THE SELF-IMAGE IN BORDERLINE PERSONALITY DISORDER: AN IN-DEPTH QUALITATIVE RESEARCH STUDY

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Patients with borderline personality disorder (BPD) suffer from affective instability, impulsivity, and identity disturbance which particularly manifest in an unstable or insecure self-image. One main problem for studies of core psychopathology in BPD is the complex subject of identity disturbance and self-image. The purpose of this study was to investigate the self-image of BPD patients with a qualitative research approach. Twelve patients with BPD were compared to 12 patients with remitted major depressive disorder (MDD) without personality disorder, using the Structured Interview of Personality Organization (STIPO). The transcribed interviews were analyzed using a combination of content analysis and grounded theory. BPD patients described themselves predominantly as helpful and sensitive; reported typical emotions were sadness, anger, and anxiety. MDD patients on the other hand reported numerous and various characteristics and emotions, including happiness, as well as sadness and anxiety. Other persons were characterized by the BPD group as egoistic and satisfied, while the MDD group described others as being balanced and secretive. BPD patients displayed an altruistic, superficial, and suffering self-image. Aggressive tendencies were only seen in other persons. Our findings support the concept of a self and relationship disturbance in BPD which is highly relevant for psychotherapy treatment.

The prevalence of borderline personality disorder (BPD) is estimated as 2% within the population and as between 10% and 20% in psychiatric samples (Torgersen, Kringlen, & Cramer, 2001). Psychiatric comorbidities are common in BPD, especially affective disorders, substance use disorders and eating disorders (Gunderson & Links, 2008; McGlashan et al., 2000; Shea et al., 2004; Walter et al., 2009; Zanarini, Frankenburg, Hen-

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nen, Reich, & Silk, 2004). In general, BPD patients suffer from impulsivity, affective instability, and identity disturbance (Gunderson, 2009; Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004). According to DSM-IV-TR, identity disturbance is one of the nine diagnostic criteria for BPD and is characterized by "a considerable and persistent insecure self-image or instable self-perception" (American Psychiatric Association, 2000). Identity disturbance or identity diffusion has been described as a lack of differentiated and integrated representations of self and others, in the lack of long-term goals and negative self-image, or in the lack of sense of continuity in self-perception over time (Fuchs, 2007; Jorgensen, 2006; Kernberg, 1984, 1992; Marcia, 2006).

While identity disturbance and self-pathology is one of the BPD symptoms, the research on this subject is sparse. Studies in this area report that (1) less differentiated and integrated representations of self and others were significantly related to the self-reported use of maladaptive strategies (e.g., self-injurious behaviors) to regulate negative affective states (Levy, Edell, & McGlashan, 2007); (2) BPD pattern is characterized by a contrast between self and others (De Bonis, De Boeck, Lida-Pulik, & Feline, 1995); (3) identity disturbances were found in half of all patients with personality disorders (Modestin, Oberson, & Erni, 1998; Wilkinson-Ryan & Westen, 2000); and (4) lower self-esteem was reported in BPD than in patients with social phobia (Rüsch et al., 2007).

This scarcity of empirical studies underscores the difficulty of operationalizing and capturing the construct of self-image in clinical-psychiatric empirical research. In contrast, the qualitative research approaches enable a direct access to personal identity and self through narratives and may elucidate how BPD patients perceived and described themselves compared to other patients without BPD.

The goal of this explorative study was to analyze for the first time the self-image of BPD patients with a qualitative research approach. The present study compared the self-image of patients with BPD and with remitted major depressive disorder (MDD) without any personality disorder, using a structured interview containing questions about self-perception and self-description.

METHODS
PARTICIPANTS

Patients who had been admitted consecutively to the Psychotherapy Treatment Unit of the Psychiatric Hospital of the University of Basel (Switzerland) and who had been diagnosed as borderline personality disorder (BPD) or major depressive disorder (MDD) according to the DSM-IV-TR criteria were included in the study in the third week of treatment. Exclusion criteria were schizophrenia, schizoaffective disorder, active psychosis, bipolar disorder, and substance intoxication or withdrawal.

