Psychiatr Q (2007) 78:129–143
DOI 10.1007/s11126-006-9033-8

ORIGINAL PAPER

# Depressive Experiences in Inpatients with Borderline Personality Disorder

**Kenneth N. Levy, Ph.D. · William S. Edell, Ph.D. · Thomas H. McGlashan, Ph.D.**

Published online: 9 March 2007


**Abstract** We investigate the quality of dependent and self-critical depressive experiences in a hospitalized sample of depressed ($n$ = 17), depressed borderline ($n$ = 29), and borderline non-depressed inpatients ($n$ = 10). Subjects were administered structured diagnostic interviews for axis I and axis II along with the Symptom Checklist-90-Revised Depression Scale (SCL-90-R-DS) and the Depressive Experiences Questionnaire (DEQ). As predicted, there were no differences between the three groups in overall level of impairment or severity of depression. Phenomenologically, however, depressive experiences were quite different. Subjects with borderline personality disorder, with and without a diagnosed depressive disorder, scored higher than subjects with depression only on the measure of anaclitic neediness. Further analyses revealed that anaclitic neediness was significantly associated with interpersonal distress, self-destructive behaviors, and impulsivity. Findings suggest the importance of considering phenomenological aspects of depression in borderline pathology.

**Keywords** Borderline personality disorder · Depression · Inpatient · Young adults

## Introduction

The experience of depression in patients with borderline personality disorder has been well documented [1–18]. However, the nature of this relationship has eluded

Dr. Edell passed away in November 2002.

K. N. Levy, Ph.D. (✉)
Department of Psychology, Pennsylvania State University, 521 Moore Building, University Park, PA 16802, USA
e-mail: klevy@psu.edu

W. S. Edell, Ph.D. · T. H. McGlashan, Ph.D.
Yale University School of Medicine, Yale University, New Haven, CT, USA

researchers and is highly controversial. Some investigators contend that borderline personality is largely a secondary or concurrent manifestation of a primary affective disorder, or a variant of a primary affective disorder [1, 2, 19–23]. However, depression in borderline personality may not be equivalent to, or even a variant of, the kind of depression found in patients with affective disorders. Evidence from family history, comorbidity, phenomenology, psychopharmacology, and biological markers indicates that a surprisingly weak and nonspecific relationship exists between borderline personality and depressive disorders [9, 24, 25].

Other theorists [5, 7, 11, 15, 26, 27] highlight the phenomenological experience of depression in borderline patients as it differs from depression in other patients. For instance, Grinker et al. [27] note that depression in borderline patients can be distinguished from that of non-borderline depressed patients by an emphasis on chronic feelings of loneliness. Likewise, Gunderson [5, 7] reports that loneliness, emptiness, and boredom typify the depressive experience of borderline patients, as opposed to guilt, remorse and a sense of failure. Masterson [15] describes borderline depression as characterized by empty, dependent, and helpless feelings, and terms this ''abandonment depression.'' Adler [28] posits that depression in borderline individuals is characterized by feelings of ''aloneness'' due to an inability to maintain stable representations of significant others. Adler [28] also discusses the experience of primitive guilt, and Kernberg [29] similarly emphasized the role of self-condemnation in the depression of borderline individuals. Kernberg [29] describes the primitive guilt of borderline patients as stemming from a punitive, sadistic, and an unintegrated superego and as resulting in a sense of ''inner badness'' with sado-masochistic expression of aggressive impulses directed inward.

All these reports have been mostly theoretical, descriptive, and anecdotal. However, clinical investigators have also identified similar subtypes of depressive experiences [30–35]. These investigators differentiate between an interpersonally oriented depression and a self-evaluative depression. The former is characterized by dependency; fears of abandonment; and feelings of loneliness, helplessness, and weakness; and the latter by self-criticism and feelings of unworthiness, inferiority, failure, and guilt.

Efforts to identify psychological subtypes among depressed patients have been used to distinguish between the depressive experiences of patients with borderline personality disorder and patients with affective disorders. For example, Blatt [33] has tied dependent depression (initially termed as anaclitic depression) to early developmental issues typically found among individuals with character disorders such as borderline personality. Self-critical depression (Initially referred to as introjective depression), is more characteristic of neurotic or 'superego' depression. Blatt [34, 36] further suggests that borderline patients are vulnerable to feeling rejected and abandoned and, subsequently, to dependent depressions resulting from impairments in evocative constancy (the ability to evoke and maintain enduring representations of self and others, especially during stressful times). Subsequently, Blatt and Auerbach [37] have proposed that borderline pathology is related to both dependent/anaclitic and self-critical/introjective pathology: Anaclitic borderline pathology evidences itself primarily in difficulties with dependency and affect- regulation. Introjective borderline pathology exhibits itself primarily in conflicts over self-worth and autonomy.

Blatt and his co-workers [38] developed the Depressive Experiences Questionnaire (DEQ), a 66-item self-report measure, to assess a broad range of feelings and

beliefs regarding the self and interpersonal relationships reported by depressed patients rather than to assess the primary clinical symptoms of depression. Factor analysis identified three factors: Dependency, Self-Criticism, and Efficacy. These factors have been found to be stable and to have good levels of internal consistency in clinical and non-clinical samples [39] and numerous studies demonstrate the validity of these factors (see [40], for a review).

Using the DEQ, Westen and colleagues [41, 42] differentiated the depression of borderline patients from both major depression and dysthymia. Westen et al. [41] found that borderline subjects with and without major depression scored significantly higher in both dependency and self-criticism than subjects with major depression only, even after controlling for severity of depression. In a second study, Wixom et al. [42] found that borderline dysthymic adolescent girls scored significantly higher on self-report dependency and self-criticism, as well as dependency on the Rorschach, than non-borderline dysthymic girls. Again, there were no group differences in the severity of depression as measured by standard self-report depression measures (e.g., Hamilton Rating Scale). Rogers et al. [43] and Southwick et al. [44] also investigated the relationship between depression and borderline pathology. Rogers et al. [43] found that depression in borderline personality is associated with self-condemnation, emptiness, abandonment fears, self-destructiveness, and hopelessness. Southwick et al. [44], using the DEQ, found that patients with borderline personality were higher in self-critical depression as compared with depressed patients without borderline personality. However, contrary to Westen and co-workers [41, 42], Southwick et al. [44] did not find the same for dependent/anaclitic depression.

