Behavioral Psychology / Psicología Conductual, Vol. 29, Nº 3, 2021, pp. 699-719
https://doi.org/10.51668/bp.8321311n

PERSONALITY, AFFECT AND COPING STYLE IN SEVERE PERSONALITY DISORDER

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Abstract

The concepts of internalization and externalization have been proposed as personality tendencies or traits related to the constructs of neuroticism and extraversion. They have been associated to the bifactorial structure of affect and also to the coping style. This paper examines the interaction of personality, affect and coping in a sample of people diagnosed with personality disorder (*n*= 358). Negative affect (NA) in internalizers is higher than in externalizers (g= 0.62), and so is the severity of symptoms (GSI: g= 0.60). Mediation analyses show that personality type produces an indirect effect on GSI, with NA and coping style as partial mediators. 88.1 % of the sample has an unfavourable coping style (U-CS). The frequency of U-CS among internalizers is bigger than among externalizers (93% vs 83%; χ^2= 7.23, *p*= .007). However, the subgroup of internalizers with a favourable coping style (F-CS) shows no difference with externalizers with the same F-CS, either in NA (*p*= .428) or in GSI (*p*= .082). Regardless of personality structure, promoting adaptive strategies of coping can alleviate the psycopathology of severe patients.

KEY WORDS: *personality disorder, negative affect, neuroticism, coping style, internalization.*

Resumen

Interiorización y exteriorización han sido estudiados como tendencias o rasgos de la personalidad, próximos a los conceptos de neuroticismo y extraversión, relacionados con la estructura bifactorial del afecto y con el estilo de afrontamiento. Este trabajo examina su interacción en personas con trastorno de personalidad (*n*= 358). El afecto negativo (AN) es superior en los interiorizadores que en los exteriorizadores (g= 0,62); también la gravedad sintomatológica (GSI: g= 0,60). Los análisis de mediación muestran que el efecto del tipo de personalidad sobre el GSI está mediado parcialmente por la disposición afectiva y por el estilo de afrontamiento. El 88,1% de la muestra presenta un estilo de afrontamiento desfavorable y su frecuencia es mayor entre los interiorizadores (93% vs 83%; χ^2= 7,23; *p*= 0,007). Pero el subgrupo de interiorizadores con estilo de afrontamiento favorable (EAF) no se diferencia de los exteriorizadores con EAF en AN (*p*= 0,428) ni en GSI (*p*= 0,082). Independientemente de la estructura de la personalidad, el aprendizaje de estrategias favorables y adaptativas puede mejorar el estado psicopatológico de pacientes graves.

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PALABRAS CLAVE: *trastorno de personalidad, afecto negativo, neuroticismo, estilo de afrontamiento, interiorización*.

Introduction

The psychological study of personality and the psychopathological investigation of personality disorders have followed separate conceptual and methodological traditions so that attempts at their confluence and mutual enrichment are not easy, nor are the results conclusive. Nevertheless, the emergence of a dimensional perspective on the categorical psychiatric tradition to understand personality disorders (polemically pointed out in the DSM-5 [American Psychiatric Association, 2013] and ratified by the ICD-11 [World Health Organization, 2018]), brings together an integration of both traditions that had seemed distant in past years. Thus, a conceptual and terminological similarity is observed between the general model of normal personality, the diagnoses of personality disorders and the very structure of all psychopathology (Tyrer, Mulder, Kim and Crawford, 2019; Widiger, Sellborm and Chmielewski, 2019).

The catalogued disorders (syndromic groupings of symptoms) can be conceived as the observable consequence of a defective latent interaction between the processes that define the individual personality and their particular environment (Svrakic, Lecic-Tosevski and Divac-Jovanovic, 2009; Tyrer, 2007). From this perspective, assessing personality, understanding its processes and promoting adaptive competence (resilience) would be the essential basis of treatment for any diagnosed disorder. Consequently, intervening on the personality and its environment seems to augur more efficiently than treating specific disorders (Widiger et al., 2019).

Personality traits are assumed to be basic biologically rooted tendencies (DeYung et al., 2010; McCrae et al., 2000) that synthesize individual differences in the typical way people behave, think and feel in different situations. Although the five-factor model (Goldberg, 1990) brings together multiple investigations carried out in various cultures, the number and definition of those traits that adequately describe personality is still a debated issue. The consensus is that the trait structure is multidimensional and hierarchical (Hopwood, 2018). A hierarchy of traits has been identified that ranges from broader domains at the top to more specific facets at the bottom (Eaton, Rodriguez-Seijas, Carragher & Krueger, 2015; Kotov et al, 2017; Sharp et al., 2015), and this range allows choosing the appropriate level for the problem to be known and treated, from the common factor and the internalization-externalization super factors, towards the negative affectivity, detachment, disinhibition and antagonism domains and the rest of the dimensions underlying the recognized disorders.

Nevertheless, the conceptualization of personality as a static structure of traits does not contemplate the intra-individual dynamic of cognitive, affective and motivational processes that would explain the behavioural consistency between situations and the longitudinal stability of personal characteristics. Incorporating intrapersonal dynamics enriches the approach to the tradition of traits and also

allows to better capture the clinical characteristics of psychopathological syndromes (and personality disorders) identified by the categorical psychiatric tradition (Hopwood, 2018).

