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A Comparative Rorschach Study of Internalized Object Relations With Borderline Personalities and Neurotics.

Sandra Kaye Pitts
Louisiana State University and Agricultural & Mechanical College

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A COMPARATIVE ROHRSCHACH STUDY OF INTERNALIZED OBJECT RELATIONS WITH BORDERLINE PERSONALITIES AND NEUROTICS

The Louisiana State University and Agricultural and Mechanical Col.

PH.D. 1979

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A COMPARATIVE RORSCHACH STUDY OF
INTERNALIZED OBJECT RELATIONS WITH
BORDERLINE PERSONALITIES AND NEUROTICS

A Dissertation

Submitted to the Graduate Faculty of the
Louisiana State University and
Agricultural and Mechanical College
in partial fulfillment of the
requirements for the degree of
Doctor of Philosophy

In

The Department of Psychology

by
Sandra Kaye Pitts
B.A., University of North Carolina, 1974
M.A., Louisiana State University, 1976
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ABSTRACT

Two Rorschach rating scales, the Mutuality of Autonomy Scale and the Symbiosis Scale, were employed to investigate differences in the internalized object relations of borderline personalities and neurotics. It was hypothesized that borderline personalities would obtain higher scores than neurotics on each of the scales, the higher scores reflecting earlier stages in the development of object relations. The frequency of subjects producing responses reflecting primitive levels of object relations as measured by the Mutuality of Autonomy Scale was predicted to be higher for the borderline personalities than for the neurotics. Also, based on the idea that part-object relationships are characteristic of the structural organization of the borderline personality, it was reasoned that the proportion of scored responses on the Symbiosis Scale determined by the Parts category would be higher in the borderline personality sample.

Twenty adult subjects for each sample were selected from an inpatient psychiatric unit according to a set of criteria which included characteristics cited by Gunderson and Singer (1975), Kernberg's descriptive analysis (1975),
and DSM-II diagnostic categories. Subjects were administered the Rorschach according to standard procedures during their hospitalization. All 40 Rorschach protocols were independently scored by two raters using the Mutuality of Autonomy Scale scoring criteria and two raters using the Symbiosis Scale scoring criteria.

Results of the statistical analysis did not support the hypotheses. Two unpredicted positive linear trends, however, were found between the scales' scores and subject characteristics. The Mutuality of Autonomy Scale scores were positively associated with number of years education. Scores on the Symbiosis Scale were highly correlated with response productivity and, though not statistically significant, tended to increase as years of education increased.

Failure to find support for the hypotheses raises questions concerning the usefulness of the scales for assessing developmental levels of object relations. Although methodological limitations imposed by the use of inpatient populations may have resulted in sample overlap and reduced the likelihood of detecting true differences, the linear trends suggest that the scores on both scales were affected by individual characteristics independent of or whose relationship to levels of object relations development is unknown.

It is concluded that our understanding of the imagery and mental contents evoked in individuals by Rorschach inkblot
stimuli and their relationship to internalized object relations is still rudimentary. Further research is needed to demonstrate the scales' value for assessing this personality dimension.
CHAPTER I
INTRODUCTION

American psychology, psychiatry, and psychoanalysis have for the past three decades devoted their attention to a previously ignored clinical disorder referred to by a multitude of terms, e.g., borderline states (Knight, 1953), preschizophrenia (Rapaport, Gill, and Schafer, 1945-46), pseudoneurotic schizophrenia (Hoch & Polatin, 1949; Weingarten & Korn, 1967), latent schizophrenia (Mercer & Wright, 1950; Forer, 1950; Zucker, 1952), ambulatory schizophrenia (Zilboorg, 1941, 1957; Fisher, 1955; Rieman, 1953), latent psychosis (Bychowski, 1953; Rorschach, 1942), psychotic character (Frosch, 1964), "as-if" character (Deutsch, 1942), and borderline syndrome (Grinker et al., 1968; Gruenewald, 1970; Masterson & Rinsley, 1975). The vast array of terms reflects not only the difficulty in classifying this spectrum of psychopathological behavior and the resulting nosological confusion, but underlying theoretical distinctions as well.

In recent years the conceptualizations of the borderline personality developed in light of ego psychology and psychoanalytic object relations theory (Kernberg, 1975; Mahler, 1975; Masterson, 1972) have contributed much more to
understanding this realm of psychopathology and to clarifying many of the seeming incongruencies surrounding the symptomatology, etiology, and diagnostic performance. In line with their formulations, the admixture of presenting symptoms, previously regarded as illustrative of the transitional qualities and the heterogeneity of conditions, has been reinterpreted as representing varieties of a chronic, unitary syndrome having a specific pathology of the intrapsychic structural organization.

From his complex, triadic analysis of the borderline conditions, Kernberg (1975) unifies this grouping of stable psychopathological constellations on the basis of their typical symptomatic pictures, their typical constellations of the defensive operations of the ego, their characteristic genetic-dynamic components, and their particular pathology of internalized object relations, which differentiates them from neurotics and psychotics. Central to his structural theory is the idea that internalized object relations impose structure on the psychic content of the unconscious conflict and that the mental contents in turn reflect the organization of the internalized object relations. The structural derivatives of this internalization process, that is the quality of the object relations and the degree of superego integration, according to Kernberg, constitute the major
part of prognostic criteria for intensive psychotherapy of borderline patients.

Similarly, Mahler (1972) acknowledges as impetus for the development of her theory of object relations, the delineation of the separation-individuation process, a major tenet of psychoanalytic metapsychology originating with Freud, "... that object relationship, i.e., the person's endowing another with object libido, is the most reliable single factor by which we are able to determine the level of mental health on one hand and, on the other, the extent of the therapeutic potential" (1972, p. 333).

Derived independently, Kernberg's and Mahler's stage theories together provide insights into the pathogenic development, the structural pathology, and the diagnostic and therapeutic phenomena distinguishing the borderline personality from other clinical entities. Inherent in both schemes is the assumption that the pathogenic events giving rise to the structural organization of the borderline personality occur before attainment of object constancy and that the psychopathology is in essence the result of impaired object relations. By contrast, with pathological conditions at later stages after object constancy has been achieved, as may occur with character and symptomatic neuroses, impairment in object relations is averted. With regard to these
conditions as well as to normality, Kernberg states "... there is no particular pathology of internalized object relations beyond that of highly individualized neurotic transference dispositions" (1972, p. 243).

Problem

In accordance with the formulations of Mahler and Kernberg, borderline personalities and neurotics should be distinguishable on the basis of their internalized object relations as reflected in their mental contents. Recent developments with the Rorschach Inkblot Test evolving from the works of psychoanalytic object relation theorists suggest that the repertoire of mental representations appearing in Rorschach responses may lend itself to assessment of one's underlying internalized object relations, thereby increasing our understanding of the intrapsychic structural organization and enhancing the diagnostic and clinical value of the instrument. The Mutuality of Autonomy Scale (Urist, 1975) was constructed to correspond with gradations in the development of object relations by focusing on the portrayal of relationships between animate and inanimate figures in Rorschach responses. Another scale, the Symbiosis Scale (Fisher et al., 1977) was designed to measure the concept of
symbiosis on the basis of the appearance in the Rorschach responses of certain categories of content believed to be derivative of the symbiotic phase of development.

**Purpose and Objectives**

The general purpose of this study, then, was to investigate differences in internalized object relations of borderline personalities and neurotic individuals as revealed through differences in their Rorschach responses. Comparisons of the responses among the two groups were made on the basis of these two Rorschach rating scales. The objectives were: 1) to investigate whether borderline personalities can be distinguished from neurotics through differences in their scores on both scales; 2) to examine the distributions of the scored responses according to the Mutuality of Autonomy Scale in both groups and to relate scores to proposed stages in the development of object relations; and 3) to examine contributions of the content subcategories of the Symbiosis Scale to the total symbiosis scores. Results of the study, it was believed, would increase understanding of the value of this instrument for the assessment of structural levels of object relations and have implications for therapeutic intervention.
CHAPTER II

REVIEW OF THE LITERATURE

History of the Concept

Prior to the 1930's few references to individuals exhibiting both neurotic- and psychotic-like characteristics appeared in the clinical literature. A 19th Century psychiatrist (Rosse, 1890) described individuals who, despite their presenting a variety of neurotic-like symptoms, were somehow different and seemed to occupy a borderland between the neurosis and psychosis, "... standing in the twilight of right, reason and despair—a vast army whose units, consisting of individuals with minds trembling in the balance between reason and madness, are not so sane as to be able to control themselves, nor yet so insane as to require restraint or seclusion" (p. 669). Wolberg (1973) cites a reference by Freud appearing in a preface to Aichorn's book on juvenile delinquency in which he used "borderline and mixed cases" to describe adolescents whose object relations were less stable than those of neurotics. Interestingly enough, both of these early references implied a sense of stability to the pathology, a feature thereafter disputed by some and one
which carried important theoretical distinctions and eventuated in much nosological confusion. For as can be discerned from the following review, until the elaboration of ego psychoanalytic theories and the concomitant shift from a descriptive to an intrapsychic focus with the borderline patient, the coexistence of both neurotic and psychotic phenomena and/or symptoms was the only characteristic which achieved consensus among investigators.

Largely under the influence of Kraepelinian and Bleulerian diagnostic systems and in accordance with the traditional psychiatric nomenclature, much of the early clinical and psychological testing literature consisted of case reports and was characterized by phraseology typifying the dichotomous approach to psychopathology (Bleuler, 1950; Knight, 1953; Piotrowski et al., 1950; Rorschach, 1942; Zilboorg, 1941). With the gradually increasing literature concerning the so-called "borderline" personality, two theoretically distinct conceptualizations of the syndrome emerged. For those investigators who by recognizing the coexistence of neurotic and psychotic-like phenomena, transcended the discrete classificatory system, the borderline syndrome implied some sort of relatively stabilized and separate clinical entity lying on the continuum of psychopathology between neurosis and psychosis (Hendrick, 1936; Deutsch, 1942; Wolberg, 1952;
Mayer, 1950; Stern, 1938). For other investigators, however, the so-called borderline or its various equivalents, e.g., "latent psychosis" (Bychowski, 1953), "ambulatory schizophrenia" (Zilboorg, 1941), "pseudoneurotic schizophrenia" (Hoch & Polatin, 1949), represented a transitional fluctuating state along the neurotic-psychotic continuum, usually with a propensity for regression, a "break with reality," and an underlying schizophrenic process masqueraded by overt psychoneurotic symptomatology. More specifically, within this category are those who by adding modifiers have attempted to delineate it symptomatically from other schizophrenias but who nevertheless subsume it under the general rubric of schizophrenia. A statement by Edward Glover in 1932 (Knight, 1953) illustrates this position, "I find the terms 'borderline' or 'pre'psychotic, as generally used, unsatisfactory. If a psychotic mechanism is present at all, it should be given a definite label. If we merely suspect a possibility of a breakdown of repression, this can be indicated in the term 'potential' psychotic (more accurately a 'potentially clinical' psychosis)" (p. 2).

A few years later Zilboorg (1941) advocated a position similar to Glover's when he coined "ambulatory schizophrenia," so as to provide a qualifier for the basic term. Rejecting the notion that schizophrenia was a narrowly defined entity
that necessarily included more advanced symptoms such as shallowness or dullness of affect, delusional formations, auditory hallucinations, or ideas of reference, he used his term to describe a normal appearing individual who maintains adequate functioning and yet is prone to engage in autistic thinking, is chronically and inwardly angry, has few intimate friends, seldom needs hospitalization, and who presents a startling indifference to his own inappropriate behaviors.

In 1949, Hoch and Polatin introduced a term "pseudo-neurotic schizophrenia" to describe a borderline syndrome group whose underlying schizophrenic process was masqueraded by overt psychoneurotic symptomatology. Following Bleuler's model of schizophrenia which included the basic and accessory symptoms, they maintained that the presence of the basic mechanisms of schizophrenia (autistic thinking, ambivalence, affective disturbances which differed quantitatively and qualitatively from those of the psychoneurotic) as well as the presence of the more easily discerned triad of "pan-anxiety," "pan-neurosis," and "pan-sexuality," warranted classification of this grouping within the category of schizophrenia. In accordance with their additional criteria distinguishing the pseudoneurotic from the overt schizophrenic--1) transient psychotic episodes, 2) subtle thinking disorders, 3) chaotic psychosexual organization in which
pregenital components are predominant, and 4) less conspicuous regression than in overt schizophrenia—the pseudoneurotic form of schizophrenia resembles the so-called borderline disorder described by those who tended to emphasize the character or ego pathology, the stability, and the separateness of the syndrome (Hendrick, 1936; Deutsch, 1942; Stern, 1938). Importantly, though, their conceptualization did not preclude the possibility of further deterioration into a classical schizophrenic process and thus was regarded by some contemporaries (Mayer, 1950) as equivocal and incompatible with the more stabilized forms of pathology described.

Axel (1955), who attempted to advance the understanding of Hoch and Polatin's concept by presenting 10 "borderline" cases that had tentatively been diagnosed as pseudoneurotic schizophrenia, emphasized more firmly than the original authors the fluid, transitional quality of the pseudoneurotic and even posited that each case is an incipient schizophrenia. Conceptualizing psychopathology on a continuum, she contended that a psychoneurotic reaction may evolve into a pseudoneurotic stage and even further into a schizophrenic type of reaction. In reference to the cases presented with the objective of understanding the schizophrenic breakdown occurring in some, she stated, "... they zigzag over the imaginary line between psychoneurosis and schizophrenia in
an impressive way and bring to the surface conspicuously the various stages of substitution of one set of defense mechanisms for another" (p. 556). Like her predecessors, she viewed the pseudoneurotic schizophrenic as essentially a schizophrenic process which might surface only when psycho-neurotic or pseudoneurotic adjustment breaks down.

Similarly, Bychowski (1953) acknowledged the "latent" psychotic's potential for developing psychosis; however, the transitional fluctuating quality was overshadowed by his deference to the psychopathology of the ego. Postulating that the dynamic structure of the latent psychotic is built upon a "dissociated ego core," he explained it as such: "In the course of early development the splitting mechanisms come into action, so that early ego states remain untouched under the cover of later ego formulations. Accordingly, archaic constellations remain fixated and preserved, as it were, for future reference" (p. 491). Concomitant with the dissociated states is the split object relationship. With regard to its manifestations in the analysis transference, he stated ". . . the ego repeats the cleavage by the archaic ego which in its deep ambivalence had split parental images into bad and good objects" (p. 501). He proceeded to explain that the persistence of the unabated primitive drives and archaic defenses render the ego extremely weakened as
evidenced by the latent psychotic's poor resiliency and vulnerability to frustration, his magical thinking, irritability, and reaction to rage with only slight provocation. From an historical perspective Bychowski's conceptualization of the borderline patient could be considered transitional in that it retains a major feature emphasized by previously cited authors, the fluctuating transitory quality or the propensity for regression into psychosis, while also elaborating on concepts such as object relationships and ego defects already introduced by predecessors of contemporary ego psychoanalytic writers.

