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The Lack of Negative Affects as an Indicator for Identity Disturbance in Borderline Personality Disorder: A Preliminary Report

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Key Words
Identity disturbance · Borderline personality disorder · Affectivity · Major depressive disorder · Qualitative research · Content analysis

Abstract
Background: Patients with borderline personality disorder (BPD) suffer from instability of their relationships, their affectivity and their identity. The purpose of the study was to investigate negative affects and identity disturbance in patients with BPD and in patients without personality disorder using questionnaire data and interview data. ***Sampling and Methods:*** Twelve patients with BPD and 12 patients with major depressive disorder without any personality disorder were assessed with the Structured Interview of Personality Organization (STIPO) and questionnaires (Inventory of Personality Organization, Beck Depression Inventory, State-Trait Anxiety Inventory). They were compared with respect to the frequency of negative affective verbal expressions using computerized content analysis methods. ***Results:*** BPD patients showed higher levels of anxiety, depression and identity diffusion in the questionnaires than major depressive disorder patients without personality disorder. However, they did not report more negative affective expressions in the interview. Patients with identity disturbance of both groups showed higher values of negative mood in the questionnaires, but less anger, less anxiety and less affective intensity in the interview. ***Conclusion:*** The preliminary findings indicate that patients with identity disturbance show high levels of negative affects in questionnaires but only few negative affects in the interview situation. More studies are needed to enhance the understanding of negative affects and identity disturbance in BPD.

Introduction

The prevalence of borderline personality disorder (BPD) is 1.3% in the general population, 15% among psychiatric inpatients and 50% among psychiatric inpatients with personality disorders (PD) [1–3].

It is well known that the psychiatric comorbidity rates in BPD patients are high: elevated rates of mood disorders, anxiety disorders, eating disorders, posttraumatic stress disorder and substance use disorder have been reported [4–8].

Patients with BPD suffer from affective instability, interpersonal instability and impulsivity [9, 10]. Affects of

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anger and hostility, self-destructive behavior, as well as elevated stress and negative mood states were found [11–13].

While identity disturbance is one of the BPD symptoms [14, 15], the research on that subject is sparse. Other BPD symptoms such as emotional dysregulation [16] or the interpersonal problems [17] received larger attention in the current research.

Identity was defined as the subjective experience of self, the feeling of the self's coherence, and its continuity over time as a psychic structure which organizes psychic experience and behavior regulation [18, 19]. Identity disturbance or identity diffusion manifests itself in the 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 [18–20].

However, the paucity of empirical studies on identity disturbance in BPD partially stems from the difficulty of operationalizing and capturing the construct of identity disturbance in clinical-psychiatric empirical research [21, 22]. Studies in this area report that (i) 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 [23]; (ii) identity disturbances were found in half of all patients with PD [24]; (iii) in comparison with normal controls, contrasting attributes were identified more often in the self-description of patients with BPD [25], and (iv) patients with BPD and severe identity disturbance showed a less favorable psychotherapeutic treatment outcome than those with less severe identity disturbance [26].

It has been suggested that BPD patients with severe identity disturbance do not verbalize their negative affects as patients without PD but they do activate these affects in interpersonal relationships [27]. In nonclinical participants significant correlations between identity diffusion and negative affects were found [28]. However, it is exactly in this dimension that they reveal problems of questionnaires in BPD patients [29, 30].

BPD patients, particularly those with high identity disturbances, may show high levels of negative affects in questionnaires without reporting these affects in a face-to-face interview. Thus, we can argue that BPD patients may show higher identity diffusion but fewer negative affects in the interview than comparison patients without PD. No published study has yet examined identity disturbance and negative affects using interview data in a controlled study. The aim of this pilot study was to investigate the association between identity disturbance and negative affects in BPD and depressed patients who do not suffer from a PD in a combined approach with questionnaire data and interview data.

Methods

Participants

Patients, who had been admitted consecutively to the Psychotherapy Treatment Unit of the Psychiatric University Clinic Basel (Switzerland), and who were diagnosed as having BPD or major depressive disorder (MDD) according 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 I and bipolar II disorder, and substance intoxication or withdrawal.

