Developmental differences in individuals with borderline personality disorder.

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DEVELOPMENTAL DIFFERENCES IN INDIVIDUALS WITH
BORDERLINE PERSONALITY DISORDER

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CHAPTER I
THE BORDERLINE CONCEPT

Modern psychiatry has provided us with numerous theoretical approaches and clinical applications to the study of psychopathology, often resulting in changing and contradictory diagnostic criteria. Both the progress and confusion in psychiatric diagnosis is demonstrated by the history of the borderline concept. Originally, it was a term for unclassifiable cases, and only gradually became recognized as a specified disorder with an independent cluster of symptoms and underlying dynamics. The inclusion of the borderline personality disorder into the Diagnostic and Statistical Manual III (APA, 1980) was a crucial step in the recognition of this category by the mental health profession.

Early History

Early developments in the borderline concept paralleled the broader changes in psychiatric thought. As a result of the scientific revolution and enlightenment period in the eighteenth century, the care for the mentally ill came under the power of a strengthening medical profession. Freed from religious evaluation, the mentally ill were given the status and privileges of patients. Separated from the poor and the criminal, they needed to be classified and treated. Thus throughout the eighteenth and most of the nineteenth century, psychiatry was descriptive in nature, in keeping with the rest of the
medical profession. Clinicians observed, recorded and classified the various symptoms their patients displayed in the asylums of the time. Although basic distinctions such as dementia praecox and melancholia were made, the majority of the less severe disorders were classified as "moral insanity" or "psychopathic inferiority." With his published classification system featuring manic depressive psychosis and forms of dementia praecox, Emil Kraepelin was the forerunner of the descriptive tradition in nineteenth century psychiatry (Kraepelin, 1896).

In his textbook of psychiatric classification, Kraepelin identified a "borderline" category between the neuroses and schizophrenias. His student Eugen Bleuler used the term "latent schizophrenia" to describe the disorder; he theorized that it preceded a full-blown schizophrenic episode. Although a "borderline" category had been identified, it was not until the emergence of psychoanalytic theory that a more in-depth understanding of the character disorders was put forth.

Freud, relying on case analyses, developed diagnostic categories which were based on the early history and intrapsychic structure of his patients. His instinctual theory, concept of unconscious motivation, ego functions and existence of transference laid the groundwork for numerous psychoanalytic theories of patients who did not fit the neurotic or psychotic categories. Freud's work on narcissistic pathology, which he saw as preoedipal and characterized by omnipotence, was later linked to borderline pathology. Freud himself used the term
borderline, mainly to refer to adolescent delinquents or acting out and impulse ridden characters. He gave these individuals a poor prognosis for analytic treatment because of their inability to form a transference in the analysis (Freud, 1914).

There was much work which stemmed from the ideas Freud put forth about character pathology; Reich, for example, concentrated on linking specific character types to the libidinal stage at which a trauma or fixation might have occurred. For instance, he wrote about an anal character, a masochistic character and an hysterical character. In his writings on the impulsive character, he cited many of the features recognized today as central to borderline pathology: primitive aggression and defensive structure as well as severe ego and superego deficits. In fact, he called these impulsive characters "borderline cases" (Mack, 1975). Others who added to Freud's original work in character pathology were Wilhelm Reich, Karl Abraham, Ernest Jones, Franz Alexander and Otto Fenichel.

Throughout the decades between the 1930's and 1950's, analysts categorized patients who were neither neurotic nor psychotic as being "borderline." However, the specific meaning of the term varied from analyst to analyst. While the borderline diagnosis was sometimes used to describe a broad unclassifiable group with general characteristics in common, it was also used to describe what we now consider to be subgroups of the character disorders, psychoses or neuroses. In spite of the disagreements over classification, however, certain aspects of the "borderline," such as impairments in relationships and
severe ego deficits, attracted the attention of most of the analysts.

For example, Melitta Schmideberg (1959) regarded the borderline group as a distinct category and did not view it as a precursor to schizophrenia. She placed the syndrome between the neuroses and psychoses and felt that borderlines maintained a stable character structure throughout their lives. Schmideberg included in the borderline category those individuals who were previously classified elsewhere due to problems with crime, substance abuse and sexual deviance. More importantly, though, she recognized the patient as having in common both difficulties in relationships and an inability to empathize with others.

Helene Deutsch (1942) noted the prevalence of depersonalization in a group of patients she diagnosed as having an "as-if personality," which was a much more narrowly defined group than Schmideberg's borderlines. While differing in matters of classification, Deutsch noted relational issues in these patients which were similar to the observations of Schmideberg. For example, the "as-if" individuals were characterized by the fact that they maintained superficial relationships which were both intense yet lacking in warmth. These patients were able to maintain a stable outer facade, in spite of their lack of satisfying relationships. Deutsch theorized that these patients, who were primarily female, had impaired relationships with their mothers in early infancy which had resulted in deficient internalizations and ego deficits.

Stern (1938) initially categorized borderline patients as a
subgroup of the neurotics, but later felt that both psychotic and neurotic mechanisms were at work. He decided the borderline category should be categorized separately. Stern's borderlines were characterized by their acting out behaviors, hypersensitivity, low self-esteem, dependence on others and rigidity of character structure. He maintained that these defects were due to a lack of early maternal nurturance and other traumas in the course of early development.

Eisenstein (1951) defined a borderline group that functioned at a neurotic level but had fleeting psychotic features, such as paranoia, depersonalization and ideas of reference. He cited several features of these borderlines which were central to the modern concept, most notable were that they had in common a fear of being alone and of losing a sense of themselves in a relationship. Also characteristic of Eisenstein's borderlines were a pattern of acting out through promiscuity and substance abuse. He cautioned that the misdiagnosis of the borderline might precipitate a psychosis in the patient and result in the failure of the treatment.

The term "ambulatory schizophrenia" was used by Zilboorg (1941) to connote patients who were pre-schizophrenic, as evidenced by their impaired reality testing, lack of intimate relationships yet ability to maintain a superficial facade of normal adaptation. Zilboorg (1957) later wrote about the conflicts between autonomy and dependence in these individuals.

Hoch and Polatin (1949) found the term borderline ambiguous and introduced the concept of "pseudo-neurotic schizophrenia" to describe
those patients who appeared neurotic on the surface but had an under-
lying psychotic structure. Although these individuals did not exhibit
floridly psychotic symptoms such as delusions and hallucinations, they
manifested non-specific anxiety, polymorphous perverse sexuality and
recurrent, yet brief psychotic episodes.

Whereas Hoch and Polatin believed that the "pseudo-neurotic
schizophrenic" patients were essentially schizophrenic, Bychowski
(1953) used Bleuler's term "latent schizophrenia" to describe patients
who exhibited neurotic functioning which may or may not develop into
a psychosis depending upon life stress. He described the symptoms
of these individuals as ranging from obsessive-compulsive and hyster-
ical ones to deviant and acting out behaviors such as delinquency,
perversions and addictions.

The work of Rado (1962) was important because he divided the
area between the neuroses and psychoses into four separate subcate-
gories. He described four disorders: the depressive, the extractive
(similar to the sociopath), the paranoid and the schizotype. Rado
described the schizotype as being incapable of experiencing pleasure
or affection for others and having overwhelming rage toward and
dependency on others.

Frosch (1964) described a borderline group he called the
"psychotic character"; these patients were characterized by psychotic
symptomatology which was relatively transient and reversible. He
maintained that the group was not specifically linked to schizo-
phrenia, but, "may run the gamut of all known psychoses, paranoid,
manic-depressive, and the rest" (p. 82). He suggested that the "psychotic character" group had the following features in common: (1) the capacity for reality testing; (2) infantile object-relations which maintain some degree of self-object differentiation and are not psychotic; (3) transiency and reversibility of psychotic breaks; and (4) the presence of primitive defenses. Frosch maintained that during the psychotic breaks, primitive aggressive and libidinal impulses temporarily overwhelmed the ego, resulting in feelings of depersonalization, unreality or more serious decompensation (Frosch, 1964, p. 91).

Easser and Lesser (1965) described severely disturbed hysterical patients who manifested psychotic characteristics. These patients were typically irresponsible, had erratic work histories, disturbed and unstable interpersonal relationships and sexual perversions such as promiscuity and frigidity (Stone, 1980).

A major contribution to the development of the borderline concept was Knight's article "Borderline States" (1953), in which he suggested that the borderline category should be recognized as independent of the neuroses and psychoses. Knight defined borderlines as the group of patients who function on a normal to neurotic level, but develop psychotic symptoms in treatment. He emphasized that a thorough assessment be done on these individuals, since both neurotic and psychotic mechanisms may have developed, further stating that "this is the crux of the problem in many borderline cases" (Knight, 1953, p. 100). In addition, Knight also recommended that the term
borderline not be used diagnostically, "for a much more precise diagnosis should be made which identifies the type or degree of psychotic pathology" (Knight, 1953, p. 108).

As a result of Knight's article, part of the psychoanalytic community began to accept and further define an independent concept of the borderline syndrome. Two conferences were held in 1955 by the American Psychoanalytic Association to discuss definitions, dynamics and treatment of the borderline. Much theoretical speculation emerged from these conferences which presaged later developments. For instance, Greenson discussed the splitting defense in borderlines and maintained that it developed from early childhood, when the infant is unable to integrate good and bad images of the mother and therefore alternates between them. Frank referred to Winnicott's concept of a transitional object, which the child uses for self-object differentiation, as an aspect of normal development which is absent in the borderline.

The 1955 conferences were significant in shaping the borderline category, which was then recognized as one of the character disorders. There was a consensus that both psychotic and neurotic levels of functioning exist in the borderline patient, although the former may emerge only under unstructured or stressful circumstances. Support for this view came from the recognition that while cognition and perception in the borderline often appear to be unimpaired, object relations are at an infantile level and defense mechanisms are of a primitive nature.
In the decades since these conferences, a plethora of research and theorizing has been done to further define the borderline category. It is beyond the scope of this thesis to review all the material written on the borderline. Instead, a review of the more recent literature will concentrate on developmental perspectives as to the etiology and differential diagnosis of borderline personality. First, some of the more descriptive, empirical work will be mentioned briefly, and then the psychoanalytic theories will be outlined. This will lead into a discussion of the purpose of this present work.

