

The Borderline States : An Increasing Need For Recognition

By

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(A) Introduction

The borderline States, a group of unclassifiable disorders, are being increasingly recognised; specially in the west, but still not included into the official nomenclature of diagnosis and classification in Psychiatry.

Starting as a "waste basket" of psychiatric illnesses, it has become an entity which is making an ever increasing progress in the elucidation of its etiology, clinical features, diagnostic criteria and management. Starting with Huges in 1884 to Shapiro in 1978, a hundred years have elapsed in this task.

The task in this article would therefore be to present this entity in a manner which would set clear guide lines for its recognition, diagnosis and management, thereby lifting the fog of uncertainty and confusion on this group.

(B) Historical Data

To understand borderline states it is interesting to know its history.

Hughes (1884) used it to designate disorders lying between schizophrenia and neurosis.

Rosse (1890) indicated that it may be a latent, potential or transitional phase of schizophrenia. The psycho-analysts gave the entity its fundamentality, when, in their therapeutic sessions they could segregate a group of people who had weak object relationship.

Schneideberg described them as having "stable instability" in their life pattern and thereby at various times displaying neurosis, psychosis, psychopathy and normality blending into one another clinically. This was a very significant view to the understanding of borderline states, indicating thereby:

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- (i) A peculiar life pattern of defective object relations.
- (ii) Presence of multiple symptomatology and hence the "Non classifiable" nature of it.
- (iii) A defect in psychological development and not a regression as in schizophrenia.

Grinker et al (1968) in a neat and systematic study further subclassified the borderline states into four sub-categories which overlay, yet are sufficiently discriminating; later, confirmed by Gunderson et al (1978). The treatment of the borderline patient is possible but difficult by all modes of therapies.

(C) Characteristics and clinical features

Gunderson et al have attempted to describe this entity by trying to delineate it from other disorders if possible. They felt it was particularly important to discriminate it because of its confusion with psychosis and neurosis or schizophrenia and affective disorders.

- (1) **Heightened affectivity.** This particular criteria express itself in four types.
 - (a) **Depression.** The depression has a quality of loneliness rather than guilt or remorse.
 - (b) Anger. Anger is defensive rather than aggressive in neurosis or psychosis.
 - (c) Anxiety.
 - (d) Anhedonia or failure to experience any pleasure and not a "flat affect".

Anger and Anhedonia are the most discriminating.

- (2) **Low achievement:** Inspite of talents the borderline have their careers blocked at a low level though they are gainfully employed. They compare with schizophrenic in a social remission.
- (3) **Impulsivity:**— Alcoholism, drug abuse, sexual deviance are a manifestation of their impulsivity. Self mutilation and other self-destructive acts may occur.
- (4) **Mild psychotic experiences:**— The borderline under a stress may cross over into the realm of psychosis but only for a short time. Regression or worsening, inspite of treatment, and paranoid ideation may occur. There is usually an absence of wide spread psychotic symptoms of any type.
- (5) **High socialization:**— Borderline patients do not like social isolation and are intolerant of being alone. They are, in short, "compulsively social".
- (6) **Manipulative suicide:**— The suicidal attempts resemble those of a hysteric, and usually evoke a saving response from others.
- (7) **Disturbed close relationship:**— This particular aspect is so unique to the borderline state that it presents a problem in its diagnosis as well as management. It is primarily due to the following that the relationships are affected.
 - (a) **Devaluation.** They do not value the

lives. They consider that others cannot contribute any thing to a relationship.

(b) **Manipulation.** Others are meant only for personal gains and hence they covertly manipulate them. To get and not to give is their aim.

(c) **Masochism.** They repeatedly, knowingly, and avoidably get hurt in their close relationships.

(d) **Dependency.** They depend on others for their actual caretaking. Such a wide and divergent modes of relationships is definitely going to play havoc in any interpersonal relationship. This results in difficulties in their personal life and a barrier to analysis and psychotherapy

(D) **Definition.** An attempt at defining a broad and heterogenous entity could be attempted by first delineating its features Gunderson and Kolb in two studies have attempted to definite it by summarizing those characteristics of borderline about which there was a consensus. One cannot but present them unchanged for defining a borderline.

