

## Disturbances of Self and Identity in Personality Disorders

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Mr. B could fill a room with his presence. A promising artist whose promise was not materializing rapidly enough for his taste, he came to psychotherapy bitter, angry, and depressed at his life circumstances. His field was not an easy one in which to gain prominence, and he felt grossly underappreciated. "I'm a god," he once said with utter earnestness, but no one seemed to acknowledge his apotheosis. He wavered between this kind of exalted view of himself and a despondent, secret fear that perhaps he was not who he thought he was. In fact, he was typically most grandiose when he was most threatened—when passed over in some way, when he failed to receive expected praise, and so forth. His ideal self—who he wanted (and in this case, thoroughly expected) to be—was as unrealistic as his conscious views of himself. He would have been satisfied with nothing but greatness, and when he feared that he might not be recognized, he became filled with a sense of helplessness, impotent rage.

Mr. B is a prototypic example of a narcissistic personality disorder—someone who is grandiose, dismissing and devaluing of others, envious, lacking in the capacity to put

himself in another person's mind and empathize with the other's feelings, and prone to responding to failure or criticism with rage and humiliation. Patients with personality disorders provide a useful vantage point on the self and identity, because many personality disorders include disturbances in self and identity at their core, and understanding what happens when self and identity go awry can provide insight into their normal structure and function, just as understanding memory deficits in amnesic patients can provide insight into the structure and function of memory.

We begin this chapter by briefly examining the multiple meanings of self, which we later apply to personality disorders. Next we consider some methodological issues of particular relevance to studying aspects of self in individuals for whom lack of self-knowledge may be diagnostic. We then turn to the clinical, theoretical, and empirical literature on disturbances in self and identity in personality disorders. We conclude by examining the data on the etiology of those disturbances.

## Domains of Self and Identity

Despite the considerable prominence enjoyed by "the self" in psychological theory and research over the past 20 years, in many respects the self is a construct characterized by identity confusion. Definitions of self range from "the entire person from a psychological perspective" (McCrae & Costa, 1982) to "what one 'takes oneself to be'" (Markus & Cross, 1990). Theorists often use self-related terms interchangeably, such as self and identity, or self and self-concept.

Here we briefly outline a set of distinctions among "self-relevant" terms that reflect an effort to integrate social psychological views of self with views of self that emerged independently from clinical observation (Westen, 1985, 1992). These two vantage points on the self have much to offer one another because of their complementary strengths and weaknesses. Social psychological research has profitably applied and adapted concepts and methods from cognitive science to the domain of self, and social psychologists routinely use methods that are replicable and allow causal inference—hallmarks of cumulative science that have often been absent from clinical treatments of the self. The clinical setting, in contrast, allows access to people's views of self over months or years and permits exploration of the complex, highly idiosyncratic associative networks that constitute self-experience in its naturalistic setting—networks that influence the way people feel, behave, and experience themselves in highly self-relevant, emotion-laden situations.

The value of clinical concepts and data is likely to become more apparent as researchers increasingly view the self-concept as having *attitude-like* properties—that is, as representations that are associated with affective and behavioral propensities. Many of the characteristics now understood to vary among attitudes—such as the extent to which they are implicit or explicit; their complexity and integration; their affective valence, intensity, and ambivalence; and so forth—have been central to clinical (particularly psychodynamic) descriptions of the self. Indeed, research and clinical observation are converging on a set of propositions about the self that would have been controversial just a decade ago. For example, self-

representations have both conscious and unconscious (explicit and implicit) aspects, and, like attitudes toward other objects, explicit views of self may be very different (and sometimes opposite) from implicit views. Further, it is now clear that many if not most aspects of the self-concept are affect laden and are associated with multiple and often contradictory (ambivalent, or, more accurately, multivalent) affective evaluations that are differentially activated under different circumstances.

For the purposes of this chapter, we offer the following (telegraphic) distinctions among several phenomena related to self, beginning with the "self" itself. Although psychologists have used the term to refer to a variety of phenomena, we would likely do well to hyphenate virtually every structure or process for which we would like to reserve the word "self," such as self-esteem, self-reflection, or self-knowledge. If, for example, we use the terms "self" and "self-concept" interchangeably, as frequently occurs in the literature, we confront a logical inconsistency: If our self-concept is our concept of our self, then our self-concept is, by definition, our concept of our self-concept (because self and self-concept are synonymous). This is surely not what we mean by the self-concept (although people's self-concepts may include their understanding of the way they see themselves—something absent in many patients with personality disorders who have trouble taking their own mental processes as objects of thought and hence distinguishing who they are from who they think they are). Logically, the only coherent (if psychologically unsatisfying) use of the term is the colloquial definition of self as *the person*—body, mental contents, attributes, and the like. This is what we mean when we say, "He was only thinking of himself," or "She has a negative view of herself" (Westen, 1992, 1994a).

It follows that *self-schemas* or *self-representations* are mental representations of the self or person, which can be implicit or explicit. Contemporary thinking about the nature of mental representations may be useful in rethinking what we mean by self-schemas or self-representations (for a review, see Smith, 1998). From a connectionist point of view, a representation is not a static entity but a *potential for reactivation* of a network

of units (metaphorically or literally interpreted as neurons) that have been previously activated together. Thus the particular "shape" of a person's representations of self at any given time (Sandler & Rosenblatt, 1962) will reflect the confluence of *chronically* activated networks (potentials for reactivation of well-worn ways of viewing the self) and *recently* activated networks (thoughts, perceptions, etc.). Current and recent experiences will activate and inhibit particular views and experiences of self—that is, they will make some views of self more likely to influence thought, feeling, and behavior. A connectionist model of self would suggest that people have multiple networks representing different aspects of self active outside of awareness at any given time, which collaborate and conflict in ways that produce an explicit self-representation.

A clinically informed connectionist model would add that networks that are active but that do not find conscious representation (whether because they simply do not reach the requisite level of activation or because they are actively inhibited from consciousness) may nonetheless play a substantial role in shaping people's feelings and actions. Further, virtually no representation of self is free of emotional entailments (although some representations, of course, have less of an affective "charge" than others). If I behave aggressively toward someone and interpret my act as assertive or as hostile, I will have two very different feelings about myself. Thus, if we were to integrate a connectionist account with a similarly dynamic view of affect regulation, we might suggest that a person's explicit representations of self at any given time are likely to reflect two simultaneous constraint satisfaction processes: one designed to settle on a representation based on goodness of fit to the data, and the other designed to settle on a representation that maximizes positive and minimizes negative affect (Westen, 1994b, 1998, 1999).

The extent to which a representation of self is distorted by emotional constraints (in a moderately positive direction, as in most people; in a strongly positive direction, as in narcissists; or in a negative direction, as in many depressed and personality-disordered individuals with depressive dynamics) should depend on the extent to which cog-

nitive and emotional constraints are strong or weak (that is, on whether the situation is clear or ambiguous enough to allow multiple attributions and whether different equilibrated solutions would produce weak or strong emotional responses). The degree to which the person's representation of self "fits the facts" should also depend on personality variables such as the individual's tolerance for negative affects of different kinds, ability to regulate self-esteem, and so forth. In this view, "self-enhancement" is a shorthand for an equilibration process by which people regulate emotions such as shame, guilt, anxiety, and pride in the context of cognitive constraints on self-representation that leave enough room for alternative attributions and, hence, for motivated cognition.

