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Personality Functioning: An Opportunity for Treatment Personalization

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As the literature shows, the categorical diagnosis of personality has received numerous criticisms [1-4]. Over the years, authors suggest that personality dysfunction is distributed along a dimensional continuum [5-8]. Dimensional assessment of personality severity has been included in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders [9], Section III, and in the World Health Organization's International Statistical Classification of Diseases and Related Health Problems [10], where levels of personality functioning are posited to account for personality complexity.

This complexity is in line with what John, Robins, and Pervin had emphasized. They define personality as a dynamic and complex concept which encompasses the individual's traits, self-concept, cognition, affect, behavior patterns, genetic make-up, perception, motivation, interpersonal dynamics, and resiliency. Much of what has been learned about personality over the past 50 years has focused on the dynamic interplay of two or more of these variables, and it is time to "put the person back together" ([11] p. 19) and recognize the complex dynamics and intrapersonal processes that are known to affect personality ([11] p. 14).

The emergence of the assessment of patients' personality functioning addresses the long-standing need to go beyond symptomatology. Mere symptom description has been shown to be incapable of providing clinicians with diagnosis and guidelines for treatment [12-14], since patients present with complexity beyond symptoms [15,16].

The Operationalized Diagnosis System (OPD System, [17]) addresses these challenges, providing a clinically relevant functional diagnosis which is comprehensive and inclusive diagnosis not only of personality structure, but also of dysfunctional relational patterns and chronic intrapsychic conflicts that underlie the patient's symptomatology and/or interpersonal difficulties. In particular, personality structure comprises reflexive perception abilities concerning the self and others, regulation of the self and object relations, internal communication, communication with the external world, and attachment capacities to internal and external objects. Each of these functions contains 24 sub-functions to be assessed as part of the personality structure diagnosis (see Table 1). Any of these dimensions can be identified as either a vulnerability or a resource for the patient's structural functioning through the Operationalized Psychodynamic Diagnosis Structure Questionnaire (OPD-SQ) [18].

Our studies using the OPD-SQ have aimed to account for the relevance of personality from this perspective by relating it to psychopathology, as other authors have done [19,20]. This has provided input for differentiating depression from complex depression. And to account for the work on personality functioning during the psychotherapeutic process through the establishment of therapeutic foci.

The first study was undertaken by Dagnino et al. [21], who evaluated 145 patients with a clinical diagnosis of depression at two outpatient psychotherapeutic care centers. One of the aims of the study was to assess the relationship between structural functioning and depressive styles. Depressive styles were measured through the Depressive Experiences Questionnaire [22], which identifies if the patient is self-critical or dependent. It was found that both styles related to specific structural vulnerabilities (which we will discuss later).

Table 1: Structural personality functions of the OPD system.

Self	Object
Perception/Cognition	
Self-perception • Reflection of self • Differentiation of affects • Identity	*Object perception* • Self-object differentiation • Holistic object perception • Realistic object perception
Regulation	
Self-regulation • Regulation of impulse • Tolerance of affects • Self-regulation-esteem	*Regulation of relationships* • Regulation of relationships • Anticipation
Communication	
Communication • Internal communication • Experiencing of affects • Utilizing fantasies Body-self	*External communication* • Establishing contact • Communicating affects • Empathy
Attachment	
Attachment to internal objects • Internalization • Utilizing introjects	*Attachment to external objects* • Accepting help • Dissolving attachment

In another study, Dagnino et al. [23] analyzed self-reports of 162 patients seeking psychotherapy in outpatient clinics. 72.33% of them were women between 18 and 70 years of age (mean age M = 30.56, and SD of 11.39) and 66% had pursued higher education studies. The aim of the study was to identify which risk factors (sociodemographic, physical disease, hereditary factor, and adverse childhood experiences) were significantly related to depressive symptomatology; furthermore, the authors sought to evaluate the influence that personality functioning has on this relationship. In line with previous studies, the authors found that impairments of personality functioning were associated with more depressive symptomatology [24-28]. However, more importantly, they found that personality functioning mediated the relationship between adverse childhood experiences and depressive symptomatology. This may be key to clinical interventions, since impairments as a vulnerability (personality functioning) are more likely to be worked on initially or throughout the process, unlike the risk factor itself.

