Archives of Psychiatry and Psychotherapy, 2021; 2: 7–14

10.12740/APP/128104

Borderline personality disorder as a syndrome of poor quality of object relations

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Summary

Objective: Interpersonal dysfunction is a hallmark feature of borderline personality disorder (BPD). Representing lifelong relational patterns based in internal representations, quality of object relations (QOR) has been theorized as a core aspect of borderline personality pathology; yet empirical inquiry of this relationship has been limited. The present study investigated the association between QOR and BPD in the context of other salient correlates of BPD.

Method: Participants were 137 outpatients obtaining care at an intensive treatment program for patients with personality dysfunction. BPD was assessed using two interview-based instruments. A separate interviewer-rated assessment of quality of object relations was administered by a different set of assessors. Participants also completed self-report measures of symptom distress, five-factor personality, and dysphoric affects.

Results: Regarding BPD severity, QOR emerged as the only significant predictor with all variables in the model. Similarly, logistic regression found that QOR was associated with a significantly greater likelihood of having a diagnosis of BPD, after accounting for the effects of the other variables in the model.

Conclusion: QOR is significantly and uniquely associated with BPD, suggesting that internalized representations of self and others play an important role underlying BPD pathology.

borderline personality disorder, object relations, interpersonal

INTRODUCTION

The DSM describes borderline personality disorder (BPD) as an enduring pattern of inner experience and behavior that demonstrates dysfunction in multiple categories: emotion regulation, interpersonal functioning (e.g. anxious preoccupation with abandonment, extremes of idealization and abandonment), identity (e.g. poor sense of self), impulse control, and cognitions (e.g. psychotic-like experiences, dissociation) [1]. However, as this categorical model allows 256 possible combinations to meet the 5 of 9 DSM-5 symptoms required for a diagnosis, the BPD construct appears very heterogeneous on the surface.

Given the heterogeneity of BPD, researchers have attempted to identify core components of the disorder, focusing attention on dysphoric affects, personality traits such as disagreeableness and emotionality, and interpersonal dysfunction[2-5]. The working group for the DSM-5 proposed significant changes to the personality disorder construct, shifting from a categorical to hybrid dimensional model. In this Alternative Model for Personality Disorders, criterion

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A identifies impairments in self (identity, self-direction) and interpersonal (empathy, intimacy) functioning as core dimensions for personality disorders, with criterion B listing the presence of pathological personality traits (e.g. antagonism, disinhibition, detachment, negative affectivity, and psychoticism) [1]. The working group's alternative construct for personality disorders is currently offered in the "DSM-5.0 Section III: Emerging Measures and Models", with the view toward its promotion to Section II upon adequate research to support its construct validity[6].

Psychodynamic theorists have posited impaired object relations as underlying the affective and relational instability of BPD[7]. Object relations refer to mental representations of self and others that emerge from early relationships[8, 9]. These psychological templates of interactions between the self and others are linked with particular affect states and influence a person's future interpersonal interactions[10]. The degree to which such representations are unstable and unrealistic corresponds to distorted identity and interpersonal experience, which in turn constitutes disordered personality. While empirical investigation of this issue has been limited, early evidence suggests an association between BPD and impaired QOR [11]. Few studies, however, have examined this relationship in clinical samples and with consideration of other affective and personality factors that are important in BPD.

BPD has been described as a disorder of profound dysphoria combined with limited or maladaptive affect regulation abilities[12]. Efforts have also been made to define BPD in terms of five-factor personality, with high neuroticism and low agreeableness mapping onto borderline personality feature [13]. However, such efforts have seldom incorporated perspectives regarding QOR. The present study was developed to investigate the association between QOR and BPD in an independent clinical sample and in the context of other salient correlates of BPD, including general symptom distress, five-factor personality, and dysphoric affects – the first study to do so – to evaluate whether quality of object relations is an underlying dimension of BPD. By including examination of general symptom distress, dysphoric affect states, and five-factor dimensions, the present study sought to determine whether QOR accounts uniquely for borderline personality pathology. As quality of object relations corresponds closely with the impairments in self and interpersonal functioning proposed in the Alternative Model for Personality Disorders, the present study's examination of quality object relations in BPD can potentially add to the construct validity of criterion A (impairments in self and interpersonal functioning) as core dimensions of personality disorders. Moreover, understanding the role of QOR in relation to other prominent cognitive-affective and trait factors in BPD can identify potential priorities for clinical work and inform intervention efforts.