Taking into account, therefore, the interaction of intra-individual processes and underlining its implementation in specific interpersonal contexts, personality can be conceptualized as the idiosyncratic way in which a person gives emotional meaning to events in their environment and responds accordingly. The person gives meaning to the environment based on their subjective experience (Wrzus and Roberts, 2017), and the basis of emotional reactivity resides in the perception of events "coloured by personality" (Uziel, 2006). A better understanding of this relationship between personality and affect will allow us to better reveal its intricate connections with psychopathology and disorders.

Positive affect (PA) and negative affect (NA) are two dimensional factors that have been proposed as the structure of emotional experience (Russell, 1980; Watson and Tellegen, 1985). PA refers to the degree of enthusiasm, activity and alertness of an individual; NA designates, for its part, the level of subjective discomfort and annoyance. Both factors have been related to extraversion and neuroticism, respectively (Barlow, Sauer-Zavala, Carl, Bullis and Ellard, 2014). Indeed, various authors have examined the confluence between the personality structure and the structure of affect (for example Carver, Sutton and Scheier, 2000; Larsen and Ketelaar, 1991; Meyer and Shack, 1989). The extraversion factor groups traits such as sociability, impulsiveness, emergence, search for novelty, positive affectivity, and susceptibility to reinforcement; the neuroticism factor includes sensitivity to anxiety, apprehension, negative affect, mood lability, susceptibility to punishment and frustration (Meyer and Shack, 1989).

Gross, Sutton and Ketelaar (1998) found that the most extroverted individuals experienced a strong positive affective reaction after watching a funny video clip and the most neurotic ones reacted with intense negative affect to an unpleasant video clip. Gomez, Gomez and Cooper (2002), with a sample of 143 students who carried out an experimental paradigm consisting of completing, recognizing and remembering words, found that extraversion positively correlated with the processing of pleasant information and neuroticism with the processing of unpleasant information, controlling the present emotional state. Uziel (2006), starting from the hypothesis that the cognitive evaluation of events could partially explain this relationship established between the "two great" personality traits and the "two great" dimensions of affect, in a sample of 226 participants who were asked to evaluate 30 daily events, found that extraversion correlated with a more positive evaluation of the events, while neuroticism correlated with more negative evaluations; the momentary affective state did not justify this effect of the personality on the evaluative judgment.

If extraversion entails a tendency to judge events more positively and neuroticism implies a tendency to judge events more negatively, it is to be expected that extraverts maintain more positive moods than introverts and neurotics suffer more negative moods than affectively stable people. Neuroticism and extraversion, according to Brown & Barlow (2009), are two personality dimensions linked to the aetiology and course of emotional disorders; and they are

related to Gray's neuropsychological constructs, the two BIS (behavioural inhibition) and BAS (behavioural activation) systems. BIS represents the individual differences in sensitivity to threat clues and BAS to reward clues. The exact correspondence between neuroticism/extraversion, negative affect / positive affect, and BIS / BAS is debated (Gray et al., 2005).

Various clinical conditions share emotional problems as a transdiagnostic element, and various processes of emotional regulation can be identified as leading to various forms of psychopathology (Sloan et al., 2017; Sheppes, Suri and Gross, 2015). Also in the specific field of personality disorders (PD), emotional dysregulation is recognized as an essential part of its psychopathological gear (Levi, McMain, Bateman, and Clouthier, 2018; Sauer-Zabala and Barlow, 2016; Sloan et al., 2017) and PD has been linked to neuroticism (Kendler, Myers and Reichborn-Kjennerud, 2011).

In this field of PD, Harford et al. (2013) analyze American epidemiological data and observe that the PD criteria that reflect impulsivity, disinhibition, anger and antagonism are related to externalizing disorders (conduct, addictive, impulse control disorders...) and that those that reflect negative emotionality and affective instability are related to internalizing disorders (anxiety, depression...). Internalization and externalization have been studied as transdiagnostic factors (Eaton et al., 2015) and are considered central and opposite domains of personality (Tyrer, 2019).

The bridge that unites personality and affect with resilience or psychopathology can be understood as a coping style (CS). CS is the behavioural and cognitive effort that individuals make to handle the demands associated with stressful events (Lazarus, 1993), a process of active and deliberate response to the overflow of personal resources. It is a complex construct, which can be conceptualized as a situational response that varies intraindividually or as an interindividual disposition, a distinctive personal trait (Beutler and Moos, 2003). Applied to psychotherapy, patients can be distinguished between those who propose change looking "inward" (internalizers) and those who do it looking "outward" (externalizers) (Beutler, Kimpara, Edwards & Miller, 2018). In the opinion of McCrae et al. (2000), the relationship between personality traits and coping has not been sufficiently studied; neuroticism is known to be associated with maladaptive coping strategies, alexithymia, and ineffective emotional regulation skills; but these authors echo the need to investigate how this relationship occurs, and point out that mediation analyses suggest that personality traits promote certain moods that influence emotional processing.

