

**PERSONALITY TRAITS AND BORDERLINE
PERSONALITY DISORDER****Assoc. Prof. Dr. Senija Tahirovic**

(stahirovic@ius.edu.ba)

International University Sarajevo

MA Sc. Adela Bajric

(bajric_adela@yahoo.com.au)

Germany

Abstract

The people with *Borderline Personality Disorder* (BPD) show pathological personality traits in three of the five domains (APA 2013). In addition to diagnostic criteria for BPD, described by Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the dimensional model of personality disorder, based on five-factor model of personality, seems to gain interest as it promises to eliminate problems associated with poor-fit, co-morbidity and unclear diagnosis.

The purpose of this study is to identify the personality traits by people who are already diagnosed with BPD using the DSM-5 categorical criteria. Based on the theoretical concepts and existing research findings as well as increased interest in the dimensional personality theory, we assume that people diagnosed with BPD will show high levels of pathology on three trait domains: negative affectivity, disinhibition and antagonism.

This study was conducted in Germany in psychiatric clinic. Fifteen participants represented a convenience sample, of patients already diagnosed with BPD. For this study Personality Inventory for DSM-5 (PID-5) was used. The findings supported the assumptions that people with BPD show some degree of anxiousness, emotional lability, hostility, impulsivity, risk taking and separation anxiety. The study also found that traits such as distractibility, withdrawal and submissiveness were also present in this participant group.

Even though, study was conducted with small number of participants it has provided contribution to the already existing knowledge and understanding in regards to common personality traits for people diagnosed with BPD.

Keywords: *Personality traits, Attachment, Borderline Personality Disorder, Childhood, Diagnostic Criteria*

Anahtar Kelimeler: *Kişilik Özellikleri, Bağlanma, Sınırdaki Kişilik Bozukluğu, Çocukluk Dönemi, Tanı Kriterleri*

1. Introduction

The word *personality* is more than meaning of the word *persona*. It could mean, how one appears to another, the part one plays in a life of another, summary of qualities one has and shows in his work, as well as dignity (Monte 1999). In the beginning of the 19th century Emil Kraepelin has mentioned word psychopathic personality, he tried to categorise personality disorders in four different types. He explained the unstable personality features as fluctuating between hypomanic and depressive, similar to the description of the today's known borderline personality disorder features (Millon, 2011).

Many theories have attempted to explain the development of personality disorder, through different and sometimes similar perspectives, considering the causal factors they deem as influential in the development of the same. They proposed many risk factors, which may be responsible for the development of personality disorder. Different schools of thought have shown that there are genetic, environmental, learning, parental, developmental, conscious and unconscious factors that drive our personality (Schultz, et al., 2005). There are neuro-chemical vulnerabilities, which influence personality disorder development (Kamali, et al., 2001). However, it is important to consider to what extent environmental factors influence the genetic predisposition, as environmental influences may trigger or suppress genetic predisposition (Schultz, et al., 2005).

Schultz and Schultz (2005) suggest that environmental and social influences shape behavior and with it influence our personality structure. The psychoanalytic theory somehow supports this idea. The theory conforms that not only basic physical drives, that happen on an unconscious level, shape behaviour and subsequent personality traits, but are influenced by social expectations that are accessible at the conscious level (Monte, 1999). Psychoanalytic theory explains that development of personality disorder is largely due to identity fusion and pathological identity formation, where person is split between idealization and devaluation, good and the bad, thus creating distorted view of interpersonal relationships (Lenzenweger, et al., 2005).

Cognitive theory may differ a little, as it pays most of its attention on the perception and interpretation of situations and their influence on the personality development. They believe that, based on the information processing theory, one's thoughts influence personality formation and cognitive distortions lead to dysfunctional thinking and over a prolonged period of time dysfunctional personality (Lenzenweger & Clarkin, 2005). The cognitive theory proposed that personality disorders are based on individual's perception and interpretation of life situations, specifically when those situations are irrationally interpreted. This would in turn lead to development of distorted cognitive schemas, that are resistant to change (Lenzenweger & Clarkin, 2005).

