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DIAGNOSING BORDERLINE DISORDERS
Louis A. Moench, M.D.*
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The physician's dictum is "primum non nocere" - first, do no harm. Dr. Allen Bergin is noted for his research showing that psychotherapy in some instances harms the patient or worsens his condition. Dr. Bergin's concern in assigning me this presentation is that we as therapists need to know something of how to recognize and understand the prime candidates for getting worse in improper therapy.

Little about the therapy of these patients will be discussed since it can't be learned from a lecture. Those not familiar with it should refer to the most experienced therapist they know. Even he will be challenged.

Let us clarify which patients we are talking about. Most therapists have been baffled by certain patients who seem to show symptoms of several neuroses, sometimes all at once, and at times psychosis as well. For patients hovering on these borders between categories, various diagnostic terms have been used, the most enduring of which has been, not surprisingly, "borderline." The term evokes images of someone precariously balancing on a fence between neurosis and psychosis. A more accurately descriptive image may be that of the traffic of one's various ego functions running back and forth between personality integration and disintegration. It is usually rush hour where these patients' psyches reside.

Helene Deutsch (1942) was struck by a depersonalization aspect to these people and described them with the term "as if personalities," meaning that they behaved as if they had a personality to rely on when they, themselves, most commonly complained of being devoid of personality, i.e. "so empty inside." The external shell, like the skin of a chameleon, would change, adapting itself to the environment at any given moment, imitating, conforming, being someone this morning, someone different this afternoon, lacking the substance inside to know how to be amid the changing scenery.

Paul Hoch and Philip Polatin (1949) wrote of these patients' multiple neurotic symptoms - depressions, compulsions, obsessions, emotional outbursts, hypochondriasis - and their anxieties, chronic and unattached to any specific fear situation. The equator, for example, may make such a patient nervous. Hoch and Polatin described pan-neurosis and pan-anxiety. They saw relationships with others as intense, unstable, and fleeting, particularly the most intimate of relationships, the sexual one. Any combination of deviance, in short, polymorphous perverse sexuality often characterizes the borderline.

Melitta Schmideberg (1947), daughter of Melanie Klein, observed that these people were found not only on the borderlands of psychosis and neurosis, but also of psychopathy and even normalcy, using defenses appropriate to any of these, and at times appearing very stable.

Robert Knight (1953) clarified that the term didn't always reflect the confusion of the patient. Sometimes it reflected the uncertainty of the psychiatrist. Borderline was the diagnosis for everyone who perplexed us. Not just a waste basket, it was the whole city dump! He advised us that the symptoms do not make the diagnosis, rather ego weaknesses do. He described macroscopic ego weakness similar to those to be discussed later, and microscopic ones consisting of various types of thought disorder and speech peculiarities, the patient's having no discomfort over their awareness.

We are all constantly confronted with problems, and how we handle them determines the label applied to us. Roy Grinker (1969) found four labels to characterize according to ego function sub-types of the borderline syndrome. (Figure 1) Features he found

Figure 1.--GRINKER CRITERIA FOR THE BORDERLINE SYNDROME

A. Psychotic Border
1. Inappropriate, nonadaptive behavior
2. Deficient self-identity and reality sense
3. Negative behavior and anger
4. Depression

B. Core Borderline
1. Vacillating involvement with others
2. Anger acted out
3. Depression
4. Self-identity inconsistent

C. As-if Person
1. Behavior adaptive, appropriate
2. Complimentary relationships
3. Lack of affect and spontaneity
4. Defenses of withdrawal and intellectualization

D. Border With Neuroses
1. Anaclitic depression
2. Anxiety
3. Resemblance to neurotic, narcissistic character

*Brother Moench is a psychiatrist in private practice in Salt Lake City.
common to all four types included these: 1. Anger as the main or only affect. 2. Defective affectional relationships. 3. Absence of firm self-identity. 4. Depressive loneliness.

