INTERPERSONAL PROBLEMS AND SOCIAL ADJUSTMENT: COMPARING AVOIDANT AND BORDERLINE PERSONALITY DISORDER SYMPTOMS

by

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The following individuals certify that they have read, and recommend to the Faculty of Graduate and Postdoctoral Studies for acceptance, the dissertation entitled:

Interpersonal Problems and Social Adjustment: Comparing Avoidant and Borderline Personality Disorder Symptoms

submitted by Katharine D. McCloskey in partial fulfillment of the requirements for the degree of Master of Arts in Counselling Psychology

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ABSTRACT

Interpersonal problems are one of the most persistent difficulties facing those with personality disorders (PDs) and are linked with dysfunction across numerous social domains. Researchers have explored the associations between PDs, interpersonal problems, and social dysfunction; however, there is limited understanding of which interpersonal problems mediate the link between PDs and social dysfunction. Using an interpersonal model of PDs, we examined which interpersonal problems mediated the association between PD symptoms and social dysfunction in adults with avoidant personality disorder (AvPD) and borderline personality disorder (BPD) symptoms. Participants were 226 adults experiencing personality dysfunction who were taking part in the Day Treatment Program at the University of Alberta Hospital in Edmonton, Canada. Using cross-sectional data from self-reported measures, we found that cold \((b = .10, 95\% \text{ CI} [.038, .176])\) and overly nurturant \((b = .04, 95\% \text{ CI} [.001, .090])\) interpersonal problems mediated the link between AvPD symptoms and social dysfunction. The only significant mediator in the link between BPD symptoms and social dysfunction was overly nurturant \((b = .05, 95\% \text{ CI} [.001, .120])\). The results from our study may aid in the development of more individualized treatments for those struggling with AvPD and BPD so as to improve social functioning as well as other clinical outcomes.
LAY SUMMARY

People with personality disorders struggle with interpersonal problems (i.e., patterns of behaving in relationships that are problematic) and social dysfunction (i.e., inability to maintain and dissatisfaction with social relationships). The purpose of this present study was to better understand the relationship between avoidant and borderline personality disorder symptoms, interpersonal problems and social dysfunction. The results indicate that for those with more avoidant personality disorder symptoms, cold and overly nurturant problems were linked with higher levels of social dysfunction, while for those with more borderline personality disorder symptoms, overly nurturant problems were linked with higher levels of social dysfunction. These results may assist in creating more effective treatments for those with these disorders.
PREFACE

The identification, design, writing, and data analysis of this thesis is original, independent work by the author, Katharine D. McCloskey. The data used in this study was collected as part of a larger study conducted by Dr. Anthony S. Joyce of the University of Alberta, and Dr. John Ogrodniczuk of the University of British Columbia, and was approved by two institutional ethics boards: Behavioral Research Ethics Board, University of British Columbia (protocol number: B00-0522) and Health Research Ethics Board, University of Alberta (protocol number: B-040601-MED).
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I would like to thank my supervisor, Dr. Dan Cox, for his guidance, support, and patience. I also extend my gratitude to my committee members, Dr. David Kealy and Dr. John Ogrodniczuk, for their valuable feedback and insight.

I am honored to be a part of a warm and supportive cohort. They are a constant inspiration and I am lucky to know them.

I thank my parents and brother for their love and support. I carry your guidance and wisdom with me always.

Finally, I thank my husband, Keith, whose unwavering encouragement and love were instrumental in making my education and future career possible. Everything feels possible with you by my side.
Chapter 1: Introduction

Interpersonal problems are one of the most persistent difficulties facing those with personality disorders (PDs; Wilberg, Karterud, Pedersen, & Urnes, 2009), and are linked with impaired family functioning (Park, Kim, & Lee, 2014), romantic relationships (Lawson & Brossart, 2009), and are generally associated with poorer overall social functioning and interpersonal relationships (Vittengl, Clark, & Jarrett, 2003). Given that interpersonal problems are integrally associated with PDs, it is critically important that we continue to improve our understanding of these associations to facilitate more effective clinical practices.