**Empirical Approaches**

Based on a belief that borderline personality can be defined by observing, describing and quantifying behavior, Grinker, Werble and Drye (1968, 1977) did a factor analytic study of fifty hospitalized patients. They began by having numerous staff members rate the behaviors of various nonpsychotic patients and then had independent raters cluster the symptoms and make discriminations based on factor analytic technique. The study defined borderlines as those patients having the following features in common: (1) intense anger, (2) impairments in interpersonal relationships, (3) an unstable sense of identity, and (4) depressive loneliness. From this cluster, the investigators found four distinct subcategories of the borderline which each "represented different pathological positions" (1977, p. 161).

Group I was characterized by their inability to maintain any
positive relationships; they were typically negativistic and angry when approached by others. The patients in Group II had more of an approach-avoidant, ambivalent style of relating to others and would respond to moves toward intimacy by a retreat into an isolated and depressed state. Grinker has referred to the patients in Group III as the "as-if" types; they were more passive and compliant than the other borderlines and had a very fragile sense of identity. The patients in Group IV were more relational; Grinker stated that these patients, "search for lost symbiotic relations with a mother figure" (1977, p. 161). They were typically female and were described as anaclitically depressed, dependent, clinging and self-pitying.

In summary, Grinker believed that the borderline patient could be defined by his or her unique observable behaviors which reflected deficits in ego functioning. Furthermore, Grinker saw the borderline personality as a stable disorder rather than as a regressive state. He hypothesized that it was linked to a developmental arrest in early childhood but that this needed to be confirmed by more statistically sound research as opposed to psychoanalytic theorizing. Grinker divided the four borderline subgroups into a developmental hierarchy based on severity of ego deficits; he saw Group I as the most severely disturbed, bordering the psychoses, and Group IV as the healthiest, bordering the neuroses.

Like Grinker, Gunderson sought to more narrowly define the borderline category through descriptive empirical research. He began his research with a review of the literature (Gunderson and Singer,
1975) in order to isolate some features most commonly associated with the category. The review revealed five characteristics:

1. intense affect of an unpleasant type,
2. a history of episodic or chronic compulsive behavior, often self-destructive in nature,
3. social adaptiveness or mimicry of good behavior,
4. a characteristic pattern on psychological tests of normal protocols on the structured tests and more severely disturbed protocols on the unstructured tests, and
5. a vasillation in personal relationships between superficial ones and intense, dependent ones.

Using this information as to common borderline characteristics, Gunderson and his colleagues did a series of comparative studies to design measures in which borderlines could be distinguished from other diagnostic categories (Gunderson, Carpenter and Strauss, 1975; Gunderson, 1977). One of the results was the Diagnostic Interview for Borderlines (DIB), a semi-structured interview which assesses functioning in the areas of

1. social adaptation,
2. impulse/action,
3. affect,
4. psychosis, and
5. interpersonal relations.

In the 1977 study, Gunderson compared 31 borderlines, 22 schizophrenics and eleven neurotic depressives. The results indicated that borderlines were more social than the schizophrenics and displayed hallucinations and delusions less frequently. Characteristic of the borderline patient was substance abuse, suicidal threats, promiscuity and an unstable work history. Their interpersonal relationships were more dependent, masochistic and intense than those of the schizophrenics, and were characterized by more devaluation, manipulation, hostility
and splitting than either the schizophrenic or neurotic-depressive groups.

The work of Grinker and Gunderson led to more descriptive, empirical research. Carpenter and Strauss (1977) did a comparative analysis of borderline and schizophrenic patients and noted many of the same distinguishing features of borderlines as were noted by Gunderson. Spitzer, Endicott and Gibbon (1979) sent questionnaires to APA members asking them to rate a patient they considered borderline and one they did not consider borderline on two item-sets of characteristics they had compiled. The results of the study confirmed Spitzer's hypothesis that there were two dimensions of the borderline personality, one which displayed some of the features of schizophrenia, such as tangential communication, suspiciousness, magical thinking and social isolation. The work of Spitzer and his predecessors resulted in the inclusion of the borderline personality disorder in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (1980). Also included in DSM III, as schizotypal personality disorder, was the group which Spitzer had recognized as having more psychotic-like features. It is worth noting that the borderline item-set in Spitzer's study is the same as the nine diagnostic criteria for borderline personality disorder that appears in DSM III (1980).

Developmental Perspectives

While the empiricists were observing and describing borderline traits, other clinicians were approaching the understanding of
borderline personality through the route of developmental impairments in early childhood. Much of the background for these perspectives came from the study of both normal and pathological child development by such theorists as Mahler (1971; 1975), Klein (1946) and Winnicott (1958; 1971). Most notably, Kernberg (1975) and Masterson and Rinsley (1975) applied these notions of early impairments to the study of the borderline. The review of the developmental perspectives of borderline personality will begin by highlighting some of the most salient literature concerning developmental impairments and will then review the work of specific theorists concerned with developmental deficits in the borderline.

The first phase of development, which many call the symbiotic period (Mahler, 1975) is characterized by the child not perceiving any separateness or boundary between him or herself and the mother. Winnicott (1958) has written about the importance of a holding environment for the child, which requires that the mother respond empathically and consistently to the child's needs. It is important for the mother to be comfortable with her own infantile impulses in order to respond empathically to those of her child. When the mother is uncomfortable with her own impulses and denies or projects them onto the child, an inhibition of the child's normal dependency may result. In addition, a child in this situation may disavow his or her own needs and conform to the desires of the parent. This early impairment in symbiosis is said to result in both a "false-self" character and a tendency toward isolativeness, detachment and a lack
of empathy.

According to Mahler, the symbiotic period takes place roughly from birth until the fifth or sixth month of life. During the next two and a half years, the child is in the separation-individuation period, which Mahler and her colleagues have divided into subphases: (1) differentiation, (2) practicing, (3) rapprochment, and (4) object constancy.

During separation-individuation, several changes occur. The child develops a sense of self separate from that of the mother. Also, if the parenting has been consistent and has been able to contain the child's aggression in a nonretaliative manner, the child begins to integrate good and bad images of the mother into a single, more ambivalent image (Winnicott, 1955). This fosters a realization that the mother is autonomous from the child and is not changed by the child's impulses toward her.

Winnicott explains that before a sense of separateness is achieved, "the human infant cannot accept the fact that this mother who is so valued in the quiet phases is the person who has been and will be ruthlessly attacked during the excited phases" (1958, p. 266). However, he goes on to explain that:

The time comes for the infant to see that here are two completely different uses of the same mother. The baby puts one and one together and begins to see that the answer is one, not two. The mother of the dependent relationships is also the object of instinctual love (1958, pp. 267-268).

Winnicott discusses the integration of good and bad images of the mother into a whole as the achievement of the depressive position,
which brings with it the ability to distinguish inner from outer reality, the ability of hold an object constant over time and the beginnings of the capacity for ambivalence, guilt and concern. The developmental deficits linked to borderline personality disorder are similar to the deficits associated with a failure to reach the depressive position in emotional development.

In the latter subphases of this period, the child obtains a mastery of separation anxiety by becoming able to maintain an image of the mother in her absence, called object constancy. Characteristic of this period is the child's vascillation between a desire for autonomy and a desire to regress to the dependence on the mother typical of the symbiotic period.

Inadequate mothering in the rapproachment subphase of separation-individuation has been linked to the development of borderline pathology. The conflict between autonomy and dependence is at its peak during this time; Mahler has described the child's pattern of darting away from the mother and then returning for "refueling" (1975). During this time, the child shows an increase in separation anxiety as well as a sense of helplessness, loneliness and a preoccupation with the mother's presence (Shapiro, 1978). It is important for the mother to respond consistently and empathically to the child's moves toward autonomy. A failure to do so, often because of the mother's difficulties with dependency and autonomy, leads the child to feel that any move toward autonomy will result in an abandonment.

Children who have difficulties in this subphase often vascillate
between clinging to their mothers and rejecting them in a hostile manner.

The use of a transitional object has been noted as common in normal development during the separation-individuation period (Winnicott, 1953). A blanket or teddy bear becomes, to the child, an object partly representative of the mother and partly representative of the child. It is an object in the child's control, which can be both loved and hated by him or her, and becomes an important intermediate between internal and external reality. The fact that the object does not change in accordance with the child's projections onto it provides a significant step toward the child's realization that the mother is not a reflection of the child's impulses, but is, in reality, separate. In addition to the teddy bear, the father has been cited as a central transitional object in the separation-individuation period of development (Abelin, 1975).

Psychoanalytically-informed clinicians have referred to the work done in child development and applied it in various ways to an understanding of borderline personality. For example, object relations theorists have studied the failure of the borderline to integrate loving and hating images and the borderline's inability to differentiate between oneself and others (Kernberg, 1975). The use of a transitional object has been a part of such discussions (Modell, 1975). Other clinicians with a developmental perspective have compared borderline characteristics, such as helplessness, loneliness, and a vascillation between fears of engulfment and fears of
abandonment, with the traits of children and their mothers in the separation-individuation period. They have further used that link to make treatment suggestions (Masterson, 1975; 1981). In addition, some analysts have made a study of the ego deficits in the borderline and have linked them to developmental impairments (Kernberg, 1975; Meissner, 1984). Also important is that theorists have made distinctions among borderlines, as they have since the term was first used, and have placed these subcategories of borderlines on a developmental continuum from healthiest to most pathological according to the severity of the childhood trauma as well as the time the impairment occurred in the child's developmental process. Whereas a discussion of all these theories is not within the scope of this thesis, some of these developmental approaches to borderline personality will be reviewed. Particular attention will be paid to the developmental differences across individuals diagnosed as borderline.

Whereas more descriptive researchers have defined the borderline in terms of impairments in functioning, Kernberg (1975; 1977) defines borderline personality in structural terms, as a level of organization. Kernberg's borderline category is broader than the one recognized by DSM III and therefore includes individuals with a wide range of differences between them. Using a variety of symptoms as descriptive markers, Kernberg maintains that all borderlines are characterized by the following nonspecific ego weaknesses: (1) lack of anxiety tolerance, (2) lack of impulse control, (3) lack of adequate subliminary channels, and (4) a predominance of primary process
thinking. Kernberg contrasts the reality testing of the borderline with that of the psychotic, stating that borderlines maintain adequate reality testing except in the context of emotional involvement. Also, unlike the psychotic, when the borderline does exhibit poor reality testing, it is usually fleeting and temporary and is restored in a structured treatment setting (Meissner, 1984). As Kernberg points out, this concurs with studies of the performance of borderlines on structured versus unstructured psychological tests (Singer, 1977).