Whether it is a state, a personality disorder, a type of personality organization, or a pseudoneurosis is debated. One therapist even claims, with incredible redundancy, the existence of a "pseudo-as-if" condition. There is disagreement that "borderline" as a diagnostic category should exist at all.

Perry and Klerman (1978), Spitzer (1979), and Gunderson and Kolb (1978) have all done confirmatory studies validating the diagnosis. It has been included in the DSM III with these diagnostic criteria. (Figure 2).

Figure 2.—DSM III CRITERIA FOR BORDERLINE PERSONALITY DISORDER

1. Impulsivity and unpredictability in at least two self-damaging areas, e.g., spending, gambling, substance abuse, overeating, shoplifting, sex.
2. Unstable and intense interpersonal relationships, e.g., marked shifts in attitude toward others, idealizing, devaluing, or manipulating others for one's own ends.
3. Inappropriate, intense, or uncontrolled anger.
4. Identity disturbances manifested by uncertainty about self-image, gender identity, goals, career choice, friendship patterns, values, loyalties.
5. Affective instability with marked shifts of a few hours to a few days from normal mood to depression, irritability, or anxiety.
6. Intolerance of being alone, e.g., depression when alone or of frantic efforts to avoid being alone.
7. Physically self-damaging acts, e.g., suicidal gestures, self-mutilation, recurrent accidents or physical fights.
8. Chronic feelings of emptiness or boredom.
(At least five of these must be present. If under 18, does not meet criteria for Identity Disorder.)

The term “borderline” is also used in another way. It describes a schizophrenia-like disorder, not clearly schizophrenia, mentioned by Kety, Rosenthal, and Wender (now of the University of Utah) in the classic study of schizophrenia in adopted-away offspring of schizophrenic parents. (It was this study that prompted Kety to respond to Thomas Szasz, “If schizophrenia is a myth, it's a myth with a high genetic component!”)

Eight factors used by these researchers to spot schizophrenia-like conditions which were not schizophrenia have also proved reliably to single out the disorder among other types of illness. Similar but not identical to borderline personality criteria, these features diagnose another DSM—III category, “schizotypal personality disorder” (Figure 3).

To understand what leads these patients to think, feel, and behave as described by these criteria, we turn to the master theoretician, Otto Kernberg, who is not only brilliant, but awesome in his command of psychoanalytic cliche and close to impossible for mere mortals to comprehend. What follows is an attempt to decipher Kernberg.

Kernberg says first that reality testing is generally maintained in borderline patients except for transient psychosis precipitated by either severe stress, alcohol or drug use, or psychoanalytic transference. This response to the unstructured situation of analytically-

Figure 3.—DSM III CRITERIA FOR SCHIZOTYPAL PERSONALITY DISORDER

1. Magical thinking, e.g., superstitiousness, clairvoyance, telepathy, "sixth sense," bizarre fantasies or preoccupations.
2. Ideas of reference.
3. Social isolation, e.g., no close friends, contacts limited to everyday tasks.
4. Recurrent illusions, depersonalization, derealization, sensing presence of a person or force not actually present.
5. Odd speech (without derailment), e.g., digression, vagueness, overelaboration, circumstantiality, metaphorical speech.
6. Inadequate face-to-face rapport due to inappropriate or constricted affect, e.g., aloofness, coldness.
7. Suspicion or paranoid ideation.
8. Undue social anxiety or hypersensitivity to real or imagined criticism.

(These characterize long-term functioning, not just episodes of illness. Does not meet criteria for Schizophrenia.)

