



Self-concept structure and borderline personality disorder: Evidence for negative compartmentalization



Aline Vater^{a, b, *, 1}, Michela Schröder-Abé^{a, 1}, Susan Weißgerber^d, Stefan Roepke^{b, c},
Astrid Schütz^e

^a University of Darmstadt, Germany

^b Charité – Universitätsmedizin Berlin, Campus Benjamin Franklin, Germany

^c Cluster of Excellence – Languages of Emotion, Freie Universität Berlin, Germany

^d Helios Klinikum Aue, Germany

^e University of Bamberg, Germany

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ABSTRACT

Background and objectives: Borderline personality disorder (BPD) is characterized by an unstable and incongruent self-concept. However, there is a dearth of empirical studies investigating self-concept in BPD. In order to bridge this research gap, the purpose of this study was to apply an in-depth analysis of structural aspects of the self-concept in BPD.

Methods: We examined the degree of compartmentalization, i.e., a tendency to organize knowledge about the self into discrete, extremely valenced (i.e., either positive or negative) categories (Showers, 1992).

Results: We hypothesized and found that BPD patients had the most compartmentalized self-concept structure and a higher proportion of negative self-attributes relative to both a non-clinical and a depressed control group. Moreover, BPD patients rated negative self-aspects as more important than positive ones relative to non-clinical controls.

Limitations: We cannot determine whether causal relationships exist between psychological symptoms and self-concept structure. Moreover, further comparisons to patients with other psychiatric disorders are necessary in order to further confirm the clinical specificity of our results.

Conclusions: Our findings indicate that a negative compartmentalized self-concept is a specific feature of BPD. Implications for future research, psychological assessment, and psychotherapeutic treatment are discussed.

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1. Self-concept structure and borderline personality disorder: evidence for negative compartmentalization

Borderline personality disorder (BPD) has been recognized as a serious mental disorder that is highly prevalent within the population and in inpatient samples (Torgersen, Kringle, & Cramer, 2001). According to theory, patients with BPD are believed to evaluate themselves in an extreme, incoherent and simplistic manner (Kernberg, 1975). Although several authors (e.g., Kernberg,

1975; Linehan, 1993; Linehan, Heard, & Armstrong, 1993) proposed theories describing self-concept disturbances in BPD, the precise nature of the self-concept in BPD has, as of yet, received relatively little empirical attention. This study aimed to close this research gap by utilizing assessment tools and theoretical models of the self from personality and social psychology and applying them to clinical research on BPD.

1.1. Self-concept disturbances in BPD

Several researchers published theories and empirical findings on the self-concept structure of patients with BPD. In the following, we provide an overview of these accounts. The concept of ‘splitting’ is one of the earliest and most cited conceptualizations of self-concept disturbances in BPD patients (Kernberg, 1975, also see Jacobson, 1964; Stern, 1938). According to Kernberg (1975), patients

* Corresponding author. Technische Universität Darmstadt, AG Psychologische Diagnostik, Evaluation und Intervention, Alexanderstr. 10, 64283 Darmstadt, Germany. Tel.: +49 6151 16 5115.

E-mail address: aline.vater@fu-berlin.de (A. Vater).

¹ A. Vater and M. Schröder-Abé contributed about equally to this work and therefore share first authorship.

with BPD are unable to integrate positive and negative aspects of the self and others into a more complex whole. Thus, BPD patients can only perceive either positive or negative aspects of themselves at a given point in time. Moreover, it is assumed that BPD patients have difficulties discerning more subtle variations between these two extremes or difficulty considering other evaluative dimensions when forming appraisals.

Even though conceptualizations involving splitting in BPD patients are still common in the scientific literature, the results of several studies contradict assumptions of split evaluations in BPD. In a study by [Veen and Arntz \(2000\)](#), participants were instructed to rate several film characters on visual analogue scales. According to splitting theory, one would hypothesize that BPD patients evaluate the film characters either extremely positively or extremely negatively. However, the results of this study contradicted a splitting conceptualization: BPD patients engaged in both extremely positive evaluations (e.g., happy) and extremely negative evaluations (e.g., unreliable). This cognitive style, which is termed multidimensional dichotomous thinking (c.f. [Beck et al., 2001](#)), has been repeatedly demonstrated in BPD (e.g., [Arntz & ten Haaf, 2012](#); [Napolitano & McKay, 2007](#)). These studies provided evidence for multidimensional thinking when BPD patients evaluate other individuals, but only one study investigated whether multidimensional thinking also occurs in BPD patients' self-evaluations. Given the aforementioned findings, one might conclude that self-concepts of BPD patients may consist of attributes of mixed valence. However, [Sieswerda, Arntz, and Wolfis \(2005\)](#) demonstrated that patients with BPD tended to produce extremely negative, but not split or dichotomous evaluations of themselves on 20 trait visual analogue scales. Consistent with this result, several studies have found that BPD patients possess a more negative self-concept than non-clinical individuals ([Klein, Wonderlich, & Crosby, 2001](#); [Roepke et al., 2011](#); [Rüsch et al., 2007](#)).

