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Disturbances of Self and Identity in Personality Disorders

DREW WESTEN
AMY KEGLEY HEIM

Mr. B could fill a room with his presence. A promise artist whose promise was not materializing rapidly enough for his taste, he turned to psychotherapy bitter, angry, and depressed at his life circumstances. His fluid was not an easy one in which to gain prominence, and he felt greatly undervalued. "Is a god?" he once said with unfeigned earnestness, but no one seemed to acknowledge his apotheosis. He was one of the kind of engrossed view of himself and a despondent, se–
crret me and 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 to be in this case—thoroughly hoped to be—
was in a sense of his conscious view 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 useless, impotent rage.

Mr. B is a prototypical example of a narcissistic personality disorder—someone who is anguished, disarming and devitalizing of others, obvious, 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 as their core, and understanding what happens when self and identity go away 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 these 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 & Kitayama, 1996). 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 enactive 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 pronouncements 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 opposed from implicit views. Further, it is now clear that many if not most aspects of the self-concept are affected 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 visually 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 the 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 quite (metaphorically or literally interpreted as neurons) that have been previously activated together. Thus the particular "shape" of a person's neural representations, as in at any given time (Saulder & Rosebott, 1962) will reflect the confluence of chronically 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 form conscious representation (whether because they simply do too 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 respect 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 will likely reflect two simultaneous constraint satisfaction processes: one 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) or a negatively positive direction, as in some depressed people. adverse reactions, or in a negative direction, as in many depressed and personality-disordered individuals with depressive dynamics, may depend on the extent to which cognizant and emotional constraints are strong or weak (it's based 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 self-representation of self "fits the facts" should also depend on personality variables such as the individual's tolerance for negative affect of different kinds, ability to regulate self-esteem, and so forth. In this view, "self-enhancement" is a shorthand for an equalization 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 self sort, people also have a multitude of de- sired, feared, and ideal self-representations associated with various affects (Higgins, 1990; Struuman, 1996; Westen, 1987, 1984b). 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 ask them to access prototype, 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 -slution of the self. People tend to have a general "level" of self-esteem to which they gravitate, which is usually very consistent with early prototypic self-concept. Self-esteem, in this sense, is 'the affective component of the person's prototype 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 "prototypes" (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 relationships, 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. E, a perceived slight or criticism, a representation of self with critical or discrediting other, is likely to activate networks that represent a shamed or humiliated self, with the attendant affect (which may or may not remain conscious expression). (On the activation of states of mind that include representations and affects, see Horowitz, 1978).

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 certain normative experiences, such as sexual abuse (Wester, 1994).

Identity is probably the broadest and most related concept, and it shares many aspects of Markus's "dynamic self-concept" (Markus & Wurf, 1978). 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 as 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 that I am a failure.") Other measures, such as the Tennessee Self.
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... and that this kind of defensive distortion of self-representations comes at considerable cost to the individual (to mention those prescribed to him or her). For instance, Sheehy, Maynard, and Ijzerman (1993) found that individuals who scored high on a self-report measure of positive mental health and those who acknowledged their distress (e.g., anxiety, depression) and blocked from participants' explicit memories showed higher levels of cognitive activity than both individuals who experienced good mental health and those who acknowledged their distress (e.g., anxiety, depression). Calvin and Block (1994) have shown that individuals described by normal observers of their behavior as exhibiting severe multiple ways interpersonally that are not revealed by their self-reports. Similarly, Robins and Reetz (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 self-esteem and self-concept, college freshmen rated their expected academic performance in college. The researchers then collected data regarding their actual performance annually until graduation. The investigators operationalyzed academic self-enhancement by computing the discrepancy between self- or 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 they 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 (Farrham, Greenland, & Banaji, 1999). Thus, in recent years, several researchers have developed methods for assessing implicit aspects of self-concept (e.g., Jadrasco, Vernon, & Pervin, 2000; Greenland, & Farrham, 2000; Pelham & Herta, 1999). For example, Greenland and Farrham (2000) have adapted the Implicit Association Test (IAT; Greenland, ...
McCober, & 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 (1993) 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 with a sibling, best friend, parent, etc. A hierarchical-clases 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 relationsh

ips. 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 & Muderrosoglu, 2001; Westen & Shefter, 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 thoughts, feelings, 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 are 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 on the pervasive role of implicit processes in thought, feeling, and behavior.

In this sense, the 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 questionnaire 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 & Muderrosoglu, 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, prototypical 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 them 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 self-awareness (explicit or implicit), as has been the norm in psychological research on aspects of s
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...theoretical variables, such as personality (e.g., security-seeking; Kruger, 1991); attitudinal factors (e.g., AIDS attitudes; Moote & Scharf, 1991); object relations (Marcia, 1994); and level of integrative complexity (Šlagic, Marcia, & Köppman, 1994).

