SELF-ESTEEM AND COPING STRATEGIES IN A SAMPLE OF EGYPTIAN PATIENTS WITH BORDERLINE PERSONALITY DISORDER


1Assistant Lecturer of Psychiatry, Faculty of Medicine, Ainshams University, Cairo, Egypt.
2Professor of Psychiatry, Faculty of Medicine, Ainshams University, Cairo, Egypt.
3Professor of Psychiatry, Faculty of Medicine, Ainshams University, Cairo, Egypt.
4Professor of Psychiatry, Faculty of Medicine, Ainshams University, Cairo, Egypt.
5Assistant Professor of Psychiatry, Faculty of Medicine, Ainshams University, Cairo, Egypt.

E-mail: safty26@hotmail.com

ABSTRACT

Background and aim of work: A few clinical and non-clinical studies suggest that BPD (Borderline personality disorder) is associated with both impaired and unstable self-esteem. The studies also suggest a close relationship between self-esteem and negative affect in BPD, even if the nature of this relationship still is unclear. To our knowledge there has been limited studies that explored the relationship between BPD with either self-esteem or coping strategies, although it is expected to vary from the general population. Gaining more knowledge about the differences in both constructs in patients with BPD compared to healthy controls, can open treatment modalities for patients with BPD and can provide ways to improve the functioning and the quality of life of those patients.

Patients and methods: A total of 50 patients with the diagnosis of borderline personality disorder (BPD) were recruited from the outpatient clinic of the Institute of Psychiatry, Ain Shams University Hospitals. 50 healthy controls (HC) matched as much as possible, were recruited from the workers and relatives of the hospitals. Any subjects with a history of organic brain disease or chronic medical illness were not included in the study population. Both the cases and controls were between the ages of 18 to 45 years, of both sexes. Both groups were compared using the Structured Clinical Interview for DSM axis I disorders (SCID-I) to exclude any psychiatric disorder in the HC and to diagnose comorbidities in the cases group, the structured Clinical Interview for DSM-IV Axis II Disorders (SCID II) to diagnose patients with BPD, the Rosenberg Self-Esteem Scale, the COPE Inventory and the Global Assessment of Functioning scale of the DSM-IV (GAF).

Results: Our results pointed to significantly lower Self-Esteem scores (P<0.001) in patients diagnosed with BPD. Regarding the coping strategies utilized by both groups, BPD cases tends to use less problem solving coping strategies such as, Positive reinterpretation and growth (), Use of instrumental social support, Active coping, Restraint, suppression of competing activities and Planning, when compared to healthy controls and were found to use more less useful coping strategies as substance use and with behavioural disengagement. Comorbidities were significantly recorded in the cases group with more than one comorbidity in more than 40% of the cases. The general functioning of the cases group was significantly lower than the control group.

Conclusion: This preliminary study suggests that patients with BPD tend to have lower self-esteem and general functioning scores than healthy controls. Also, patients with BPD tend to utilize less problem solving and more less useful coping strategies when compared to healthy controls. Comorbidities are significantly higher in patients with BPD.

Key words: Borderline personality disorder–Self-esteem – Coping strategies – Personality disorders.
I. INTRODUCTION

Borderline personality disorder (BPD) prevalence rates are between 0.2–1.8% in the general community, with some research estimating 2.7–5.9% of the world’s general population [1, 2], 15–25% among psychiatric inpatients and 10% of all psychiatric outpatients [2, 3]. BPD is associated with high psychosocial and socioeconomic costs. The economic burden of diseases associated with BPD is higher than that of those associated with depression and comparable to that of patients with schizophrenia [4]. BPD is associated with severe functional impairment, substantial treatment use, and high rates of mortality by suicide [5,6]. In addition, patients with BPD are frequently encountered in emergency departments, where they present following a suicide attempt or threatened suicide. More than 500,000 such events occur each year in the United States [7], and 10% of BPD patients die by suicide [8]. Moreover, this disorder is a leading contributor to the burden of disease in the community as it is associated with adverse long-term outcomes that include severe and continual functional disability [9], physical ill health [10], and premature mortality [11].

