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Attributions for Rejection and Acceptance in Young Adults with Borderline and Avoidant Personality Features

Kathy R. Berenson
Gettysburg College

Olga U.A. Nynaes
Gettysburg College

Emily S. Wakschal
Gettysburg College

See next page for additional authors

Roles

Olga U.A. Nynaes '16, Gettysburg College
Emily S. Wakschal '16, Gettysburg College
Laura M. Kapner '17, Gettysburg College
Erin Sweeney '18, Gettysburg College

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Abstract
Individuals with borderline and avoidant personality disorders show interpersonal dysfunction that includes maladaptive responses to rejection and reduced emotional benefits from acceptance. To identify the attributional styles that may underlie these difficulties, we examined causal attributions for rejection and acceptance among undergraduates high in features of each disorder and a healthy comparison group. In Study 1, participants rated how likely they were to attribute hypothetical rejection and acceptance experiences to positive and negative qualities of the self and others, as well as external circumstances. In Study 2, we examined these same attributions in daily diary assessments of real rejection and acceptance experiences. Although the two studies showed some differences in results, they both linked borderline personality features with suspicious, selfbolstering responses and avoidant personality features with perceived inferiority. Distinct attributional styles may contribute to the distinct interpersonal problems characteristic of these conditions.

Authors
Kathy R. Berenson, Olga U.A. Nynaes, Emily S. Wakschal, Laura M. Kapner, and Erin C. Sweeney

ATTRIBUTIONS FOR REJECTION AND ACCEPTANCE IN YOUNG ADULTS WITH BORDERLINE AND AVOIDANT PERSONALITY FEATURES

KATHY R. BERENSON, OLGA NYNAES, EMILY S. WAKSCHAL, LAURA M. KAPNER, AND ERIN C. SWEENEY
Gettysburg College, Gettysburg, PA

Individuals with borderline and avoidant personality disorders show interpersonal dysfunction that includes maladaptive responses to rejection and reduced emotional benefits from acceptance. To identify the attributional styles that may underlie these difficulties, we examined causal attributions for rejection and acceptance among undergraduates high in features of each disorder and a healthy comparison group. In Study 1, participants rated how likely they were to attribute hypothetical rejection and acceptance experiences to positive and negative qualities of the self and others, as well as external circumstances. In Study 2, we examined these same attributions in daily diary assessments of real rejection and acceptance experiences. Although the two studies showed some differences in results, they both linked borderline personality features with suspicious, self-bolstering responses and avoidant personality features with perceived inferiority. Distinct attributional styles may contribute to the distinct interpersonal problems characteristic of these conditions.

Keywords: causal attributions, rejection, acceptance, borderline, avoidant

The causal attributions that people make for their experiences have been examined as possible contributors to maladaptive af-

fective and interpersonal reactions, including aggression (Dodge, 1980), depression (Joiner & Wagner, 1995), and loneliness (Vanhalst et al., 2015). However, there has been no previous research examining the attributions that may contribute to the distinct patterns of relational difficulties that are characteristic of borderline and avoidant personality disorders. It is common and useful to compare borderline and avoidant personality disorders, because they are both associated with high psychosocial distress/impairment, and high rejection sensitivity (Berenson et al., 2016), yet they also have notable differences. Borderline symptoms are characterized by instability in multiple domains, and include impulsivity and anger. Avoidant symptoms, by contrast, involve more persistent inhibition and feelings of inadequacy (American Psychiatric Association, 2013). Just as individual differences in interpersonal attributions differentially predict aggression and social withdrawal among rejection-sensitive adolescents (Zimmer-Gembeck, Nesdale, Webb, Khatibi, & Downey, 2016), they are likely to be differentially associated with borderline and avoidant symptomatology.

Symptoms of borderline personality disorder fluctuate with situational context and are highly responsive to negative interpersonal triggers (Berenson et al., 2016; Dixon-Gordon, Gratz, Breetz, & Tull, 2013; Hepp et al., 2017; Miskewicz et al., 2015; Sadikaj, Moskowitz, Russell, Zuroff, & Paris, 2013). Individuals high in borderline features show stronger increases in shame than healthy individuals as a function of perceived rejection (e.g., Chapman, Walters, & Dixon Gordon, 2014; Scott et al., 2017), suggesting that they may characteristically blame themselves for their painful interpersonal experiences. At the same time, the more intense anger and retaliatory aggression that these individuals show when perceiving rejection (e.g., Berenson, Downey, Rafaeli, Coifman, & Paquin, 2011; Chapman et al., 2014; Scott et al., 2017), suggest that causal attributions that blame others may also be prominent.