CS is related to symptomatological disturbance (Fernández and Díaz, 2001; Guo, Xue, Zhao and Liu, 2005; Pelechano, 1992), and to PD (Bijttebier and Vertommen, 1999; Kruedelbach, McCormick, Schulz and Grueneich, 1993; Lago et al., 2008; Ramos, 2015). It also contributes to self-harm and suicidal behaviour typical of borderline PD (Rietdijk, van den Bosch, Verheul, Koeter, & van den Brink, 2001). Wigenfeld et al. (2009) find that people with borderline PD attach greater importance to negative events than depressive patients and controls, and use less the most favourable coping strategy focused on the problem. Furthermore, emotion-focused coping positively correlates with all psychopathology measures, it

is more stable and more difficult to change in therapy. Task-focused CS negatively correlates with neuroticism (Connor-Smith & Flachsbart, 2007); avoidant and emotion-focused coping are associated with an increased risk of suicidal ideation (Chou et al., 2017).

According to Beutler et al. (2018), the essential constructs into which the different studied coping styles (understood as traits or dispositions) can be grouped are those of internalizer and externalizer. Both terms would summarize the conceptual variations of coping styles that appear in the clinical literature better than the concepts of introversion and extraversion. They are relatively normally distributed in the population, but produce recognizable psychopathological patterns when combined with moderate and high levels of dysfunction. Externalizers are clinically recognized because they tend to evitative behaviours or lack behavioural control in stressful situations, and they often blame others for their discomfort; internalizers, on the other hand, tend to face the threat in an inhibited and self-accusatory way.

As we can see, research in personality, affect and coping is converging even in terminology, something that can be confusing if contexts are not distinguished and models are not integrated. The present research aims to study the relationship between personality structure, affect structure and coping style in a group of people diagnosed with severe PD in whom personality and affect show their most psychopathological aspect. As personality structure, the model that emerged psychometrically in previous research (Ramos, Broco, Sánchez & Doll, 2020) is chosen, which allows an exhaustive and exclusive classification of the entire sample and that corresponds to a high level of "super factors" in the taxometric hierarchy (Kotov et al, 2017; Widiger et al., 2019): internalization and externalization. The internalizing type is characterized by schizoid, phobic-inviting, schizotypal, and dependent traits; the externalizing group exhibits narcissistic, histrionic, antisocial, and aggressive-sadistic traits. In the tradition of classical typologies, a model that classifies people into three groups was proposed: resilient, under-controlled and over-controlled (Asendorpf, Borkenau, Ostendorf and Van Aken, 2001; Block and Block, 1980; Spech, Luhman and Geiser, 2014). The resilient profile is associated with mental health; the over-controlled group is characterized by inhibition and anxiety (internalizing tendencies); the under-controlled group is characterized by antisocial behaviours and aggressiveness (externalizing tendencies). As the structure of affect, the bifactorial model of Watson and Clark (1992) is chosen, which considers positive affect and negative affect as two orthogonal axes or two independent dimensions.

Negative affect is expected to be associated with internalizing personality and positive affect with externalizing personality. Consequently, the group of internalizers will present a greater negative affect than the group of externalizers. The relationship between personality and symptomatic severity will be mediated by affective disposition (specifically, by negative affect). However, the use of functional coping strategies could alleviate the pathological effect of negative affect on symptom intensity. If this prognosis can be confirmed, learning functional coping strategies would emerge as a prominent goal in a therapeutic intervention designed for people with severe PD.

Specifically, the following hypotheses are raised: 1) Internalizers exhibit greater negative affect than externalizers; 2) the effect that the personality type produces on the symptomatic severity is not direct, but is mediated by the affective disposition; 3) unfavorable or dysfunctional coping style is found more frequently among internalizers than externalizers; and 4) internalizers who use a favourable or functional coping strategy do not differ in symptomatological severity from externalizers who also use functional coping strategies.

Method

Participants

Adults with a diagnosis of PD who were admitted successively between 2008 and 2020 in a PD Unit participate voluntarily in a hospital intervention program. N= 358. All meet criteria for severe PD, diagnosed by the psychiatrists responsible for its treatment in the Mental Health Centers and corroborated through clinical interviews in the PD Unit itself. Their age range is from 18 to 58 years (M= 35.7, SD= 8.6); the majority are women (79.6%), single (66.2%), living with a relative (80%), and without their own home (55.5%). Their employment situation is unemployment (61.6%), temporary disability (24.4%) or permanent disability (14%). Only 13.1% have university studies and 38.4% have a recognized degree of disability (between 33% and 81%). 59.7% had received a diagnosis of borderline PD by the psychiatrists from the Mental Health Centers; the rest, of unspecified (20.6%) or mixed (17.1%) PD.

