Interpersonal Consequences of Borderline Personality Disorder

Alan King

Salisbury State University

Running Head: Interpersonal Consequences

Salisbury
STATE UNIVERSITY

COMPLETION OF THESIS

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This is to certify that on 12.09.94
(date)

Gary Alan Levy
(name of student) successfully completed the

oral defense of his/her Thesis entitled Interpersonal Consequences of Borderline Personality Disorder

presented in partial fulfillment of the requirements for the Master of Arts degree in Psychology.

Thesis Committee Chairman

Thesis Committee Member

Thesis Committee Member

DEPARTMENT OF PSYCHOLOGY
Salisbury, Maryland 21801-6837
(301) 543-6370 ■ TTY (301) 543-6083 ■ FAX (301) 543-6068

Abstract

In an attempt to explore the interpersonal consequences of borderline personality disorder, we compared two contrasting personality types, narcissistic and borderline. Male and female students viewed one of four videotapes depicting male or female narcissists and borderlines. The First Impression Questionnaire was used to measure participants' perceptions of each personality type. It was hypothesized that borderline personality styles would be perceived more negatively than narcissistic personality styles. It was also hypothesized that the male borderline would be more negatively evaluated than the female borderline, and that the female narcissist would be more negatively evaluated than the male narcissist. In addition, we attempted to determine how a person is perceived when first seen in a neutral context, and then in a situation in which more dysfunctional personality characteristics are revealed, followed by a return to a neutral context. Results supported the first hypothesis and indicated that borderlines were more negatively perceived than narcissists. The second hypothesis was not supported in that both male and female borderline were perceived to be more negative than both male and female narcissists. A sequential time analysis failed to produce negative carry over effects following presentation of personality disorders,

suggesting that an initial neutral impression may override a subsequent negative impressions of disordered personality when evaluated in a second neutral segment. Gender by sequential time analysis interactions were discussed in light of prior conceptions of the healthy female and male gender roles.

The literature on Borderline Personality Disorder (BPD) suggests that this particular diagnosis has an established pejorative meaning (Gallop et al., 1989). BPD has become the "Red Flag" diagnosis of the psychiatric community. The mere diagnosis alone can generate negative feelings. The behaviors associated with borderlines have been identified as difficult. Studies have suggested that individuals given a diagnosis of BPD can give the perception of being difficult patients (Adler, 1981; Gallop & Wynn, 1987; Sederer & Thorndike, 1986). Those who work in the helping profession have described difficult patients as "hateful" (Groves, 1978), "obnoxious" (Martin, 1975), "special problem" (Burnham, 1966), "too sick" (Michaels, 1977), help rejecting "crocks" (Kuch, Sherman, & Curry, 1977), treatment "failures" (Quitken & Klein, 1967), and "threatening" (Cornfield & Fielding, 1980). These descriptions represent extremely negative feelings which may suggest that clinicians may have a stereotypical impression of BPD.

Historical Concept

The term "borderline" did not arise without heavy controversy and dispute. There were mainly two groups of theorists that embarked upon the concept of borderlines within the psychoanalytic

community. One group believed that these patients had a mild form of schizophrenia, and the second group believed the disorder to be on a continuum between neurosis and psychosis (Goldstein, 1987). Zilboorg (1941) used the term "ambulatory schizophrenia" to refer to patients with a mild form of schizophrenia but could function without having to be hospitalized. Hoch and Polatin (1949) coined the term "pseudoneurotic schizophrenia" to refer to patients that seemed neurotic but were actually schizophrenic. These patients showed a more pervasive anxiety and thought disturbance.

Stern (1938) was the first to use the term "borderline" to describe patients that were felt to lie on the continuum between neurosis and psychosis. He described these patients as not profiting from traditional psychoanalysis. Deutsch (1942) used the term "as if personality" for patients that functioned as if they were normal, however had very disturbed relationships. They were also described as having a lack of identity, and "fixed" at an early level of development (Gunderson & Singer, 1975).

Knight (1953) believed that the term borderline did in fact represent a separate entity. He was among the first psychoanalysts to clearly separate the borderline condition form schizophrenia (Akiskal, 1981). In 1959, Schindeberg described the borderline as "stable in his instability" referring to the borderline syndrome as

an enduring life-long pattern with severe personality disturbance (Aarkrog, 1981).