Moreover, studies have demonstrated that people with a BPD diagnosis are likely to have numerous co-occurring psychiatric disorders, such as mood disorder, anxiety disorder and substance use disorder [12–17].

Self-esteem is one of the most widely studied topics in modern psychology with more than 25,000 publications during the last 30 years. It is an important psychological construct because it is a central component of individuals’ daily experience. It refers to how people feel about themselves and reflects and affects their ongoing transactions with their environment and the people they encounter [18]. This wide and diverse literature suggests that high levels of self-esteem are associated with an array of outcomes including productivity (e.g., academic achievement, occupational success) and psychological subjective well-being [19].

A few clinical and non-clinical studies suggest that BPD is associated with both impaired and unstable self-esteem. Rüsch, Lieb, Göttler et al. [20], found that female patients with BPD had a lower level of self-esteem, higher state shame and shame proneness than a group of patients with social phobia. Other studies found that low self-esteem is associated with increased severity of BPD symptoms [21]. Moreover, Self-esteem has been found to be one of the strongest predictors associated with poorer global outcomes and satisfaction with life in patients with BPD [22].

Coping was defined by Lazarus and Folkman, as a set of cognitive and behavioral efforts that are applied to address the occurrence of demands considered to exceed one’s personal resources [23]. One of the classifications of coping divides coping in 3 categories: the ‘problem-focused coping’ that refers to dealing with problems via increasing effort, seeking information, and goal setting, the ‘emotion-focused coping’ that consists of regulating emotional distress like using relaxation techniques and venting of emotions, and finally the ‘avoidance approach’ which aims to withdraw from the stressor either cognitively by trying to block the thoughts or behaviorally by walking away [24].

Positive coping creates positive feelings that foster improved communication and occupational growth. Furthermore, positive coping can inhibit the emergence of harmful health conditions, and manifest as problem-solving behavior and positive appraisals, while negative coping can affect a person’s mindset and in return affects his life negatively [25].

Less is known about how BPD patients cope with this increased negative affect and stress. Failure in implementing effective coping strategies in patients with BPD, including emotion regulation and radical acceptance, was postulated by Linehan [26] and was shown in several studies [27-29]. Strategies related to externalizing coping were recorded in patients with BPD [30]. Other studies reported ineffective coping strategies, such as stress avoidance [31] and low frequencies of problem solving [32], were found in patients with BPD, as compared with healthy controls. Moreover, the coping of patients has been suggested to be an important factor in deciding the therapist’s intervention choice and predicting the symptom change after treatment [33].

Rationale of the work

To our knowledge there has been limited studies that explored the relationship between BPD with either self-esteem or coping strategies. Gaining more knowledge about the differences in both constructs in patients with BPD compared to healthy controls, will guide clinicians towards defects in self-esteem and coping strategies in patients with BPD. Also, it will open different targets for therapists to improve their patients’ wellbeing and functioning, aiming to decrease the overall burden that the disorder put on the community.
II. MATERIALS AND METHODS

The design

It is a cross-sectional comparative study. The Epi Info version 6 (Centres for Disease Control and Prevention; Atlanta, Georgia) was used to calculate the sample size after reviewing the existing literature of similar studies.

Ethical Consideration

The study was conducted in accordance with the Helsinki Declaration for medical research of 1975 and in compliance with the guidelines of the Research and Ethics committee of the Institute of Psychiatry, Ain Shams University. All patients and controls were asked to sign a written informed consent prior to participation. They were informed about the procedure of the study, that no benefit would be withdrawn if they choose not to participate or withdraw at any time. Confidentiality was maintained throughout the study.

Selection of cases

A total of 50 patients with the diagnosis of borderline personality disorder (BPD) were recruited from the outpatient clinic of the Institute of Psychiatry, Ain Shams University Hospitals. BPD patients had to be either without any psychotropic medication or on stable psychotropic medication for more than 6 months. Of the 50 cases, 5 patients were not included in the study, as three patients failed to continue the assessments and two patient withdrew their consent to participate in the study.