One of the earliest forerunners of ego-analytic theorists, Ives Hendrick (1936) proposed a theory of ego development and ego defect to enlighten character problems which he believed could not be fully understood with the instinct-ego conflict model. Due to some failures in transformations and executions of ego functions, ego defects "are made apparent by excessive inhibition or incomplete object relationships . . ." or "... by the presence of modified fantasies which are consciously though secretly experienced; they are accompanied by relatively little of the active guilt feeling and defensive repression . . ." (p. 321). His article is important because of the similarity of his ideas to those of
later ego theorists concerning intrapsychic events and resolutions of the borderline condition.

In the earliest clinical account of the "borderline" group of patients, Stern (1938) described the often-observed symptoms of exaggerated narcissism, inordinate hypersensitivity, psychic rigidity, the use of projective mechanisms, and difficulties in reality testing. In conjunction with the symptomatic picture, he acknowledged a correspondingly greater portion of the borderline patient's ego functioning being part of the illness than in that of the psychoneurotic.

Another investigator within the early mainstream of ego psychology, Deutsch (1942) observed a group of patients who, despite their emotional emptiness, appeared "as if" they were genuine and complete. The "as if" personality, considered by some (Modell, 1963; Rinsley, 1977, p. 48) to constitute a subgrouping within the borderline spectrum, was characterized by narcissism, a weak and unintegrated superego structure, and impoverished object relationships. The "as if" individual's reality testing nevertheless was preserved so as to exclude them from the psychoses. Underlying their superficially adaptive behavior, which usually presented as a continuous seeking of external reality, were transitory identifications based upon partial-object cathexes.
An article appearing a decade later, Leo Rangell's (1955) report of a previous year's panel addressing the clinical and theoretical issues of the borderline case, recapitulated the historical development of the "borderline" concept through the mid-1950's, including antecedents of current object relations theories. The panel's proceedings were devoted to discussing the less intense, although still existing dispute over the validity of the term itself, to clarifying some of the nosological confusion, and to examining questions concerning the introduction and nature of parameters in the classical psychoanalytic technique with borderline patients. As reported by Rangell, Ralph Greenson attributed much of the diagnostic and theoretical incongruencies to the use of the term by some to denote a fluid, transitional stage from neurosis and psychosis and by others to denote a fairly stabilized clinical picture with coexisting manifestations of psychosis, neurosis, and healthy ego functioning. Greenson's description of the "chronic borderline state" and his explanation in terms of ego functions, along with the presentations of other discussants, e.g., Zetzel, Gitelson, Zilboorg, and Frank, serve to illustrate the relative shift in emphasis from libido theory to that of ego functioning occurring at that time. The importance of assessing an individual's total ego functioning, a position already
advocated by Knight (1953), then, was receiving ever-widening acceptance and hence became a unifying factor and impetus for advancements in theory, diagnosis, and treatment with borderline patients. Borrowing Freud's metaphor of the retreating army to illustrate libidinal regression, Knight (1953) conceptualized the ego functions in a similar way. The "forward holding position" of the borderline's ego-defensive operation and the lag of others accounted for the wide range of adaptive and maladaptive functioning viewed in an individual as well as for the variety of symptomatic pictures presented by different borderline individuals. Perhaps it goes without saying that a reinterpretation of the transitory aspect in light of the spectrum of functioning implied in the qualitative and quantitative combination of various ego functions made the debate concerning the transitional nature versus the stability of the syndrome one of relative obsolescence. Of significance for this study, too, is the developmental formulation that Greenson offered in conjunction with his clinical description, an explanation amplified by later object relations theorists. As Rangell paraphrased it,

"... Greenson feels that there is a defect in the development of ego functions, stemming genetically from a disturbance in early object relations and with it in early identifications. In normal maturation there occurs a fusion of good and bad objects and introjects
which leads to ambivalence and which coincides with a more stable self-representation. In these patients, however, lack of fusion results in fragmentation, confusion between self and not-self, and faulty reality testing. The process of defusion can bring about the same result, and is usually accompanied by instinct defusion with a loss of neutralized instinctual energy necessary for proper ego functioning. . . . From the standpoint of libidinal development, there is usually a polymorphous-perverse picture. There is a prominence of organ pleasures at the expense of object relations, an inability to distinguish between forepleasures and true orgasm, and a wide range of libidinal zones and aims" (pp. 288-289).

In subsequent literature the particular impairment in object relations common to borderlines which differed from psychoneurotics and psychotics became an increasingly prominent area of focus.

**Historical Antecedents to Current Object Relations Theories of the Borderline Personality**

Rinsley (1977) has traced the earliest historical antecedents to current object relations theories of the borderline personality to Abraham's (1916) and Freud's (1917) formulations of the melancholic. "Freud clearly perceived in the melancholic the persistence of that form of object relations that proceeds from failure to achieve the differentiation of self from object, so that the latter variously and significantly reflects ("mirrors") the former" (1977, p. 49). The contributions of other writers cited by
him as having a significant influence on the works of current theorists are Rado's (1928) "double-introjection theory," Klein's (1940) theory of the paranoid and depressive positions and the concept of a split object, Fairbairn's (1954) elaboration of sequential stages in the development of object relations and transitional techniques, and Jacobson's (1964) writings on the development of self and object representation and the vicissitudes of ego and superego formation.

Frosch (1964) distinguished the "psychotic character" from the psychotic on the basis of differences in their object relationships and in three interrelated aspects of reality testing. The "psychotic character" a term he proposed to reduce the nosological confusion created by the multitude of terms (e.g., ambulatory schizophrenia, pseudoneurotic schizophrenia, borderline states, latent psychosis) designated a unitary syndrome whose features rather than representing a transitional phase from neurosis to psychosis are an integral part of the character structure. The admixture of presenting symptoms according to Frosch reflects varieties of a crystalized clinical entity characterized by a relatively higher level of object relationships than that achieved by the psychotic patient; a relative preservation of reality testing; a capacity for reversible regression so that there is transience to the psychotic character's symptomatology; and a
reality-syntonic adaptation. Having delineated what he believed to be three interwoven yet distinct areas of ego functions toward reality—the relationship with reality, the feelings of reality, and the capacity to test reality—he maintains that with the psychotic the disturbances occur in all three areas, whereas in the psychotic character the disturbances occur primarily in the first two areas of functioning. The capacity to test reality in the latter disorder, while being relatively less disturbed, is nevertheless defective and may be lost temporarily. An integral part of the ego's relationship to reality, according to Frosch, is the level of one's object relationships which are more advanced in the psychotic character than the psychotic. Viewed along a spectrum, the primitive object relationships of psychotics may fall "from cosmic identity, on through autistic and symbiotic relationships," (p. 89) while those of the psychotic character have progressed beyond the state of objectlessness to an infantile recognition of objects. With the self-object boundaries in the psychotic character being more firmly established, the dedifferentiation episodes are transient as opposed to the more long-standing episodes characteristic of psychotics.

Like Frosch, Modell (1963) regarded 'borderline' pathology as a fairly stable one and distinguishable from
schizophrenia on the basis of the former's further development along the object relations continuum. Unlike the schizophrenic who can totally abandon his relations to external objects, the borderline patient according to Modell maintains object relationships. Referring to Winicott's concept of the transitional object, Modell posited that ego development in both groups may have been arrested at this stage and that the schizophrenic's capacity to abandon his relationships is determined by the presence of some other factor, perhaps a biological one.

According to Zetzel (1971), the borderline personality is characterized by a relative developmental failure in three basic attributes: 1) the achievement of a self-object differentiation, 2) the recognition, tolerance, and mastery of separation loss in narcissistic injury, 3) the internalization of ego identification and self-esteem which, in turn, permits autonomy and the capacity to maintain stable one-to-one interpersonal relationships. These developmental failures or impairments may become manifest in difficulty in distinguishing reality and fantasy, magical expectations, episodes of anger and suspicion, excessive fears of rejection, a limited capacity to tolerate painful affect, a tendency to become highly manipulative and demanding, and a propensity for serious regression in intensive, unstructured treatment
situations. A brief evaluation of the patient's presenting mental status offers insufficient evidence to make a diagnosis of borderline personality since for many of these patients, the borderline character features become apparent only during the course of treatment and in the context of the one-to-one therapeutic relationship.

**Current Object Relations Theories of the Borderline Personality**

Kernberg's (1966, 1972, 1975) conception of the borderline personality organization was developed in light of psychoanalytic object relations theory and contemporary ego psychology. Rejecting the notions of the borderline as a transitory stage fluctuating between neurosis and psychosis, he states, "There exists an important group of psychopathological constellations which have in common a rather specific and remarkably stable form of pathological ego structure" (p. 1). According to Kernberg, borderline patients exhibit various symptomatic pictures and are characterized by a particular set of defensive constellations, a particular kind of pathology of internalized object relations, and a pathological condensation of pregenital and genital strivings under the influence of oral aggressions. His comprehensive theory integrates the symptomatic, structural, and
genetic-dynamic viewpoints. Descriptively, borderline personalities present typical neurotic symptoms which under closer scrutiny reveal various symptomatic constellations. Though not an exhaustive listing, the diagnostic elements include anxiety, polysymptomatic neurosis, polymorphous perverse sexual trends, the classical pre-psychotic personality structures, impulse neurosis and addictions, and lower-level character disorders, e.g., the infantile, narcissistic, and antisocial personality structures.

Kernberg integrates Freud's tripartite structural theory, Hartmann's broader focus on the ego's cognitive and defensive structures, and his analysis of structural derivatives of the internalized object relationships. His structural analysis is based upon his four-stage theory of internalized object relations:

**Stage 1.** Coextensive with the first month of life, this earliest stage of development "... precedes the establishment of the primary undifferentiated self-object constellation built up under the influence of pleasurable gratifying experiences of the infant in interactions with his mother" (1972, p. 234). Arrest at this stage according to Kernberg would preclude the possibility of building up the "all good"
self-object image and all other derived intrapsychic and interpersonal object relations. Autistic psychoses are expected to ensue from the pathology at Stage 1.

Stage 2. This stage spans approximately the 2nd and 3rd months of life and consists of "... the establishment and consolidation of an undifferentiated self-object image or representation of a 'rewarding' (or 'libidinally gratifying') type under the organizing influence of gratifying experiences of the child-mother unit... Simultaneously, a separate primitive intrapsychic structure representing an undifferentiated 'all bad' self-object representation is built up under the influence of a painful and frustrating psychophysiological state... In this way two sets of opposite primitive constellations of self-object affect dispositions are built up and fixated by memory traces as polar opposite intrapsychic structures" (1972, pp. 234-235). Arrest or regression to the second stage of development results in a lack of self-object differentiation.
and hence a failure to establish ego boundaries or to differentiate self from non-self in reality. A merger of the "all good" self-object images is evoked by frustration. Associated with arrest at this stage is the excessive use of the primitive mechanism of projection to expel the bad internalized object relations, resulting in paranoid distortions, overwhelming fears of primitive annihilation, and counter attempts to omnipotently control others. Most types of adult schizophrenia, some severe schizoid personalities, and the symbiotic psychoses of childhood are related to arrest at this stage of development.

**Stage 3.** Roughly spanning the 4th to 12th months of life, this stage consists of the differentiation of the self-image and object-image within the core "good" self-object representation, followed by the self-object differentiation within the core "bad" self-object representation. Concomitant with this intrapsychic differentiation is the differentiation
of self from non-self in the interpersonal world and the establishment of reality testing. Part-object relationships are characteristic for this stage since neither integration of the positive and negative self introjects nor of the positive or negative object introjects has occurred. "Splitting," the process by which libidinally and aggressively determined introjections (good self and object, bad self and object) are dissociated to prevent the arousal of anxiety, normally occurs during this stage. "Pathological splitting of the perception of other people into 'all good' ideal ones and 'all bad' persecutory ones is a central defense mechanism of patients with borderline personality organizations who present a pathological fixation or regression to Stage 3 of development of internalized object relations" (1972, p. 240). Reinforcing the defensive use of splitting are primitive idealization, projective identification, and denial which constitute the defensive constellation in the psychotic as well. In contrast to the psychotic who employs these defenses
to protect himself from his fears of engulfment and annihilation, the borderline personality utilizes them to achieve complete separation between love and hate. The nonspecific manifestations of ego weakness characteristic of the borderline patient (e.g., lack of impulse control, lack of anxiety tolerance, lack of sublimatory channels, as well as severe self-destructive patterns) are thought to be largely due to insufficient neutralization of instinctual energy which in turn is heavily dependent on the integration of contradictory affect states occurring in the context of internalized relationships.

Stage 4. Kernberg approximates the inception of this stage at some point between the 12th and 18th months of life and believes that it continues throughout childhood. The coalescence of both the positive and negative self and object images and the integration and further differentiation of affects occurs during this stage, resulting in both an integrated self-concept and an integrated concept of others.
Within the realm of internalized object relations a higher structure evolves. The 'ideal self' along with ideal object images, when integrated with the internalized prohibitive aspects of parental figures, become part of the superego. Pathological conditions at Stage 4 encompass the neuroses and higher levels of character pathology, particularly the hysterical, obsessive-compulsive, and depressive-masochistic characters. Individuals at this level have a well-integrated ego and ego identity and a stable self- and object-concept.

**Beyond Stage 4.** Progression beyond Stage 4 entails the development of a well-integrated and less punitive superego and realistic ego ideals and goals, thereby effectuating an equilibrium between one's internal needs and the environment.

Mahler's (1972, 1975) conceptualization of the developmental progression of object relationships evolved from her extensive observation of the mother/infant symbiotic dyad. The infant's differentiation from the "normal phase of human
symbiosis," a phrase that she and Benedek independently applied to the period of the mother/infant dual unity, entails a gradual step-like structural development leading to object constancy at approximately 36 months of age. Her explication of the subphase vulnerabilities and vicissitudes of a defective separation-individuation process from a developmental perspective elucidate the etiology of borderline pathology and the intrapsychic structural manifestations proposed by Kernberg. More recently she (Mahler and Kaplan, 1977) has enlarged her earlier developmental scheme by examining the interlocking strands of narcissism, psychosexual development, and object relations through the separation-individuation process.