Humanistic theory focused less on the risk factors, it did point out that failure to fulfill innate needs would lead to the dysfunctional personality formation. Maslow also mentioned that learning and social influences might help or hinder the progress through the hierarchy of needs (Schultz, et al., 2005).

Linehan (1993) pointed out that, specifically for BPD, combination of risk factors is a indication of personality dysfunction. She suggested that invalidated social

environment and labile attachment to the primary caregiver were significant risk factors for personality formation. However, she mentioned that biological vulnerabilities and developmental context must also be taken into account, as they are also significant in personality development. Biosocial developmental model is based on the idea that borderline personality disorder is related to missing ability for emotional regulation in all areas of functioning, although other risk factors such as biological vulnerability, developmental context and their interactions must also be considered (Crowell, Beauchaine, & Linehan, 2009). Biological mechanisms, such as serotonin, dopamine, vasopressin, and acetylcholine are related to development of BPD (Kamali, Oquendo, & Mann, 2001). The twin studies have also shown genetic component as well as family environment, to be linked to the BPD development (Crowell, Beauchaine, & Linehan, 2009).

The Five Factor Model (FFM) of personality is a theory, which describes the human personality based on five dimensions of personality, namely, openness to experience, conscientiousness, extraversion, agreeableness, and neuroticism. The developmental history of this theory dates to early 1900's when several psychologists attempted to describe personality through lexical approach, by collecting terms that could be attributed to the personality description (McCrae & John, 1992). This was further developed by Cattell who proposed Sixteen Personality Factor model that was based on the original ideas from Gordon Allport and Henry Odbert, and included factors such as warmth, reasoning, emotional stability, dominance, liveliness, rule-consciousness, social boldness, sensitivity, vigilance, abstractedness, privateness, apprehension, openness to change, self-reliance, perfectionism, and tension (Fehriinger, 2004). At the same time, other groups of researchers (Ernest Tupes, Raymond Cristal, Paul Costa, Jeff McCrae, and Lewis Goldberg) also studied the personality factors, and proposed very similar personality traits, differing only in names of the traits (McCrae & John, 1992). The idea of dimensional description of personality received little interest until the 1980's. From that point onward, the FFM, especially the version provided by Costa and McCrae, discovered and is currently receiving growing attention in research (McCrae, et al., 1992).

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According to McCrae and Costa the FFM refers more to the body of research, than theory of personality. They argued that a personality should be viewed as a system, and that a theory should provide a definition of that system. The FFM is based on the trait theory of human personality, which suggested that "individuals can be characterized in terms of relatively enduring patterns of thoughts, feelings, and actions; that traits can be quantitatively assessed; (and) that they show some degree of cross-situational consistency" (McGrae & Costa, 2008, pp. 160). They argue further that study of behavior would give us information about that behavior in context, but it may not be generalisable, whereas the traits would describe the individuals's recurrent patterns of acting, their character and describe how they differ from others. This in turn, according to the trait theory, would allow empirical generalisations how people with similar traits would behave and react (McGrae, et al., 2008).

The FFM is based on 6 postulates. *Basic tendencies* subdivided into individuality, origin, development and structure postulate that all adults show different

personality traits that are based on their patterns of thoughts, feelings, and actions. Those traits are endogenous basic tendencies, developed through intrinsic maturation and other biological processes and are organised in a hierarchical structure. *Characteristic adaptations* subdivided into adaptation and plasticity postulate that people tend to react to their environment and change their patterns of thoughts, feelings, and behaviors accordingly. The *Objective biograpy*, subdivided into multiple determination and life course, postulated that action and experience is influenced by characteristic adaptations and are driven by complex functions and people are capable of planning and organising based on those adaptations consistent with their personality traits. The *self-concept*, subdivided into self-schema and selective perception, postulated that people would maintain cognitive-affective view of self and that self view will be consistent with personality traits. *External influences*, subdivided into interaction and reciprocity, postulated that social and physical environment shape characteristic adaptations, which in turn influence the flow of behavior. And *dynamic processes* subdivided into universal dynamics and differential dynamics postulated that thoughts, feelings, and behaviors are regulated in part by universal mechanisms, and are affected by basic tendencies of the individual's personality traits (McGrae, et al., 2008).