Clinically experienced interviewers trained to pay particular attention to distinguishing Axis I mental state conditions from Axis II personality trait phenomena interviewed subjects who screened positive for BPD with the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I/P; First, Spitzer, Gibbon, & Williams, 1996) and for DSM-IV Axis II Disorders (SCID-II; First, Gibbon, Spitzer, Williams, & Benjamin, 1997).

The MDD control group was matched for age and sex. All MDD patients suffered from a mild depressive episode and were remitted after two weeks of inpatient treatment.

The choice and number of both samples are consistent with the general sampling standards of the qualitative research approach (Frommer, 1999). IRB approval was obtained, and all participants signed written informed consent form.

STIPO INTERVIEW

The Structured Interview of Personality Organization (STIPO) was used to examine the identity diffusion and the self-image (Clarkin, Caligor, Stern, & Kernberg, 2003). The STIPO Interview is a manual for the evaluation of individual personality organization according to Kernberg's psychodynamic conceptualization of personality organization (Kernberg, 1984). The manual includes six dimensions of personality organization; one of these is identity. The STIPO understands identity on the basis of a person's commitment in work, learning and leisure time activities, the degree of integration and stability of self-perception and self-esteem regulation.

During the interview, patients were asked to describe themselves so the interviewer could get a vivid and complete image of the patient's personality. It was permitted to ask the questions repeatedly, if the description was too superficial or consisted of a sequence of adjectives, or if the person had serious problems with the self-description.

QUALITATIVE METHODOLOGY AND RESEARCH STRATEGIES

Qualitative methodology suited this study because of the lack of empirical knowledge on BPD self-image in literature. In general, qualitative methodology is the appropriate scientific method for describing, understanding, and interpreting complex phenomena of psychosocial or psychological nature which have not yet been explored. Qualitative research follows an idiographic scientific approach with a variety of methods. The methods used in this study employ a descriptive-interpretative approach.

Qualitative research underlies special evaluation criteria, analogous to those of validity and reliability in quantitative research. Scientific rigor is attained by techniques such as: purposeful sampling, combination of analysis methods and the researcher's field experience, and is measured by criteria such as: presence of the participant's perspective; clarification of the study context; demonstration of relation between data and results;

conceptual density of emerging categories, success of communicating the results, originality and contribution to scientific knowledge. Findings are not expected to be statistically projectable to a wider population, but can lead to context-dependent generalizations or generalizations to a broader theory. The persons involved in a studied phenomenon (i.e., clinicians) profit from the findings by a better understanding of the field and individual cases, and can make predictions about similar cases (Elliott, Fischer, & Rennie, 1999).

The identity part of the STIPO-Interview was recorded digitally. The interviews lasted from 26 minutes (3,243 words) to 49 minutes (5,996 words). To allow data analysis, all 24 taped interviews were transcribed and analyzed according to the rules of the Ulmer Textbank (Mergenthaler & Stinson, 1992). The first stage was to develop thematic units from the STIPO interviews, in order to create text comparison tables of all 24 interviews on each thematic unit, concentrating on interindividual similarities and contrasts.

Four research group members were involved in developing the thematic units for the comparison tables through several meetings. Two of the group members had been involved in conducting the interviews. All disagreements were considered and discussed until group consent was achieved (Frommer & Rennie, 2001).

In a second analysis stage, we used grounded theory coding methods, one of the best known qualitative research strategies (Strauss & Corbin, 1990). To enhance the level of abstraction of the patients' statements and to make meanings more explicit, codes are created in interaction with the data-text. In this way, we redefined data meanings and developed various categories. This kind of analysis is a cyclical process. We went through the different analysis stages several times, dropping a category or code if a more useful one was emerging (Strauss & Corbin, 1990). Ultimately, we aimed at the emergence of a complex category system. The following five categories were finally analyzed: 1. Self-description, 2. Description of others, 3. Typical emotions, 4. Typical episode in the person's life, 5. Phrases with little meaning.

This analysis was repeated by two researchers to ensure reliability. The senior author used the expertise of an analysis group (in which two further members of the research group participated) for the discussion of a series of cases and conducted the second analysis stage.