Selection of Controls

50 healthy controls (HC) matched as much as possible, were recruited from the workers and relatives of the hospitals. Healthy controls had no lifetime mental illness and were not on any psychotropic medication. They had no diagnosis after assessment with both SCID I and SCID II. Any subject with a history of organic brain disease or chronic medical illness was not included in the study population. Both the cases and controls were between the ages of 18 to 45 years, of both sexes.

Tools

A socio-demographic data sheet was designed to collect information including gender, age, years of education, occupation, and income.

The Structured Clinical Interview for DSM axis I disorders (SCID-I): Is a clinician-administered, semi-structured interview for use with psychiatric patients or with non-patient community subjects who are undergoing evaluation for psychopathology. The SCID-I was developed to provide a broad coverage of psychiatric diagnoses according to DSM-IV. We used the Arabic Version [34].

Two versions of the measure were used:

The SCID-I/P (patient edition) is the standard SCID-I designed for research subjects identified as psychiatric patients and covers all the 51 specific DSM-IV Axis I diagnoses, which was used for the patients group [35].

The SCID-I/NP (non-patient edition) is for subjects who are not self-identified as psychiatric patients and was used for the control group. [35].

Structured Clinical Interview for DSM-IV Axis II Disorders (SCID II) [36] is a semi structured interview which is considered the standard instrument to diagnose Personality disorders and is extensively used in Psychiatric research. Each diagnosis of BPD was verified with the patients’ therapist (psychiatrist) and a senior supervising psychiatrist.

The Rosenberg Self-Esteem Scale [37] (Cronbach's α = .96) was used to assess respondents’ global self-esteem. The RSES is a self-rating instrument consisting of 10 items that are rated on a 4-point Likert scale; all items are added to derive a total score. We used the Arabic version translated by Abdelkhalik et al. [38].

The COPE Inventory [39] is a multidimensional coping inventory to assess the different ways in which people respond to stress. The COPE inventory comprises 15 four-item scales that assess a variety of coping strategies. Participants indicate how frequently they use each coping strategy on a four-point scale anchored by “usually do not do this at all” and “usually do this a lot.” It is based on both a theoretical and empirical model, the COPE
inventory incorporates both “problem-focused”, “emotion focused” and other “less useful” coping strategies and addresses the deficiencies of prior instruments. We used the Arabic version [40].

The Global Assessment of Functioning scale of the DSM-IV (GAF) [41]. The GAF scale assesses how severe a person's mental illness is and how much a person's symptoms affect his or her everyday life. Interviewers subjectively rate the social, occupational, and psychological functioning of an individual, covering the range from positive mental health to severe psychopathology. The GAF is constructed as an overall measure with 100 scoring possibilities of the level of functioning (1 – 100), whereas higher scores indicate greater levels of functioning.

III. PROCEDURE

The scales administration took around 3 hours to complete for each patient. The primary author was responsible for the examination and administration of scales. SKID was re-administered by a senior investigator to confirm the diagnosis.

Statistical analysis

The collected data was revised, coded, tabulated, and introduced to a PC using Statistical package for Social Science [42]. Data was presented and suitable analysis was done according to the type of data obtained for each parameter.

For descriptive statistics, Mean and Standard deviation (± SD) were used for numerical data. Frequency and percentage were used to represent non-numerical data.

For analytical statistics, Student t Test was used to assess the statistical significance of the difference between two study group means. Chi-Square test was used to examine the relationship between two qualitative variables. Fisher’s exact test was used to examine the relationship between two qualitative variables when the expected count is less than 5 in more than 20% of cells. ANOVA test was used to assess the statistical significance of the difference between more than two study group means. Post Hoc Test is used for comparisons of all possible pairs of group means. P value: used to indicate level of significance (P<0.05) indicates significance.

IV. RESULTS

Sample characteristics (Table 1)

The sample consisted of 45 patients with borderline personality disorder and 50 healthy controls. The calculated mean ages for patients and healthy controls were 27.4±4.4 years and 27.9±3.8 respectively (t=0.55, p=0.584).