Aside from actual self-representations of this sort, people also have a multitude of *desired*, *feared*, and *ideal* self-representations associated with various affects (Higgins, 1990; Strauman, 1996; Westen, 1985, 1994b). Clinical experience suggests that these representations may also be either implicit or explicit. For example, many people have strong fears of becoming like a parent with whom they have attempted to disidentify (see McWilliams, 1998), and they may become guilty or angry when their behavior resembles that of the parent, even though they may not be consciously aware of why they are feeling what they are feeling and what provoked it. Reducing a discrepancy between wished-for, feared, or ideal self-representations and their corresponding actual self-representations leads to various positive and negative affect states (e.g., guilt, shame, anxiety, embarrassment, pride). Thus people are motivated to change their actual self-representations to increase their correspondence with desired or ideal self-representations and to maximize their discrepancy from feared representations. They can do this by changing who they are (e.g., behaving differently), altering their actual self-representations, or changing their desires, wishes, or ideals for themselves.

When we ask research participants to describe themselves, we typically call on them to access prototypic, explicit representations, which are what we usually mean by the global term, "self-concept." The same is usually true when we ask them about their

*self-esteem*, or affective valuation of the self. People tend to have a general "level" of self-esteem to which they gravitate, which is usually loosely congruent with their prototypic self-concept. Self-esteem, in this sense, is the affective component of the person's prototypic attitude toward the self. Even at the level of explicit prototypes, however, people have specific views of themselves (e.g., of their abilities in different domains), which are associated with different affective evaluations (Harter, 1996).

In everyday life, on-line constructions of self and associated feelings reflect in part the activation of particular affect-laden "potentials" (chronically activated networks), as well as discrepancies between actual, feared, desired, and wished-for self-representations. As a result, people experience fluctuations in self-esteem, as different twists of the neural kaleidoscope lead to novel but nonrandom patterns of self-experience. Of particular relevance in this regard are relationship schemas, or *self-with-other representations*, that are often involved in the activation of specific views of self (Baldwin, 1992; Ogilvie & Ashmore, 1991). For a patient with a narcissistic personality disorder such as Mr. B, a perceived slight or criticism, a representation of self with critical or dismissing other, is likely to activate networks that represent a *shamed or humiliated self*, with the attendant affect (which may or may not attain conscious expression). (On the activation of states of mind that include representations and affects, see Horowitz, 1998).

Thus far, we have described a number of ways in which the person can take the self as object—that is, we have focused on *representations of self*. As James (1890/1918) observed, however, the self as object is not isomorphic with a person's subjective sense of self, or self as subject. This *sense of self* includes (1) a sense of continuity of experience (sense of self as having continuity of consciousness and memory over time); (2) a sense of agency (sense of self as an active agent of one's actions); and (3) an experiential sense of self as thinker and feeler of one's own thoughts (Westen, 1992). The sense of self is rarely an object of reflection and has received little empirical attention, although it is central to many psychological views of self and can become disrupted in

certain forms of psychopathology and by certain nonnormative experiences, such as sexual abuse (Westen, 1994a).

*Identity* is probably the broadest self-related concept, and it shares many aspects of Markus's "dynamic self-concept" (Markus & Wurf, 1987). Most definitions of identity derive at least in part from Erikson (1963, 1968), who emphasized that identity is both a highly personal construction, developed through the integration of various identifications and disidentifications with significant others and reference groups, and a social construction, developed through internalization of roles and reflected appraisals of others. Important components of identity include (1) a sense of personal sameness or continuity over time and across situations, (2) a sense of inner agency, (3) a commitment to certain self-representations as self-defining, (4) a commitment to certain roles as self-defining, (5) acknowledgement of one's role commitments and views of self by significant others, (6) a commitment to a set of core values and ideal self-standards, and (7) and commitment to a worldview that gives life meaning (Wilkinson-Ryan & Westen, 2000).

To summarize, we should be careful when using the term "self" that we all have the same processes in mind when using the same word. Some of the more psychologically meaningful uses of the term may be better denoted by more specific terms, notably "self-representation" (implicit and explicit views of self), "self-esteem" (feelings about the self), "sense of self" (experience of continuity, consciousness, and agency), and "identity" (commitment to aspects of self as defining and meaningful over time).

### Assessing Domains of Self and Identity

Equally important as definitional clarity is the question of how to operationalize these constructs. The traditional way of measuring self-relevant thoughts and feelings is via self-report. For example, the most widely used self-esteem scale, the Rosenberg Self-Esteem Scale (SES; Rosenberg, 1965), consists of 10 items that tap the individual's feelings of general self-worth (e.g., "All in all, I am inclined to feel I am a failure"). Other measures, such as the Tennessee Self-

Concept Scale (TSCS; Roid & Fitts, 1994), assess numerous specific domains of self-esteem, such as feelings about the social self and physical self. Other instruments assess highly specific domains of self-esteem (for a review, see Byrne, 1996), such as the Sexual Self-Esteem Scale (Gaynor & Underwood, 1995) and the Body Esteem Scale (BES; Franzio & Shields, 1984).

From a clinical point of view, self-report instruments such as these can be very useful in tapping explicit, but not implicit, self-esteem (Westen, 1985, 1991, 1992), a problem that has recently prompted development of implicit measures that we suspect are likely to revolutionize the literatures on self and self-esteem (Devos & Banaji, Chapter 8, this volume). Traditional self-report measures rely on a set of largely implicit assumptions that are problematic: (1) that conscious and unconscious views of self are similar; (2) that the representations activated when people are asked to describe explicit, prototypic aspects of self are the same representations activated in everyday life that guide relevant thought, feeling, and behavior; (3) that people have the expertise and knowledge to report on dimensions of self that may be subtle; and (4) that defensive and self-presentation biases are either minimal or can be detected using self-report scales designed to detect bias. For example, if Mr. B, described at the beginning of this chapter, were to complete the Rosenberg Self-Esteem Scale, he would almost certainly strongly endorse many items indicative of high self-esteem. Multiple sources of narrative and behavioral data suggested, however, that Mr. B was at times filled with self-doubt, feelings of inferiority, and abject despair about himself—feelings that were only consciously accessible to him in fleeting moments under very specific circumstances. Even if an occasional item “caught” some of these feelings, his score would be difficult to distinguish from that of someone with moderately high self-esteem who rated every item a solid 4 out of 5, as opposed to mostly 5s with an occasional 1 or 2.

An increasing body of data suggests that the kind of defensive inflation of explicit views of self characteristic of people such as Mr. B can be measured reliably using observational methods such as narrative interviews or observation of behavior in groups

and that this kind of defensive distortion of self-representations comes at considerable cost to the individual (not to mention those around him or her). For example, Shedler, Mayman, and Manis (1993) found that individuals who scored high on a self-report measure of positive mental health but low on a clinician-based assessment of the same construct (assessed from participants' earliest memories) showed higher levels of coronary reactivity than both individuals with genuinely good mental health and those who acknowledged their distress (e.g., anxiety). Colvin and Block (1994) have shown that individuals described by neutral observers of their behavior as narcissistic suffer in multiple ways interpersonally that are not revealed by their self-reports.

Similarly, Robins and Beer (2001) found that self-enhancement of personal abilities can have short-term benefits but that people who rely on substantial self-enhancement ultimately experience less well-being and show worse adaptation than people who perceive themselves more accurately. In a longitudinal study, along with completing questionnaire measures of variables such as narcissism and self-esteem, college freshmen rated their expected academic performance in college. The researchers then collected data regarding their actual performance annually until graduation. The investigators operationalized academic self-enhancement by computing the discrepancy between prior academic performance (as measured by high school GPA and SAT scores) and self-reported performance. Students who self-enhanced early in their academic careers were more likely to disengage from academics over time, as reality failed to support their inflated expectations, and were more likely to drop out of school.

