A Preliminary Report on Defenses and Conflicts Associated with Borderline Personality Disorder

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ABSTRACT

The authors present preliminary psychodynamic findings from a naturalistic study of borderline personality disorder compared to antisocial personality disorder and bipolar type II (depression with hypomania) affective disorder. An independent psychodynamic interview of each subject was videotaped from which ratings were made of the presence of 22 defense mechanisms and 11 psychodynamic conflicts.

A factor analysis of ratings from 81 subjects supported the separation of borderline (splitting, projective identification) from narcissistic defenses (devaluation, omnipotence, idealization, mood-incongruent denial). While certain groups of defenses were associated with each diagnosis, defense ratings did not significantly discriminate the three diagnostic groups, suggesting a limit to their diagnostic value.

Among 27 subjects rated, borderline personality was strongly associated with two conflicts: separation-abandonment, and a global conflict over the experience and expression of emotional needs and anger. Antisocial personality was psychodynamically distinct and more heterogeneous. Bipolar type II was associated with two hypothesized depressive conflicts: dominant other and dominant goal. Chronic depression, which was more common in both personality disorder groups than in bipolar type II, was associated with a third depressive conflict, overall gratification inhibition. Overall, conflicts were powerful discriminators of the three diagnostic groups. The heuristic value of these findings is discussed.

FOR THE PAST SEVERAL YEARS we have been conducting a study of the psychopathology and course of borderline personality disorder to determine whether this diagnosis is valid and can be discriminated from other disorders. We selected two near neighbor disorders for this comparison on which there has been systematic research. We chose antisocial personality disorder because of a possible overlap in impulse pathology, and bipolar type II affective disorder because recurrent depression and hypomania represent disturbances in affect regulation which may overlap with borderline personality disorder. To determine the discriminative validity of borderline personality disorder from these two comparison disorders, we have examined descriptive features, and the prevalence of accompanying syndromes such as depression, alcohol, and drug abuse. We are following their course for patterns of impulse problems, social role dysfunction, and response to life events (Perry 1985; Perry and Cooper 1985). In addition to this descriptive work, we are systematically examining the psychodynamics of these disorders using a framework of defense mechanisms and psychodynamic conflicts, ascertained outside of psychoanalytic or other treatment contexts. This preliminary report addresses the question of whether the borderline personality disorder is associated with psychodynamics that differentiate it from these two comparison disorders.

The psychodynamic literature has generally viewed the antisocial and borderline personality disorders as strongly related or even identical regarding their underlying psychodynamics. Kernberg (1975) stated that most cases of antisocial personality disorder have an underlying borderline personality organization. This concept is defined by the presence of intact reality testing, identity diffusion, and the use of certain primitive defenses revolving around splitting, which defend against the activation of pathological internalized object relations (Kernberg, 1981). Kernberg has suggested that the major deficit in borderline psychopathology is the inability to integrate positive and negative identifications and introjects. The reliance

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suggested that some individuals engage in antisocial behavior in order to provoke institutions, such as the correctional system, into providing the containment which they feel is woefully lacking from other sources. As Adler (1982) suggested, the containment and holding functions offered by the correctional system may provide necessary controls for individuals who have ego deficits related to impulse control.

The psychodynamic literature generally has attributed the shared features among borderline and antisocial individuals—such as erratic temper, impulsivity, unstable interpersonal relations—to an underlying psychodynamic constellation. This includes: (1) a weak ego with poor affect tolerance and affect regulation that includes an ongoing lack of neutralized energy to support tolerating delays in gratification; (2) a defensive constellation in which repression is conspicuously absent and splitting operations predominate, thus causing the individual to view the world as sets of polarities; (3) conflicts centered around the need to fend off feelings of emptiness and fears of abandonment which thereby influence how the individual relates to others.

In reviewing their series of cases, several authors have hypothesized that certain conflicts are common in affective disorders. Cohen et al. (1954) examined 12 cases of bipolar manic depression and ascribed to them problems with conformity to an authoritarian ideal of being special or outstanding, while lacking the ambition and autonomy to meet such expectations. The manic state is presumed to serve a compensatory role for loss of self-esteem attendant to failing to perform up to expectations. Arieti and Bemporad (1980) described three different conflicts that underlie depressive disorders: the dominant other, dominant goal, and overall gratification inhibition conflicts. These are described more fully below.

This study begins with the assumption that the literature on the psychodynamics of the three disorders in question offers a rich collection of clinically meaningful hypotheses. This study examines some of these within the context of systematic validation (Reichenbach, 1938), outside of the context of psychoanalytic or other treatments. We test the following hypotheses.

1. The borderline level defenses as defined by Kernberg represent two dimensions of defensive functioning that can respectively be described as borderline and narcissistic.
2. Borderline defenses are closely associated with borderline psychopathology, while narcissistic defenses are better associated with antisocial psychopathology. Neither set of defenses is highly associated with bipolar type II disorder.
3. Four conflicts associated with borderline psychopathology: separation-abandonment; global conflict over experiencing and expressing emotional needs and anger; object hunger; fear of fusion. Two conflicts are associated with antisocial psychopathology: rejection of others; resentment over being thwarted by others. Three conflicts are associated with the bipolar II diagnosis: dominant other; dominant goal; overall gratification inhibition.

4. Our final hypothesis is that chronic depression will be associated with one conflict: overall gratification inhibition.

