment are likely to also be conscientious. Clough et al. (2001) also state that individuals high on mental toughness experience low anxiety and have a high sense of self-belief; from this, it is expected that a negative correlation will be found between mental toughness and neuroticism. An implications for potential therapeutic interventions designed to modify an individual’s level of mental toughness is assumed. Mental toughness is influenced more by environmental factors and thus may be more malleable than those mainly influenced by genetic factors (Horsburgh et al., 2009)

6.3 Stress, coping and defense styles

Stress and mental health have been repeatedly found to vary inversely (e.g., DeLongis, Lazarus, & Folkman, 1988) and with likely reciprocal influence (Hammen, 2005). Defining stress as the organism’s reaction to external survival-related demands (Lazarus & Folkman, 1984), and mental health as “. . . a state of well-being in which the individual . . . can cope with the normal stresses of life . . .” (World Health Organization, 2001), it is also clear that stress and mental health are linked by definition (Stead, Shanahan, & Neufeld, 2010). Within the Five Factor Model of personality, neuroticism is mostly strongly associated with poor stress regulation (Williams & Moroz, 2009; Lazarus & Folkman, 1984).

Stress and coping typically go hand in hand. When people find themselves hard-pressed to deal with some impediment or some looming threat, the experience is stressful (Carver, Scheier, & Fulford, 2008), and in these circumstances individuals use coping styles. Depending on what kind of coping people use, their well-being and psychological health could be better or worse because clearly, coping style is relevant to one’s performance, conduct, and health under stress (Maddi, 2006). Most contemporary views of stress and coping can be traced, in one way or another, to the work of Lazarus and Folkman and their colleagues (e.g., Lazarus & Folkman, 1984). Lazarus and Folkman (1984) have defined coping as “the efforts to master, reduce, minimize or tolerate the negative consequences of internal or external demands.” The importance of coping style in predicting scores across a number of mental health variables is well established (e.g., Maltby, Day, & Barber, 2004; Zeidner & Endler, 1996). Copings are different with different effects on health mental health. It is common to refer to three classes of responses: 1) Problem-focused coping consists of attempts to remove the obstacle or to minimize its impact 2) Emotion-focused coping consists of attempts to reduce the distress emotions caused by the obstacle 3) Avoidance coping is a class of responses that appear to be aimed either at avoiding any acknowledgment that the problem exists.

Difference in coping responses is considerable based on optimism and pessimism. Optimists tend to use more problem-focused coping strategies than pessimists. When problem-focused coping is not a possibility, optimists turn to adaptive emotion-focused coping strategies such as acceptance, use of humor, and positive reframing. These are strategies that keep them engaged with the effort to move forward with their lives. Pessimists tend to cope through overt denial and by disengaging from the goals with which the stressor is interfering. Moreover, these differences in coping responses appear to be at least partially responsible for differences between optimists and pessimists in the emotional well-being they experience (Carver, Scheier, & Fulford, 2008).

While coping strategies are aroused in stressful circumstances, the situations in which individuals feel anxious would evoke defense mechanisms. The role that defense mechanisms play in protecting against anxiety is integral to understanding many psychodynamic theories of personality and psychopathology (Freud, 1962). The function of the defense mechanism is to protect the individual from experiencing excessive anxiety (Cramer, 2009). Two theoretical models of defense use, based on the dimension of maturity, have been proposed by Vaillant (1971) and Cramer (2006). According to these models the 3 types of defenses people use reflect their level of personality maturity (Salehinezhad et al., 2011); therefore, defense styles also have contributions to mental health and well-being in term of personality.

6.4 Other related variables to mental health

Studies usually present many other factor related to mental health that are usually considered separately. Among these factors there are some interesting and relatively newly researched concepts in regard to mental health.

6.4.1 Religion and spirituality

Psychologists typically ignore religion. Religion is seen as an exotic specialty area, like sexual fetishes or the detection of random number sequences. Religion is like sex to a Victorian or dreams to a behaviorist—an awkward and embarrassing phenomenon best (Bloom, 2012). Religion has often been overlooked, neglected, minimized, and marginalized, despite the fact that religion was of great interest to the founding figures of the field, including Gordon Allport and Henry Murray. Across the lifespan, spirituality and religion are important, perhaps central, dimensions of human experience (Emmons, Barrett, & Schnitker, 2008) insofar as Piedmont (1999) proposed an extension of the Big Five dimensions of personality by considering a sixth factor named “Spiritual Transcendence”. Thus, it should be considered more than before as we see this tendency in recent years specially, in the field of personality psychology. research in the context of mental health and quality of life has shown that Religious/Spiritual Well-Being is positively correlated with different parameters of psychological and physiological health (e.g., Koenig, McCullough, & Larson, 2001; Unterrainer et al., 2010; Dezutter, Soenens, & Hutsebaut, 2006; Maltby & Day, 2004). For example researches find that religious people, on average, report higher subjective well-being and also have fewer psychosocial pathologies such as domestic abuse (Diener & Tay, 2011)