One possible explanation for the discrepancy between Southwick et al.'s [44] findings and those of Westen and his colleagues [41, 42] is gender differences in the respective samples. Participants in Westen's studies [41, 42] consisted mostly of women, whereas, participants in Southwick et al.'s study [44] were predominately men. A number of studies have found that women tend to score higher on the dependency factor than do men [45–48]. Another possible reason for the discrepancy relates to participant ages. Westen's studies [41, 42] involved adolescents and young adults, whereas Southwick et al.'s studies [44] involved middle-aged, Vietnam veterans. There is some evidence that individuals preoccupied with relationships either gradually become secure (by finding or creating a trusting, positive marital–romantic relationship) or become more self-protectively avoidant as they age [49, 50]. Thus, Southwick's middle-aged veterans [44] may have become more avoidant and less dependent than Westen's adolescent subjects [41, 42].

Another reason, however, may concern the DEQ itself. Subsequent to the development of the DEQ, Blatt et al. [51] using small space analysis [52] identified two subscales within the Dependency factor. The first was an Anaclitic Neediness subscale characterized by items that expressed anxiety related to feelings of helplessness, fear of separation and rejection, loss of gratification, and frustration that were not linked to a particular relationship. The second was an Interpersonal Depression subscale characterized by items that measure loneliness in response to disruptions of specific relationships, sadness in response to a loss and/or in relation to an actual person. Blatt [51] hypothesized that the Interpersonal Depression scale represented a more adaptive depression because it is related to real losses and not a non-specific generalized sense of loss and abandonment. Consistent with this idea, Blatt et al. [51] found that the new Anaclitic Neediness subscale had significantly greater correlations with independent measures of depression, whereas the

Interpersonal Depression subscale had significantly higher correlations with measures of self-esteem (although still related to depression measures). Thus, the combining of Anaclitic Neediness and the Interpersonal Depression subscales in the original Dependency factor might have confounded findings by weakening the strength of the correlations between the DEQ Dependency factor and other measures or obscure differential relationships with other measures.

Another important issue raised from prior theorizing (e.g., Adler, Kernberg, Blatt) and the findings of Westen and colleagues [41, 42], Southwick et al. [44] and Rogers et al. [43] concerns the relationship of borderline pathology to self-criticism (introjective pathology). Previous researchers have investigated dependent/anaclitic and self-critical/introjective dimensions by comparing borderline patients with non-borderline patients, but have not explored the relations of these dimensions to specific aspects of borderline pathology (e.g., self-destructive behavior or affective lability).

In a separate line of research, Clarkin et al. [53], using the eight DSM-III-R borderline personality disorder criteria as rated from the SCID-II, identified three factors: Identity Problems and Interpersonal Difficulties; Affect Difficulties and Self-Harm; and Impulsivity. These factors identified by Clarkin et al. [53] have, for the most part, been replicated in later studies by other investigators [54, 55] and may be useful in exploring the relation between dependent/anaclitic and self-critical/introjective depression dimensions with that of borderline personality pathology.

In the present study, we investigate the quality of depressive experiences in borderline patients. We attempt to replicate and extend previous findings by examining differences in the phenomenology of depressive experiences in patients diagnosed with borderline personality disorder and a DSM-III-R depressive disorder as compared to patients with borderline personality disorder without a DSM-III-R depressive disorder, and as compared to patients with a DSM-III-R depressive disorder but without borderline personality disorder. We attempt to extend previous findings by examining recent distinctions in the phenomenology of depressive experiences by employing the new DEQ subscales. Additionally, we attempt to extend previous findings by exploring the relationship between Clarkin et al.'s [53] borderline personality factors and the DEQ factors and subscales.

Based on the theoretical formulations and research reviewed above, we hypothesize that the severity of depression as measured by a standard depression subscale will not differentiate between subjects with borderline personality and those without. Borderline depression, however, will be related to anaclitic neediness and intense concerns about loss of gratification and experiences of frustration, but not interpersonal depression. Additionally, borderline depression will be related to self-criticism. However, this relation will be due mostly to identity disturbance, rather than interpersonal conflicts or affect-regulatory problems. Moreover, these relationships will not be an artifact of depressive mood, gender, or age.

## Method

### Participants

Participants were 56 (24 male and 32 female) non-neurologically impaired adolescent and young adult inpatients (M = 19.9 years, SD = 6.0). Twenty-nine patients were diagnosed with borderline personality disorder and a depressive disorder

(major depression, dysthymia or both), 17 patients were diagnosed with a depressive disorder without borderline personality disorder, and 10 patients were diagnosed with borderline personality disorder and no concurrent depressive disorder. Subjects were predominately white, single, and middle class based on the Two Factor Index of Social Position [56]. As part of their diagnostic evaluation subjects were evaluated with semi-structured clinical interviews for DSM-III-R disorders and were assessed for current level of psychosocial functioning using the Global Assessment of Functioning scale [57]. Subjects also completed a number of self-report measures including the Depressive Experiences Questionnaire [58] and the Symptom Checklist-90-Revised [59].

## Measures

### Diagnostic interviews

*Structured Clinical Interview for DSM-III-R-Patient Version* [60]. The SCID-P is a structured clinical interview for DSM-III-R Axis I diagnoses for patients older than 18 years of age.

*Schedule for Affective Disorder and Schizophrenia–Epidemiological Version* [61]. The K-SADS-E is a structured clinical interview for DSM-III-R Axis I diagnoses for patients less than 18 years of age.