**Methods**

**Sample Selection**

We initially recruited 91 subjects from ambulatory mental health settings (49%), a series of advertisements for symptomatic volunteers for each diagnostic group (45%), and from the Probation Department of the local District Court (7%). We then administered initial semistructured diagnostic interviews lasting over two hours each to diagnose all three disorders and to fill out diagnostic scales.

**Subject Diagnoses**

Definite borderline personality disorder was diagnosed if the subject met the DSM-III requirement of five or more criteria and also had a score above a preselected cutoff (150) on an earlier version of the Borderline Personality Disorder (BPD) Scale (Perry and Cooper 1985). Borderline traits were diagnosed if the subject met at least four of the DSM-III criteria and met a lower cutoff score (130) on the early version of the BPD Scale, but did not fulfill the criteria for definite BPD.

Because earlier examination of the diagnostic literature on borderline disorders revealed a heterogeneous group of descriptions (Perry and Klerman, 1978), it is important to be explicit regarding the descriptive characteristics of this diagnosis as used in this study and the scale by which we measure borderline psychopathology. Table 1 compares the nine subscales of the BPD Scale, used in subsequent analyses, with the DSM-III criteria. While there is a significant overlap in features, there are several differences. First, unlike DSM-III, the BPD Scale quantifies how much of a given characteristic an individual has. Second, the BPD Scale includes aspects of BPD which are not found in DSM-III: subscale 3, a history of regressing in psychiatric treatment; subscales 6 and 7 (partly), the instability of how the individual perceives others and himself, commonly described as splitting dynamics and identity diffusion, and subscale 9, the tendency to regress during crises. While the BPD Scale and the DSM-III criteria have a high level of agreement, as shown by a kappa coefficient of .70 in this sample, the individuals who have definite BPD by the BPD Scale cutoff score are fewer and more disturbed than those who only meet DSM-III criteria.
TABLE 1

OVERLAP BETWEEN THE BPD SUBSCALES AND THE DSM-III CRITERIA FOR BORDERLINE PERSONALITY DISORDER

<table>
<thead>
<tr>
<th>BPD Subscale</th>
<th>DSM-III Criterion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Anxiety Intolerance</td>
<td>5. Affective Instability</td>
</tr>
<tr>
<td>2. Self-destructive Impulses</td>
<td>1. Impulsivity</td>
</tr>
<tr>
<td>3. Regression in Treatment</td>
<td>2. Unstable, Intense Relationships</td>
</tr>
<tr>
<td>4. Dependent Relationships</td>
<td>3. Inappropriate Anger</td>
</tr>
<tr>
<td>6. Unstable Perception of Others</td>
<td>4. Identity Disturbance</td>
</tr>
<tr>
<td>7. Disturbances in Identity and Self-perception</td>
<td>8. Chronic Feelings of Emptiness or Boredom</td>
</tr>
<tr>
<td>8. Chronic Feelings of Emptiness</td>
<td>9. Regression in Crises</td>
</tr>
</tbody>
</table>

The other diagnoses were made as follows. Antisocial personality disorder was diagnosed according to DSM-III criteria requiring the onset of conduct disorder before age 15, and a pattern of antisocial behavior after age 18 that includes significant antisocial behavior in the last five years. Bipolar type II was diagnosed according to the Research Diagnostic Criteria (Spitzer et al., 1978), requiring a history of major, minor, or intermittent depressive disorder and hypomania (i.e., periods of euphoric, expansive, or irritable moods lasting seven days or longer with two or more accompanying symptoms), but no history of a manic episode (i.e., without severe impairment or hospitalization).

Psychodynamic and Descriptive Measures

After admission to the study, subjects received two other interviews relevant to this report. The first was the Diagnostic Interview Schedule which yields information relevant to the subject's history of various DSM-III major psychiatric disorders (Robins et al., 1981). Next, an experienced clinician blind to diagnosis conducted a psychodynamically oriented interview of the subject which was videotaped. This served as the raw data from which ratings on defenses and conflicts were made. Both rating procedures are described below.

Defense Mechanisms

We selected 22 defense mechanisms representing immature, borderline, and neurotic categories. We defined each defense and constructed a respective scale to reflect whether a defense is absent, probably, or definitely present (Perry and Cooper, in press). Each scale point is anchored with examples. The scales tap the use of defenses in the interview, as well as historical report of their use limited to the past two years. While the scales do not provide an exhaustive catalogue of defensive functioning, they do codify evidence rules for clinical judgment and offer clear examples. Three trained research assistants with some clinical background observed each videotape and made individual ratings followed by a group consensus rating for each defense. This procedure yielded a median reliability of .57 for the consensus ratings used in subsequent data analyses. For most of the analyses, however, we combined related defenses into summary scales which had a median intraclass reliability of .74. Defense ratings were available on 73 study subjects and an additional 8 neurotic subjects. The neurotic subjects were added specifically to increase the stability of the factor analysis of the borderline level defenses. Their inclusion would in no way bias the results.