Instruments

a) *90 Symptoms Checklist*-Revised (SCL90-R; Derogatis, 1992), Spanish version by González de Rivera (2002). This self-report checklist measures the degree of distress. The participant scores on a Likert-type scale from 0 to 4 to what extent they feel annoying in the last weeks for each of the 90 indicated symptoms. It has 10 scales (Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism) and three global indices (Global Severity Index, Positive Symptom Distress Index, & Positive Symptom Total). Its reliability is acceptable, with high internal consistency coefficients (α> .81) and test-retest above .78. This study uses the Global Severity Index (GSI), which is a generalized and indiscriminate measure of the intensity of symptomatic discomfort. Cronbach's alpha coefficient in our sample was α= .97.
b) *Millon Clinical Multiaxial Inventory-II* (MCMI-II; Millon, 1999). This self-report inventory consists of 175 items with a dichotomous response (true/false) and provides a profile of 10 basic personality scales (Schizoid, Avoidant, Dependent, Histrionic, Narcissistic, Antisocial, Sadistic, Compulsive, Negativistic, & Masochistic) plus three severe pathological personality scales (Schizotypal, Borderline, & Paranoid), as well as other scales of clinical syndromes that are not used in this study. The internal consistency according

to the cited manual is satisfactory, with KR coefficients between .81 and .95 obtained in the original sample.

c) *Coping Style Questionnaire* (CSQ; Roger, Jarvis, & Najarian, 1993), short Spanish version in Guarino, Sojo, and Bethelmy (2007). This is a self-report questionnaire that measures the coping style (emotional, rational, detached and avoidant) with 40 items and four response alternatives. The emotional and avoidant coping scales represent maladaptive or unfavourable strategies and the other two scales represent adaptive or favourable strategies. This instrument shows acceptable reliability (Cronbach's α from .65 to .78), and construct validity with the "Emotional Intelligence Inventory", the "Interpersonal Reactivity Inventory" and the "Emotional Sensitivity Scale". In our sample, α= .73 for the unfavourable coping scales (UCS= emotional + avoidant) and α= .80 for the favorable coping scales (FCS= rational + detached). The variable "predominant coping style" (PCS) is defined by dichotomously classifying the participants according to whether their UCS > FCS or vice versa.

d) *Positive and Negative Affect Schedule* (PANAS; Watson, Clark, & Tellegen, 1988), Spanish version of Joiner, Sandín, Chorot, and Lostao (1997). This self-report instrument measures two independent dimensions of affect, the pleasant and the unpleasant emotions. It includes 20 representative adjectives of emotions (10 of positive emotions such as lively, proud or active, and another 10 of negative emotions such as overwhelmed, sad or fearful), with which the subject evaluates the magnitude that each emotion was experienced in a specified time (one day, the last week, etc.) with a 5-point scale (not at all, a little, moderately, quite a lot, a lot). The scores range between 10 and 50 on each of the two scales. Its reliability is adequate, with Cronbach's α= .89 for the positive affect scale (PA) and .85 for the negative affect scale (NA), as well as its construct validity and factorial structure (see Crawford & Henry, 2004). In this study, the internal consistency levels (Cronbach's alpha) were .93 for PA and .92 for NA.

Procedure

The participants, after signing a therapeutic contract, joined the 6-month multi-professional treatment program inspired by the therapeutic community model. The program includes, as one more aspect of the individual evaluation, a battery of self-report instruments, some of which were used in this study.

The participants complete the questionnaires during the first weekend of admission, except for the PANAS that is carried out daily and for which, for this work, the average in NA and PA of the first month is collected. The scores are processed in a split database to preserve anonymity. The work complies with the ethical and regulatory guidelines for publication and has been approved by the Hospital Research Commission.

Analysis of data

The two categories of the variable "personality type" (INT= internalization and EXT= externalization) are obtained from the scores in each of the 13 personality scales of the MCMI-II through cluster analysis. In recent work (Ramos et al., 2020) the procedure is detailed and the naming of the categories is justified based on their association with different clinical variables. In the present study, the sample is larger (48 more patients) and analyses have been redone from the direct scores. The variable "affective disposition" is operationalized for some analyses as a continuous variable based on the direct scores on the PANAS and, for others, as a dichotomous variable with the mean of the distribution as a cut-off point, obtaining high and low levels in each one of the two categories: negative affect (NA) and positive affect (PA).

Using the Student's t-test for independent samples, mean differences in NA, PA and GSI (continuous dependent variables) were contrasted according to personality type and coping style (dichotomous independent variables). Using the Chi2 test of independence of distributions, the association between "personality type" and "affective disposition" is contrasted, as well as between both variables and the "predominant coping style" (PCS).

Mediation models are analyzed with the PROCESS program (Hayes, 2018), successively proposing the "affective disposition" and the "coping style" as mediating variable (M) of the effects of the independent variable "personality type" (X) on the dependent variable "symptomatic severity" (Y), obtained from the SCL90-R GSI score.

Finally, combining the personality type with the PCS, 4 profiles are obtained: internalizer with unfavourable coping style (INTUNF), internalizer with favourable coping style (INTFAV), externalizer with unfavourable coping style (EXUNF) and externalizer with favourable coping style (EXFAV). These profiles are contrasted with the variables affective disposition (NA and PA) and symptomatic severity (GSI). After verifying that the conditions of normality (Kolmogorov-Smirnov test) and homoscedasticity (Levene's test) of the distribution do not exist, non-parametric tests (Kruskal-Wallis and Mann-Whitney) are performed to contrast hypothesis 4. The SPSS Statistics v.26 programme was used.