Kernberg focuses on the separation-individuation period as the time of arrest in object-relations development for the borderline. Specifically, he sees the development arrest in the borderline as occurring after a tentative self-object differentiation has been achieved but before the mastery of object constancy (Shapiro, 1978). Kernberg finds the splitting defense central to an understanding of borderline pathology and discusses it in terms of the borderline child having failed to integrate good and bad self and other images into a cohesive whole. This splitting, according to Kernberg, gives way to other defenses characteristic of borderlines, such as primitive idealization, projective identification, omnipotence versus devalument and primitive denial.

The patients that Kernberg sees as functioning on a borderline level of organization vary widely in terms of symptomotology and presenting complaints. He notes that neurotic symptoms occur across almost all borderlines and are not necessarily indicative of severity of illness. Some of the major character constellations that may
function on a borderline level, according to Kernberg, are the hysterical, paranoid, hypomanic, schizoid, impulse-ridden and depressive-masochistic character types. He differentiates between them in terms of severity of illness and respective prognosis, "according to the degree to which repressive mechanisms or splitting mechanisms predominate" (1975, p. 13). The character types are on a continuum with the hysterical personality as the higher level, the infantile personality as a middle level and the narcissistic personality as the lower level of borderline organization.

Central to Kernberg's differentiation of levels of borderline organization is the structural analysis, which is an assessment of the ego structure as well as the quality of the internalized object relationships of the individual. In evaluating the structural derivatives of internalized object relationships, Kernberg refers to the work done in normal child development, such as the concepts of object constancy and the ability to integrate positive and negative images. The more the self and object images are blurred, and the more extreme the splits are between good and bad introjects, the more severely disturbed is the individual.

Although he does recognize variabilities in terms of the borderline's awareness of his or her pathology, Kernberg states that these patients have a weak observing ego and a "poor ability to realistically assess the limitations of others" (1975, p. 85). Elaborating on this point, he maintains that the borderline patient shows rapid fluctuations in perceptions of him or herself and others in treatment,
and demonstrates little insight as to the contradictions in his or her perceptions. Of particular emphasis is the strength of the negative transference in treatment, which Kernberg views as the result of the patient's projections of primitive negative introjects onto the therapist. As he states, "To establish a therapeutic alliance with the therapist becomes equal to submission to him as a dangerous and powerful enemy, and this further reduces the capacity for the activation of the observing ego" (1975, p. 82).

Kernberg's recommendation for treatment of the borderline is the working through of the negative transference in the "here and now" as opposed to an emphasis on genetic reconstructions. He advocates limit setting around acting out of the transference and emphasizes interpreting the defenses of these patients as the negative transference evolves. In addition, Kernberg advises against interpretation of more benign feelings about the therapist, so as to foster an alliance. He does not agree with the notion of supportive therapy for these patients, but maintains that a confrontation of the projective and introjective processes and their resultant transference distortions and acting out will eventually foster a strengthening of the patient's observational capacities.

Like Kernberg, Masterson (1976; 1981) and Rinsley (1977) look to early developmental arrests in the separation-individuation period to account for the conflicts and character structure of the borderline. Masterson cites the response of the mother in this period as central to the borderline child's later development of abandonment
depression and a sense of hopelessness and emptiness along with fears of abandonment and fears of engulfment. Specifically, the mother of the borderline, who Masterson suggests is probably borderline herself, withdraws nurturance when the child attempts to separate from her. The child is caught in an impossible situation in which the support of the mother is needed in order to complete the developmental process, yet the only way to obtain such supports from the mother is to cling dependently to her. As a result of this bind, the child maintains a split image of the mother as both loving and nurturant as well as rejecting and cold.

Masterson puts borderline pathology on a continuum according to the point of developmental arrest and cites variabilities in borderlines according to whether they primarily have a fear of engulfment or a fear of abandonment. Specifically, he maintains that the lower-level borderline primarily fears engulfment from others; this borderline is arrested earlier in the separation-individuation period than the higher-level borderline. The higher-level borderlines fear abandonment more than engulfment and defend against it through a clinging, dependent relational style. They are closer to the neuroses than the lower-level borderlines in terms of severity of pathology (Masterson, 1981).

Masterson recommends psychotherapy for the borderline which addresses the clinging and distancing defenses and the central effect of abandonment depression. He emphasizes the importance of confronting transference acting out, especially in the early phases of treatment.
In addition, Masterson stresses that the therapist be supportive of the patient's moves toward autonomy. He cautions that, more than in the treatment of the neuroses, the therapist's own development and maturity has an impact in the therapy. Masterson maintains that many treatment failures of borderlines are due to the therapist's inability to provide the environment necessary for the patient to change (1981).

Like Masterson, many theorists have based their discussions of the developmental impairments of borderlines on the uniquely intense yet unstable transference reactions they develop in therapy. Reminiscent of the child in the rapprochement subphase, the borderline adult often vasillates between wanting to merge with the therapist and wanting to reject the therapist and assert his or her sense of separateness.

Modell, for instance, comments on the borderline's use of the therapist in terms of the child's use of the transitional object. He maintains that the borderline patient does not ask the therapist for help because the possibility that the therapist might refuse is a terrifying and intolerable statement of the therapist's separateness. Rather than to directly ask for help, the patient either makes demands of the therapist or maintains the illusion of not wanting anything from him or her. The presence of the therapist, however, serves as a comforting object like the blanket, as a transition between oneness and separateness (Modell, 1975).

Meissner (1982; 1984) has written extensively about the developmental continuum of borderline pathologies. He has distinguished
between higher order and lower order borderlines according to the transferences they develop in therapy and the countertransference reactions that they elicit from the therapist. According to Meissner, Kernberg oversimplified the borderline concept by stating that all borderlines evoke strong emotional countertransference reactions from the therapist which reflect the chaotic and fragmented intrapsychic structure of these patients.

Meissner (1982) believes that the introjective and projective mechanisms of the borderline vary along a continuum and are reflected in variabilities in countertransference reactions. The lower order borderlines include schizoid personalities, psychotic characters, and pseudoneurotic schizophrenics. Their introjective configurations are usually close to the surface, meaning that these individuals tend to see others in terms of the split self and object representations of their inner world. In treating these borderlines, the therapist is more likely to have intense emotional internal reactions than if he or she were working with a higher-order borderline. Meissner asserts that the treatment of the lower-order borderlines needs to involve an active therapeutic stance with the frequent use of limit-setting, confrontation and clarification.

The higher-order borderlines include those patients who have been labelled primitive hysterics, as-if, borderline and false-self personalities. For these patients, the development of the transference is less intense, as well as more gradual and muted than for the first group. The introjective splits are less severe, meaning that
they have a more stable inner structure. Whereas the lower-order borderlines are more prone to severe regressions and have transferences which are delusional in nature, these more healthy borderlines are rarely delusional and are able to maintain a perspective on their introjective-projective constellations. The therapist is able to be less active and maintain a more analytic stance with these patients.

In addition to variabilities in terms of introjective and projective mechanisms, Meissner (1984) points to variabilities in borderlines along a wide range of commonly noted deficits. For example, higher-order borderlines may undergo a controlled regression in therapy whereas the more severely disturbed borderlines are prone to more flamboyant and self-destructive acting out. Within the borderline spectrum, Meissner sees differences in terms of anxiety tolerance, impulse control, severity of impairments in object constancy, reality testing and the strength of abandonment fears. He suggests that more careful assessments be done across the borderline spectrum, since it does encompass a wide range of pathology. Meissner stresses that subdivisions of the borderline category according to object relationships, ego and superego deficits, self-cohesiveness and proneness to regression will more clearly define the wide range of treatment approaches available to the borderline according to the severity of the pathology.

The work of Noam (1985) in understanding borderline pathology is informed by the psychoanalytic, Piagetian and life-span developmental traditions. He feels that an understanding of the borderline
patient must take into account the way that individual experiences him or herself in relation to others. According to Noam, an individual's orientation to the world is shaped by the interplay between stage of development, phase in the life-cycle and interpersonal style of relating to others. Stage, phase and style are interrelated, and a change in one may have an impact on the others. Noam defines stage in the Piagetian structural sense, as a way in which a person organizes meaning or makes sense of the world. He finds ego developmental measures like those of Loevinger, Kohlberg and Selman helpful in determining the developmental stage of an individual. Noam defines phase as the various "task organizations at different points in the life-span" (1985, p. 7) and uses this concept to provide a context for borderline pathology. For example, an understanding of the borderline adolescent would have to take into account the seeking of autonomy as a contextual concern at this particular life-phase. Of course, the way in which the borderline adolescent experiences or makes sense of this task will depend on his or her stage of meaning organization and on the interpersonal style of the individual. In terms of style, Noam has distinguished between a relational style, where the self is organized around closeness, and a boundary style, where the self is organized around self-reliance.

Prior to his work on stage, phase and style, Noam (1982; 1984) formulated three subgroups of borderline patients based, primarily, on level of structural ego development. Since this earlier work influenced my thinking in this study, it will be described here. It is important to note, however, that the actual life-span phase is not a part of these
descriptions of borderline subtypes, instead the subtypes are discussed in terms of the underlying developmental logic which each individual has achieved or at which he or she has become impaired.

Moving up the hierarchical ladder of ego development and interpersonal complexity, Noam observed what he called an impulsive-physical, an acting-out and an interpersonal borderline. (The interpersonal borderline has been renamed the mutual borderline in his recent work.) Noam suggests that separation-individuation vulnerabilities, while common to all borderlines, take on different forms in the individual according to the developmental context in which they appear. For example, the interpersonal borderline has negotiated many of the developmental milestones expected at late adolescence and early adulthood. The borderline pathology of these individuals is colored by both the strengths and the vulnerabilities of this life-span developmental stage. In terms of strengths in normal development, individuals at this stage have an ability to perceive a shared reality and to coordinate two points of view (Selman, 1980). Concomitant with this is the importance placed on forming a relationship with an exclusive-other that occurs at this point in the life-span. Given this, Noam asserts that interpersonal borderlines derive a sense of self worth from being part of a relationship. In keeping with this, their separation anxiety will be expressed in the context of an intimate relationship. Although this has its pitfalls, it does facilitate a working alliance in psychotherapy.