It seems that no theories and their explanations on how a personality dysfunction occurs, can be viewed in isolation, as no single factor has so far been found to influence personality development in isolation. It seems that personality development is complex and it is influenced by many different factors, as those above summarized, and when trying to understand we would need to take a holistic point of view, or run the risk of missing valuable information regarding personality formation.

1.1 . General DSM criteria of personality disorder and Borderline Personality Disorder

The general criteria for personality disorder, specific diagnostic features of all personality disorders currently present in the DSM-5 are presented in the following text. Later on we will present specific diagnostic features of Borderline Personality Disorder (BPD).

The APA has presented a set criteria and the Table 1 will present those as outlined in the DSM-5.

Table 1 General Personality Disorder

Criteria
A. An enduring pattern of inner experience and behaviour that deviates markedly from the expectation of the individual's culture. This pattern is manifested in two (or more) of the following areas: <ol style="list-style-type: none">1. Cognition (i.e., ways of perceiving and interpreting self, other people, and events).2. Affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response).3. Interpersonal functioning.

4. Impulse control.

- B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.
- C. The enduring pattern leads to clinically significant distress or impairment in social, or other important areas of functioning.
- D. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.
- E. The enduring pattern is not better explained as a manifestation or consequence of another mental disorder.
- F. The enduring pattern is not attributable to the physiological effects of abuse (i.e., a drug abuse, a medication) or another medical condition (e.g., head trauma).

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It is important to note that only when personality traits are inflexible and maladaptive, and cause significant distress or impairment in functioning, can be considered as personality disorder. Furthermore, it is important to evaluate if the symptoms are present over a long period of time, and evaluate if the symptoms were also evident in early adulthood. As some transient situational stressors and mental states may impact the personality development and change, it is important to evaluate if the traits are stable over time and not due to the situational changes (American Psychiatric Association, 2013).

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To further understand, the general diagnostic criteria, it is important to note that personality disorders are divided in three clusters. The APA (2013) has outlined the different clusters and rationale behind it. They are as follows: Cluster A is divided into paranoid, schizoid and schizotypal personality disorders. They are characterised by odd, eccentric cluster of symptoms. The Cluster B is divided into borderline, narcissistic, histrionic and antisocial personality disorders. They present more dramatic, emotional and erratic cluster. The Cluster C is divided into avoidant, dependent and obsessive-compulsive personality disorders. They are characterised by anxious and fearful cluster of symptoms (American Psychiatric Association, 2013).

One personality disorder, attracting increasing scientific interest, is the BPD. This disorder is characterised by “persistent and pervasive cognitive, emotional, and behavioural dysregulation”, and it is considered “among the most severe and perplexing behavioural disorders” (Crowell, Beauchaine, & Linehan, 2009, p. 495). Due to the severity of this disorder, the empirical research has focused on uncovering causal factors of the disorder development, with limited success (Crowell, et al., 2009). In the DSM-5, revisions were made and the following paragraphs will provide newest version of the diagnostic criteria of the BPD.

According to the APA a personality disorder “is an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual’s culture, it is pervasive and inflexible, has onset in adolescence or early adulthood, it is stable over time, and leads to distress or impairment” (American Psychiatric Association, 2013, p. 645).

APA provided a set of diagnostic features of the BPD that needs to be met for the disorder to be diagnosed. Table 2 will show a diagnostic criteria that need to be met in order for the BPD to be diagnosed.