All patients signed an informed consent, following a full explanation of the study. Clinically experienced interviewers trained to pay particular attention to distinguishing axis I mental state conditions from axis II personality trait phenomena interviewed the subjects who screened positive for BPD with the Structured Clinical Interview for DSM-IV Axis I Disorders [31] and for DSM-IV Axis II Disorders [32].

Twelve patients diagnosed as having BPD and 12 comparison patients with MDD and without any PD were included in this pilot study.

Out of the total sample of 24 patients, 19 (80%) were female, 5 (20%) male. The mean age was 29.3 years (SD = 8.6).

To investigate the association between identity disturbance and affectivity, we divided both groups (BPD and MDD) into those with and those without identity disturbance.

Identity disturbance was defined as high values for identity diffusion [Inventory of Personality Organization (IPO) identity scale >30 and/or Structured Interview of Personality Organization (STIPO) identity section >1.0].

Questionnaire Data

The participants were administered the State-Trait Anxiety Inventory [33]. Depressive symptoms were assessed with the Beck Depression Inventory [34]. To evaluate identity diffusion, the IPO [35] was used. The scales of the IPO measure the constructs of identity diffusion, primitive defenses, reality testing, aggression and moral values.

Interview Data

The STIPO was used to investigate affective verbal expression. The STIPO interview [36] provides a guide to the evaluation of the individual's personality organization according to the psychodynamic conceptualization of Kernberg [37]. The STIPO is scored by the interviewer while being administered. Each item is rated on a 0–2 scale, with 0 reflecting the absence of pathology in the characteristic, 2 indicating the clear presence of pathology in the characteristic being assessed and a score of 1 representing an intermediate status. The identity section was recorded on audio tape. The interviews took between 26 (3.243 words) and 49 min (5.996 words). These interviews were transcribed in accordance with the rules of the Ulmer Textbank [38].

The transcripts were analyzed by using the computerized content analysis methods 'Dresdner Angstwörterbuch' (Dresden Anxiety Dictionary, DAW) [39], a German version of the Gottschalk-Gleser Tests [40], and the 'Affektives Diktionär Ulm' (Affective Dictionary Ulm, ADU) [41]. Both methods compare the patient's text with a defined set of affect-associated words (DAW n = 4,070, ADU n = 26,823). These procedures generate several individual affective content scales which are quantified by the length of the text. The test of reliability and validity, using 160 clinical texts, shows that the computerized content analysis is a reliable and valid method that can be used in different research fields [39].

Statistical Analyses

All descriptive and inference-related statistical analyses were conducted with SPSS/15.0 for Windows. The parametric method used was the t test for independent samples for group comparisons. χ^2 tests were used as nonparametric methods to test for intergroup differences. Statistical tests were performed with Bonferroni-corrected p values.

Results

Table 1 summarizes the demographic and social characteristics of the sample. Patients with BPD (n = 12) and with MDD but without PD (n = 12) did not differ significantly in their age and gender. Half of the BPD patients (n = 6) lived alone. Seven BPD patients (58%) had only 1 PD, 3 (25%) had 2 PD diagnoses, and 2 BPD patients (17%) had 3 PD diagnoses. Additionally, 7 of the BPD patients suffered from a co-occurring MDD (58%), 4 had an alcohol use disorder (33%), 2 an anxiety disorder (17%) and 2 a co-occurring eating disorder (17%).

As table 2 shows, BPD patients had significantly higher values in state anxiety, trait anxiety, depression score and identity diffusion than MDD patients without PD.

BPD patients with and without co-occurring MDD did not differ significantly in state anxiety (Z = –0.57, p =

Table 1. Demographic and social characteristics of patients with BPD and MDD

	Patients with BPD (n = 12)	Patients with MDD (n = 12)	p
Age, years	26.3 ± 6.2	32.3 ± 9.9	t =– 1.78, d.f. = 22, NS
Female gender	9 (75.0)	10 (83.3)	χ^2 = 0.25, d.f. = 1, NS
Marital status			
Married	1 (8.3)	3 (25.0)	
Single	9 (75.0)	7 (58.3)	
Divorced/separated	2 (16.7)	2 (16.7)	
Living situation			
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			
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)	

Figures in parentheses are percentages.