As for the sex distribution was not significantly different (11 males and 34 females) in the patients group and (17 male and 33 females) in the controls (X2 =1.04, p=0.308). Borderline patients and healthy controls showed comparable characteristics regarding the years of education (P=0.293).

<table>
<thead>
<tr>
<th></th>
<th>Case</th>
<th>Control</th>
<th>Test of sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>27.4 ± 4.4</td>
<td>27.9 ± 3.8</td>
<td>t = -0.55</td>
</tr>
<tr>
<td>Years of education</td>
<td>17.4 ± 1.03</td>
<td>17.8 ± 2.1</td>
<td>t = -1.06</td>
</tr>
<tr>
<td>Gender</td>
<td>N %</td>
<td>N %</td>
<td>p value</td>
</tr>
<tr>
<td>Male</td>
<td>11 (24.4%)</td>
<td>17 (34.0%)</td>
<td>0.584 NS</td>
</tr>
<tr>
<td>Female</td>
<td>34 (75.6%)</td>
<td>33 (66.0%)</td>
<td>Fisher</td>
</tr>
<tr>
<td>Occupation</td>
<td>N %</td>
<td></td>
<td>Fisher</td>
</tr>
<tr>
<td>Student</td>
<td>7 (15.6%)</td>
<td>4.0%</td>
<td>0.031 S</td>
</tr>
<tr>
<td>Unemployed</td>
<td>2 (4.4%)</td>
<td>0.0%</td>
<td>Fisher</td>
</tr>
<tr>
<td>Employed</td>
<td>36 (80.0%)</td>
<td>96.0%</td>
<td>Fisher</td>
</tr>
</tbody>
</table>

Table (1): A comparison between cases and control regarding the basic demographic data

- t: t test value
- $\chi^2$: Chi square test value

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The analyses of self-esteem (Figure 1) revealed significant differences between the patients diagnosed with BPD and HC. Our results indicate that patients diagnosed with BPD showed significantly (P<0.001) lower self-esteem compared to those in the control group. The estimated means±SD for BPD patients’ self-esteem was 19.9±6.5 compared to 29.2±4.3 in the control group.

Assessing the difference in coping strategies (Table 2) between the two groups revealed significant difference especially in strategies that can be considered as problem focused, such as Positive reinterpretation and growth (t=-9.75, P=<0.001), Use of instrumental social support (t=-3.85, P=<0.001), Active coping (t=-8.39, P=<0.001), Restraint (t=-8.45, P=<0.001), suppression of competing activities (t=-5.46, P=<0.001) and Planning (t=-7.58, P=<0.001). The use of the previous mentioned strategies negatively correlated with the diagnosis of BPD as shown in the table.

As for other coping strategies that would be considered more emotion focused, there were significant difference between their usage when comparing the two groups. Cases tend to use Focusing on and venting of emotions (t=2.14, P=0.035) more than HC. While the controls group tend to use other strategies like religious coping (t=-3.52, P=0.001) and acceptance (t=-7.66, P<0.001), more.

Our results showed that patients with BPD tend to resort to less useful coping strategies more than HC. This was significant with the strong significance between the use of substance use (t=3.71, P=<0.001) and ofbehavioural disengagement (t=5.17, P=<0.001) in patient with BPD in relation with healthy controls.

Table (2):
A comparison between cases and control regarding the coping strategies utilized