Table 2 Diagnostic Criteria of Borderline Personality Disorder 301.83 (F60.3)

Diagnostic Criteria

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning in early adulthood and present in a variety of contexts, as identified by five (or more) of the following:

- A. Frantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self-mutilating behavior covered in criterion 5).
- B. A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealization and devaluation.
- C. Identity disturbance: markedly and persistently unstable self-image or sense of self.
- D. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (Note: Do not include suicidal or self-mutilating behavior covered in criterion 5).
- E. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
- F. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and rarely more than a few days).
- G. Chronic feelings of emptiness.
- H. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
- I. Transient, stress-related paranoid ideation or severe dissociative symptoms.

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The most important aspect of the BPD is the instability in different areas of functioning, such as relationships, how patients see themselves, their affected instability and impulsivity (American Psychiatric Association, 2013). This group of patients shows perceptual problems, exhibit extreme reactions to real or imagined separation or rejection,

it shows fear and tries to avoid real or imagined abandonment. They react with fear or anger when faced with separation, and changes in plans. The idealisation of important people can easily change to devaluation, if the patient believes they did not receive enough care, love and affection as expected. They also show very unstable self-image, and will show identity disturbances with sudden shifts in goals, values and motivation. In addition, sexual preferences may also change due to the unstable self-image (APA, 2013).

Furthermore, a person with BPD will also show some level of impulsivity, that is deemed as self-damaging. Some of the impulsive behaviours include reckless driving, gambling, unsafe sex, substance abuse or eating disturbances. Some people may exhibit self-mutilating behaviours such as cutting, burning, or nail biting. In addition, suicidal gestures, and/or attempts are common among this group of people. Reactive mood is a common feature exhibited by people suffering from BPD. They will often show periodic changes in mood, from fear, to anger, irritability or dysphoria. At times, paranoid ideation or dissociation may also be exhibited by this patient group (2013).

To the above named main features, associated features may also be exhibited. For example, those people may sabotage their positive outcomes by ending a task short before its completion. They may also show transient psychosis-like symptoms, when placed under pressure. The BPD may co-occur with other mental disorders, such as depression, anxiety, posttraumatic stress and bipolar disorder. In addition, other personality disorders may also co-occur (2013).

In addition to the diagnostic criteria described above, this study will be using the dimensional assessment of BPD. The dimensional model of personality disorder, based on five-factor model of personality, seems to gain interest as it promises to eliminate problems associated with poor-fit, co-morbidity and unclear diagnosis (Thompson, 2011). It also promises to go beyond the current criterion, to give more comprehensive description of personality disorders (Trull & Widiger, 2013). They also suggest that personality disorders could better be explained as an extension of normal personality, than disease. The initial analysis of five factor model suggested a dimensional structure of personality reflected in extraversion vs introversion, agreeableness vs antagonism, continuousness vs constraint, emotional stability vs neuroticism and intellect (Trull, et al., 2013). They described trait domains such as negative affect, detachment, antagonism, disinhibition and psychoticism to describe personality functioning, maintaining the description behind the individual traits (Thompson, 2011).

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It has been further suggested that people with BPD will show pathological personality traits in three of the five domains. Namely, they will display negative affectivity, characterised by emotional lability, with frequent mood changes, emotions that are easily aroused, intense and out of proportion to the events and circumstances. They will also display anxiousness, with intense feelings of nervousness, tension, panic, fear of falling apart or losing control. Those feelings are most likely to be present in interpersonal circumstances.

Eventhough five-factor model of personality was not fully accepted in the DSM-5, its relevance can not be ignored. The BPD is a complex disorder that is often difficult

to diagnose and treat. For this reason, this study will be utilising both models in an attempt to familiarise the reader with all aspects of BPD and help improve assessment and diagnostic criteria of the same.