Kernberg (1967) provided a synthesis of the literature and developed his psychostructural concept of the "borderline personality organization." He also saw these patients as lying between a state of neurosis and psychosis but saw this position as a stable, pathological organization rather than as a fluctuating state (Goldstein, 1987). Gunderson and Singer (1975) reviewed the descriptive literature on borderline patients in an attempt to narrow the definition on borderline personality disorder. This hallmark review developed an operational criteria that included: a) intense affect; b) history of impulsive behavior; c) social adaptiveness; d) brief psychotic experiences; e)bizarre performance on psychological testing; and f) chaotic interpersonal relationships.

Spitzer et al. (1979) as well as the American Psychiatric Association Task Force on Nomenclature and Statistics set out to develop criteria for the two major uses of the term borderline. To refer to borderline schizophrenia the term "schizotypal" was adopted, and the term "unstable personality" was used to refer to borderline personality. The latter term was later rejected and

reinstated as borderline personality disorder, while schizotypal became a separate entity.(Dawson & MacMillan, 1993).

These terms were then interpreted into the Diagnostic and Statistics Manual of Mental Disorders- Third Edition (DSM-III) as schizotypal personality and borderline personality (American Psychiatric Association, 1980). The grouping for BPD was characterized by impulsivity, identity disturbance, self-destructive acts, affective instability and feeling of emptiness. Work has continued since this publication and new criteria has been derived and updated for the DSM-III-R and DSM-IV. These definitions were based on a consensus of committee members formed by the American Psychiatric Association, and were based on the combined theoretical orientations of the committee members, data on how psychiatrists in practice use the term, and empirical data collected to date (Linehan, 1987).

Etiology

The earliest works on the etiology of borderline personality disorder focused on the early mother-child relationship and was explained by the object-relations theorists. Mahler (1975) referred to the separation-individuation (16 months- 3 years) process as the integral differentiation between self and others.

The rapproachment subphase (16-25 months) of separation-individuation is a stage of the child's growth where the child realizes the separateness from self and mother (Rinsley, 1980, Wong, 1980). An inability to resolve the rapproachment crisis can cause the child to be become "fixated" and interfere with the child moving on to the next subphase of achieving individuality and object constancy (Mahler, 1972).

Kernberg's theory of borderline personality organization emphasized excessive aggression. He believed this personality disorder lacked the integration of the concept of self and of the concept of significant others. This syndrome is referred to as identity diffusion, that is characterized by chronic difficulties combining one's own motivations, behaviors, and interpersonal relationships and integrating them with the motivations, behaviors, and interpersonal relationships with those others that are significant in their life (Clarkin and Kernberg, in Paris, 1993).

Masterson and Rinsley (1975) have suggested that the development of BPD is a result of the mother's punitive responses to the child's attempt to separate and gain autonomy during the rapproachment subphase. Masterson (1981) suggested that contributing factors may come for both sides of the mother child relationship, however, the central issue in the development of BPD

was the mother's unavailability during the separation-individuation process (Dawson & MacMillan, 1993).

Later works on etiology have focused on biological factors contributing to BPD. Reekum et al. (see Paris, 1993) supports the view that biological factors are significant in the etiology of borderline conditions. They propose that genetic predisposition, family history, and biological markers play a substantial role in the etiology of BPD. Specifically, they suggest that possible variables could include: 1) Brain injury to specific limbic sites, which can cause a disorder in impulse control, affective dysregulation, cognitive disability, and a predisposition to psychotic decompensation; 2) A family history of developmental disturbances such as, being exposed to family members engaging in substance abuse, physical/sexual abuse, marital discord, and erratic parenting. These factors may contribute to abnormal psychosexual development, injuries to self, and through learning/modeling may directly affect behavioral development; 3) A genetic predisposition for impulse control disorder, which might lead to higher risk activities, which could result in traumatic brain injury; and 4) Any combination of insults to cognitive functioning that surpasses the critical mass of cognitive functioning. For example "brain injuries in previously highly

functioning individuals have lesser impact on behavior than equivalent brain insults in individuals with fewer cognitive and ego strengths" (Reekum et al., see Paris, 1993 p.32-33).