Psychodynamic Conflicts

Using the same videotaped interview, raters assessed conflicts on a separate occasion in a two-stage process. In the first stage, several experienced dynamically trained clinicians observed the videotaped interview. They described the subject's intrapersonal (i.e., idiographic) conflicts in a specified format. This format begins with the subject's psychodynamically relevant wishes and countervailing fears. They listed evidence from the interview that supported each wish or fear. This requirement served to check the clinicians' more speculative tendencies, while justifying those clinical inferences that were offered. Theoretical terms were not used because these would render ratings in the second stage harder to make. Next, the clinicians described the resultant of the subject's conflicts in terms of symptomatic outcomes such as depression, suicide attempts, rage outbursts, and so forth. The resultant was also described in terms of avoidant outcomes, that is, how a subject minimizes or avoids experiencing the conflicts and concomitant affects and symptoms. Finally, the clinician raters described both the specific stressors that activated the subject's conflicts and the subject's best available level of adaptation to his conflicts. In the present sample of 32 idiographic conflict summaries, one of the clinicians was not fully blind to diagnosis in the majority of cases, although subject diagnosis was never discussed throughout the procedure.

These idiographic conflict summaries were then rated in the second stage by two or three clinician raters on the Psychodynamic Conflict Rating Scales we devised (Perry and Cooper, unpublished). These 11 scales reflect patterns of cognition, fantasy, affect, behavior,
and object relations that characterize certain conflicts. Two or three raters—variously Drs. Cooper, Holzman, and Perry—read each idiographic conflict summary and rated whether each of the 11 conflicts was absent, probably present, definitely present, or present and central to the individual's psychodynamics. Two of the three raters were blind to diagnosis, which was not discussed. The median intraclass reliability coefficient for the individual raters was .53. A consensus rating was then made for each conflict (which should yield a more reliable rating) and was used in all analyses. Ratings were available on 32 subjects, of whom 27 were in one of the three exclusive diagnostic groups.

We selected 11 focal conflicts for their potential relevance to the psychodynamics of borderline, antisocial, and affective disorders. We have characterized these as conflicts because each contains elements of competing wishes and fears. However, some of the conflicts could also be described as attitudes about oneself or others, or deficits in interpersonal relations and self-regulation. We do not construe these as exclusive, nor do we construe this study as a test of a conflict versus deficit model of borderline psychopathology. Abbreviated descriptions of the conflicts follow.

Three conflicts were based on descriptions given by Arieti and Bemporad (1980).

1. The individual with a "dominant other" conflict requires a nurturing and supportive relationship with a particular dominant individual in his life. He is overly sensitive to criticism and rejection from this individual since he depends on the person as a source of self-esteem.

2. The "dominant goal" conflict is found in individuals who derive their self-esteem largely from areas of achievement with overriding goals. These individuals shun other forms of satisfaction in pursuit of such goals and are particularly vulnerable to setbacks in the goal areas of life.

3. The "overall gratification inhibition" conflict is found in individuals who believe it wrong to derive satisfaction from their life and are inhibited from seeking out gratification by pursuit of goals, relationships, and everyday involvements. They often feel powerless and dyshoric and see life as empty and futile.

We hypothesized that the next four conflicts would be most relevant to borderline psychopathology.

4. Individuals with "separation-abandonment" conflict become strongly attached and painfully prone to separation and abandonment feelings. Significant others are experienced as a necessary part of the subject's emotional life. This results in extreme anxiety, bargaining, manipulation, and helplessness when rejection is threatened or occurs.

5. The "global conflict over experiencing and expressing emotional needs and anger" characterizes individuals who are usually inhibited from clearly experiencing their own needs and anger. They generally feel that both of these are unacceptable vis-à-vis significant others. A pervasive sense of self-loathing, anxiety, and dysphoria commonly arises whenever they become aware of their own needs or anger. In addition, they are generally blocked in expressing themselves except when desperate, in which case they may act in either very entitled or self-destructive ways.

6. Individuals with "object hunger" experience an emotional void in their lives and believe that their stability is endangered without attachment to some person most of the time. However, this need is not specific to one individual and they fear that one object will never suffice. The result is that they are often indiscriminate, so that many attachments are short-lived. The capacity to be alone is very diminished.

7. 'Fear of fusion' is a conflict in which the individual sees his wishes for contact with significant others as potentially engulfing and overwhelming. While these individuals desire close relationships, they are overly sensitive to real or imagined threats of others' intrusiveness and frequently misinterpret others' interest as an attempt to control them. As a result interpersonal closeness is often accompanied by protestation and anxiety over the threat of loss of differentiation between the individual and others.

We hypothesized that two of the final four conflicts (9 and 10) would be common in antisocial personality disorder.

8. "Countedependent" conflict characterizes individuals who feel the need to maintain autonomy by disavowing their own dependency needs. Their vulnerabilities lie chiefly in fears of loss of control and autonomy at times when dependency or affection feelings and wishes arise toward others.

9. "Rejection of others" is a conflict experienced by individuals with an underlying negative view of themselves who are unable to regulate their mood or have lasting good feelings about themselves, both of which they desire. As a result they seek a sense of being valuable from others' praise, or they may idealize selected others as if their positive attributes will somehow rub off. Conversely, they may devalue themselves and others when their negative self-view nears awareness.

10. "Resentment over being thwarted by others" is a conflict in which individuals believe that others have no right to impose limits, controls, or sanctions on them; rather, they believe they should be able to do whatever they want whenever they want. The subjects may not be aware of their resentment and covert expression of it. Resentment may show itself in either or both active-aggressive or indirect and passive-aggressive ways.
11. The final conflict in this group is “ingratiation-disappointment.” Individuals experiencing this conflict feel they are less worthy than others but desire recognition and acceptance for being worthy. As a result, they try to please those around them. They seek approval by making excessive promises, but frequently feel angry and resentful when their promises cost them more than they get back in return. They frequently end up disappointing others and themselves as well when failures bring disapproval rather than the approval to which they feel entitled.