As she delineates it, the first development phase, the autistic phase, extends from birth to approximately the second month of life. An objectless state of "primitive hallucinatory disorientation" (1975, pp. 7-8), during which the goal is essentially homeostasis, the tension-reducing operations of either partner of the dyad are indistinguishable to the neonate. Mahler regards this phase as part of the period Freud designated as primary narcissism. It corresponds to Stage 1 of Kernberg's structural theory.

The phase of symbiosis begins when the infant has some awareness of a need-satisfying object and extends
approximately to the sixth month of life. According to Mahler, it is characterized by "... hallucinatory or delusional, somatopsychic omnipotent fusion with the representation of the mother and, in particular, the delusion of a common boundary of the two actually and physically separate individuals" (1975, p. 9). Essential to movement beyond the "symbiotic orbit" and entrance into the separation-individuation phase is an optimal symbiotic gratification which is dependent upon the enterropropreoceptive pleasure and increasing pleasure in outer sensory perception. With an adequate symbiotic experience the development of ego functions proceeds, a rudimentary capacity to mediate between inner and outer perceptions becomes operative, the foundation for body image formation is laid, and pleasurable memory traces become linked with the mother's ministrations, thereby leading to higher forms of object relations. Deprivation or failure during this period, which can be neurologically and/or environmentally based, results in a symbiotic psychosis or regression to autism. Childhood psychosis, according to Mahler's formulation, consists of a combination of both autistic and symbiotic psychotic pathology. In autistic psychosis the regression to objectlessness precludes the capacity to retain any memory traces of good mothering. The symbiotic psychotic child, however, has some awareness of
the need-satisfying object to the extent of wishing to merge with its "good" aspect to avoid re-engulfment by its "bad" aspect. This stage roughly corresponds with Kernberg's Stage 2.

The next phase, the separation-individuation phase, has greater relevance to the psychopathology of borderline personality structures and is divided into four subphases: differentiation, practicing, rapprochement, and separation-individuation proper. With optimal symbiosis the differentiation subphase is begun at approximately six months of age. Curiosity, visual and tactile exploration, and initial venturing toward physical separation from the mother characterize the infant's behavior. The practicing subphase proceeds from about 10-16 months of age and is highlighted by free upright locomotion and a shift in cathexis to the outside world. Three interrelated developments recognized by Mahler as facilitating the early individuation process are the body differentiation from the mother, the establishment of a specific bond with her, and the growth of the autonomous ego apparatuses. Mahler proposes that an optimal psychological distance is one which permits the child freedom and exploration at some physical distance from the mother while yet offering assurance of the mother's continued emotional availability. "It is the specific unconscious need
of the mother that activates, out of the infant's infinite potentialities, those in particular that create from each mother 'the child' who reflects her own unique and individual needs. This process takes place, of course, within the range of the child's innate endowments" (1975, p. 19). Adequate "mirroring" is regarded by Mahler as a crucial variable for the infant's developing a sense of safety and exchanging his own magical omnipotence for autonomy in his developing self-esteem. The autonomous achievements occurring during this subphase serve as a main source of narcissistic enhancement from within. Self-love, primitive valuation of accomplishments, and omnipotence constitute three important components of narcissism of this phase. Both the differentiation and practicing subphases roughly fall within Kernberg's Stage 3.

At approximately 16 months of age, coinciding with the mastery of upright locomotion, the period of rapprochement begins and extends until the end of the second year. Contrary to the infant's relative obliviousness to the mother observed in previous practicing subphases, this period is highlighted by the infant's seemingly constant concern for the mother's whereabouts and a wish to have her participate in all of his new skills and acquisitions. Concomitant with the acquisition of perceptual cognitive faculties and primitive skills is a
greater differentiation between the intrapsychic self- and object-representation. Vulnerability during this subphase is viewed by Mahler as a significant factor in the etiology of adult borderline pathology. A mother's inability to accept the renewed demandingness of the infant's increasing autonomy impedes the separation process and resolution of the "rapprochement crisis," the crossroads at which the infant begins to relinquish the delusion of his omnipotence. The resulting narcissistic disturbance and deficiency in the integration and internalization mechanisms are the pathogenic foundations for the intrapsychic structural impairments in the borderline individual. Similar to Kernberg, Mahler relates the borderline's transference phenomena to reliance on splitting; "... the child has split the object world, more permanently than is optimal, into 'good' and 'bad'. By means of this splitting, the 'good' object is defended against the derivatives of the aggressive drive" (1971, p. 714). The timing of developmental events in the arrest posited to occur in borderline personalities, however, differs for the two theorists. Mahler places the time of developmental arrest somewhat later (16-25 months) than Kernberg (4-18 months).

With adequate resolution of the rapprochement crisis, that is the achievement of individual identity, the child
enters into the last subphase of separation-individuation, known as separation-individuation proper or the move toward object constancy. By the end of the third year coalescence of the positive and negative images of the mother and thus a level of whole object relations has been achieved and structuralization proceeds to normalcy or at worst to a neurosis. This last subphase (25-36 months) falls within Kernberg's Stage 4.

**Empirical and Definitive Studies**

Despite the vast literature on the borderline personality and its many equivalents, no consensus exists concerning a general definition of the syndrome or the identification of diagnostic criteria. Noticeably lacking are systematic empirical studies. One of the few research studies was conducted by Grinker et al., (1968; Grinker, 1977) with 51 borderline patients who were selected by an experienced psychiatrist on the basis of the uncertainty and difficulty in arriving at a diagnosis. Their lengthy investigation utilized personnel observations and extensive descriptions of the patients' behaviors, independent ratings by trained nonstaff, and complex statistical techniques including factor, discriminate, and cluster analyses. From their
statistical analyses they identified four behavioral manifestations of the borderline syndrome: 1) "the prevalence of anger," 2) "a defect in affectionate relations," 3) "an absence of indications of self-identity," and 4) "the presence of depressive loneliness." Four subgroups were distinguishable:

I. "Psychotic Border," a group characterized by difficulties in their relationships and behavior and affect which is predominantly negativistic, angry, and maladaptive.

II. "Core Borderline Syndrome," a group characterized by alternating anger and depression, vacillation toward and away from interpersonal relationships, and a tendency to act out.

III. "As-if Personality," a group characterized by a lack of a sense of personal identity and whose adaptation is passive and superficial.

IV. "Border with a Neurosis," a group characterized by anaclitic depressions in the face of frustration and relatively more positive affect than the other groups.

Based on their findings Grinker et al., concluded that the borderline syndrome is a nonschizophrenic disorder representing an arrested development of ego functioning which shows a considerable degree of stability and internal consistency.

In a study with acutely ill hospitalized patients, Gunderson, Carpenter, and Strauss (1975) utilized operational criteria to define borderline and schizophrenic samples and
then compared the matched groups on prognostic variables, symptoms, and two-year outcome results. From 142 patients who had met previous screening criteria and who presented a wide spectrum of psychiatric problems, the borderline sample was determined by first excluding all individuals "... who had severe or continuous psychotic symptoms (including hallucinations, delusions, thinking disorders and bizarre behavior)" and then eliminating from the reduced sample individuals with a diagnosis other than borderline. Results showed that psychotic symptoms among these patients, if present, were transient, circumscribed, and experienced as alien-like. Dissociative items were scored positively in 60% of the borderline sample. Depression was the most frequently occurring affective symptom although anxiety and anger also occurred frequently. Anger was self-reported more frequently than observed by an interviewer.

A comparison of the two groups' symptomatology in three categories of items—psychotic symptoms, affective symptoms, and dissociative experiences—revealed that borderline patients showed significantly fewer psychotic symptoms and significantly fewer dissociative experiences. A significantly greater number of schizophrenic subjects demonstrated anxiety while both samples showed comparable levels of depression. Statistical analysis of items comprising the
thought disorder dimension revealed marked differences in the two samples, with the borderline group rarely scoring positively on any of the included items. No significant differences in mean prognostic scores or outcome measures evaluating areas such as length of hospitalization, social contacts, and employment were obtained between the two groups. Comparing their sample selection process and results with those of the earlier study conducted by Grinker et al., (1968), these authors concluded that their sample fell closer to the schizophrenic pole of the spectrum than subjects in the former study. Like Grinker, they found considerable anger and depression among borderlines; however, only anger in the presence of intense dissociative experiences discriminated between borderlines and schizophrenics. Another finding common to both studies was that of little change in the functioning of borderlines at a two-year follow-up.

From their comprehensive overview of the descriptive literature concerning borderlines Gunderson and Singer (1975) identified the following six distinguishing characteristics that seemed to have achieved some consensus among researchers and which they believed offered a rational means for diagnosing borderlines during an initial interview:

1. The presence of intense affect usually of a hostile or depressive nature.
2. A history of impulsive, self-destructive behavior including drug overdose or dependency, self-mutilation, promiscuity, manipulative suicide attempts, and other self-destructive tendencies.

3. An inadequate social adaptation which may reflect a superficial identification with others.

4. Brief psychotic experiences usually with a paranoid quality.

5. A discrepantly more bizarre, disturbed performance on unstructured psychological tests such as the Rorschach than on objective or structured measures, such as the Wechsler Adult Intelligence Scale.

6. Interpersonal relationships characterized by vacillation between fleeting, superficial relationships to intense, dependent relationships involving manipulation, devaluation, and demandingness.

Horner (1976) attempted to integrate these features within a theoretical framework based upon the development of object relations.

Four methodological issues recognized by Gunderson and Singer as contributing to the seeming incongruencies among the various studies were discussed:

1. Author or source of the description, i.e., whether a description is provided by a clinical researcher focusing on observable symptomatology, a psychoanalytically-oriented psychotherapist focusing on psychodynamic formulations, or a clinical psychologist presenting psychological test findings.

2. The methods used to collect the data, e.g., the administration of the Rorschach versus the use of a structured interview.

3. The context in which the individual is observed, i.e., whether the individual is an inpatient or an outpatient who voluntarily seeks therapy.
4. The sample selection process.

In a more recent study Gunderson (1977) used the Diagnostic Interview for Borderlines (DIB) to assess their psychopathology in five areas of functioning identified in the previous study (Gunderson and Singer, 1975) and to determine the discriminant value of these characteristics when compared with other psychiatric groups. According to his results, the borderlines were significantly less stable in their work history during the past two years and were less likely to have areas of special achievement than were neurotic depressives. They were more likely to have an active social life and appear appropriate with socioeconomic peers than were schizophrenic patients.

Many of the items concerning impulse action patterns discriminated borderlines from both schizophrenics and neurotics. Borderlines were more likely to report having mutilated themselves, slashed their wrists, and to have made manipulative suicidal threats more frequently than the other two groups. Repeated abuse of drugs occurred more frequently among the borderlines. In general, while no particular type of acting out characterized the borderline sample, some form of acting out behavior was reported by every borderline patient.
Affectively, borderlines reported considerable depression, anxiety and anger; however, they were not significantly different on this dimension from the other two groups. Schizophrenics were more likely to present flat affect than the borderlines.

A comparison of the groups on the presence of psychotic symptoms reveal that borderlines experienced derealization less frequently than schizophrenics, but had more brief paranoid experiences than neurotics. Widespread delusions and hallucinations were much more prevalent in schizophrenics than borderlines. The most common psychotic symptom reported by the borderlines was psychotic ideation of a depressed nature. Another less frequently reported symptom was ideas of reference. Virtually no nihilistic or religious delusions, delusions of thought insertion, or delusions of somatic passivity were reported by borderlines. Contrary to an earlier study by Gunderson, Carpenter, and Strauss (1975), dissociative experiences were rarely reported by borderlines.

The interpersonal relationships of the borderline patients were depicted as dependent, masochistic, manipulative, and devaluative. They reported associating with many people and also having frequent break-ups in their intense relationships. A comparison of DIB responses revealed that schizophrenics were more likely to be socially isolated than
borderlines and that the quality of the borderline's interpersonal relationships was less stable and more intense than those of the other two groups. Problems with manipulation, devaluation, and anger discriminated borderlines from both comparison groups. Furthermore, masochistic and dependent behavior distinguished the borderlines from the schizophrenic sample. In support of the results reported by Grinker et al., (1968), borderlines were more likely to be involved in disturbed anaclitic relationships than were the other two clinical groups. The results of this most recent study lend empirical support for the set of distinguishing characteristics proposed by Gunderson's and Singer's original article as well as for some of the findings reported by Grinker et al., (1968) and Gunderson, Carpenter, and Strauss (1975). Moreover, as Gunderson has advocated, the distinguishability among the three groups would seem to warrant inclusion of the "Borderline" as a distinct entity in the psychiatric nomenclature.

Use of the Rorschach With Borderline Conditions

Less extensive than the clinical literature, the psychological testing literature devoted to reporting Rorschach behavior of individuals who would, according to the current concepts, be classified as borderline personalities, has
been largely impressionistic and based on unsystematic collection and analyses of data. As with the clinical material, the plethora of near equivalents appearing in the Rorschach literature—latent schizophrenic (Rorschach, 1942; Mercer & Wright, 1950; Forer, 1950; Zucker, 1952), latent psychotic (Rorschach, 1942), overideational preschizophrenic (Rapaport, Gill, & Schafer, 1945-46), schizophrenic character (Schafer, 1948), ambulatory schizophrenic (Fisher, 1955; Zilboorg, 1941; Rieman, 1953; Kutash, 1957), pseudoneurotic schizophrenic (Weingarten & Korn, 1967; Stone & Dellis, 1960), pseudocharacterological schizophrenic (Stone and Dellis, 1960), sub-clinical schizophrenic (Peterson, 1954), borderline schizophrenic (McCully, 1962; Kutash, 1957)—reflects clinical, nosological, and theoretical distinctions. Despite the seeming confusion, two consistently reported observations with borderline groups can be found. First, appearing in the Rorschach protocols of these individuals is a combination of neurotic- and psychotic-like features. Secondly, a disparity exists between these individuals' adaptive functioning in the environment and indicators in their Rorschach responses of internal disorganization and disturbances. As early as 1921 Hermann Rorschach (1942) described a 45-year-old woman whose Rorschach protocol was markedly more disturbed than her adequate social behavior.
In noting the self-references, the loss of distance from the cards, the scattered sequence, and the variability in the quality of responses, he acknowledged not only the difficulty in differentiating on the basis of one's Rorschach performance between a "latent psychosis" and a manifest one, but hypothesized that the responses of a latent schizophrenic may appear more deviant than those of a manifest disorder, an observation that later received support from other studies (Zucker, 1950; Mercer & Wright, 1950; Singer, 1977).