Stone (1980, 1981) reviewed the literature on biological factors and concluded that BPD is related to several of the major Axis I disorders in terms of clinical characteristics, family history, treatment response, and biological markers. In recent years however Gunderson and Phillips (1991) concluded that the relationship between depression and BPD is nonspecific. More recently the focus of etiology has turned to a more integrated biological and social learning theory model emphasizing the existence of biological factors and environmental and social factors.

In line with a biosocial learning theory model Everly and Millon (1985) describe BPD as a continuation of the less severe dependent, histrionic, and passive-aggressive personality disorders. Millon breaks the disorder into the distinct subtypes, each with separate developmental histories: 1) the borderline dependent, 2) the borderline histrionic, and 3) the borderline passive-aggressive personality disorders. The dependent variation of the borderline disorder appears to be shaped by parental overprotection, which later sets the stage for rejection by those

on whom these patients come to rely. The histrionic variation appears to be shaped by inconsistent variable ratio reinforcement patterns that leave these individuals continually "performing" in order to secure support, attention, and nurturance. The passive-aggressive variation appears to be shaped through environmental, especially parental, inconsistency. These parents tend to display extreme affection at one time and verbal and physical abuse at another. These inconsistencies lead to prolonged interpersonal conflicts and disappointments which could account for cyclic swings of extreme behaviors in the borderline patient.

Linehan (1989) has adapted her Dialectical Behavioral Therapy (DBT) based on a biosocial theory similar to that of Millon. She believes that biological irregularities combined with invalidating environments during childhood contribute to the development of emotion dysregulation. These dysfunctional environments also fail to teach the child how to label and regulate arousal, how to tolerate emotional stress, and when to trust personal emotional responses as reflections of valid interpretations of events.

Gunderson and Singer (1975) have concluded that anger is the most prevalent affect in borderlines. This anger is usually displayed in violent outbursts toward love objects or people trying to help them. These outbursts are relatively unpredictable and

more often irrational. These "temper tantrums" often result as a defense mechanism to deal with anxiety or perceived stressful situations.

Depression is also commonly identified with borderlines. Next to anger, depression is the most frequently identified affect. Their depression is seen in the form of loneliness, emptiness, and alienation. The depression has a great deal to do with the experience felt when a love object rejects the borderline (Harticolis, 1977). When a relationship is disrupted by the threat of separation the borderline will quickly become angry and hostile accompanied by characteristic manipulative, self-destructive acts in an attempt to gain control over the withdrawing person. These acts can come in the form of wrist-slashing, overdosing, and even severe bulimia (Gunderson & Zanarini, 1989).

Clarkin and Kernberg (see Paris, 1993) outline the primitive defense mechanisms commonly used by borderlines. They explain that these defenses protect the borderline from intrapsychic conflict and thereby reduce their adaptive effectiveness and flexibility to perceived stress producing situations. The most commonly associated defense with borderlines is splitting. This occurs as the separation of objects as "all good" and "all bad". This protects the borderline by means of keeping apart contradicting

experiences. To the borderline patient, people are categorized as being all good or all bad because the idea of people being both good and bad at the same time is intolerable (Groves, 1976). Although splitting is usually the most prominent defense, borderlines also exhibit defenses such as: primitive idealization, projective identification, omnipotence, devaluation, and denial (Kernberg, 1967).

Primitive idealization creates an unrealistic, all good and powerful image of a person. Projective identification projects externally aggressive feelings toward another person usually in attempts to gain control of that person. Omnipotence and devaluation refer to a highly inflated, grandiose self and depreciated, emotionally degrading representations of others, respectively. Denial seems to reinforce splitting in that borderlines will tend to deny they had contradicting feelings of another person. Their memory does not recall feeling one way about that person at one time, and a completely opposite way about them at another time (Clarkin & Kernberg, see Paris, 1993).