The DSM-5 has included the alternative model in the section 3 of the new manual. The inclusion of the alternative model was mostly due to the acknowledgement that the categorical model of personality disorder diagnosis has its own limitations, and that the inclusion of the alternative models may help reduce those shortcomings (Trull & Widiger, 2013). The model proposed that there are 2 primary criteria: 1) personality functioning ranging from little to no impairment to extreme impairment, and degree of impairment identified through 4 elements: *identity*, *self-direction*, *empathy*, and *intimacy*; and 2) pathological personality traits. The traits of the alternative model proposed in the DSM-5 are based on the FFM, with minor changes of the names of the traits, having the content remain the same. There is, however, one major change, namely the original FFM includes over 100 maladaptive traits, and the DSM-5 reduced the dimensional traits to 25. There was a need to simplify the model so that it becomes user friendly, however, it has been suggested that the reduction of maladaptive traits could result in inadequate coverage of the domains. The new DSM-5 model of personality disorder provided a questionnaire that is designed to test all of the 25 traits as well as the 5 main domains, and as such it will be used in this study.

2. Materials and Methods

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This study was designed to identify personality traits by people who are already diagnosed with BPD using the DSM-5 categorical criteria.

2.1. Hypotheses

Based on the theoretical concepts and existing research findings, we assume that:

Hypothesis 1:

People diagnosed with BPD will show high levels of pathology on three trait domains: negative affectivity, disinhibition and antagonism.

- Sub-hypothesis 1.1: The participants will score high on negative affectivity domain characterised by emotional lability, anxiousness, separation insecurity and depressivity.
- Sub-hypothesis 1.2: The participants will score high on disinhibition domain, characterised by impulsivity and risk taking.
- Sub-hypothesis 1.3: The participants will score high on antagonism domain, characterised by hostility.

2.2. Participants

Fourteen women and one man aged between 18 and 54 years participated in this study, the mean age being 33 years. Participants were selected based on three selection

criteria: they must have had a prior diagnosis of borderline personality disorder as a primary diagnosis, they had to be older than 18 years of age, and they had to show clear distance from suicidal thoughts and behaviour.

General Participant Information are as follows. Two participants stated they were single (13.3%), 6 participants stated they were living de facto (40%), one participant stated they were married for the first time (6.7%), one participant stated they were married for more than one time (6.7%), and 5 participants stated they were separated or divorced (33.3%). Additionally, 3 participants stated they were housewives (20%), 2 participants worked full time (13.3%), 1 participant worked part time (6.7%) and 9 participants stated they were not working (60%). From the total of 15 participants, 3 completed primary school (20%), 5 completed secondary school (33.3%), 5 completed high school (33.3%), one participant started but did not complete apprenticeship (6.7%) and one participant acquired university degree (6.7%).

The rationale to include 15 participants was based on the in part qualitative nature of this study. This was a convenience sample, as those patients who met the selection criteria and were being treated in the inpatient clinic. 15 patients were asked to participate and all agreed to participate in the study.

2.3. Measures

To assess dimensional personality traits, Personality Inventory for DSM-5 (PID-5) was used. This is a 220-item self-rated personality trait assessment scale for adults aged 18 years or more. This personality inventory has been based on the Five Factor Model (FFM), and utilised trait domains as proposed by the DSM-5, section 3.

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The inventory was divided into 5 domains: negative affect, detachment, antagonism, disinhibition and psychoticism. Each domain has different facet scales. The negative affect includes emotional lability, anxiousness, separation anxiety, and depressivity. The detachment includes withdrawal, anhedonia, and intimacy avoidance. The antagonism includes manipulateness, deceitfulness, and grandiosity. The disinhibition includes irresponsibility, impulsivity, and distractibility. And psychoticism includes unusual beliefs and experiences, eccentricity, and perceptual dysregulation.

However, the questionnaire contains total of 25 trait facets, and those facets have been identified to play a significant role in specific disorder evaluation. The 25 facets that are used to assess personality traits are anhedonia, anxiousness, attention seeking, callousness, deceitfulness, depressivity, distractibility, eccentricity, emotional lability, grandiosity, hostility, impulsivity, intimacy avoidance, irresponsibility, manipulateness, perceptual dysregulation, preservation, restricted affectivity, rigid perfectionism, risk taking, separation anxiety, submissiveness, suspiciousness, unusual beliefs and experiences, and withdrawal.

