

Interpersonal Features of Borderline Personality Disorder

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### ***Core features of BPD: Impairments in interpersonal function***

The organizing principle in our view of personality disorders is the observation that the “characteristic that seems to define them all is a pervasive persistent abnormality in maintaining social relationships” (Rutter, 1987), a serious liability in a social species. Chronic difficulties in interpersonal relationships do not exhaust, of course, the features associated with personality disorders: early onset, subjective distress, dysfunction in role performance, and the rigid behavioral styles defined in the DSM and ICD. They do, however, include aspects of chronicity, style, and role dysfunction that are apparent to both patients and others, and this transparency provides valuable leverage—both scientific and clinical—for understanding and treating personality disorders.

### ***Standards for validity of the BPD phenotype***

Any attempt at greater clarity in defining phenotypes for borderline personality disorder (BPD) must be theoretically coherent. The atheoretical approach of the DSM has stimulated research by encouraging researchers to operationalize the measurement of descriptive criteria relevant to the syndrome, but it has done little to promote our understanding of the latent variables that underlie these criteria or of the psychological mechanisms that create and maintain the disorder.

The hypothesis to be explored here is that many of the interpersonal features of BPD arise through maladaptive functioning of the attachment system (Bowlby, 1979; Cassidy & Shaver, 1999). Attachment theory is best understood as a theory of interpersonal behavior and its influence on emotion regulation, making it especially pertinent to BPD in which difficulties in emotion regulation play such a prominent role: “Attachment theory is fundamentally about emotional experiences and their regulation” (Tidwell, Reis, & Shaver, 1996, p. 729).

Several corollaries follow from the attachment hypothesis:

- The interpersonal difficulties of BPD are related to adversity early in life that has perturbed the attachment system. A minority of people who are insecurely attached develop BPD, however, so this premise is understood to be a necessary but not sufficient condition. Other diatheses must create vulnerability to attachment stress, and a leading candidate is a temperamental substrate that has been described by Thomas and Chess (1977) and others as characteristic of the “difficult child,” who has “irregularity in biological functions, negative withdrawal responses to new stimuli, non-adaptability or slow adaptability to change, and intense mood expressions which are frequently negative” (p. 23). More recently, these ideas have been expanded by Linehan (1993) in her biosocial model of BPD.
- Frustration of attachment needs creates an attributional bias toward perceived interpersonal rejection. This bias is associated with perceptions of exclusion, alienation, “not belonging,” and, in many cases, shame (when the reasons for rejection are imputed to the self). This social cognitive set leads frequently to anger when the schema of being rejected and excluded is activated.
- Many of the interpersonal behaviors of the person with BPD can be understood as frustrated (and frustrating) bids for attachment, i.e., self-defeating attempts to secure the usual provisions of attachment relationships—a secure base in general and a safe haven in times of acute distress, reflected in proximity seeking to potential attachment figures and separation distress when apart.

- In adulthood, the provisions of attachment are most commonly provided in romantic relationships; therefore, persons with BPD demonstrate the greatest difficulty in this domain of interpersonal functioning.
- Indiscriminate bids for attachment will also complicate, however, functioning in other domains (e.g., friendship and more casual social contacts) when persons with BPD attempt to gratify attachment needs in domains where they are not appropriate. Such efforts intrude increased emotional intensity and elements of “romance” into arenas where they do not belong. As a result, BPD is associated with greater domain disorganization in general and more boundary violations characterized by excessive emotional intensity.

An early conclusion from attachment research was that, within social interactions, the key is not the frequency or intensity of behaviors but rather the way they are organized (Rutter, 1987). That is, a child’s attachment to a parent could not be characterized from the frequencies of behaviors such as crying or smiling but rather from the organization of those behaviors in relation to the behaviors of the parent. Thus, any phenotype must pay attention to the patterning and “functional equivalence” of behaviors and not only their topography. These observations also mean that attention must be paid to social cognitive variables in conjunction with interpersonal behavior. Although the most transparent evidence of dysfunction is provided by interpersonal behavior, the organizing principles for such behavior are in the minds of interactants, and these principles have cognitive and affective components (cf. Mischel & Shoda, 1995).

Phenotypes should point the way toward greater understanding of etiology, maintenance, and remission (or exacerbation). This explanatory orientation has at least two implications: one, phenotypes should have developmental relevance (to help us understand etiology and onset), and two, they should be capable of generating and testing hypotheses about mechanisms and processes that maintain or exacerbate the disorder. This is a high standard, of course, and as a first step, it is probably more realistic to expect that research will establish the existence of risk factors by documenting associations between aspects of interpersonal behavior and BPD. Next steps will require longitudinal work that establishes certain risk factors as causal and that explicates the psychological mechanisms that underlie them.