Although most of the research on contextual triggering of symptoms in borderline personality disorder has focused on maladaptive responses to negative interpersonal cues, the mere presence of others is also associated with increases in shame and anger among individuals with this disorder (Gadassi, Snir, Berenson, Downey, & Rafaeli, 2014). Moreover, in experiments that

manipulated experiences of rejection and inclusion (with the Cyberball paradigm), more negative emotions and negatively biased social perceptions were reported by participants with borderline personality disorder than by healthy participants across both conditions (De Panfilis, Riva, Preti, Cabrino, & Marchesi, 2015; Gutz, Renneberg, Roepke, & Niedeggen, 2015). In light of accumulating evidence that individuals with borderline symptomatology derive limited emotional benefit from experiences of acceptance, support, and inclusion (Bhatia, Davila, Eubanks-Carter, & Burckell, 2013; Reichenberger et al., 2016), it seems likely that maladaptive causal attributions for these experiences may be a contributing factor. For example, they may be more likely than healthy individuals to discount positive interpersonal experiences with circumstantial attributions, or to sour these experiences with negative explanations that cast the self or others in an unfavorable light.

Avoidant personality disorder is characterized by especially low self-esteem (Lynum, Wilberg, & Karterud, 2008), and when feeling criticized, individuals with avoidant personality disorder rate themselves even more negatively than those with borderline personality disorder do (Bowles, Armitage, Drabble, & Meyer, 2013). Individuals with avoidant personality disorder are also significantly less prone to angry outbursts than those with borderline personality disorder (Berenson et al., 2017), presumably because like those with a primary diagnosis of social phobia, they avoid challenging the perceived superiority of others (Antony, Rowa, Liss, Swallow, & Swinson, 2006; Berenson, Johnson, Zhao, Nynaes, & Goren, 2018; Heerey & Kring, 2007). The tendency to see themselves as inferior suggests that individuals with avoidant personality features may make maladaptive causal attributions for negative interpersonal experiences that blame the self, while viewing others in a positively biased manner that elevates them above blame.

The diagnostic criteria for avoidant personality disorder explicitly focus on concerns about negative social experiences (such as rejection and negative evaluation), and no previous research has explicitly examined the reactions of individuals with this disorder to acceptance, inclusion, and support. Nevertheless, research on social phobia (a closely related condition; Ralevski et al.,

2005) suggests that avoidant personality disorder may also be associated with more negative interpretations of positive social experiences. Indeed, social anxiety is correlated with fear of positive evaluation (Weeks, Heimberg, & Rodebaugh, 2008; Weeks, Jakatdar, & Heimberg, 2010), which in turn predicts more distress and self-criticism when receiving positive social feedback (Reichenberger, Wiggert, Wilhelm, Weeks, & Blechert, 2015; Wallace & Alden, 1997). Among those with social anxiety, positive social situations have been found to evoke negative interpretations (Laposa, Cassin, & Rector, 2010) and negatively biased self-evaluations (Alden & Wallace, 1995; Taylor & Alden, 2005). By contrast, individuals high in social anxiety show a positive bias in their evaluations of others' behavior (Alden & Wallace, 1995), consistent with the idea that social anxiety involves viewing others as superior to an inferior self, rather than a more pervasive negativity bias. Individuals with avoidant personality features may therefore attribute positive interpersonal experiences to negative qualities of the self and positive qualities of others.

THE CURRENT RESEARCH

The interpersonal attributions made by individuals high in borderline or avoidant features may help explain their characteristic maladaptive responses to rejection and difficulties benefitting from acceptance. Relative to healthy participants, those high in borderline features were expected to make interpersonal attributions involving negative views of both the self and others, and also to attribute positive experiences to external circumstances. Those high in avoidant features, by contrast, were expected to make interpersonal attributions involving negative views of the self and positive views of others. We tested these predictions in two studies. Study 1 examined attributions for hypothetical experiences of rejection and acceptance. Study 2 examined attributions for real-life rejection and acceptance experiences in the context of a daily diary. As previous research has found depression to be associated with attributional styles (e.g., Joiner & Wagner, 1995), both of the current studies included a measure of depression symptoms for use as a covariate.

STUDY 1

METHOD

Participants. Participants were undergraduate students at a college in the U.S. who had previously met eligibility requirements and given us permission to contact them about opportunities to participate in related paid research studies. Eligibility requirements were based on borderline and avoidant features, mental health treatment history, and validity scale scores, all of which had been assessed as part of a different study. The borderline and avoidant personality disorder subscales from the *Schedule for Nonadaptive and Adaptive Personality—II* (SNAP-II; Clark, 2003) assess each criterion of these personality disorders with multiple true-false items. In this research, both subscales had alpha coefficients of .89. Mental health treatment history was assessed with a questionnaire item that asked participants to indicate if they had ever received any treatment for mental health problems, such as psychiatric medication, therapy/counseling, or both. Inconsistent and unrealistically socially desirable responses were both assessed using SNAP-2 scales, and any participants with t-scores of 65 or above were considered ineligible for having provided invalid data.