Table 2. Anxiety, depressive mood and identity in patients with BPD and MDD

	BPD patients (n = 12)	MDD patients (n = 12)	p
STAI			
State anxiety	2.70 ± 0.51	2.13 ± 0.68	t = 2.34, d.f. = 22, p = 0.029
Trait anxiety	2.93 ± 0.44	2.17 ± 0.58	t = 3.64, d.f. = 22, p = 0.001
BDI			
Depression score	24.17 ± 11.00	12.45 ± 9.78	t = 2.69, d.f. = 22, p = 0.014
IPO			
Primitive defenses	44.17 ± 8.73	34.75 ± 6.51	t = 3.0, d.f. = 22, p = 0.007
Identity diffusion	66.25 ± 11.90	45.08 ± 12.52	t = 4.24, d.f. = 22, p < 0.0001
Reality testing	50.33 ± 13.16	29.25 ± 8.06	t = 4.74, d.f. = 22, p < 0.0001
Aggression	37.58 ± 8.68	23.50 ± 3.92	t = 5.12, d.f. = 22, p < 0.0001
Moral values	26.83 ± 4.17	21.75 ± 5.35	t = 2.60, d.f. = 22, p = 0.016

STAI = State-Trait Anxiety Inventory; BDI = Beck Depression Inventory.

Table 3. Identity diffusion and negative affects in patients with BPD and MDD

	Patients with low identity diffusion (n = 11)	Patients with high identity diffusion (n = 13)	p
BPD group	3 (25)	9 (75)	
MDD group	8 (67)	4 (33)	
Negative affects			
DAW			
Death anxiety	0.38 ± 0.13	0.25 ± 0.12	t = –2.57, d.f. = 22, p = 0.017
Mutilation anxiety	0.37 ± 0.13	0.32 ± 0.11	t = –1.11, d.f. = 22, NS
Separation anxiety	0.55 ± 0.10	0.52 ± 0.13	t = –0.79, d.f. = 22, NS
Guilt anxiety	0.30 ± 0.10	0.23 ± 0.08	t = –1.66, d.f. = 22, NS
Shame anxiety	0.45 ± 0.14	0.42 ± 0.13	t = –0.51, d.f. = 22, NS
Total anxiety	1.07 ± 0.17	0.90 ± 0.14	t = –2.75, d.f. = 22, p = 0.012
ADU			
Anger	2.68 ± 1.14	0.85 ± 0.86	t = –4.50, d.f. = 22, p < 0.0001
Depression	7.91 ± 2.72	6.18 ± 2.00	t = –1.79, d.f. = 22, NS
Shame	2.88 ± 1.83	2.05 ± 0.96	t = –1.41, d.f. = 22, NS
Guilt	0.17 ± 0.34	0.10 ± 0.20	t = –1.41, d.f. = 22, NS
Affective intensity	34.79 ± 8.39	26.82 ± 5.56	t = –2.78, d.f. = 22, p = 0.011

Figures in parentheses are percentages.

0.57), trait anxiety (Z = 0.37, p = 0.37), depression score (Z = –0.81, p = 0.42) and identity diffusion (Z = –0.49, p = 0.63).

However, BPD and MDD patients showed no significant differences in their verbalized negative affects in the interview (AUD and DAW).

Nine BPD patients (69%) and 4 MDD patients (31%) showed identity disturbance with high values for identity diffusion. As displayed in table 3, patients with high identity diffusion reported significantly less anxiety (total anxiety, fear of death), less anger and less affective intensity than patients with low identity diffusion.

Discussion

BPD patients suffer from instability of their affectivity, their identity and their relationships [42–44]. One main problem for studies of core psychopathology in BPD is the complex subject of identity and identity disturbance [45, 46]. In this pilot study the associations between negative affects and identity disturbance were investigated in a combined approach using questionnaire data and interview data.

