

## Interpersonal behaviours and BPD. Are specific interpersonal behaviours related to borderline personality disorder? An empirical study using the Core Conflictual Relationship Theme standard categories.

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### Summary

**Aim.** It is common knowledge that disturbed interpersonal functioning is a key feature of borderline personality disorder (BPD). However, it remains uncertain whether patients with BPD have specific interpersonal behaviours that can be validly and objectively identified. This study examined the interpersonal behaviours of patients with BPD.

**Method.** The narratives of interpersonal interactions of the 66 participants were rated using the Core Conflictual Relationship Theme (CCRT) method.

**Results.** Results showed that once other Axis II disorders were controlled for, only three CCRT components significantly predicted scores on the Borderline Personality Disorder Scale: not wishing to be good as a CCRT Wish component, others not being untrustworthy as a response of other component, and not being open to others as a response of self component. However, while these findings were significant, the percentage of variance explained remained low.

**Conclusions.** The authors argue that future research will need to examine subgroups within BPD if specific interpersonal behaviours are to be reconsidered.

**Borderline Personality Disorder / Personality Disorders / Interpersonal functioning / Interpersonal Relational Patterns / Core Conflictual Relationship Theme Method / CCRT**

### INTRODUCTION

Following the work of Freud [1], many psychodynamic and psychoanalytic researchers have investigated patients' core repetitive interpersonal schemas and several methods have

been developed over the last 30 years to systematically analyse these schemas (e.g. [2, 3, 4]). These methods have been used in various areas of psychotherapy research such as in understanding change in psychotherapy (e.g. [5, 6]), psychotherapy process [7, 8, 9], childhood trauma [10], dreams [11], and Axis I psychopathology [12, 13, 14].

Specific personality disorders, including borderline personality disorder (BPD) have also been investigated. Ruiz, Pincus and Bedics [15] used the SASB (Structural Analysis of Social Behaviour [2]) to compare patients with BPD to patients with schizotypal personality disorder and with patients presenting no Axis II disorder. They found that the interpersonal function-

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ing of patients with BPD involved control, domination and aggression. These findings supported in part Benjamin's [16] SASB coding of the DSM-III and III-R diagnostic descriptors and casebook illustrations for BPD [17, 18], which she summarised as follows:

"(In the interpersonal functioning of BPD, there) is morbid fear of abandonment and a wish for protective nurturance, preferably by constant physical proximity to the rescuer (lover/caretaker). The baseline is friendly dependency on a nurturer, which becomes hostile control if the caretaker/lover fails to deliver enough (...). There is a belief that the provider secretly if not overtly likes dependency and neediness, and a vicious introject attacks the self if there are signs of happiness/success." (p. 174)

Concurrent with this and the works of Ruiz and collaborators [15], Stern and colleagues [19] investigated the stereotypical interpersonal functioning of patients with BPD using the SASB. In comparing patients with a major depressive episode and BPD to patients with the same Axis I disorder but without BPD, they found that the interpersonal functioning of patients with BPD involved aggression, criticism and isolation.

In other studies, the CCRT (Core Conflictual Relationship Theme method [4]) was used to examine the interpersonal functioning of patients with BPD. For example, Drapeau and colleagues [20] tested the value of different models of BPD interpersonal functioning found in the scientific literature. While some of these models could successfully distinguish patients with BPD from patients without BPD, the authors concluded that existing models do not generally provide much discriminant power to distinguish the two groups. In a follow-up study, Drapeau and Perry [21] compared the relationship patterns of 68 patients with BPD to those of 139 patients with other personality disorders. Results indicated that patients with BPD have more wishes to be distant yet they also wanted to be like others, and more wishes to hurt others and to be hurt. Results also indicated that patients with BPD perceive others as controlling, and that patients with BPD tend to be less open, helpful and self-confident than patients without BPD in their interpersonal interactions.

There seems to be little doubt that disturbed interpersonal functioning is a key feature of BPD

(see [22] for a brief review). However, it remains uncertain whether patients with BPD have *specific* disturbed interpersonal behaviours that can be validly and objectively identified. This study is a follow-up to the Drapeau and Perry (2009) study which sought to compare the interpersonal patterns of patients with BPD diagnoses with those of patients without BPD. Unlike in the original study, the present study, which examines the group of patients with BPD only, aimed to determine if specific interpersonal variables can be related to BPD as assessed using a continuous scale.