Researchers have explored the associations between PDs, interpersonal problems, and social dysfunction; however, there is limited understanding of how these three constructs are related. Further, few studies have controlled for other PDs when examining the association between a PD and interpersonal problems. This obscures our understanding of a specific PD and patterns of interpersonal problems. In this study we examined which interpersonal problems mediated the association between PD symptoms and social dysfunction in adults with avoidant personality disorder (AvPD) and borderline personality disorder (BPD) symptoms using the interpersonal model of PDs. AvPD and BPD are frequently compared in research due to their high levels of comorbidity (Grant et al., 2008), as well as their similar levels of chronicity, prevalence, and social impairment (Torgersen, Kringlen, & Cramer, 2001; Wilberg, Karterud, Pedersen, & Urnes, 2009). Additionally, both PDs share a hypersensitivity to the threat of social rejection (Berenson et al., 2016), but differ in what motivates this interpersonal sensitivity. By better understanding the subtle differences between interpersonal motives and how they impact interpersonal problems and psychosocial outcomes, our findings may aid in better understanding the course and treatment of AvPD and BPD.
Chapter 2: Literature Review

Interpersonal Problems and Personality Disorders

Within the interpersonal model of PDs, unique interpersonal motives underlie each PD (Horowitz & Wilson, 2005). An interpersonal motive is a wish to attain a desired state or avoid an undesired one. Behaviors are then enacted in an attempt to satisfy the interpersonal motive; however, in the case of PDs, these behaviors often run counter to the interpersonal motive. When the behavioral strategies repeatedly thwart the interpersonal motive, distress and interpersonal problems result.

The interpersonal motive underlying AvPD is the fear of interpersonal judgement and rejection (Horowitz & Wilson, 2005). People with AvPD tend to crave acceptance and companionship but fear the judgment and subsequent rejection that may occur if they let others know them intimately (Beck, Freeman, & Davies, 2003). Low self-esteem leaves people with AvPD susceptible to believing the perceived or real judgments from others (e.g., “She thinks I am annoying, therefore it must be true”). Believing themselves to be unlikeable, those with AvPD avoid showing their true selves in hopes that they will successfully keep others from perceiving their shortcomings. The avoidant behaviors enacted to avoid judgment and rejection include minimizing social contact, intimacy, and new relationships. By controlling their participation in social environments where they are vulnerable to negative evaluation, people with AvPD hope to avoid the pain they anticipate feeling when they are inevitably rejected (Beck et al., 2003). Their motive becomes frustrated when their avoidance behaviors unintentionally bring about the very thing they wished to avoid: judgment and rejection from others (Horowitz & Wilson, 2005).

AvPD has been associated with cold and submissive interpersonal problems (Wilson,
Cold interpersonal problems are marked by difficulties in expressing or experiencing affection, getting along with and forgiving others, and entering into long-term commitments (Alden & Capreol, 1993). For those with AvPD, cold interpersonal behaviors are enacted as a protective mechanism whereby they keep others at an emotional distance to avoid the pain of negative judgment and subsequent rejection. Submissive interpersonal problems are marked by difficulties in being assertive and making their needs and desires known to others (Alden & Capreol, 1993). Submissive behaviors are utilized by those with AvPD to avoid taking risks that could lead to humiliating interactions or bringing attention to themselves lest they invite judgment. However, instead of satisfying the AvPD interpersonal motive, cold and submissive interpersonal behaviors ultimately thwart their desire to avoid judgment and rejection.