Much of the research on borderlines has been conducted in hospitals where they find themselves following frequent suicide attempts. It has been clearly indicated that BPD patients provoke a high level of stress on their caregivers. Nurses dealing with

borderline patients have reported feeling frustrated, drained, helpless, frightened, angry, guilty, provoked, and intolerant (Colson et al. 1986). These reactions and feelings can generate intense countertransference reactions. Colson et al. (1986) suggest that these countertransference responses include feelings of anger, hostility, and helplessness by the caregiver.

Literature has established the presence of empathy as contingent in the effective establishment of a therapeutic relationship (Carper, 1979; Leninger, 1980; Rogers, 1957). As noted before, BPD patients have been viewed as "difficult" patients to treat. Numerous investigators report patients that staff view as difficult to treat are marked by a character pathology and have been described as hateful, problematic, help- rejecting, treatment failures, and threatening (Burnham, 1966; Cornfield & Fielding, 1980; Groves, 1978; Kuch, Sherman, & Curry, 1977, Quitkin & Klein, 1967). Other studies have shown that patients with a high character pathology are difficult to empathize with, are dangerous, and are seen as divisive (Colson et al., 1985). Gallop et al. (1989) suggests that patients with a BPD diagnosis received significantly less empathic responses than patients with other diagnoses.

Some caregivers find it difficult to treat borderlines because they see their behaviors as "deliberate" and "bad" rather than as a symptom of their diagnosis. They feel compelled to withstand the borderlines manipulation and attention seeking behaviors. Gallop, Lancee, and Garfinkel (1989) found that in analogue situations nurses gave responses to borderlines that were belittling and contradicting. This study examined how the diagnostic labels of schizophrenia and BPD impacted the expressed empathy of nurses. They hypothesized that the label borderline personality disorder is sufficient enough to diminish empathy for hypothetical patients with this diagnosis. They found that nurses expressed more empathy toward schizophrenic patients than with patients with BPD.

In summary, the term borderline, with its now vast literature may trigger preconceived impressions in the minds of those who treat them. Research has demonstrated that knowledge about the characteristics of an individual may influence the perception of the whole person (Asch, 1946). Moreover, Anderson (1974) has suggested that social judgment begins from a principle of information integration. As it refers to personality theory he suggested that given some traits of a person, inferences are readily made about other traits of the same person. He suggested personality perception involves a network of interrelations between

the semantic, judgmental and experiential dimensions. At the semantic level, if a person is described as honest they may also be seen as dependable and sincere simply because of the relations among the verbal meanings of these terms. The judgmental level, a person described in a certain manner, such as "difficult", may be seen as troublesome because of a mediating judgment of unlikableness. The experiential level of personality perception involves situations where traits of a person are correlated because experience has shown them to be correlated in fact. For example, meeting someone that is honest may then imply to you that they are also likeable because in past experiences honesty correlated with likableness. In essence, people with personality labels, such as those diagnosed with BPD, may be largely a judgmental and linguistic matter.

Gunderson and Zanarini (1987) estimate that 15% to 25% of both inpatient and outpatient clients have a diagnosis of BPD. Of these, two-thirds are female. Simmons (1992) believes that this phenomenon may stem from the differences in parenting of males and females and from expectations of "normal" behavior for males and females. Males exhibiting borderline characteristics are more likely to lash out at others and therefore may receive a diagnosis of antisocial personality. Henry and Cohen (1983) concluded that

borderline symptoms are more congruent with the male sex role and less tolerable or more pathological for females. Being argumentative or sexually promiscuous for females is more likely to receive a BPD diagnosis than for males. Males are more likely to receive a diagnosis of antisocial personality disorder and females a BPD diagnosis for the same symptoms.

Broverman, Broverman, and Clarkson (1970) found that clinicians described healthy females as submissive, dependent, nonadventurous, noncompetitive, less aggressive, less objective, more excitable, and more emotional when compared to descriptions of healthy males and healthy adults (a person of nonspecified gender). Simmons (1992) also suggests that women may be considered unstable if they show behaviors such as excitement, depression, competitiveness, or submissiveness.