*Personality Disorder Examination* [62]. The PDE is a semi-structured diagnostic interview that assesses the presence of DSM-III-R personality disorders. In adult subjects traits must be present and pervasive for a minimum of 5 years. In adolescent subjects traits are considered present, if it has been pervasive and persisted for a minimum of 3 years. Using the eight DSM-III-R borderline personality disorder criteria as rated from the PDE, we also created the three factors identified by Clarkin et al. [53] as follows: Identity Problems and Interpersonal Difficulties (unstable relationships, frantic efforts to avoid abandonment, identity disturbance, and feelings of emptiness criteria); Affect Difficulties and Self-Harm (affective instability, intense anger, and suicidality criteria); and Impulsivity (impulsivity criterion).

### Diagnosis

All structured interviews were conducted by trained doctoral and master's level clinicians with extensive experience using the instruments and who had established a high level of reliability before administering any clinical interviews for this study. Interviewers were blind to scores on all the self-report measures, and self-report measures were not used in making diagnoses or rating criteria in the structured interviews.

Diagnoses were established by ''best estimate'' methods at an evaluation conference with information from the admission notes, hospital chart, clinician descriptions, and K-SADS or SCID and PDE interview data. This method is in accordance with the LEAD standard advanced by Spitzer [63] and others [64]. Ratings, conducted alongside the current interviews on a sub-sample of 45 subjects, confirmed high interrater reliability. Kappa coefficients for categorical diagnoses were as follows: Major Depression 0.81; Dysthymia 0.68; and Borderline Personality

Disorder 0.84 (weighted kappa). The Intraclass correlation coefficient (ICC) for dimensional ratings of Borderline Personality Disorder criteria was 0.91. These reliabilities compare favorably to those reported by other investigators.

### Depression measures

*The Symptom Checklist-90-Revised* [59] The SCL-90-R is a 90-item self-report measure of clinical functioning tapping nine relevant domains that focus on experiences of distress and symptomatology within the last seven days. Subjects rate items on a 5-point scale of distress ranging from 0 ''not at all'' to 4 ''extremely.'' In the present study we used only examined the depression subscale. Groups were compared on raw scores because no standardized T score value norms exist for adolescent inpatients. Raw scores were computed by summing each item on a factor and dividing by the number of items comprising the factor. Thus, each factor's scores could range from 0 to 4.

*Depressive Experience Questionnaire* [58]. The DEQ, is a 66-item, 7-point Likert-type, self-report questionnaire. The measure was scored using the factor-weighting procedure provided by Blatt et al. [58]. In addition, we used Blatt's [51] newly derived Anaclitic Dependency (10 items from the Dependency factor) and Interpersonal Depression (8 items from the Dependency factor) subscales. Internal consistency in the present sample for the DEQ factors and subscales were at acceptable levels with Cronbach alpha coefficients as follows: Dependency 0.77; Anaclitic Neediness 0.77; Interpersonal Depression 0.73; Self-Criticism 0.87; and Efficacy 81.

### Psychiatric functioning

*The Global Assessment of Functioning Scale* [57] The GAF provides a single global rating of functioning and symptomatology. Scores range from a low score of 1 (e.g., needs constant supervision, serious suicide act with clear intent and expectation of death) to a high score of 100 (e.g., superior functioning in a wide range of activities, no symptoms).

## Results

### Preliminary analyses

There were no gender differences in the distribution of axis I or axis II disorders or in the make-up of the three groups. The depressed non-borderline group was slightly yet significantly older than the other two groups (Ms = 22.5 vs. 17.8; $F$ (55) = 2.84, $P < 0.03$). There were no other significant differences in regard to any other demographic data or in the distribution of axis I and II diagnoses (with the obvious exception of borderline personality disorder).

### Group comparisons

A two-way (group × gender) MANOVA was performed on the SCL-90-R Depression Scale (SCL-90-R DS) and the DEQ factors and subscales. The overall

$F$ value for the effect of diagnostic group was significant ($F$ (10, 64) = 2.52, $P < 0.01$). Means from univariate test are shown in Table 1, with subscripts summarizing the results of Tukey B post-hoc comparisons. As can be seen, consistent with prior expectations, the three groups were not distinguished by the severity of depression as assessed by the SCL-90-R-DS. There was a trend towards significance for the Dependency factor with the depressed-only group scoring lower. The groups significantly differed on the Anaclitic Neediness subscale, with both groups of borderline subjects scoring higher than depressed-only subjects. There was no difference between groups on the Interpersonal Depression subscale or on the Self-Critical and Efficacy factors. The overall $F$ values for the effect of gender and the interaction effect were insignificant. The findings remained the same when covarying for severity of depression or age.

Although there was not a significant univariate effect of diagnostic group (non-borderline depressed, borderline depressed, and borderline non-depressed) on self-criticism, a planned comparison between the non-borderline depressed and two borderline groups combined produced a significant result, $t(53) = 2.13$, $P < 0.04$. As expected, borderline depressed and borderline non-depressed patients scored higher on self-criticism.

## Correlational analyses

Table 2 shows the correlations between the depression measures and the borderline personality factors identified by Clarkin et al. [53]. Of note, Anaclitic Neediness was significantly related to all three factors. Self-Criticism, on the other hand, was significantly related only to Factor I-Identity Problems and Interpersonal Difficulties. There were no other significant correlations.

Because of the mixture of intra and interpersonal difficulties in Clarkin et al.'s [53] Factor I (and to a lesser degree the affect and impulsivity problems in their Factor II), we created composites in addition to Clarkin et al.'s [53] factors also using the DSM-III-R borderline personality disorder criteria from the PDE. Composite I is the sum of DSM-III-R criteria 6 and 7 (identity disturbance and feelings of emptiness), which represents identity disturbance. Composite II represents interpersonal difficulties and is the sum of criteria 1 and 8 (unstable relationships and frantic efforts to avoid abandonment). Composite III represents self-destructive behaviors and is the sum of criteria 4 and 5 (intense anger and suicidality criteria).