<table>
<thead>
<tr>
<th></th>
<th>Case Mean</th>
<th>Case SD</th>
<th>Control Mean</th>
<th>Control SD</th>
<th>t</th>
<th>P-value</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive reinterpretation and growth</td>
<td>8.7</td>
<td>2.4</td>
<td>13.1</td>
<td>2.0</td>
<td>-9.75</td>
<td>&lt;0.001</td>
<td>S</td>
</tr>
<tr>
<td>Mental disengagement</td>
<td>10.4</td>
<td>2.6</td>
<td>10.4</td>
<td>2.9</td>
<td>-0.03</td>
<td>0.975</td>
<td>NS</td>
</tr>
<tr>
<td>Focus on and venting of emotions</td>
<td>12.1</td>
<td>2.9</td>
<td>10.9</td>
<td>2.4</td>
<td>2.14</td>
<td>0.035</td>
<td>S</td>
</tr>
<tr>
<td>Use of instrumental social support</td>
<td>9.1</td>
<td>2.9</td>
<td>11.5</td>
<td>3.2</td>
<td>-3.85</td>
<td>&lt;0.001</td>
<td>S</td>
</tr>
<tr>
<td>Active coping</td>
<td>7.9</td>
<td>2.6</td>
<td>12.2</td>
<td>2.4</td>
<td>-8.39</td>
<td>&lt;0.001</td>
<td>S</td>
</tr>
<tr>
<td>Denial</td>
<td>7.3</td>
<td>2.9</td>
<td>6.3</td>
<td>2.9</td>
<td>1.65</td>
<td>0.103</td>
<td>NS</td>
</tr>
<tr>
<td>Religious coping</td>
<td>9.8</td>
<td>4.5</td>
<td>12.8</td>
<td>3.8</td>
<td>-3.52</td>
<td>0.001</td>
<td>S</td>
</tr>
<tr>
<td>Humour</td>
<td>8.2</td>
<td>3.4</td>
<td>9.0</td>
<td>3.5</td>
<td>-1.03</td>
<td>0.307</td>
<td>NS</td>
</tr>
<tr>
<td>Behavioural disengagement</td>
<td>10.1</td>
<td>2.2</td>
<td>7.5</td>
<td>2.7</td>
<td>5.17</td>
<td>&lt;0.001</td>
<td>S</td>
</tr>
<tr>
<td>Restraint</td>
<td>7.1</td>
<td>2.4</td>
<td>11.4</td>
<td>2.6</td>
<td>-8.45</td>
<td>&lt;0.001</td>
<td>S</td>
</tr>
</tbody>
</table>
Taking a closer look on comorbidities (Figure 2,3) found with the cases. Around 53.3 % of the total cases had comorbidities, with 40% of the total cases having more than one comorbidity. 14 patients of a total of 45 (31.1%) had the diagnosis of a substance use disorder as a comorbidity, this was either alone or with other comorbidities. Anxiety disorders were the second most common comorbidity in the cases’ group with 24.4% diagnosed. This
was followed with the diagnosis of unipolar depression in 15.6% of the cases and only 1 of the patients had comorbid Bipolar Affective Disorder.

Comparing the general functioning (Table 3) using GAF between both groups revealed significant differences (P<0.001). Better functioning was noticed in the control group, with 62% scoring more than 81, in comparison to only 13.3% scoring more than 81 in the cases.

### Table (3):

<table>
<thead>
<tr>
<th>GAF</th>
<th>Case</th>
<th>Control</th>
<th>Test of sig.</th>
<th>p value</th>
<th>significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>91-100</td>
<td>0</td>
<td>2</td>
<td>t</td>
<td></td>
<td></td>
</tr>
<tr>
<td>81-90</td>
<td>6</td>
<td>29</td>
<td>\chi^2</td>
<td>8.6</td>
<td>&lt;0.001 S</td>
</tr>
<tr>
<td>71-80</td>
<td>20</td>
<td>17</td>
<td>t</td>
<td></td>
<td></td>
</tr>
<tr>
<td>61-70</td>
<td>12</td>
<td>2</td>
<td>\chi^2</td>
<td>8.6</td>
<td>&lt;0.001 S</td>
</tr>
<tr>
<td>51-60</td>
<td>4</td>
<td>0</td>
<td>t</td>
<td></td>
<td></td>
</tr>
<tr>
<td>41-50</td>
<td>3</td>
<td>0</td>
<td>\chi^2</td>
<td>8.6</td>
<td>&lt;0.001 S</td>
</tr>
</tbody>
</table>