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 phenomenal experiences; (2) processes being reported do not require training, expertise, or norms (e.g., "I have high self-esteem" relative to whom?); (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 make 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 parts 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 8c Yae-

ner, 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 "inferior, humiliated, and despised" self-image and an "ominous, vindicated, triumphant one" (p. 234). Indi-


guals 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, & Przybeck, 1999). Modern interest in personality pathology emerged in the 19th century when Prichard (1835) coined the term "moral insanity" to describe deviant behav-


ior patterns in individuals whose reasoning processes, unlike those of patients with psy-


chosis, remained intact. This distinction re-


maintains the basis of the "insanity defense," which is predicated on a view of people as either capable or incapable of moral deci-


sion making based on the intactness of their cognition.

The concept of personality disorder emerged in the 1930s and 1940s in the psyche-


analytic literature, as clinicians and the-
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The clinical literature offers a wealth of phenomenological and theoretical descriptions of pathology of self in patients with PDs. These phenomena are not only currently as much as in the past, but they may even more recently be emerging. The disorders that have received the most attention are borderlines and narcissists. The latter displays considerable ease, 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.

The DSM-III-R criteria for personality disorders are divided into two main categories: 1) pervasive disturbance of self and identity and 2) interpersonal defectiveness. The former category includes: identity diffusion; role and occupational identity; and identity congruence, which refers to the degree to which a person's self-other perceptions are shared by others.

For example, the term 'identity diffusion' refers to a pervasive disturbance of self and identity that is characterized by a lack of a stable, well-defined sense of self. Patients with identity diffusion may have difficulty maintaining a consistent sense of self, and may experience a range of feelings and behaviors that are inconsistent with their self-concept. This can lead to feelings of confusion, disorientation, and discomfort.

Pathology of Self in Personality Disorders

The clinical literature offers a wealth of phenomenological and theoretical descriptions of pathology of self in patients with PDs. These phenomena are not only currently as much as in the past, but they may even more recently be emerging. The disorders that have received the most attention are borderlines and narcissists. The latter displays considerable ease, 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.
1984) and elaborated by Akhtar (1984, 1992), the identity disturbance seen in patients with BPD 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 prickly and guileless), 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. Whereas the patient lacks a sense of the self as continuous through time, the sense of "a life lived as pieces" captures this experience (Priggit, 1972). Third is a lack of authenticity, manifest in a characterless 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. Fourth are feelings of emptiness and emotional numbing that lead to fears of inner darkness and fears of being alone (because loneliness becomes frightening if the self can only be defined in relation to significant others). A fifth feature is gender dysphoria, manifested in opposite-gender behavior and confusion regarding choice of sexual partner and the gender to which one belongs. The sixth feature is inordinate ethical and moral relativism, which involves a lack of stable values and cultural or ethnic affiliation. Similar to the dysmorphic-like quality of the insubstantial 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: others often observed in patients with identity disturbances, disorders 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 disturbances believed to characterize BPD as taken from the extant theoretical, clinical, and empirical literature. Their description resembles Kernberg's (1975) and Akhtar's (1984, 1989) descriptions of BPD 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 hyperventilating 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 borderlines patients are also prone to particular representations of self (e.g., self as globally bad or Joashness; Westen et al., 1992) and self-worth paradigms (e.g., abandoned self-esteem other, victimized self-victimizing others; Nig, Loth, Westen, Gold, & Sif, 1992). In addition, as emphasized by Kernberg (1984) and supported by subsequent research (Baker, Sif, Westen, Nig, & Loth, 1992), borderline patterns tend to "color" 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 disturbances in borderline personality disorder is sparse. Taylor (1993), points out that the DSM criterion that captures identity disturbance has proved one of the least reliable criteria among the eight criteria largely from the vagueness of the term "identity disturbance: markedly and persistently unstable self-image or sense of self" (APA, 1994, p. 634) and its nonpeculiarity to BPD. In an effort to refine the concept of
identity disturbance empirically, Williamson-Kyan and Westen (2000) developed a 36-item identity disturbance instrument for clinical research 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 unidimensional 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 (i.e., 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, Williamson-Bryan 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), inconstancy (objective incoherence in behavior: which the patient typically does not feel 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 the BPD diagnosis remained predictive of 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 coherence, suggesting that the identity disturbance seen in borderline patients is not generic 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, so 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 grandiose 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 a 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 (Goldinmen, 1953). Like many other theorists, Kohut’s (1971, 1977) use of the term “self” is incoherent, 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 is this distinctive sense in the nucleus of a person’s central ambitions and ideals and the talents and skills used to actualize them (Kohut, 1971). Wölfl
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 groundless self—an idealized representation of self that emerges in children through empathic mirroring by their parents (“mommy, daddy!”) and provides the nucleus for later ambitions and aspirations. The second he calls the idealized parent image—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 or herself 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, ego, 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 those 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, 1999b) 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 more recent version of the Q-sort (Westen & Shedler, 1999a). The following items related to self were among the 20 most highly rated (i.e., highly descriptive) items out of the 240 items in the instrument in an aggregated 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 exaggereated ideal self. When the investigators generated DSM-IV diagnoses and instead derived agnostic prototypes empirically using Q-sort analysis (a clustering technique), the narcissistic cluster that emerged included the following traits among those most descriptive: fast 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 deserted body image feels self as unattractive, grotesque, disgusting, etc. (Westen & Shedler, 1999b). Interestingly, the 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 inferiority. 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 overgrandiosity and the former reflecting both grandiose ideal self-representations and dashed deviated (fearful) representations of self.