METHODS

Participants and setting

Participants were 137 consecutively admitted psychiatry outpatients seeking treatment at the Evening Treatment Program (ETP) at the University of Alberta Hospital in Edmonton, Canada. The ETP is an intensive outpatient group therapy program, involving several group therapy sessions each week, for individuals suffering from severe personality dysfunction. The primary admission criteria to the program – and the study – were (1) the presence of significant personality dysfunction that may or may not fully meet criteria for a particular personality disorder diagnosis; (2) engagement in a meaningful daily activity, such as employment, education, parenting, or volunteering; (3) capacity for group participation; and (4) a minimum age of 18 years. Research ethics approval was granted by the University's Health Research Ethics Board, and participants provided written informed consent.

Measures

Borderline personality disorder

Borderline personality disorder was assessed using two methods. First, the Structured Clinical Interview for DSM–IV Personality Disorders [14] was used to determine a categorical diagno-

sis of BPD (all other personality disorders were also diagnosed, and the Structured Clinical Interview for DSM–IV was also administered to assess for DSM-IV Axis I disorders) [14]. These interviews were administered by trained research assistants; diagnoses were validated by the independent clinical diagnosis assigned jointly by an ETP therapist and psychiatrist, both of whom saw the patient for the initial program intake. Second, a dimensional assessment of BPD features was obtained using the Borderline Personality Disorder Scale (BPDS) [15]. This interviewer-rated scale involves the assessment of nine domains of functioning salient to BPD: anxiety intolerance, self-destructive impulses, regression in treatment, dependent relationships, angry-hostile relationships, unstable perception of others, disturbances in identity and self-perception, chronic feelings of emptiness, and regression in crises. The BPDS reports good psychometric properties and has been found to correspond with DSM diagnosis of BPD, whilst providing a dimensional score whereby higher scores reflect greater severity of BPD[16].

General psychiatric symptoms

General psychiatric symptom distress was assessed using the BSI-53 [17], a 53-item self-report measure of psychiatric symptoms. The BSI-53 is frequently used to assess an array of symptom domains commonly experienced by patients seeking mental health treatment. The BSI-53 encompasses nine symptom domains, each of which reports good internal consistency, and provides a composite score, the Global Severity Index (GSI), that reflects overall severity of psychiatric symptom distress. Higher GSI scores indicate greater severity of psychiatric symptoms. The present study used the GSI to represent general psychiatric distress.

Dysphoric affects

The Dysphoric Affect Scale (DAS) [12] is a 50-item self-report measure that assesses the degree to which the individual experiences various dysphoric affective and cognitive states theorized to be central to borderline personality pathology. Reflecting intense inner pain, the dysphoric states assessed by the DAS encompass extreme feelings, destructiveness or self-destructiveness, fragmentation, and victimization. Respondents are asked to estimate the percentage of time that each dysphoric state was experienced over the past month. A higher overall mean score reflects greater severity of dysphoric affective and cognitive states. The DAS reports good psychometric properties, and patients with BPD evince higher DAS scores than those with other personality disorders [17, 18].

Five factor personality

Five-factor personality was assessed using the NEO Five-Factor Inventory (NEO-FFI) [19], a 60-item, self-report questionnaire that measures personality according to the five-factor model. The five-factor model is an established framework for understanding personality according to five highly replicated trait dimensions: neuroticism (emotionality), extraversion, openness, agreeableness, and conscientiousness. Inventories based on the NEO-FFI are among the most widely used instruments for assessing five-factor personality dimensions, reporting good psychometric properties across different populations[20]. NEO-FFI items are scored from 0 (“strong disagreement”) to 4 (“strong agreement”), and a mean score is calculated for each dimension.

Quality of Object Relations

The Quality of Object Relations Scale (QORS) [8], an interview-based instrument, was used to assess lifelong relational patterns, presumed to reflect enduring inner psychological representations of self-other relations. The interviewer takes into account behavioral manifestations, affect regulation, self-esteem regulation, and historical antecedents in the assessment of quality of object relations. The interviewer considers the following five levels of object relations: (1) primitive, involving intense reactivity to separation and/or inordinate dependence on others for a sense of identity; (2) searching, indicating a tendency for short-lived optimism followed by disillusionment in relationships as substitutes for earlier objects; (3) controlling, involving ambivalence and struggles to control and avoid being controlled; (4) triangular, referring to real or fantasized triangular or competitive relationships; and (5) mature, indicat-

ing mutually fulfilling relationships that encompass the capacity for tenderness and mourning. An overall dimensional score is derived, signifying the overall quality of an individual's relationship patterns and inferred inner representations. The QORS has been used in a number of studies, with consistently satisfactory levels of rater reliability and concurrent validity [21,22]. QORS interviews were conducted by trained clinicians who were not involved in patients' diagnostic assessments.