Individuals who met four or more criteria for borderline personality disorder and no more than three criteria for avoidant personality disorder on the SNAP-2 were eligible for the borderline personality (BP) features group. Those who met three or more criteria for avoidant personality disorder and no more than two borderline personality disorder criteria on the SNAP-2 were eligible for the avoidant personality (AP) features group. Individuals who met no more than two criteria of either disorder and reported no history of mental health treatment were eligible for the healthy comparison (HC) group.

A total of 98 participants (80.6% female) completed this study (38 BP, 25 AP, 35 HC). They were between 18–22 years of age (M = 19.40, SD = 1.32), and 74.5% identified as White. There were no significant between-group differences in gender, age, or racial/ethnic background. A history of mental health treatment was reported by 14 in the BP group (36.8%) and 10 in the AP group (40.0%).

Attributions for Rejection and Acceptance Questionnaire. To examine attributions, we developed a questionnaire based on the 18 situations that are included in the Rejection Sensitivity Questionnaire (Downey & Feldman, 1996), designed to capture common concerns about rejection and acceptance among college students. Each situation involved asking something of a parent, friend, romantic partner, roommate, classmate, or professor. We presented each situation twice, with a negative and positive outcome, in a random order. Participants were asked to imagine themselves in the situation and to rate the attributions they would make for the outcome using a 6-point scale ranging from 1 (not at all) to 6 (completely). For example, one set of items asked about the following acceptance situation:

> You ask your parent(s) for help in deciding what programs to apply to, and they help you. How would you explain the reasons why your parent(s) helped you? (a) because of something positive about yourself, (b) because of something negative about yourself, (c) because of something positive about your parents, (d) because of something negative about your parents, or (e) because of external circumstances.

We calculated the mean rating for each attribution type (positive self, negative self, positive other, negative other, circumstantial) separately for the rejection and acceptance situations. The 10 resulting attribution scales all had alpha coefficients between .89 and .95, indicating high internal consistency. The complete measure is available from the authors.

Depression Symptoms. To assess depression symptoms, we used five items from the depression subscale of the Brief Symptom Inventory (BSI; Derogatis, 1993). Participants rated how often during the past seven days they were bothered or distressed by specific problems, such as feelings of worthlessness, from 1 (not at all) to 5 (extremely). Internal consistency of this scale was $\alpha = .89$.

Procedure. Eligible individuals were invited to participate in an internet-based study for monetary compensation. Emails were sent to them, containing a link to the study consent form. After providing informed consent, they completed the Attributions for Rejection and Acceptance Questionnaire and the depression
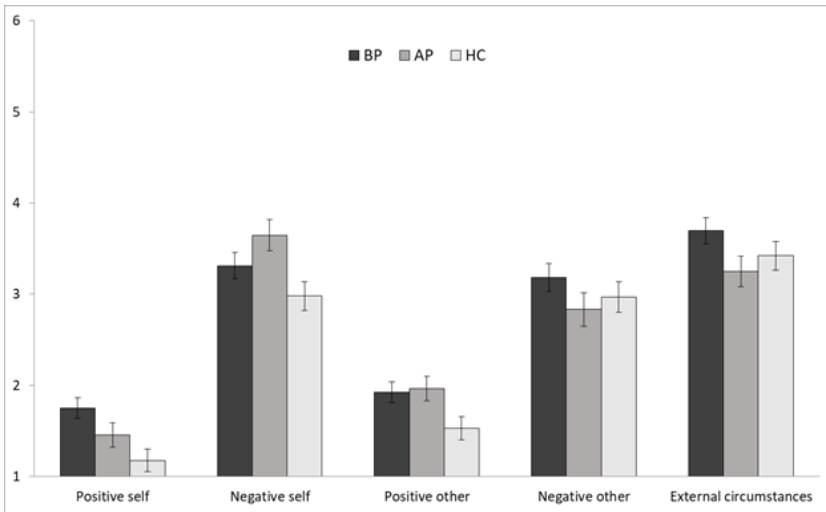
FIGURE 1. Attributions for hypothetical rejection by group, adjusting statistically for participant gender and depression symptoms.

symptoms scale from the Brief Symptom Inventory, described above.

RESULTS AND DISCUSSION

For each type of attribution, group mean ratings were examined in an analysis of covariance (ANCOVA) with participant gender and depression symptoms as covariates. The estimated marginal group means for the five types of attributions are shown in Figures 1 and 2, (for rejection and acceptance, respectively).