## METHOD

### Participants

All patients who were admitted to the Austen Riggs Center, a residential treatment center for adults with treatment-refractory disorders, and who agreed to participate in ongoing research projects were assessed using a Guided Clinical Interview (GCI [23]) for DSM Axis I-V assessment. Reliability on the diagnoses was good, with  $K_w = 0.86$  for Axis I, and 0.89 for Axis II.

Complete data (see Measures) was available for 66 patients with BPD who were admitted to the center and who agreed to participate in research projects. Of these, 57 were women (86%) and 9 were men, with a mean age of 31 years ( $SD=10.70$ ). On Axis I, 87% of the sample presented with mood disorders, principally major depression and dysthymia, and 79% had anxiety disorders, including generalised anxiety disorder, post traumatic stress disorder and social phobia. Two out of three participants also had a second diagnosis on Axis II, including DSM-IV schizotypal personality disorder (PD) or dependent PD, or DSM-III-R self-defeating PD which was also assessed. Further details about the sample can be found elsewhere [10, 21, 24].

### Measures

*Borderline Personality Disorder Scale (BPDS)*. The BPDS consists of 36 items and provides a quantitative assessment of borderline pathology [25]. It was preferred to the DSM criteria for the data

analysis because it is more quantitative. Reliability for the Borderline Scale was  $ICC(2,1)=0.91$ , and  $Kappa=0.68$  for the BPD diagnosis. Scores above 28 indicate a definite BPD; participants had a mean score of 33 ( $SD=3.94$ ).

*Core Conflictual Relationship Theme method (CCRT).* The interpersonal functioning of the participants was assessed using the CCRT [4]. The method was applied to the verbatim transcription of semi-structured interviews specifically designed to collect 10 brief stories or vignettes of an interaction the participant had with another person (see [26]). The interview covered three general areas of interpersonal functioning, including interactions related to work and occupation, close relationships and therapy. However, participants freely chose which interaction to report.

Using the verbatim transcriptions of the interviews, the CCRT is used to assess three components found in interpersonal narratives: (1) the wishes, needs, or intentions of the participant in the interaction (W); (2) the response of others to the participant (RO); and (3) the response of the subject (RS) to the other. These components are assessed by trained raters using standard categories provided by the method, which cover 35 Wishes, 30 ROs, and 31 RSs. The proportion of each W (vis a vis all wishes), RO (vis a vis all ROs), and RS (vis a vis all RSs), is then calculated.

Interrater reliability for the wishes was mean  $ICC(2,1)=0.63$ , with half the scores above 0.70. For the ROs, mean  $ICC(2,1)$  was 0.68, with half above 0.70. For the RSs, the mean  $ICC(2,1)$  was 0.67, with half above 0.70.

### Data analysis

Stepwise regressions were used to determine which CCRT standard categories are most significant in predicting the participants' score on the BPDS. All W, RO, and RS standard categories without a median of "0" were simultaneously entered into the regression. In two follow up regressions, we controlled for the total number of Axis I disorders and for other Axis II disorders.

## RESULTS

Data analysis yielded a six step model explaining 19% of the total variance (see Tab. 1), in which patients with BPD did not have a wish to be opened up to nor to be good; perceived others' reactions (ROs) as controlling and bad, and reacted to others by feeling depressed or ashamed. Controlling for the total number of Axis I disorders did not give significantly different results.

**Table 1.** The CCRT of patients with BPD: results from a stepwise regression ( $F(6,170)=6.83^{***}$ ,  $r^2=0.19$ )

	Parameter estimate	F	Partial $r^2$
W 8: be opened up to	- 23.98	7.11**	0.04
W 26: be good	- 30.70	9.54**	0.03
RO 20: are controlling	17.21	5.51*	0.02
RO 25: are bad	30.74	7.82**	0.03
RS 22: feel depressed	25.24	10.37***	0.04
RS 26: feel ashamed	46.70	6.18**	0.02

p value \*0.05; \*\*0.01; \*\*\*0.001

When controlling for the three most prevalent PDs (schizotypal, dependent, and self-defeating personality disorders), which together accounted for 43.7% of the total variance in BPDS scores, results showed that patients with BPD do not have the wish to be good [W26:  $F=4.76$ ,  $p=0.03$ ], are not open to others [RS 8:  $F=2.83$ ,  $p=0.09$ ] and do not see others as not trustworthy [RO 8:  $F=3.16$ ,  $p=0.07$ ]. Each of these three CCRT components added an additional 1% to the explained variance for a total  $R^2$  of 47%.