APPROACH TO ANALYSES

Preliminary analyses evaluated age and gender as potential covariates. Independent samples t-tests were used to examine severity of borderline personality features (i.e., BPDS scores) between patients with and without a BPD diagnosis, and between patients who did and did not meet criteria for personality disorder diagnosis among non-BPD patients. Zero-order correlations were computed to evaluate bivariate associations among study variables. Variables were selected for multivariate analyses if they were significantly associated with categorical BPD diagnosis and/or dimensional BPDS scores. Logistic and linear regression models were then conducted with categorical and dimensional BPD as separate dependent variables, respectively. Predictor variables were entered in steps, beginning with general symptoms (step 1), dysphoric affects (step 2), five-factor personality (step 3), and quality of object relations (step 4) in order to examine the proportion of variance accounted for by each group of variables. To facilitate interpretation, standardized coefficients and odds ratios are reported.

RESULTS

Demographic data and psychiatric diagnoses are provided in Table 1.

Table 1. Demographic Data and Psychiatric Diagnoses of Study Participants, N=137

	n	%
Gender		
Male	47	34.3
Female	90	65.7
Marital Status		
Never Married	48	35.0
Married or Common-law	54	39.4
Separated, Divorced, or Widowed	34	24.8
Employment Status		
Full-time	77	56.2
Part-time	19	13.9
Not Working	41	29.9
Ethnicity		
Caucasian	130	94.9
Other	7	5.1
Previous Mental Health Treatment		
No	14	10.2
Yes	123	89.8
Highest Level of Education Obtained		
High School or less	44	32.1
Technical College	56	40.9
University	27	19.7
Postgraduate	10	7.3

Previous Psychiatric Hospitalization		
No	105	76.6
Yes	32	23.4
SCID Psychiatric Diagnoses		
Major Depressive Disorder-Single Episode	60	43.8
Major Depressive Disorder-Recurrent	5	3.6
Bipolar Disorder	42	30.7
Dysthymia Disorder	24	17.5
Substance Related Disorders	47	34.3
Schizophrenia and Other Psychotic Disorders	13	9.5
Panic Disorder	24	17.5
Agoraphobia or Specific Phobias	55	40.1
Obsessive Compulsive Disorder	68	49.6
Social Phobia	42	30.7
Posttraumatic Stress Disorder (PTSD)	33	24.1
Generalized Anxiety Disorder (current or past)	20	14.6
Somatoform Disorder	10	7.3
Eating Disorders	19	13.9
Avoidant Personality Disorder	37	27
Dependent Personality Disorder	3	2.2
Obsessive Compulsive Personality Disorder	27	19.7
Paranoid Personality Disorder	11	8
Schizotypal Personality Disorder	2	1.5
Schizoid Personality Disorder	3	2.2
Histrionic Personality Disorder	2	1.5
Narcissistic Personality Disorder	3	2.2
Borderline Personality Disorder	40	29.2
Antisocial Personality Disorder	7	5.1
Personality Disorder NOS	4	2.9
No DSM-IV Personality Disorder	51	37.2
One DSM-IV Personality Disorder	53	38.7
Two or more DSM-IV Personality Disorders	33	24.1

Preliminary analyses indicated no significant associations between BPD and age and gender. As expected, preliminary analysis indicated significantly higher dimensional BPDS scores among patients with a categorical diagnosis of BPD (n = 40), M = 32.05, SD = 5.66, compared to patients with other personality disorder diagnoses and personality dysfunction (n = 97), M = 23.97, SD = 6.12, $t(135) = 8.07$, $p < .001$, $d = 1.37$. Among this latter group, 47.4% (n = 46) had a DSM-IV personality disorder diagnosis, while 52.6% (n = 51) did not meet criteria for a specific DSM-IV personality disorder—with no significant difference in BPDS scores observed between these groups. Zero-order correlations (Table 2) revealed all variables of interest to be significantly associated with both categorical and dimensional BPD with the exception of Extraversion and Openness. These latter variables were hence dropped from further analyses.

Table 2. Zero-order correlations among dimensional and categorical borderline personality disorder (BPD) and general symptoms, dysphoric affect, five-factor personality, and impaired quality of object relations (QOR), N = 137.