Religious attitudes and orientations had a significant effect on psychological distress and/or psychological well-being whereas church attendance and belief salience showed no such effect (Dezutter, Soenens, & Hutsebaut, 2006). This is related to theoretical model of religious coping proposed by Maltby and Day (2003). They indicated that Intrinsic related positively with positive coping which, in turn, relates to higher levels of mental health. Extrinsic, on the other hand, tends to relate to maladaptive appraisals of stress and less positive coping, which serve to explain the negative association with mental health. Unterrainer et al. (2010) investigated the relationship between Religious/Spiritual Well-Being and indicators of Psychological Well-Being (including personality). They found that religiosity and spirituality could contribute to the genesis of mental health and disease (Unterrainer et al., 2010) with respect to sense of coherence, “positive” personality dimensions “Extraversion” and “Openness”. To conclude, religiosity and spirituality may

represent important aspects of human personality (Löckenhoff, Ironson, O’Cleirigh, & Costa, 2009). By introducing the concept of “religious/spiritual well-being”, new studies are viable, concerning the consideration of religiosity/spirituality as an important personality trait in the context of Psychological Well-Being. Finally it is notable that although researches reveal the relation of religion with subjective well-being, however, Yet, people are rapidly leaving organized religion in economically developed nations where religious freedom is high. Thus, it appears that the benefits of religion for social relationships and SWB depend on the characteristics of the society (Diener & Tay, 2011).

6.4.2 Sense of coherence

The other construct which is suggested to assist an individual to maintain physical and psychological well-being in the face of stressors is sense of coherence (SOC) (Antonovsky, 1987; Kobasa, 1979). Antonovsky (1993) proposed that with this global orientation, one has the feeling that life is comprehensible, manageable and meaningful. Sense of coherence is not a coping style, but has stress-buffering effects. It is the ability to perceive a stressor as comprehensible, manageable, and meaningful (Gauffin, Landtblom, & Rätty, 2010). Individuals with a greater sense of coherence are more likely to respond to a stressor with adaptive and most suitable strategies which has a positive outcome for health and well-being (Modin, Ostberg, Toivanen, & Sundel, 2011; Pallant & Lae, 2002). This construct along with coping styles would highlight their effects not only on mental health and well-being (e.g., Modin et al., 2011) but also on physical well-being regarding to diseases (e.g., Gauffin, Landtblom, & Rätty, 2010) in a mutual relationship (Bergman et al., 2011).

6.4.3 Emotional intelligence

Emotional intelligence consists of the interaction between emotion and cognition that leads to adaptive functioning (Salovey & Grewal, 2005). Mayer et al. (2004) argued that emotional intelligence is best conceived of as ability, similar to cognitive intelligence. However, emotional intelligence has also been conceptualized as a trait (Neubauer & Freudenthaler, 2005), similar to personality characteristics such as extraversion or conscientiousness. (Schutte et al., 2007). Better perception, understanding, and management of emotion of individuals with higher emotional intelligence make it less likely that they will experience mental health problems and emotional intelligence has useful additional predictive information over and above the Big Five Dimensions for mental health functioning (Schutte et al., 2007; Ciarrochi, Deane, & Anderson, 2002).

7. Conclusion

As Cloninger (2004) argued, much less is known about the relationship of personality to health as a state of physical, mental, and social well-being. Traditionally, the profession of clinical psychology has been interested in the alleviation of human suffering. Studies of positive psychological functioning have been far outweighed by those concerned with psychological distress and dysfunction (Joseph & Wood, 2010). It is time to pay more attention to healthy aspects of personality and mental process or in other words good mental health (Davydov et al., 2010) in order to find what kind of features are prominent in healthy individuals rather than what kind of features should not be seen in individuals and also in order to include wellness and mental health promoting factors. Considering

the notion of clinicians who are really and actually engaged in psychopathology, and believe that general personality traits and personality disorders are placed in one spectrum, we can change our approach regarding mental health. Mental health and mental illness are not two distinct phenomena. They might have fluctuation in different situations and might appear in just some kind of situations considering psychological, social, cultural and situational factors. Even in defining abnormal traits there are divergence between social- personality perspectives and clinical perspectives (Rosenthal & Hooley, 2010). Is it really possible to draw a distinction border between health and illness? If yes, to what extent?