In life-span terms, the acting-out borderline has many of the
traits and vulnerabilities common to young adolescents. Noam describes these borderlines as very protective of their separateness from others; they define a relationship in terms of whether the parties involved meet each others needs. Their interpersonal exchanges are characterized by a "fair-weather" reciprocity as opposed to a sense of mutuality (Selman, 1980). Noam suggests that inpatient treatment of these borderlines might involve an effort on the part of the therapist to engage the patient in a shared activity, such as a walk or lunch. This meets the patient at his or her developmental level, rather than to expect the patient to accept the traditional analytic situation, which he or she might experience as very invasive and one-sided.

The impulsive borderline is comparable to a 3-6 year old child in terms of normal cognitive and emotional development. Noam describes these borderlines as viewing the world in concrete terms. Their sense of themselves and others is based on immediate outcomes or around their physical experience of a situation, such as whether or not they receive immediate gratification from someone. There is little or no awareness of a cooperative interchange or a reciprocity in their interactions with others (Selman, 1980). Unlike other borderlines whose pathology is at a more regressed level than their normal developmental capacities, the impulsive borderline has not moved past splitting as a normal cognitive mechanism. Noam points out that the reason these patients are often called primitive is because the treatment team or therapist has failed to find a way to treat them. He maintains that an awareness of the developmental limitations of these patients would prevent
the therapist from making interpretations at a level of abstraction that the patient is not equipped to understand.

This selective review of the literature provides a glimpse of the vast amount of work that has been done in the effort to more clearly refine the borderline category. Many theorists agree that there is a continuum of borderline pathology (Masterson, 1975; Meissner, 1984; Noam, 1982; Grinker, 1968), however theorists have taken vastly different routes in studying these variabilities. Whereas Grinker and Gunderson have done empirically verifiable research, it is one-dimensional in scope. Specifically, their work has focused on symptomatology and easily observable traits. Kernberg, Masterson and Meissner have approached the study of the borderline from a psychoanalytic perspective and have relied primarily on their own cases to support their hypotheses. However, their work has more depth than that of the empiricists; they have provided us with a glimpse into the internal world of self-object representations and introjective and projective fantasies of these patients. Noam has added depth to the understanding of the borderline as well by introducing the consideration of the context of borderline pathology within the developmental life-span.

There needs to be further research on developmental differences in borderlines: research which is both empirically verifiable and theoretically well informed. Part of the confusion in studying the borderline is that theorists define the category differently; for example, Kernberg's borderline concept is a level of organization,
whereas the DSM III criteria stress observable symptoms. This present work is an initial effort to investigate differences among borderlines who are narrowly and clearly defined; the individuals in this study are diagnosed as having a borderline personality disorder according to DSM III criteria. This is important, since critics of the psychoanalytic theorists can easily state that the differences noted were due to the likelihood that more disorders than just the borderline category were examined.

This study is informed by both the psychoanalytic literature and the structural life-span developmental literature. It seeks to answer the question of whether there are developmental differences in individuals diagnosed as having borderline personality disorder and whether these differences have any relationship to the patient's use of the inpatient milieu treatment program of a psychiatric hospital. As has been seen in the literature review, there are many definitions of developmental differences, from variabilities in ego functions, object relations, defensive styles to life-span stage levels. This study uses two constructs in which to compare borderlines: (1) observational capacities and (2) precipitants to symptom expression. Based on the literature, it is hypothesized that these constructs will reflect developmental differences.

The first construct is that of observational capacities; it is hypothesized that there will be differences in observational capacities among the borderline patients. This construct was defined both by the concept of social perspective taking abilities in normal
development (Selman, 1980; Noam, 1982) and the psychoanalytic notion of an observing ego (Kernberg, 1975; Greenson, 1967) in clinical work. Therefore, observational capacities refers to the level of insight of the patients, their understanding of their pathology and why they are in the hospital, their ability to connect feelings with actions and to make use of feedback from the treatment team. This construct can be seen as reflecting a basic ego function; variabilities in the capacity to observe one's behavior across borderline patients would suggest other variabilities in ego functioning across borderline population.

The second construct is the precipitants to symptom expression among borderlines; it is hypothesized that borderlines will vary in terms of when they become symptomatic. It is expected that distinct stressors and styles of reacting to them will become apparent across the borderline group. This construct is primarily derived from Noam's subgroups of borderlines, which he based, partially, on the distinct vulnerabilities that were seen across a borderline spectrum. This study seeks to further define those vulnerabilities. For example, I imagine that the interpersonal borderlines will become symptomatic when loss is threatened and the acting-out borderlines will become symptomatic when their sense of separateness is threatened. Although I am not as clear about the impulsive borderlines, I imagine that they will become symptomatic when their immediate needs are not gratified. This concept of variabilities in precipitants to symptom expression also is derived from the analytic literature; Masterson,
for example, distinguishes higher and lower level borderlines partly by whether they are more fearful of engulfment or abandonment (Masterson, 1981).

It is expected that qualitatively distinct borderline subgroups will emerge based on a comparison of the patients across these two constructs. By choosing observational capacities and precipitants to symptom expression, I am looking for developmental differences of several forms. Specifically, the first construct, as was mentioned, is an indicator of ego strengths. The second construct reflects the relational style as well as defensive style of the patient. For example, it might reflect differences in how patients defend against separation anxiety: by seeking to merge with another person or by seeking to withdraw. This is, at once, both a defensive style and a style of relating to and interacting with others.

Given these possible differences in defensive and interactional style across the borderline population, important implications for the treatment of these patients are raised. By studying accounts of borderline patients in an inpatient psychiatric hospital, I am looking for variations in their use of the hospital milieu. I anticipate that variations may occur in correlation with the subtypes. For example, the borderline who becomes symptomatic when loss is threatened may develop strong and possibly enmeshed bonds with the nursing staff. In contrast, the borderline who acts out when his or her sense of separateness is threatened may be viewed as uncooperative in a milieu which demands that the patient actively participate in many group
activities. Quite possibly, when a patient is labelled borderline, the staff may not look further to assess the individual developmental limitations and strengths of that person. A goal of this study is to shed some light on these variations across borderlines and their implications in the milieu treatment of these patients in inpatient settings.
CHAPTER II
CONDUCT OF THE STUDY

Selection of the Cases

The data was collected from written accounts of the treatment course of a number of inpatients at a private psychiatric hospital. The hospital charts of twenty patients between the ages of 18 and 35 who had an Axis II discharge diagnosis of borderline personality disorder (301.83) were selected for the study.

Patients were considered to have met the selection criteria for diagnosis if they had: (1) a discharge diagnosis of borderline personality disorder and either (2) a score of 7 or greater on the Diagnostic Interview for Borderlines (DIB) or (3) a score of 7 or greater on the Gunderson-Retrospective (GUND-R). The DIB is a semi-structured interview akin to the DSM-III criteria for borderline personality disorder (Gunderson and Zanarini, 1982). A rating of seven or greater suggests that the individual has met the criteria for this diagnostic category. The GUND-R was adapted from the DIB by Gunderson and Zanarini to be used on medical records. Copies of these measures are in the appendix.

In order to be selected for the study, a minimum hospital stay of sixty days was required. In addition, the data was collected from a sixty to ninety day interval in the hospital chart, usually the first ninety days of the treatment. The purpose of the time
limit was to avoid inconsistencies in patient descriptions or treatment outcomes due to a varied length of hospital stay.

The cases were selected from two sources: (1) a list of patients who had been administered a DIB in another study and had scored a seven or greater and (2) a list of all patients who had been discharged with an Axis II diagnosis of 301.83. The additional selection criteria were then applied to the cases compiled from both lists and a final list of eligible patients was divided into males and females. It was correctly anticipated that there would be far less male borderlines than females (APA, 1980), so all eight of the male patients who met the selection criteria were included in the study. The remaining twelve cases were randomly selected from the list of female borderlines who met the selection criteria. The twenty cases, their ages, gender, DIB or GUND-R scores and Axis I diagnoses are presented in Table 1.

Data Collection

After the records were selected, the names of the patients were replaced by identifying numbers and eventually given different names and background information in this study in order to protect their anonymity.

Basic identifying information was documented on Coding Sheet A. On Coding Sheet B, the following information was documented for each case: (1) any of the eight DSM III symptoms of borderline personality disorder that the patient displayed; (2) the specific precipitants
<table>
<thead>
<tr>
<th>No/Sex/Age</th>
<th>Name</th>
<th>DIB Score</th>
<th>GUND-R Score</th>
<th>Length of Admission</th>
<th>AXIS I Diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 F 21</td>
<td>Jean</td>
<td>9</td>
<td>--</td>
<td>3 mos.</td>
<td>305.91 mixed substance abuse</td>
</tr>
<tr>
<td>2 F 38</td>
<td>Shirley</td>
<td>9</td>
<td>--</td>
<td>3 mos.</td>
<td>300.40 dysthymic disorder</td>
</tr>
<tr>
<td>3 M 25</td>
<td>William</td>
<td>10</td>
<td>--</td>
<td>4 mos.</td>
<td>300.40 dysthymic disorder</td>
</tr>
<tr>
<td>4 F 28</td>
<td>Cindy</td>
<td>10</td>
<td>--</td>
<td>2 mos.</td>
<td>301.13 cyclothymic disorder</td>
</tr>
<tr>
<td>6 F 34</td>
<td>Leslie</td>
<td>10</td>
<td>--</td>
<td>21 mos.</td>
<td>300.40 dysthymic disorder</td>
</tr>
<tr>
<td>8 M 25</td>
<td>Peter</td>
<td>10</td>
<td>--</td>
<td>4 mos.</td>
<td>305.60 cocaine abuse</td>
</tr>
<tr>
<td>9 F 21</td>
<td>Cheryl</td>
<td>10</td>
<td>--</td>
<td>14 mos.</td>
<td>296.82 atypical depression</td>
</tr>
<tr>
<td>10 M 21</td>
<td>John</td>
<td>--</td>
<td>8</td>
<td>17 mos.</td>
<td>None</td>
</tr>
<tr>
<td>11 M 19</td>
<td>Charles</td>
<td>--</td>
<td>8</td>
<td>9 mos.</td>
<td>None</td>
</tr>
<tr>
<td>12 F 20</td>
<td>Debra</td>
<td>10</td>
<td>--</td>
<td>12 mos.</td>
<td>None</td>
</tr>
<tr>
<td>13 F 27</td>
<td>Sarah</td>
<td>10</td>
<td>--</td>
<td>5 mos.</td>
<td>296.32 major depression, recurrent w/out melancholia</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>292.11 amphetamine delusional disorder</td>
</tr>
<tr>
<td>14 F 23</td>
<td>Lisa</td>
<td>9</td>
<td>--</td>
<td>9 mos.</td>
<td>296.22 major depression w/out psychotic features</td>
</tr>
<tr>
<td>16 F 22</td>
<td>Jill</td>
<td>10</td>
<td>--</td>
<td>2 mos.</td>
<td>303.92 alcohol abuse</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>305.92 other substance abuse</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>296.52 major depression, bipolar</td>
</tr>
<tr>
<td>17 F 26</td>
<td>Denise</td>
<td>--</td>
<td>9</td>
<td>5 mos.</td>
<td>300.30 obsessive-compulsive</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>296.81 atypical depression</td>
</tr>
</tbody>
</table>
### Table 1 (continued)