Rejection Attributions. The groups differed in attributing hypothetical rejections to positive qualities of the self, $F(2, 93) = 5.276$, $p = .007$. Positive self-attributions were significantly higher among the BP group ($M = 1.754$, $SE = .113$) than the HC group ($M = 1.178$, $SE = .123$), $t (93) = 3.226$, $p = .002$. The AP group had an intermediate mean score ($M = 1.458$, $SE = .133$) and did not differ significantly from either the BP group, $t(93) = 1.730$, $p = .087$, or the HC group, $t(93) = 1.4990$, $p = .137$, in positive self-attributions.
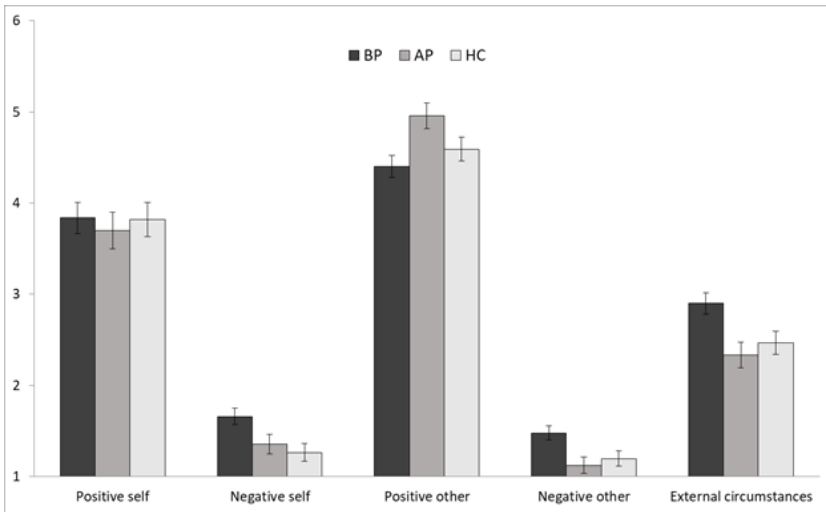
FIGURE 2. Attributions for hypothetical acceptance by group, adjusting statistically for participant gender and depression symptoms.

Negative self-attributions for rejection also showed significant between-group differences, $F(2, 93) = 3.976$, $p = .022$. These were significantly higher among the AP group ($M = 3.648$, $SE = .169$) than the HC group ($M = 2.982$, $SE = .156$), $t(93) = 2.816$, $p = .006$. The BP group's negative self-attributions ($M = 3.313$, $SE = .143$) did not differ significantly from either the AP group $t(93) = -1.543$, $p = .126$, or the HC group $t(93) = 1.461$, $p = .147$.

Group differences also emerged for attributing rejection to positive qualities of others, $F(2, 93) = 3.223$, $p = .044$. Positive other-attributions for rejection were significantly higher in the AP group ($M = 1.966$, $SE = .135$), $t(93) = 2.305$, $p = .023$, and the BP group, ($M = 1.925$, $SE = .115$), $t(93) = 2.175$, $p = .032$, relative to the HC group ($M = 1.531$, $SE = .135$). The BP and AP groups did not significantly differ from one another, $t(93) = -.058$, $p = .954$.

There were no significant between-group differences in attributing rejection to negative qualities of others, $F(2, 93) = 1.188$, $p = .309$, or to external circumstances, $F(2, 93) = 2.230$, $p = .113$.

While it was surprising to find that participants high in BP features tended to attribute hypothetical rejection to positive qualities of both the self and others, this is perhaps an illustration of the contradictory and defensively-motivated interpersonal responses experienced by individuals with BP. As predicted, at-

tributions for hypothetical rejection among participants high in AP features were consistent with negative views of the self and positive views of others.

Acceptance Attributions. There were no significant between-group differences in attributing acceptance to positive qualities of the self, $F(2, 93) = .163$, $p = .850$. However, the groups differed in attributing acceptance to negative qualities of the self, $F(2, 93) = 4.422$, $p = .015$. Negative self-attributions were significantly higher among the BP group ($M = 1.660$, $SE = .091$) than both the HC ($M = 1.266$, $SE = .099$), $t(93) = 2.756$, $p = .007$, and the AP groups ($M = 1.355$, $SE = .107$), $t(93) = 2.347$, $p = .021$, suggesting that participants high in BP features were more likely to explain others' kindness towards them as motivated by pity. The AP and HC groups did not significantly differ from one another, $t(93) = .594$, $p = .554$.

Between-group differences were also found for attributing acceptance to positive qualities of others, $F(2, 93) = 4.802$, $p = .010$. The AP group ($M = 4.960$, $SE = .141$) reported these attributions significantly more than the BP group ($M = 4.401$, $SE = .120$), $t(93) = 2.790$, $p = .006$, and marginally more than the HC group ($M = 4.590$, $SE = .131$), $t(93) = 1.867$, $p = .065$. The BP and HC groups did not significantly differ from one another in positive other-attributions for acceptance, $t(93) = -.997$, $p = .322$.