**Table 1** Comparison of groups on depression measures

| Depression Measure | Depressed | BPD + Depression | BPD only | $F$ Ratio |
|---|---|---|---|---|
| GAF | 38.5 | 39.5 | 35.3 | 0.73 |
| SCL-90-R-DS | 1.53 | 1.85 | 1.81 | 0.74 |
| Dependency | –0.41 | 0.06 | 0.15 | 2.00 |
| Anaclitic Neediness | 40.7a | 49.2b | 55.9b | 7.25** |
| Interpersonal Depression | 41.3 | 43.5 | 46.3 | 1.51 |
| Self-Criticism | 0.18 | 0.83 | 0.88 | 2.18 |
| Efficacy | –0.63 | –0.92 | –0.41 | 0.66 |

** $P < 0.01$

**Table 2** Correlations of the SCL-90-R Depression subscale and the DEQ factors and subscales with the Clarkin et al. BPD factors

| Depression Measure | BPD Factor 1 | BPD Factor 2 | BPD Factor 3 |
|---|---|---|---|
| SCL-90-R | 0.08 | 0.09 | 0.08 |
| Dependency | 0.25 | 0.18 | 0.24 |
| Anaclitic | | | |
| Neediness | 0.41** | 0.32* | 0.51*** |
| Interpersonal | | | |
| Depression | 0.28 | 0.16 | 0.18 |
| Self-Criticism | 0.33* | 0.22 | 0.20 |
| Efficacy | 0.04 | –0.12 | –0.12 |

Note: BPD factor 1 = Identity and interpersonal concerns; BPD factor 2 = Self-destructive behaviors; BPD Factor 3 = Impulsivity

* $P < 0.05$; ** $P < 0.01$; *** $P < 0.001$

Finally, Composite IV represents lability and impulsivity and is the sum of criteria 2 and 3 (affective instability and impulsivity). Table 3, summarizes the correlations between the depression measures and the composite scales. As shown in Table 3 and consistent with our hypotheses, the Self-Criticism factor was highly correlated with Composite I and moderately related to Composite III. The DEQ Dependency factor was moderately related to Composite II (Interpersonal Distress). The Anaclitic Neediness subscale was significantly related to Composite II, Composite III (Self-Destructive Behavior) and Composite IV (Lability and Impulsivity). Interpersonal Depression was related to Composite II, but in contrast to Anaclitic Neediness was unrelated to Composites III and IV. Efficacy was unrelated to any of the composites. The SCL-90-RD was moderately related only to the Composite I (Identity Problems).

## Discussion

We found that young adult inpatients with borderline personality disorder, irrespective of the presence or absence of a diagnosed DSM-III-R depressive disorder,

**Table 3** Correlations of the SCL-90-R Depression subscale and the DEQ factors and subscales with the BPD composites

| Depression Measure | BPD Composite 1 | BPD Composite 2 | BPD Composite 3 | BPD Composite 4 |
|---|---|---|---|---|
| SCL-90-R | 0.29* | –0.05 | 0.08 | 0.18 |
| Dependency | 0.11 | 0.22 | 0.21 | 0.18 |
| Anaclitic | | | | |
| Neediness | 0.21 | 0.37** | 0.36** | 0.41** |
| Interpersonal | | | | |
| Depression | 0.12 | 0.29* | 0.25 | 0.09 |
| Self-Criticism | 0.57*** | 0.02 | 0.26* | 0.17 |
| Efficacy | 0.13 | –0.09 | –0.09 | –0.12 |

Note: BPD Composite 1 = Identity concerns; BPD Composite 2 = Interpersonal distress; BPD Composite 3 = Self-destructive behaviors; BPD Composite 4 = Lability and impulsivity

* $P < 0.05$; ** $P < 0.01$; *** $P < 0.001$

exhibited as severe depression as those with a depressive disorder but without borderline personality disorder. Additionally, our data support the hypothesis that individuals with borderline personality, both with and without a comorbid depressive disorder, can be differentiated from those depressed without borderline personality disorder by the phenomenology of their depressive experiences. Borderline personality disorder was significantly related to Anaclitic Neediness characterized by increased feelings of helplessness, fears and apprehensions concerning separateness and rejection, and intense concerns about loss of gratification and experiences of frustration. In addition, these differences are not an artifact of severity of depression, severity of illness, age, or gender. Moreover, the strong correlations between Anaclitic Neediness and all three of Clarkin et al.'s borderline personality disorder factors [53] and the Interpersonal Difficulties (Self-Desctructive Behavior and Lability and Impulsivity composites) suggest that this result is not an artifact of overlapping items between the measures. Likewise, the correlation between the Self-Criticism factor and the Self-Destructive Behavior composite suggest the same.

Our findings also help to clarify the relationship that Westen [41, 42] and Southwick [44] and their respective colleagues found between borderline pathology and self-criticism. In the present study the association between these two variables resulted from the relationship between self-criticism to identity disturbance and self-destructive behavior. This finding is consistent with the idea that borderline depression may result, in part, from internal representations of oneself as evil or having an ''inner badness.'' This dynamic has been described by Kernberg, Adler, and Gunderson and is similar to Blatt's introjective depression but goes beyond guilt to a more primitive sense of self as wicked or demonic. Westen et al. [41] suggest that this aspect of borderline depression is ''introjective-like'' rather than the more coherent mature internalization characteristic of neurotic or ''superego'' depression. Along these lines, Perry and Cooper [65] theorize that borderline patients typically have a longstanding sense of rage that, when consciously experienced, is harshly turned upon themselves in a way that often begets self-destructive impulses and acts. This ''introjective-like'' depression is thought to be distinct from the ongoing erosion of confidence and self-esteem typical on non-borderline depressed patients, who tend to be burdened by an overly self-critical nature and are often driven by perfectionistic goals to which they aspire and often fall short. This interpretation must remain speculative, however, because no measure in our study or any previous research has been devised to differentiate the sense of evilness or inner badness that seems to characterize the borderline individual's experience from the perfectionist/self-critical experiences typical of neurotic level depression.

