

SELF-CONCEPT CORRELATES OF THE PERSONALITY DISORDERS

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This study investigated the extent to which the DSM personality disorder dimensions are associated with discrete patterns of self-concept. Participants were 366 men and women who were receiving mental health services and who completed the Wisconsin Personality Disorders Inventory to assess the personality disorders and Benjamin's INTREX questionnaire to describe their "typical" self-concepts. Although there was some overlap between categories, most were associated with fairly distinct patterns of self-concept. The disorders also clustered together in meaningful ways along the major axes of Benjamin's interpersonal model of the self-concept.

The concept of the self has been increasingly included in cognitive models of psychopathology (e.g. Higgins, 1987; Strauman, 1989; Westen, 1992), although the term has referred to different constructs in different theories (Markus & Cross, 1990). Self-concept is generally considered to be a product of social transactions, although the specific role of others is seldom made clear (Markus & Cross, 1990). For example, Sullivan (1953) suggested that important aspects of the self are influenced by the manner in which the individual has been treated by important others. Also, the construct of the self is thought to be instrumental in regulating the cognitive and interpersonal behavior of the individual (Graziano, Jensen-Campbell, & Finch, 1997). The clear implication of such theories is that environmental experiences have a significant impact on the pattern and form of an individual's behavior, and furthermore, that self structures may mediate this relationship. Overall, contemporary literature typically emphasizes that the self or self-concept is: (a) a complex and multifaceted cognitive structure; (b) an active memory structure that functions to mediate and regu-

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late behaviors; and (c) a dynamic structure that is both highly stable and highly malleable (Markus & Wurf, 1987; Stein & Markus, 1996).

Benjamin has applied her Structural Analysis of Social Behavior (SASB; Benjamin, 1993, 1996) to the DSM personality disorders in a manner that attempts to clarify the relationship between the self-concept, interpersonal history, and current interpersonal behavior. She speculates that each personality disorder is characterized by a particular learning history that shapes individual patterns of interpersonal and intrapsychic behavior. Following Sullivan (1953), she construes the self-concept as heavily influenced by the actions of significant others and suggests that the various personality disorders should be characterized by different self-concepts, which, in turn, correlate closely with the social histories posited for specific personality disorders. The concept of the "self" is operationalized as the introject in the SASB model (see Figure 1, introject), which captures the results of experiences with others that are internalized or "turned inward upon the self" (Benjamin, 1996, p. 48). For example, Benjamin hypothesizes that individuals with borderline personality disorder exhibit a self-concept characterized by high levels of self-attack and self-neglect, in part because they were themselves attacked and neglected in their interpersonal history and reacted accordingly by recoiling and attempting to wall off the stress (Benjamin & Wonderlich, 1994). The obsessive compulsive personality disorder, on the other hand, is predicted to display a self-concept characterized by high degrees of self-control and simultaneous self-neglect (i.e., unbalanced perfectionism) largely because they were inappropriately coerced to perform by caregivers early in life and submitted to these demands (Benjamin, 1993, 1996).

The general aim of the present study was to consider the extent to

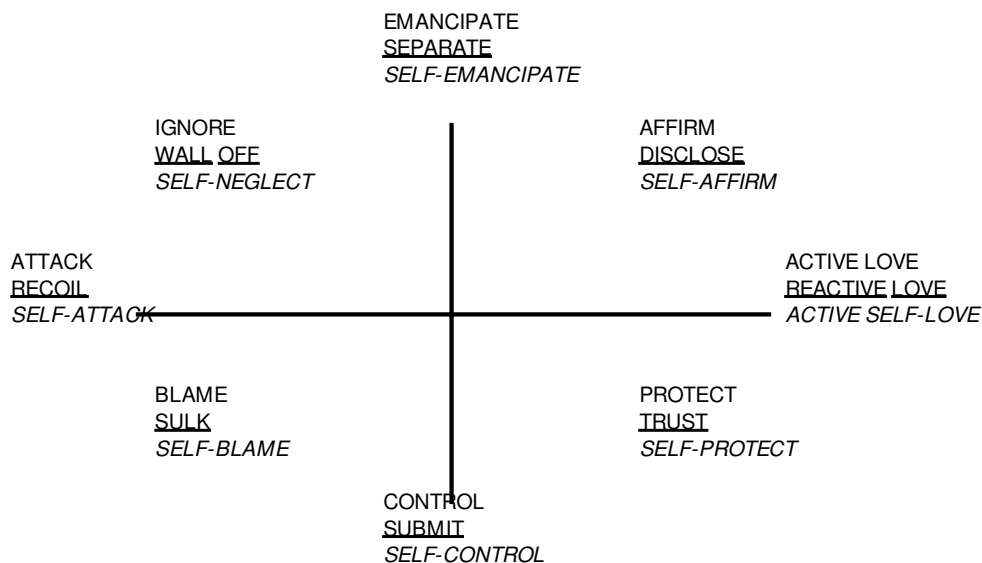


FIGURE 1. The SASB simplified cluster model, all three surfaces (bold, focus on other; underlined, focus on self; italics-introject). © 1996 The Guilford Press. Reprinted with permission

which the DSM personality disorders are associated with discrete patterns of self-concept. In other words, we were interested in understanding the relationship of specific personality disorders and general self representation. This does not provide a direct test of Benjamin's predictions regarding personality disorders and specific introjections, as that would require a finer-grained and more dynamic assessment of self-concept over time rather than the more global and static self ratings elicited in the present study.