As expected and previously described BPD patients showed high levels of negative affects and identity diffusion in the questionnaires [47]. In previous studies no differences in severity of depression were found between patients with BPD, with MDD, and with BPD and co-occurring MDD in questionnaires [48]. Reasons for the higher level of the depression score in BPD patients might be that the depressed patients suffered from a mild depression and that they were already remitted after 2 weeks of inpatient treatment. However, this group difference was not found in verbal expressions of negative affects in the interview. Both BPD and MDD patients verbalized the same quantity and intensity of negative verbal expressions in the interview. BPD patients, especially those with identity disturbance, showed high levels of negative affects in the questionnaire but few negative affects in the interview situation. Patients with identity disturbance verbalized significantly less anxiety, anger and less affective intensity than those without identity disturbance.

These findings support the theory of BPD which highlights these patients' difficulties in verbalizing their affects in interpersonal relationships [49–51]; rather they would show their affects and emotions in their behavior, which could activate problems in interpersonal interactions. Particularly the exploration of identity seems to activate primitive defensive operations, such as splitting, which are characterized by important behavioral components rather than by verbal communication [27].

Interestingly, we also found high levels of identity diffusion in patients suffering from MDD without any PD. Based on these preliminary findings, we argue that identity disturbance is associated with less negative affects in the interview. It has been described that not all BPD subjects suffer from an identity disturbance [51]. However, as reported, identity disturbance is a core criterion of BPD psychopathology.

It is also possible that BPD patients with identity disturbance represent a BPD subgroup whose vulnerability reflects more self and interpersonal problems than other BPD psychopathology such as impulsivity or aggression [6, 52]. This would also be highly relevant for psychotherapy as the lack of negative affects and identity disturbance could be a focus of the treatment.

The strength of the pilot study was the first investigation of negative affects and identity disturbance in a combined approach using questionnaire and interview data. The analysis of verbal expressions allowed a direct access to personal identity through the narrative process. It is likely that the questionnaires and the interview do not measure the same construct. Whereas the questionnaires evaluate affects mainly by self-reflection, the interview data measure affects during an interactional process. However, this difference between questionnaire data on one hand and interview data on the other may elucidate the discrepancy between self-perception and interactional behavior in BPD patients with identity disturbance.

We conclude that the lack of negative affects in the interview may indicate identity disturbance in BPD.

Due to the small sample size these findings are limited. Future studies conducted with larger samples will enhance our understanding of the link between affectivity and identity disturbance in BPD patients.