Similar to Southwick et al. we did not find a relationship between dependency and borderline pathology in our mixed-sex sample; however, we did find a relationship between Anaclitic Neediness and borderline pathology. Thus, it is likely that combining the more adaptive Interpersonal Depression subscale and the less adaptive Anaclitic Neediness subscale in the original Dependency factor might confound findings by weakening the strength of the correlations between the DEQ Dependency factor and other measures. It would be interesting to examine whether Southwick et al. [44] could find a similar pattern in their data.

Our findings that the borderline non-depressed group scored similarly to the borderline depressed group on the depression measures and higher than the depressed-only group suggest that depression may be ever more pervasive for those with borderline personality than generally acknowledged. That is, young adult

inpatients with borderline personality disorder do not have to have a diagnosed depressive disorder in order to be experiencing significant depression. Our finding is also consistent with recent findings from Westen and Shedler [66, 67]. For example, Westen and Shedler [66] found that borderline patients are most distinguished by their intense poorly modulated affect and by their ubiquitous dysphoria and desperate efforts to regulate their dysphoric affect. Additionally, quantitative unitary measures of depression such as the Beck Depression Inventory, the Hamilton Rating Scale, and SCL-90-R, which focus on symptoms and the severity of depression, appear to have limited utility in characterizing the quality of depression in patients with borderline pathology. Moreover, considering that the borderline non-depressed group scored as similarly to the borderline depressed group on the depression measures and higher than the depressed-only group, it is likely that structured interviews such as the SCID, with their focus on symptoms, also may not pick up on the distinctive phenomenology of borderline pathology. Conversely, although individuals diagnosed with borderline personality disorder typically present with dysphoric affect, this affect does not necessarily correspond to an Axis I major depression. Therefore, the quality and symptoms of depression in patients with borderline personality disorder needs to be carefully assessed, and the mere presence of depression cannot necessarily be assumed to indicate an Axis I major depression. Merely assessing the severity or the symptomatology of depression may be problematic for both clinical work and research. Indeed it may be that theoretically-driven, phenomenological dimensions ultimately have greater diagnostic utility than conventional so-called ''atheoretical'' DSM symptom clusters for understanding the experience of depression in patients with borderline personality disorder (although whether this perspective will yield knowledge of etiology, course, or treatment still needs to be established).

One other implication of our findings concerns the importance of the careful assessment for borderline personality disorder in inpatients that meet criteria for a depressive disorder. A number of studies indicate that many patients with major depression have concomitant personality disorders—even in outpatient settings [68–70]. Moreover, depressed patients with borderline personality disorder generally fare less well in treatment than depressed patients without borderline personality [71–78]. Similarly, pharmacological studies have found differences in medication response between borderline and non-borderline depressives [23, 79–82], with borderline depressives being less responsive to medications and sometimes even having a paradoxical effect [83, 84]. In terms of suicidality associated with major depression, recent research has found that objective severity of current depression does not distinguish patients who attempt suicide from those who have never attempted suicide. However, borderline personality disorder, higher scores on subjective depression, rates of lifetime aggression, and impulsivity all increase the frequency and lethality of suicidality in depressed patients [85–88]. These studies suggest that, although the severity of depression in terms of symptomatology is insufficient to explain suicidal behaviors in individuals who have major depression, the presence of borderline personality disorder, irrespective of a depressive disorder, increases the number and severity of suicide attempts. Given these findings, clinicians who consider axis I mood disorder diagnoses to be primary and borderline pathology to be less relevant for treatment planning may be seriously mistaken. In addition,

depression researchers who fail to assess for borderline personality disorder may find spurious results.[1]

A number of limitations of the present study are noteworthy. First, our sample was small and heterogeneous (high rates of multiple diagnoses). Although on the one hand, the study's small sample size renders the high level of significance in the expected direction as more impressive, small sample size, and therefore low power, is a potential weakness regardless of the results because the probability of rejecting a true null hypothesis is only slightly smaller than the probability of rejecting the null hypothesis when the alternative is true [89]. This limitation is offset to some degree by the fact that our results replicate previous findings. Heterogeneity notwithstanding, our sample is also representative of severely disturbed inpatient samples, and therefore has clinical relevance and ecological validity. Additionally, this limitation is less important when focusing on dimensions rather than on categorical personality diagnoses. Nevertheless, the sample's heterogeneity may mask or distort the very relations we are seeking to explore. Another limitation concerns the fact that our data were collected between prior to the advent of DSM-IV and therefore our diagnoses are based on DSM-III-R criteria. However, the symptoms for major depressive disorder are the same in both editions of DSM. With regard to BPD, there was only one change in the criteria. DSM-IV added the criterion of stress-related paranoid ideation or dissociative symptoms. Lastly, our findings may not be generalizable to outpatients, especially in light of research that suggests differences between in-and outpatients both regarding depression and personality disorders [90, 91]. Thus, the inclusion of outpatients, or even non-patients, representing a less severe end of the continuum, could alter our findings.

Strengths of the study include careful diagnostic work-ups of patients by highly trained clinicians using reliable structured interviews, the use of the new DEQ subscales, and the examination of BPD symptom clusters based on factor analysis. The use of the new DEQ subscales helps clarify previous inconsistencies in the literature and provides an incremental contribution to the literature on the relationship between personality dimensions and borderline personality disorders. The examination of BPD symptom clusters based on factor analysis is important because borderline personality disorder is a heterogeneous disorder which has implications for understanding developmental pathways, mechanisms of pathology, and treatment response.

In summary, our results suggest that the emptiness, sense of inner badness, and concern with potential abandonments and sense of aloneness experienced by patients with borderline personality is not simply the co-occurrence of two discrete diagnoses. But rather, as a number of theorists [10, 28, 29, 37, 80] and investigators [3, 18, 41] have contended, these feelings seem central to the pathology itself. Future research should focus on the social-cognitive processes [92–94] underlying these differences in the subjective experience of depression.