Negative other-attributions for acceptance, $F(2, 93) = 5.187$, $p = .007$, by contrast, were significantly higher among the BP group ($M = 1.480$, $SE = .078$) than both the HC group ($M = 1.199$, $SE = .085$), $t(93) = 2.298$, $p = .024$, and the AP group ($M = 1.124$, $SE = .091$), $t(93) = 3.068$, $p = .003$. Participants high in BP features were more likely to regard acts of kindness towards them as signs of others' weakness or as having malicious ulterior motives. The AP group did not significantly differ from the HC group in attributing acceptance to negative qualities of others, $t(93) = -.583$, $p = .561$.

Finally, the groups also differed in the extent to which they attributed hypothetical acceptance to external circumstances, $F(2, 93) = 5.658$, $p = .005$. Circumstantial attributions for acceptance were significantly greater among the BP group ($M = 2.900$, $SE = .117$) than both the HC group ($M = 2.467$, $SE = .128$), $t(93) = 2.343$, $p = .021$, and the AP group ($M = 2.335$, $SE = .138$), $t(93) =$

2.946, p = .004. The AP and HC groups did not significantly differ from one another in making circumstantial attributions for acceptance, $t(93)$ = −.681, p = .498.

As predicted, the BP group attributed hypothetical acceptance to negative qualities of the self, negative qualities of others, and external circumstances more than the HC group did. Also as predicted, participants in the AP group were more likely than those in the BP and HC groups to attribute acceptance to positive qualities of others. However, the AP group's attributions for hypothetical acceptance did not show the expected evidence of more negative self-views.

Depression Symptoms. Across the entire sample, depression symptoms were correlated with attributing rejection to negative qualities of the self (r = .439, p < .001), and with attributing acceptance to external circumstances (r = .458, p < .001). In other words, depression was associated with internal attributions for negative events and external, unstable attributions for positive events, consistent with the literature on depressive attributional styles (Joiner & Wagner, 1995). Depression was also associated with attributing acceptance to negative qualities of the self (r = .266, p = .008). It was not significantly associated with attributing interpersonal experiences to the positive or negative qualities of others.

STUDY 2

Although responses to hypothetical scenarios are commonly used to assess attributions, we cannot assume that these assessments are generalizable to the attributions that people make for their real-life experiences. We conducted a second study using daily diaries to examine whether the same between-group differences in attribution patterns observed in Study 1 would occur for real-life experiences of rejection and acceptance.

METHOD

Participants. Participants were undergraduate students at a college in the U.S., recruited for this study using the same eligibility

criteria used in Study 1. A total of 81 participants completed this study, including: 25 in the BP group (64.0% female), 22 in the AP group (95.5% female), and 34 in the HC group (91.2% female).

Participants were between 18 and 22 years of age (M = 19.23, SD = 1.325), and 81.5% identified as White. A history of mental health treatment was reported by 10 in the BP group (40.0%) and 9 in the AP group (40.9%). Data from 16 more participants who started Study 2 were excluded because they had terminated their participation prior to completing seven diary entries, and one additional participant was excluded for leaving many of the diary questions about rejection and acceptance blank.

Diary Assessments of Attributions. In each diary entry, participants first completed state mood ratings, as well as ratings of both the self and a significant other, all for purposes beyond this paper. Each diary entry ended with a series of open-ended questions about two recent experiences—one in which they felt rejected, followed by one in which they felt accepted.

For rejection experiences, the series of prompts read: "Has anyone let you down or made you feel rejected/insecure since the last time you completed this survey? (Yes/No.)" When participants answered affirmatively, they were presented with these follow-up prompts: "(1) Approximately how long ago did this happen? (2) Briefly describe what the person said or did that made you feel let down or rejected/insecure. (3) What thoughts crossed your mind as to why the person said or did what they did?"

For acceptance experiences, participants were first asked: "Has anyone helped you or made you feel cared about/accepted since the last time you completed this survey? (Yes/No.)" Affirmative answers were followed up with: "(1) Approximately how long ago did this happen? (2) Briefly describe what the person said or did that made you feel helped or cared about/accepted. (3) What thoughts crossed your mind as to why the person said or did what they did?"

Participants who responded that the specified experience (of rejection or acceptance) had not occurred since the last survey were prompted to answer the same series of questions about a past experience instead. To illustrate, the follow-up prompts for past rejection experiences read:

> Think about a recent time when someone let you down or made you feel rejected/insecure, that you have not already described in this research study. (1) Approximately how long ago did this happen? (2) Briefly describe what the person said or did that made you feel let down or rejected/insecure. (3) What thoughts crossed your mind as to why the person said or did what they did?

We excluded from analysis any experiences that had occurred more than 1 week ago.

Two independent raters blind to participants' group membership coded responses for the extent to which they expressed each of the attributions described in Study 1 (positive self, negative self, positive other, negative other, external circumstances). Considering both the participant's description of the situation and explanation for it, raters gave each response a code of 2 if the attribution was clearly present, 1 if it was suggested but not definitely present, and 0 if it was absent. Inter-rater correlations for each attribution variable ranged from .67 to .93. Analyses utilized the average of the two sets of ratings.