There has begun to be a profound shift in psychology's center of gravity- or its locus of control-from outside to inside the person (McCrae, 2002). We thought that psychopathology was the result of life stress, and those events such as marriage, retirement, and loss of spouse would surely bring about major transformations of intrapsychic and interpersonal styles. We thought we would be happy if we won the lottery. We now know that these assumptions are naive, just to the extent that they leave out of account the contributions of the individual (Neyer & Asendorpf, 2001) and among many factors contributing in individuals, personality scores higher. Research among adults suggests that personality is a major determinant for adults 'well-being in recent 25 years ago (e.g., Garcia, 2011; McCrae, 2002) and this is not limited to adulthood. The relationship of personality to well-being has been investigated among adolescents and shows similar results (e.g., Fogle, Huebner, & Laughlin, 2002; Garcia, 2011).

The same significant shift also involves researches about psychopathology, clinical psychology and mental health. And it is the increasing emphasis on the promotion of positive functioning in clinical psychology and mental health. This shift is important because of three main reasons: first of all clinical psychology has always been concerned with well-being but having adopted the language of psychiatry it has inadvertently restricted itself to a narrow definition of well-being which in practice is the absence of distress and dysfunction. The adoption of positive functioning serves to expand the remit of the field of clinical psychology and mental health realm. Secondly By adopting positive functioning as a goal there is the possibility that we are able to increase our ability to predict and treat distress and dysfunction (Jodeph & Wood, 2010; Wood & Tarrier, 2010). And finally, positive characteristics can buffer the impact of negative life events on distress, potentially preventing the development of disorder (Wood & Tarrier, 2010).

In respect to recent revolution in conceptualization of personality, personality disorders and mental disorders in a spectrum and recent tendency to put mental health research in the context of positive psychology (Seligman et al., 2005; Quevedo & Abella, 2011), prospective efforts ought to consider the ubiquitous shade of personality in mental health and psychological well being studies (Garcia, 2011; McCrae, 2002). Personality psychology has made striking advances in the past two decades, demonstrating the importance of individual differences in a wide variety of life domains (McCrae, 2002) insofar as Once again, personality psychology may become "the intellectual center of all the social sciences"(Baumeister,1999,p.371). This is enough to believe that researches, studies, policies and practical implication in respect to mental health and health can be better organized and conceptualized within the realm of personality psychology which incorporates not only all psychology within psychology, but also includes broad biological, psychological, and social systems within humans (Mayer, 2005)

8. References

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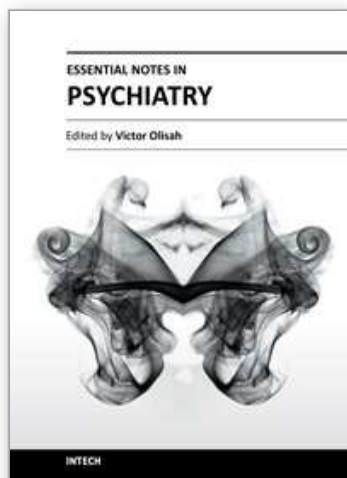
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Essential Notes in Psychiatry

Edited by Dr. Victor Olisah

ISBN 978-953-51-0574-9

Hard cover, 580 pages

Publisher InTech

Published online 27, April, 2012

Published in print edition April, 2012

Psychiatry is one of the major specialties of medicine, and is concerned with the study and treatment of mental disorders. In recent times the field is growing with the discovery of effective therapies and interventions that alleviate suffering in people with mental disorders. This book of psychiatry is concise and clearly written so that it is usable for doctors in training, students and clinicians dealing with psychiatric illness in everyday practice. The book is a primer for those beginning to learn about emotional disorders and psychosocial consequences of severe physical and psychological trauma; and violence. Emphasis is placed on effective therapies and interventions for selected conditions such as dementia and suicide among others and the consequences of stress in the workplace. The book also highlights important causes of mental disorders in children.

How to reference

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Mohammad Ali Salehinezhad (2012). Personality and Mental Health, Essential Notes in Psychiatry, Dr. Victor Olisah (Ed.), ISBN: 978-953-51-0574-9, InTech, Available from: <http://www.intechopen.com/books/essential-notes-in-psychiatry/personality-and-mental-health>

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