[1] Research with anxiety disorders has found similar findings with regard to the relationship between suicidality and impulsivity, aggression, and borderline personality disorder [95, 96]. Although initial studies suggested that individuals with panic disorder and anxiety symptoms are at increased risk for suicidality [97, 98], recent research indicates that panic disorder is not associated with suicidality in the absence of risk factors that include personality disorders, aggression, and impulsivity [95, 96]. In contrast, major depression was not a risk factor for suicidality in panic disordered patients [96].

**Acknowledgments** We wish to acknowledge the efforts of Diana Bowling, Kathleen E. Garnet, Pamela Harding, Steven Joy, Helen Sayward, Rachel Yehuda, and Kathy Zampano for diagnostic interviewing. We thank Adriana Gonzalez, Megan Elliot, Jennifer Hernandez, and Rachel Tomko for editorial assistance and John Kolligian, Jr. and Daniel F. Becker for their helpful comments to earlier drafts of the paper.

## References

1. Akiskal HS: Subaffective disorders: Dysthymic, cylothymic, and bipolar II disorders in the ''Aborderline'' realm. Psychiatric Clinics of North America 4:3–24, 1981.
2. Akiskal HS, Chen SE, Davis GC, et al.: Borderline: An adjective in search of a noun. Journal of Clinical Psychiatry 46:41–48, 1985.
3. Comtois KA, Cowley DS, Dunner DL, et al.: Relationship between borderline personality disorder and axis I diagnosis in severity of depressing and anxiety. Journal of Clinical Psychiatry 60:752–758, 1999.
4. Fryer MR, Frances AJ, Sullivan T, et al.: Comorbidity of borderline personality disorder. Archives of General Psychiatry 45:348–352, 1988.
5. Gunderson JG: Borderline Personality Disorder. Washington DC: American Psychiatric Press, 1984.
6. Gunderson JG: Personality disorders. In: Nicholi AM Jr (Ed). The New Harvard Guide to Psychiatry. Cambridge, MA: Belknap Press, 1988.
7. Gunderson JG: Borderline patient's intolerance of aloneness: Insecure attachments and therapist availability. American Journal of Psychiatry 153:752–758, 1996.
8. Gunderson JG, Elliott GR: The interface between borderline personality disorder and affective disorders. American Journal of Psychiatry 142:277–288, 1985.
9. Gunderson JG, Phillips KA: A current view of the interface between borderline personality disorder and depression. American Journal of Psychiatry 148:967–975, 1991.
10. Kernberg O: Borderline personality organization. Journal of the American Psychoanalytic Association 15:641–685, 1967.
11. Kernberg OF: Technical considerations in the treatment of borderline personality organization. Journal of the American Psychoanalytic Association 24:795–829, 1976.
12. Klein DF: Psychopharmacology and the borderline patient. In: Mack JE (Ed). Borderline States in Psychiatry. New York: Grune & Stratton, 1975.
13. Kroll J, Ogata S: The relationship of borderline personality disorder to the affective disorders. Psychiatric Developments 2:105–128, 1987.
14. Leibowitz MR, Klein DF: Interrelationship of hystroid dysphoria and borderline personality disorder. Psychiatric Clinics of North America 4:67–87, 1981.
15. Masterson J: Psychotherapy of the Borderline Adult. New York: Brunner/Mazel, 1976.
16. Perry JC: Depression in borderline personality disorder: Lifetime prevalence at interview and longitudinal course of symptoms. American Journal of Psychiatry 142:15–21, 1985.
17. Perry JC: A prospective study of life stress, defenses, psychotic symptoms, and depression in borderline and antisocial personality disorder and bipolar type II affective disorder. Journal of Personality Disorders 2:49–59, 1988.
18. Zanarini MC, Frankenburg FR, Deluca, et al.: The pain of being borderline: Dysphoric states specific to borderline personality disorder. Harvard Review of Psychiatry 6:201–207, 1998.
19. Akiskal HS: The temperamental borders of affective disorders. Acta Psychiatrica Scandinavica 89:32–37, 1994.
20. Carroll BJ, Feinberg M, Smouse P, et al.: The Carroll rating scale for depression. I. Development, reliability, and validation. British Journal of Psychiatry 138:194–200, 1981.
21. Davis GC, Akiskal HS: Descriptive, biological, and theoretical aspects of borderline personality disorder. Hospital & Community Psychiatry 37:685–692, 1986.
22. Schultz SC, Camlin KL: Treatment of borderline personality disorder: Potential of the new antipsychotic medications. Journal of Practical Psychiatry and Behavioral Health 5:247–255, 1999.
23. Pope HG, Jonas JM, Hudson JI, et al.: The validity of DSM-III borderline personality disorder: A phenomenologic, family history, treatment response, and long-term follow-up study. Archives of General Psychiatry 40:23–30, 1983.