The interpersonal motive underlying BPD is the fear of abandonment (Horowitz & Wilson, 2005). This fear of abandonment may be tied to childhood neglect where the child was physically left alone and emotionally ignored (Horowitz, 2004). In response to this fear of abandonment, individuals with BPD tend to engage in frantic interpersonal behaviors, oscillating between overinvolvement and withdrawal (American Psychiatric Association, 2013; Jovev & Jackson, 2004). Others may perceive overinvolvement as dependent, intrusive, or emotionally demanding. People with BPD tend to engage in overinvolvement to receive reassurance that they are loved, accepted, and supported. Withdrawal behavior is perceived as cold, aloof, and hostile, and may be utilized by those with BPD to protect against abandonment by limiting interpersonal relationships altogether. This frantic, oscillating pattern of behavior results in aversive reactions by interpersonal partners, leading people with BPD to believe that they are or will be abandoned.
BPD has been associated with cold and dominant interpersonal problems (Wilson et al., 2017). Those with dominant interpersonal problems struggle with aggression and a desire to control and coerce others (Alden & Capreol, 1993). People with BPD who display dominant problems may attempt to satisfy their interpersonal motive of avoiding abandonment through coercion (e.g., “If you break up with me, I will physically harm myself”). Cold behavior might be used to avoid entering into a relationship where abandonment may then occur (e.g., “If I reject you first, then you cannot hurt me by leaving”). These BPD behaviors likely illicit feelings in others of fear, anger, and frustration, leading to others’ desire to avoid the person with BPD. This avoidance can be perceived as abandonment. Thus, the interpersonal motive underlying BPD—fear of abandonment—is thwarted.

Social Dysfunction

Both PDs and interpersonal problems have been robustly associated with social dysfunction. Social dysfunction occurs when an individual has poor relationships with others (e.g., frequent arguments) and is unsatisfied with their social role performance (e.g., in their role as a parent, feeling dissatisfied in their ability to be supportive and communicative with their children) (Weissman, 1981). PDs and interpersonal problems have been associated with poorer overall social functioning and interpersonal relationships, both in cross-sectional and longitudinal research (Coid et al., 2009; Skodol, 2008). PDs and social dysfunction are associated with increased risk of suicide (Kelly, Soloff, Lynch, Haas, & Mann, 2000), nonsuicidal self-injury (Brown, Comtois, & Linehan, 2002), and impulsive aggression (Koenigsberg et al., 2003). The personal and social impact of PDs and social dysfunction indicate the importance of exploring potential interpersonal mediators so as to design more nuanced and effective PD treatments.
The Current Study

Prior research has established that PDs, interpersonal problems, and social dysfunction are linked; however, it is unclear which interpersonal problems mediate the association between PDs and social dysfunction. Further, research has not consistently controlled for other PD symptoms when examining interpersonal problems, which makes links between interpersonal problems and PDs difficult to interpret due to the influence of comorbid PD symptoms. In the present study, we examined which interpersonal problems mediated the association between AvPD symptoms and social dysfunction, as well as BPD symptoms and social dysfunction. To reduce their influence, we controlled for other PD symptoms. We examined these associations in an outpatient sample who experienced personality related dysfunction (i.e., having one or more PD or chronic dysfunction due to subclinical PD symptoms).

Based on the interpersonal motive that those with AvPD wish to avoid rejection and judgment, we hypothesized that (H1) cold and submissive interpersonal problems will mediate the association between AvPD symptom severity and social dysfunction. Cold behaviors may facilitate maintaining an emotional distance and thus avoiding potential rejection, while submissive behaviors may be utilized to avoid attracting attention and subsequent judgment. Based on the interpersonal motive that those with BPD wish to avoid abandonment, we hypothesized that (H2) cold and dominant interpersonal problems will mediate the association between BPD symptom severity and social dysfunction. Dominant behavior may be used by those with BPD to coerce others into remaining in relationships, and cold behavior might be used to avoid entering into a relationship where abandonment may then occur.
Chapter 3: Method

Participants and Procedure

Participants were 226 patients taking part in the Day Treatment Program at the University of Alberta Hospital in Edmonton, Canada, for personality dysfunction. Data for the present study were collected prior to treatment. Personality dysfunction was defined as having one or more PDs or severe chronic dysfunction due to subclinical personality disorder symptoms. Determination of personality dysfunction was made by experienced clinicians through clinical interview. Study inclusion was: (a) meeting diagnostic criteria of a DSM-IV personality disorder or substantial personality dysfunction, (b) unemployed and not currently a student, and (c) at least 18 years of age. Exclusion criteria included: (a) presence of psychosis, (b) acute suicidality, (c) substance dependence, and (d) involvement with another mental health agency.