Other Research on Self and Identity

Dissociation 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, dependent personality disorder, and obsessive-compulsive personality disorder. The link to self-esteem makes sense in light of depressed 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 the study of these disorders. The SASB is a multidimensional model of social interactions 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 ways in which individuals relate to others, shaping the self-concept and associated strategies of "interacting" with oneself. This view allows for the emergence of personality disorders, which are characterized by persistent and inflexible patterns of interpersonal behavior. A significant influence on the development of personality disorders is the attachment style that an individual develops during childhood. Securely attached individuals are more likely to form strong and stable relationships, whereas insecurely attached individuals may experience difficulties in forming and maintaining relationships, which can lead to the development of personality disorders.

Etiology of Self Pathology in Personality Disorders

As with most forms of psychopathology, the etiological variables include genetic influences, environmental events, and gene-environment interactions and transactions. Here we provide a brief overview of three areas of research that have relevance to the etiology of PDs and the development of personality disorders. The first area of research examines the relationship between personality traits and PDs, where a significant association between certain personality traits and PDs has been observed. For example, individuals with PDs often exhibit traits such as impulsivity, aggression, and risk-taking behavior, which are also characteristic of individuals with PDs. The second area of research examines the role of early life experiences in the development of PDs. Early experiences, such as childhood trauma,虐待, or neglect, have been shown to contribute to the development of PDs. The third area of research examines the role of biological factors in the development of PDs. For example, abnormalities in brain structure and function have been observed in individuals with PDs, suggesting a biological basis for these disorders.

Behavior Genetics

The vast majority of behavioral-genetic studies of personality have focused on normal personality traits, such as those characterized by 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, Jung, Jackson, & Vernon, 1995; Plomin & Caspi, 1999). The most frequently studied traits, extraversion and neuroticism, have producedheritability estimates of 54% to 74%, and of 42% to 64%, respectively (Dwyer, 1990). When measures other than a 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 traits can support either genetic or environmental causes. Hence, twin and adoption studies tend to provide more definitive evidence.

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 PD 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 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 constriction, and behavior or appearance that is odd or eccentric. Early observers of schizophrenia (e.g., Bleuler, 1911/1950; Knae pelig, 1894/1919) often noted peculiarities in language and behavior among the relatives of their schizophrenic patients. Bleuler called this "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 schizotypal personality disorder ultimately resulted in the creation of the DSM-IV diagnosis of schizotypal personality disorder (SPD).
The relevance of aspects of self remains unclear. While SPD is now well established (Kendler & Walsh, 1993; Lennvizerger, 1998), for example, using data from the Washington Family Study, Kendler and his colleagues (e.g., Kendler et al., 1997; Kendler, McGue, Huangberg, & Wemelin, 1996; Kendler & Walsh, 1997) found a significant familial relationship between SPD and schizophrenia. In the same study (1984), it was found that 33% (7 of 21) of identical twins had SPD, whereas only 4% (1 of 23) of fraternal twins showed the diagnosis.

Antisocial personality disorder, in contrast, appears to have both genetic and environmental roots, as documented in adoption studies (Casarett, Zander, Troughour, Howard, & Stewart, 1981). 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 marker. 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 schizophrenia and antisocial personality disorder, research on the behavioral genetics of BPD has yielded much less evidence of heritability. Most studies of familiality have emerged in several studies (e.g., Reiss, 1981), however, the bulk of the evidence does not support genetic explanations (Oehm, 1983; Nigg & Goldsmith, 1994). For example, Zangrando (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, 1974; Widiger & Allen, 1985) 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 SPD have shown substantial heritability, including one of particular importance: SPD for one present purpose—problems with identity (Liveley et al., 1993).