Kernberg clarifies the symptoms and character types further. The anxiety is free-floating. The neurotic picture is polysymptomatic and unusual. For example, phobias are multiple and not related to external objects so much as to the body, e.g. fear of talking, of blushing, or of being looked at, or to transitional elements such as dirt and contamination, or to social situations with paranoid elements to the fear. The obsessions and compulsions are egosyntonic. True, one wants to rid himself of them, but one also rationalizes them. Hypochondriasis in these patients isn't of an anxious nature, e.g. cardiac palpitations, so much as health ritual or withdrawal from social life to concentrate on health. Conversion reactions are multiple, elaborate, and bizarre, e.g. bodily hallucinations. For example, a patient of mine described mucus draining from her sinuses down a channel she could feel in the right side of her throat, down into her chest cavity where the mucus "fumed" out an imaginary hole in the wall of her chest. Dissociations such as fugue, amnesia, twilight states, sixth senses, telepathic feelings, and supernatural communications or transportations are common, and can, among L.D.S. people, easily be mistaken for revelatory experience. Sexuality, polymorphous and perverse, commonly takes the form not of fixed and stable deviations but bizarre combinations, for example erotic pleasure from eliminatory rather than genital aims, homosexuality together with heterosexual exhibitionism, or asexual behavior but bizarre sadomasochistic fantasies.

Prepsychotic personality styles are often evident,
including paranoid, schizoid, hypomanic, or cyclothymic types. These may actually be variations of affective disorders, for example rapid-cycling manic depressives and the phobic-anxious or hystero-dysphoric atypical depressive syndromes described by Donald Klein. Impulse neuroses and substance abuse or addiction are frequently found.

Characteristically, the impulsive behavior is ego-dystonic most of the time but pleasurable and welcome during its actual repetitive eruptions. Much sexual promiscuity falls into this category and perhaps can be understood better as failure of impulse control than as sin through willful disregard of commandments. Infantile, narcissistic, antisocial, and depressive-masochistic character disorders also fall within the borderline personality category.

What underlies these symptoms and categories, according to Kernberg, is a weakened ego (Figure 4). He finds these signs of ego weakness present: 1. Diminished anxiety tolerance. Not the degree of anxiety felt but the mode of handling increased anxiety is what is important. Borderline patients handle increased anxiety loads with movement toward ego regression. 2. Poor impulse control. This is an erratic and unpredictable effort to disperse tension, unlike repetitive, specific diminished control such as may be found in a habit disorder or a quick temper. 3. Diminished development of sublimatory channels. Borderline personalities lack the creative enjoyment and achievement commensurate with their intelligence and social environment.

Kernberg describes a shift toward primary process or nonlogical thinking. This is only subtly present under normal conditions but may become florid in nonstructured circumstances. For this reason, projective psychological testing is extremely helpful in making the diagnosis. Primitive fantasies, peculiar verbalizations, and poor compliance to the “givens” of the test are expected.

Specific defensive operations are employed. To understand these requires a review of ego development for which Margaret Mahler’s model is useful (Figure 5).

During the stage of primary autism, the first two months of life, a child has no capacity to distinguish himself from his world. He, his mother, and the objects in the room are all parts of the same whole. The mere

<table>
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my mother; this is whom I belong to." If mother is always present to gratify his needs, he never learns to regard her as separate from him. If mother frustrates his needs excessively by not being available or responsive, his mind may revert to a time when he thought she was always there. This is regressive refusion or failure to establish the proper boundaries. Again, psychosis results.

Eventually, perception and memory tell the infant his mother doesn't always come running. She has a nongratifying side too, a bad side. He doesn't always feel ecstatic over her; sometimes he feels mean and nasty. To recognize this badness in the picture of his mother and even in his picture of himself creates more anxiety, and must be warded off by a defense called splitting. He splits the mother picture into two mothers, one good and one bad. They are kept apart to protect the good one from the bad one. He does the same with his own self picture, turns it into a good and a bad self.

As he begins practicing to experience the world, he shores up the good side by another defense. He finds other good objects out there, makes them better than they really can be, and puts their embellished pictures into his mind to protect him further from the bad mother and the bad self. This defense is called primitive idealization.

Yet another defense protects him. Whereas he took the pictures of his good mother, good objects and good self internally, he banishes the pictures of his bad mother, bad objects, and bad self externally or projects them onto the external world. Thus, where Aunt Edeltraud could hold him with ease at the third month, her trying to hold him at the seventh month causes a terrible fuss. We call this stranger anxiety. The infant is telling himself through the fuss, "This is not my mother, this is someone unlike her, someone bad." The danger in projecting badness and aggression outward, attributing it to others, is that one soon sees too many bad and aggressive others out there to endanger one.