There are six diagnostic characteristics.

(i) An intense affect in the form of anger and depression

(ii) Impulsive behaviour including self mutilation,

(iii) Social adaptiveness shown in satisfactory job performance and good appearance.

(iv) Brief psychotic episodes.

(v) Good performance on structured test like the WAIS and bizarre responses on unstructured test like the Rorschach and superficial transient interpersonal relationships alternating with intense dependent relationships.

(E) **Classification.** Grinker et al, further subclassified the borderline into four categories, so that some order could be brought into the over all clinical picture. Grunewald later tested them and came to the conclusion that these were justified.

(i) **Bordering on the psychosis.** Disturbed close relationships, impulsivity leading at times to loss of ego boundaries and a short term psychosis.

(ii) **Bordering on the neurosis.** Marked anxiety and a child like clinging depression.

(iii) **The core syndrome.** Characterised by loneliness, depression, confusion and anger. Vacillation of relationships back and forth.

(iv) **"As if" personality.** Devoid of affect, no spontaneity, yet socially functional with a diffuse identity due to complementary behaviour. The whole behaviour is 'put on' with a threat of withdrawal every time.

(F) **Differential diagnosis.** The borderline syndrome as seen above has a core syndrome of (i) Defects in affectual relationship. (ii) Anger as the main affect. (iii) Lack of a consistant self identity. Over and above these are the defensive symptoms utilised by them resulting in a overlap with neurosis, psychosis, personality disorder, addiction and perversions. If

one keeps in mind the core syndrome then one may not have difficulty in diagnosis. However confusion over neurotic depression and schizophrenia would be most frequent.

(a) **Neurotic depression.** The affect in a borderline is a more frequently sustained dysphoria and an anhedonia. Disturbed interpersonal relationships, problems of countertransference and more chances of paranoid ideas are seen in borderline.

(b) **Schizophrenia.** Flat affect was more common in schizophrenia. Lack of an intense relationship is found in schizophrenia while the sociability and work-performance was better in the borderline state.

From the above it seems that interpersonal relationships and impulse/action patterns are the most useful discriminators of the borderline rather than symptoms and signs.

(G) **Psychopathology.** A lot has been written about the psychopathology. However amidst the conflicting and confusing data, we have chosen only those aspects which helps us in understanding the clinical picture.

The pathology of the borderline is related to difficulty in management of impulse and affect which is seen characteristically in interpersonal relationships and emerges most clearly in relatively unstructured settings. The intensive relationship at therapy provides the first insight into the psychopathology.

(1) **Transference and counter-**

transference problems :—

The response of borderline patients in intensive therapy is immediate, intense, and chaotic, similar to a child's response to a object like a Teddy bear. They recognise the therapist as a different entity (Teddy bear) which is unlike a psychotic, but interpret the warmth of the therapist (warmth of the Teddy bear) as coming from the self and not because of the therapists (Teddy bear) qualities which is unlike a neurotic.

Hence they feel alone, helpless, needy and appear unable to realise that the therapist will remain with them in a caring way. They thus present the manifest conflict of extreme dependence and intense fears of closeness. The solution to this appears to be a constant awareness to maintain a distance from the therapist resulting in the borderline being unanalyzable. In counter-transference too, the therapists response is rapid, intense and stereotype. Since borderline are more sensitive to minor frustrations they will withdraw and devalue the therapist, as they seem to understand the empathy of the therapist as coming from themselves. This in turn evokes a guilt anxiety in the psychiatrist who empathically regresses to understand their patient resulting in the patients confirmation of their fears by projective identification. Why does the patient develop this life-style in relationships? To understand this one has to take recourse to,

(2) Development of mother-infant interaction and object relations?

The symbiosis of the mother-infant relation ends by the child's growing awareness of self-object differentiation which later on goes to the child's obtaining an object constancy. In the borderline the child comes to realise the self-object differentiation but not an object constancy and hence they can not tolerate the separation or ambivalence without regression.

(3) **Egodefenses:**— The use of specific primitive egodefenses has been described as characteristics of borderline states. Splitting is the mechanism commonly used where the positive and negative fantasied relationships remain alternatingly in consciousness with the complementary side dissociated. In the gratifying relationship the patient develops positive fantasies with the negative ones being split off and vice versa in a frustrating relationship.