METHOD

PARTICIPANTS

Participants in this study were selected from participants in the original WISPI validation study who were identified as currently receiving some form of mental health care (Klein, Benjamin, Rosenfeld, Treece, Husted, & Greist, 1993). Patients were recruited from psychiatry inpatient and outpatient services, community mental health centers, a psychology clinic, and a student counseling center, or by means of posted announcements and staff referral. Others were recruited from the general public by means of media advertisements, posted announcements, visits to classrooms, and solicitation from visitors to the university hospital. They were asked if they had ever received mental health services or counseling of any kind and included in the sample if they reported receiving any of these services at the time of recruitment. Informed consent was obtained from all participants. The sample of 366 current patients was 73% female, 27% male. Their ages ranged from 17 to 82, ($M = 31$, $SD = 11.1$). With respect to education, 16% were high school graduates, 48% had attended some college or technical school, 17% were college graduates, and 12% had some postgraduate education.

MEASURES

The Wisconsin Personality Disorders Inventory. The Wisconsin Personality Disorders Inventory (WISPI) is a self-report inventory for the Axis-II personality disorders, which is based both on the descriptions in the DSM-III, DSM-III-R, and on Benjamin's (1993, 1996) interpersonal conceptions of the personality disorders. Information on the development of the inventory, its psychometric characteristics, norms for patients and nonpatients, and comparisons with other personality disorder assessments have been reported previously (Klein et al., 1993). It has also been revised in accord with DSM-IV (Klein & Benjamin, 1996). The correlations of the WISPI scores for the DSM-III version and counterpart scales of other self-report scales averaged .39 for the MCMI and .69 for the PDQ; when corrected for attenuation, the coefficients were .43 and .93, respectively (Klein et al., 1993).

Intrex Introject Scale. The measure of self-concept was the Long Form of Benjamin's (1983) Intrex questionnaire. The 36 items correspond to the

eight clusters on the introject surface of Benjamin’s SASB model as illustrated in Figure 1. This structure was derived by factor analysis and conforms to the general circumplex structure posited for the SASB model (Benjamin, 1983, 1994, 2000). For example, one of the four items tapping SASB Cluster 6, Self-blame, was “I put myself down, tell myself that I have done everything wrong and that others can do better”. Each item was rated on a scale from 0 (never or not at all typical of me) to 10 (always or extremely typical of me). There are five items for each of the primary poles of the model (Clusters 1, 3, 5, and 7) and four items for the points in between (Clusters 2, 4, 6, and 8). Ratings of the items for each cluster were averaged to yield scores for the eight Clusters shown in Figure 1.

RESULTS

There was a high degree of intercorrelation among the WISPI personality disorder scores and also among the adjacent SASB clusters in the introject measure. Therefore, partial correlation analysis was used to control for the variance shared between personality disorder dimensions and the SASB clusters when estimating the association between a given personality disorder scale and a given SASB cluster score. For example, when the correlation between scores on the Paranoid Scale and SASB Cluster 1 was computed, the WISPI scores for the ten other personality disorder scales and the seven other SASB clusters were first partialled out of the analysis so that a partial correlation coefficient represented the unique association between the paranoid score and SASB Cluster 1. The results of these analyses are summarized in Table 1.

This approach had the effect of highlighting the most prominent self-concept features of each personality disorder. For the majority of the personality disorder categories, there were only two partial correlation coeffi-

TABLE 1. Partial-correlations Between WISPI Personality Disorder (PD) and SASB Cluster Scores

WISPI PD score	SASB cluster score							
	1	2	3	4	5	6	7	8
Paranoid	-.16	.01	-.02	.04	.16	-.10	.02	-.06
Schizoid	.10	.05	.09	-.11	.03	-.07	-.02	.12
Schizotypal	-.05	.07	.08	-.04	-.10	.07	.19	.07
Histrionic	.01	.03	.12	.10	-.12	.04	.02	-.03
Narcissistic	.04	.02	.02	-.02	.06	.06	-.14	.00
Antisocial	.20	-.07	.09	-.01	.08	-.11	-.01	-.04
Borderline	-.00	.00	-.16	.06	-.01	.18	.06	.17
Avoidant	.05	-.05	-.18	.09	.09	.15	.11	.01
Dependent	.06	.01	-.00	-.22	.08	.09	-.10	-.03
Compulsive	-.15	-.02	-.02	-.02	.34	-.01	-.07	.11
Passive-aggressive	.22	-.05	.06	.01	-.19	-.07	.12	.06

df = 344. Coefficients that are significant at .05 or less (two-tailed) are in bold type.
See Figure 1 for labels associated with the SASB clusters.