	M (*SD*)	1	2	3	4	5	6	7	8	9
1. SCID BPD diagnosis	—									
2. BPD Scale Score	26.33 (7.01)	.53**								
3. General symptoms	1.31 (.60)	.34**	.38**							
4. Dysphoric affect	15.56 (14.41)	.27**	.36**	.64**						
5. Neuroticism	2.76 (.60)	.25**	.31**	.65**	.44**					
6. Extraversion	1.86 (.59)	.04	.01	-.09	-.12	-.14				
7. Openness	2.35 (.52)	.07	.13	.05	.07	-.02	.27**			
8. Agreeableness	2.54 (.51)	-.37**	-.19*	-.15	-.06	-.16	.16	-.05		
9. Conscientiousness	2.29 (.65)	-.24**	-.19*	-.30**	-.16	-.37**	.12	-.13	.14	
10. QOR impairment	6.27 (.99)	.41**	.61**	.18*	.18*	.11	-.07	-.01	-.22*	-.22*

*p < .05; **p < .01; point-biserial correlations conducted for SCID BPD diagnosis (column 2)

Logistic regression analysis revealed a significant negative association between Agreeableness and BPD diagnosis (low Agreeableness was associated with a significantly greater likelihood of having a diagnosis of BPD). Furthermore, after accounting for the effects of the other variables in the model, findings indicated that greater impairment of QOR was associated with a significantly greater likelihood of having a diagnosis of BPD (Table 3).

Table 3. Standardized coefficients and odds ratios from final logistic and linear models predicting categorical and dimensional BPD, respectively, N = 137.

	Categorical BPD		Dimensional BPD	
		OR	β	t
Global Symptom Index (BSI-53)	.45	1.57	.12	1.25
Dysphoric Affects (DAS)	.18	1.20	.13	1.57
Neuroticism (NEO-FFI)	.08	1.08	.12	1.36
Agreeableness (NEO-FFI)	-.69	.50**	-.03	-.42
Conscientiousness (NEO-FFI)	-.22	.42	.04	.57
Impaired Quality of Object Relations (QORS)	.91	2.48**	.56	8.19**

*p < .05; **p < .01

The addition of impaired QOR accounted for 10% of the variance (final model Nagelkerke R^2 = .42). In the linear regression model with BPD severity as the dependent variable, only impaired QOR emerged as significant, accounting for 28% of the variance in BPDS scores (final model R^2 = .44).

DISCUSSION

The present study found a significant association between impaired QOR and the diagnosis and severity of BPD. Moreover, this relation was robust in that it remained significant after accounting for the effects of general psychiatric distress, dysphoric affects, and five-factor personality. Indeed, with the exception of trait agreeableness, these other variables were non-significant in multivariate models predicting BPD. In line with previous findings [11], these results add support to the theory that distorted object relations occupy a central role underlying the pathology of BPD. Lower levels of QOR indicate insecurity in relation to others, including primitive defense mechanisms and controlling behavior in order

to handle perceived or real abandonments and losses. Primary concerns among individuals at the lower range of QOR include perceived rejections and deflated self-image upon separation from objects. As Clarkin and colleagues [7] describe, perceptions of others are not consistent over time and can quickly change. Because these shifting perceptions are combined with intense affect, relationships with others are typically problematic.

Delineating core components of BPD helps to further understand the etiological factors of the condition, shape clinician responses, and optimize treatment strategies. Gunderson [23] advocates for a paradigm shift to include interpersonal dysfunction as a major phenotype of BPD, describing BPD as emerging from "genetically based hypersensitivity to interpersonal interactions that interacts with adverse early caretaking experiences and later stressors to become elaborated into disorganized and controlling interpersonal strategies" [24, p. 22]. Further studies could help refine our understanding of the causes of impaired object relations in BPD, especially as it relates to both genetic and environmental antecedents. It is, however, important to note that the present study was limited by not controlling for other personality disorder psychopathology, making it difficult to specify whether the maladaptive object relations were unique to BPD.

The present findings also contribute to the broader discussion of the multidimensional nature of personality disorder [25]. As quality of object relations corresponds closely with the impairments in self and interpersonal functioning proposed in the Alternative Model for Personality Disorders, our findings can potentially add to the construct validity of criterion A's impairments in self and interpersonal functioning as core dimensions of personality disorders.

Hopwood et al. [26] state that the success of the Alternative Model for Personality Disorder depends on its ability to bridge the diagnostic construct with evidence-based approaches to assess and treat patients with personality pathology. Aligning the personality disorder construct with the rich literature of psychodynamic psychotherapy and theory – such as object relations in transference-focused therapy [e.g. 27]—could make the diagnosis more clinically useful. Identifying the severity of self and interpersonal functioning could also help clinicians determine appropriate levels of care and type of treatment that would be most effective for each patient [28], and prepare the clinician to expect counterproductive interpersonal behaviors [e.g. 29] and anticipate therapeutic challenges [e.g. 30].

KEY POINTS:

- Object relations represent lifelong relational patterns based in internal representations.
- After accounting for the effects of general psychiatric symptoms, dysphoric affect, and 5-factor personality, impaired QOR was associated with a significantly greater likelihood of having a diagnosis of BPD and increased severity of BPD, suggesting that impaired object relations may underlie the affective and relational instability of BPD.

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Funding Details: None.

Disclosures: None.