Immel, Dagnino, and Hunger-Schoppe [29] analyzed the data of 96 patients with depression (age: M = 30.56, SD = 11.39; 78.5% women; 44.6% students, 28.3% employees). They explored predictors for therapy dropout and symptomatic change in depressive patients. For these outcomes, two predictors were included: personality structure measured through the OPD-SQ and personality configurations in terms of self-criticism and dependency measured through the Depressive Experience Questionnaire (DEQ). They found that the patients' structural integration was associated with both symptomatic change and dropout.

All these studies, their results, and those of other authors, confirm that the training of therapists should include techniques addressing patients' structural integration (beyond symptoms). In summary, our results have shown, through the administration of the OPD-SQ that general and/or specific dysfunctions in personality functioning are related to more depressive symptomatology, presence of adverse childhood experiences, greater self-criticism, greater dependence, high dropout, and depressive styles.

The Diagnosis of Personality Functioning: Tailoring Psychological Treatments

The mandate to consider the heterogeneity and diversity of patients was first formulated in 1967 by one of the founding fathers of modern clinical psychology, Gordon Paul [30], with his famous question: "What treatment, by whom, is most effective for this individual with that specific problem, and under which set of circumstances?"

Our findings are in line with this mandate, which is referred to in many ways, such as adaptive indication [31], personalized treatment [32], precision diagnosis [33-37], person-specific [38,39], idiographic [40,41], and responsiveness [42] in the same way the term 'tailoring' is used.

Tailoring psychological treatments is indeed what we should do. Wright and Woods [43] emphasize the need to develop formal within-person models for each patient to provide a tailor-made understanding of their particular clinical presentation. We propose that addressing patients' specific personality dysfunctions constitutes one transdiagnostic and clinically sensible way [44]. The individualization of treatment based on structural vulnerabilities/dysfunctions is necessary since the mere knowledge about the descriptive, diagnostic status of a patient does not provide information about etiology or guidance concerning relevant reinforcing variables [45]. Our proposal is in line with studies reported by Ferrero et al. [13], in which an individualized treatment adapted to the patients' psychopathological functioning will lead to better outcomes.

Assessing personality functioning through the OPD-SQ to screen for the heterogeneity and complexity of patients can make it possible to derive patient-specific interventions and treatment planning [29,46,47].

An example of this application that can serve as an initial guide is provided in Dagnino et al. [21] where, specific vulnerabilities were identified for patients with a dependent or self-critical depressive style. Patients with a self-critical type showed vulnerability in integrating internal bonds, while patients with a dependent style showed vulnerabilities in the perception of self and in the management of interpersonal relationships. Thus, for instance, in a tailored psychotherapy, we would know that a patient with depression of a self-critical style has poorly integrated internal bonds. This may indicate deficiency of internalized relationships capable of caring, protecting, and calming. In consequence, these patients are likely to have threatening and persecutory objects that emerge during the process. The therapist must be attentive to intervene and try to "silence" them. The objective will be to "replace" those persecutory objects through the repairing relationship with the therapist [48].

On the other hand, we would know that a patient with a dependent style has self-perception vulnerabilities, which could be treated with mentalizing techniques [49]. Also, these patients have a decreased structural capacity to handle the relationship with objects, which could eventually be worked on in connection with self-perception functioning. To do this, it is important for the therapist to be able to help the patient to regulate his/her relationship with others. This can be achieved by fostering an observing with the patient his/her self with some distance [50,51]. This allows to be more conscious about impulsive ways of acting in front of others and, through this, being able to manage and resolve the emotional storms. It will also, allow the patient to recognize and validate its own interests.

We expect this line of transdiagnostic personality dysfunctions and its targeted treatments to provide a window of opportunity to address the significant public health burden currently affecting the globe while also improving the training of therapists through the development of competencies related to each of the dimensions of personality. In this regard, the validation of an instrument that finely and profoundly measures personality functioning, such as the OPD-SQ, represents a pivotal contribution.

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