In general, self-report instruments have difficulty teasing apart genuine self-esteem and associated representations of self from impression management and self-deception (Farnham, Greenwald, & Banaji, 1999). Thus, in recent years, several researchers have developed methods for assessing implicit aspects of self-concept (e.g., Aidman, 1999; Bosson, Swann, & Pennebaker, 2000; Greenwald & Farnham, 2000; Pelham & Hetts, 1999). For example, Greenwald and Farnham (2000) have adapted the Implicit Associations Test (IAT; Greenwald,

McGhee, & Schwartz, 1998) to measure implicit self-esteem and self-concept. The procedure rests on the premise that the strength of association between pairs of concepts and attributes (e.g., self-good, other-bad) is reflected in response latency.

Researchers have developed other methods of accessing implicit aspects of self as well. Ogilvie and Ashmore (1991) developed a way of measuring self-with-other representations that samples people's explicit self-representations but avoids asking them to make generalizations about patterns in the way they represent themselves across relationships. Participants rate themselves on a set of dimensions across numerous relationships of their choosing (such as relationships with a sibling, boss, parent, etc.). A hierarchical-clusters analysis reduces the data to a small set of clusters of prominent self-with-other themes, that is, ways the person describes self with others that appear to cut across a subset of relationships. Although this method does not, strictly speaking, measure implicit representations, it *aggregates* data within participants in ways that capture implicit themes or personal constructs.

Westen and colleagues (Westen & Cohen, 1993; Westen & Muderrisoglu, 2001; Westen & Shedler, 1999a, 1999b) have been approaching the measurement of aspects of self through narrative methods. Their method is predicated on the view that the representations of self that influence thought, feeling, and behavior in everyday life, like many other personality processes, are less likely to be revealed in participants' answers to direct questions about themselves of the format, "Are you the kind of person who . . ." than in their narrative descriptions of their lives (and particularly of emotionally meaningful interpersonal interactions). The assumptions underlying this method rest on clinical observation and on research showing that this is, in fact, the way clinicians of all theoretical persuasions assess personality (Westen & Arkowitz-Westen, 1998), as well as on the burgeoning literature in cognitive neuroscience on the pervasive role of implicit processes in thought, feeling, and behavior.

In this view, by virtue of the "architecture" of cognition, emotion, and motivation, people cannot be expected to report

what is implicit, even if their reports are not substantially biased by motives for self-presentation or self-esteem maintenance. Nor should we expect that people without expertise in personality assessment—namely, participants themselves—should be uniformly the best observers of personality, particularly in cases such as personality disorders, in which lack of self-insight is diagnostic. In fact, self-report questionnaires and structured interviews have produced poor validity coefficients in diagnosing personality disorders such as narcissistic, paranoid, and passive-aggressive (Perry, 1992). (In fact, passive-aggressive personality disorder was deleted from the latest edition of the DSM (American Psychiatric Association, 1994), in part because it could not be measured reliably by asking people to describe themselves.) In contrast, recent data suggest that narrative-based assessment of patients' personality pathology produces correlations between the treating clinician and a pair of independent interviewers in the range of  $r = .80$  (Westen & Muderrisoglu, 2001).

In describing these methods that rely less on self-report, we do not mean to offer the simple view that self-reports are bad and other forms of measurement are good. Whether self-reports provide valid data about aspects of self depends on the way they are used. When used to assess people's explicit, prototypic views of self, well-constructed self-report instruments produce valid data. To the extent that the aim is not simply to know about people's generalizations about themselves, however, the use of self-report methods can become problematic. If the aim is to understand self-representations as they manifest in daily life (and, presumably, as they affect thought, feeling, and behavior), we might do well to rely less on participants to aggregate their views over time, essentially providing their explicit theories about themselves. At the very least, we might do well to ask them to describe what they are thinking and feeling in situations relevant to the domain of interest and to aggregate these descriptions over time ourselves. Perhaps most important, when used to assess people's self-representations without qualifying by level of consciousness (implicit or explicit), as has been the norm in psychological research on aspects of self,



self-reports are likely to produce misleading data for a substantial subset of individuals for whom discrepancies between implicit and explicit views are as psychologically interesting as their convergence (Westen, 1998).

Measurement of identity is another field that has seen substantial progress in recent years. Based on Erikson's theory, Marcia (1966, 1980) devised a semistructured interview to assess adolescents' and adults' levels of commitment and exploration with regard to occupational choices and ideological concerns. Using the data from these interviews, individuals can be reliably classified into four identity statuses, which represent different levels of identity resolution: identity achievement, moratorium, foreclosure, and identity diffusion.

Identity achievement in Marcia's system represents the most mature level of identity development. Individuals with this status have explored and subsequently made commitments to various occupational and ideological choices. Moratorium is often a stage on the way to identity development, although it may also represent a permanent state of instability. In moratorium, the individual explores various identity issues without making any firm commitments. Individuals with a foreclosed status have prematurely settled on occupations and beliefs that others have prescribed for them, without undertaking a period of exploration or questioning. Individuals with this status typically express black-and-white views and lean toward an authoritarian stance to the world. Identity diffusion, the status most relevant to personality pathology, is not unusual in normal adolescence and early adulthood. It describes those individuals who have not determined an ideological or occupational direction and who may be characterized by social isolation, withdrawal, and a lack of a sense of continuity over time. In a broader sense, identity diffusion is Erikson's term for the failure to achieve an integrated sense of self. Identity diffusion typically involves phenomena such as a subjective sense of incoherence, inability to commit to roles, and repeated shifts in ideology. Marcia's (1980) identity statuses have generated considerable research over the past 20 years, documenting the relationship between identity status and a range of

theoretically related variables, such as personality (e.g., security-seeking; Kroger, 1995); attitudes (e.g., AIDS attitudes; Moore & Barling, 1991); object relations (Marcia, 1994); and level of integrative complexity (Slugoski, Marcia, & Koopman, 1984).

To summarize, assessment of aspects of self and identity is less straightforward than it might appear and less straightforward than has typically been the case, although exciting new methodological developments promise to change the way researchers measure and understand self-related processes. Of particular importance is the development of methods of assessing implicit self-representations and implicit aspects of self-esteem, which are especially important to address in research with clinical populations, such as in patients with personality disorders. Self-reports are likely to be appropriate for some purposes and not for others; for this reason, they should not be the default in assessment. Self-reports are most likely to be valid when (1) processes being reported are available to introspection, such as behaviors and conscious phenomenology; (2) processes being reported do not require training, expertise, or norms (e.g., "I have high self-esteem" relative to whom?) that lay observers may not have; (3) domains being assessed do not have implications for self-esteem and hence are less likely to elicit defensive biases; and (4) domains being assessed are only minimally relevant with respect to social desirability, so that self-presentation biases are less likely to be engaged.