TABLE 2. Clusters that Are the Most and Least Characteristic of Each Personality Disorder

PD Category	Most characteristic significant positive	Least characteristic significant negative
Paranoid	Self-control	Self-emancipate
Schizoid	Self-neglect	Self-protect
Schizotypal	Self-attack	—
Histrionic	Active-self-love	Self-control
Narcissistic	—	Self-attack
Antisocial	Self-emancipate	Self-blame
Borderline	Self-blame	Active-self-love
Avoidant	Self-blame	Active-self-love
Dependent	Self-control	Self-protect
Compulsive	Self-control	Self-emancipate
Passive-aggressive	Self-emancipate	Self-control

To be included, the correlation had to be significant at .05 or less.

cients that were significant, one positive and one negative. These patterns are summarized in Table 2. The patterns were unique for 7 of the 11 disorders. For example, the pattern of high self-neglect and low self-protection that characterized the schizoid personality disorder was not repeated for any other category.

There were two instances when personality disorders shared the same patterns: Paranoid and compulsive disorders had the highest positive correlations with self-control and the highest negative correlations with self-emancipation. Borderline and avoidant disorders shared high positive correlations for self-blame and high negative correlations for active-self-love.

It is also interesting to look at the one instance when two disorders showed self-concept patterns that were opposites. The association of the passive-aggressive scores with high self-emancipation and low self-control was the mirror image of the patterns already noted for the paranoid dimension.

DISCUSSION

As illustrated in Figure 1, the SASB model, which provided the foundation for the self-concept measure used in this study, consists of the orthogonal dimensions of interdependence (autonomy vs. control on the vertical axis) and affiliation (love vs. attack on the horizontal axis). An overview of the patterns of correlations between these major axes of the SASB model and the personality disorder dimensions suggests that the disorders cluster together in meaningful ways along these dimensions.

Passive-aggressive, anti-social, and schizoid personality disorders all showed fairly high degrees of autonomy in terms of their self-concept ratings. While schizoid autonomy might be characterized by higher degrees of hostile disengagement, both the passive-aggressive and antisocial were more simply emancipated, differing from each other only through the presence of a greater degree of self-attack in the passive-aggressive individuals.

On the other hand, the paranoid and compulsive personality disorders showed a very different self-representation characterized by high degrees of self-control and the absence of self-emancipation. The compulsive personality, however, was associated with some degree of self-neglect, which provides a slight separation from the paranoid dimension.

While paranoid, schizoid, antisocial, compulsive, and passive-aggressive personality disorders were primarily characterized by their status on the dimension of autonomy versus self-control, the histrionic, narcissistic, borderline, and avoidant disorders were more clearly defined by the dimension of affiliation. For example, both the borderline and avoidant were characterized by a high degree of self-blame and the absence of self-love. The avoidant also showed a more well defined tendency toward self-attack. On the other hand, the histrionic and narcissistic disorders showed greater affiliation in their self-concepts. While the narcissistic disorder was clearly defined by an absence of self-attack, there was not a corresponding tendency toward self-love. The histrionic disorder, on the other hand, did show the heightened degrees of self-love, but this was coupled with an absence of self-control, which fits clinical characterizations of the histrionic as impulsive and self absorbed. The picture for dependent was mixed, combining a low but significant positive correlation with self-control with a high but negative correlation for self-protection—a pattern that is consistent with the dependent's sense of personal incompetence and their need to defer to others in order to ensure their presence and protection.

We draw several conclusions from this study. The fact that we find different self-concept patterns for the various personality disorder dimensions lends validity to the basic assumption in the DSM that these are indeed distinct aspects of disorder. The fact that the self-concept patterns for the various personality disorders are clustered differentially along the main axes of the Benjamin SASB model provides support for her interpersonal conception of these disorders. In addition, comparison of the self-concept patterns for disorders that are frequently difficult clinically to distinguish may aid in differential diagnosis. For example, the overlap between some features of antisocial and borderline disorders may be resolved by keeping in mind their opposite correlations for self-blame and the strong emphasis on self-emancipation in the antisocial that is not shared by the borderline. Other clinical applications may flow from a more detailed consideration of specific links in Benjamin's formulation between self-concept, interpersonal developmental history, and the dynamics of treatment than is possible to describe here. In light of the modest-to-high concurrent correlations between the WISPI and PDQ and MCMI-I self-report measures, these findings may have wider generalizability. As the WISPI was based on Benjamin's interpersonal formulation of the personality disorders, however, we would expect the associations between the WISPI and Intrex self-concept scores to be stronger than what might be found for self-report measures derived from other conceptions.

Although these findings are limited by the absence of complex behavioral observations or longitudinal measurement strategies that would allow a more precise testing of self-concept associated with personality disorders, the approach does provide an avenue for making discriminations be-

tween the DSM personality disorders in terms of their self-perception. Conceptual advances in the personality disorders may be aided by consideration of self-concept variables.

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