## DISCUSSION

While up to six indicators of interpersonal behaviour were first found to significantly predict BPDS scores, after controlling for other Axis II disorders, only half of these remained significant predictors and thus can be considered to be, at least to some extent, uniquely related to BPD. These included not wishing to be good as a CCRT Wish component, others not being un-

trustworthy as a response of other component, and not being open to others as a response of self component.

The wish to be good in the CCRT method refers to an individual's desire to do the right thing, to be perfect, and to be correct. The absence of this motive in patients with BPD may be in part due to difficulty in regulating impulsivity and disinhibition, or in a lack of desire thereof. A number of studies have shown disinhibition and impulsivity to be core personality traits in BPD [27, 28]. From a developmental perspective, Putnam and Silk [29] have suggested that toddlers, in a proper environment, learn to delay gratification as emotion regulation skills develop, and develop beyond needing the caregiver to soothe and assist in self-regulation by increasing voluntary or effortful forms of control. In examining BPD, they suggest that these individuals "seem to act like toddlers, with emotions that erupt suddenly, that seem oblivious to the social context in which they are expressed" (p. 918). The absence of the wish to do the right thing may similarly suggest a disinterest in, or a lack of consideration for socially and interpersonally appropriate behaviour regulation.

Results also showed that others were not seen as not trustworthy, as deceitful or as dishonest. Although patients with BPD are said to be hypervigilant to danger signals (e.g. [30, 31]), our results suggest they may nonetheless have difficulty both in identifying true and significant signs of danger and in avoiding it. Indeed, this last finding may indicate that patients with BPD fail to see that others are not trustworthy, hence leading to repetitive abusive interactions or relationships, as suggested by Drapeau and Perry [21]. Our finding that not being open (i.e. as a response of self; in the CCRT method, this includes being inhibited, not being expressive, and being distant) is an important interpersonal marker in patients with BPD is congruent with a study conducted by Stern and colleagues [19] which showed that behaviours of recoil from others are common in this patient population. Schmal and colleagues [32], amongst others, have suggested that patients with BPD are highly sensitive to rejection, a trait Gunderson [22] describes as being closely related to fears of abandonment. It is possible, although hypothetical at this point, that the participants' response of withdrawal aims to

protect them from possible abandonment from significant others, or, more generally, that this behavior is related to attachment difficulties. A number of studies have indeed demonstrated that individuals with BPD are likely to have preoccupied or dismissing attachment patterns (e.g. [33]). More specifically, Levy and colleagues [34] have shown that 47% of patients with BPD are dismissing in their attachment, which may be one of the reasons why participants in this study reported not being open in their interpersonal interactions.

However, while this study generally produced results that are both significant statistically and generally congruent with the literature, the proportion of variance explained by the three CCRT components remains very low once other Axis II disorders are controlled for, with approximately 1% of the variance in BPDS scores accounted for by each of the three CCRT components, for a total of 3% of variance explained. Although the use of the CCRT to identify a core set of specific interpersonal behaviours in patients with BPD can be questioned [20, 21], including in patients with BPD, it is also possible that no such clearly identifiable behaviours exist in BPD. Indeed, according to a neurobehavioral model suggested by Depue and Lenzenweger [35, 36, 37], BPD may be viewed as an emergent phenomenon, meaning it is the result of complex interactions between a number of different underlying factors and that it cannot be reduced to these variables taken in isolation. Similarly, the chaotic interpersonal functioning of patients with BPD, just like numerous other diagnostic criteria reported in the literature, may be viewed as a construct to be assessed as a whole and which cannot be broken down into a single set of specific, clearly identifiable interpersonal behaviours. This may be due to the diversity found in BPD, which is reflected in other research findings, including those of Young and colleagues [38] who suggested that patients with BPD can flip from one schema mode to another, and of those of Ryan and Shean [39] who, like numerous other authors, suggest that there may exist a number of specific subgroups with BPD that have yet to be researched. Perhaps, it is this - the study of possible subgroups within BPD -, that will lead to the identification of specific interpersonal be-

haviours as these behaviours may be linked to specific subgroups, not to BPD as a whole.

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