RESULTS
SOCIAL AND CLINICAL DATA

In the overall sample, 19 (79%) patients were women and 5 (21%) were men. The average age was 29.3 years ($SD = 8.6$). BPD patients ranged in age from 18 to 37 years (mean = 26 years, $SD = 6.2$), MDD patients without a personality disorder were between 20 and 51 years old (mean = 32

years, SD = 9.9). There was no significant difference in age (t = −1.78, df = 22, p = 0.089) or gender (χ^2 = 0.25, df = 1, p = 0.615) between the two groups. The social and clinical data of BPD and MDD patients are shown in Table 1.

SELF-DESCRIPTION

BPD patients described themselves predominantly as sensitive or friendly in comparison with other people or as cooperative, for example one BPD patients said: "sensitive, a peace loving person. I have a big heart, yes just friendly and nice to other people" (No. 3), another person remarked: "I'm not a special person, (but) I'm good at helping people" (No. 9). Only one BPD patient (No. 8) did not characterize herself as sensitive or friendly, but as stubborn, added though that she often hears this from other people. Table 2 shows all statements from the BPD group. With the exception of one person, all BPD patients described altruistic features such as sensitive, caring, helpful or friendly.

The MDD group on the other hand did not show such a homogenous self description. Table 3 illustrates the categories of the MDD patients. Their statements are generally more sophisticated and more elaborate

TABLE 1: Social and Clinical Characteristics of Patients with BPD and MDD

	Patients with BPD (n = 12)	Patients with MDD (n = 12)
Age in years, mean (SD)	26.3 (6.2)	32.3 (9.9)
Female gender, n (%)	9 (75.0)	10 (83.3)
Marital status n (%)		
Married	1 (8.3)	3 (25.0)
Single	9 (75.0)	7 (58.3)
Divorced/separated	2 (16.7)	2 (16.7)
Living situation n (%)		
Living alone	6 (50.0)	2 (16.7)
Living with parents	—	3 (25.0)
Living with partner	6 (50.0)	7 (58.3)
Occupational status n (%)		
Employed	4 (33.3)	4 (33.3)
Unemployed	3 (25.0)	3 (25.0)
Pupil/student/occupational	3 (25.0)	2 (16.7)
Retired	2 (16.7)	3 (25.0)
Number of other personality disorders n (%)		—
One	3 (25.0)	
Two	2 (16.7)	
Three	2 (16.7)	
Co-occurring personality disorders n (%)		—
Avoidant	5 (41.5)	
Paranoid	4 (33.2)	
Dependent	3 (25.0)	
Antisocial	1 (8.3)	
Co-occurring MDD n (%)	7 (58.0)	—

BPD = Borderline personality disorder; MDD = Major depressive disorder

TABLE 2: Self-Image of Patients with Borderline Personality Disorder (*n* = 12)

BPD Patient	Self-description	Description of others	Typical emotions	Typical episode
No. 1	impulsive, thoughtful, too contemplative	egoistic, disloyal, intolerant	bad conscience	and then I just broke her (the injured animal's) neck
No. 2	very sensitive . . . a good listener	others don't get sick	grief, despair	beautiful childhood and then . . . illness
No. 3	sensitive, a peace loving person	evil, insensitive and brutish	fears, anger, despair	clumsiness, never good experiences
No. 4	friendly and helpful most of the time	explosive, egoistic	grief	I love to take center stage
No. 5	friendly, dear sociable	unfriendly, unbalanced, evil	sorrow, fear	(I'm asking myself) do they always laugh at me?
No. 6	friendly, a strong will of my own	superficial	melancholy	I set a high value on trivia
No. 7	patient	satisfied, happy	sadness, fear	feelings of inner emptiness
No. 8	often told that I am stubborn	—	All strong emotions	Didn't say anything, went to the room crying
No. 9	good at helping others	cheerful, in a good temper	disgust and self-hatred	I went to the kitchen and cried
No. 10	cautious, standing up for others	satisfied, happy	sadness	I hid and no one found me
No. 11	sensitive, a good listener	adventurous, sociable	sadness	I was onstage and wanted to entertain
No. 12	high empathy	stubborn, boring	melancholy	I need a long start-up time

than those of the BPD group. For example, one depressive patient said: "I'm a moody person but you can also have a nice chat with me. In general, I'm an open person who approaches people" (No. 8). The qualities mentioned include helpful, as well as reliable, honest, humorous, and inquisitive. Some features also indicate typical mood problems of the depressive episode: "I'm honest, funny, most of the time in a good mood, but I do have some bad phases now and then" (No. 9).