Rapaport, Gill, and Schafer (1945-46) conducted an important study with the so-called borderline patient. Using the general term "preschizophrenic," they subdivided 33 patients into 17 "overideational" and 16 "coarctated" preschizophrenics and reported the results of their performance on a battery of tests which included the Rorschach. The coarctated preschizophrenics were "... characterized by blocking, withdrawal, marked anxiety, feelings of strangeness, incompetence, extreme inhibition of affect, and some kind of sexual preoccupation" (Vol. I, p. 21). In contrast, the overideational group displayed "... an enormous wealth of fantasy, obsessive ideation, obsessions, and preoccupations with themselves and their bodies; these subjects were intensely introspective and preoccupied with their own ideas, and at first sight were often not easily distinguishable from
obsessional neurotics" (Vol. I, p. 21). Among what they believed were indications of autistic thinking—a large number of M with notable lack of color responses, arbitrary form responses if abundant, an extreme number of space responses, and pathological verbalizations—they emphasized the last "... an analysis of verbalizations is the most crucial and most frequently helpful procedure in the search for traces of autistic thinking ... they occur with startling frequency in a very large share of the records of schizophrenics, preschizophrenics, and related conditions" (Vol. II, p. 330). Included in their elaborate scheme of deviant verbalizations were several divisions, some of which have been adopted as such or with some slight modification in formal scoring systems (Exner, 1974; Friedman, 1952; Phillips and Smith, 1953) — fabulized responses\(^1\), fabulized combinations\(^2\), confabulations\(^3\), and contaminations\(^4\).

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\(^1\)A response, while not contradicting reality possibilities, shows an unduly affective elaboration. Example: Card II in reference to the black areas and the white space in the middle, "Lake ... dangerous rocks" (Vol. II, p. 332).

\(^2\)Two or more separately interpreted areas are combined on the basis of their spatial relationship; the resulting response is a percept which does not usually occur in nature. Example: Card VIII in reference to the side pink and the lower middle pink-orange area, "Two prairie dogs ... climbing on a butterfly" (Vol. II, p. 332).
Briefly, their results indicated that the average number of fabulized responses and fabulized combinations in the overideational preschizophrenics exceeded those of all other groups, e.g., paranoid schizophrenics, undifferentiated schizophrenics, depressive neurotics, and control subjects. Secondly, the incidence of confabulations in the overideational preschizophrenics equaled those of the unclassified schizophrenic groups. Thirdly, the frequency of contamination responses was considerably greater in the schizophrenic groups, was extremely rare in the preschizophrenic group, and tended to be higher in the deteriorated groups of schizophrenics. Generally though, contamination responses were infrequent even in the schizophrenic groups. In a later study, Schafer (1948) reclassified the preschizophrenic patient sample into three groups: schizoid character, schizophrenic character, and incipient character. Implied in his description of the "schizophrenic character," which he used interchangeably with the more popular "ambulatory

\[3\] A response in which percepts are combined on the basis of spatial relationship or some other quality shared by each, e.g., color. These responses represent the extreme tendencies present in both the fabulized responses and fabulized combinations. Example: Card V, "Two people lying down, tired, resting . . . somebody helping them, nature might be helping them . . . might be God" (Vol. II, p. 333).

\[4\] A response in which two interpretations to the same area are fused into one. Example: Card II, "Two people . . . holding up candles . . . like a temple here, too . . . might be ringing a church bell" (Vol. II, p. 338).
The characteristics of schizophrenia were two characteristics which thereafter occupied a place of prominence in both the clinical and psychological testing literature—first, the seemingly good stability of this group's personality functioning and secondly, the ego-syntonic nature of their "schizophrenic style of thinking." Despite the presence of confabulations, fantastic elaborations, self-references, fabulizing absurd percepts, and other peculiar verbalizations in test battery responses, these individuals were noted to function relatively well on the Wechsler Scale, a feature reported by later authors (Piotrowski, 1950; Mercer & Wright, 1950; Forer, 1950; Shapiro, 1954; Kutash, 1957; Stone & Dellis, 1960; McCully, 1962; Weingarten & Korn, 1967).

Acknowledging the equivalency of latent schizophrenia, borderline cases, and preschizophrenia, Zucker (1952) summarized the results of five cases of latent or early schizophrenia, many of which were in agreement with Rapaport, Gill, and Schafer (1945-46). Generally, these individuals showed a minimal loss of reality testing, a lack of conventional thinking, a tendency to engage in autistic fantasies, an estrangement from reality, ideas of reference, a tendency to attribute reality to the cards, and chaotic sexuality.
The general findings of the case reports appearing thereafter in the literature substantiated the results reported by Rorschach and Rapaport, Gill, and Schafer:

1. The Rorschach records revealed the presence of bizarre responses, contaminations, deviant ideation, perseveration, and confabulations (Fisher, 1955; Mercer & Wright, 1950; Forer, 1950; Kutash, 1957; Rieman, 1953).

2. A disparity existed between these individuals' seemingly good adaptive functioning in their environment and the extent of psychopathology suggested in the Rorschach record (Mercer & Wright, 1950; Forer, 1950; Kutash, 1957; Fisher, 1955; McCully, 1962; Weingarten & Korn, 1967).

3. Acceptance by the examinee of his pathological verbalizations was noted. "They have learned to accept their own disorganization and have learned to some degree to assimilate it rather than to treat it as a foreign element within themselves" (Fisher, 1955, p. 88).

4. Simultaneously, Rorschach protocols contained indicators of successful adaptive efforts to counterbalance the psychotic features referred to as "intact neurotic structure" (Miale, 1947) or
"profusion of neurotic defenses" (Weingarten & Korn, 1967). Weingarten, using a response sequence, illustrated the alternating defenses, regression to a more primitive level of organization, and "reconstitution through neurotic defenses" (p. 452).

Assessment of the adaptive features as well as the manifestations of primary process thinking, that is, the appraisal of the individual's ego functioning using the Rorschach received greater attention by diagnosticians (Shapiro, 1954; Holt, 1960) and paralleled a shifting emphasis in the clinical literature from the traditional impulse-defense model to the ego-structural approach. A proponent of the structural-dynamic interpretation of the Rorschach, Kutash (1957), reasoned that the highly variable clinical picture of the borderline patient is attributable to differential impairment of ego functions. With regard to the borderline patient, he recognized as the greater value of the instrument its ability to assess impairment in ego functions than its diagnostic or predictive utility.

Gruenewald's (1970) examination of Rorschach records for dynamic, structural, and genetic components represented one of the first attempts to evaluate the Rorschach data in light of ego psychoanalytic theories. Although lacking
scientific rigor and specific response examples, evidence for structural defects in the ego, disturbances in the object relationships, and tenuous impulse control was reported.

Two more recent studies with the borderline patient illustrate what is believed to be a trend among current investigators to advance our understanding of the developmental and structural aspects of these individuals by translating theoretical concepts into measurable Rorschach variables through the use of adjuncts to traditional scoring methods. Singer (1977) summarized the findings of several studies employing Friedman's Developmental Level Scoring System (1952) for the Rorschach. Borderlines and remitting schizophrenics differed significantly from non-remitting schizophrenics on 13 of 30 variables and a few other selected formal scores. The former two groups, however, revealed little differences on many items. A significantly greater number of borderline subjects than remitting and non-remitting schizophrenics gave two or more fabulized combination responses. Based on a further study of the components of fabulized combinations in which 61% of remitting schizophrenics versus 36% of borderline patients gave fabulized combinations integrating all parts which were, according to the scoring criteria, appropriate percepts for the particular blot area, the authors concluded:
... borderline persons are more likely to circumstantially lace together rather poorly defined unrealistic percepts than are the remitting schizophrenics. This appears to reflect the usual clinical impression that remitting schizophrenics, after their disordered episodes, often return to quite good levels of cognitive functioning and communication, while borderline persons are more likely to have islands of low-level, unrealistic ideas mixed among their thoughts on an enduring basis (p. 209).

Comparing the Rorschach responses of borderlines, schizophrenics, and neurotics using traditional forming scoring variables and Holt's Primary Process Scoring System, Katz (1976) reported that the total productivity (R) of borderlines was significantly higher than that of schizophrenics or neurotics, that the percentage of good form responses was significantly lower in borderlines than in neurotics, and that a large majority of borderline protocols contained confabulated and contaminated responses. In comparison with schizophrenics, borderlines had a significantly greater number of FC responses and a higher Z frequency than schizophrenics. Contrary to predictions, they showed more manifestations of primary process content in formal deviations of thought than schizophrenics. The tendency to yield formal deviations instead of very bizarre content at a more primitive level of primary process was interpreted as lending support for the previous literature findings and conclusions that borderlines may have a more subtle thought disorder.
In conclusion then, the Rorschach studies by and large have addressed the problem of establishing reliable criteria for the differential diagnosis of the borderline personality from the neurotic and schizophrenic. In some studies the objective, whether implicit or stated, to detect and thereby arrest a latent process attests to the controversy concerning the degree of stability implied in the term borderline personality and its equivalents. While some disagreement concerning nosology, etiology, symptomatology, and structural organization of the borderline personality continues to exist, contributions of psychoanalytic ego psychology have helped clarify what previously appeared to be inconsistencies in the diagnostic and clinical picture of these individuals. Concomitant with theoretical shifts, the focus of the Rorschach studies appears to have expanded to encompass not only traditional diagnostic considerations and interpretations within a classical psychoanalytic framework, but to investigate the intrapsychic structural components of the borderline personality as well.

Hypotheses

General objectives and specific hypotheses for this study were generated from theories of contemporary ego
psychoanalytic writers (Kernberg, 1966, 1972, 1975; Mahler, 1972, 1975) who regard the borderline personality as a stable form of pathological intrapsychic structure characterized by impairments in internalized object relations and ego disturbances. Having conceptualized the process of self-object differentiation as a continuum with sequential phases or stages, these theorists, though differing in the age approximations, nevertheless agree that the developmental arrest in the internalization process occurs during a later stage for the borderline than for the psychotic disorder but at an earlier stage than for the higher levels of character and symptomatic neuroses. Developmental disturbances are posited to occur before the attainment of object constancy; borderline psychopathology is in essence a result of impaired object relations. Object relations of character disorders, neurotics, and normals in contrast are fairly stable and integrated. In accordance with these theories, then, it was reasoned that borderline personalities and neurotic individuals would differ in their levels of internalized object relations as measured by their Rorschach responses. Comparisons of responses among the two groups were made on the basis of two Rorschach rating scales developed out of psychoanalytic object relations theory, the Mutuality of Autonomy Scale (Urist, 1975) and the Symbiosis Scale (Fisher et al., 1977).
A discussion of both scales and their scoring criteria are presented in the following chapter. General objectives and specific hypotheses of this study are stated below:

The first objective was to ascertain whether or not borderlines can be distinguished from neurotics through differences in their scores on both scales.

Hypothesis 1: Borderline patients will obtain higher scores than neurotics on the Mutuality of Autonomy Scale, a Rorschach rating scale designed to measure the developmental level of one's object relations. The progressive levels of the internalization process are ordered on this scale so that higher scores indicate more primitive levels along a continuum.

Hypothesis 2: Borderline patients will obtain higher total scores than neurotics on the Symbiosis Scale, which is believed to be another useful clinical measure for assessing the degree of separation-individuation achieved. Scores are derived from the accumulated number of responses whose content is thought to be a derivative of the symbiotic phase of development. Higher scores reflect a less well differentiated and integrated self and object concept.

The second objective was to examine the distribution of all scored responses according to the Mutuality of Autonomy Scale among both samples and to relate the scores to the
proposed stages in the development of object relations. Scale levels 1, 2, and 3, as described in the scoring criteria are thought to correspond to intrapsychic stages at which self-object differentiation and integration has been achieved, whereas levels 4, 5, 6, and 7 are thought to reflect stages preceding the attainment of object constancy.

Hypothesis 3: A higher proportion of borderline personalities than neurotics will have responses scored at levels 4, 5, 6, and 7.

The final objective was to examine the contribution of the content subcategories of the Symbiosis Scale to the total symbiosis scores. Based on the ideas of Kernberg and Mahler that part-object relationships are characteristic of the phase preceding integration of positive and negative introjects and of the structural organization of the borderline personality, the contribution of the Parts subcategory to the total symbiosis score was expected to be higher for borderline personalities than for neurotics.

Hypothesis 4: The proportion of Part responses to the total symbiosis scores for borderline personalities will be higher than the proportion of Part responses for neurotics.
CHAPTER III

METHOD

Subjects

The two samples for this study included a total of 40 adult participants, 20 who met criteria for Borderline personality, and 20 who met the criteria for the Neurotic comparison group. All subjects for both samples were selected from inpatients on the psychiatric unit at Parkland Memorial Hospital, Dallas, Texas, an acute treatment unit for a broad spectrum of psychiatric disorders. As a charity hospital and training site for a university medical center, it serves all ethnic groups and socioeconomic classes in the metropolitan area. No measure of a subject's socioeconomic class was made; however, both samples were composed primarily of patients whose socioeconomic status was estimated to be in the upper-lower to middle class range. The author attempted to match subjects according to sex and race. Time limitations, however, made it necessary for data collection to be completed before 20 pairs perfectly matched on these variables could be obtained. The male and female subjects in the Borderline sample numbered 6 and 14, respectively, and in
the Neurotic sample, 5 and 15, respectively. Racial compositions of the two samples were comparable. Caucasians and Blacks numbered 17 and 3, respectively, in the Borderline sample and 19 and 1, respectively, in the Neurotic group. Probability values obtained from chi-square (sex) and Fisher exact probability tests (race) revealed no significant differences between the two samples with respect to these characteristics. Sample characteristics and probability values are shown in Table 1.

**Borderline Sample.** Criteria for this sample included five of the six principal characteristics originally identified by Gunderson and Singer (1975) and later supported by Gunderson (1977) and additional criteria adopted to secure a more well-defined population:

1. Presence of intense affect, usually of a depressive or hostile nature.

2. A history of impulsive or self-destructive behavior, including drug overdose or dependency, promiscuity, self-mutilation, manipulative suicidal attempts, or other self-destructive tendencies.