Furthermore, the mode model of schema therapy represents a valuable approach for understanding shifts in emotions, cognitions and behaviors in BPD ([Young, Klosko, & Weishaar, 2003](#), also see [Arntz & van Genderen, 2009](#)). According to assumptions of this model, early maladaptive schemas are defined as dysfunctional representations acquired early in life, containing both explicit and implicit beliefs that guide information processing ([Arntz, Klokman, & Sieswerda, 2005](#), p. 227). The schema modes of patients with BPD represent different facets of their self-concept that are not sufficiently integrated, which causes the abrupt cognitive/affective shifts frequently observed in BPD ([Young et al., 2003](#)).

Apart from the theories and findings reported above, there are a small number of empirical studies that have tested hypotheses based upon various theoretical conceptualizations of BPD: A study by [Wilkinson-Ryan and Westen \(2000\)](#) asked clinicians to rate one patient on a self-concept questionnaire. According to their results, patients with BPD were more apt to be characterized as having an incoherent and inconsistent self-concept than patients with other personality disorders and non-clinical individuals. Using an adapted version of the repertory grid test, a study by [De Bonis et al. \(1995\)](#) showed that BPD patients describe themselves more in terms of opposites than in terms of salient attributes. [Roepke et al. \(2011\)](#) showed that patients with BPD report lower self-concept clarity than non-clinical controls and that self-concept clarity increases with therapy.

The studies reported above have certain caveats: Some studies used fixed formats (e.g., a standardized set of visual analogue scales) that may not validly capture unique features of a person's self-concept ([Sieswerda et al., 2005](#)). One study exclusively relied on ratings of clinicians (e.g., [Wilkinson-Ryan & Westen, 2000](#)). Other studies relied on self-report questionnaires yielding one sum score only (e.g., [Roepke et al., 2011](#)), thereby, operationalizing self-

concept as a unitary, one-dimensional construct. Several authors argued, however, that self-concept should be viewed as a multifaceted phenomenon that encompasses a diverse set of images, schemas or concepts ([Markus & Wurf, 1987](#); [Marsh & Shavelson, 1985](#); [Shavelson, Hubner, & Stanton, 1976](#)). That is, a person's self-concept consists of multiple self-aspects that are defined by situations, roles, goals, other persons, interests or traits (for an overview, see [Showers, 1992](#)).

1.2. Showers' model of self-concept organization

In the following, we describe a model of self-concept structure from personality and social psychology ([Showers, 1992](#)). This model has not been previously applied to BPD. We believe that it could be extremely useful for capturing specific features of identity disturbance in BPD: Firstly, it captures structural aspects of the self-concept, and thus, goes beyond approaches that mainly examined the content of the self-concept (e.g., negativity). Secondly, the assessment method allows for an idiosyncratic definition of multiple self-aspects for each participant.

According to [Showers \(1992\)](#), the self-concept is compartmentalized when positive and negative self-descriptive attributes are segregated into separate self-aspects. For example, a person may identify two significant self-descriptive aspects ("work" and "spare time"). A compartmentalized self-concept is present when the first aspect "work" only consists of negative attributes (such as "unsure", "unhappy", "hopeless"), whereas the second aspect "spare time" only consists of positive attributes (such as "happy", "interested", "friendly"). In contrast, a person whose self-concept is structured in an integrative way would generate self-aspects including both positive and negative attributes (e.g., "work" consisting of attributes such as "unhappy", "incompetent", "interested", and "friendly" and "spare time" consisting of attributes such as "unsure", "hopeless", "talkative", and "organized").

[Showers \(1992\)](#) identified additional independent dimensions for characterizing a person's self-concept structure: (1) proportion of negative attributes and (2) differential importance. The proportion of negative attributes score reflects the overall negativity of the self-concept. Individuals who have high scores use more negative attributes to describe self-aspects than individuals with low scores. Differential importance represents the level of importance a person assigns to positive or negative self-aspects, respectively. While individuals with high scores assign greater importance to positive self-aspects, individuals with low scores rate negative self-aspects as being more important.

According to [Showers \(1992\)](#), individuals with a compartmentalized self-concept structure are more vulnerable to mood swings and to fluctuations in self-esteem in response to daily events. For instance, if external triggers activate a compartmentalized self-concept aspect that contains solely negative attributes, the individual is flooded with negative self-beliefs resulting in negative mood and deterioration of self-esteem. In contrast, if negative external triggers activate an integrated self-concept aspect, negative attributes may enter the individual's mind, but at the same time, the remaining positive attributes are simultaneously activated. Thus, individuals with an integrated self-concept structure tend to have more stable self-esteem and are less likely to experience mood swings.

According to the model, the (dis-)advantages of having a compartmentalized self-concept structure further depend on the relative importance assigned to positive and negative self-aspects. In addition to assigning positive and negative attributes to different self-aspects, individuals with a positive compartmentalized self-concept structure rate positive self-aspects as being more important than negative ones, while individuals with a negative

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