Projective identification is a defense and used along a spectrum of psychopathology from normal to psychotic. The severity of the illness is directly proportional to the amount of projection. This however only helps in weakening his ego-function. He however projects both positive and negative aspects of himself unlike a paranoid and thereby develops extreme dependency, loneliness, fears of parting and fears of the loss of the capacity to love.

(4) **Family.** The families were overtly "sick" specially in the "bordering on psychosis group" but not of any particular mental illness. However family type was not indicative of the type of border-

line disorder that the patient may suffer from.

(G) **Psychological tests.** There was gross abnormality in an unstructured test like the Rorschach with evidence of structural defects of the ego, disturbed object relationship and difficulty of impulsivity. The WAIS which is more structured did not show any scatter or any bizarre responses indicative of a psychotic disorder.

(H) **Management.** Very few studies and efforts have been made in the management of this illness as its classification and clinical features have been more intensively studied.

(I) **Intensive psychotherapy.** Which has shed light on the subject is usually contraindicated as in psychosis, the lack of transference and countertransference problems makes the borderline unanalyzable. In fact non-keeping of appointments, anger and frustration on the part of both, the patient and the therapist contributes only to a firmer diagnosis of the borderline states.

(b) **Millieu therapy** the few so called "cures" have been with this therapy. It should consist of a warm and accepting attitudes, with direct advise and experiences about the social behaviour.

(c) **Behaviour therapy** is usually ineffective, thereby suggesting that external influences, perhaps only in early life, may be reversed at a critical period.

(l) **Prognosis and follow up** Pavenstedt suggests that the syndrome may appear in childhood. Also a five years follow up

study (Werble) have found most of the borderline living in the community but socially inept and awkward. Fifty percent had been rehospitalised and these patients gave no evidence of a movement towards schizophrenia.

Conclusion and Discussion.

In conclusion the borderline state can be effectively delineated and studied as far as its psychopathology, types and clinical features are concerned but still a lot remains to be understood in its management. Yet the borderline is increasing, as are other neurosis while psychosis are changing to more restricted and constricted personalities.

From the matter presented here, we would like to conclude—

(1) There is some evidence specially by the symptomatology, that a disorder like the borderline state may exist. In practice, one does come across such cases where, one senses a frustration in diagnosis by its everchanging symptomatology, resistance to treatment and frequent relapses. Retrospectively one feels a sense of rational and coherent thinking regarding these cases if one categories them in the borderline states. However this sense of well being is only for the academecian and not for the clinician who would want some positive therapy. Hence we can easily be lead to cling to this straw to save ourselves, only temporarily.

(2) Karl Menninger suggested that psychiatric diagnosis should not be compartmentalised. One person may suffer from depression at one time and phobia at

another time. Hence he classified illnesses as reactions to a particular type of stress. Then, the borderline state, with its multiple symptomatology is nothing but a person who is a "Forme frustes" or an arrest of the stages in the development of a full blown psychiatric reactions.

(3) The anti-psychiatrists suggest that the psychiatric disorders are nothing but a reaction or handling of the external and international world by a person in response to a stress. As the psychotics are reducing in number and more neurotics and borderline are emerging, the borderline state may be the ultimate modification of an ingenious mind to defend itself, maintain contact with the real world and confuse the psychiatrist who dare treat them to bring them back into this troubled world. A rather far fetched idea but one must not forget that borderlines do exist and evolution is the order of man.

(4) Inspite of all these, however, the most likely explanation may be that the borderline is only a personality disorder because of its varying and multiple characteristics, resistance to treatment and a slight mal adjustment in the long run.

Does the borderline represents a new evolving psychiatric disturbance or is it an entity existing due to inadequate diagnostic criteria of present, or is it a new fad of the psychiatrist? Only time and an active effort on the part of every psychiatrist to prove or disprove it will tell.

SUMMARY

The broderline states, a much written and discussed about disorder in recent times, has been presented for an easy understanding of its symptomatology diagnosis and treatment. The possibilities of its being a new fad, a disorder in evolution or a personality disorder is discussed and commented upon.

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