It has been identified that people with BPD will display negative affectivity, characterised by emotional lability, anxiousness, separation insecurity, depressivity. The domain disinhibition will be characterised by increased impulsivity and risk taking. And lastly, in the antagonism domain there will be the hostility trait facet (American Psychological Association, 2013). Each trait facet consists of 4 to 14 items. Each item is rated on a 4-point scale. Items are rated 0 = very false to 3 = very true.

Although PID 5 is one of the newest personality inventories, it has already shown high test-retest reliability, and construct validity, that is able to capture personality pathology as outlined in the DSM IV (Bastiaens, et al., 2015; Fossati, Krueger, Markon, Borroni, & Maffei, 2013).

2.4. Procedures and Analysis

After receiving the information about the potential candidates, contacts with them were made and selection criteria were examined. The verbal information about the study, aims, procedure and ethical issues were provided to candidates. The participation was voluntary and confidential. All participants were instructed to sign a consent form prior to the receiving the questionnaires. The participants were asked to fill out the Personality Inventory for DSM 5. The participants were supplied with information how to fill out questionnaires. All participants were provided with an opportunity to individually discuss any difficult parts of the questionnaires.

The data analyses from PID 5 were done with use of the IBM SPSS. We have also used cross tabulation, also known as contingency table, is a statistical method to observe frequency distribution of set variables This allowed us to primary analysis of data, provide structure and method for further analyses. Furthermore, this study will utilise Spearman’s Rho correlation coefficient, a statistical method, a non-parametric measure of statistical significance between two variables. This correlation can be used for both continuous and ordinal variables (Wilson, et al., 2011). Due to the facts that most of our variables are ordinal or nominal, this measure was the most suited for the assessment of relationships between a range of variables used in this study.

3. Results and discussions

The following table 3 will display the results from the 5 traits domains captured by the PID-5

Table 3 The Distribution of the PID-5 Domains

	Negative Affect	Detachment	Antagonism	Disinhibitio n	Psychoticism
1	Low	low	none	low	low
2	Average	average	none	average	low
3	Average	low	low	low	average
4	Low	low	low	low	low
5	Average	low	Low	low	low
6	Average	low	Low	average	average

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7		Average	average	Low	average	low
8		Low	low	None	low	low
9		Average	average	None	low	low
10		Average	low	Low	low	low
11		Low	average	Average	average	average
12		Average	average	Average	average	low
13		Low	none	Low	low	none
14		Average	low	Low	average	low
15		Low	low	Low	low	low
Total	N	15	15	15	15	15
	Std. Deviation	0.507	0.594	0.640	0.507	0.516
	Mean	1.60	1.27	0.87	1.40	1.13

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a. Limited to the first 100 cases.

As we can see from the table, all of the participants displayed some level of disturbance across all of the domains. The most obvious finding is that the most of the participants displayed a negative affect trait dominance, followed by the disinhibition trait.

Hypothesis 1: People diagnosed with BPD will show high levels of pathology in three trait domains: negative affectivity, disinhibition and antagonism. The results indicate that people with BPD show from low to average levels of pathology across all three domains, however, the results also indicated that other two domains, namely detachment and psychoticism also showed medium levels of psychopathology for some participants. Nevertheless, following a Spearman's Rho statistical analysis, it has been found that there is a statistically relevant relationship between disinhibition and detachment $r = 0.58$, $p < 0.05$, therefore the hypothesis is only partially supported (see Table 4)

Table 4 Relationship Between Domains utilising Pearson's Rho Correlation Analysis