### Self and Identity in Personality Disorders

Issues of self play a role in many forms of psychopathology. People who are depressed tend to have negative views of self. Individuals with schizophrenia often have difficulty representing key aspects of self at all and distinguishing the most basic attributes of self (thoughts, feelings, etc.) from those of others. This is perhaps most apparent in auditory hallucinations, in which individuals with schizophrenia may mistake their own psychological processes for someone else's voice. The most blatant form of identity disturbance is found in dissociative identity

disorder (DID; APA, 1994), formerly called multiple personality disorder. In DID, the patient's identity consists of two or more partial identities, sometimes called partselves or alters, that are "split off" and carry out different functions. In this disorder, usually the result of extreme sexual and/or physical abuse in childhood (Lewis & Yeager, 1994), the person may have no awareness of actions carried out in one state while in another. What distinguishes DID is not only the fragmented identity in the Eriksonian sense but also profound deficits in the *sense of self*—particularly the subjective experience of self as agent and as continuous through time.

Profound disturbances in aspects of self also distinguish many forms of personality disorder. For example, McWilliams (1994) describes the self-representations of the "paranoid self" as involving a polar opposition between an "impotent, humiliated, and despised" self-image and an "omnipotent, vindicated, triumphant one" (p. 214). Individuals with paranoid personality disorder frequently maintain self-esteem through attempts to thwart authority figures or institutions. Success in defying authority provides a sense of vindication and temporary feelings of safety and moral righteousness.

#### What Are Personality Disorders?

Personality disturbances have captured the attention of observers for much of recorded history, beginning at least with Hippocrates' and Galen's efforts to link character styles to biological variables (an approach recently brought back into currency by Cloninger, Cloninger, Svrakic, Bayon, & Przybeck, 1999). Modern interest in personality pathology emerged in the 19th century when Prichard (1835) coined the term "moral insanity" to describe deviant behavior patterns in individuals whose reasoning processes, unlike those of patients with psychosis, remained intact. (This distinction remains the basis of the "insanity defense," which is predicated on a view of people as either capable or incapable of moral decision making based on the intactness of their cognition.)

The concept of *personality disorder* emerged in the 1930s and 1940s in the psychoanalytic literature, as clinicians and the-

orists discovered a class of patients whose problems seemed to lie less in circumscribed symptoms (such as phobias or obsessive-compulsive thoughts and rituals) than in their enduring ways of thinking, understanding themselves and others, regulating their impulses and feelings, and interacting with other people (Kernberg, 1975; Reich, 1933). Coupled with similar observations in the early to mid-20th century by descriptive psychiatrists of patients who seemed to have enduring melancholic traits or peculiarities of thinking that did not quite cross the threshold for psychosis, the concept of personality disorder found its way into the official *Diagnostic and Statistical Manual of Mental Disorders (DSM)*.

In the original version of the manual (APA, 1952), the disorders presently termed personality disorders (PDs) were grouped under headings such as "personality pattern disturbance" and "personality trait disturbance." The major impetus to research on PDs came with the publication of DSM-III (APA, 1980), which introduced a multiaxial system of diagnosis, including a separate "axis" devoted primarily to PDs. The current edition of the DSM (DSM-IV; APA, 1994) defines a personality disorder as "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment" (p. 629). The PDs include 10 disorders, grouped into three thematic clusters based loosely on factor-analytic research. The odd or eccentric cluster (cluster A) includes schizotypal, schizoid, and paranoid PDs. The three disorders share social peculiarity and withdrawal, with varying degrees and types of cognitive disturbance. The dramatic, emotional, or erratic cluster (cluster B) includes histrionic, borderline, narcissistic, and antisocial PDs. These PDs share features such as self-centeredness, impulsivity, and difficulty empathizing with others' experience. The anxious or fearful cluster (cluster C) includes obsessive-compulsive, avoidant, and dependent PDs. These disorders (particularly obsessive-compulsive) are less easily characterized by a single set of shared features, although one central thread is anxiety (warded off in obsessive-compul-



sive individuals, expressing itself strongly in social situations in avoidant individuals, and tied to fears of separation and independence in dependent patients).

To illustrate the diagnosis of the personality disorders, we use the example of narcissistic personality disorder, an example of which opened this chapter. Narcissistic personality disorder (NPD) is characterized by a "pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts" (APA, 1994, p. 661). NPD has nine criteria, of which five are necessary to make the diagnosis: (1) has a grandiose sense of self-importance; (2) is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love; (3) believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions); (4) requires excessive admiration; (5) has a sense of entitlement; (6) is interpersonally exploitative; (7) lacks empathy, is unwilling to recognize or identify with the feelings and needs of others; (8) is often envious of others or believes that others are envious of him or her; and (9) shows arrogant, haughty behaviors or attitudes (p. 661).

The DSM-IV classification is not flawless, and although substantially influenced by empirical research, particularly since the inception of DSM-III, it continues to face numerous challenges. For example, many researchers have argued that a dimensional system would more accurately describe individuals with personality pathology than the current categorical system, and the 10 diagnoses included in the manual are highly overlapping (Clark, Livesley, & Morey, 1997; Oldham et al., 1992; Westen & Shedler, 2000; Widiger, 1993). Nonetheless, the DSM-IV provides a rough map of the terrain of personality disturbance that represents a significant advance over the babble of personality descriptions that existed before some effort to standardize categories and criteria.

#### Pathology of Self in Personality Disorders

The clinical literature offers a wealth of phenomenological and theoretical descrip-

tions of pathology of self in patients with PDs, although empirical literature has only more recently begun to emerge. The disorders that have received the most attention are borderline and narcissistic. This makes considerable sense, given the central role of self-pathology in both disorders: the identity confusion characteristic of borderline patients and the grandiosity characteristic of narcissistic patients. We review, as well, the empirical findings on other disorders for which data are available.

#### *Self and Identity in Borderline Pathology*

Kernberg (1976, 1984) has provided the most extensive theoretical and phenomenological description of borderline pathology. Kernberg focuses on what he calls borderline personality *organization* (BPO), which he locates on a continuum between psychotic and neurotic (by which he means relatively high-functioning) forms of personality structure. Patients with borderline personality organization lack the overt disturbances in self and reality testing characteristic of psychotic patients. However, they lack the capacity to regulate impulses and emotion and to understand the self and others in ways that allow healthier people to love and to work successfully. While similar in many respects to the DSM-IV diagnosis of borderline personality disorder (BPD), BPO is a broader construct that encompasses a number of DSM-IV PDs in addition to BPD. For Kernberg, patients with paranoid, schizoid, schizotypal, and antisocial personality disorders typically function at a borderline level, as do many patients with histrionic and dependent personality disorders.

In Kernberg's conceptualization, pathology of self is a hallmark of borderline pathology. People with more adaptive forms of personality organization can integrate contradictory representations of the self and others and can represent themselves as essentially the same person across time and situations, even though they recognize that they may behave differently at different times. In contrast, patients with BPO suffer from a lack of integration of self-representations, for which Kernberg (1984) uses Erikson's term, "identity diffusion" (Clarkin, Kernberg, & Somavia, 1998; Kernberg, 1984). As outlined by Kernberg (1975,

1984) and elaborated by Akhtar (1984, 1992), the identity diffusion seen in patients with BPO consists of six basic clinical features. The first involves contradictory character traits that produce representations of self that are difficult to integrate. The patient may evidence gross contradictions in behavior (e.g., behaving alternately in ways that are prudish and promiscuous), perceptions of self (e.g., seeing the self as a complete success or a total failure), or vocational interests. These contradictions make it difficult for the patient and others to get a clear picture of the person as an integrated person. The second feature is the temporal discontinuity of the self, whereby the patient lacks a sense of the self as continuous through time. The sense of "a life lived in pieces" captures this experience (Pfeiffer, 1974). Third is a lack of authenticity, manifest in a chameleon-like identity in which the person changes who she is and perceives herself to be depending on who she is with—a phenomenon first described by Deutsch (1942) as the "as-if" personality. (We use the female pronoun here and the male pronoun later in describing narcissistic personality disorder as a convenience, reflecting the differential rates of the two disorders in men and women.) Fourth are feelings of emptiness and emotional numbing that lead to feelings of inner deadness and fears of being alone (because aloneness becomes nothingness if the self can only be defined in relation to significant others). A fifth feature is gender dysphoria, manifest in opposite-gender behaviors and confusion regarding choice of sexual partner and the gender to which one belongs. The sixth feature is an inordinate ethnic and moral relativism, which involves a lack of stable values and cultural or ethnic affiliation. Similar to the chameleon-like quality of the inauthentic self described previously, the patient's beliefs and values may change along with those of members of her social group. Akhtar (1992) added a seventh clinical feature often observed in patients with identity diffusion: disturbances in body image, seen particularly in borderline patients with bulimia.