Statistical Analyses

All reliability coefficients were calculated using the intraclass correlation coefficient for multiple raters (Shrout and Fleiss, 1979). Factor analysis of the borderline level defenses was carried out using a principal components factor analysis with a varimax rotation (SAS, 1979). Spearman rank order correlation coefficients (rs) were used for all correlations between ordered variables. This statistic minimizes the distorting effects of subjects with extreme scores on the variables which might otherwise inflate the apparent degree of association. The canonical discriminant function analysis (SAS, 1979) was used to determine whether the summary defense scales or the conflict scales could discriminate the three major diagnostic groups at a significant level.

Results

Defense Mechanisms

The first question was whether the defenses attributed to borderline personality organization (Kernberg, 1975) covary as one or two dimensions. We hypothesized that three defenses, splitting of self-images, splitting of others’ images, and projective identification would correlate highly reflecting a borderline dimension, while three other defenses, omnipotence, primitive idealization, and devaluation, would intercorrelate representing a dimension having to do with the narcissistic regulation of self-esteem.

Table 2 shows the results of a factor analysis of the eight defenses described by Kernberg as characteristic of a borderline level of personality organization. Two factors emerged as predicted. The borderline factor including the first three defenses accounted for 28% of the variance. The second, narcissistic, factor, including mood-incongruent, or manic denial which we did not predict, accounted for almost 18% of the variance. This confirmed our hypothesis that these eight defenses do not represent a single underlying dimension but rather two.

We examined the intercorrelation of all the defenses (correlation matrix not shown), with a special interest in the relation between repression and splitting. Repression correlates nonsignificantly with splitting of self-images (-.08, n = 81) and splitting of others’ images (-.05, n = 81).

Table 3 displays the correlations between the defense mechanism summary scales and the borderline and antisocial diagnostic variables. Correlations were calculated for both categorical and continuous diagnostic variables.

TABLE 2

FACTOR STRUCTURE OF EIGHT BORDERLINE-LEVEL DEFENSES (N = 81)

<table>
<thead>
<tr>
<th>Defense</th>
<th>Factor I Loadings</th>
<th>Factor II Loadings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Splitting of Self-images</td>
<td>.82</td>
<td>.22</td>
</tr>
<tr>
<td>Splitting of Others’ Images</td>
<td>.82</td>
<td>.11</td>
</tr>
<tr>
<td>Projective Identification</td>
<td>.63</td>
<td>-.12</td>
</tr>
<tr>
<td>Bland Denial</td>
<td>.19</td>
<td>.18</td>
</tr>
<tr>
<td>Mood-incongruent Denial (Manic or Depressive Denial)</td>
<td>-.05</td>
<td>.59</td>
</tr>
<tr>
<td>Omnipotence</td>
<td>-.06</td>
<td>.82</td>
</tr>
<tr>
<td>Primitive Idealization</td>
<td>.31</td>
<td>.51</td>
</tr>
<tr>
<td>Devaluation</td>
<td>.16</td>
<td>.60</td>
</tr>
<tr>
<td>% Total Variance Explained</td>
<td>28.1%</td>
<td>17.7%</td>
</tr>
</tbody>
</table>

1. The disavowal defenses—including denial, projection, bland denial, and rationalization—show a low positive correlation with the number of antisocial symptoms (rs = .22, p < .10), but a negligible correlation with the BPD Scale or diagnosis.
2. Action defenses—including acting out, passive aggression, and hypochondriasis—show a small significant correlation (p < .05) with both the BPD Scale (rs = .26) and diagnosis (rs = .23). These did not correlate with antisocial symptoms or diagnosis.
3. The borderline summary defense scale correlates moderately (rs = .36, p < .01) with the BPD Scale and somewhat less with the BPD diagnosis (rs = .19, p < .10). There is a slight nonsignificant negative correlation with antisociality.
4. The narcissistic defenses as a group do not correlate significantly with borderline psychopathology, whereas they do correlate with both antisocial symptoms (rs = .23, p < .05) and the antisocial diagnosis (rs = .22, p < .10).

5. Obsessive defenses correlate with neither borderline nor antisocial variables. There is a moderate correlation with the bipolar II diagnosis (rs = .37, p < .001; data not shown in table).

**TABLE 3**

**CORRELATIONS BETWEEN DEFENSE MECHANISM SUMMARY SCALES AND THE BORDERLINE AND ANTISOCIAL DIAGNOSTIC VARIABLES (N = 73)**

<table>
<thead>
<tr>
<th>Defense Summary Scale</th>
<th>BPD Scale</th>
<th>BPD Diagnosis</th>
<th>ASP Score</th>
<th>ASP Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disavowal neurotic denial, projection, bland denial, rationalization</td>
<td>-.06</td>
<td>-.07</td>
<td>.22</td>
<td>.17</td>
</tr>
<tr>
<td>Action acting out, hypochondriasis, passive aggression</td>
<td>.26</td>
<td>*</td>
<td>.23</td>
<td>.05</td>
</tr>
<tr>
<td>Borderline splitting of self-images, splitting of others' images, projective identification</td>
<td>.36</td>
<td>**</td>
<td>.19</td>
<td>.09</td>
</tr>
<tr>
<td>Narcissistic omnipotence, idealization, devaluation</td>
<td>-.10</td>
<td>-.06</td>
<td>.23</td>
<td>.22</td>
</tr>
<tr>
<td>Obsessional undoing, isolation, intellectualization</td>
<td>-.14</td>
<td>-.03</td>
<td>-.02</td>
<td>.03</td>
</tr>
</tbody>
</table>

† p < .10;
* p < .05;
** p < .01

BPD Scale = Borderline Personality Disorder Scale; BPD Diagnosis = borderline diagnosis rank ordered as follows: definite borderline, borderline traits only, not borderline; ASP Score = the sum of all the subject's positive antisocial symptoms listed in DSM-III; ASP Diagnosis = ASP versus not ASP.