As seen in the mental health profession, BPD may have become such a negative stereotype that its label and accompanying characteristics may interfere with the therapeutic relationship. The interpersonal relationships of borderlines shift from clinging to sadistic. These rapid shifts as well as other intense behaviors and feelings create turmoil in the borderlines lives. A related issue has to do with the depth of affect experienced by others in response to the behavior of borderlines: Is the negative affect

(countertransference) specific to a display of borderline behavior, or does previous borderline behavior have a long lasting effect on others, who might now respond negatively to borderlines, even when the borderline is not displaying clinical symptoms?

This study investigated the effect borderline behavior has on a non-clinically oriented audience having no experience with the diagnosis. Students were asked to respond to an enactment of borderline behaviors compared to a base line condition when the same actor had been depicted in a neutral script and a follow-up condition of an equivalent neutral script following the borderline enactment. These comparisons provide information regarding the depth of the affect experienced by the audience. More specifically, if negative affect is engendered following a borderline enactment, relative to a neutral enactment, would the negative affect carry over to a now neutral enactment, or would the audience be able to respond neutrally, after experiencing the borderline portrayal? In addition to assessing the effect of borderline behavior on others, this study analyzed 1) if male and female borderlines are responded to in the same way, and 2) whether male and female students experience the behaviors of borderlines differently. Finally this study will also compare responses to borderline enactments to those enactments depicting the behaviors

of the narcissistic personality. Previous research (Carroll et al., 1993) has suggested that audiences are more accepting of narcissism in males, than in females. For a review of this see Weinhold (Thesis, 1994).

Method

Subjects and Procedures

The subjects for this study were 44 men and 105 women enrolled in a state university. They ranged in age from 18-51, with a mean age of 22.99. Informed consent was obtained from all 149 participants. One subject was eliminated because of missing data for a total of 148 subjects for data analysis. All participation was voluntary and subjects were guaranteed anonymity.

Subjects were randomly assigned to view 1 of 4 videotaped enactments portraying either a: 1) male borderline, 2) male narcissist, 3) female borderline, and 4) female narcissist. Each tape consisted of 3 segments each approximately four minutes in length. The first and third segments, the neutral conditions, depicted a male or female college student reading the Salisbury State University housing contract (1993-1994). In the second segment, the experimental condition, the same student orally answered a roommate selection questionnaire according to a scripted

enactment portraying one of the two personality disorders. Following the completion of each segment, subjects were instructed to complete a brief questionnaire.

Instrumentation

First Impressions Questionnaire. (FIQ; Bryan, Coleman, Ganong, & Bryan, 1986) The FIQ is a 40-item semantic differential scale designed to assess perceptions of an individual. Each item of the FIQ consists of a pair of contrasting descriptors with seven blank spaces between them. Each are given a value, with 1 being negative and 7 positive. For purposes of this study the FIQ was modified by omitting nine original items and limiting the range of values from 1 to 5. The modified FIQ consisted of six empirically derived scales: Evaluative, Potency, Activity, Satisfaction/Security, Predictability, and Stability (see Ganong et al., 1990, for internal consistency ratings).

Each scale measured a different dimension of the target's personality. The Evaluative scale represented a judgment regarding the relative positiveness of the target. This scale tapped the dimensions of: honest-dishonest, loving-unloving, kind-cruel, and moral-immoral. The Potency scale measured perceptions of the target's power and ability. Some items on this scale tapped the dimensions of competent-incompetent, intelligent-unintelligent,

independent-dependent. The Activity scale assessed perceptions of the target's actions (eg., defensive-aggressive, active-passive). The Satisfaction/Security scale measured views about the target's sense of well-being (eg., secure-insecure, satisfied-dissatisfied). The last two scales only include a few items within each scale and measured the perceptions of the target's personality (predictability, predictable-unpredictable, and stability, stable-changeable, deliberate-impulsive).

In addition to the FIQ, participants were asked to rate masculinity and femininity of the actor using 5-point differentials. Participants were also asked to rate their mood after watching the video on a 5-point scale, with 1 being worsening of mood and 5 being improvement in mood. A final question asked subjects to respond to the open-ended question:"What would you say about this person to someone like a best-friend?" We were interested in finding out the general affective tone of the respondents after viewing each segment, and whether this affect carried over to the third segment after seeing the subject demonstrate their particular personality pathology.