Focusing more specifically on borderline personality disorder as defined in DSM-III and DSM-IV, Westen and Cohen (1993) summarized the most central components of

identity disturbance believed to characterize BPD as taken from the extant theoretical, clinical, and empirical literatures. Their description resembles Kernberg's (1975) and Akhtar's (1984) descriptions of BPO in many respects. It includes the following features: (1) a lack of consistently invested goals, values, ideals, and relationships; (2) a tendency to make temporary hyperinvestments in roles, value systems, worldviews, and relationships that ultimately break down and lead to a sense of emptiness and meaninglessness; (3) gross inconsistencies in behavior over time and across situations that lead to a relatively accurate perception of the self as lacking coherence; (4) difficulty integrating multiple representations of the self at any given time; (5) a lack of a coherent life narrative or sense of continuity over time; and (6) a lack of continuity of relationships that results in the loss of shared memories that contribute to a coherent sense of self over time. In terms of the distinctions with which we began, most of these disturbances are disturbances in the sense of self (the subjective experience of agency and continuity over time) and identity, although borderline patients are also prone to particular representations of self (e.g., self as globally bad or loathsome; Westen et al., 1992) and self-with-other paradigms (e.g., abandoned self-rejecting other, victimized self-victimizing other; Nigg, Lohr, Westen, Gold, & Silk, 1992). In addition, as emphasized by Kernberg (1984) and supported by subsequent research (Baker, Silk, Westen, Nigg, & Lohr, 1992), borderline patients tend to "split" their representations of self and others into good and bad and to have difficulty forming coherent, integrated representations that incorporate both positive and negative features in ways that capture the realities of human personality.

Empirical research on identity disturbance in borderline personality disorder is sparse. Taylor (1995) points out that the DSM criterion that captures identity disturbance has proved one of the least reliable criteria among the PDs, stemming largely from the vagueness of the item ("identity disturbance: markedly and persistently unstable self-image or sense of self" [DSM-IV, APA, 1994, p. 654]) and its nonspecificity to BPD. In an effort to refine the concept of

identity disturbance empirically, Wilkinson-Ryan and Westen (2000) developed a 36-item identity-disturbance instrument for clinician report, based on clinical, theoretical, and empirical descriptions of identity disturbance. Their aims were (1) to use factor analysis to identify whether identity disturbance is a unitary construct; (2) to examine the relation between aspects of identity disturbance and BPD; and (3) to assess the extent to which borderline pathology independently contributes to variance in identity diffusion, holding constant a history of sexual abuse. The role of sexual abuse is of significance because between 50% and 75% of patients with BPD report a history of sexual abuse (see Zanarini, 1997) and because sexual abuse is known to disrupt multiple aspects of self, leading to dissociation (and, in extreme cases, dissociative identity disorder).

Using a practice research network approach, in which researchers quantify descriptions of patients provided by a random sample of clinicians using psychometric instruments designed for clinician report, Wilkinson-Ryan and Westen (2000) found identity disturbance to be a multidimensional construct consisting of four factors: role absorption (tendency to define the self based on a single role or label, such as "adult child of an alcoholic"), painful incoherence (the patient's subjective distress and concern about lack of coherence), inconsistency (objective inconsistency of behavior, which the patient typically does not find troubling), and lack of commitment (to roles, values, and long-term relationships). Three of the four factors distinguished borderline patients from other patients in the sample, including those with other PDs, with painful incoherence most associated with BPD. The lack of commitment factor did not distinguish between patients with BPD and patients with other forms of pathology, casting doubt on its specificity as a diagnostic criterion, despite its centrality in the clinical construct. Although all factors also correlated with a history of sexual abuse, regression analysis showed that BPD diagnosis continued to predict identity disturbance on all four dimensions when sexual abuse history was held constant. Sexual abuse history contributed independently to only one identity disturbance factor, painful

incoherence, suggesting that the identity disturbance seen in borderline patients is *sui generis* and does not appear to be a consequence of abuse history.

#### *Self and Identity in Narcissistic Personality Disorder*

Although many of Kernberg's major contributions have been in the understanding of borderline phenomena, his theories of narcissistic disturbance contributed substantially to the development of the diagnosis of NPD in DSM-III, just as they did to the borderline diagnosis. According to Kernberg (1984), whereas borderline patients lack an integrated identity, narcissistic patients are developmentally more advanced, in that they have been able to develop a consistent view of themselves. A core feature of their pathology, however, lies in the view of self that they need to construct to maintain self-esteem, namely one that is grossly inflated. According to Kernberg, not only are the conscious self-representations of narcissistic patients inflated but so also are the representations that constitute their ideal self. Actual and ideal self, in his view, exist in dynamic relation to one another: One reason that narcissistic patients must maintain such an idealized view of self is that they have a correspondingly grandiose view of who they should and must be, divergence from which leads to tremendous feelings of shame, failure, and humiliation.

The concept of a grandiose self is central to the theory of Heinz Kohut, one of the other major theorists of narcissistic personality pathology, whose ideas, like those of Kernberg, contributed to the DSM diagnosis of NPD (Goldstein, 1985). Like many other theorists, Kohut's (1971, 1977) use of the term "self" is inconsistent, sometimes used to refer to all of personality and at other times limited to self-representations. His main contribution, however, was his attempt to describe the self as a core structure at the heart of personality (hence the term "self psychology," which refers to the theoretical system he developed within psychoanalysis).

The Kohutian self in this distinctive sense is the nucleus of a person's central ambitions and ideals and the talents and skills used to actualize them (Kohut, 1971; Wolf,

1988). It develops through two pathways, or what Kohut calls "poles" of the self, which provide the basis for self-esteem. The first is what he calls the *grandiose self*—an idealized representation of self that emerges in children through empathic mirroring by their parents ("mommy, watch!") and provides the nucleus for later ambitions and strivings. The second he calls the *idealized parent imago*—an idealized representation of the parents, which provides the foundation for ideals and standards for the self. Parental mirroring allows the child to experience himself as reflected in the eyes of a loving and admiring parent; idealizing a parent or parents allows the child to identify with and become like an idealized other. In the absence of adequate experiences with parents who can mirror the child and serve as appropriate targets of idealization (for example, when the parents are self-involved or abusive), the child's self-structure cannot develop, preventing the achievement of cohesion, vigor, and normal self-esteem (which Kohut describes as "healthy narcissism"). As a result, the child develops a disorder of the self, of which pathological narcissism is a prototypic example.