Although behavioral genetic data are proving increasingly important in understanding the etiology of personality disorder (e.g., Liveley, Jung, & Yarnes, 1998), their relevance to aspects of self remains unclear. While SPD is now well established (Kendler & Walsh, 1993; Lennvizerger, 1998), for example, using data from the Washington Family Study, Kendler and his colleagues (e.g., Kendler et al., 1997; Kendler, Clugston, Greenberg, & Wemelin, 1996; Kendler & Walsh, 1997) found a significant familial relationship between SPD and schizophrenia. In the same study (1984), it was found that 33% (7 of 21) of identical twins had SPD, whereas only 4% (1 of 23) of fraternal twins showed the diagnosis.

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Although behavioral genetic data are proving increasingly important in understanding the etiology of personality disorder (e.g., Liveley, Jung, & Yarnes, 1998),
This method involves brief separations of caregivers 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. Secure infants exhibit either resistant-ambivalent avoidance attachment styles. Resistant-ambivalent infants experience their caregiver as unsafe consistently to meet their needs, resulting in considerable separation anxiety, a reluctance to explore their surroundings because of preocupation 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 style: 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 anticosmic 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-esteem, e.g., Nakanishi, Eisskonits, Dunn, & Whitehead, in press. For example, Rosenberg and Horowitz (1996) assessed the attachment status of adolescent inpatients and found a strong association 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 precociously attached 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 dysphoric 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, Hausser, & Bornman-Spurrell, 1996), are likely to be classified as "unresolved" using the AAI. These individuals tend to have inherent internal working models of both self and others.

Fonagy and colleagues have studied several personality disorders, primarily BPD, from an attachment perspective, focusing on the development of what they call mentationization (e.g., Fonagy, Target, & Gergely, 2000). Mentationization involves the capacity to understand one's own and others' mental states, such as wishes, beliefs, and feelings. A hallmark of mentationization is the ability to attribute beliefs, desires, and other mental states to others that are based either on one's own beliefs and desires or 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 relationship between parents' mentalization of their children 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, Mora, Steele, & Higgott, 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, dovetailed with research on the understanding of social causality in adult and adolescent patients with BPD. Borderline patients show significantly lower levels of understanding of causal factors 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, Made, Ruffiss, & Ivers, 1980). Thus the studies 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 self (Borsook & O’Neill, 1992; Lieb, Westen, Bottery, & Mendel, 1992; Levi, Blatt, & Shaver, 1994). 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, comforting, and empathically 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, Cowie, & Hannon, 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, other experiences, abuse, 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 (Dawes & Frawley, 1994; Westen, 1994).

Self esteem also suffers, as children often blame themselves for the abuse or fail to resolve it as a unique entity and an event. Numerous studies of both clinical and nonclinical samples of survivors of child sexual abuse have identified self-esteem as a key aspect affected by the abuse experience (Bolger, Patterson, & Kistler, 1998; Bayen, Detrich, & MacKen, Dyckman, & Sherrid, 1993; Kendall-Tackett, Williams, & Fiedler, 1993; Romano & Delucia, 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
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all other four are important for the development of self and identity, the dynamics of attachments 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 altering in some way. Recent studies (Coley, Kostenberg, Hening, Turner, & Bennett, 1996; Hestand, Cottle, Gould, Lawry, & Weiss, 1995; Isem & Sosdewyn, 1999) find that self-blame for abuse is both children and adults who were sexually abused as children 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 & Metzakranz, 1983) and the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbarg, 1979). The effects of early abuse on aspects of self can be seen as early as these three dimensions of self can be measured. In self-recognition studies, maltreated toddlers frequently display neutral or negative affect on recognition of themselves is the micro, suggesting feelings of shame or isolation (Casler, 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 abuse 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. Childood trauma, particularly sexual abuse, has been linked to BPD in a number of studies (Humphreys & van der Kolk, 1988; Worell 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 subcortical development, brain development may also affect functioning in these domains. For example, sex-related disturbances have been observed in combat veterans from the Vietnam War (Brendt, 1982, 1983). During war, some soldiers dissociate, particularly when committing or observing atrocities, and the requisition 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 (Allan, 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, Small, & Bernstein, 1999). A history of neglect was associated with greater risk of symptoms of antisocial, borderline, paranoid, avoidant, passive-aggressive, and schizoid 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 borderline, dependent, obsessive-compulsive, passive-aggressive, and schizoid personality disorder.

To summarize, if research on the etiology of PDs in its infancy, research on the etiologi of self pathology in PDs is probably best described as embryonic. Data on behavioral genetics and attachment relationship 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 on 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. Difficulties maintaining commitments 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.

Acknowledgments

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References


Baldwin, M. (1992). Relational schemas and the processing
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- Treatment of Personality Disorders

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- Identity Resolution

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VI. PHRYGENETIC AND ONTOLOGICAL DEVELOPMENT