The participants in this study were 69 men and 157 women. The age of the sample ranged from 18 to 68, with a mean age of 37.4 years ($SD = 10.95$). The most frequent PD diagnoses were borderline (35.4%) and avoidant (33.6%). Further, 50.4% of the sample met the criteria for at least one Cluster C PD, followed by Cluster B with 39.4%, and Cluster A with 12.8%. The majority of the sample were Caucasian (88.9%). Single participants accounted for 38.9% of the sample, married were 42.3%, divorced were 16.6%, and widowed were 2.2%. Participants who did not complete high school made up 17.1% of the sample, 20.4% graduated high school, 20.8% completed some post-secondary, and 41.2% completed postsecondary programs.

The study was approved by two institutional ethics boards: Behavioral Research Ethics Board, University of British Columbia and Health Research Ethics Board, University of Alberta.
Measures

**Personality Disorder Symptoms.** The Wisconsin Personality Disorders Inventory-IV (WISPI-IV; Smith, Klein, & Benjamin, 2003) is a 204-item measure assessing PD symptoms. The WISPI-IV contains 11 scales that correspond to the diagnostic criteria for the DSM-IV’s 11 PDs. Respondents indicated on a 1 (*Never/Not at all*) to 10 (*Always/Extremely*) scale the degree that each statement applied to their usual selves during the past five years. AvPD and BPD symptoms were computed using mean scores, with higher scores indicating greater PD symptom severity. Strong convergent validity was found between the WISPI-IV and SCID-II (Klein et al., 1993), and its internal consistency (coefficient alpha) ranged between .74 and .91 (Smith, Tracey et al., 2003).

**Social Dysfunction.** The Social Adjustment Scale-Self Report (SAS-SR; Weissman & Bothwell, 1976) is a 54-item self-report measure. Each item was rated on a five-point scale with higher scores indicating greater social dysfunction. Respondents indicated their level of social dysfunction in seven domains (i.e., type of work, social and leisure, extended family, partner, parental, family unit, and economic) during the past two weeks. We derived a total social dysfunction score by computing the mean of the responses, with higher scores indicating greater social dysfunction. The SAS-SR has shown high internal consistency and test-retest reliability (Edwards, Yarvis, Mueller, Zingale, & Wagman, 1978).

**Interpersonal Problems.** The Inventory of Interpersonal Problems-64 (IIP-64; Alden, Wiggins, & Pincus, 1990) is a 64-item questionnaire designed to assess difficulties in relating to other people. Each item was rated on a five-point scale ranging from 0 (*Not at all*) to 4 (*Extremely*). For the purposes of this study, we used the four subscales that represent the primary interpersonal problems: dominant, submissive, cold, and overly nurturant. Responses were
summed with higher scores indicating greater problem severity. The IIP-64 has displayed strong psychometric properties (Strupp, Horowitz, & Lambert, 1997).

The Structured Clinical Interview for DSM-IV (SCID-II). The SCID-II (First, Benjamin, Gibbon, Spitzer, & Williams, 1997) is a semi-structured clinical interview that was developed to assess DSM-IV PDs. An interviewer rated 107 responses using a 3-point scale for which 1 indicated the criterion was absent, 2 indicated the criterion was present but subthreshold, and 3 indicated that the criterion was present at threshold. The scoring provided PD diagnoses and was used to identify personality dysfunction that did not meet full PD diagnostic criteria but did result in severe chronic dysfunction. The SCID-II has shown excellent inter-rater reliability (Lobbestael, Leurgans, & Arntz, 2011) and high internal consistency (Maffei et al., 1997).