3. An adequate social adaptation which may reflect a superficial identification with others. Vocational history may reveal a somewhat steady but nonprogressive employment.
Table 1
Sample Characteristics

<table>
<thead>
<tr>
<th>Variable</th>
<th>Borderline PERSONALITIES</th>
<th>Neurotics</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>20</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Age:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>27.10</td>
<td>29.35</td>
<td>.43</td>
</tr>
<tr>
<td>Range</td>
<td>18-40</td>
<td>19-46</td>
<td></td>
</tr>
<tr>
<td>SD</td>
<td>5.99</td>
<td>7.21</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
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<tr>
<td>Male</td>
<td>6</td>
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<td>.72</td>
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<tr>
<td>Caucasian</td>
<td>17</td>
<td>19</td>
<td>.30</td>
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<tr>
<td>Marital Status:</td>
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<tr>
<td>Never Married</td>
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<td>4</td>
<td></td>
</tr>
<tr>
<td>Married</td>
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<td>2</td>
<td></td>
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<tr>
<td>Separated</td>
<td>2</td>
<td>8</td>
<td></td>
</tr>
<tr>
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<td>5</td>
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<tr>
<td>Widowed</td>
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<td>1</td>
<td></td>
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<tr>
<td>Education (years):</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>11.90</td>
<td>11.80</td>
<td>.40</td>
</tr>
<tr>
<td>Range</td>
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<td>6-14</td>
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<td>SD</td>
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<tr>
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<td>11</td>
<td>14</td>
<td>.33</td>
</tr>
<tr>
<td>Yes</td>
<td>9</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Number of Previous Hospitalizations:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>27</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Rorschach Responses:</td>
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<td></td>
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<tr>
<td>Mean</td>
<td>27.95</td>
<td>26.05</td>
<td>.71</td>
</tr>
<tr>
<td>Range</td>
<td>16-44</td>
<td>11-59</td>
<td></td>
</tr>
<tr>
<td>SD</td>
<td>9.40</td>
<td>10.26</td>
<td></td>
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</tbody>
</table>
4. Transient psychotic episodes which may have a paranoid quality.

5. Interpersonal relationships characterized by a vacillation between fleeting, superficial relationships to intense, dependent relationships involving manipulation, devaluation, and demandingness.

6. A diagnosis of borderline, paranoid, schizoid, cyclothymic, sociopathic, or other severely disturbed character disorder configurations, exhibiting the characteristics above. This is in accordance with Kernberg's (1975) descriptive analysis of the borderline personality, which, he believes, encompasses a spectrum of extremely disturbed character disorders with specific presenting symptomatology, e.g., anxiety, polysymptomatic neurosis, polymorphous perverse sexual trends, impulse neurosis and addictions.

7. No evidence of organicity or mental retardation.

8. No evidence of continuous psychotic symptoms, including hallucinations, delusions, thinking disorders, and bizarre behavior.

9. No other diagnosis considered definitive of Schizophrenia, Major Affective Disorder, or Psychotic Depressive Reaction.

The set of criteria was distributed to the unit's chief psychiatrist, residents in psychiatry, the Ph.D.-level clinical psychologist, and doctoral students in clinical psychology, with a request for referrals who satisfied all of the above criteria. Former patients who met the above set of criteria and who had been administered the Rorschach during their recent hospitalization on the unit as part of a psychological evaluation
were also eligible for the study. A final decision regarding the suitability of the referral was determined conjointly by the investigator and the referring person.

Subjects in the Borderline sample ranged in age from 18 to 40 with a mean of 27.10 and a standard deviation of 5.99. The educational level ranged from 8 to 19 years with a mean of 11.90 and a standard deviation of 2.59. Nine or 45% of these patients had had previous psychiatric admissions. Six or 30% reported having had two or more hospitalizations and among these were two members who had been hospitalized seven times. Total number of hospitalizations for this group was 27.

At the time of this study the Diagnostic and Statistical Manual of Mental Disorders, third edition (DSM-III) was being introduced to the psychiatric unit's staff; however, its adoption was postponed until further clarification was received from the Department of Psychiatry. The administrating psychiatrist and psychiatry residents, therefore, continued to employ DSM-II categories in their psychiatric evaluations and diagnostic formulations. In line with their understanding of the concept of borderline personality and familiarity with the psychoanalytic literature, the term Borderline Personality was employed by them as a
diagnostic category, in some cases as a specific personality disorder and in other cases cojointly with a DSM-II personality disorder category. For some patients the resident or chief psychiatrist included in his diagnostic formulation multiple diagnoses or qualifying phrases according to DSM-II guidelines. For the purposes of this study, only the Neurotic and Personality Disorder Categories are included here. Eleven members of the sample were diagnosed as Borderline personality disorders. Four members received a diagnosis of severe Hysterical personality; three were diagnosed as Antisocial personalities; one member was diagnosed as Inadequate personality; and one received a diagnosis of Passive-Dependent personality with histrionic features.

Fifteen subjects or 75% admitted to having suicidal ideation at the time of the present admission. Four subjects reported having made only one suicide attempt; 12 or 60% reported having made at least two attempts and three of these indicated that they had made four or more suicide attempts. Thirteen members of the sample reported some type of drug abuse. Five indicated that they had abused a multiple number of drugs; two reported abuse of hallucinogens only; two reported abuse of barbituates or minor tranquilizers; three reported
longstanding abuse of alcohol and one reported short-term alcohol abuse. Promiscuous behavior was reported by four individuals, one of whom had a history of at least two arrests for prostitution. Head-banging was reported by two of the subjects. Several members had one or more legal convictions, including one who had been incarcerated briefly for armed robbery and assault and battery, one who had been incarcerated after a conviction on a stolen motor vehicle charge, and three who had been arrested for shoplifting.

Intense affects, though varying among subjects, served as one of the chief, admitting complaints for Borderline personality subjects. Eight (49%) reported feelings of depression; one reported feeling only anger; seven reported alternating feelings of anger and depression. Both anxiety and anger were reported by one subject, and alternating periods of anger, depression, and anxiety were reported by three subjects.

Ascertaining whether a patient had experienced transient psychotic episodes was somewhat difficult, particularly in cases in which the patient served as the only informant. Nevertheless, the evaluation data and historical information available suggested that previous occurrences of episodes which could be construed
as psychotic was highly probable for all 20 members, and that for 16 of the 20 subjects at least one psychotic episode was considered certain. The most frequently reported psychotic experience, brief episodes of paranoid ideation, was reported by 10 members or 50% of the sample. The next most frequently occurring types of experiences, brief auditory and visual hallucinations, were reported by 25% and 20% of the subjects, respectively. Three subjects reported depersonalization experiences and two were known to have experienced derealization. Psychotic-like episodes involving rage and some destructive act was described by three subjects; psychotic ideation related to depression was described by one subject. Two subjects reported dissociative episodes; one reported having ideas of reference, and two described psychotic-like episodes following periods of alcohol abuse. Frequencies of the various psychotic experiences reported by Borderline personality subjects are shown in Figure 1.

**Neurotic Comparison Sample.** Subjects for the Neurotic comparison group met all of the following criteria:

1. A diagnosis of some type of symptomatic or character neurosis. Subsumed under this grouping are various symptom neuroses, e.g.,
Figure 1
Frequency of Psychotic Experiences in Borderline Patients

PSYCHOTIC EXPERIENCES

A - Depersonalization
B - Derealization
C - Dissociative Episodes
D - Ideas of Reference
E - Paranoid Ideation
F - Auditory Hallucinations
G - Visual Hallucinations
H - Alcohol-related Psychotic Episodes
I - Psychotic Ideation - Depressive
J - Psychotic Ideation - Rage
hysterical, phobic, depressive, as well as other neuroses, and the higher levels of character pathology, e.g., hysterical personality, obsessive-compulsive personality, passive-aggressive personality, and unspecified personality disorders who exhibit no severe degree of disturbance.

2. No previous diagnosis considered certain of any psychotic disorder, including Schizophrenia, Major Affective Disorder, Psychotic Depressive Reaction, or Unspecified Psychosis.

3. No chronic addictions to alcohol or other drugs.

4. No evidence of organicity or mental retardation.

As with the former sample, this set of criteria was distributed to the unit's professional staff and the selection procedure was the same as outlined above.

Members of this sample ranged in age from 19 to 46 with a mean age of 29.35 and a standard deviation of 7.21. The educational level ranged from 6 to 14 years with a mean of 11.80 and a standard deviation of 1.99. Comparisons of the two samples using two-tailed t-tests revealed no significant differences on these two variables. Probability values are given in Table 1.

Six members (30%) of the Neurotic group reported previous hospitalizations, three of whom had been hospitalized on at least two previous occasions. The number of previous hospitalizations for all 20 members totaled 11. A chi-square analysis to determine if the
two samples differed with respect to previous hospitalizations versus no previous hospitalizations was not significant (p=.328). A t-test to determine if the two groups differed with respect to the mean number of hospitalizations was also nonsignificant.

Nine members of this sample were diagnosed as Depressive neurosis, four as Hysterical personality, and three as Passive-Dependent personality. One member fell into each of the following diagnostic categories: Obsessive-Compulsive neurosis; Obsessive-Compulsive personality; Passive-Aggressive, Passive-Dependent personality; and Passive-Aggressive personality.

Suicidal ideation was reported by 11 members of the Neurotic sample. Twelve (60%) reported no history of any type of suicidal gesture or serious attempt. Five members reported having made one suicide attempt, and two members had a history of two attempts. One subject, in reporting three episodes of drug overdose, indicated that all were merely gestures designed to attract attention from family members.

As specified by the selection criteria, an individual with a history of chronic drug addiction was excluded from the Neurotic group. Nevertheless, drug abuse of various kinds was reported by Neurotics with similar
frequency to that of Borderline personalities. Eight subjects (40%) reported no drug abuse of any kind as compared to seven members in the Borderline sample. Five Neurotic subjects indicated that they had abused alcohol for only brief periods of time, whereas in the former sample, alcoholic abuse was for three members, a longstanding problem. Abuse of barbituates or minor tranquilizers was reported by two members of the Neurotic sample. One member reported abuse of narcotic analgesics as a teenager and one reported abuse of amphetamines.

Other self-destructive behaviors, like those reported by members of the Borderline personality sample, were reported rarely by Neurotics. Instead, self-defeating behaviors, e.g., incurring financial debts, experiencing interpersonal problems with supervisors or coworkers, were more likely to be reported. Frequencies of self-destructive ideation and behaviors for the two samples are shown in Table 2.

Transient psychotic episodes were reported by only two subjects in the Neurotic sample. One reported a single depersonalization experience, and one reported visual hallucinatory experiences.

Anticipating that psychototropic medication would have been administered to some of the prospective subjects prior to psychological testing and realizing the difficulty in
Table 2
Frequency of Patients Reporting Self-Destructive Ideation or Behavior

<table>
<thead>
<tr>
<th></th>
<th>Borderline Personalities</th>
<th>Neurotics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>N</strong></td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td><strong>Suicidal Ideation:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>15</td>
<td>11</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td><strong>Suicidal Gestures and Attempts:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>One</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2-3</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>4 or more</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td><strong>Drug Abuse:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Alcohol-Short Term</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Alcohol-Longstanding</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Barbit., Tranquilizers</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Narcotics</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Multiple Drugs</td>
<td>5</td>
<td>3</td>
</tr>
</tbody>
</table>
matching subjects for this variable, the author introduced no control for psychotropic medication. Any prospective subject who was believed to be heavily sedated as a result of medication, however, was excluded from the study.

Twelve of the Borderline patients and 11 Neurotic patients had received no psychotropic medication prior to administration of the Rorschach. Of those Borderline patients who had received medication, two had received several administrations of a sedative hypnotic during the few days preceding their participation in the study, two had been taking routine neuroleptics, one had received only one administration of a neuroleptic, one was receiving a tricyclic antidepressant, one was receiving anticonvulsant medication, and one had received both neuroleptics and a CNS depressant. Among the Neurotic patients who had received medication, two had been administered a combination of CNS depressants, one had received only one administration of a neuroleptic, two were taking a tricyclic antidepressant, one had received both neuroleptics and a CNS depressant, one was receiving Lithium Carbonate, one member had received a combination of a CNS depressant, anticonvulsant, and a tricyclic antidepressant, and one had received a combination of a CNS depressant and an anticonvulsant.
Measures of Object Relations

Two recently developed Rorschach scoring scales whose theoretical underpinnings are found in current object relations theory were employed. With one of the scales, the Mutuality of Autonomy Scale (Urist, 1975), the assessment of one's internalized object relations is determined primarily by the structural properties of an object representation in a response while with the other scale, the Symbiosis Scale (Fisher et al., 1977), a score is content-derived.

In order to demonstrate the structural theorists' position that an individual's capacity to experience self-other relationships are consistent and enduring and can be defined along a developmental continuum, Urist (1975) constructed the Mutuality of Autonomy Scale to measure the structure of a patient's object relations on the basis of the Rorschach responses. Specifically, the scale focuses on the progression of the separation-individuation process to assess "... the degree to which relationships between figures on the Rorschach were perceived in terms of mutuality of autonomy," by defining scale points which correspond to gradations in the developmental sequence. The scale's 7 points and their assigned numerical value are presented in Table 3.
Table 3
Mutuality of Autonomy Scale Scoring Criteria

1. Figures are engaged in some relationship or activity where they are together and involved with each other in such a way that conveys a reciprocal acknowledgment of their respective individuality. The image contains explicit or implicit reference to the fact that the figures are separate and autonomous and involved with each other in a way that recognizes or expresses a sense of mutuality in the relationship. (For example: on Card II, "Two bears toasting each other, clinking glasses.")

2. Figures are engaged together in some relationship or parallel activity. There is no stated emphasis or highlighting of mutuality, nor on the other hand is there any sense that this dimension is compromised in any way within the relationship. (Card III: Two women doing their laundry.)

3. Figures are seen as leaning on each other, or one figure is seen as leaning or hanging on another. The sense here is that objects do not "stand on their own two feet," or that in some way they require some external source of support or direction.

4. One figure is seen as the reflection, or imprint, of another. The relationship between objects here conveys a sense that the definition or stability of an object exists only insofar as it is an extension or reflection of another. Shadows, footprints, etc., would be included here.

5. The nature of the relationship between figures is characterized by a theme of malevolent control of one figure by another. Themes of influencing, controlling, casting spells are present. One figure may literally or figuratively be in the clutches of another. Such themes portray a severe imbalance in the mutuality of relations between figures. On the one hand, figures may be seen as powerful and helpless, while at the same time others are omnipotent and controlling.
6. Not only is there a severe imbalance in the mutuality of relations between figures, but here the imbalance is cast in decidedly destructive terms. Two figures simply fighting is not "destructive" in terms of the individuality of the figures, whereas a figure being tortured by another, are considered to reflect a serious attack on the autonomy of the object. Similarly, included here are relationships that are portrayed as parasitic, where a gain by one figure results by definition in the diminution or destruction of another.