Examples of Rejection Attributions. For rejection situations, illustrative examples of positive self-attributions include: "They didn't help me because they've seen that I can handle things very well on my own," "They wouldn't want to date me because they know I could do much better than them," or "They rejected me because they felt jealous of me." An example of a negative self-attribution is: "They wouldn't want to date me because I'm unattractive." Positive other-attributions for rejection include: "They didn't help me because they really have my best interest at heart and know that I'd be better off without their help" or "They couldn't spend time with me because they had promised to spend the day volunteering for charity and always honor their commitments." Negative other-attributions include: "They said no because they are a lazy jerk" or "They want me to fail so they'll look better by comparison." A circumstantial attribution for rejection would be "They weren't there because they got sick or their car broke down."

Examples of Acceptance Attributions. For acceptance situations, an example of a positive self-attribution is: "They helped me because they value me as a friend," whereas an example of a nega-

tive self-attribution is: "They helped me because they knew I'd fail otherwise." While positive other-attributions for acceptance include: "They helped me because they are a really caring person," negative other-attributions for acceptance include: "They don't have many friends, so they'd probably go out with anyone and wouldn't have the guts to say no" or "They're only spending time with me because they want me to pay for their dinner and movie." An example of a circumstantial attribution for acceptance is: "They helped me because it's their job."

Depression Symptoms. During their initial study session, participants had completed five items from the depression subscale of the Brief Symptom Inventory (BSI; Derogatis, 1993) assessing depression symptoms in the last seven days, just as in Study 1. Internal consistency in this sample was α = .85.

Procedure. Individuals eligible for one of our three study groups were sent an email about the study and given the opportunity to sign up for a study session. During that session, participants provided informed consent, and completed the measure of depression symptoms (described above) as well as other tasks and questionnaires beyond the scope of this paper. Finally, they were informed about a 12-day diary study they could complete on the internet for additional compensation. Interested individuals were sent the study link by email; those who had not responded by the following month were sent up to two additional emails reminding them of their invitation to participate. Once participants had begun completing diary entries, they were sent daily email reminders until they had finished 12 entries that were at least 18 hours apart. Study participation ended early when participants explicitly asked to discontinue it, or when they had not completed any diary entries for more than two weeks. Participants were compensated based on the number of diaries they had completed. All but two of the included participants completed all 12 diaries, and the remaining two completed 9–11 diaries. Diary completion began between 0 and 79 days after the initial study session (*M* = 3.53, *SD* = 9.93) and took between 12 and 57 days (*M* = 16.14, *SD* = 7.91). All study procedures were approved by the Institutional Review Board.
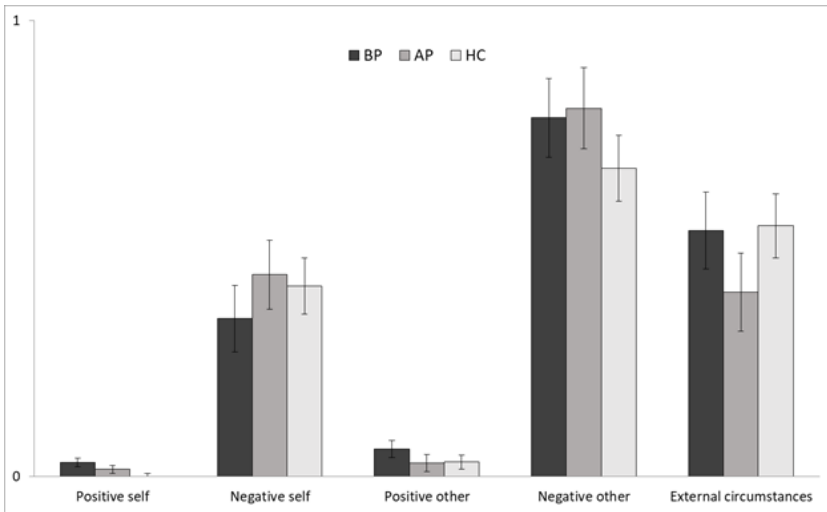
FIGURE 3. Attributions for daily life rejection by group, adjusting statistically for participant gender and depression symptoms.

RESULTS AND DISCUSSION

We examined group mean ratings for each type of attribution in an analysis of covariance (ANCOVA) with participant gender and depression symptoms as covariates. Results are depicted in Figures 3 and 4 for rejection and acceptance, respectively.