**Discriminant Function Analysis of Defenses**

Taking all of the defense data together, we performed a canonical discriminant function analysis to determine whether the five summary defense variables could discriminate the three diagnostic groups. Only nonsignificant trends emerged. This suggests that the association between personality pathology and defenses, as measured by a single interview, is limited among these closely related disorders, making it difficult to discriminate them clearly.

**Conflicts**

**Table 4** displays the percentage of each diagnostic group rated so far that definitely has each of the 11 conflicts. Among the 10 subjects with borderline personality disorder, the following five conflicts are common: the global conflict over the experience and expression of emotional needs and anger (100%), separation-abandonment (80%), overall gratification inhibition (70%), object hunger (60%), and fear of fusion (40%).

Among the eight subjects with antisocial personality disorder, three conflicts that are also found in borderline patients are prevalent: overall gratification inhibition (75%), the global conflict over the experience and expression of emotional needs and anger (63%), and fear of fusion (38%). However, unlike the borderline group, separation-abandonment and object hunger are absent, while three other conflicts are moderately common: resentment over being thwarted by others (50%), counterdependent (38%), and dominant other (38%) conflicts.

**TABLE 4**

**PERCENTAGE OF EACH DIAGNOSTIC GROUP WITH DEFINITE CONFLICT RATING OF 2 OR 3 (NUMBER IN EACH DIAGNOSTIC GROUP)**

<table>
<thead>
<tr>
<th>Borderline (10)</th>
<th>Antisocial (8)Bipolar II (9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Dominant Other</td>
<td>20%</td>
</tr>
<tr>
<td>2. Dominant Goal</td>
<td>0</td>
</tr>
</tbody>
</table>
Two of the three conflicts Arieti and Bemporad described as underlying the psychological organization of depression are most common in the bipolar type II group: dominant other (56%) and dominant goal (22%) conflicts. The third hypothesized depressive conflict, overall gratification inhibition, is present (33%) but is less common than in either personality disorder group.

A number of conflicts are definitely present in more than one diagnostic group. In order to determine the magnitude and specificity of the relation between each conflict and each diagnostic group, we examined their intercorrelations. Table 5 presents the correlations between the psychodynamic conflict ratings and the continuous borderline and antisocial diagnostic variables on the 27 subjects who were members of the three exclusive diagnostic groups. Bipolar type II is not included as a variable in this analysis because it is discrete, not continuous. In order of magnitude, three conflicts are highly correlated with the BPD Scale and diagnosis: separation-abandonment, the global conflict over the experience and expression of emotional needs of anger, and object hunger. Of these, separation-abandonment is also significantly negatively correlated with the antisocial variables, indicating that it possesses a highly specific association with borderline psychopathology in this sample. Fear of fusion demonstrates only a nonsignificant correlation with borderline psychopathology, thus failing to support our hypothesis. Finally, dominant goal conflict is negatively correlated with borderline psychopathology.

The antisocial variables have modest correlations with two conflicts: resentment over being thwarted by others, and rejection of others. The antisocial variables correlate negatively with both the separation-abandonment and dominant other conflicts.

**TABLE 5**

<table>
<thead>
<tr>
<th>Conflict</th>
<th>BPD Scale</th>
<th>BPD DiagnosisASP Score</th>
<th>ASP Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dominant Other</td>
<td>-.22</td>
<td>-.20</td>
<td>-.34</td>
</tr>
<tr>
<td>Dominant Goal</td>
<td>-.32</td>
<td>-.34</td>
<td>-.12</td>
</tr>
<tr>
<td>Overall Gratification Inhibition</td>
<td>.21</td>
<td>.19</td>
<td>.20</td>
</tr>
<tr>
<td>Separation-Abandonment</td>
<td>.70</td>
<td>.80</td>
<td>-.33</td>
</tr>
<tr>
<td>Global Exper. &amp; Express. Emotional Needs &amp; Anger</td>
<td>.61</td>
<td>.51</td>
<td>-.17</td>
</tr>
<tr>
<td>Object Hunger</td>
<td>.49</td>
<td>.59</td>
<td>-.13</td>
</tr>
<tr>
<td>Counterdependent</td>
<td>-.05</td>
<td>-.13</td>
<td>.02</td>
</tr>
<tr>
<td>Fear of Fusion</td>
<td>.27</td>
<td>.25</td>
<td>-.17</td>
</tr>
<tr>
<td>Rejection of Others</td>
<td>-.01</td>
<td>-.11</td>
<td>.41</td>
</tr>
<tr>
<td>Resentment over Being Thwarted by Others</td>
<td>.05</td>
<td>.10</td>
<td>.58</td>
</tr>
<tr>
<td>Ingratiation-disappointment</td>
<td>-.04</td>
<td>-.13</td>
<td>-.33</td>
</tr>
</tbody>
</table>

rs > .29, p < .10; rs > .34, p < .05; rs > .45, p < .01; rs > .54, p < .001.