Demographics questionnaire. The demographic questionnaire asked participants their gender, age, racial/ethnic background, level of education, and relationship status.

Analyses

The ordinary least squares regression procedure with bootstrapping was utilized to test the mediating effects of interpersonal problems on AvPD and BPD symptoms and social dysfunction (Hayes, 2013). Data analyses were conducted using the PROCESS macro for SPSS (version 24). Two multiple mediation models were run to test the indirect effects (i.e., mediating effects) between AvPD symptoms and BPD symptoms on social dysfunction through each interpersonal problem. In both models we controlled for other PD symptoms, gender, and age. Standardized coefficients are presented to facilitate interpretation.
Chapter 4: Results

Covariates

Bivariate correlations were run with the primary study variables (see Table 1), age, and gender. Significant correlations with demographic variables indicated that younger patients had greater social dysfunction ($r = -.14, p < .05$) and BPD symptoms ($r = -.24, p < .01$), and that women had more BPD symptoms ($r = .19, p < .01$). Although age and gender were not significantly correlated with AvPD, they were controlled for in both models to facilitate comparisons between the two models. To control for other PD symptoms, we included PD symptom severity scores (from the WISPI-IV) for PDs other than the PD included in the model (i.e., AvPD, BPD).
Table 1

*Bivariate Correlations and Descriptive Statistics*

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Avoidant personality disorder symptoms</td>
<td>—</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Borderline personality disorder symptoms</td>
<td>.596**</td>
<td>—</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Dominant</td>
<td>.101</td>
<td>.291**</td>
<td>—</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Submissive</td>
<td>.453**</td>
<td>.264**</td>
<td>-.031</td>
<td>—</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Cold</td>
<td>.443**</td>
<td>.285**</td>
<td>.363**</td>
<td>.274**</td>
<td>—</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Overly nurturant</td>
<td>.297**</td>
<td>.339**</td>
<td>.216**</td>
<td>.474**</td>
<td>.160*</td>
<td>—</td>
<td></td>
</tr>
<tr>
<td>7. Social dysfunction</td>
<td>.423**</td>
<td>.358**</td>
<td>.188**</td>
<td>.295**</td>
<td>.393**</td>
<td>.346**</td>
<td>—</td>
</tr>
<tr>
<td>M</td>
<td>5.37</td>
<td>3.73</td>
<td>1.16</td>
<td>2.29</td>
<td>1.59</td>
<td>2.10</td>
<td>2.50</td>
</tr>
<tr>
<td>SD</td>
<td>1.98</td>
<td>1.40</td>
<td>.71</td>
<td>.89</td>
<td>.76</td>
<td>.76</td>
<td>.49</td>
</tr>
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</table>

* *p < .05. **p < .01.
Multiple Mediation Models

Partially supporting our first hypothesis that cold and submissive interpersonal problems would be significant mediators, cold interpersonal problems significantly mediated the association between AvPD and social dysfunction ($b = .10$, 95% CI [.038, .176]), but submissive interpersonal problems did not ($b = .01$, 95% CI [-.064, .101]). Cold problems accounted for 24.8% of the association between AvPD and social dysfunction. Further, overly nurturant problems also mediated the association between AvPD and social dysfunction ($b = .04$, 95% CI [.001, .090]), accounting for 9.7% of the association between AvPD and social dysfunction (see Table 2 and Figure 1).
### Table 2

**Standardized Coefficients for the Multiple Mediation Models Examining Association Between Avoidant Personality Disorder and Social Dysfunction and Borderline Personality Disorder and Social Dysfunction**