To protect one's self from them, one must identify with them and control them. Because they are representations of one's self, one controls one's own badness by controlling the imagined badness of the people out there. This is called projective identification, the attribution of a disavowed aspect of the self to another.

Eventually, the infant develops motor skills, can walk to the next room, and can be gone more and more from mother to explore the world. The further he goes, the greater is the separation anxiety, the thought that his good mother will not be coming back to nurture him. To calm the anxiety she must become involved with him and share with him the delight of each new discovery and each new skill he acquires. Rapprochement occurs.

Finally the child has developed enough skill to be somewhat capable of satisfying his own needs. Moreover, he learns that the mother who leaves is the same mother who stays. Piaget's idea of the child's recognizing that a chair is still a chair no matter from what angle it is viewed applies to recognizing a mother as well. Her being gone doesn't make her the bad internalized mother. This is merely a frustrating aspect of her basically good self. He can rely on this basic goodness. This is called object constancy.

At this point the splitting has healed. He no longer has to keep apart the good, negative and aggressive side of himself, but he does it in a way other than distorting the reality of the external world and his relationships in it. He merely does not allow its awareness to become conscious. This we call repression.

If repression is incomplete, neurosis develops. The problem with borderlines isn't partial failure of repression such as a neurotic shows. Nor is it the failure to differentiate self images from object images, i.e. the loss of ego boundaries such as a psychotic shows. A borderline person is one who fails to give up the defense of splitting. It is an arrest of ego development at the post-differentiation/pre-object constancy stage.

What are the manifestations of this type of ego weakness (Figure 4)? First, splitting the world and one's inner self into good and bad sides. In most of us good and bad sides tend to neutralize our strivings into acceptable and adaptive channels. In borderlines the split prevents neutralization, and the aggression is unusually strong. This explains the histrionic outbursts, the ascerbic demeanor, the suicidal efforts, and the self-mutilation, e.g. wrist and arm cutting which isn't suicidal but an attempt to punish the bad side of oneself.

Because of splitting, abrupt reversals of feeling occur toward others. The woman who is enamoured with Bob this week is just as enamoured next week - with David, while Bob is merely a fleeting memory. The wonderful bishop who took much time to set up a budget for my patient to get her out of debt became, in her eyes, next month the meddler whose only concern was to extract his 10%. These abrupt reversals of feeling also occur toward one's self. A grandiose and wonderful self becomes a worm in the gutter, in fact, a superlatively bad worm. The grandiosity isn't given up, the direction just changes from grandiose self-praise to grandiose self-reproach.

Second, primitive idealization, i.e. seeing certain others as totally good and powerful, both so they will protect one from the threatening world, and so one's inner badness can't contaminate those others in a relationship. Finally, association with such an ideal person provides direct gratification of one's narcissistic needs. While seeing her parents as hostile and the
bishop as thwarting her, my patient was thrilled to have become so close to the mission president and his family. She exploited his generous offer for help and support with unrelenting phone calls, imposing herself on his family for holidays, and moving to his town of residence when he was released.

The therapist also might be idealized by his patient. If he questions how any person could be so wonderful, the patient may leave rather than tolerate the idea that the therapist is not. If one points out that a villainous person in a patient’s life can’t be all bad, the patient will ignore it if he needs the therapist enough, or will convert the therapist into a bad person if he does not.

The patient does not hold genuine regard for the idealized person. Rather he uses the person to gratify his own needs. My patient had seen five internists for the same medical problem, each the best doctor in his field when first consulted, then discarded for a new best one as his luster diminished.

Third, projective identification occurs, i.e. getting someone out there to represent the disavowed badness of one’s self. Fraternalizing with the enemy is necessary to keep him from attacking one with one’s own badness. Commonly this is seen in a marriage wherein a harsh, authoritarian male espouses a submissive, dependent female who will express the unacceptable “weak” part of him, and then dominates her to control the weakness.