Overall gratification inhibition conflict does not correlate significantly with either borderline or antisocial diagnostic variables, despite its prevalence in both diagnostic groups. This indicates that it is not specific to either diagnosis.

**Discriminant Function Analysis of Conflicts**

Next, we performed a canonical discriminant function analysis in order to determine whether conflicts could discriminate the three major diagnostic groups. Five conflicts (2, 4, 6, 7, 10) were selected by *a priori* judgment. Discrimination of all three diagnostic groups from one another was highly significant using two canonical functions. The first canonical equation heavily reflects subjects' scores on separation-abandonment and dominant goal conflicts, with ASP subjects scoring the lowest and BPD subjects scoring the highest. The second canonical
equation largely reflects resentment over being thwarted by others, counterdependent, and object hunger conflicts, with ASP and BPD subjects scoring highest and bipolar II subjects scoring lowest. Visual inspection of the plot of subjects in Figure 1 indicates that only four subjects appear to be misclassified: two antisocial subjects appear more closely aligned with the bipolar type II subjects, and two bipolar II subjects appear more aligned with the borderline group.

**Chronic Depression**

The final hypothesis addresses whether there is a relationship between chronic depression and the overall gratification inhibition conflict. Table 6 displays only the significant correlations between chronic depression and the diagnostic, defense, and conflict variables. Chronic depression was defined as present when subjects were scored on the Diagnostic Interview Schedule as being depressed most of the time for the previous two-year period.

Chronic depression is modestly associated with the BPD Scale and diagnosis. It is also associated with the individual defenses of devaluation, passive aggression, and hypochondriasis, and with the action defenses summary scale. Overall gratification inhibition conflict demonstrates the largest correlation with chronic depression ($r_s = .52, p < .001$), while three other conflicts demonstrate lower correlations: fear of fusion, object hunger, and ingratiating-disappointment (negative relationship). None of these three conflicts correlates significantly with overall gratification inhibition conflict, indicating that the latter conflict has a unique and powerful relation to chronic depression.

**Case Example: Borderline Personality Disorder**

**Psychiatric History**

Ms. A. is a twenty-seven-year-old single woman who was in outpatient psychotherapy at entry into the study. She was the youngest of three children from an intact family. She described an early childhood and adolescence replete with feelings of isolation from both parents and her considerably older siblings. She described her father as a very stern, quiet man who showed almost no affection toward any of the children. She recalled that he never touched or hugged her, and she felt that he did not really care about her. She saw her father as a punitive individual whose primary concern was to discipline the children, such as using a strap to punish her. Ms. A. described her mother as histrionic, intrusive, and emotionally volatile, often screaming arbitrarily about seemingly unimportant events. Ms. A. was very nervous around her mother, because her mother was only precariously in control of her emotions, at best.
TABLE 6
DIAGNOSTIC AND PSYCHODYNAMIC VARIABLES ASSOCIATED WITH CHRONIC DEPRESSION

<table>
<thead>
<tr>
<th>Diagnostic (N = 82)</th>
<th>Spearman r</th>
</tr>
</thead>
<tbody>
<tr>
<td>BPD Scale</td>
<td>.29 **</td>
</tr>
<tr>
<td>BPD Diagnosis</td>
<td>.37 ***</td>
</tr>
<tr>
<td>Defenses (N = 72)</td>
<td>.30 **</td>
</tr>
<tr>
<td>Hypochondriasis</td>
<td>.47 ***</td>
</tr>
<tr>
<td>Passive aggression</td>
<td>.40 ***</td>
</tr>
<tr>
<td>Devaluation</td>
<td>.34 ***</td>
</tr>
<tr>
<td>Action Defense Summary Scale</td>
<td></td>
</tr>
<tr>
<td>Conflicts (N = 32)</td>
<td>.52 ***</td>
</tr>
<tr>
<td>Overall Gratification Inhibition</td>
<td>.31 †</td>
</tr>
<tr>
<td>Object-Hunger</td>
<td>.37 *</td>
</tr>
<tr>
<td>Fear of Fusion</td>
<td>-.32 †</td>
</tr>
</tbody>
</table>

Ingratiation-Disappointment

† p < .10;
* p < .05;
** p < .01;
*** p < .001.

Before the age of fifteen, Ms. A. was generally very compliant at both home and school, with no history of conduct disorder. Following high school, she lived at home until twenty-two, when she left abruptly. She lived briefly with two men who provided her a place to stay. At twenty-three she worked as a prostitute for a three-month period, and since has worked at a series of other jobs without any career development, apart from attending college part-time.

Ms. A. reported attaching herself very easily and steadfastly to others, stating "I'll attach myself to somebody out of necessity and I'll pick someone who won't leave me alone." Her relationships had a superficial quality, and she conveyed no sense of the particular characteristics or identities of her significant others. She would often spend the night with friends and sleep in the same room or bed just to avoid being alone. Ms. A. would feel frantic, depersonalized, and sometimes terrified of becoming crazy when alone. She reported several "as-if" experiences when younger, in which she adopted the identities of her significant others. Her sense of identity diffusion was profound. "When I look in the mirror," she said, "I often wonder, will I still see the same person; sometimes I seem to change completely, and I might look like I did when I was a teenager."