7. Relationships here are characterized by an overpowering, enveloping force. Figures are seen as swallowed up, devoured, or generally overwhelmed by forces completely beyond their control.

Note: A Rorschach response which meets one of the above descriptions is assigned a score which corresponds to the numerals shown. Scores range from 1 - 7.
Six different scores were derived: 1) an overall score given by raters on the basis of all scorable responses, 2) a score reflecting the single healthiest response, 3) a score reflecting the most pathological response, 4) a score representing the average of the best eight scored responses, 5) an average of the worst eight scored responses, and 6) the arithmetic average of all scored responses. With an inpatient population covering a broad spectrum of psychopathology, highly significant intercorrelations (p<.001) were obtained among the Rorschach ratings and two other measures of the separation-individuation dimension, an Autobiography scale and a Staff rating scale. Intertest correlations using all 6 scores were significant beyond the .001 level with the overall score, a subjective score, yielding the highest correlation with the other two measures. Correlations obtained using the average score of all responses were slightly lower. These results were interpreted as lending support for the assumption that the Rorschach may tap structural aspects of one's object relations. Interscorer reliability ratings in terms of the percentage of agreement between scale raters ranged from .52 for percent of exact hits to .86 for percent within one scale point.

Another scale was developed by Fisher, Moelis, and Wright (1977) to objectively measure the concept of symbiosis.
Although the scale was constructed and validated on the basis of children's Rorschach responses (mean ages = 10.38, 9.47, 9.36, 8.10, 9.53, 11.10), it is believed that this scale may have useful research and clinical applications with adult populations. Examination of the protocols revealed inter-group differences in four areas of response content which they believed were reflecting important dimensions of the separation-individuation process and were consistent with their conceptualization of symbiosis:

1. Parts. The appearance of parts of animate and inanimate objects, they hypothesized, may reflect a poorly integrated self-concept or identity sense.

2. Touch. The authors hypothesized that the appearance of responses showing touch between animate and inanimate or between animate objects may reflect a lack of differentiation or separation and some sort of a dependent unity between self and object.

3. Death. Death-related content was believed to be reflecting separation-individuation anxiety, that is, anxiety related to loss of sense of self versus the perceived loss of others.

4. Orality. Although no particular hypothesis relating orality and symbiosis was offered, dependency and emotional need implied by oral content was believed to be compatible with the concept of symbiosis.

Complete scoring criteria and examples for each category are presented in Table 4. An individual's total symbiosis score equals the number of responses which contain content
Table 4
Symbiosis Scale Scoring Criteria

I. Parts
   A. Discrete parts
      1. Score parts of animate objects (e.g., a man's face; a dog's tail). Score all anatomy responses with the following exceptions:
         - blood
         - skin, pelts, hides
         - general dissections without reference to a specific organ
         - general reference to the insides of a body
         - germs and bacteria
      2. Score parts of inanimate objects (e.g., a table leg, a part of a car). The part must not be functional by itself and the subject must clearly indicate that the part is detached from its usual whole. For example, do not score "a window" or "a chimney," but do score "a window lying on the ground" and "a chimney standing in a field." Do not score "an arrowhead," but do score "an arrowhead without the shaft" or "a broken-off arrowhead."

   B. Parts missing
      1. Score animate and inanimate objects which are missing a part or parts (e.g., a monkey without a tail, a leaf with its stem missing, a man without a face, an airplane without one wing).
      2. Do not score parts missing simply because an object is represented as damaged (e.g., holes in the wings, crushed, burned, decayed).

II. Touch
   A. Nonhostile contact
      1. Score any direct physical contact between two animate objects.
      2. When one or more inanimate object is involved, physical contact alone is not sufficient for
a score. Subject must verbalize: (though verbalization can refer to past, future, or intentional activity) caught, tangled, interwoven, hanging, clinging, supporting, leaning, connected, grasping, holding (only in sense of protection, support, security, comfort, but not for a specific instrumental act such as "holding a ball" or "holding a sword"), pinned up, nailed up, etc. (e.g., do not score: "Someone waving a flag" or "a man standing on a box" or "picture on a wall" or "skin on a wall"). Do score: "Someone clutching a rope" or "a man being supported by a platform" or "a picture or skin hanging on a wall." To score an animate object on an inanimate object, verbalization must explicitly indicate that animate object derives special support, help, or comfort from inanimate object (e.g., score: "Two seahorses resting on coral"; but do not score "a man standing on a table" or "a man sleeping" or "a woman lying on a bed").

3. Score umbilical imagery: (e.g., a dog on a leash, a fish on a hook, flying a kite, a yo-yo, a girl water skiing, a pregnant woman, Siamese twins, embryo, newborn, just born).

B. Hostile contact
1. Score hostile contact between objects only if there is a portrayal of sustained, enduring physical contact. That is, score for squeezing, choking, wrestling, crushing, hair pulling, tied up, chained, hand cuffed, impaled, etc., but do not score for hitting, punching, slapping, crashing into, colliding. Do not score for pushing or pulling or grabbing unless specified that it is sustained, e.g., score "He kept pushing."

2. Score for trapped, jailed, locked in a room, caught. (Score state of being caught in sense of trapped, can't move, immobilized or caught in a trap. Do not score predatory acts, e.g., "fox caught a rabbit").

III. Death
A. Score references to death and dying: (e.g., gravestones, devils, angels, ghosts, skulls,
IV. Orality

A. Score sucking, blowing, biting, chewing, smoking, swallowing, eating, kissing, drinking, spitting, etc. Do not score yawning or mouth open.

B. Score for specific references to food and drink. Do not score water per se, but do score milk, beer, brew, corn in a field, etc. or a glass of water.

C. Score for any states of being hungry or thirsty, e.g., "a man who is hungry," "an animal is hungry."

D. Score for any utensil or instrument associated with food (e.g., silverware, plate, coffee cup, blender); references to cooking and preparing food and drink (e.g., chef, cook, pots, pans, cook-stove) and places specifically associated with food and drink (e.g., grocery store, restaurant, bar).

E. Score references to substances used in connection with the lips and mouth (e.g., toothpaste, lipstick, chapstick, cigarette), but do not score "mouth" or "lips" unless they qualify under other scoring criteria (e.g., Parts).

Note: A single score is given for each Rorschach response containing content from any of the four scoring categories. When content from two or more categories is present in a response, only a single score is given for the most prominent or emphasized category. An individual's total symbiosis scale score equals the number of responses which contain content from the scoring categories.
from the scoring categories. Accordingly, a high score is indicative of a poorly differentiated self-concept.

In subsequent validation efforts, the authors demonstrated that children reared in symbiotically oriented versus non-symbiotically oriented families differed in their stream of fantasy elicited by the Rorschach stimuli, with the children in symbiotic families yielding a greater frequency of responses from the four categories. Part-whole correlations, computed to determine any differences among the contributions of categories to the total symbiosis score, in two of three validation studies revealed that the Parts category contributed relatively more to the total score than did other categories. An interscorer reliability coefficient established on the basis of 47 protocols was .91. The interscorer reliability rating in terms of percentage of agreement between two raters was 94.8.

Procedure

The investigator or a designated Ph.D. student in clinical psychology individually administered the Rorschach to all subjects according to the procedure described by Beck et al. (1961). Verbatim transcriptions of the free association and inquiry were taken. Some of the inpatients were referred with diagnostic and prognostic questions as well as for the
purposes of this research and were administered other psycho-
logical tests in addition to the Rorschach. Only the Rorschach
protocols, however, were presented to the study's raters.
Prior to Rorschach testing, a statement about the study was
made by the examiner and the informed consent form presented.
As was specified in the written form, a subject's right to
ask any questions, discontinue with the testing, or withdraw
consent at any time was verbally emphasized by the examiner.
Following the signing of the informed consent form and
testing, the examiner obtained demographic information from
the patient and later verified it by the unit records.
Former patients who were referred for the study were seen
during the followup treatment session by the investigator
and referent (either the unit psychiatrist or psychiatry
resident) to explain the purposes of the study and to request
permission to include their Rorschach protocol in the research
data. Any person agreeing to the use of their Rorschach
record signed an informed consent form. As presented in
Table 1, the mean number of Rorschach responses did not
differ significantly for the two samples. The number of
responses per record (R) in the Borderline personality
sample ranged from 16-44, with a mean of 27.95 and a standard
deviation of 9.40. In the Neurotic sample R productivity
ranged from 11-59, with a mean of 26.05 and a standard deviation of 10.26.

Two Ph.D. clinical psychologists and two advanced doctoral students in clinical psychology other than the examiners served as independent raters. Each was briefly trained by the investigator to use the scoring criteria of either of the two scales, and to control for possible bias effects, the two pairs of raters scored all 40 protocols according to the criteria of only one scale. The order of the protocols was randomized differently for each of the four raters.

The two raters using the Symbiosis Scale scoring criteria were instructed to indicate for each scored response the specific content category (Parts, Touch, Death, Orality). Responses containing content in two or more of the four categories were scored for the most prominent or emphasized category. Four content scores were obtained by adding the number of responses containing content from each of the respective categories and a total symbiosis score by summing these four subscores. For statistical analyses an individual's total symbiosis score and four content subscores were derived by averaging the two sets of ratings. Interscorer reliability computed on the basis of the percent of agreement between raters was 87.95.
The two raters using the Mutuality of Autonomy Scale scoring criteria were asked to assign a score ranging from 1 through 7 to each response which corresponded with one of the scale's seven levels and to make comments about difficulties encountered in the scoring process. Where scoring differences existed between the two raters, a third rater made a final decision regarding the particular scale level and score assigned to a response. Interscorer reliability computed on the basis of percent of agreement between raters was 69.04 for percent of exact hits and 96.95 for percent within one scale point.

**Statistical Analysis**

To test the first and second hypotheses, that the scores on both scales will differ between the Borderline and Neurotic samples, a one-way analysis of covariance with multiple covariates was used. This model utilizes the concepts of the one-way analysis of variance and simple linear regression analysis, providing an adjusted measure of the differences between means of the two clinical populations, terms attributable to the linear association of the dependent variable with the covariates, and an error term (Afifi & Azen, 1972). The two sample groups served as the independent
variable and the scores on the two scales constituted the dependent variables. The three covariates were age, years of education, and response productivity. Differences in the scores for the two samples are measured after adjusting for the linear relationships between the scores and the subject's ages, educational levels, and number of responses. As a parametric test, the model assumes at least equal interval data, an assumption presumably met by the measurements obtained on the Symbiosis Scale but which appears less certain with the Mutuality of Autonomy Scale. In his development of this scale, Urist (1975) employed a monotonic transformation of the raw scores, CM-III transformation, described by Lingoes and Rookman (1972) which results in creating an equal interval scale. After comparing the overall average correlation of the Mutuality of Autonomy Scale and other scales using the transformed scores with the correlation obtained using the original or non-transformed scores, he found only an .002 improvement in the overall correlation average and concluded that the original scale, for statistical purposes, could be considered an interval scale.

To determine whether the proportion of Borderline patients yielding responses at levels 4, 5, 6 and 7 of the Mutuality of Autonomy Scale was greater than the proportion of Neurotics, a 2 X 2 chi-square test was used. Additionally,
the proportions of responses falling at each of the scale levels for both samples were computed. A one-tailed t-test was employed to determine if the proportion of Part responses of the Symbiosis Scale was higher in the Borderline patients than in the Neurotic patients.
CHAPTER IV
RESULTS

In accordance with the theories of contemporary ego psychoanalytic writers, it was reasoned that Borderline personalities and Neurotics would differ in their levels of internalized object relations purportedly measured by two Rorschach rating scales developed out of psychoanalytic object relations theory. The first objective was to ascertain whether Borderline personalities could be distinguished from Neurotic patients through differences in their scores on the Mutuality of Autonomy Scale and the Symbiosis Scale. Hypothesis 1 stated that Borderline personalities would obtain higher scores than Neurotics on the Mutuality of Autonomy Scale. Results of the analysis of covariance (Table 5) did not support this hypothesis. One of the subjects in the Borderline sample received no scores and was excluded from all statistical analyses with the Mutuality of Autonomy Scale data. Individual's scores, representing an average of a subject's scores, for the Borderline sample ranged from 1.67 to 5.22, with a sample mean of 2.54 and a standard deviation of .89. In the Neurotic sample individual scores ranged from 1.60 to 2.90, with a sample mean of
Table 5

Analysis of Covariance for the Mutuality of Autonomy Scale Scores

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covariates</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>.042</td>
<td>1</td>
<td>.042</td>
<td>.109</td>
<td>.747</td>
</tr>
<tr>
<td>Education</td>
<td>2.206</td>
<td>1</td>
<td>2.206</td>
<td>5.729</td>
<td>.024</td>
</tr>
<tr>
<td>R Productivity</td>
<td>.103</td>
<td>1</td>
<td>.103</td>
<td>.267</td>
<td>.613</td>
</tr>
<tr>
<td>Main Effects</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sample</td>
<td>.427</td>
<td>1</td>
<td>.427</td>
<td>1.109</td>
<td>.307</td>
</tr>
<tr>
<td>Explained</td>
<td>2.967</td>
<td>4</td>
<td>.742</td>
<td>1.927</td>
<td>.139</td>
</tr>
<tr>
<td>Residual</td>
<td>13.073</td>
<td>34</td>
<td>.385</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>16.040</td>
<td>38</td>
<td>.422</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2.21 and a standard deviation of .41. Listings of individual's scores by diagnostic categories are given in Tables 6 and 7. As shown in Table 5, the linear relationship between Mutuality of Autonomy Scale scores and years of education, however, was significant (p=.02, 1 df). The Pearson product-moment correlation between these two variables was .374 (p<.01). The distribution of subjects' Mutuality of Autonomy scores as a function of education years for both samples and the total regression line is shown in Figure 2.