Results

Table 1 shows descriptive demographic and clinical data that characterize the sample. A correlation r= -.506 (p< .001) is observed between the two PANAS scales. With their dichotomization based on their respective means [NA= 26.4 (9.01); PA= 27.5 (8.7)], we obtain χ^2= 22.65 (p< .001) which confirms the dependence of the two dimensions of affect.

Table 1
Demographic and clinical characteristics of the sample (*N*= 358)

Variables	*n*	%	
Gender			
Female	285	79.6	
Male	73	20.4	
Personality type			
Internalizer	157	51.1	
Externalizer	150	48.9	
Negative affect			
Low	196	54.7	
High	162	45.3	
Positive affect			
Low	196	54.7	
High	162	45.3	
Coping style			
Unfavourable	260	88.1	
Favourable	35	11.9	
	Range	*M*	*DT*
Age	18-58	35.61	8.62
Symptoms severity (GSI)	0.41-3.83	2.37	0.70
Affective disposition (PANAS)			
Negative affect	10-50	26.44	9.01
Positive affect	10-50	27.52	8.70
Unfavourable coping (CSQ-EmEv)	0.33-2.78	1.67	0.43
Favourable coping (CSQ-RaDe)	0.12-2.62	1.08	0.36

Notes: GSI= Global Severity Index from the 90 Symptoms Checklist-Revised (SCL90-R); CSQ-EmEv= Emotional and avoidant coping scales from the Coping Style Questionnaire (CSQ); CSQ-RaDe= Rational and detached coping scales from the CSQ.

The frequency of internalizers with high NA (58.5%) and low PA (62%) is higher than that of externalizers (31% and 40%, respectively) [NA: χ^2= 21.89, p< .001; AP: χ^2= 13.99, p< .001). The degree of intensity of the negative affect dimension is consequently higher in the group of internalizers (Table 2). This same table 2 specifies the differences in affective disposition according to the coping style. 88.1% of the sample presented an unfavorable or dysfunctional coping style; its frequency is higher among internalizers than among externalizers (93% vs 83%; χ^2= 7.226, p= .007).

Table 2
Differences (*t*-Student) by personality type and by coping style in the two affect dimensions (NA and PA) and symptoms severity (GSI)

Variables	*n*	*M (SD)*	Dif	*t*	*p*	95% CI	*g*
Personality type							
AN							
INT	152	28.5 (8.94)	5.25	5.31	.000	3.3 - 7.2	0.62
EXT	138	23.3 (7.77)					
AP							
INT	152	25.3 (8.24)	-5.12	-5.15	.000	(-7.1) - (-3.2)	0.60
EXT	138	30.4 (8.69)					
GSI							
INT	155	2.6 (0.59)	0.42	5.50	.000	0.27 - 0.57	0.60
EXT	147	2.2 (0.73)					
Coping style							
NA							
UC	249	26.6 (8.54)	6.24	3.78	.000	3.0 - 9.5	0.72
FC	30	20.4 (8.59)					
PA							
UC	249	27.0 (8.41)	-6.39	-3.84	.000	(-9.7) - (-3.1)	0.74
FC	30	33.4 (10.03)					
GSI							
UC	260	2.47 (0.64)	0.76	5.50	.000	0.5 - 1.0	1.16
FC	35	1.70 (0.79)					
Affective disposition							
GSI							
Low NA	157	2.08 (0.66)	-0.67	-9.66	.000	(-0.8) - (-0.5)	1.13
High NA	129	2.76 (0.52)					
Low PA	146	2.49 (0.62)	0.22	2.70	.007	0.1 - 0.4	0.31
High PA	140	2.28 (0.73)					

Notes: NA= Negative affect scale from the Positive and Negative Affect Schedule (PANAS); PA= Positive affect scale from the PANAS; UC= Unfavourable coping; FC= Favourable coping; GSI= Global Severity Index from the 90 Symptoms Checklist-Revised (SCL90-R); CI= confidence interval; INT= internalizer; EXT= externalizer.

Mediation models (Figure 1) show that the effect of personality type on symptoms' severity is partially mediated by affective disposition and coping style because both indirect and direct effects are significant (Table 3).

Figure 1
Models of mediation on symptom severity of personality type (a) and coping style (b) with the two dimensions of affect as mediating variables, and (c) of personality type with the two coping styles as mediating variables