Most research on NPD of relevance to self has examined the diagnostic efficiency of various diagnostic criteria. The results of these studies generally support the centrality of grandiose representations and grandiose fantasies as defining features of narcissistic patients (Gunderson, Ronningstam, & Smith, 1995). In two studies not limited to DSM criteria, Westen and Shedler (1999a; Shedler & Westen, 1998) used a personality pathology Q-sort with a large national sample of patients with PDs to examine the psychological characteristics of patients diagnosed with different PDs. Both studies produced similar findings; we describe here the larger study ( $N = 530$ ) with the most recent version of the Q-sort (Westen & Shedler, 1999a). The following items related to self were among the 20 most highly ranked (i.e., highly descriptive) items out of the 200 items in the instrument in an aggregate description of patients diagnosed by their treating clinicians with NPD: has an exaggerated sense of self-importance; tends to feel mistreated, misunderstood, or victimized; and expects self to be "perfect" (an item that supports Kernberg's view of the

narcissistic patient's exaggerated ideal self). When the investigators ignored clinicians' DSM-IV diagnoses and instead derived diagnostic prototypes empirically using Q-factor analysis (a clustering technique), the narcissistic cluster that emerged included the following items among those most descriptive: has fantasies of unlimited success, power, beauty, talent, brilliance, and so forth; has an exaggerated sense of self-importance; expects self to be "perfect"; tends to feel false or fraudulent; and has a disturbed or distorted body image (sees self as unattractive, grotesque, disgusting, etc.; Westen & Shedler, 1999b). Interestingly, this empirically derived prototype included not only the manifestly grandiose self-representations, fantasied self-representations, and ideal self-representations of narcissistic patients but also some of their underlying fears about themselves, such as feelings of fraudulence and unattractiveness. We are unaware of self-report studies similarly finding such fears to be characteristic of the explicit prototypic views of self reported by narcissistic patients. The discrepancy between self- and observer reports corroborates theoretical assertions that implicit and explicit representations may be very different in narcissistic patients (e.g., Westen, 1990), with the latter primarily reflecting overt grandiosity and the former reflecting both grandiose ideal self-representations and dreaded devalued (feared) representations of self.

#### *Other Research on Self and Identity Disturbance in Personality Disorders*

Empirical literature relating to self in other personality disorders is limited. Two recent studies have linked self-esteem to PD diagnosis or PD traits (Sinha & Watson, 1997; Watson, 1998). These studies found that low self-esteem was a significant predictor of 7 of 11 PD diagnoses and showed the strongest association with borderline personality disorder, avoidant personality disorder, and obsessive-compulsive personality disorder. The link to self-esteem makes sense in light of depressive and self-doubting dynamics seen clinically in patients with many PDs, particularly those found in these studies to have low self-esteem.

Research using Benjamin's (1974, 1996a, 1996b) Structural Analysis of Social Behavior (SASB) is also relevant to issues of self in PDs. The SASB is a three-dimensional circumplex model with three surfaces that provides a sophisticated method of assessing complex interpersonal and intrapersonal processes. Of particular relevance is one surface of the SASB, called the "introject circumplex," which captures the way an individual treats him- or herself. It is so named because of the assumption that internalized (introjected) treatment by significant others shapes the self-concept and associated ways of "interacting" with oneself, a view amply supported by research (Benjamin, 1974, 1996a). One axis of the introject circumplex represents the attachment dimension (in this case, attachment to self), with end points of self-love and self-hate. Although systematic work with samples of patients with PDs remains to be done, Benjamin has recently offered an extensive application of the SASB to the study and treatment of PDs (1993, 1996a, 1996b), and research on the introject surface is likely to provide useful information on self-esteem and self-abuse in patients with PD.

### Etiology of Self Pathology in Personality Disorders

As with most forms of psychopathology, prime etiological variables include genetic influences, environmental events, and gene-environment interactions and transactions. Here we provide a brief overview of three areas of research of relevance to the etiology of PDs that have particular implications for the origins of self-disturbance: behavior genetics, attachment, and trauma.

#### Behavior Genetics

The vast majority of behavior-genetic studies of personality have focused on normal personality traits, such as those that make up the Five-Factor Model (Widiger & Trull, 1992) and Eysenck's (1967, 1981) three-factor model (extraversion, neuroticism, and psychoticism). These studies have generally shown moderate to large heritability for a range of personality traits, from 30% to 60% (Livesley, Jang, Jackson, & Vernon,

1993; Plomin & Caspi, 1999). The most frequently studied traits, extraversion and neuroticism, have produced heritability estimates of 54% to 74%, and of 42% to 64%, respectively (Eysenck, 1990). When measures other than self-report are used, heritability estimates decrease somewhat but remain within the moderate range (e.g., Plomin & Caspi, 1999).

Compared to research on normal personality traits, studies of the heritability of PDs have been rare (see Nigg & Goldsmith, 1994). The most common design has been family studies, in which researchers begin with the PD proband and then assess other family members. The major limitation of this method is that familial aggregation of disorders can support either genetic or environmental causes. Hence, twin and adoption studies tend to provide more definitive data.

A number of family, twin, and adoption studies have focused on the genetic basis of PDs, although the majority of these studies have examined only a subset of the DSM PDs, particularly schizotypal, antisocial, and borderline personality disorders. These disorders appear to reflect a continuum of heritability, with schizotypal most strongly linked to genetic influences, antisocial linked both to environmental and genetic variables, and borderline showing the smallest estimates of heritability.

Research on the heritability of schizotypal personality disorder provides the clearest evidence of a genetic component to a personality disorder. (Schizotypal personality disorder is defined by criteria such as odd beliefs or magical thinking, unusual perceptual experiences, odd thinking and speech, suspiciousness, inappropriate or constricted affect, and behavior or appearance that is odd or eccentric.) Early observers of schizophrenia (e.g., Bleuler, 1911/1950; Kraepelin, 1896/1919) often noted peculiarities in language and behavior among the relatives of their schizophrenic patients. Bleuler called this presentation "latent schizophrenia" and considered it to be a less severe and more widespread form of schizophrenia. Further research into the constellation of symptoms characteristic of relatives of schizophrenic patients ultimately resulted in the creation of the DSM diagnosis of schizotypal personality disorder (SPD; Spitzer, En-

dicott, & Gibbon, 1979). A genetic relationship between schizophrenia and SPD is now well established (Kendler & Walsh, 1995; Lenzenweger, 1998). For example, using data from the Roscommon Family Study, Kendler and his colleagues (e.g., Kendler et al., 1993; Kendler, McGuire, Gruenberg, & Walsh, 1995; Kendler & Walsh, 1995) found a significant familial relationship between SPD and schizophrenia. Torgersen (1984) found that 33% (7 of 21) of identical co-twins had SPD, whereas only 4% (1 of 23) of fraternal co-twins shared the diagnosis.

Antisocial personality disorder, in contrast, appears to have both genetic and environmental roots, as documented in adoption studies (Cadoret, Yates, Troughton, Woodworth, & Stewart, 1995). An adult adoptee whose biological parent had an arrest record for antisocial behavior is four times more likely to have problems with aggressive behavior than a person without a biological vulnerability. At the same time, a person whose *adoptive* parent had antisocial personality disorder is more than three times more likely to develop the disorder, regardless of biological history.