References

1 Lenzenweger MF, Lane MC, Loranger AW, Kesserl RC: DSM-IV personality disorder in the National Comorbidity Survey Replication. Biol Psychiatry 2007;62:553–564.
2 Lenzenweger MF: Epidemiology of personality disorder. Psychiatr Clin North Am 2008;31:395–403.
3 Widiger TA, Weissman MM: Epidemiology of borderline personality disorder. Hosp Community Psychiatry 1991;42:1015–1021.
4 Akiskal HS: The temperament borders of affective disorders. Acta Psychiatr Scand 1994; 89:S32–S37.
5 McGlashan TH, Grilo CM, Skodol AE, Gunderson JG, Shea MT, Morey LC, Zanarini MC, Stout RL: The Collaborative Longitudinal Personality Disorder Study: baseline axis I/II and II/II diagnosis co-occurrence. Acta Psychiatr Scand 2000;102:256–264.
6 Shea MT, Stout RL, Yen S, Pagano M, Skodol A, Morey LC, Gunderson JG, McGlashan TH, Grilo CM, Sanislow CA, Bender DS, Zanarini MC: Associations in the course of personality disorders and Axis I disorders over time. J Abnorm Psychol 2004;113:499–508.
7 Skodol AE, Oldham JM, Gallaher PE: Axis II comorbidity of substance use disorders among patients referred for treatment of personality disorders. Am J Psychiatry 1999; 156:733–738.
8 Walter M, Gunderson JG, Zanarini MC, Sanislow CA, Grilo CM, McGlashan TH, Morey LC, Yen S, Stout RL, Skodol AE: New onsets of substance use disorders in borderline personality disorder over seven years of follow-ups: findings from the Collaborative Longitudinal Personality Disorders Study. Addiction 2009;104:97–103.
9 Gunderson JG, Links PS: Borderline Personality Disorder. A Clinical Guide, ed 2. Washington, American Psychiatric Press, 2008.
10 Sanislow CA, Grilo CM, McGlashan TH: Factor analysis of the DSM-III-R borderline personality disorder criteria in psychiatric inpatients. Am J Psychiatry 2000;157:1629–1633.
11 Zanarini MC, Frankenburg FR, DeLuca CJ, Hennen J, Khera GS, Gunderson JG: The pain of being borderline: dysphoric states specific to borderline personality disorder. Harv Rev Psychiatry 1998;6:201–207.
12 Henry C, Mitropoulou V, New AAS, Koenigsberg HW, Silverman J, Siever LJ: Affective instability and impulsivity in borderline personality and bipolar II disorders: similarities and differences. J Psychiatr Res 2001;35: 307–312.
13 Walter M, Bureau JF, Holmes B, Bertha, EA, Hollander M, Wheelis J, Lyons-Ruth K: Cortisol response to interpersonal stress in young adults with borderline personality disorder: a pilot study. Eur Psychiatry 2008; 23:201–203.
14 American Psychiatric Association (APA): Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), ed 4. Washington, American Psychiatric Publishing Inc, 2000.
15 Kernberg OF: Severe Personality Disorders. Psychotherapeutic Strategies. New Haven, Yale University Press, 1984.
16 Linehan MM: Cognitive Behavioral Treatment of Borderline Personality Disorder. New York, Guilford Press, 1993.
17 Fonagy P, Target M, Gergely G: Attachment and borderline personality disorder: a theory and some evidence. Psychiatr Clin North Am 2000;23:103–122.
18 Erikson EH: Identity and Life Cycle. New York, Norton, 1980.
19 Kernberg OF: Aggression in Personality Disorders and Perversions. New Haven, Yale University Press, 1992.
20 Bender DS, Skodol AE: Borderline personality as a self-other representational disturbance. J Pers Disord 2007;21:500–517.
21 Walter M, Dammann G, Selinger J, Frommer J: Identity and identity disturbance in personality disorders: definition, conceptualisation and perspectives from a psychodynamic point of view. Schweiz Arch Neurol Psychiatr 2008;159:304–312.
22 Oldham J, Clarkin JF, Appelbaum A, Carr A, Kernberg P, Lotterman A: A self report instrument for borderline personality organization; in McGlashan TH (ed): The Borderline. Current Empirical Research. Washington, American Psychiatric Press, 1985, pp 3–18.
23 Levy KN, Edell WS, McGlashan TH: Depressive experiences in inpatients with borderline personality disorder. Psychiatr Q 2007; 78:129–143.