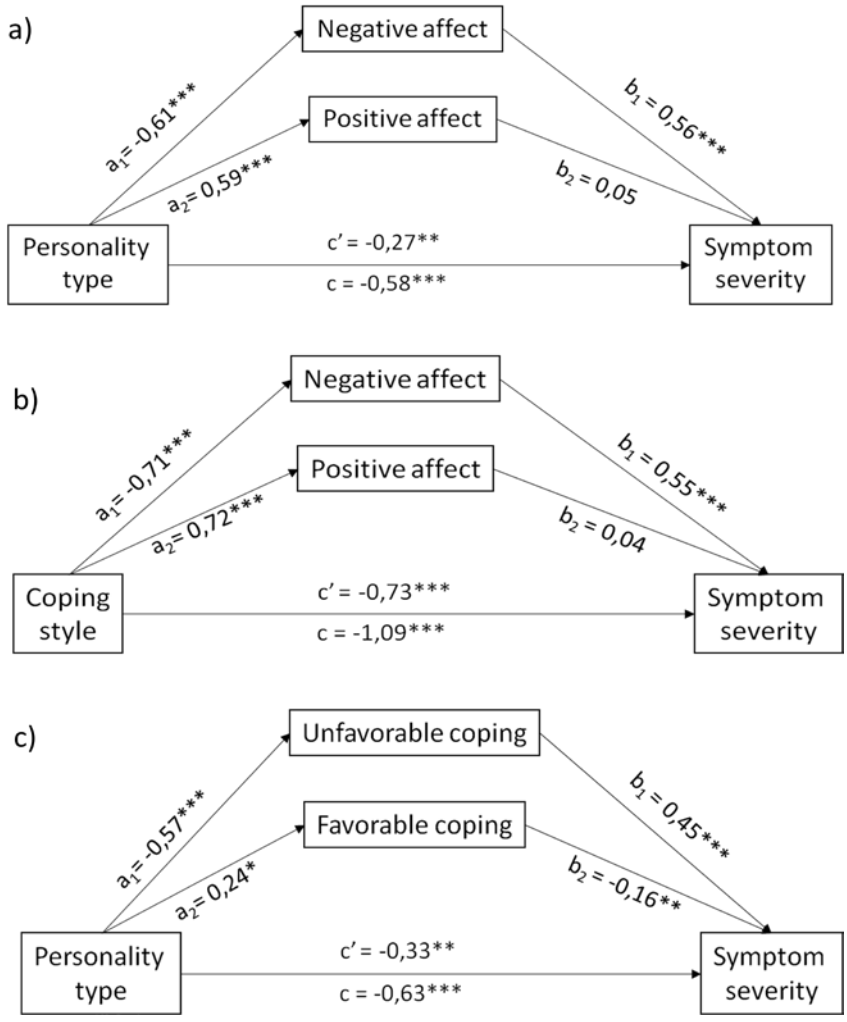


Table 3
Mediation analysis: direct and indirect effects of personality type (model a) and coping style (model b) on symptom severity (GSI) (n= 286)

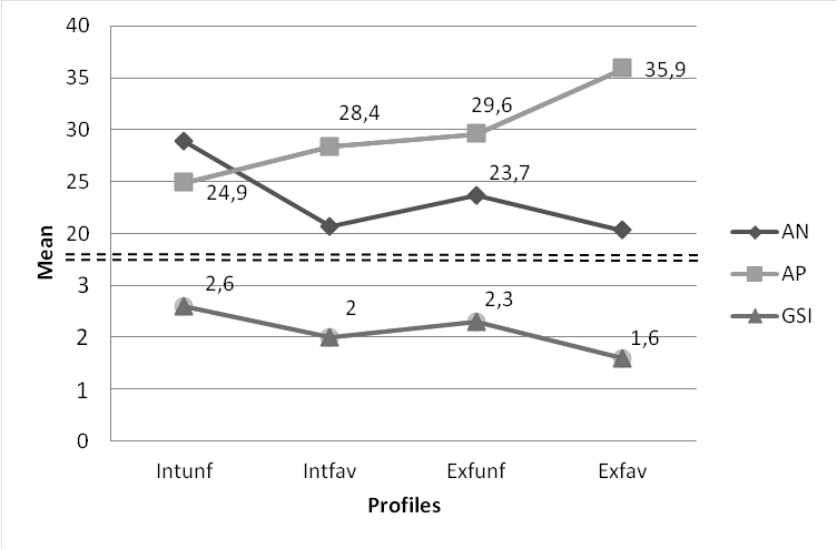
	Model		Coefficients			
Model a	R^2	F	B	β	t	p
Effect of P on NA	.09	28.88***	-5.29	-0.61	-5.37	< .001
Effect of P on PA	.09	26.79***	5.16	0.59	5.18	< .001
Indirect effect of P on GSI	.09	26.60***	-0.40	-0.58	-5.16	< .001
Total effect on GSI	.35	50.94***				
Direct effect of P			-0.19	-0.27	-2.67	.008
Effect of NA			0.04	0.56	9.95	< .001
Effect of PA			0.01	0.05	0.87	.383
Model b						
Effect of CS on NA	.05	14.31***	-6.24	-0.71	-3.78	< .001
Effect of CS on PA	.05	14.79***	6.39	0.72	3.84	< .001
Indirect effect of CS on GSI	.11	36.11***	-0.75	-1.09	-6.01	< .001
Total effect on GSI	.39	58.07***				
Direct effect of CS			-0.50	-0.73	-4.64	< .001
Effect of NA			0.04	0.55	10.01	< .001
Effect of PA			0.01	0.04	0.78	.436
Model c						
Effect of P on UC	.08	25.96***	-0.24	-0.57	-5.09	< .001
Effect of P on FC	.01	4.20*	0.08	0.24	2.05	.041
Indirect effect of P on GSI	.10	32.16***	-0.44	-0.63	-5.67	< .001
Total effect on GSI	.31	43.81***				
Direct effect of P			-0.23	-0.33	-3.25	.001
Effect of UC			0.75	0.45	8.91	< .001
Effect of FC			-0.32	-0.16	-3.29	.001