The responses were coded as to whether each response represented either a negative affective tone towards the target or a lack of a negative affect (neutral or positive). Negative

responses included: name calling, personal attacks, negative comments on attractiveness, negative comments on competency, and ways the target could improve. Negative responses received a (1) coding and positive or neutral responses received a coding of (0). All responses were coded independently by 4 raters (Coefficient of agreement was .94).

Development of Videotape Scripts

In the first segment of this enactment, entitled the neutral condition, the student read the housing contract given to all students choosing to reside in the university resident halls. In the second segment, entitled the experimental condition, the student was interrupted by a brief telephone call which served as a reminder for the student to complete the roommate selection questionnaire. This questionnaire consisted of several items including such questions as: "Where do you see yourself five years from now?" and "Describe your greatest assets and your greatest weaknesses." In the third segment, the neutral condition, the student continued to read the residence life housing contract.

The script for the middle segments in the narcissism and borderline conditions were constructed by including the contents of items contained in the Millon Clinical Multiaxial Inventory-II (Millon, 1987) Borderline and Narcissism Scales. Ten items from

each scale were included verbatim in each script. Only those responses ranked highest (three on a one to three scale) in the MCMI-II manual, were used in the construction of the scripts. All met "substantive, structural, and external gauges of validity" and were considered a "broad and robust measure maximum weighing on degree of dysfunctionality in prior validation studies" (Millon, 1987; p. 87). The MCMI-II is a self-report instrument used to distinguish borderlines from nonborderlines (Gunderson & Zanarini, 1987). Both scripts were identical in structure and different in either Borderline or Narcissistic content.

Neutrality Check Procedures

Actors were solicited from the university theater department. One male and one female majoring in communication arts were selected and videotaped while reading two sections of the housing contract of the University. Sixty-seven undergraduates who were unaware of the purposes of the study, were asked to view one of the two (neutral) videotapes. Participants were then instructed to rate each actor on a five point bipolar rating scale at the completion of each of the two segments. The rating scales contained the following items: The actor's physical attractiveness, likableness, personal adjustment, interest in further interaction, masculinity and femininity. One additional scale was developed to

serve as validity checks for the content of the neutral segments; it tapped the offensiveness/inoffensiveness of its content. Analysis by t-tests for the male and female actor's ratings are shown in Tables 1 and 2. Table 1 compared the male and female ratings between segment one and three. No significant differences were found for either the male or female actors between the first and third neutral segments. Table 2 compared the first male and female segments (neutral), and the third male and female segments (neutral). Significant differences were found only between Masculinity and Femininity indicating the male was perceived as more masculine then the female and the female was perceived as more feminine then the male.

Insert Tables 1 & 2 about here

Results

The nine FIQ subscales were analyzed using a 2 (gender of subject) X 2 (gender of target) X 2 (personality type) X 3 (time) mixed multivariate analysis of variance. This analysis produced significant multivariate interaction between personality type and time, $F(18,123)=13.10$, $p<.0001$, and between target gender and time, $F(18,123)=3.40$, $p<.0001$.

An examination of the univariate analysis of variance tests indicated that significant differences were found on 6 of the 9 subscales for personality type by time, and significant differences for gender of target by time effects for 4 of the 9 dependent variables. These significant F values are summarized in Table 3 and Table 4 respectively.

Insert Tables 3 & 4 about here

Results of the corresponding simple effects analysis for personality type by time indicated that borderlines were perceived to be more insecure, less powerful, more aggressive, more unpredictable, and more unstable then the narcissistic personality type during the experimental condition compared to the neutral condition.

The results of the corresponding simple effects analyses for gender of target by time interaction produced some interesting findings. On the Evaluative scale at time 1, females were more negatively perceived, but after seeing each gender displaying their clinical symptoms, males were evaluated more negatively. There was no significant difference at time 3 on the Evaluative scale. Females were perceived as being more active at both time 1 and time

2, while there were no significant differences at time 3. Females were also found to be more unpredictable at time 3, and no differences at either time 1 or time 2.

It was also found that females were more changeable at time 1 than males, but no differences were at time 2 and time 3. Males were found to be less negatively mood arousing than females at time 2. Time 1 and time 3 produced no significant differences in mood. The last significant difference came in the perception of Masculinity and Femininity. Over all three time segments males were perceived as more masculine than the females, and the female was perceived as more feminine than the male. The significant F values are summarized in Table 5.