24. Mcglashan TH: Borderline personality disorder and unipolar affective disorder: Long-term effects of comorbidity. Journal of Nervous and Mental Disease 175:467–473, 1987.
25. Nigg JT, Goldsmith HH: Genetics of personality disorders: Perspectives from personality and psychopathology research. Psychological Bulletin 115:346–380, 1994.
26. Adler G, Buie DH: Aloneness and borderline psychopathology: The possible relevance of childhood developmental issues. International Journal of Psycho-Analysis 60:83–96, 1979.
27. Grinker RR, Werble B, Drye R: The Borderline Syndrome. New York: Basic Books, 1968.
28. Adler G: Borderline Psychopathology and its Treatment. New York: Jason Aronson, 1985.
29. Kernberg OF: Borderline Conditions and Pathological Narcissism. Northvale, NJ: Jason Aronson, 1975.
30. Arieti S, Bemparod JR: Severe and Mild Depression: The Therapeutic Approach. New York: Basic Books, 1978.
31. Arieti S, Bemparod JR: The psychological organization of depression. American Journal of Psychiatry 137:1360–1365, 1980.
32. Beck AT: Cognitive therapy of depression: New perspectives. In: Clayton PJ, Barrett JE (Eds). Treatment of Depression: Old Controversies and New Approaches. New York: Raven Press, 1983.
33. Blatt SJ: Levels of object representation in anaclitic and introjective depression. Psychoanalytic Study of the Child 24:107–157, 1974.
34. Blatt SJ: Interpersonal relatedness and self-definition: Two personality configurations and their implication for psychopathology and psychotherapy. In: Singer JL (Ed). Repression and Dissociation: Implications for Personality Theory, Psychopathology and Health. Chicago: University of Chicago Press, 1990.
35. Bowlby J: The making and breaking of affectional bonds: I. Aetiology and psychopathology in the light of attachment theory. British Journal of Psychiatry 130:201–210, 1977.
36. Blatt SJ, Shichman S: Two primary configurations of psychopathology. Psychoanalysis and Contemporary Thought 6:187–254, 1983.
37. Blatt SJ, Auerbach JS: Differential cognitive disturbances in three types of borderline patients. Journal of Personality Disorders 2:198–211, 1988.
38. Blatt SJ, D'afflitti JP, Quinlan DM: Experiences of depression in normal young adults. Journal of Abnormal Psychology 85:383–389, 1976.
39. Zuroff DC, Quinaln DM, Blatt SJ: Psychometric properties of the DEQ. Journal of Personality Assessment 55:65–72, 1990.
40. Blatt SJ, Zuroff DC: Interpersonal relatedness and self-definition: Two prototypes for depression. Clinical Psychology Review 12:527–562, 1992.
41. Westen D, Moses MJ, Silk KR, et al.: Quality of depressive experience in borderline personality disorder and major depression: When depression is not just depression. Journal of Personality Disorders 6:382–393, 1992.
42. Wixom J, Ludolph P, Westen D: The quality of depression in adolescents with borderline personality disorder. Journal of the American Academy of Child and Adolescent Psychiatry 32:1172–1177, 1993.
43. Rogers JH, Widiger TA, Krupp A: Aspects of depression associated with borderline personality disorder. American Journal of Psychiatry 152:268–270, 1995.
44. Southwick SM, Yehuda R, Giller EL: Psychological dimensions of depression in borderline personality disorder. American Journal of Psychiatry 152:789–791, 1995.
45. Chevron ES, Quinlan DM, Blatt SJ: Sex roles and gender differences in the experience of depression. Journal of Abnormal Psychology 87:680–683, 1978.
46. Pidano AE, Tennen H: Transient depressive experiences and their relationship to gender and sex-role orientation. Sex Roles 12:97–110, 1985.
47. Rude SS, Burham BL: Connectedness and neediness: Factors of the DEQ and SAS dependency scales. Cognitive Therapy & Research 19:323–340, 1995.
48. Sanfiliop MP: Masculinity, femininity, and subjective experience of depression. Journal of Clinical Psychology 63:453–472, 1994.
49. Mickelson KD, Kessler RC, Shaver PR: Adult attachment in a nationally representative sample. Journal of Personality & Social Psychology 73:1092–1106, 1997.
50. Diehl M, Elnick AB, Bourbeau LS, et al.: Adult attachment styles: Their relations to family context and personality. Journal of Personality & Social Psychology 74:1656–1669, 1998.
51. Blatt SJ, Zohar AH, Quinlan DM, et al.: Subscales of attachment within the dependency factor of the Depressive Experiences Questionnaire. Journal of Personality Assessment 64:319–339, 1995.

52. Guttman L: Facet theory, smallest space analysis and factor analyses. Perceptual and Motor Skills 54:491–493, 1982.
53. Clarkin JF, Hull JW, Hurt SW: Factor structure of borderline personality disorder criteria. Journal of Personality Disorders 7:137–143, 1993.
54. Sanislow CA, Grilo CM, Mcglashan H: Factor analysis of the DSM-III-R borderline personality disorder criteria in psychiatric inpatients. American Journal of Psychiatry 157:1629–1633, 2000.
55. Sanislow CA, Grilo CM, Morey LC, et al.: Confirmatory factor analysis of DSM-IV criteria for borderline personality disorder: Findings from the Collaborative Longitudinal Personality Disorders Study. American Journal of Psychiatry 159:284–290, 2002.
56. Hollingshead AB, Redlich FC: Social Class and Mental Illness. New York: John Wiley and Sons, 1958.
57. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 3rd Ed., revised. Washington, DC: Author, 1987.
58. Blatt SJ, D'afflitti JP, Quinlan DM: Depressive Experiences Questionnaire. New Haven, CT: Yale University, 1979.
59. Derogatis LR: The SCL-90-R: Administration, Scoring and Procedures Manual II. Baltimore: Baltimore Clinical Psychometric Research, 1983.
60. Spitzer RL, Williams JBW, Gibbon M: Structured Clinical Interview of DSM-III-R-Patient Version (SCID-P). New York: Biometrics Research Department, New York State Psychiatric Institute, 1987.
61. Orvaschel H, Puig-Antich J: Schedule for Affective Disorder and Schizophrenia for School Age Children-Epidemiological Version (K-SADS-E), 4th Ed. Pittsburgh: Western Psychiatric Institute & Clinic, 1987.
62. Loranger A: Personality Disorder Examination (PDE manual). Yonkers, NY, DV Communications, 1988.
63. Spitzer RL: Psychiatric diagnosis: Are clinicians still necessary? Comprehensive Psychiatry 24:399–411, 1983.
64. Pilkonis PA, Heaper CL, Ruddy J, et al.: Validity in the diagnosis of personality disorders: The use of the LEAD standard. Psychological Assessment: A Journal of Consulting and Clinical Psychology 3:46–54, 1991.
65. Perry JC, Cooper SH: Psychodynamics, symptoms, and outcome in borderline and antisocial personality disorders and bipolar type II affective disorder. In: McGlashan TH (Ed). The Borderline: Current Empirical Research. Washington DC: American Psychiatric Press, 1985.
66. Westen D, Shedler J: Revising and assessing axis II, part I: Developing a clinically and empirically valid assessment method. American Journal of Psychiatry 156:258–272, 1999.
67. Westen D, Shedler J: Revising and assessing axis II, part II: Toward an empirically based and clinically useful classification of personality disorders. American Journal of Psychiatry 156:273–285, 1999.
68. Shea MT, Glass DR, Pilkonis PA, et al.: Frequency and implications of personality disorders in a sample of depressed outpatients. Journal of Personality Disorders 1:27–42, 1987.
69. Zimmerman M, Pfohl B, Coryell W, et al.: Diagnosing personality disorder in depressed patients: A comparison of patient and informant interviews. Archives of General Psychiatry 45:733–737, 1988.
70. Farmer R, Nelson-Gray RO: Personality disorders and depression: Hypothetical relations, empirical findings, and methodological considerations. Clinical Psychology Review 10:453–476, 1990.
71. Clarkin JF: Treatment of personality disorders. British Journal of Clinical Psychology 35:641–642, 1996.
72. Greenberg MD, Craighead WE, Evans DD, et al.: An investigation of the effects of comorbid axis II pathology on outcome of inpatient treatment for unipolar depression. Journal of Psychopathology & Behavioral Assessment 17:305–321, 1995.
73. Nurnberg HG, Raskin M, Levine PE, et al.: Borderline personality disorder as a negative prognostic factor in anxiety disorders. Journal of Personality Disorders 3:205–216, 1989.
74. Shea MT, Widiger TA, Klein MH: Comorbidity of personality disorders and depression: Implications for treatment. Journal of Consulting & Clinical Psychology 60:857–868, 1992.
75. Brown DD, Nolen-Hoeksema S: Therapeutic empathy and recovery from depression in cognitive behavioral therapy: A structural equation model. Journal of Clinical and Consulting Psychology 60:441–449, 1992.
76. Pfohl B, Stangl D, Zimmerman M: The implication of DSM-III personality disorders for patients with major depression. Journal of Affective Disorders 7:309–319, 1984.