Notes: The mediating variables were Negative Affect (NA) scale and Positive Affect (PA) from the PANAS for the models a and b, and Coping style (CS) for the model c. P= Personality (internalizer vs externalizer); GSI= Global Severity Index from the 90 Symptoms Checklist-Revised (SCL90-R); UC= Unfavourable coping; FC= Favourable coping. ***p< .001; **p< .005; *p< .05.

Figure 2 shows the score in affective disposition (NA and PA) and in symptoms' severity (GSI) for each of the profiles created by crossing personality type with coping style. The profile groups score differently in NA, PA and GSI (Kruskal-Wallis: $\chi^2_{(3)}$= 36.248, p< .001; $\chi^2_{(3)}$= 31.918, p< .001; $\chi^2_{(3)}$= 45.621, p< .001, respectively). Table 4 shows the descriptions of each profile and Table 5 shows the Mann-Whitney test comparing them two by two. The subgroup of internalizers with favourable coping style (INTFAV) does not differ from externalizers (EXFAV and EXUNF) in NA, PA or GSI. Coping style interferes in the effect that personality type has on affective disposition and symptoms intensity.

Figure 2
Mean score on the two PANAS scales and symptom severity (GSI) according to the profiles created by crossing the variables personality type with coping style

Note: NA= Negative Affect (PANAS); PA= Positive Affect (PANAS); GSI= Global Severity Index from the



90 Symptoms Checklist-Revised (SCL90-R); Intunf= internalizing-unfavorable; Intfav= internalizer-favourable, Exunf= externalizer-unfavourable; Exfav= externalizer-favourable. The ploted horizontal line indicates a scale change in Y axis.

Table 4
Descriptive statistics on affective disposition and symptom severity according to the subgroups created after crossing the variables personality type and coping style.

Variable (instrument)	*n*	*M*	*SD*	95% CI
Negative Affect (PANAS)				
Intunf	140	28.95	8.77	27.5 - 30.4
Intfav	10	20.74	6.68	15.9 - 25.5
Exunf	109	23.71	7.26	22.3 - 25.1
Exfav	20	20.25	9.56	15.8 - 24.7
Positive Affect (PANAS)				
Intunf	140	25.00	8.22	23.6 - 26.4
Intfav	10	28.41	7.78	22.8 - 34.0
Exunf	109	29.66	7.95	28.1 - 31.2
Exfav	20	35.94	10.25	31.1 - 40.7
Global Severity Index (SCL90-R)				
Intunf	144	2.62	0.56	2.5 - 2.7
Intfav	11	2.02	0.72	1.5 - 2.5
Exunf	115	2.27	0.67	2.1 - 2.4
Exfav	24	1.56	0.78	1.2 - 1.9

Notes: PANAS= Positive and Negative Affect Schedule; SCL90-R= Symptoms Checklist-Revised; Intunf= Internalizer with unfavourable coping; Intfav= Internalizer with favourable coping; Exunf= Externalizer with unfavourable coping; Exfav= Externalizer with favourable coping.

Table 5
Mann-Whitney (U) test for non-parametric contrast of differences between the personality x coping profile groups taken two by two, and effect size (r).

Variables	Negative affect			Positive affect			Global Severity Index		
	U	*p*	*r*	*U*	*p*	*r*	*U*	*p*	*r*
Intunf x Intfav	333.00	.006	-.23	516.00	.166	-.11	419.50	.009	-.21
Intunf x Exunf	5024.50	.000	-.29	5178.50	.000	-.28	5762.50	.000	-.26
Intunf x Exfav	609.00	.000	-.32	572.00	.000	-.34	475.50	.000	-.44
Intfav x Exunf	406.00	.183	-.12	489.50	.595	-.05	526.50	.360	-.08
Intfav x Exfav	82.00	.428	-.14	57.00	.058	-.35	88.00	.082	-.29
Exunf x Exfav	705.50	.012	-.22	691.50	.010	-.23	670.00	.000	-.34

Notes: Intunf= Internalizer with unfavourable coping; Intfav= Internalizer with favourable coping; Exunf= Externalizer with unfavourable coping; Exfav= Externalizer with favourable coping.

Discussion

The concepts "internalizing/externalizing" appear as superordinate factors in the hierarchy of mental disorders (Kotov et al., 2017), as central dimensions of PD (Tyrer et al., 2019) and as essential constructs that group the styles of coping investigated (Beutler et al., 2018). Their relationship with the personality traits neuroticism and extraversion has been highlighted (Widiger et al., 2019), and the association of both with the affect structure has been demonstrated (Barlow et al., 2014). This confluence of results (Oltmanns et al., 2018) requires an integration effort that avoids ambiguities and promotes the understanding of the complexity of mechanisms related to psychopathology and human suffering.