A brilliant borderline girl, to “work” her way through college, became the mistress of a wealthy older man who fed her narcissistic needs with expensive gifts. Her borderline mother was appalled, yet in a classic display of projective identification of her own erotic cravings and narcissistic needs as belonging to her daughter, remarked to her daughter who had just received a fur coat from her lover, “You should have asked for mink!”

Fourth, denial must be invoked to reinforce the splitting. The patient is consciously aware that at this time his feelings, thoughts, and perceptions about himself are at complete variance with those he may have had last week. But the contradiction has no emotional impact on him. In the extreme, this allows one to be a Sunday School teacher by day and a prostitute by night. Another of my patients divorced her husband and then went to the Young Special Interest Dances, hopeful of finding a nice L.D.S. man who might be a future mate. She found a nice man and told me he treated her very kindly in bed that night. The next week she avoided him at the dance, realizing she had slipped, met another nice man instead, and was treated equally kindly in bed that night.

One patient terminated therapy with me by declaring bankruptcy, leaving an unpaid doctor bill of $1,000. When I saw her a few weeks later, she reacted to me as an old friend and as if nothing unusual had transpired.

Fifth, omnipotence and devaluation are a common tandem. We have discussed the value of attributing omnipotence to an idealized other, using him to exploit and manipulate the environment and to destroy potential enemies. There is also a self–omnipotence or aggrandizement, the right to expect homage, to be treated as a privileged person for whom usual rules do not apply.

Devaluation is the corollary. If the object of interest can provide no further gratification or protection, he is dropped, because no real love or attachment existed in the first place. Devaluation prevents his becoming a powerful persecutor. Revengeful attempts to destroy him may appear. To the misfit borderline teenage girl without popularity, failure to make the pep club can only be tolerated by seeing the girls who did as nobodies.

The internalized object relations are pathological. We have said ego boundaries are generally intact, but not totally so. They do weaken when one uses projective identification, or when one allies with the idealized other. This is identity diffusion and is perhaps best seen in the “as if” person who, for lack of a good/bad integrated self-concept, borrows whatever concept diffuses from the outside for the moment and tries to be that kind of person. The loosening of ego boundaries is especially true in the transference of unstructured, insight-oriented therapy. The capacity to see the therapist realistically fails, and the patient may become psychotic.

Depression is common, but not the depression of guilt or shame. Guilt requires experiencing of tension between one’s good and one’s bad self. Acknowledging one’s aggression toward a basically good but frustrating other brings concern for the other and shame for one’s self. Splitting eliminates the tension, hence the guilt. Many an L.D.S. bishop has discovered the difficulty in trying to inspire to repentance one who lacks the capacity for guilt. Borderline depression is the depression of defeat by external forces, impotent rage and rejection. Borderline patients may behave in outrageous ways in therapy to elicit rejection and usually get it. After all, they’ve been at this business for years. Therapists are new at it.

In relationships with others with whom they cannot empathize and whose motives they misevaluate, there is the “porcupine dilemma.” They have a great need to be close enough to feel the warmth but fear being pricked by the quills.

Treatment can’t be standardized. Much ingenuity is required, not only to adapt treatment to the individual patient, but to adapt it to his different ego states at any given time. Remember, the goal is not to uncover unconscious conflict, because that is not the problem. It is to firm up the defective ego. This requires an active

*concluded on pg. 22*
therapist’s being a real person, an educator, a coach, lending the patient the benefit of one’s hopefully healthy ego. He assists the patient in seeing what role the patient does play and could play in life, and what he can become. He helps the patient recognize true feelings, especially the positive ones. He enhances the patient’s sense of self, giving appropriate feedback for small accomplishments. He helps the patient improve interpersonal skills and see the motives of people around him realistically. He is a model of humanness, in short, the patient’s ally in the real world.

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