Ms. A. recalled approximately 25 episodes of depression lasting two weeks or longer beginning about age sixteen. She also described distinct periods of elevated mood with hypomanic symptoms, which usually terminated in depression, often of suicidal proportions. She has no sense of control over her mood changes. Her limited psychotic episodes of several hours each usually occurred when she was alone and had no overlap with affective disorder episodes. Her self-destructive acts and three suicide attempts were most often precipitated by painful feelings of aloneness. Once she tried to cut off her breasts; another time she tried to cut off her fingers claiming, "I didn't deserve them." Diagnostically, Ms. A. met all eight DSM-III criteria for borderline personality disorder, and her BPD Scale score was within the upper half of those cases with definite borderline personality disorder. She also had bipolar type II affective disorder. An abbreviated idiographic conflict summary follows.

Wish

The raters who viewed the videotaped interview emphasized that Ms. A. had a central conflict revolving around the wish to have a caretaking other complete her sense of self without incurring a dreaded fusion with that person. This is a predominant wish to be cared for and nurtured by a need-satisfying person who is totally trustworthy. This wish leads her to attach herself to others while oblivious to their actual characteristics. For instance, she stated, "I am dependent on people like a drug." Paradoxically, the dynamic interview included no direct reference to her mother—a striking absence. Ms. A. assigns control for her life to other people and thereby maintains fantasies of fulfilling her yearnings through passivity and powerlessness.

Fear
Ms. A. chronically fears being abandoned and losing fragments of herself if she invests emotionally in others. She seeks to fend off and modulate these fears through her almost parasitic attachment to others. The casual manner in which she referred to events of major importance, such as her suicide attempts, suggests that she is also frightened of her own rage. A primary way in which she handles this rage is by projecting it onto others whom she eventually views as “devouring” or using her.

Symptomatic Outcome

As a result of her conflicts, Ms. A. often experiences confusion and impulsiveness when alone, and zestlessness and passivity when around others. In response to separation experiences, she has been extraordinarily self-destructive, e.g., making suicide attempts after breaking off a relationship or prior to moving, or becoming a prostitute upon leaving her family of origin. Repeated depersonalization suggests that she finds awareness of her feelings, and her investments and considerable disappointment in others, to be dangerous.

Avoidant Outcome

Ms. A. minimizes her dread of abandonment and feelings of loneliness by keeping her need for involvement with others generalized and nonspecific, and focusing on passive nurturance. This passive position is maintained by viewing herself as a little girl. This became symptomatic when she sought to cut off her breasts, which she equated with womanhood, and her fingers, which could make her productive and creative. She also uses her mistrust of real people (i.e., those who do not satisfy her needs) as a mechanism to protect her fantasy pursuit of idealized nurturing others. Finally, detachment from painful feelings, such as her suicide attempts or her disappointment with her father, provides her with a way to avoid involvement with others who have needs of their own and who might separate from her.

Specific Stressors

Ms. A. is most vulnerable to the loss of people or situations that add structure to her life. Situations that demand adult independent action are also stressful.

Best level of adaptation. Her best level of functioning probably occurred as a child when she was able to gratify some of her needs for structure and a modicum of safety from those around her by acting in a compliant manner and maintaining the position of the little girl in the household. Her attempts to cope as an adult have not been as successful.

Psychodynamic Conflict Rating Scale scores. On the PCRS, Ms. A. had two central conflicts: separation-abandonment, and object hunger. Two other conflicts were rated definitely present: the global conflict over the experience and expression of emotional needs and anger, and fear of fusion. The raters also noted that five other conflicts were probably but not definitely present: dominant other, overall gratification inhibition, counterdependent, rejection of others, and resentment over being thwarted by others. Overall, more conflicts were scored positive for Ms. A. than for most subjects with personality disorders.

Discussion

Our findings strongly suggest that psychodynamic data, including characteristic defense mechanisms and conflicts, provide a rich basis for differentiating three disorders which otherwise share aspects of impulse and affect pathology. We found distinct clusters of defense mechanisms and conflicts associated with the borderline and antisocial personality disorders, and with both bipolar II and chronic depression.

The findings on defense mechanisms make several things clear. First, the separation of borderline from narcissistic defenses is supported both by factor analysis and by the differential correlations with clinical borderline and antisocial diagnostic variables. These findings pose a challenge to Kernberg’s (1975) proposal that the above narcissistic and borderline defenses occur together, thus comprising a common structural aspect to borderline personality organization. Our findings suggest that some antisocial individuals do not use the defenses of splitting and projective identification, and conversely, some borderline patients do not use omnipotence, devaluation, and primitive idealization. This is further supported by the finding that borderline and antisocial individuals have different patterns of using the immature defenses: borderline subjects use more action defenses, while antisocial subjects use more disavowal defenses.

There are two caveats to consider with the above findings. First, antisocial personality was defined by a history of the antisocial behaviors that comprise the DSM-III criteria. This recent diagnostic concept is not necessarily the same as the psychopathic, sociopathic, or antisocial personality disorder concepts that antedated DSM-III (Hare, 1985). It is therefore possible that some clinicians may have in mind a subset of antisocial personality disorder, in which there are coexisting borderline traits. A second caveat is that it is possible that with repeated measurement of defenses—such as in ongoing psychotherapy—borderline and antisocial subjects might demonstrate more similar defensive functioning than in an initial interview. On the other hand, repeated measurement often has the opposite effect. Differences in defensive functioning could become more distinct over time.
An interesting finding is that the defenses of repression and splitting of self- or others' images do not correlate with one another. The independence of splitting and repression challenges the notion that these two defenses occur as two ends of a developmental continuum in which the individual progresses from one to the other. This data supports the idea, noted by Robbins (1976), that repression and splitting may occur together in some individuals.