77. Shea MT, Pilkonis PA, Beckham E, et al.: Personality disorders and treatment outcome in the NIMH Treatment of Depression Collaborative Research Program. American Journal of Psychiatry 147:711–718, 1990.
78. Tyrer P, Casey P, Gall J: Relationship between neurosis and personality disorder. British Journal of Psychiatry 142:404–408, 1983.
79. Gunderson JG: Pharmacotherapy for patients with borderline personality disorder. Archives of General Psychiatry 43:698–700, 1986.
80. Soloff PH, George A, Nathan RS, et al.: Progress in pharmacotherapy of borderline personality disorder. Archives of General Psychiatry 43:691–697, 1986.
81. Soloff PH: Pharmacological therapies in borderline personality disorder. In: Paris J (Ed). Borderline Personality Disorder: Etiology and Treatment. Washington DC: American Psychiatric Press, 1993.
82. Soloff P: Psychobiologic perspectives on treatment of personality disorders. Journal of Personality Disorders 11:336–344, 1997.
83. Koenigsberg HW: The combination of psychotherapy and pharmacotherapy in the treatment of borderline patients. Journal of Psychotherapy Practice and Research 3:93–107, 1994.
84. Soloff PH, George A, Nathan RS, et al.: Paradoxical effects of amitriptyline on borderline personality. American Journal of Psychiatry 143:1603–1605, 1986.
85. Brodsky BS, Oquendo M, Ellis SP, et al.: The relationship of childhood abuse to impulsivity and suicidal behavior in adults with major depression. American Journal of Psychiatry 158:1871–1877, 2001.
86. Corruble E, Damy C, Guelfi JD: Impulsivity: A relevant dimension in depression regarding suicide attempts? Journal of Affective Disorders 53:211–215, 1999.
87. Mann JJ, Waternaux C, Hass GL, et al.: Toward a clinical model of suicidal behavior in psychiatric patients. American Journal of Psychiatry 156:181–189, 1999.
88. Soloff PH, Lynch KG, Kelly TM, et al.: Characteristics of suicide attempts of patients with major depressive episode and borderline personality disorder: A comparative study. American Journal of Psychiatry 157:601–608, 2000.
89. Rossi JS: Statistical power of psychological research: What have we gained in 20 years? Journal of Consulting & Clinical Psychology 58:646–656, 1990.
90. Charney DS, Nelson JC, Quinlan DM: Personality traits and disorder in depression. American Journal of Psychiatry 138:1601–1604, 1981.
91. Pilkonis PA, Frank E: Personality pathology in recurrent depression: Nature, prevalence and relationship to treatment response. American Journal of Psychiatry 145:435–441, 1988.
92. Blatt SJ, Auerbach JS, Levy KN: Mental representations in personality development, psychopathology, and the therapeutic process. General Psychology Review 1:351–374, 1997.
93. Westen D, Lohr N, Silk K, et al.: Object relations and social cognition in borderlines, major depressives, and normals: A Thematic Apperception Test analysis. Psychological Assessment 2:355–364, 1990.
94. Yeomans F, Levy KN: An object relations perspective on borderline personality disorder. Acta Neuropsychiatrica 14:76–80, 2002.
95. Placidi GPA, Oquendo MA, Malone KM, et al.: Anxiety in major depression: Relationship to suicide attempts. American Journal of Psychiatry 157:1614–1618, 2000.
96. Warshaw MG, Dolan RT, Keller MB: Suicidal behavior in patients with current or past panic disorder: Five years of prospective data from the Harvard/Brown Anxiety Research Program. American Journal of Psychiatry 157:1876–1878, 2000.
97. Weissman MM, Klerman GL, Markowitz JS, et al.: Suicidal ideation and suicide attempts in panic disorder and attacks. New England Journal of Medicine 321:1209–1214, 1989.
98. Lepine JP, Chignon JM, Teherani M: Suicide attempts in patients with panic disorder. Archives of General Psychiatry 50:144–149, 1993.