Insert Table 5 about here

The open-ended question asked for subjects thoughts about the person on the video. Responses were scored either as negative or as positive-neutral. Each of the four raters rated the responses by using the accompanying scoring manual. To determine if there was a carry over effect from the first segment to the third segment the total number of negative responses for each rater in segment 1 were compared to the total number of negative responses to segment

3. There was no significant difference between the two segments (Correlated $t(3)=.95$, $p>.05$).

Discussion

Results of this study, as anticipated, indicated that participants perceived the borderline personality style more negatively than the narcissistic personality style. Borderlines were perceived as being more insecure, less powerful, more aggressive, more unpredictable, and more unstable then the narcissistic personality style. This is consistent with Millon's contention (Millon, 1985) that BPD is a more severe personality disorder than narcissistic personality disorder. It may be that interpersonal reactions to narcissism are less severe because this personality style seems to be more prevalent and more socially valued (Lasch, 1979).

In analyzing for a carry over effect we attempted to answer many questions in regard to implications for treatment. As mentioned earlier, recent studies have shown that the diagnosis alone may have become a negative stereotype for borderlines (Gallop et al., 1989). If so, clinicians appear to have some long lasting impression of borderlines. Our results, however, showed that there was no carry over effect from our neutral conditions. This shows that the participants did not change their impression of the target

from the first time they observed the actor to the last time, even after seeing the borderline's behaviors. This may suggest that clinicians, even after witnessing a borderline behavioral display, may maintain more acceptance of the client when they are behaving appropriately (i.e. neutral condition). On the other hand, this might suggest that audiences make a first impression during the initial neutral condition and viewing a borderline behavioral display does not effect this initial impression. To gain clarification on this issue, future research might attempt to compare only an initial borderline condition and then look a the effects of this initial impression on a subsequent follow up neutral condition.

Also in analyzing for a carry-over effect it was diffiicult to determine if "boring" and "bored" were negative affects or neutral ones. These were responses many students gave to the open-ended question. Although our independent sample concluded that the script was neutral it produced some unintended negative responses. This may have been corrected had we used an open-ended question relating to their affect after viewing the video segment in the independent sample.

Results of our gender role analysis indicated some rather interesting findings. The Evaluative scale contains the most items

on the inventory. This scale represents a judgment regarding the overall positiveness of the target. Females were more negatively evaluated at time 1 and males were more negatively evaluated at time 2. This drastic change in perception may be explained by the participant feeling more compassion for the female after viewing her particular pathology. This may be further explained on the Satisfaction/Security scale, which measured the targets sense of well-being, where females were perceived more negatively only in time 3 and no difference were indicated at the other two times. Participants seemed to be less critical of the female after viewing her exhibiting the clinical symptoms. Perceiving her as more insecure (lonely) only at time 3 suggests that the participants either felt differently about her after seeing segment 2 or that after seeing her for the third time the gender-role stereotypes, mentioned earlier by Broverman et al. and Simmons, were employed.

Males were perceived as more stable at time 1 than females, but there were no significant differences at time 2 and 3, possibly lending further support to traditional gender-role stereotypes (Broverman et al., 1970). This again suggests that participants may have felt differently after viewing the second segment.

Finding no differences between perceptions on the Masculinity and Femininity scales seems to contradict prior research by Carroll

et al. (1993), that suggested narcissism is more acceptable in males than in females. However, these results are based solely on two items of a five point differential scale. Previous research has utilized more highly distinctive scales of measure to distinguish gender traits and the use of these scales may account for the differences in findings (Personal Attributes Questionnaire; Spence & Helmreich, 1978).

The final scale assessed the participants mood after watching each segment. A significant difference was found only at time 2. This suggests that females were more negatively mood arousing then males, possibly this implying that the female pathological symptoms impacted more negatively on participants then did the male. This might suggest a higher acceptance of emotional narcissistic and borderline pathology in males than in females.