DESCRIPTION OF OTHERS

BPD patients described other persons as unfriendly, selfish, and satisfied. One BPD patient said: "She must have an extreme lust for life . . . and is unfriendly, unbalanced, and nasty (No. 4).

MDD patients described others predominantly as balanced, but also as secretive or introverted or uncommunicative, for example ". . . she is always in a good mood, laughs a lot, doesn't ponder too much" (No. 9) or "rather secretive, not the person who approaches others and talks to them but someone who is generally very patient" (No. 8). While BPD patients named selfish and happy all the time, other persons are frequently described as balanced and secretive by MDD patients—with features that

TABLE 3. Self-Image of Patients with Major Depressive Disorder (*n* = 12)

MDD Patient	Self-description	Description of others	Typical emotions	Typical Episode
No. 1	helpful, trying to be happy	unathletic, dull, introverted, self-centred	grief but also happiness and satisfaction	trying not to be the center of attention
No. 2	a strong will, very sensitive	hostile, self-confident, sloppy	joy, love, but also fear and incertitude	we're good friends, I still bake biscuits for him
No. 3	strong, self-confident	insecure and pessimistic	fear, failure, self-confidence	I can make them laugh
No. 4	reliable, I find it difficult to oppose people	can show bad temper	fear, anger	trying to assert myself
No. 5	spontaneous, with zest for life	uncommunicative, cautious	joy, grief, annoyance	I took the time and helped
No. 6	I'm special in my life's plan	repressing, superficial	sadness, self-worthlessness	No one knew of my illness
No. 7	active, I know what I don't want	rather cold, not very emotional	disappointment, grief	I have few problems with communication
No. 8	I'm very moody	rather secretive	loneliness, grief	I laid into my boyfriend
No. 9	honest, funny	happy, laughs a lot	fear	I slipped and fell over
No. 10	curious, humorous	very balanced	extreme positive and negative feelings	—
No. 11	I provoke catastrophes, inquisitive	—	melancholy, luck	I didn't hesitate for long
No. 12	honest, communicative	introverted	love, joy, satisfaction	I'm good at understanding the feelings of fellow men

not only include affective characteristics, but also a reference to a relationship, an aspect that is missing within the description of the BPD group (Table 2).

TYPICAL EMOTIONS

BPD patients described exclusively negative emotions that occur in their lives and were typical for the person. As listed in Table 2, sadness, despair, anger, and fear were mentioned most frequently. One patient also said disgust and self-hatred (No. 9). If positive emotions came up, they were mentioned clearly subordinated: "fears, despair, anger, or even aggression, sometimes depression, very rarely some happiness" (No. 3).

The MDD group on the other hand did also mention other positive emotions like happiness, luck, and love even though grief was predominant. One patient said: "Well I feel pretty much every emotion there is—joy, actually love, but also somehow fear, insecurity, . . . but I try to compensate for them with a lot of happiness" (No. 2).

These emotions are described as being part of their self, as typical feel-

ings in both groups, which is why we included them as one category of self-description (BPD No. 6: "I think melancholy is definitely an emotion accompanying my life").

TYPICAL EPISODE OF THE PERSON'S LIFE

Generally, BPD patients refer to negative experiences when asked to describe a typical episode, usually experiences of being alone or excluded. One patient said: "I thanked, didn't say a word, and went to my room crying" (No. 8). Another BPD patient narrated a scene where a goose had been hit by a car and the patient held the animal in her arms while other people just stood and watched, ". . . and then I just broke her neck to spare her further pain" (No. 1).