24 Modestin J, Oberson B, Erni T: Identity disturbance in personality disorders. Compr Psychiatry 1998;39:352–357.
25 De Bonis M, De Boeck P, Lida-Pulik H, Feline A: Identity disturbances and self-other differentiation in schizophrenics, borderlines, and normal controls. Compr Psychiatry 1995;36:362–366.
26 Hull JW, Clarkin JF, Kakuma T: Treatment response of borderline inpatients. J Nerv Ment Dis 1993;181:503–509.
27 Clarkin JF, Yeomans FE, Kernberg OF: Psychotherapy of Borderline Personality Disorder. Focusing on Object Relations. Arlington, American Psychiatric Publishing, 2006.
28 Lenzenweger MF, Clarkin JF, Kernberg OF, Foelsch PA: The Inventory of Personality Organization: psychometric properties, factorial composition, and criterion relations with affect, aggressive dyscontrol, psychosis proneness, and self-domains in a nonclinical sample. Psychol Assess 2001;13:577–591.
29 Zimmermann M: Diagnosing personality disorders: a review of issues and research methods. Arch Gen Psychiatry 1994;51:225–245.
30 Frommer J, Rennie D: Qualitative Psychotherapy Research. Methods and Methodology. Berlin, Pabst, 2001.
31 First MB, Spitzer RL, Gibbon M, William JBW: Structured Clinical Interview for DSM-IV Axis I Disorders/Patient Edition (SCID-I/P). New York, New York State Psychiatric Institute, Biometrics Research Department, 1996.
32 First MB, Gibbon M, Spitzer RL, Williams JBW, Benjamin L: Structured Clinical Interview for DSM-IV Personality Disorders (SCID-II). Interview and Questionnaire. Washington, American Psychiatric Press, 1997.
33 Spielberger CD: STAI Manual. Revised. Palo Alto, Psychologists Press, 1983.
34 Beck AT, Ward CH, Mendelson M, Mock J, Erbaugh J: An inventory for measuring depression. Arch Gen Psychiatry 1961;4:561–571.
35 Kernberg OF, Clarkin JF: The Inventory of Personality Organization. White Plains, New York Hospital-Cornell Medical Center, 1995.
36 Clarkin JF, Caligor E, Stern B, Kernberg OF: Structured Interview of Personality Organization (STIPO). Cornell University, Personality Disorders Institute, 2003.
37 Kernberg OF: A psychoanalytic theory of personality disorders; in Clarkin JF, Lenzenweger MF (eds): Major Theories of Personality Disorder. New York, Guilford Press, 1996.
38 Mergenthaler E, Stinson CH: Psychotherapy transcription standards. Psychother Res 1992;2:125–142.
39 Berth H: The measurement of anxiety through computerized content analysis – automation of the Gottschalk-Gleser Test. Psychother Psychosom Med Psychol 2001; 51:10–16.
40 Gottschalk LA, Gleser GC: The Measurement of Psychological States through the Content Analysis of Verbal Behavior. Berkeley, University of California Press, 1969.
41 Hölzer M, Scheytt M, Kächele H: Das 'Affektive Diktionär Ulm' als eine Methode der quantitativen Vokabularbestimmung; in Züll C, Mühler P (eds): Textanalyse. Ulm, Ulmer Textbank, 1991.
42 Links PS, Eynan R, Heisel MJ, Barr A, Korzekwa M, McMain S, Ball JS: Affective instability and suicidal ideation and behavior in patients with borderline personality disorder. J Pers Disord 2007;21:72–86.
43 Fossati A, Barratt ES, Borroni S, Villa D, Grazioli F, Maffei C: Impulsivity, aggressiveness, and DSM-IV personality disorders. Psychiatry Res 2007;149:157–167.
44 Paris J, Gunderson JG, Weinberg I: The interface between borderline personality disorder and bipolar spectrum disorders. Compr Psychiatry 2007;48:145–154.
45 Skodol AE, Gunderson JG, Pfohl B, Widiger TA, Livesley WJ, Siever LJ: The borderline diagnosis I: psychopathology, comorbidity, and personality structure. Biol Psychiatry 2002;51:936–950.
46 Jorgensen CR: Disturbed sense of identity in borderline personality disorder. J Pers Disord 2006;20:618–644.
47 Frommer J: Qualitative research in diagnostic processes. Psychopathology 1999;32:121–126.
48 De Bonis M, De Boeck P, Lida-Pulik H, Hourtané M, Féline A: Self-concept and mood: a comparative study between depressed patients with and without borderline personality disorder. J Affect Disord 1998; 48:191–197.
49 Kernberg OF: Structural interviewing. Psychiatr Clin North Am 1981;4:169–195.
50 Stein MB, Pinsker-Aspen JH, Hilsenroth MJ: Borderline pathology and the Personality Assessment Inventory (PAI): an evaluation of criterion and concurrent validity. J Pers Assess 2007;88:81–89.
51 Wilkinson-Ryan T, Westen D: Identity disturbance in borderline personality disorder: an empirical investigation. Am J Psychiatry 2000;157:528–541.
52 Lenzenweger MF, Clarkin JF, Yeomans FE, Kernberg OF, Levy KN: Refining the borderline personality disorder phenotype through finite mixture modeling: implications for classification. J Pers Disord 2008;22:313–331.