Rejection Attributions. Replicating what we had previously found for hypothetical rejection attributions in Study 1, the groups differed in the extent they attributed real-life rejection to positive qualities of the self, $F(2, 76) = 3.520$, $p = .035$. Positive self-attributions for rejection were significantly higher among the BP group ($M = .031$, $SE = .009$) than the HC group ($M = .000$, $SE = .007$), $t(76) = 2.632$, $p = .010$. The AP group ($M = .016$, $SE = .009$) did not differ significantly from either the BP group, $t(76) = -1.163$, $p = .249$, or the HC group, $t(76) = 1.386$, $p = .170$, in positive self-attributions.

No significant group differences were found for other types of attributions for real-life rejection, $Fs < 1$, *ns*. In other words, we were unable to replicate the group differences in negative self-attributions and positive other-attributions that we had previously observed for hypothetical rejection in Study 1.
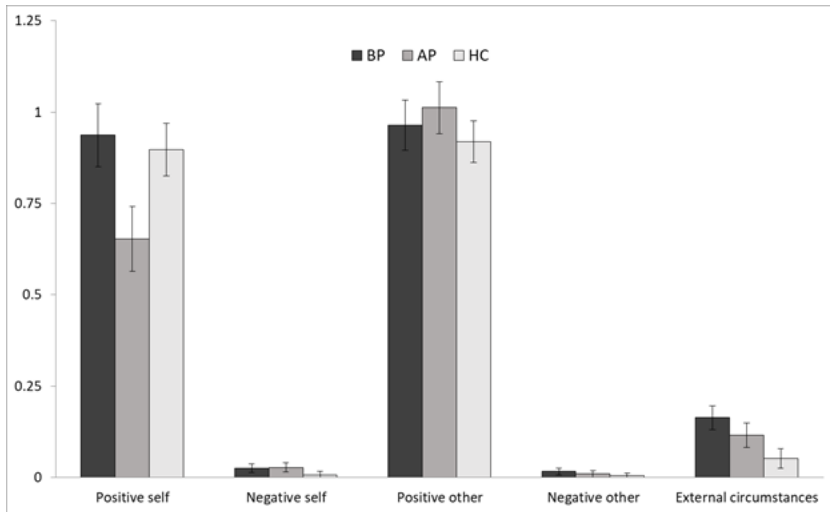
FIGURE 4. Attributions for daily life acceptance by group, adjusting statistically for participant gender and depression symptoms.

Acceptance Attributions. Study 2 replicated the group differences in attributing acceptance to external circumstances that we had found in Study 1, $F(2, 76) = 3.316$, $p = .042$. Circumstantial attributions for real-life acceptance were significantly higher among the BP group ($M = .164$, $SE = .033$) than the HC group ($M = .052$, $SE = .027$), $t(76) = 2.534$, $p = .013$. The AP group ($M = .116$, $SE = .034$) did not differ significantly from either the BP group, $t(76) = -1.007$, $p = .317$, or the HC group, $t(76) = 1.458$, $p = .149$, in circumstantial attributions for acceptance.

We also found group differences in positive self-attributions for real-life acceptance in Study 2, $F(2, 76) = 3.152$, $p = .048$. Consistent with our prediction that self-views would be especially negative in AP, positive self-attributions for acceptance were significantly lower among the AP group ($M = .653$, $SE = .088$) than the HC group ($M = .898$, $SE = .072$), $t(76) = -.131$, $p = .036$, and the BP group ($M = .937$, $SE = .086$), $t(76) = -2.265$, $p = .026$. The HC and BP groups did not significantly differ from one another in positive self-attributions for acceptance, $t(76) = -.337$, $p = .737$.

Study 2 did not replicate the significant group differences in negative self-attributions, positive other-attributions, or nega-

tive other-attributions that we had previously found for hypothetical acceptance.

Depression Symptoms. Correlations between self-reported depression symptoms and attributions during the diary period were not statistically significant. One possible explanation is that unlike Study 1, which assessed attributional style and depression during the same study session, Study 2 often involved a substantial time lag between the depression assessment and the last of the series of daily attribution assessments. Hence, the levels of depression reported during the initial session may not accurately reflect the levels of depression experienced during the diary period.

Associations between Hypothetical and Daily Life Attributions. Because many of the same participants ($n = 55$) also completed Study 1 (either before or after their participation in Study 2), we examined the relationships between the attributions made in these two studies. Significant cross-study correlations emerged for attributing rejection to positive qualities of the self ($r = .429$, $p = .001$), negative qualities of the self ($r = .365$, $p = .006$), and external circumstances ($r = .322$, $p = .016$). This suggests that the hypothetical and open-ended diary assessments captured similar attributional tendencies for these items but not for attributing rejection to others.