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		Negative Affect	Detachment	Antagonism	Disinhibition	Psychoticism
Negative Affect	Correlation Coef.	1.000	0.364	0.054	0.389	0.203
	Sig. (2-tailed)	.	0.183	0.848	0.152	0.467
	N	15	15	15	15	15
Detachment	Correlation Coef.	0.364	1.000	0.075	0.582*	0.261
	Sig. (2-tailed)	0.183	.	0.789	0.023	0.348
	N	15	15	15	15	15
Antagonism	Correlation Coef.	0.054	0.075	1.000	0.378	0.282
	Sig. (2-tailed)	0.848	0.789	.	0.165	0.309
	N	15	15	15	15	15
Disinhibition	Correlation Coef.	0.389	0.582*	0.378	1.000	0.325
	Sig. (2-tailed)	0.152	0.023	0.165	.	0.237
	N	15	15	15	15	15
Psychoticism	Correlation Coef.	0.203	0.261	0.282	0.325	1.000
	Sig. (2-tailed)	0.467	0.348	0.309	0.237	.
	N	15	15	15	15	15

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*. Correlation is significant at the 0.05 level (2-tailed).

Sub-hypothesis 1.1: The participants will score high on negative affectivity domain characterised by emotional lability, anxiousness, separation insecurity and depressivity.

We conducted a frequency analysis to evaluate what personality trait facets were somewhat (1), moderately (2), or extremely (3) present. The results showed that 11 participants (73.3%) showed anxiousness personality trait by scoring more than 1 point on the PID 5, anxiousness scale. Furthermore, the results showed that 7 participants (46.7%) showed increased depressivity personality trait by scoring more than 1 point on the PID 5 depressivity scale. Six participants (40%) scored more than 1 point on the PID 5 separation anxiety scale ($M = 1.47, SD = 0.64$). The emotional lability trait was evident in 12 participants (80%) who scored more than 1 point on the PID 5 emotional lability scale.

As it can be seen from the Table 5, most of the participants displayed some to moderate levels of anxiousness, depressivity, emotional lability. However, following the Spearman’s Rho analysis, there was statistically no significant relationship between four of the trait facets rejecting the hypothesis.

Table 5 Negative Affectivity Domain Frequencies

	Anxiousness	Depressivity	Separation Anxiety	Emotional Lability
1	some	Some	no	some
2	some	Some	some	moderate
3	moderate	Some	no	Some
4	no	No	no	some
5	some	Some	no	moderate
6	some	No	some	some
7	some	Some	no	some
8	some	No	no	No
9	moderate	Some	no	some
10	some	No	moderate	moderate
11	no	Some	some	No
12	some	No	some	some

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13		no	No	no	some
14		some	No	some	some
15		no	No	no	No
Total	N	15	15	15	15
	Std. Deviation	0.640	0.516	0.640	0.655
	Mean	1.87	1.47	1.47	2.00

a. Limited to the first 100 cases.

Sub-hypothesis 1.2: The participants will score high on disinhibition domain, characterised by impulsivity and risk taking. Although the frequency table outlines that some of the participants show impulsivity and risk taking traits (see Table 6), after Spearman’s correlation analysis, there was no statistical relationship found between the two traits. As only 5 participants scored some to moderate on the two trait facets respectively, and as no relationship was found between the two trait facets, the hypothesis is not supported.

The results indicated that eight participants (53.4%) showed increased impulsivity personality trait by scoring more than 1 point on the PID 5 impulsivity scale ($M = 1.6, SD = .63$). The risk taking trait was evident in 5 participants (33.4%) who scored more than 1 point on the PID 5 risk taking scale. The Table 6 will present disinhibition domain trait frequencies.

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Table 6 Disinhibition Domain Trait Frequencies

	Impulsivity	Risk Taking
1	No	No
2	Some	No
3	Some	No
4	No	No
5	Some	None
6	Some	Some
7	Some	Some

8	No	No
9	No	None
10	No	Some
11	Some	Moderate
12	Some	Some
13	No	No
14	Moderate	No
15	No	No
Total	N	15
	Std. Deviation	0.632
	Mean	1.60
		15
		0.799
		1.27

a. Limited to the first 100 cases.