Hypothesis 2, that Borderline patients will obtain higher scores on the Symbiosis Scale than Neurotics, was not supported. Total scores obtained by members of the Borderline sample ranged from 1.50 to 23.50 with a mean of 10.93 and a standard deviation of 5.42. In the Neurotic sample scores ranged from 1.00 to 27.50 with a mean of 8.35 and a standard deviation of 5.53. Results of the analysis of covariance are given in Table 8 and as shown, the linear association of response productivity with the Symbiosis Scale scores was highly significant (p=.001). The Pearson product-moment correlation of .617 was significant beyond the .0001 level (Table 9). A scattergram of the Symbiosis Scale scores and number of Rorschach responses and the total regression line is shown in Figure 3.
Table 6
Diagnoses and Scores Received by Members of
The Borderline Personality Sample

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>Mutuality of Autonomy Scale Score</th>
<th>Symbiosis Scale Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Borderline Personality</td>
<td>1.80</td>
<td>2.00</td>
</tr>
<tr>
<td>Borderline Personality</td>
<td>3.00</td>
<td>23.50</td>
</tr>
<tr>
<td>Borderline Personality</td>
<td>5.22</td>
<td>7.00</td>
</tr>
<tr>
<td>Borderline Personality</td>
<td>2.80</td>
<td>8.50</td>
</tr>
<tr>
<td>Borderline Personality</td>
<td>2.00</td>
<td>15.50</td>
</tr>
<tr>
<td>Borderline Personality</td>
<td>2.50</td>
<td>7.50</td>
</tr>
<tr>
<td>Borderline Personality</td>
<td>2.17</td>
<td>10.00</td>
</tr>
<tr>
<td>Borderline Personality</td>
<td>2.83</td>
<td>13.50</td>
</tr>
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<td>Borderline Personality</td>
<td>2.50</td>
<td>11.50</td>
</tr>
<tr>
<td>Borderline Personality</td>
<td>1.67</td>
<td>1.50</td>
</tr>
<tr>
<td>Borderline Personality</td>
<td>2.00</td>
<td>10.50</td>
</tr>
<tr>
<td>Antisocial Personality</td>
<td>2.00</td>
<td>5.50</td>
</tr>
<tr>
<td>Antisocial Personality</td>
<td>----</td>
<td>11.50</td>
</tr>
<tr>
<td>Antisocial Personality</td>
<td>2.00</td>
<td>17.00</td>
</tr>
<tr>
<td>Primitive Hysterical Personality</td>
<td>4.20</td>
<td>13.00</td>
</tr>
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<td>Primitive Hysterical Personality</td>
<td>2.42</td>
<td>9.50</td>
</tr>
<tr>
<td>Inadequate Personality</td>
<td>1.67</td>
<td>8.50</td>
</tr>
<tr>
<td>Primitive Passive-Dependent, Histrionic Features</td>
<td>3.00</td>
<td>21.50</td>
</tr>
<tr>
<td>Diagnoses</td>
<td>Mutuality of Autonomy Score</td>
<td>Symbiosis Scale Score</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Depressive Neurosis</td>
<td>1.75</td>
<td>4.50</td>
</tr>
<tr>
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<td>2.60</td>
<td>1.00</td>
</tr>
<tr>
<td>Depressive Neurosis</td>
<td>2.40</td>
<td>7.50</td>
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<td>4.00</td>
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<td>Depressive Neurosis</td>
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<td>Depressive Neurosis</td>
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<td>9.00</td>
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<tr>
<td>Obsessive Compulsive Neurosis</td>
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<td>11.50</td>
</tr>
<tr>
<td>Obsessive Compulsive Personality</td>
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<td>Hysterical Personality</td>
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<td>Hysterical Personality</td>
<td>2.56</td>
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<td>2.20</td>
<td>8.00</td>
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<td>9.50</td>
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<td>Passive Dependent Personality</td>
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<td>6.50</td>
</tr>
<tr>
<td>Passive Aggressive Personality</td>
<td>2.90</td>
<td>11.50</td>
</tr>
<tr>
<td>Passive Aggressive-Passive Dependent Personality</td>
<td>1.60</td>
<td>5.50</td>
</tr>
</tbody>
</table>
Figure 2
Mutuality of Autonomy Scale Scores
As a Function of Years Education

Mutuality of Autonomy Scale Scores
YEARS EDUCATION

△ Borderlines
● Neurotics

YEARS EDUCATION
6 7 8 9 10 11 12 13 14 15 16 17 18 19
Table 8
Analysis of Covariance of Symbiosis Scores

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covariates</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
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<td>.047</td>
<td>.002</td>
<td>.962</td>
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<tr>
<td>Education</td>
<td>27.623</td>
<td>1</td>
<td>27.623</td>
<td>1.425</td>
<td>.255</td>
</tr>
<tr>
<td>R Productivity</td>
<td>426.137</td>
<td>1</td>
<td>426.137</td>
<td>21.985</td>
<td>.001</td>
</tr>
<tr>
<td>Main Effects</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sample</td>
<td>25.201</td>
<td>1</td>
<td>25.201</td>
<td>1.300</td>
<td>.276</td>
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<tr>
<td>Explained</td>
<td>498.239</td>
<td>4</td>
<td>124.560</td>
<td>6.426</td>
<td>.001</td>
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<tr>
<td>Residual</td>
<td>678.399</td>
<td>35</td>
<td>19.383</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1176.638</td>
<td>39</td>
<td>30.170</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 9
Correlations Between Covariates and Scores on Each Scale

<table>
<thead>
<tr>
<th>Scale</th>
<th>Covariate</th>
<th>r</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>Education</td>
<td>.374</td>
<td>.009</td>
</tr>
<tr>
<td>Mutuality of Autonomy</td>
<td>Age</td>
<td>.121</td>
<td>.231</td>
</tr>
<tr>
<td></td>
<td>R Productivity</td>
<td>.048</td>
<td>.386</td>
</tr>
<tr>
<td></td>
<td>Education</td>
<td>.218</td>
<td>.088</td>
</tr>
<tr>
<td>Symbiosis Scale</td>
<td>Age</td>
<td>.013</td>
<td>.468</td>
</tr>
<tr>
<td></td>
<td>R Productivity</td>
<td>.617</td>
<td>.00001</td>
</tr>
</tbody>
</table>
Figure 3
Symbiosis Scale Scores
As a Function of Response Productivity

Symbiosis Scale Scores

NO. OF RESPONSES

Borderlines
Neurotics
The second objective was to examine the distribution of Mutuality of Autonomy Scale scores in both samples and to relate the scores to the proposed stages in the development of object relations. Scale levels 1, 2, and 3 are thought to correspond to intrapsychic stages at which both a differentiation of self and object and an integration of the self-and-object-concept have been achieved. By contrast, levels 4, 5, 6 and 7 are thought to reflect progressively more primitive stages preceding the attainment of object constancy. Accordingly, it was reasoned that the two samples would differ not only in the overall level of their responses but that the responses of the Borderline patients and Neurotics would be dichotomous, Neurotics being unlikely to give responses at levels 4, 5, 6 or 7, and Borderline patients, although expected to give responses at all levels, being likely to have some responses falling at the more pathological levels. Hypothesis 3 stated that a higher proportion of Borderline personalities than Neurotics will have responses scored at levels 4, 5, 6 and 7. Results of the 2 X 2 chi-square analysis did not support this hypothesis. Eleven Borderline patients and nine Neurotics gave at least one response falling at any of the levels 4, 5, 6 and 7 (p=.75, 1 df). Figure 4 shows the percentages of responses in each sample falling at the seven levels and indicates that responses
Figure 4
Percentage of Responses at Each Level of the MA Scale
Borderline Personalities and Neurotics

- Borderlines
- Neurotics

PERCENTAGES

MUTUALITY OF AUTONOMY SCALE LEVELS
at levels 4, 5, 6 and 7 combined accounted for 23% of the total number of responses in the Borderline personality sample and a corresponding 13% in the Neurotic sample. Twenty percent of the responses of Borderline patients were scored at levels 5, 6 and 7 as opposed to 8% of the responses in the Neurotic sample. The frequency of pathological responses within an individual record varied widely both within and between samples. In the Neurotic sample six of the nine patients received only one score at any of the lower four levels. Moreover, for five of these records, this single pathological response appeared in conjunction with other scores all falling in the two highest levels. Two of the Neurotics each had two pathological responses, and one member of the sample had three responses scored at levels 4, 5, 6 or 7. By contrast, the frequency of pathological scores received by any one of the 11 Borderlines ranged from a single scored response to as many as eight scored responses. The appearance of a single pathological response among other responses all scored as either a 1 or 2 occurred in records of four Borderline patients. Two members of this sample had three scores falling at any of the four more primitive levels, and two members each had eight responses in their records which were scored at levels 5, 6 or 7.
The final objective was to examine the contributions of the four content subcategories to the total scores on the Symbiosis Scale. Based on the ideas of Kernberg and Mahler that part-object relationships are characteristic of the stages preceding the integration of positive and negative introjects and of the intrapsychic structural organization of the borderline personality, it was reasoned that the contribution of the Parts subcategory to the total Symbiosis Scale scores would be greater for Borderline personalities than for Neurotic patients. Hypothesis 4, that the proportion of Part responses to the total symbiosis scores for Borderline personalities will be higher than the proportion of Part responses for Neurotics, was not supported; however, by a one-tail t-test ($p=.688, 38\, \text{df}$). The proportion of Parts/Total Symbiosis Scale scores ranged from .27 to .95 among the 20 subjects in the Borderline sample, with a mean of .58 and a standard deviation of .20 while in the Neurotic sample the proportions ranged from .00 to 1.00 with a mean of .56 and a standard deviation of .26. As shown in Figure 5, differences between the two samples in the proportions for each of the other three content categories were also small.
Figure 5
Mean Proportions of Content/Total Symbiosis Scores in the Two Samples

PROPORTIONS

CONTENT CATEGORIES

Parts  Touch  Death  Orality

Borderline
Neurotic
Evaluating the intrapsychic organization and structural aspects of the personality has received increasingly greater emphasis from the various psychoanalytic writers whose attention has focused on the realm of psychopathology falling between the neuroses and psychoses. While the still existing ambiguities surrounding the concept of borderline personality may represent the various components of the psychopathological spectrum emphasized, e.g., drives, defenses, cognitive structures, narcissism, object relations, there nevertheless seems to be some consensus that the disorder(s) constitute a clinical entity separate from neurotic and psychotic conditions. Kernberg has attempted to consolidate the many perspectives in his structural theory of the borderline personality organization, which is based upon his stage theory of internalized object relations. A central assumption of his formulation, that mental contents reflect the organization of internalized object relations, served as the underpinning for the present study. Using two Rorschach rating scales designed to tap the levels of object relations, this research was devoted to investigating differences in
the object relations of borderline personalities and neurotics. The objectives were to ascertain whether borderline personalities could be distinguished from neurotics through differences in their scores on the Mutuality of Autonomy Scale and the Symbiosis Scale, to examine the distribution of Mutuality of Autonomy Scale scores in both samples and relate the particular scoring levels to stages in the development of object relations, and to examine the contributions of the content categories of the Symbiosis Scale to the total symbiosis scores. Four hypotheses were generated:

Hypothesis 1: Borderline personalities will obtain higher scores than Neurotics on the Mutuality of Autonomy Scale.

Hypothesis 2: Borderline personalities will obtain higher scores than Neurotics on the Symbiosis Scale.

Hypothesis 3: A higher proportion of Borderline personalities than Neurotics will have responses scored at levels 4, 5, 6 and 7 of the Mutuality of Autonomy Scale.

Hypothesis 4: The proportion of Part responses to total Symbiosis Scale scores will be higher for Borderline personalities than for Neurotics.
None of these hypotheses were supported by the statistical analyses. The results did, however, reveal two unpredicted significant linear trends between the scales' scores and characteristics of the total sample (n=40) members. Higher Mutuality of Autonomy Scale scores were associated with greater number of years education. Secondly, Symbiosis Scale scores were positively correlated with response productivity. Although not statistically significant, as indicated by the probability value in Table 7, there was a tendency for higher Symbiosis Scale scores to be associated with greater number of years education. Contrary to predictions, the frequency of subjects yielding responses at the four higher scoring levels of the Mutuality of Autonomy Scale (4, 5, 6, 7), which purportedly correspond with more primitive stages in object relations development, was not significantly different for the two samples. The incidence of responses scored at these four levels, however, was higher for the Borderline personality sample (23%) than for the Neurotic group (13%). Moreover, at the three highest scoring levels (5, 6, 7) the incidence of scores was more discrepant for the Borderlines (20%) and Neurotics (8%). When considered with these discrepancies and the within-sample variability in performance on the Mutuality of Autonomy
Scale, the nonsignificant results and unpredicted findings lend themselves to several interpretations.

The first explanation concerns a methodological limitation, encompassing both the deficiencies of the study's diagnostic criteria and the selection of the samples from an inpatient population. The spectrum and degree of psychopathology reflecting both qualitative and quantitative variability in ego functions of the borderline personality and the inherent difficulties in the diagnostic process have long been recognized (Knight, 1953). Zetzel (1971) attempted to differentiate borderline states and the borderline personality, concluding that the former, a group of conditions whose diagnoses are equivocal, is more likely to be apparent very early in the clinical setting and may be easily confused with the borderline personality, which frequently becomes recognizable later and only in the context of intensive psychotherapy. Difficulty in distinguishing borderline psychopathology from less severe character disturbances and psychoneurotics on the basis of clinical interviews, it is reasoned, would be compounded by the selection of the Neurotic comparison group from an inpatient population because of the presumed intrapsychic regression necessitating their psychiatric hospitalization. The representation by an inpatient Neurotic population of more typical neurotic psychological
functioning, in retrospect, is questionable and may have reduced the likelihood of detecting differences in their intrapsychic processes. Kernberg (1977) has proposed that three distinct personality structural organizations exist: the neurotic, the borderline personality, and the psychotic. The question remains though: To what extent can the intrapsychic organization of a neurotic individual in a regressed state, as would be more likely seen in a hospital setting, become indistinguishable from that of a borderline personality? In addition, considering the long-recognized adaptive functioning of the borderline personality (Rorschach, 1942; Gunderson & Singer, 1975), contamination of the Neurotic sample by undetected, more severe levels of pathology should also be considered as a possible factor contributing to the failure to find support for the hypotheses and illustrates the problem of using only descriptive criteria for selection of the diagnostic groups.

In planning this study, an attempt was made to circumvent the possibility of overlap between the two samples by adopting a set of criteria for the Borderline personality sample which included distinguishing behavioral characteristics having achieved some consensus among clinicians, and, simultaneously, which were consistent with those manifestations or symptoms of the specific structural organization
and psychodynamic conflicts cited by psychoanalytic writers. For the Neurotic sample, no specific features were established; inclusion was based on the DSM-II descriptions. Given the incidence of previous psychiatric hospitalizations and self-destructive behaviors present in functioning otherwise seen as fairly well-adapted, perhaps more stringent criteria for the Neurotic sample, i.e., excluding individuals with any history of psychiatric admissions, suicidal gestures, or transient psychotic episodes would have insured more dichotomous groups. Another desirable modification in the procedure, though difficult to implement because of ethical considerations and administrative arrangements, would have been to delay the Rorschach administration until a patient had progressed from an acute disrupted phase to a relatively more stabilized level of functioning. The failure to find differences in scores of the two samples on both scales and the appearance of pathological responses among the Neurotic individuals may be attributable to contamination of the Neurotic sample by lower levels of pathology, to the regressed nature of the Neurotics' functioning at the time of their participation, or to a combination of the two factors.