<table>
<thead>
<tr>
<th>Independent variable (IV)</th>
<th>Mediator (M)</th>
<th>Effect of IV on M (a)</th>
<th>Effect of M on social dysfunction (b)</th>
<th>Direct effect (c')</th>
<th>Indirect effect (a x b)</th>
<th>Indirect effect 95% CI</th>
<th>Total effect (c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoidant personality disorder symptoms</td>
<td>Total effect</td>
<td></td>
<td></td>
<td>.257**</td>
<td>.142</td>
<td>.043-.254</td>
<td>.399***</td>
</tr>
<tr>
<td>Dominant</td>
<td>-.169*</td>
<td>.042</td>
<td></td>
<td>-.007</td>
<td>-.038-.023</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Submissive</td>
<td>.532***</td>
<td>.021</td>
<td></td>
<td>.011</td>
<td>-.064-.101</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cold</td>
<td>.364***</td>
<td>.271***</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overly nurturant</td>
<td>.176*</td>
<td>.224**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Borderline personality disorder symptoms</td>
<td>Total effect</td>
<td></td>
<td></td>
<td>.177</td>
<td>.082</td>
<td>-.024-.190</td>
<td>.259*</td>
</tr>
<tr>
<td>Dominant</td>
<td>.094</td>
<td>-.010</td>
<td></td>
<td>-.001</td>
<td>-.031-.020</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Submissive</td>
<td>.259*</td>
<td>.077</td>
<td></td>
<td>.020</td>
<td>-.025-.066</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cold</td>
<td>.044</td>
<td>.331***</td>
<td></td>
<td>.015</td>
<td>-.052-.085</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overly nurturant</td>
<td>.232*</td>
<td>.210**</td>
<td></td>
<td>.049</td>
<td>.001-.120</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note:* Covariates were age, gender, and other personality disorder symptoms.

*p < .05. **p < .01. ***p < .001.
Our second hypothesis was not supported; neither cold ($b = .02$, 95% CI [-.052, .085]) nor dominant ($b = .00$, 95% CI [-.031, .020]) interpersonal problems significantly mediated the association between BPD symptoms and social dysfunction. The only significant mediator was overly nurturant ($b = .05$, 95% CI [.001, .120]), which accounted for 18.9% of the association between BPD and social dysfunction (see Table 2 and Figure 2).
Figure 2 Standardized regression coefficients for the relationship between borderline personality disorder and social adjustment mediated by overly nurturant interpersonal problems. Path coefficient between borderline personality disorder and social dysfunction, while controlling for the mediators, is in parentheses. Covariates were age, gender, and other personality disorders symptoms. *p < .05. **p < .01. ***p < .001.
Chapter 5: Discussion

We examined the association between AvPD and BPD symptom severity, interpersonal problems, and social dysfunction in an outpatient sample seeking treatment for personality dysfunction. Our aim was to identify which interpersonal problems mediated the association between each PD and social dysfunction while controlling for other PD symptoms. By controlling for other PD symptoms, we were better able to understand the mediating effects of interpersonal problems for AvPD and BPD.

Avoidant Personality Disorder

Consistent with our hypotheses, cold interpersonal problems mediated the association between AvPD symptoms and social dysfunction. For those with AvPD, their interpersonal motive is to avoid rejection and judgment. In an attempt to fulfill this motive, they maintain cold interpersonal behaviors such as keeping social distance, which in turn limits situations where they may be judged. As a result of keeping fewer relationships and limiting intimacy, those with AvPD may lack the social skills to establish and maintain a variety of interpersonal relationships. Research indicates that personality pathology begins in childhood and may influence later PD diagnoses (Cohen, Crawford, Johnson, & Kasen, 2005). Avoidant symptoms established during childhood and adolescence may inhibit learning social skills and result in cold interpersonal problems in adulthood. Thus, a lack of interpersonal skills coupled with an entrenched cold interpersonal style may result in general social dysfunction.

An unexpected finding was that overly nurturant interpersonal problems mediated the AvPD-social dysfunction association. Overly nurturant’s mediating effect may be explained by its manifestation within a subset of AvPD relationships. People with AvPD are described as socially avoidant until they are certain of being liked (American Psychiatric Association, 2013).
Thus, in established relationships (e.g., family, romantic partner), a person with AvPD may demonstrate overly nurturant behavior (i.e., extreme attempts to please and care for others) as a signal that they also desire to feel cared for (Horowitz, 2004). Instead of receiving the care and support that they seek, their behavior may be judged as cloying and obsequious, resulting in avoidance and rejection. When those with AvPD are judged and rejected, feelings of hurt and resentment may arise, which in turn leads to social dysfunction.