<table>
<thead>
<tr>
<th>No/Sex/Age</th>
<th>Name</th>
<th>DIB Score</th>
<th>GUND-R Score</th>
<th>Length of Admission</th>
<th>AXIS I Diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 M 18</td>
<td>Mark</td>
<td>--</td>
<td>8</td>
<td>24 mos.</td>
<td>None</td>
</tr>
<tr>
<td>20 M 26</td>
<td>Bruce</td>
<td>--</td>
<td>8</td>
<td>3 mos.</td>
<td>None</td>
</tr>
<tr>
<td>21 F 26</td>
<td>Janet</td>
<td>--</td>
<td>9</td>
<td>3 mos.</td>
<td>296.30 major depression, recurrent</td>
</tr>
<tr>
<td>24 F 26</td>
<td>Melanie</td>
<td>--</td>
<td>10</td>
<td>23 mos.</td>
<td>303.93 alcohol abuse, in remission</td>
</tr>
<tr>
<td>25 F 18</td>
<td>Rosanne</td>
<td>--</td>
<td>10</td>
<td>20 mos.</td>
<td>305.90 mixed substance abuse</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>305.00 alcohol abuse</td>
</tr>
<tr>
<td>26 F 32</td>
<td>Jennifer</td>
<td>--</td>
<td>10</td>
<td>40 mos.</td>
<td>None</td>
</tr>
</tbody>
</table>
to the expression of those symptoms just prior to or during hospitalization; (3) the observational capacities of the patient; (4) the patient's response to the inpatient milieu; and (5) the patient's response to individual psychotherapy. Copies of both forms are in the appendix of this text.

All descriptive material in the chart concerning the ninety day interval of hospitalization was considered data for the study. This included the nursing notes, therapist and administrator progress notes and treatment plans, psychological assessment reports, documentation of periodic reviews and planning conferences as well as intake and discharge summaries. Since this information differed in its level of behavioral descriptiveness and use of interpretation, the type of input was specified on the coding sheet. For example, data that was highly interpretive, such as that obtained from psychological assessments, was recorded under the "C" heading on Coding Sheet B. The data obtained from case conferences and periodic reviews, consisting of information which was somewhat interpretive and abstracted, yet also including behavioral descriptions, was coded under the "B" heading. Finally, the data taken from the nursing notes, which consisted of behavioral observations more than interpretive formulations, was coded under the "A" heading. The criteria for all headings is outlined in Coding Sheet C in the appendix. The data felt to be of most value for the study was the descriptive, least interpretive information; however, it was hoped that there would be agreement across the various types of information. In the cases where there was not such agreement, the piece of data in question was
not used in analyzing the patient.

**Analysis of the Cases**

Based on the literature (Noam, 1982) and on previous pilot coding I had done, I had in mind some qualitatively distinct variations in precipitants to symptom expression in borderline individuals. For example, I hypothesized that some borderlines would become symptomatic when the loss of an intimate relationship was threatened, whereas others would react pathologically when their control or sense of separateness was threatened. Others might react to their basic needs not being immediately gratified or might use their symptoms as a means of escaping intense effect.

I compiled a list of those possible clusters of precipitants based on my hypotheses and on a general reading of the data. Along with this, I listed the symptoms and behaviors that were characteristic of the borderline patient. These symptoms and precipitants are shown in Table 2. Using this list, I read each case carefully and coded the symptoms and their precipitants. After these were recorded, I assigned a letter or letters to each case that best described why that individual became symptomatic. Refer to Table 3 for a list of the letters and their corresponding precipitant clusters. I then divided the cases into subgroups according to their precipitant clusters. The Relational subgroup included those cases assigned an A or AE; the Protective subgroup was designated by the letters B, BC or BCD; and the Primitive subgroup contained all cases with a letter F alone or
<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Precipitants</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. major suicide attempts</td>
<td>1. express pathology in the context of an intimate relationship.</td>
</tr>
<tr>
<td>1a. major suicide threats</td>
<td></td>
</tr>
<tr>
<td>2. minor suicide attempts</td>
<td>2. expresses pathology when there is a loss of an intimate relationship</td>
</tr>
<tr>
<td>2a. minor suicide threats</td>
<td></td>
</tr>
<tr>
<td>3. cutting (wrist slashing, scratching), not major suicide attempt</td>
<td>3. expresses pathology in context of relationships, although not involved/intimate ones</td>
</tr>
<tr>
<td>4. overdoses on pills (in suicide attempt)</td>
<td></td>
</tr>
<tr>
<td>5. multiple drug or ETOH abuse</td>
<td>4. expresses pathology when there is sense of loss - w/out intimate relationship</td>
</tr>
<tr>
<td>6. AWA from hospital</td>
<td></td>
</tr>
<tr>
<td>7. physically violently rageful incidents on unit, assaultive</td>
<td>5. expresses pathology in an attempt to gain control (retaliate), express a sense of separateness or autonomy, fear of boundary loss</td>
</tr>
<tr>
<td>8. masochistic dynamics</td>
<td></td>
</tr>
<tr>
<td>9. chronic sense of emptiness</td>
<td>6. expresses pathology because needs for immediate gratification have not been met</td>
</tr>
<tr>
<td>10. poor sense of identity/fluidity of ego boundaries</td>
<td>7. expresses pathology when experiencing profound neediness/deprivation in relation to an important other</td>
</tr>
<tr>
<td>11. dysphoria/depression</td>
<td></td>
</tr>
<tr>
<td>12. frequent 3-day notices</td>
<td>8. expresses pathology when experiencing profound neediness/deprivation in relation to many others (staff, etc.)</td>
</tr>
<tr>
<td>13. frequent splitting w/staff</td>
<td></td>
</tr>
<tr>
<td>14. frequent power struggles w/staff</td>
<td>9. expresses pathology when experiencing fears of abandonment. Acute separation anxiety</td>
</tr>
<tr>
<td>15. somatic complaints</td>
<td></td>
</tr>
<tr>
<td>16. demonstrated poor impulse control in hospital</td>
<td>10. pathology is a &quot;soothing presence&quot; (such as pills as nurturance, comfort)</td>
</tr>
<tr>
<td>17. psychotic symptoms (delusions, hallucination)</td>
<td></td>
</tr>
</tbody>
</table>
Table 2 (continued)

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Precipitants</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. verbally rageful incidents on unit</td>
<td>11. expresses pathology in response to disorganization—out of terror of needs not being met</td>
</tr>
<tr>
<td>19. clinging, enmeshed on unit, openly needy</td>
<td>12. expresses pathology in response to anxiety of intense affect</td>
</tr>
<tr>
<td>20. isolative, withdrawn on unit</td>
<td>13. expresses pathology in response to anxiety over ambivalence toward another, i.e., wanting closeness but fearing one's own destructiveness.</td>
</tr>
<tr>
<td>21. agitated, anxious state on unit</td>
<td>14. expresses pathology to feel intense pain -- in contrast to the deadness</td>
</tr>
<tr>
<td>22. dynamic of avoiding sadness</td>
<td>15. pathology is expressed as a &quot;cry for help&quot;</td>
</tr>
<tr>
<td>23. dissociated state on hall</td>
<td></td>
</tr>
<tr>
<td>24. angry sullen stance on hall</td>
<td></td>
</tr>
<tr>
<td>25. provocative</td>
<td></td>
</tr>
<tr>
<td>26. impulsively promiscuous or other sexual acting out</td>
<td></td>
</tr>
<tr>
<td>27. never in an adult, intimate relationship</td>
<td></td>
</tr>
<tr>
<td>28. passive in hospital</td>
<td></td>
</tr>
<tr>
<td>29. minor impulsive acts, such as drugs (pot smoking), ETOH in hospital</td>
<td></td>
</tr>
<tr>
<td>30. dependency on staff, others</td>
<td></td>
</tr>
<tr>
<td>31. intolerance of being alone</td>
<td></td>
</tr>
<tr>
<td>32. affective instability (crying, rageful)</td>
<td></td>
</tr>
<tr>
<td>33. oppositional style on hall</td>
<td></td>
</tr>
<tr>
<td>34. demanding</td>
<td></td>
</tr>
<tr>
<td>35. regressive on hall</td>
<td></td>
</tr>
</tbody>
</table>
## Table 3

"Precipitant to Symptom Expression" Clusters

<table>
<thead>
<tr>
<th>Code</th>
<th>Precipitants from Table 2</th>
<th>Precipitants to Symptom Expression</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>1, 2, 7</td>
<td>Relational:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Symptoms express a longing for or distress due to loss of an intimate relationship. Borderline pathology is expressed in the context of an intimate, exclusive relationship.</td>
</tr>
<tr>
<td>B</td>
<td>3, 4, 8</td>
<td>Somewhat Relational:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Symptoms express sense of loss or longing, but not for an exclusive-other. Pathology is expressed in the context of a variety of relationships.</td>
</tr>
<tr>
<td>C</td>
<td>5</td>
<td>Protective:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Symptoms express a need for control, separateness, assertion of boundaries and/or are retaliative in nature.</td>
</tr>
<tr>
<td>D</td>
<td>6</td>
<td>Unrestrained:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Symptoms express a need for immediate gratification and reflect an inability to delay impulses.</td>
</tr>
<tr>
<td>E</td>
<td>9, 10, 14, 15</td>
<td>Solace-Seeking:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Symptoms express a cry for help, a need for an internal soothing presence, the need to feel intense pain in order to ward off acute separation anxiety or pervasive emptiness.</td>
</tr>
<tr>
<td>F</td>
<td>11, 12</td>
<td>Primitive Anxiety:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Symptoms express anxiety over fear of disorganization or over intense, overwhelming affect and involves flight from the anxiety-provoking agent.</td>
</tr>
</tbody>
</table>
in combination with a C, D or E.