In contrast to schizotypal and antisocial personality disorders, research on the behavioral genetics of BPD has yielded much less evidence of heritability. Modest degrees of familiarity have emerged in several studies (e.g., Reich, 1989); however, the bulk of the evidence does not support genetic explanations (Dahl, 1993; Nigg & Goldsmith, 1994). For example, Torgersen (1984), in the only twin study on borderline PD, failed to find evidence for the genetic transmission of the disorder, although the sample was relatively small. However, some authors (e.g., Nigg & Goldsmith, 1994; Widiger & Allen, 1994) have suggested that the personality trait neuroticism, which is highly heritable, is at the core of many borderline features (e.g., negative affect and sensitivity to stress). Further, other components of BPD have shown substantial heritability, including one of particular importance for our present purposes—problems with identity (Livesley et al., 1993).

Although behavioral genetic data are proving increasingly important in understanding the etiology of personality disorders (e.g., Livesley, Jang, & Vernon, 1998),

their relevance to aspects of self remains unclear. With some notable exceptions, studies have not examined self-representations, sense of self, identity, or other related constructs. Nevertheless, to the extent that one can take personality self-descriptions as a mixture of relatively accurate descriptions of personality and as self-representations ("theories" of the self; Epstein, 1973), they are likely to provide at least indirect data on the heritability of some aspects of self. Further, because traits such as neuroticism are likely to be accompanied by particular kinds of self-representations (e.g., negative views of self), then aspects of self can be presumed, like other personality traits, to range in heritability, with most showing moderate heritability.

#### Attachment

An environmental variable that has proven robust as a predictor of various forms of personality pathology is attachment history. Bowlby (1969, 1973) defined attachment as a behavioral system designed to provide proximity to attachment figures, who ensure the protection and hence the survival of offspring. The balance between proximity, which is essential for survival, and distance, which is necessary over time for exploration, is achieved behaviorally and is regulated by an "internal organization" that includes representations of the self and attachment figures. According to Bowlby, the major determinant of the quality of the child's attachment is the caregiver's ability to respect the child's desire for a secure base while facilitating his or her exploratory behaviors and remaining available to offer the child love and care when needed (Bowlby, 1977). Provided these conditions are met, the child is likely to develop a secure attachment characterized by "a representational model of himself as being both able to help himself and as worthy of being helped" (1977, p. 206). Subsequent research has supported the central role of maternal sensitivity or attunement in the development of secure "internal working models" of relationships in infancy (e.g., De Wolff & van IJzendoorn, 1997).

Ainsworth, Blehar, Waters, and Wall (1978) devised the Strange Situation to identify the attachment patterns of infants.



This method involves brief separations of caregiver and infant and observation of the infant's reactions, particularly during reunion periods. Two-thirds of infants show secure attachment, meaning that they show distress when separated and pleasure on reunion. Insecure infants exhibit either resistant-ambivalent or avoidant attachment styles. Resistant-ambivalent infants experience their caregiver as unable consistently to meet their needs, resulting in considerable separation anxiety, a reluctance to explore their surroundings because of preoccupation with the caregiver, and alternations between clinging and resistant behavior. In contrast, infants experiencing repeated rejection by their caregivers when seeking to have their needs met tend to develop an avoidant style. As a result, they typically deny their need for love and emotional support and adopt an outwardly self-sufficient style; in the Strange Situation such infants will show little outward concern regarding the coming and going of the caregiver. More recently, a fourth type of attachment has been identified as disorganized (Main & Solomon, 1990). The disorganized pattern usually results from chronic neglect or abuse (Cicchetti, Toth, & Lynch, 1995) and is indicated by confused and disoriented behavior when the infant reunites with the caregiver. The child may appear frightened in the caregiver's presence and be very difficult to soothe.

A quantum leap forward in linking infant attachment to later outcomes came with the development of the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1985), which was devised to assess the attachment status of adults through an analysis of narrative accounts of important attachment relationships during childhood. The AAI yields four primary attachment classifications that closely parallel the infant attachment styles: autonomous (secure), dismissing (avoidant), preoccupied (resistant), and unresolved (disorganized).

Given the extent to which many PDs are disorders of attachment at core (e.g., the social distancing of schizoid and avoidant patients; the detachment of antisocial patients; the unstable, disorganized attachments of patients with BPD), attachment history and attachment status are of obvious relevance to the development of PDs and of related

disturbances of self (see, e.g., Nakash-Eisikovits, Dutra, & Westen, in press). For example, Rosenstein and Horowitz (1996) assessed the attachment status of adolescent inpatients and found strong associations between a dismissing attachment style and the presence of conduct disorder, substance abuse, narcissistic personality disorder, antisocial personality disorder, and self-reported narcissistic, antisocial and paranoid traits. In contrast, adolescents with a more preoccupied attachment style were more likely to have a mood disorder, obsessive-compulsive personality disorder, histrionic personality disorder, borderline personality disorder, or schizotypal personality disorder, and self-reported avoidant, anxious, and dysthymic traits. Other research suggests that adult patients with BPD (Fonagy et al., 1996) and adults who were hospitalized as adolescents for severe personality pathology (Allen, Hauser, & Borman-Spurrell, 1996), are likely to be classified as "unresolved" using the AAI. These individuals tend to have incoherent internal working models of both self and others.

Fonagy and colleagues have studied severe personality disorders, primarily BPD, from an attachment perspective, focusing on the development of what they call *mentalization* (e.g., Fonagy, Target, & Gergely, 2000). Mentalization involves the capacity to understand one's own and others' mental states, such as thoughts, wishes, beliefs, and feelings. A hallmark of mentalization is the ability to attribute beliefs, desires, and other mental states to others that are based neither on one's own beliefs and desires nor on simple physical realities. In other words, it refers to the capacity to imagine another person's mental experience, which is crucial in understanding and predicting their actions. Development of this capacity depends on the responses of caregivers, who both make inferences about and help clarify the contents of the child's mind and allow the child to explore the mind of the caregiver. This process provides the child with reflected appraisals of self, while simultaneously providing important information about the mental states of other people. Secure attachment to the caregiver should both reflect and facilitate this process.

Fonagy and colleagues (1996) have operationalized mentalizing capacity as assessed

from AAI narratives and have used these data to study the relation between parents' mentalization ability and the attachment status of their children. Compared with low-mentalizing parents, parents scoring in the higher range of mentalizing capacity were three to four times more likely to have securely attached children (Fonagy, Steele, Moran, Steele, & Higgitt, 1991). Painful and traumatic experiences can lead people to shut down their internal worlds, a reaction already apparent by the preschool years in maltreated children (Cicchetti, 1991). Thus parents who are low in mentalizing may be transmitting this characteristic directly to their infants through social learning processes or by reproducing in their behavior some of the same parenting practices (such as abuse or neglect) that led them as children to close their minds to their own and others' mental states.

Fonagy's research on mentalizing dovetails with research on the understanding of social causality in adult and adolescent patients with BPD. Borderline patients show significantly lower levels of understanding of causality in the social world than patients with other psychiatric disorders (e.g., major depression), as assessed from narratives such as early memories (similar to the AAI) and Thematic Apperception Test stories (e.g., Westen, Ludolph, Misle, Ruffins, & Block, 1990). Thus the stories they tell show less attention to people's internal states, less coherence, and more unexplained or peculiar transitions.

Research on mentalizing is relevant to questions about self and identity because the complexity and depth of representations of others tend to correlate highly with the complexity and depth of representations of self (Bornstein & O'Neill, 1992; Leigh, Westen, Barends, & Mendel, 1992; Levy, Blatt, & Shaver, 1998). Thus children who learn to avoid thinking about other minds—either because of their own maltreatment or because they have learned to avoid thinking about mental states from their parents, who themselves were maltreated—are unlikely to form complex, multifaceted representations of self. They are also less likely to have the kind of comforting, comfortable, and appropriately mirroring interactions with caregivers that help children develop positive self-esteem

and to internalize methods of self-soothing and self-regulation that help people regulate their self-esteem.