Another reason cold and overly nurturant interpersonal problems were mediators in the AvPD model may be due to cold and overly nurturant reinforcing each other. For example, AvPD individuals become socially withdrawn (i.e., cold) as a defense against the anticipated pain of rejection and criticism (Horowitz, 2004). Once they have alienated others and subsequently find themselves isolated and lonely, they may crave connection and seek to build relationships by prioritizing others’ needs above their own (i.e., overly nurturant). Finally, when they begin to feel like they are being taken advantage of or that their overly nurturant efforts are rebuffed, they complete the cycle by defensively returning to cold interpersonal behavior. Others may perceive individuals with AvPD who display both cold and overly nurturant interpersonal problems as unpredictable and unstable, which may result in interpersonal partners negatively evaluating and rejecting those with AvPD. People with AvPD who swing from cold to overly nurturant interpersonal behavior may overwhelm others, which results in those with AvPD having fewer relationships, more frequent conflict, and general social dissatisfaction. When those with AvPD perceive or experience the judgment and rejection they fear, it may strengthen their AvPD symptoms as well as their interpersonal problems, thus increasing social dysfunction.
Borderline Personality Disorder

Overly nurturant interpersonal problems was the only significant mediator in the relationship between BPD symptoms and social dysfunction. This could be explained by the variability of interpersonal behaviors shown in BPD patients (Beck et al., 2003). Although BPD has typically shown an association with dominant and cold interpersonal problems (Wilson et al., 2017), there is some evidence that supports the association between BPD patients and overly nurturant interpersonal problems (Hilsenroth, Menaker, Peters, & Pincus, 2007; Leihener et al., 2003). Overly nurturant people find it difficult to maintain personal boundaries and are often too willing to meet the needs of others while neglecting their own (Alden & Capreol, 1993).

Caretaking, which is consistent with overly nurturant behavior, has been shown to be an interpersonal feature of BPD (Choi-Kain, Zanarini, Frankenburg, Fitzmaurice, & Reich, 2010). When considering the BPD interpersonal motive (i.e., an intense fear of abandonment (Horowitz, 2004), those with BPD may be eager to please and care for others to be liked, thus avoiding the threat of abandonment. However, overly nurturant behavior can be off-putting, which results in others’ avoidance of those with BPD. People with BPD may sense others’ desire to withdraw, thus confirming their abandonment fear. Subsequently, those with higher BPD symptom severity and overly nurturant interpersonal problems may experience dwindling relationships, which negatively impacts their satisfaction across multiple social domains.

Our hypothesis that cold and dominant would be significant mediators in the association between BPD symptoms and social dysfunction was not supported. It is possible that the treatment-seeking outpatient sample in our study exhibited a greater need for relatedness, which is reflected through their overly nurturant interpersonal problems. Cold and dominant patients
with BPD may be less likely to attend or seek-out treatment and thus were not well represented in this sample.

**Comparing Avoidant and Borderline**

Overly nurturant interpersonal problems was a significant mediator between AvPD and social dysfunction as well as BPD and social dysfunction. However, overly nurturant was nearly twice as strong in the BPD model. This could be due to BPD’s interpersonal motive (i.e., fear of being abandoned), whereby a person relies heavily on overly nurturant behavior as a means to be liked and depended upon. In an attempt to avoid rejection and judgement, a person with AvPD may rely on a variety of interpersonal behaviors, which may result in a greater variety of interpersonal problems relative to those with BPD. This weakens the reliance on overly nurturant as the primary interpersonal style for people with AvPD, which ultimately weakens the mediating strength of the interpersonal problem in contributing to social impairment.