: t: t test value \: \chi^2=Chi square test value

GAF = Global Assessment of Functioning scale of the DSM-IV

### V. DISCUSSION

Several studies studied the aspect of self-esteem in BPD patients in comparison to healthy controls. Our results pointed to a significant association between lower self-esteem and BPD. We are in concordance with the findings of previous investigators[43, 44]. Also with Winter D et al, who found that BPD patients were characterized by low self-esteem and low self-positivity when consciously evaluating information with reference to themselves[45]. While Kanter JW found that self-esteem is low in BPD patients compared to healthy controls[46]. Other authors found similar results as well, Bungert et al, [21] found that low self-esteem correlated with BPD symptoms severity, while Pohl S et al, [47] found that BPD patients had lower self-esteem than healthy controls yet self-esteem did not correlate with symptom severity.

The findings of the current study are in concordance with previous studies done by Kremers et al in 2006 [32], and Vollrath et al. in 1996 [48], that reported that patients with BPD had lower frequencies of problem-solving strategies. Yet, Kramer in 2012 [49] found that BPD patients didn’t differ in Problem solving and information seeking domains which contradicts our findings.

Several lines of evidence have implicated that ineffective coping strategies, such as stress avoidance [31] and low frequencies of problem solving [32], were found in patients with BPD, as compared with healthy controls. This goes in line with our findings.

Linehan [26] has suggested that BPD patients fail to implement effective coping strategies. This was later found in several studies [27-29]. Our study is another one that found similar results.

To our knowledge only one study by in Egypt [50] explored coping strategies in patients diagnosed with BPD with comorbid substance use disorder. Similar to the results we found in our study, the diagnosis of BPD recorded significantly less usage of problem-focused strategies such as active coping, planning, suppression of competing activities, restraint and seeking of instrumental social support. Their results were different than our study when viewing strategies like denial, seeking of emotional social support and turning to religion where they found that BPD patients resorted to use those strategies more, while we didn’t find significant differences between healthy controls.

Similar to our findings, several studies have demonstrated that people with a BPD diagnosis are likely to have numerous co-occurring psychiatric disorders, such as mood disorder, anxiety disorder and substance use disorder [12-17]. In an interesting study, Shen and co-workers [51] has determined that BPD was highly concurrent with “bipolar disorder and anxiety disorder” (43.49%), “depressive disorder and anxiety disorder” (41.49%), this aligns with our study yet the prevalence of Bipolar Disorder was estimated much higher in their study, this might be explained by the fact that our sample size was not enough to determine prevalence rates accurately.
Lastly, healthy controls were found to have better functioning in our study. Others have suggested through their studies that self-esteem was one of the strongest predictors with global outcome and satisfaction of life in patients with BPD [52].

Strength and Limitations

The strength of this research lies in deepening our understanding of the aspects of both self-esteem and coping strategies in patients with BPD. It builds on growing evidence of the importance of both aspects as our findings have several clinical implications and can provide guidance for mental health professionals on targets in therapy and opens doors for future research to study the relationship between self-esteem and coping strategies and various life domains.

Worth mentioning, is that this study is not without limitation; firstly, the small sample size from one hospital which limits the generalization of the obtained results to all Egyptian BPD patients. Secondly, coping processes are assessed using self-report questionnaires, making the results more prone for biases of social desirability and self-deception. Lastly, though the GAF scale’s advantage of simplicity, it comes with a number of limitations. Most importantly, that the rating score can be influenced by rater’s attitude towards the GAF and their knowledge of the patients’ day-to-day life, along with other confounding variables.

VI. CONCLUSION

The finding of this study suggests that patients with BPD tend to have lower self-esteem scores than healthy controls. Also, patients with BPD tend to utilize different coping strategies than healthy controls. Comorbidities are significantly higher in patients with BPD, while general functioning is significantly lower in BPD patients when compared to healthy controls.

REFERENCES


48. Hossam Eldin Sweify (2018), The Relationship between Coping Strategies and Antisocial and Borderline Personality Disorders among a sample of Drug Dependents and Non Drug Dependents, MD thesis, Department of Psychology, Faculty of Arts, Assiut University.