### Trauma

Attachment and trauma tend to be strongly associated, or at least interdependent (Allen, Coyne, & Huntoon, 1998; van der Kolk, 1987). The presence of trauma often suggests a problematic attachment history, whereas problematic attachment, particularly disorganized or unresolved attachment status, usually signals the presence of prior trauma. As with problematic attachment, traumatic experiences may have profound effects on multiple aspects of self and identity, depending on the type of trauma (e.g., physical and sexual abuse, combat experiences, assault, motor vehicle accidents) and variables such as severity and frequency of the trauma and the age of the victim at the time of the traumatic event or events.

Physical and sexual abuse of children are among the most common forms of childhood trauma. Childhood trauma, particularly sexual abuse, may have profound effects on the development of self and identity in survivors. For example, dissociation in many sexual abuse survivors disrupts the organization of self-representations and the continuous sense of selfhood over time and across situations, contributing to an impaired sense of identity (Davies & Frawley, 1994; Westen, 1994a).

Self-esteem also suffers, as children often blame themselves for the abuse out of a desire to avoid having to regard the world (and/or an attachment figure who abuses them) as malevolent and unsafe. Numerous studies of both clinical and nonclinical samples of survivors of child sexual abuse have identified self-esteem as a key area affected by the abuse experience (Bolger, Patterson, & Kupersmidt, 1998; Brayden, Deitrich-MacLean, Dietrich, & Sherrod, 1995; Kendall-Tackett, Williams, & Finkelhor, 1993; Romano & DeLuca, 2001). Finkelhor and Browne (1985) developed a model of sexual abuse-related trauma that proposed four dynamics that account for the effects of the trauma, including stigmatization, betrayal by a trusted person, powerlessness, and traumatic sexualization (which refers to the child's sexuality having

been shaped in a developmentally inappropriate way as a result of the abuse). Although all four have implications for the development of self and identity, the dynamics of stigmatization and powerlessness may have the most impact on the victim's self-esteem.

Sexual abuse survivors also frequently experience feelings of self-blame, either internalized from being blamed by significant others or internally generated as a way to attain a sense of control over the future and a hope of redeeming the self by changing or atoning in some way. Recent studies (Cofey, Leitenberg, Henning, Turner, & Bennett, 1996; Hazzard, Celano, Gould, Lawry, & Webb, 1995; Liem & Boudewyn, 1999) find that self-blame for abuse in both children and adults who were sexually abused as children is a strong predictor of current psychological distress, such that individuals with high scores on measures of self-blame also show elevations on measures such as the Brief Symptom Inventory (Derogatis & Melisaratos, 1983) and the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961).

The effects of early abuse on aspects of self can be seen as early as these dimensions of self can be measured. In self-recognition studies, maltreated toddlers frequently display neutral or negative affect on recognition of themselves in the mirror, suggesting feelings of shame or badness (Cicchetti, 1991). From an attachment perspective, childhood sexual abuse is likely to have a substantial impact on internal working models of self and relationships, particularly when the abuser was an attachment figure or when attachment figures either did not protect the child or did not respond in protective and nonblaming ways following disclosure.

Research has demonstrated clear links between trauma and the development of personality disorders, most notably borderline and antisocial personality disorder, although links to specific aspects of self and identity are yet to be studied. Childhood trauma, particularly sexual abuse, has been linked to BPD in a number of studies (Herman & van der Kolk, 1989; Westen et al., 1990; Zanarini, 1997). Although early trauma is likely to have particularly profound effects on the development of a sense of self

and identity through its impact on subsequent development, later traumatic events also affect functioning in these domains. For example, self-related disturbances have been observed in combat veterans from the Vietnam War (Brende, 1982, 1983). During war, some soldiers dissociate, particularly when committing or observing atrocities, and the requisites of war often encourage the loss of a sense of personal agency. Some of these experiences later persist as symptoms of posttraumatic stress and related disorders. Experiences of adult rape can also affect the sense of personal agency and can reduce self-esteem through feelings of self-blame (Ullman, 1997).

Using data from the Children in the Community Study, a community-based, prospective longitudinal study conducted in upstate New York beginning in the 1970s, several studies have provided evidence for a link between child abuse and neglect and later development of PDs. Participants with a documented history of maltreatment in childhood were more than four times more likely to have received a PD diagnosis during early adulthood than their nonabused peers, and different types of maltreatment (e.g., neglect, sexual abuse, physical abuse) showed differential relationships with Axis II PDs (Johnson, Cohen, Brown, Smailes, & Bernstein, 1999). A history of neglect was associated with greater risk of symptoms of antisocial, borderline, narcissistic, avoidant, passive-aggressive, and schizotypal personality disorder. Sexual abuse history was associated with a higher incidence of symptoms of borderline, histrionic, and depressive personality disorder. Physical abuse history was associated with increased risk for symptoms of antisocial, borderline, dependent, depressive, passive-aggressive, and schizoid personality disorder.

To summarize, if research on the etiology of PDs is in its infancy, research on the etiology of self pathology in PDs is probably best described as embryonic. Data on behavioral genetics and attachment relationships provide suggestive evidence for the influence of both biology and early experience on the subsequent development of self-related pathology in personality disorders. Children who are temperamentally high on negative affect (neuroticism) are likely to be more vulnerable to negative self-evaluation,

and children with disrupted or abusive attachment relationships tend to have difficulty forming complex and accurate representations of their own minds, which may inhibit identity formation and make self-regulation through self-reflection more difficult. Data on the influence of traumatic experiences such as sexual abuse provide more direct evidence of a link between childhood experience and self-related pathology, with pervasive impact of trauma on domains such as self-esteem. Adolescent and adult experiences (such as rape) no doubt can substantially influence domains of self as well, although at least theoretically, the impact of such experiences should generally be less pervasive and more readily treatable, particularly for individuals without a prior traumatic history.

### Conclusion

As we have suggested throughout this chapter, personality disorders provide a potentially important vantage point for studying self and identity, but much of the empirical landscape remains to be developed. Clinical observation points to a number of phenomena that can substantially enrich our understanding of the normal development and functioning of aspects of self, such as:

1. Dissociation, which has implications for the sense of agency and continuity at the core of the sense of self
2. Contradictory or alternating self-representations, as seen in BPD, which have implications for the organization of self-representations and the way people gain control over the activation of representations
3. Grandiose and unrealistic actual and ideal self-representations, as seen in NPD, which have implications for theories of possible selves and mental health (e.g., the extent to which positive illusions may have a curvilinear relation with mental health)
4. Substantial divergences between implicit and explicit self-esteem and implicit and explicit self-representations, as seen in narcissistic and antisocial personality disorders, which have implications for the understanding of attitudinal aspects

of self-representation and for the role of affect regulation and self-esteem regulation in personality

5. Difficulty maintaining commitment to values, standards, and roles, as in BPD, which has implications for the understanding of how people normally establish and maintain identity.

Collaborations between social and clinical psychologists are likely to prove particularly useful, allowing researchers to apply methods and concepts from each subdiscipline to the samples and phenomena that have traditionally been defined as the terrain of the other, to test the limits of each approach, and to forge integrations between them.

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