Another potential explanation for the stronger role of overly nurturant in the link between BPD symptoms and social dysfunction may be due to when each PD’s interpersonal problems arise in the course of relationships. Both PDs share a hypersensitivity to the threat of social rejection (Berenson et al., 2016), but there exists subtle differences in their interpersonal motives. Those with AvPD seek to avoid negative evaluation and rejection and engage in behaviors to satisfy this motive preemptively before a relationship has been established (Millon & Davis, 1996). Those with BPD are motivated to avoid abandonment, which suggests that their behaviors to satisfy this motive occur once a relationship is perceived to have commenced. For those with AvPD, cold behaviors may be perceived to carry less risk for rejection than overly nurturant ones, perhaps explaining why overly nurturant was not as strong in the AvPD model. Once a person with BPD has established a relationship with someone, they have a strong desire
to maintain the relationship and avoid abandonment, perhaps explaining the strong reliance on overly nurturant interpersonal behaviours.

Both models showed low, albeit insignificant, dominant interpersonal problems. Low dominance was expected in the AvPD model due to dominant interpersonal problems likely inviting more overt opportunities for rejection from others. Although dominance was hypothesized to be a significant mediator in the BPD model, it showed a weak and insignificant relationship. This may be due to dominant and cold interpersonal problems being associated with more severe pathology and those with cold and dominant interpersonal problems are less likely to seek help.

Practical Implications

The results from our study may aid in the development of more individualized treatments for those struggling with AvPD and BPD. By addressing PD-specific patterns of interpersonal problems, and their unique impact on social functioning, we may be better able to formulate targeted treatments to achieve improved clinical outcomes. For example, our results may be used to extend previous research that identified two AvPD subtypes according to their patterns of interpersonal problems, and found that each subgroup responded more effectively to different treatment interventions (Alden & Capreol, 1993). In our study, overly nurturant was a significant mediator for both AvPD and BPD, which may indicate that clinicians develop interventions that help bring awareness to problematic patterns of behavior that result from an overly nurturant interpersonal style. Interventions could focus on boundary setting, the effects of overly nurturant behavior on others, and exploring the interpersonal motive that drives overly nurturant behavior.

By understanding interpersonal problems and their mediating role between PD severity and social dysfunction, clinicians may be better able to attune themselves to the client-clinician
relationship. Research has shown that interpersonal coldness predicted poorer treatment outcomes, which may be due to an impaired therapeutic alliance (Benjamin, 1994). Clinicians with cold PD clients may find it more difficult to empathically relate, which could inhibit their ability to effectively conceptualize clients’ concerns and facilitate effective treatments. As a result of feeling misunderstood, clients may become frustrated and be more likely to withdraw from treatment. By noting the interpersonal problems that negatively affect the social relationships in clients’ lives, clinicians may be better able to adjust their own demeanor to strengthen the therapeutic alliance and improve treatment outcomes. Evidence suggests that BPD symptoms remit in response to positive interpersonal events (Links & Heslegrave, 2000), which suggests that a clinicians’ own interpersonal styles may play a critical role in the treatment of PDs.

**Limitations and Future Directions**

Several limitations from this study should be considered in future research. First, the sample predominately consisted of female participants. Most research on AvPD and BPD has been done in predominantly female samples (Trull, Jahng, Tomko, Wood, & Sher, 2010). Incorporating more men into future studies will facilitate better understanding the implications of our findings to male and female samples. Second, the majority of our data were collected via self-report. Future research that incorporates more clinical interviews as well as data obtained from peers and family will reduce the risk of response bias. Additionally, the cross-sectional design of the study means that directionality cannot be determined. Longitudinal designs will help to establish directionality as well as provide more information regarding PD symptoms and interpersonal problems’ stability over time. It may also be worth exploring how interpersonal problems and social dysfunction change over time in a longitudinal treatment design. Finally, the
sample included in this study consisted of participants who were seeking help for personality dysfunction. The traits associated with help-seeking behavior that may exist within our sample may not be present in other PD populations. Using non-treatment seeking samples would help elucidate the generalizability of our findings.
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