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Sub-hypothesis 1.3: The participants will score high on antagonism domain, characterised by hostility. The results showed that 7 participants (46.7%) showed increased hostility personality trait by scoring more than 1 point on the PID 5 hostility scale. As about half of the participants showed some hostility, the hypothesis is not supported.

Additionally, our study also found that more than half of the participants showed distractibility, withdrawal and submissiveness traits. This study also found that other traits such as anhedonia, distractibility, eccentricity, intimacy avoidance, perceptual dysregulation, rigid perfectionism, submissiveness, suspiciousness and withdrawal personality traits were also present at least some of the time with mean ranging from 1 to 1.67. Personality traits such as attention seeking, calousness, deceitfulness, grandiosity, irresponsibility, manipulativenness and unusual beliefs and experiences all had results less than 1.

4. Conclusion and Recommendations

Our findings indicated that people who were already diagnosed with BPD, based on the DSM-5 categorical criteria, show disturbances on the dimensional trait domains, findings consistent with the current and past research on the personality disorder domain disturbances (Fossati, Krueger, Markon, Borroni, & Maffei, 2013; Thompson, 2011), as well as alternative diagnostic criteria in the section 3 of the DSM-5 (American

Psychiatric Association, 2013). Firstly, the presence on all 5 domain disturbances could not fully be explained, as it appears not be consistent with the current research findings of the above mentioned studies and theoretical underpinnings. And secondly, although those participants showed disturbances on all 5 domains, there was no statistically significant relationship between the traits in each domain. The accidental finding of this study was that study also found out that more than half of the participants showed distractibility, withdrawal and submissiveness traits. This study also found that other traits such as anhedonia, distractibility, eccentricity, intimacy avoidance, perceptual dysregulation, rigid perfectionism, submissiveness, suspicionsness and withdrawal personality traits were also present at least some of the time ranging from 1 to 1.67, meaning low but still existing.

The DSM-5 domain testing shows growing interest, however, there is a gap in research to further evaluate the BPD trait domains and trait facets. Nevertheless, the findings of our study could be possibly explained by the following arguments. Namely, our study did not screen co-morbid personality disorders, therefore, it possibly allowed inconsistencies in trait domain scores between our findings and the main stream research findings. It may be that some of the participants displayed traits of narcissistic, dependent, insecure personality traits, these were, however, not excluded, but also not considered in data analysis. It could also be that the BPD diagnostic criteria still require further fine tuning due to the disorder complexity, which could cause the diagnostic inconsistencies to remain. This opinion is supported by the Krueger, Derringer, Markon, Watson, and Skodol (2012), who stipulate that personality traits relate to the formal personality disorder, however, may not constitute the same. They acknowledge this gap in research and further encourage continuing assessment of the relationship between pathological traits and the DSM-5 personality disorder criteria (Krueger, et al., 2012). And lastly, our sample constituted of 15 participants, a rather small sample to draw reliable and valid relational conclusions of 25 different trait facets.

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Nonetheless, the findings of our study supported the original FFM and the dimensional DSM-5 model, as the results still showed that BPD traits are dimensional.. It has been shown that the severity of domains does vary from trait to trait and that there is a statistically significant consistency between personality disorder traits, as proposed by the growing literature, and personality disorder DSM-5 criteria for at least 2 domains.

Although some of the hypotheses were not supported, the main aim of the study has been met. We believe that findings of this study are relevant as they show, consistent with many studies, that BPD is a complex disorder, and that variables, such as all 5 trait domains of the dimensional trait theory are related to this disorder. The results of this study did provide some evidence to support the reliability of the dimensional models of personality disorder as outlined in the DSM-5 section 3. Nevertheless, having in mind the above explained limitation of this study in regards to number of participants, additional research needs to be done in order to prove reliability of dimensional models of personality disorder.

The BPD occurrence is not declining, and therefore we ought to expand our research relating to this phenomenon even further to improve our diagnostic criteria, treatment plans and outcomes. The next stage of our research would be to apply the same

instruments with control group, namely to do research with aim to investigate differences on personality traits between people with BPD and those who has no diagnoses.

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