Unlike the BPD patients, the stories of the MDD patients were less negative and overall more balanced. Positive experiences in relationships are described, which contrasts with the lack of these positive experiences in the narratives of the BPD patients. Thus one patient told how she always made biscuits for her older neighbor as a Christmas present. He finally found out and "since that time we are actually friends" (No. 2) or "then I had the idea to make her laugh and I really managed to do it, what made me really happy" (No. 3).

PHRASES WITH LITTLE MEANING

BPD patients exclusively describe negative experiences in relationships. Furthermore some of their statements have little relationship to the questions. While the text material of the MDD group could be assigned completely to the categories, we found a lot of comments from BPD patients that could not be assigned or which showed that the person had great difficulties in self-description and which did not help in the characterization of the person. "I can't think of anything at the moment" (No. 3), "I have to think about it, if you have to describe yourself, that's weird" (No. 7), or: "that's quite difficult, I'd probably make a speech about how that crosses my mind in the first place, to write an introduction and then slowly get to the most important points" (No. 12).

DISCUSSION

Only few empirical studies exist that have investigated identity disturbance or self-image in BPD, although these aspects are highly relevant and are connected to the decisive relevant representations acquired in interpersonal relationships and therapeutic alliances (Fonagy & Bateman, 2006; Bender & Skodol, 2007).

Using qualitative research methods and remitted MDD patients as a comparison group, we examined the question how BPD patients perceive and describe themselves. We could demonstrate that BPD patients do not

describe themselves as having more conflicting or negative characteristics. On the contrary, BPD patients picture themselves as helpful and friendly, whereas others are characterized as content, selfish, and evil.

As well known BPD patients reported negative emotions and affects, like sadness, despair, anger, and anxiety (Dammann & Benecke, 2004; Links et al., 2007). However, compared to remitted MDD patients, who reported various emotions, including joy, love, happiness, sadness, and anxiety, BPD patients did not mention any positive emotions in the interviews. Although BPD patients describe their personality as positive-altruistic, their emotions were exceptionally negative. It can be argued that it is rather the negative view of emotions than the negative view of self (De Bonis, De Boeck, Lida-Pulik, Hourtané, & Féline, 1997) which may represent the self-psychopathology of BPD in the interview. This finding is consistent with the widespread concept of emotional dysregulation (Linehan, 1993; Verheul et al., 2003) and the concept of identity diffusion which postulate a superficial and not integrated self in BPD (Clarkin, Yeomans, & Kernberg, 2006). A more mature and complex affective process, such as mourning, which demonstrates the capacity for integrated object relations, was not found in the interviews.

The evaluation of the category "phrases with little meaning," which exclusively included statements of the BPD patients, underscore that the BPD patients show difficulties in describing themselves coherently and indicate more defense mechanisms than MDD patients in the interview situation. These altruistic-positive but superficial self-descriptions could also relate to a separation of aggressive impulses and fractions of the self which could as well be connected with the general difficulties in interpersonal relationships in BPD.

In the future, we need to determine whether those BPD patients with severe identity diffusion and more self-image problems show more BPD symptoms and show a less favorable course of the disorder. One therapy study found that BPD patients with severe identity diffusion respond less favorably to psychotherapy treatment than do patients with less severe identity diffusion (Hull, Clarkin, & Kakuma, 1993).

To our knowledge, this is the first qualitative study of the self-image of BPD patients which, due to the chosen research method, offers a direct approach to the self and may enhance the understanding of the complex BPD psychopathology.

However, the study contains several methodological limitations. We conducted a qualitative study with a small number of cases—as is typical for qualitative studies. For this reason, the generalizability of these results is limited. It remains unclear whether the results could not be explained equally well by the comorbid psychiatric disorders of the BPD group. A comparison group with remitted MDD patients is chosen in many longitudinal studies with BPD patients (Skodol et al., 2005). However, the depressive symptoms may have biased the results. Each of these limitations identifies important questions that future studies need to answer.

These limitations notwithstanding, we think our results retain some significant clinical implications. We conclude that the self-image of BPD patients is characterized by an inconsistency of a positive-altruistic self-description on one hand, and a negative description of emotions and others on the other. This inconsistency could add to a painful incoherence of the patient's self-image which could be addressed in psychotherapy.

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