In this work, the internalizing/externalizing typology has emerged psychometrically as an empirical result of a cluster analysis based on the responses of people with severe PD to a personality questionnaire (the MCMI-II) configured according to the traditional psychiatric categorization of the DSM. This finding supports the stubbornness with which both constructs emerge in independent research (Harford et al., 2013; Wright et al., 2015). This is close to the typology of under-controlled vs. over-controlled (Asendorpf et al., 2001).

The results confirm that internalizers exhibit a greater negative affect than externalizers and report a greater symptoms disturbance, in line with the results of research linking neuroticism with NA (Gómez et al., 2002; Gross et al., 1998; Meyer and Shack, 1989; Uziel, 2006) and with psychopathology (Lahey, 2009; Hafferty et al., 2019; Ormel et al., 2013). Griffith et al. (2010) came to find an almost perfect correlation between internalization and neuroticism. Neuroticism refers to individual differences in negative emotional response to threat, frustration or loss, and therefore it is equivalent to high NA (Ormel et al., 2013). It is a robust predictor of various physical and mental disorders, comorbidity between them and

use of health resources (Lahey, 2009). The levels of NA and PA obtained in our study are similar to those of other clinical samples (Díaz-García et al., 2020) and higher than those of general samples (Crawford and Henry, 2004; López-Gómez, Hervás and Vázquez, 2015; Watson et al., 1988).

To clarify the relationship between the structure of personality and affective disposition, mediation analyses were carried out, and the results show that the effect that personality type produces on symptoms severity is partially mediated by affective disposition and also by coping style. Similarly, coping style produces effects on symptoms intensity not mediated by NA. These findings suggest that personality type, affective disposition, and coping style are not equivalent, although they are related and may share processes.

We found among internalizers a greater prevalence of an unfavourable or dysfunctional coping style (emotional and avoidant), which makes plausible the claim that the effort to focus on the emotion and to avoid the threatening situation that overflows the personal balance can be an explanatory mechanism for the association between internalizing personality type and perceived disturbance. This finding is in line with those of Gómez et al. (2002), Gross et al. (1998) and Uziel (2006) regarding the information processing biases typical of those who score high in neuroticism, and also in line with the typology of overcontrollers (Kerber, Roth and Herzberg, 2021).

Neuroticism has been proposed as a constituent of the general factor of psychopathology (Caspi et al., 2014; Caspi and Moffitt, 2018; Oltmanns et al., 2018). Its approach by different means may explain the similar effectiveness shown by various formal psychotherapies in various disorders and the effectiveness of unified protocols for various pathologies (Sauer-Zavala, Wilner, & Barlow, 2017). The role of positive affect has hardly been investigated and has not been the focus, specifically, in the intervention with PD (Meehan, Clarkin & Lenzenweger, 2018), something that should be corrected in future research and clinical work.

On the other hand, if neuroticism is a relatively stable trait for years (which makes it possible to predict vulnerability to adversity), task-focused learning of coping strategies is an important protective factor that should be strengthened (Hafferty et al., 2019). This introduces us to the comment on the finding that we consider most relevant in this work: the use of favourable coping strategies (rational and detached styles) could alleviate the effect that personality (directly and through affective disposition) exerts on distress and pathology. Indeed, the subgroup of internalizers who use a favourable or functional coping strategy do not differ in symptoms' severity from the externalizers who also use such coping strategies. Coping styles are of particular interest because they are potentially modifiable with treatment (Chou et al., 2017). Correcting, for example, the avoidance style and the suppression of thought can avoid risks of suicide among patients with PD (Cukrowicz et al., 2008). Furthermore, CS is one of the predictors of change in psychotherapy: when treatment is adapted to the internalizing or externalizing style of coping, its effectiveness improves (Beutler et al., 2018).

Among the limitations of this work, it should be noted, firstly, that the data come exclusively from self-report questionnaires; particularly, the evaluation of coping strategies would have acquired greater objectivity through the observation

and judgment of third parties. Secondly, the consideration of other potentially influential variables in the relationship between personality typology, affect, coping and symptoms severity (such as automatic thoughts, perception of self-efficacy, self-esteem, etc.) could show different results. Thirdly, the correlational design does not allow establishing causal relationships, nor does it allow access to the dynamics of intra-individual psychic processes (Wright et al., 2015). The choice of a single criterion of clinical severity (GSI) is excessively reductionist, although it is a generally accepted index of perceived psychological disturbance. Finally, it would be necessary to examine the change produced by the treatment in the three areas investigated: personality structure, affective disposition and use of coping strategies, something proposed for future research.

The integration of personality, personality disorders and psychopathology is still an open field for research, caring that the pragmatic and political aspects do not slow down its development too much (Tyrer et al., 2019). Complementing the traits approach with the processes approach, as has been proposed for borderline PD (Meehan et al., 2018), would allow better integration of categorical with dimensional aspects, cognitive-behavioural with object relations traditions, personality with disorders (Wright, 2011).

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RECEIVED: June 17, 2020
ACCEPTED: April 6, 2021