The descriptions of observational capacities were summarized for all cases and were given a rating of .0, .5 or 1.0 depending on whether their observational capacities were best described as poorly developed, fair to good, or an asset to their treatment progress, respectively. Observational capacities were defined as the patient's ability to connect feelings with actions, ability to use feedback and view one's own behavior with some perspective and the quality of the patient's interactions in the milieu.

The descriptions of the success of the milieu and of psychotherapy were not summarized; this data was coded in order to provide contextual considerations to the subgroups of borderlines. For example, I was interested in whether patients described as relationally oriented were able to make better use of the milieu than those who seemed to emphasize separateness and control as opposed to affiliativeness. Thus, after the subgroups had been delineated, the data concerning symptoms, observational capacities and success of treatment was read over carefully in the service of contrasting these three subgroups.

It is important to note that the decisions about subgroups evolved not only out of ranking the cases according to the list of precipitants to symptom expression, but through a careful reading of all the descriptive information that had been compiled. In almost all instances, my clinical impressions concurred with the ratings that had been assigned. There were a few instances where the
individuals could not be clearly placed in a subgroup using the rating system alone, however an additional careful reading of the data made it possible to assign the person to a specific subgroup. It is important to emphasize that my clinical judgements, although inevitably subjective, were an important tool in the analyzing of the cases. The use of rating and ranking scales served to refine my clinical judgements and provide clearer guidelines for the contrasting of the cases.
CHAPTER III

THE CASE STUDIES

Summary of Results

The data will be presented in detailed case studies of select subjects from the study. The cases have been divided into three subgroups that vary according to precipitants to symptom expression. Although each of the twenty cases was evocative in a unique way, the presentation of the results will stress similarities within subgroups and variabilities across them. For this reason, two cases will be chosen from each subgroup to be elaborated on; an effort has been made to pick the two most representative cases in each category: in a sense, these cases reflect the mean of each subgroup.

Some general guidelines will be used in presenting the cases. First, a brief summary of the patient will be given, which will include identification of the individual, previous hospitalizations, symptoms and precipitants to current hospitalization. Next, relevant family background and a history of the illness until just prior to hospitalization will be briefly described. An account of the current hospital course will follow, including examples of precipitants to symptom expression and an elaboration of how borderline pathology was expressed in each individual case. After noting the observational
capacities of the subject, an account will be given of their response to inpatient hospitalization, emphasizing what was useful in the treatment of some borderlines as opposed to others.

It is important to note that identifying information has been altered to protect the confidentiality of each subject. This includes names, occupations and details of family background. An effort has been made to substitute qualitatively similar information in order to prevent misrepresentation or distortion of the data.

Before beginning the case analyses, a summary of the results will be provided. It will include the following: (1) subgroups based on precipitants to symptom expression; (2) symptomotology across subgroups; (3) observational capacities across subgroups; and (4) other differences across subgroups.

Subgroups based on precipitants to symptom expression

Three distinct subgroupings of borderlines emerged from an analysis of the precipitants to symptom expression. Table 4 shows the specific cases which were found in each category.

The first subgroup will be called "relational" borderlines; there were six cases that fit comfortably in this cluster and two that displayed some aspects of the category. This group included borderlines whose symptom expression was typically in the context of an intimate relationship; they would often seek out another person in which to engage with around their distress. Connected to this is the fact that separation anxiety, although a common symptom of borderline personality disorder, was particularly acute for this group.
Table 4

Borderline Subgroups Based on Precipitants to Symptom Expression

<table>
<thead>
<tr>
<th>Subgroups</th>
<th>Cases and their Precipitant Clusters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relational</td>
<td>2 (AE); 4 (ADE); 6 (AE); 11 (AE); 24 (AE); 25 (AE)</td>
</tr>
<tr>
<td>n=6</td>
<td></td>
</tr>
<tr>
<td>Protective</td>
<td>3 (B); 8 (BC); 12 (BC); 13 (BC); 20 (BCD); 26 (BC)</td>
</tr>
<tr>
<td>n=6</td>
<td></td>
</tr>
<tr>
<td>Primitive</td>
<td>9 (DF); 10 (CDF); 14 (BF); 16 (BEF); 19 (EF); 21 (CF)</td>
</tr>
<tr>
<td>n=6</td>
<td></td>
</tr>
<tr>
<td>Between Relational and</td>
<td>1 (ABC)</td>
</tr>
<tr>
<td>Protective n=2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>17 (ACD)</td>
</tr>
</tbody>
</table>
All of these six borderlines became symptomatic when loss of some sort was threatened, as opposed to none from the second group and two from the third group. In addition, symptoms often provided a soothing presence for these borderlines or served to communicate to others a need for help. Another commonality was that their symptoms often served to put them in touch with their pain at times when they were unable to experience their distress on an affective level. These borderlines were often described as passively needy by staff members and were prone to rapid and severe regression to an inactive, dependent state when faced with a lack of structure.

The individuals in the next subgrouping will be called "Protective" borderlines; there were six patients in this category and two that had features of both this and the first group. These borderlines were somewhat relationally oriented but were usually not involved in an exclusive, intimate relationship like the previous individuals. In contrast, they were more likely to use various staff and patients on the unit to engage with around the expression of their pathology. The precipitants to symptom expression for these patients involved a need for self-protection, control or an assertion of separateness from another. There was often a retaliative quality to their display of symptoms.

There were six individuals in the last subgroup, who will be called the "Primitive" borderlines. In contrast to the other groupings, these patients were not very relationally oriented. There was a passive and schizoid quality to their interactions on the unit.
Their ability to delay impulses was poor and a need for immediate gratification was often a precipitant to symptom expression. However, they typically became symptomatic due to a fear of internal disorganization and as a means of escaping intense affect. Like the first group, yet in a more isolative, withdrawn manner, their symptoms sometimes served as manifestations of a soothing presence that did not exist internally and could allow them to concretely feel pain that could not be tolerated on an affective level.

Two cases displayed aspects of both the Relational and the Protective borderlines, and were therefore placed in a separate subgroup.

**Borderline symptomatology across subgroups**

One might assume that the eight DSM III symptoms of borderline personality disorder would be distributed evenly across subgroups of the disorder. However, an analysis of the frequency of twelve borderline symptoms revealed clusters that were specific to each subgroup; see Table 5 for more details. The twelve symptoms were pulled from a list of thirty-five symptoms compiled from descriptions of the twenty subjects in the study.

Cutting or scratching, not as a suicide attempt, was slightly more common among the Relational borderlines. Depression, dysphoria and sexual acting out and promiscuity was also more characteristic of these individuals. The Protective borderlines were described as more oppositional by the staff and had a higher incidence of verbally rageful outbursts than the other groups. They had a slightly higher
### Table 5

**Borderline Symptomatology Across Subgroups - Frequency**

<table>
<thead>
<tr>
<th>Symptoms (from Table 2)</th>
<th>Relational n=6</th>
<th>Protective n=6</th>
<th>Primitive n=6</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 cutting (not a major suicide attempt)</td>
<td>4*</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>5 multiple drug or ETOH abuse</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>7 assaultive, physically violent</td>
<td>1</td>
<td>2*</td>
<td>1</td>
</tr>
<tr>
<td>11 dysphoria, depression</td>
<td>5*</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>17 psychotic symptoms</td>
<td>0</td>
<td>1</td>
<td>2*</td>
</tr>
<tr>
<td>18 verbally rageful incidents on hall</td>
<td>2</td>
<td>5*</td>
<td>3</td>
</tr>
<tr>
<td>20 isolative, withdrawn on hall</td>
<td>0</td>
<td>0</td>
<td>4*</td>
</tr>
<tr>
<td>22 dynamic of avoiding sadness</td>
<td>0</td>
<td>1</td>
<td>3*</td>
</tr>
<tr>
<td>26 sexual acting out, promiscuity</td>
<td>3*</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>33 oppositional style on hall</td>
<td>0</td>
<td>4*</td>
<td>0</td>
</tr>
<tr>
<td>4 drug overdose (as suicide attempt)</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>15 somatic complaints on hall</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

* Symptom noticeably elevated for this subgroup.
incidence of assaultive behavior on the unit and, like the Relational borderlines, cutting was a symptom in many of the cases.

The Primitive borderlines were distinguished by their somewhat higher incidence of psychotic symptomatology. They were typically described as being isolative and withdrawn in the milieu and of avoiding painful affect, particularly sadness.

Observational capacities across subgroups

The presence and strength of an observing ego in these subjects, which includes their capacity for insight-oriented psychotherapy, was based on descriptions of their progress as noted in the charts. This included the patient’s ability to connect feelings with actions, ability to interact collaboratively in the milieu and her or his use of feedback. The descriptions were summarized then rated on a scale of .0 to 1.0; a mean was then obtained for each subgroup. These results are summarized in Table 6. The highest mean was achieved in the Relational subgroup; the Primitive borderlines obtained a slightly lower mean. Whereas most subjects in these two groups were viewed somewhat positively in terms of observational capacities, this was in contrast to the Protective borderlines. Individuals in this category were viewed more negatively in terms of observational ego strengths; three out of the six borderlines obtained a rating of .0 in this area.