Phenotypes should demonstrate excellent sensitivity and good (but not perfect) specificity. If we take a dimensional approach and use latent variable methods, the underlying latent variables that are associated with key phenotypic features are also likely to influence other near neighbors that share some of the same characteristics (e.g., other cluster B personality disorders), and therefore, specificity will not be perfect.

To establish their clinical significance, phenotypes should demonstrate convergent and predictive validity with functioning in normative social roles and with day-to-day interpersonal behavior. It is important to establish relationships not only with measures of symptoms and other features of personality but also with measures of functioning, especially those corroborated by key informants, e.g., members of the patient’s social network, clinicians.

### ***Extent to which the current phenotype meets these standards***

The ability of current phenotypes to meet these standards is limited, for reasons that are both intrinsic (lack of a theoretical framework) and extrinsic (lack of data to address longitudinal questions and issues of validity).

The current interpersonal phenotype embodied in the DSM-IV involves essentially two criteria:

- A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
- Frantic efforts to avoid real or imagined abandonment

In factor analytic studies of the BPD criteria set, other criteria have sometimes been included in an “interpersonal” or “relationship” factor, but these two are the ones that have the greatest face validity.

The Revised Diagnostic Interview for Borderlines (DIB-R; Gunderson & Zanarini, 1992) has a richer characterization of interpersonal problems that includes:

- Intolerance of aloneness
- Abandonment, engulfment, and annihilation concerns
- Counterdependency
- Unstable close relationships
- Recurrent problems in close relationships (e.g., devaluation, entitlement)
- Troubled psychiatric relationships

We have attempted in our own research to assess interpersonal functioning at multiple levels of resolution and in sufficient detail so that this work might inform issues of process and mechanism. These levels of resolution are included in Figure 1, and they range from the global (overall judgments of adult attachment style, summarizing many years of functioning) to the molecular (moment-to-moment reactions to human faces). We argue for the need for research at multiple levels of analysis, especially those that get us closer to day-to-day transactions and mechanisms that underlie interpersonal difficulties.

We have also begun to develop a catalog of interpersonal behaviors in the therapeutic setting that are associated with BPD, and examples are included in Appendix 1.

### ***Relevant existing measures***

Data on adult attachment are collected typically in two different ways, reflecting different research traditions. The first method, growing out of the developmental and clinical literature, relies on the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1985), and the second method, growing out of the social psychological literature, uses self-report questionnaires to assess aspects of adult attachment in romantic relationships and other social domains in adulthood. Two questionnaires used frequently are the Experiences in Close Relationships Scale-Revised (ECR-R; Fraley, Waller, & Brennan, 2000) and the Relationship Styles Questionnaire (RSQ; Griffin & Bartholomew, 1994). Based on a factor analysis of extant self-report measures assessing adult romantic attachment, the ECR-R yields continuous scores for two dimensions of attachment (anxiety and avoidance) and further classifies individuals into one of four attachment categories (secure, preoccupied, dismissive, or fearful). It has been revised using item response theory (IRT) models to identify items that provide the maximum amount of information about the attachment dimensions. The RSQ requires a forced-choice endorsement of one of four possible attachment styles (secure, preoccupied, dismissive, or fearful) in close relationships, a 7-point rating of similarity to each of these styles, and responses to 30 items that generate a dimensional score for the 4 styles.

Global measures of functioning in major social roles are often used to assess aspects of interpersonal behavior, and two commonly used exemplars are the Social Adjustment Scale (SAS; Weissman & Paykel, 1974) and the Longitudinal Interval Follow-Up Evaluation (LIFE;

Keller et al., 1987). The Revised Adult Personality Functioning Assessment (RAPFA; Hill, Harrington, Fudge, Rutter, & Pickles, 1989; Hill, Fudge, Harrington, Pickles, & Rutter, 2000) was developed with the more specific agenda of linking social behavior to interpersonal models of personality dysfunction. The RAPFA is an investigator-based interview that asks about functioning over substantial periods of time in up to six domains: work, romantic relationships, friendships, non-specific social interactions, negotiations, and day-to-day coping. The RAPFA was designed to assess interpersonal behaviors according to the rules and demands underlying each social domain, severity and type (e.g., discordant, avoidant) of impairment within each domain, and disorganization across domains.

The most comprehensive self-report measure of interpersonal behavior is the Inventory of Interpersonal Problems: (IIP; Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988). This questionnaire can be scored to investigate a variety of interpersonal themes. Alden, Wiggins, and Pincus (1990) developed scoring rules for 8 subscales organized around a circumplex defined by the usual dimensions of affiliation and control. Pilkonis, Kim, Proietti, and Barkham (1996) identified 5 subscales that are characteristic of patients with PDs: interpersonal sensitivity, interpersonal ambivalence, aggression, need for social approval, and lack of sociability. We have also identified a subset of 8 items (consistent across self-reports and informant ratings) that correlated most highly with dimensional scores for BPD features (see Table 1).