We found that obsessional defenses correlated with the bipolar type II diagnostic variables and not with variables reflecting either personality disorder. This strongly matches our clinical observation that the bipolar type II group is generally healthier than either impulsive spectrum personality disorder.

It is important to stress the limits of our overall findings on defense mechanisms. The canonical discriminant function analysis failed to demonstrate significant discrimination of the three diagnostic groups based on the five summary defense scales. However, we believe that this differentiation can be increased. First, improved reliability of defense ratings should be attainable by using the same rating procedures with trained clinicians rather than less experienced raters. Lower reliability tends to wash out potential findings. Second, supplementing the present ratings with serial measures, such as ratings of subjects' life vignettes for defensive functioning, should also increase the discrimination of the diagnostic groups. This procedure has been used by Vaillant (1976) to great effect. Third, comparing these findings with those obtained by a Rorschach method of measuring defense mechanisms should further validate the differences between diagnostic groups regarding defensive functioning (Cooper, Perry, and Annow, in press).

In our examination of conflicts we found many more differences among the three diagnostic groups than would occur by chance. Apart from determining whether conflicts can discriminate the disorders, it is important to reflect on what our findings tell us about the psychopathology of each disorder. Both the prevalence and the specificity of the association between each conflict and each disorder are important.

Separation-abandonment is the conflict with the strongest and most specific association with borderline personality disorder. Some descriptive features of BPD clearly relate to this conflict: anxiety intolerance, overly dependent relationships, feelings of emptiness, and the tendency to regress in psychiatric treatment. We have reported elsewhere (Perry and Cooper, 1985) that borderline psychopathology correlates with low venturesomeness and with high neuroticism, dependence, and emotional reliance on others. Prospectively, levels of depressive and anxiety symptoms are high, although manic symptoms are not (Perry, 1985). These symptoms are consistent with a chronic disturbance in separation and loss mechanisms, perhaps interacting with unstable relationships rather than a bipolar diathesis. One result of this conflict is that borderline patients often transfer their dependence onto psychiatric health care facilities that include more total holding environments than psychotherapy alone provides (Perry and Cooper, 1985).

The central importance of conflict over separation-abandonment is consistent with certain psychoanalytic hypotheses about the etiology of borderline psychopathology. For instance, Adler and Buie ascribe a formative role to early abandonment experiences that are accompanied by a painful sense of aloneness and reactive rage (Adler and Buie, 1979); (Buie and Adler, 1982). Because these patients fail to develop the capacity for evocative memories, they are unable to mitigate the pain of various separation experiences and soothe themselves.

A second conflict, the global conflict over the experience and expression of emotional needs and anger, is highly prevalent in borderline individuals, although less specific to borderline psychopathology. It is likely that borderline subjects are more prone to develop this conflict because of the presence of separation-abandonment conflict. Descriptive aspects of borderline psychopathology that relate to this conflict are: anger and hostility in close relationships, self-destructive dyscontrol of impulses, regression during treatment and during crises, and unstable perceptions of self and others. The action defenses—hypochondriasis, passive aggression, and acting out—help manage this conflict by avoiding awareness of emotional needs and anger while expressing some of these in ways that maintain attachments by entangling others. Splitting defenses also avoid awareness of contradictory feelings that, at least in fantasy, would result in punishment or rejection if expressed. This conflict and these defenses suggest that borderline individuals frequently have strong underlying affective reactions involving both longings and aggressive feelings that are often not evident on the surface.

Other conflicts were common in borderline personality disorder, but not as specific to it. They may be more ubiquitous among personality disorders in general. Object hunger may reflect a history of relative emotional neglect with a subsequent fear that attachment to affective reactions involving both longings and aggressive feelings that are often not evident on the surface.

Antisocial personality disorder demonstrates more heterogeneity in relation to conflicts than does borderline personality. This may result from the diagnostic criteria which are based only on observable antisocial behaviors, excluding underlying personality traits or dynamics.

Two conflicts moderately common in antisocial personality disorder also correlate with the degree of antisocial symptoms. Resentment over being thwarted by others has the most specific relation to antisociality. Related to this are the disavowal defenses that...
project, deny, and rationalize impulses and actions. The second conflict, rejection of others, relates to a problem in regulating self-esteem. Narcissistic defenses characterize antisocial psychopathology as well. These results suggest that there is a subset of antisocial individuals in whom narcissistic psychopathology has a role in producing antisocial behavior. Together, these findings challenge us to define psychodynamically meaningful subtypes of antisocial personality disorder potentially responsive to different treatments.

The overall gratification inhibition conflict has an intriguing association with chronic depression. Inhibitions against seeking out rewarding experiences, activities, and relationships may initiate or sustain chronic depression. This conflict is common in both personality disorders but does not correlate highly with the degree of either type of psychopathology. This suggests that the association between chronic depression and both personality disorders is indirect, since it is mediated by the intervening high prevalence of overall gratification inhibition conflict among personality-disordered individuals.

Two conflicts, object hunger and fear of fusion, correlate to a lesser degree with chronic depression. Neither conflict correlates with overall gratification inhibition. Both conflicts share the inability to sustain satisfying close relationships, a theme that chronic depression and personality disorders share to some degree.

The present report has several limitations. First, the number of subjects is modest, especially for the data on conflicts. Second,


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