Other differences across subgroups

Of the six subjects in the Relational subgroup, five were female
Table 6

Observational Capacities Across Subgroups of Borderlines

<table>
<thead>
<tr>
<th>Subgroup</th>
<th>Poor 0</th>
<th>Fair .5</th>
<th>Excellent 1.0</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relational</td>
<td>#2</td>
<td>#6</td>
<td>#4</td>
<td>.67</td>
</tr>
<tr>
<td></td>
<td>#11</td>
<td></td>
<td>#24</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>#25</td>
<td></td>
</tr>
<tr>
<td>Protective</td>
<td>#3</td>
<td>#13</td>
<td></td>
<td>.25</td>
</tr>
<tr>
<td></td>
<td>#8</td>
<td>#20</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>#12</td>
<td>#26</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primitive</td>
<td>#21</td>
<td>#9</td>
<td>#14</td>
<td>.50</td>
</tr>
<tr>
<td></td>
<td>#10</td>
<td>#19</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>#16</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
and one was male. The Protective subgroup was comprised of three females and three males; the Primitive subgroup had four females and two males. There did not appear to be any noteworthy difference between DIB or GUND-R scores across subgroups; see Table 7.

Relational Borderlines

Case #2, Shirley

Shirley is a 38 year old, white, separated bank clerk with three children. This psychiatric hospitalization was her second and followed a major overdose of barbituates, as did the first hospitalization two years prior to this. Since her late teens, she has had a history of acute decompensation and suicidal feelings in response to marital stress. At such times, her potential to succeed in killing herself has been judged as serious by mental health professionals. Her decompensations have typically included a diminished grasp of reality, often accompanied by dysphoric affect. The present attempt on her life was precipitated by her husband's request for a divorce, which coincided with her youngest child's leaving home to pursue a career in the city.

History prior to present illness. As a young child, Shirley suffered the loss of her mother and was sent, along with her three sisters, to live with an aunt. The aunt, who had rapid and unpredictable mood swings, was sometimes too incapacitated to care for the children and sent them to an orphanage for extended periods of time. From an early age, Shirley was the parentified child, caring for the
Table 7
DIB and GUND-R Means across Subgroups

<table>
<thead>
<tr>
<th>Subgroup</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relational</td>
<td>9.5</td>
</tr>
<tr>
<td>Protective</td>
<td>9.7</td>
</tr>
<tr>
<td>Primitive</td>
<td>9.0</td>
</tr>
</tbody>
</table>
other siblings to compensate for lack of adequate caretaking. When she was in her teens, a younger sister committed suicide. Shirley got married a few years later and had children shortly thereafter. The marital relationship was stormy and was marked by her impulsivity and extreme sensitivity to separations. She interpreted any autonomy seeking in the family as a rejection of her. As the children got older, Shirley’s husband questioned his commitment to the marriage; she responded with depression, suicidal ideation and a pre-psychotic decompensation which culminated in the massive overdose precipitating the current hospitalization. In describing her reaction to the possibility of losing her husband, Shirley stated, "It would be like death--or worse."

Hospital course. Perhaps most apparent in Shirley’s short-term hospital stay was her extreme sensitivity to separation, which she experienced as an abandonment. Her individual psychotherapy fostered a regression in her to a passive, dependent state. When her therapist unexpectantly cancelled an appointment, she paced the halls, crying uncontrollably. She became very dependent on the staff, easily feeling deprived and rageful. The rage, however, was split off and self directed, resulting in her suicidality. As was expected, her depression, neediness and suicidality coincided with threats of loss. Vascillations in her mood were connected to weekly family meetings in which the future of the marriage was discussed. The staff noted that she had little ability to separate her needs and interests from those of her husband; since her sense of self hinged on a merging
with his character, to lose him meant annihilation to her. She was described by the nursing staff as compliant yet provocative at times, setting up various struggles between her therapist and administrator.

**Observing ego.** The treatment fostered a quick regression and Shirley's main concern was with getting her own needs met. The nursing staff noted that Shirley had little perspective concerning herself. Although she was described as "superficially compliant," she rarely initiated staff contact for the purpose of self-reflection.

**Success of the treatment.** This three month hospitalization sought to provide Shirley with the structure that would enable her to safely examine issues around separation and autonomy. The structure of the milieu helped her to control her impulses and internalize some sense of delay during times of extreme stress and proneness to be self-destructive. In addition, the milieu, with its emphasis on taking an active role in one's treatment, thwarted the extreme regression that may have occurred without such a bounded framework. Shirley developed a good working alliance in therapy and readily engaged with an interim therapist when her own doctor was called away suddenly at the sixth week of treatment. Shirley was discharged on voluntary status with the Axis II outcome of "slightly improved." She continued with individual psychotherapy on an outpatient basis.

**Case #25, Rosanne**

At the time of admission, Rosanne was an 18 year old single, white, Catholic girl from a working class family consisting of both
parents and a younger brother. She had a history of depression and self-destructive acting out which began in her early teens and was exacerbated by arguments with her parents or by a threat of separation or loss. For the several years prior to this admission, Rosanne had not been in school, but had been employed as a prostitute with a wealthy New York clientele. Since her last admission, she had been under the care of a great aunt who Rosanne had learned was terminally ill just prior to admission. During an argument with her parents upon learning the bad news, Rosanne reached for a knife and attempted to stab her mother and herself with it.

**History prior to present illness.** From an early age, Rosanne was described as moody and irritable; she had tantrums and sometimes became dysphoric when leaving to go to school for the day. A passive and poorly educated woman, Rosanne's mother had given birth to her at age sixteen and needed to work full-time following the birth. By all accounts, Rosanne's parents were naive and inadequate providers. Her father consistently abused Rosanne physically throughout childhood and early adolescence. Rosanne felt that her mother was uninvolved and refused to intervene on her behalf. Four years prior to this admission, Rosanne slashed her wrists "so somebody would notice her"; during this time she had begun using drugs and alcohol. She was hospitalized, evaluated and released six months later. Between that and the present admission, Rosanne left home to stay with a great aunt. During this time, she became seriously involved with an older man, who introduced her to the world of prostitution. She stopped
going to high school and lived luxuriously on the money she made in her new found profession. Rosanne became seriously depressed and suicidal when this man broke up with her and she made several superficial scratches on her arms. This loss, combined with the impending loss of her great aunt, left Rosanne depressed, self-loathing and rageful at her parents for not providing enough. Following the attempted stabbing, her parents agreed to her admission for long-term treatment of her borderline personality disorder.

**Hospital course.** Throughout her inpatient hospitalization, Rosanne demonstrated the same regressive dependence on another and the same vulnerabilities to separations that had characterized her youth thus far. When faced with losses, she tended toward impulsive promiscuity or self-destructive acting out. In response to the termination of various staff members to whom she had been close, she left the hospital without permission and engaged in unprotected intercourse which eventually resulted in a pregnancy and abortion. When she feared that she might be pre-maturely discharged from the hospital, she slashed her wrists (requiring several stitches), and walked down the halls dripping blood and wailing. Similarly, when she felt rebuffed by her mother after a family meeting, she signed a 3-day notice and retracted it only after getting some reassuring communication from her mother.

Throughout her hospital stay, Rosanne spent her time almost exclusively with a paranoid and volatile young male patient whom she both felt nurtured and protected by yet feared. The staff described
her as "symbiotically tied" to this patient and noted that, in response to a lack of nurturance from her mother, Rosanne had looked to her sado-masochistic ties with men for caretaking. When she was not with this boyfriend, Rosanne was usually alone or talking to staff members. She had rapid mood swings, from rage to whiney depression, and often bickered with the other adolescent girls on the unit.

Observing ego. Given her age, Rosanne was viewed by the staff as having a good sense of her pathology and her pitfalls. She often initiated staff talks to discuss her role in interactions on the unit. At times, she would vascillate rapidly between feeling like a "hopeless case" and being "too good for this place"; after a while, however, she was able to stand back and realize that she had behaved inconsistently. At the start of the hospitalization, she was said to have had little ability to "plan, anticipate or imagine," yet her capacity for abstract concept formation and social judgements improved over the course of her long-term stay in the hospital.

Success of the treatment. Rosanne used the hospital well; she formed a healthy dependency with several nursing staff members and worked productively during staff talks. However, her exclusive relationship with the adolescent male was a testimony to how much she needed this sort of enmeshment both for nurturance and to ward off her separation anxieties. It was difficult for the staff to monitor or curtail this relationship; whereas the structured milieu, with its regulation of ground privileges and limits on availability of
potentially harmful substances, contains most types of borderline
acting out, it failed to discourage this sado-masochistic romance.

Protective Borderlines

Case #8, Peter

Peter is a 25 year old, single, white male from a wealthy
Protestant family from Boston. He was referred for this inpatient
hospitalization, his first, by his therapist after a several year
decline in school performance, a pattern of multiple drug abuse and
a serious suicide attempt. In contrast to his high achieving family,
he flunked out of college and had spent recent years in relative
isolation, unemployed and unable to care for himself. Peter was
using a variety of street drugs, mainly cocaine, on a daily basis.
After spending one month on a drug treatment unit, he was transferred
to a treatment unit with a behavioral emphasis for the remainder of
his several month stay.

History prior to present illness. Peter was the youngest child
in a large, achievement-oriented and prominent family. He primarily
played with his sisters in childhood and had very few male friends.
His father was either passive or unavailable and Peter had no strong
paternal figure when growing up. In contrast, Peter's mother was
very dominant and his childhood is best characterized by the frequent
power struggles he had with her. In responding to his mother, he
either submissively complied or, at seemingly random times, bitterly
asserted himself. Peter became increasingly disillusioned with his
father in adolescence and his self-esteem was quite low. In his early twenties, after being asked to leave college, he had numerous and brief sexual encounters with men. He became disheveled, unkempt and withdrawn. His inability to care for himself, his increasing use of street drugs and an attempt on his own life by inhaling toxic fumes led to this current hospitalization. At the time of admission he was confused and overwhelmed; he did not understand the reasons for the hospitalization.

**Hospital course.** Peter had a difficult time on the behavioral treatment unit, which emphasized written contracts along with group discussions of one's issues. The staff found Peter to be oppositional; he frequently had altercations with both patients and staff. His contracts were rarely completed on time and the staff remarked that he had little focus and appeared superficially involved at best. He was not responsive to the milieu therapy groups, such as relaxation and social skills training and was seen as a disrupting influence in these gatherings.