### ***Specific recommendations for research***

We believe that research on personality disorders can progress most effectively by an increased emphasis on identifying specific mechanisms that create and maintain impairments in interpersonal functioning. Such research will require greater specificity, both in the development of theory and the articulation of related hypotheses and in the development of approaches to measurement that are closer to the “lived experience” of day-to-day social functioning.

Many of the extant measures in the areas of attachment and general social functioning are too global for these more specific purposes. Experience sampling methods and behavioral and physiological paradigms linked to processes and mechanisms specific to BPD may offer more promise. In addition, the collection of longitudinal observational data is critical to the discovery of risk factors, moderators, and mediators that inform the natural history of this psychopathology.

In the specific area of adult attachment, we have no current operationalization of “disorganized” attachment, which may be the most pertinent category for BPD and which is prevalent in the most disadvantaged childhood samples in the developmental literature. The insecure styles that have been articulated in adulthood (e.g., preoccupied, dismissive) represent a level of coherence and organization (and a kind of developmental achievement) that may not be characteristic of the most impaired BPD patients.

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**Figure 1: Levels of Analysis of Interpersonal Functioning**

Time Frame:	<b>Attachment Style</b> Entire life span
Instruments:	Interpersonal Relations Assessment Experiences of Close Relationships
Scoring:	Attachment Q-Sort Attachment Prototype Ratings

  

Time Frame:	<b>Social Functioning</b> Last 5 years
Instrument:	RAPFA
Scoring:	RAPFA total and domain scores RAPFA dysfunction scales

  

Time Frame:	<b>Social Network Analysis</b> Last year
Instrument:	EgoNet social network
Scoring:	Network size, density, coherence, and structure

  

Time Frame:	<b>Social Interaction</b> One week (twice daily)
Instrument:	Social Interaction Diary
Scoring:	Frequency and duration of interactions Quality of interactions and mood

  

Time Frame:	<b>Social Cognition</b> Moment-to-moment
Instrument:	Facial Perception Paradigm
Scoring:	Attributes and affects in faces

**Table 1: Inventory of Interpersonal Problems (IIP) items that correlate most highly with best-estimate BPD dimensional scores across both self- and other-reports**

Item	Correlation with IIP self-report	Correlation with IIP other-report
I get irritated or annoyed too easily	.38	.33
I feel too guilty for what I have done	.37	.35
I argue with other people too much	.37	.31
I lose my temper too easily	.36	.33
I am too sensitive to criticism	.35	.35
I am too sensitive to rejection	.35	.46
I act like a child too much	.34	.40
I am affected by another person's moods too much	.34	.35

## **Appendix 1: Interpersonal characteristics of patients with borderline personality disorder in the therapeutic setting**

### Face-to-face interpersonal behavior

*Verbal and nonverbal behaviors convey intense affect. Such affect is primarily negative, but can be labile and even positive at times. Little attempt is made to suppress affect.*

Becomes highly aroused and agitated within the session.

Becomes angry, and even rageful, with the therapist.

Talks more loudly and rapidly than other patients.

*Behavior is mood (and arousal) dependent.*

Behavior varies considerably from session to session as a function of the patient's current mood state.

High in-session levels of arousal narrow the patient's cognitive capacities and behavioral repertoire, e.g., patient perseverates on certain topics and refuses to be re-directed or to develop a broader agenda for the session.

*The affect has a "willful" quality, i.e., it is expressed not to be observed, described, and understood but rather to compel the therapist to "do something" about it.*

Demands that the therapist provide immediate relief.

Says provocative or critical things about the therapist's skill and ability to help the patient.

*Infringes on conventional personal boundaries.*

Inspects the therapist's possessions and belongings more closely than other patients.

Physically approaches the therapist more closely than other patients.

Touches the therapist.

Asks personal questions of the therapist.

*Has a rapid tempo in establishing the relationship.*

Addresses the therapist in overly familiar ways early on.

### Interpersonal impact

*Stimulates feelings and urges to act that are not present with the "average" patient.*

Stimulates angry and aggressive urges in the therapist—urges to control, urges to retaliate.

*Produces feelings of confusion and helplessness in the therapist.*

Presents self in very different states of mind at different times and finds it difficult to remember alternative states.

Finds it difficult to take the perspective of the other and to try to solve interpersonal problems on this basis.

Such lability and lack of psychological "continuity" encourage negative global internal attributions on the part of the therapist, e.g., "this patient just doesn't 'get it' with other people and I'm not sure that I can help them improve." (Cf. Maltzberger and Buie [1974] and their table of negative cognitions and attributions.)