A final limitation to the study may have been the length of the forced choice response form. The length and redundancy of filling out the same questionnaire may have caused participants to circle items without paying attention to the item. A suggestion for future studies may be to include a replication check within the questionnaire, to assess attention to task. Furthermore, the lack of significant findings between segments on the open response

question may have been a function of the unstructured nature of the question, rather than to a lack of measurable emotion.

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Table 1

T-Tests for Video Segments 1 and 3

Dependent Measure	Female 1	Female 3	t	df	Male 1	Male 3	t	df
Attractive	3.24	3.65	-.70	72	3.67	3.53	.69	58
Likableness	3.23	3.32	-.48	72	2.10	3.30	-1.23	58
Masculinity	1.84	1.97	-.59	72	3.27	3.43	-.75	58
Femininity	3.95	3.81	.59	72	2.43	2.55	-.43	57
Adjustment	3.35	3.31	.29	71	3.13	3.03	.42	58
Interaction	2.56	2.59	-.14	71	2.74	2.59	.57	52
Offensive	3.00	2.89	.57	34	2.93	2.85	.56	54

Table 2
T-Tests for Male and Female Actors in Video Segments 1 and 3

Dependent Measures	F1	M1	t	df	F3	M3	t	df
Attractive	3.24	3.67	.78	65	3.65	3.53	-.65	65
Likableness	3.23	2.10	-.74	63	3.32	3.30	-.12	65
Masculinity	1.84	3.27	6.22*	65	1.97	3.43	6.38*	65
Femininity	3.95	2.43	-5.96*	65	3.81	2.55	-5.04*	64
Adjustment	3.35	3.13	-1.03	65	3.31	3.03	-1.54	64
Interaction	2.56	2.74	.63	61	2.59	2.59	-.01	62

*$p < .05$

Table 3

Analysis of Variance for Personality Type By Time

Variable	Segments 1 vs. 3		Segments 1+3 vs. 2	
	F	p	F	p
Evaluative	1.70	.194	5.05	.026*
Satis./Secur.	.02	.653	73.61	.0001**
Potency	.26	.609	79.70	.0001**
Activity	.02	.887	5.66	.019*
Predict.	.16	.682	47.09	.0001**
Stability	.28	.593	52.45	.0001**
Masculinity	.03	.846	3.67	.057
Femininity	3.51	.063	1.65	.200
Mood	.08	.768	.10	.745

df=1,140
*p<.05
**p<.001

Table 4

Analysis of Variance for Target Gender By Time

Variable	Segments 1 vs. 3 F	p	Segments 1+3 vs. 2 F	p
Evaluative	2.71	.101	7.10	.009*
Satis./Secur.	1.44	.232	2.59	.109
Potency	.38	.538	1.79	.183
Activity	1.94	.166	1.08	.300
Predict.	.43	.512	1.55	.215
Stability	.19	.660	7.53	.007*
Masculinity	3.72	.056	7.72	.006*
Femininity	8.80	.004*	2.06	.153
Mood	2.74	.100	7.61	.007*

df=1,140
*p<.05

Table 5

Simple Effects for Significant Interactions Between Narcissistic and Borderline Personality Types and Video Segments

	Segment 1			Segment 2			Segment 3		
Variable	N	B	F	N	B	F	N	B	F
Evaluative	40.61	42.82	2.87	63.44	59.95	3.10	42.04	42.68	.04
Satis./Secur.	8.08	8.51	1.11	9.39	14.04	117.67**	7.84	8.52	2.32
Potency	16.99	17.79	1.65	16.66	25.83	103.62**	17.52	17.97	.65
Activity	8.76	8.78	.003	9.45	10.19	5.19*	9.11	9.08	.01
Predict.	2.35	2.56	2.83	2.19	3.19	68.11**	2.41	2.59	1.76
Stability	4.92	5.10	1.23	5.21	8.22	61.53**	4.90	5.09	.19
Masculinity	3.17	3.05	.15	2.78	3.07	3.37	3.11	2.90	.03
Femininity	2.92	3.30	2.99	3.54	3.48	.21	3.16	3.27	.00
Mood	3.06	3.03	.05	3.65	3.52	.14	2.79	2.81	.03

*$p < .05$
**$p < .01$
df= 1,140