Aside from these methodological limitations, a second focus invoked to explain the unpredicted relationships
revealed in the analyses is directed at the two scales and their validity. With the two samples combined, a positive linear relationship was obtained between the Mutuality of Autonomy Scale scores and the number of years of education, while the other two covariates, age and response productivity, appeared to be independent of these scores. With the Symbiosis Scale, a positive linear relationship between the scores and the response productivity was obtained, and the linear association between scores and education approached the .05 level of significance. Age appeared to be independent of the scores.

Examining the requisites of the scales' scoring criteria and relating them to traditional Rorschach variables and the ego functions reflected may provide some understanding of the present results. Considering the figure imagery and activity required in scorable responses on the Mutuality of Autonomy Scale, it can be reasoned that the Mutuality of Autonomy Scale scores are related to the traditional Rorschach variables M, and to a lesser extent, Z, which are regarded as indices to fantasy activity and synthesizing capacities, respectively. While the evidence for any direct relationship between these Rorschach variables and educational level is lacking, research has demonstrated a positive relationship between characteristics associated with educational level
and M and Z. In his overview of the literature concerning Rorschach determinants and dimensions of personality, Beck (Vol. II, 1961) cites numerous studies deriving support for positive relationships between M and Z and qualities thought to be associated with years of education, such as intelligence measures (Levine, Glass, and Meltzoff, 1959; Levine, Spivack, and Wight, 1959; Tucker, 1950; Hertz, 1942; Wittenborn, 1949), verbal fluency (Lotsof, 1953), and creativity (Singer, Wilensky, and McCraven, 1956). It is suggested, then, that the scores on the Mutuality of Autonomy Scale were positively affected by subjects' fantasy activity, ability to organize and integrate stimuli, and perhaps the capacity to articulate perceptions, expectedly higher in subjects with increasingly greater number of years of education. Hence, a subject's approach to the Rorschach, seemingly independent of one's level of psychopathology and internalized objects relations, may have affected scores on the Mutuality of Autonomy Scale. Rapaport, Gill, and Shafer's early study with "coarctated" and "overideational" preschizophrenics (1945-46) illustrates the variant performances observed among individuals whose level of pathology was believed to be of comparable severity. The "coarctated" and "overideational" preschizophrenics presented two distinct diagnostic and behavioral styles—the former characterized by blocking, inhibition of affect,
withdrawal, and anxiety, and the latter producing an abundance of fantasy and pathological verbalizations of various kinds. If, as has been suggested, the Mutuality of Autonomy Scale scores were affected by the degree of fantasy activity and organizational abilities, the scale's usefulness as an instrument for assessing derivatives of object relations may be restricted to those specific subsets of psychiatric population predisposed to utilize fantasies and to organize their perceptions. The discriminative value of the scale would be reduced in the relatively more torpid, constricted individuals.

Scores on the Symbiosis Scale, in contrast to the Mutuality of Autonomy Scale scores, showed only a slight positive trend with educational level but were highly associated with the number of separate responses produced. Characteristics associated with educational level, such as fantasy productivity and organizational abilities appear, then, to have had a less direct effect on the symbiosis scores than on the Mutuality of Autonomy Scale scores. Rather, the response productivity emerged as an important variable affecting the symbiosis scores. A conclusion drawn by Fiske and Baughman that an individual's "... capacity to organize or integrate a complex stimulus into a single percept, is largely independent of productivity," (1953,
p. 30) would be consistent with these findings. A further explanation for the results lies in the differences in the derivation of the scores for the two scales. Integration and organizational capacities would be more directly reflected in the Mutuality of Autonomy Scale scores than in the Symbiosis Scale scores in which a response showing a high degree of integration would also be more likely to contain content from several categories, but would, because of scoring directions, receive only a score for one category. Closer examination of the Rorschach data would seem to substantiate this line of reasoning. Not infrequently, more integrated and elaborate responses contained content from more than one of the Symbiosis Scale content categories, but were scored only for the most prominent one. Conceivably, then, a subject showing a higher degree of integration and organization may, because of the nature of the Symbiosis Scale scoring, attain a lower score than an individual whose focus was likely to be relatively less encompassing and more attuned to details. This seems more plausible if one considers that the Parts category, which includes as a major part of its criteria parts of animate objects, accounted for more than 55% of the scores in both of the samples. The linear trend also appears to be consistent with Fiske and Baughman's (1953) finding that Hå becomes more frequent with an increase
in R and may be an artifact of R. Accordingly, this raises some question about the usefulness of the Parts category as a derivative of the symbiotic phase of development. One could contend that the high number of R is not a causative factor, but rather a resultant or concomitant of the high contribution of Parts scores, with the implication being that this interpretation has greater significance for understanding personality functioning. Nevertheless, in view of the failure to find any differences between the two samples in the Parts scores or total symbiosis scores, it appears, as with the Mutuality of Autonomy Scale, that personality characteristics independent of or whose relationship to the level of internalized object relations is unknown were affecting the Symbiosis Scale scores.

Finally, questions and comments specifically about the scoring criteria of both scales may further elucidate the findings. In spite of the respectable interscorer reliability ratings obtained with the scales, scoring difficulties were expressed by the raters. The need for more definitive criteria in scoring examples for each of the seven levels of the Mutuality of Autonomy Scale and further clarification of the Touch category on the Symbiosis Scale was requested. Noted in some of the Rorschach protocols were themes of destruction, envelopment by outside forces, and dependency,
which were portrayed through abstractions rather than in actual defined figures. Although the Mutuality of Autonomy Scale scoring criteria does not include such verbalizations as scorable responses, it is believed that these types of elaborations may have some assessment value for the level of internalized object relations like that attributed to figure imagery. Similarly, imagery expressing figures' intentional activity may be of some importance, but it is not scored as are responses in which some previous destruction is implied or in which only the victim of a previous destructive act is portrayed. Occurring rarely in the data were responses depicting two relationships whose level of mutuality of autonomy differed. In such cases the raters were instructed to score for the more pathological level expressed; however, to improve the scoring accuracy, some provision for allowing more than one score per response is suggested. A question arises, too, concerning the interpretive value of popular responses, i.e., Card VII, two female figures (D2), or Card VIII, two animals (D1). Considering the very high frequency with which these responses occurred, their significance is doubtful and perhaps should be excluded from the scorable responses. Further clarification of the Mutuality of Autonomy Scale's level 2 and examples of responses not scorable would be helpful. Does the naming of two figures
performing identical actions constitute "parallel activity" if there is no implication of a relationship? Merely naming in plural form objects located in the same area on opposite sides of the inkblot as performing the same activity, i.e., "two animals eating," perhaps could be more accurately interpreted as a level 4 response or a response falling between levels 3 and 4.

With the Symbiosis Scale, as alluded to earlier, some clarification of the criteria for the Touch category is needed. According to the scoring criteria, any direct physical contact of a nonhostile nature between animate objects is scored, while hostile contact between objects is scored only if it is portrayed as sustained and enduring. The assumption underlying this distinction, however, is questionable as it can be reasoned from object relations theory that nonhostile contact between animate objects which is not portrayed as enduring or sustained would represent a higher form of object relationship rather than a derivative of the early symbiotic phase. Also, the rationale for allowing only one score per response is not known, but as illustrated in the present data, this procedure may have resulted in altering the contribution of the content scores as well as lowering the total symbiosis scores. To control for the possible effects of R, the establishment of a minimal
Summary and Suggestions for Future Research

In summarizing the inferences from the results of the study, it is believed that the research was beset with an unforeseen methodological limitation which may have accounted for the nonsignificant differences in the Rorschach performance of Borderline personalities and Neurotics. Contrary to predictions, no significant differences were found between the Mutuality of Autonomy Scale scores of Borderline personalities and Neurotics. Similarly, the scores on the Symbiosis Scale did not differ significantly for the two groups. The frequency of subjects producing responses at those Mutuality of Autonomy Scale levels believed to correspond to stages preceding attainment of object constancy (4, 5, 6, 7) did not differ for the two groups. The contribution of the Parts category of the Symbiosis Scale to the total symbiosis scores also did not differ for the two groups, and proportions contributed to the total symbiosis scores by the other three categories were comparable for the Neurotic and Borderline personality samples. The selection of the two samples from an inpatient population, however, raised some...
question concerning the true representativeness of the Neurotic responses on the Rorschach as compared to those of typical or better adapted neurotic individuals, the implication being that the Neurotics in this study may not have differed significantly from the Borderline personalities because of their regressed state of functioning. This methodological problem appears to have been compounded by the insufficiently rigorous selection criteria for the Neurotic sample which did not specify the exclusion of patients with a history of previous psychiatric hospitalizations, previous suicidal attempts, or transient psychotic episodes. In addition to the presumably regressed functioning measured in the Neurotic sample, the contamination of the Neurotic sample by individuals whose intrapsychic functioning is more pathological than a neurotic disturbance was also considered as a factor contributing to the results.

Following from the limitations described above, the use of more stringent criteria to insure more dichotomous populations is recommended for future research. Secondly, to obtain a truer representation of typical neurotic functioning and to reduce the chance of having overlap between samples, selection from individuals who are engaged in ongoing treatment at an outpatient psychiatric clinic or comparable setting is suggested. With referrals made from
clinicians who have formulated some understanding of a patient from a psychodynamic framework, the diagnostic and selection process could be based upon both knowledge of intrapsychic functioning and descriptive criteria.

A comparison of samples who have been selected on the basis of their performance on other personality instruments as well as behavioral criteria is also suggested since it presumably would increase the chances of obtaining more dichotomous samples and permit one to draw firmer conclusions about the scales' assessment value.

To explain the unpredicted linear relationship between the Mutuality of Autonomy Scale scores and years of education and the positive correlation between Symbiosis Scale scores and R, it was suggested that other characteristics independent of or whose relationship to level of internalized object relations is unknown were affecting the scores. A subject's ability to organize and integrate stimuli and to engage in fantasy, it was proposed, may have accounted for the positive correlation obtained between Mutuality of Autonomy Scale scores and years education. Thus, even if fantasy themes do provide valid information about object relations, the discriminative value may be restricted to a subset of psychiatric populations. Unlike the Mutuality of Autonomy Scale, Symbiosis Scale scores
showed no significant positive relationship to years education but were highly correlated with R. Scoring criteria and the content categories were discussed as possible factors in these results. Whether increased scores were an artifact of R or alternatively were a concomitant of a detailed, less integrative approach to the Rorschach task having some diagnostic significance remains unanswered at the present time.

In conclusion, then, it appears that our understanding of the imagery and mental contents evoked by Rorschach inkblot stimuli and their relationship to internalized object relations is still rudimentary. Further research is needed to demonstrate the scales' value for assessing this personality dimension.
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APPENDIX

INFORMED CONSENT FORMS
Title of Study  A Rorschach Study of Internalized Object Relations

Investigators  Sandy Pitts

LAY SUMMARY AND INFORMED CONSENT

The purpose of this research study is to investigate differences in people's interpersonal relationships as measured by the Rorschach Inkblot Test, a commonly used personality instrument.

As part of this study, we will administer the Rorschach according to standard procedure. The data we collect from you will be combined with that collected from others and compared to other groups of people with different personality characteristics. The information obtained from this study will help us to better understand how to use the test for assessing psychological problems.

Unless you were referred for a diagnostic evaluation, we will not use the Rorschach data to assess your overall personality. All identifying information will be removed from the test data to insure your anonymity and all information will remain confidential.

Risks or discomforts of testing are that you may experience some anxiety or uncomfortable emotions during administration of the test.

Benefits that may result from the information gained may not help you personally but may help others.

If you have questions at any time, you may ask the examiner. You do not have to participate in this study. If you do not wish to participate, this will in no way affect any present or future patient care. Moreover, should you decide at any time that you do not
wish to continue with the study, you may stop your participation without any change in the treatment and care you are receiving now or in future treatment.

CONSENT:
Having read the information statement and had an opportunity to ask questions, I hereby willingly consent to be tested.

Date ________________ Signed ____________________________________
(Patient)

Examiner ____________________________
Title of Study  A Rorschach Study of Internalized
Object Relations

Investigators  Sandy Pitts

LAY SUMMARY AND INFORMED CONSENT

The purpose of this research study is to investigate differences in people's interpersonal relationships as measured by the Rorschach Inkblot Test, a commonly used personality instrument.

As part of this study, the Rorschach will be administered according to standard procedure to all subjects. The data collected from each participant will be combined with that collected from others and compared to other groups of people with different personality characteristics. The information obtained from this study will help us to better understand how to use the test for assessing psychological problems.

During your hospitalization at Parkland Memorial Hospital's Psychiatric Unit, you were administered the Rorschach along with other psychological instruments as part of an evaluation. Your test data has been filed with other records. For the purposes of the study, with your consent, the investigator would like to include your Rorschach record in the research data. All identifying information would be removed from the test data to insure your anonymity, and all information would remain confidential.

Risks or discomforts involved are that you may experience some anxiety or uncomfortable emotions concerning the inclusion of your record in the study.

Benefits that may result from the information gained may not help you personally but may help others.

If you have questions regarding any aspect of the study, the examiner will answer them. You do not have to participate in this study. If you do not wish to participate, this will in no way affect any present or future patient care. Moreover, should you decide in the near future that you do not wish your test data to
be included, you may withdraw your consent without any change in the treatment and care you are receiving now or in future treatment.

CONSENT:
Having read the information statement and had an opportunity to ask questions, I hereby willingly consent to the use of my Rorschach data in the study.

Date ____________________ Signed _________________________
(Patient)

Examiner _________________________
VITA

Sandra Kaye Pitts was born in Charlotte, North Carolina, on February 4, 1952, the daughter of Josephine McNeilly Pitts and Clifton Aaron Pitts. After completing her high school education at Glen Alpine High School in June, 1970, she entered the University of North Carolina at Chapel Hill, N.C., where she received her Bachelor of Arts with majors in psychology and religion in May, 1974. In September, 1974, she entered the graduate program in psychology at Louisiana State University and was awarded the Master of Arts degree in December, 1976. She fulfilled an APA-approved internship in clinical psychology at the University of Texas Health Science Center in Dallas, Texas from September, 1978 to August, 1979. Since September, 1979, she has been employed with the Graduate School of Biomedical Sciences at the University of Texas Health Science Center, Dallas, Texas, as an assistant instructor in the Department of Psychology.

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