For acceptance attributions, a marginally significant correlation emerged with respect to attributing acceptance to positive qualities of the self ($r = .256$, $p = .060$). None of the other four attribution types showed statistically significant cross-study correlations. This suggests very little overlap in the attributional tendencies being captured by the two types of acceptance attribution assessments. One possible explanation for this divergence involves differences in the nature of the acceptance situations that were the focus of Study 1 versus Study 2. In Study 1, the situations were derived from the Rejection Sensitivity Questionnaire and specifically focused on times when the self was in the vulnerable position of explicitly expressing a desire or need to someone. In Study 2, by contrast, the acceptance experiences described by participants typically involved much less vulner-

ability, such as when they had received someone's kindness or support without having asked for it.

SUMMARY AND CONCLUDING DISCUSSION

Because shame and rage characteristically emerge in response to perceived rejection or abandonment among individuals with BP, we had expected individuals high in BP features to show elevations in attributing rejection and acceptance to negative qualities of the self and others. Surprisingly, we found that it was quite normative for participants in both studies to attribute rejection to negative qualities of the self and others, and there were no significant differences between the BP and HC groups in doing so. Moreover, in both studies, the BP group was significantly more likely than the HC group to attribute rejection to positive qualities of the self. This unexpected result may perhaps reflect the high rate of co-occurrence of BP with narcissistic personality disorder and narcissistic features (American Psychiatric Association, 2013). Indeed, given the links between aggression and threats to positive self-views (Baumeister, Smart, & Boden, 1996; Bushman & Baumeister, 1998), attempts to bolster self-esteem in the face of perceived rejection may help explain why rejection often precipitates angry reactions in BP.

Across both studies, the BP group was more likely than the HC group to dismiss received acceptance as a coincidence or byproduct of external circumstances. Such an attribution would likely dampen the benefits typically associated with acceptance when it is viewed as a deserved reward or a sign of another's benevolent caring. Indeed, hypothetical acceptance also elicited more negative attributions towards both the self and others in the BP group than HC, with the BP group showing more suspicion that others' acts of kindness had been motivated by pity, others' weakness, or others' malicious intent.

Although results for the AP group differed across the two studies, they were generally consistent with our predictions that attributions in this group would reflect perceived inferiority to others. Relative to the HC group, the AP group made more negative self-attributions and more positive other-attributions for rejection (Study 1), more positive other-attributions for accep-

tance (Study 1), and less positive self-attributions for acceptance (Study 2).

The differences in results that arose between Study 1 and Study 2 preclude simple conclusions but do not imply that either set of results is invalid. The attribution assessments in these two studies were quite different from one another and appeared to be tapping into different things, especially with respect to the acceptance attributions. Indeed, attribution research has always relied heavily on participants' imagined responses to hypothetical situations, both for assessments of depressive attributions (e.g., Peterson et al., 1982; Seligman et al., 1984) and hostile attributions (e.g., Crick, 1995), and the strength of this approach lies in the ability to specify particular kinds of situations and attributions for participants to consider. Though the open-ended assessments used in Study 2 offer advantages for external validity, the situations that participants wrote about and the ways in which they wrote about them did not always address their attributions for rejection and acceptance as explicitly and completely as we would have liked. Rather than see one study's methods as more valid than the other, it makes sense to see them as two different sides of the same coin.

LIMITATIONS AND FUTURE DIRECTIONS

Our BP and AP groups were healthy enough to be in college, and are not representative of clinical samples. Furthermore, because we sought to compare BP to AP, we did not include participants high in features of both disorders, thereby limiting the external validity of our results. The high proportion of participants who were women, especially in our AP groups, limits our ability to generalize the results to men with these disorders. Finally, it is unclear whether our HC group was truly healthy, in that we did not rule out the presence of untreated disorders other than BP and AP. Future studies should include representative and thoroughly-assessed clinical samples.

Study 2 had further limitations, including reduced statistical power due to small sample sizes in the BP and AP groups and failure to assess depression symptoms during the diary period. In addition, because participants completed ratings of a liked

or loved significant other for another study (reported in Berenson et al., 2018) prior to answering the questions about rejection and acceptance that were the focus of Study 2, it is possible that priming of security (e.g., Mikulincer & Shaver, 2007) may have reduced the differences between the groups.

Future studies should more directly address the hostile intent and internal-stable-global dimensions of attributional style that have dominated the literature on aggressive and depressive attributions, respectively. For example, although we found no group differences in attributing rejection to negative qualities of others, it remains unknown whether group differences would have emerged if we had explicitly focused on negative qualities of others that involve hostile intent, rather than also including other kinds of flaws. Likewise, the group differences that we found for attributing rejection to negative qualities of the self may have been stronger had we specifically focused on personal flaws that are stable and global in nature.

Our results suggest that, along with the maladaptive interpretations of negative interpersonal cues emphasized in the diagnostic criteria and research literature for both BP and AP, aberrant interpretations of positive relational cues are also a source of suffering for individuals with these personality features. This highlights the importance of clinical attention to patients' difficulties benefitting from others' expressions of caring and kindness, both in daily life and within the therapeutic relationship.

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