Underlying his oppositionalism was a feeling of not being cared for and a sense of abandonment. He had numerous somatic complaints, and would sometimes aggravate a developing cold by caring for himself poorly. He frequently filed 3-day notices, usually when he was not getting the attention he hoped for from the staff. Peter often became verbally rageful when his needs were not met by others. Also characteristic of him was fierce splitting between his mother and his therapist. At times, Peter was able to talk with others about his
low opinion of himself and his separation issues with his mother. However, treatment team felt that most of what Peter revealed about himself, although it was not inaccurate, was done in the service of getting what he wanted rather than in the interest of self-reflection.

Observing ego. Peter's capacities for self observation were poor. He was repeatedly judged by the treatment team as being unable to recognize his own role in interactions and as not being able to see the effects he had on others. In general, Peter could not see beyond his overwhelming sense of deprivation and his needs for immediate gratification. One member of the nursing staff remarked that, "when Peter gets an angry thought, it is as if he is wearing blinders and cannot listen to any feedback, especially about his effect on others." As mentioned previously, Peter was a continual disruption in the milieu.

Success of the treatment. The milieu treatment was not successful because of Peter's oppositionalism and ego deficits in the area of self-reflection. His individual psychotherapy was also problematic; he frequently engaged in splitting between therapist and staff or his mother and effectively undermined the treatment. His working alliance with his therapist was tenuous at best; he often missed appointments or demanded a new doctor. After several months in this milieu treatment unit, Peter was discharged outright because of his inability to get past his antagonistic and disrupting presentation.
Case #12, Debra

At the time of her admission, Debra was a 20 year old white, Catholic college student from a middle-class, suburban New Jersey family consisting of five children and both parents. Her difficulties began in high school and included suicidal ideation, wrist cutting and abusing prescription medications in order to "retaliate against and punish" her parents. Exacerbated by an upcoming separation from her family in order to go to college, Debra became increasingly suicidal. After an unsuccessful attempt to communicate her distress to her mother, Debra, in a violent rage, tried to strangle her younger sister. This led to the current hospitalization, which was her first.

History prior to the present illness. Debra was the oldest daughter in a family of five children; she had two older brothers and two younger sisters. In her early childhood, Debra was very close to her father and bitterly resented the loss of his attention when the younger sisters were infants. According to her mother, even when Debra did receive attention from her father she felt that others had been given more. In late adolescence, Debra began spending a lot of time alone in her room. She had few friends and insisted on her privacy to members of her family. While by herself, Debra repeatedly cut her arms with a knife and banged her fist, stating later that these were angry, retaliative gestures aimed at getting the attention of her parents. The damage that she had done to her palm was eventually discovered, medical attention was required and psychotherapy
was begun. Her mood fluctuated between anger at her parents for trying to influence her life and melancholia due to the upcoming separation from her family. Debra maintained an avoidant, angry style throughout these years, frequently asserting that nobody really cared what happened to her. As the time to leave for school in Colorado approached, Debra became increasingly depressed and angry, which culminated in the strangling incident.

**Hospital course.** Debra repeatedly cut herself and was provocative in a rageful manner throughout most of her long-term hospitalization. The rage was seen as a defense against underlying sadness and vulnerability around issues of separation and loss. Difficulties arose when she felt too confined on the unit; she experienced the milieu as robbing her of her privacy and the staff as trying to control and influence her. She primarily kept to herself, stating that the only way she could feel in control was by hiding in the corner of her room. An establishing of a sense of separateness from others was essential to her.

A distressing pattern emerged in her treatment course; she would become rageful or self-destructive when feeling uncared for and, as limits were set on her, she escalated into more provocative and harmful acting out. A variation on this pattern was that Debra would keep her self-destructive feelings to herself, provoking a confrontation from staff, and would then become enraged when asked about revealing any plans to harm herself. She experienced the staff's attempts to contain her as their trying to control her; the treatment team
experienced her as withholding and not willing to give assurances that she was not suicidal. After hearing the results of a treatment review, Debra cut herself with the top of a coke can; she had figured discharge had been recommended and feared the abandonment. Like her decompensation before beginning college, it was clear that Debra, although avoidant and private, depended upon ties to others in order to maintain a sense of herself.

**Observing ego.** At first, Debra was seen as having little ability to understand the outcomes of her actions or to see beyond the extreme possibilities that she constructed for herself. She was not sure what led to her becoming rageful or self-destructive. Several months into the treatment, however, she began to connect her actions with the underlying sadness around loss and separation.

**Success of the treatment.** As stated in her treatment review, the focus of the hospitalization was on containing her acting out behaviors and aiding Debra in examining some of the painful feelings that she usually expressed through actions. Although the treatment was at a stalemate for the initial months, she gradually began to talk about losses and the fact that people were important to her. She established close ties with her therapist and various members of the treatment team and expressed appropriate sadness around terminations.
Case #9, Cheryl

At the time of her admission, Cheryl was a 21 year old, single, white, Catholic college student. She was hospitalized due to depression and suicidality, rapid mood fluctuations and a number of psychotic symptoms. At times she was paranoid, with ideas of reference and delusions that others were forcing her to do things against her will. In addition, she had auditory and visual hallucinations, such as images of snakes and skeletons. Numerous somatic complaints also characterized her initial presentation. These symptoms occurred around the time she left home for college and worsened while away at school. During this time, she reported that she had been raped by an older friend of the family whom her parents had forced her to see.

History prior to present illness. Cheryl was adopted in infancy into an upper middle class family which included Caucasian parents and three other adopted children, all of Asian descent. Cheryl's adopted parents were already in their late forties at the time of her adoption. Throughout her childhood and adolescence, her parents were highly overprotective of the children, not allowing them to join in activities outside the home with peers. Her father was particularly over-involved with Cheryl and there seemed to be a sexual quality to their interactions throughout her childhood until the present time. They would typically hold hands, hug and kiss
in a sexualized manner. Any sexual activity between them has been denied by both of them. To complicate these sexualized interactions was the fact that Cheryl's father would become increasingly depressed in response to any move toward autonomy on her part. Throughout elementary school, her school performance was marked by frequent absences due to somatizations, such as headaches or stomachaches. Her grades were poor. Cheryl did not have any close friends throughout childhood and, upon admission, had shown no interest in romantic involvements or dating. Upon anticipation of leaving for college, she began ruminating about people trying to manipulate her, control her life and force her to do things against her will. These symptoms worsened and reached a culmination with the reported sexual attack by the family friend who her parents "forced on her."

**Hospital course.** Cheryl's long-term hospital course was rocky. She did not interact well with other patients, often isolating herself in a secluded foyer area or in her room. Described as having a boyish and sulky presentation, Cheryl would typically insult others if they encroached upon her space. Throughout her hospitalization, Cheryl was anxious and emotionally labile, often with no clear precipitant for an outburst. There were numerous accounts of Cheryl suddenly racing from her quiet sulking in the foyer to the kitchen to grab a knife and attempt to stab herself. She would emerge from her silence to a frenzied wailing, at times accompanied by accounts of having seen a snake or skeleton. Cheryl was impulsively and unpredictably self-destructive, using any sharp or lethal object in
her path. She was also impulsively rageful and would lash out and hit a patient or impulsively sling a plate at someone. The treatment team found that the more chaotic the unit was, the more likely it was that Cheryl would have one of her outbursts. She seemed to respond on an intuitive and primitive level to her surroundings; in a sense, she served as a barometer for the anxiety level of the unit. When she felt her needs would not be met because others were needy, she panicked and made her presence known. In addition to responding to the vasculations on the unit, Cheryl also became symptomatic as a flight from intense affect. It was often possible to trace one of her outbursts back to the fact that there had been a distressing family meeting the previous day, or an evocative therapy hour. Rather than to make use of a staff talk to contain her, Cheryl sought out containment in a very pre-verbal, regressed manner; by shrieking through the halls, kicking a garbage can or stabbing herself with tacks, she was communicating her need for containment. These episodes would result in her being placed in lock door seclusion, providing her with the sense of safety and caretaking that she wanted.

Observing ego. Given the nonverbal, primitive manner in which Cheryl communicated her distress, it was apparent that she was not at a level where she could articulate her feelings to herself or to others. At one point in her treatment, she was able to understand that the frightening images she saw were images inside of her. In general, however, this woman had very little awareness of her illness or of the impact that her actions had on others. She was egocentric
and self-serving, as would be expected of an infant whose only concern is survival.

**Success of the treatment.** As the treatment progressed, Cheryl showed significant improvements. Through confrontation and limit setting on the part of the staff, Cheryl began to internalize a sense of containment. As a result of frequent mandatory staff talks and her intensive psychotherapy, she began to internalize the ability to verbalize her feelings. She was able to talk to her parents about her need for autonomy and their thwarting of her efforts at independence. In addition to the helpfulness of the milieu treatment, Cheryl responded well to the course of medication she was given which decreased her dysphoria. Around termination from the unit, Cheryl regressed and many of her former symptoms recurred, however she was able to get past this with some success.

**Case #19, Mark**

At his time of admission, Mark was an eighteen year old, single, white college freshman who was from a wealthy background. Mark was admitted for hospitalization on the recommendation of his college counseling center after a major suicide attempt by ingesting a large amount of pills and alcohol. Mark had been isolative throughout his first semester in college, often playing guitar alone in his room. Recently, he had been rebuffed by a woman whom he had been interested in romantically. Just prior to his suicide attempt, he had a dissociative experience where he imagined he was floating above the
traffic outside his dorm room, bathed in white light. He felt an overwhelming sense of aloneness and emptiness, as if he were separated from the universe in some fundamental way. Frightened by this sensation, he impulsively destroyed several breakable items in his room and began ingesting pills that were available. A roommate discovered him several hours later.

History prior to present illness. Mark came from a high achieving family. His father's occupation made it necessary for them to relocate often; his childhood was spent in various American schools across Europe. When he was three, his only sibling died at the age of one and a half. Mark was described as quiet, private and withdrawn throughout his elementary school years. He spent his free time taking long walks in the woods, often remarking that the wilderness was his closest companion. Throughout Mark's elementary school years his parents were not getting along; they divorced when he was fifteen. In addition, his mother had been alcoholic and seriously depressed during the time of marital difficulties. After the divorce, Mark went to boarding school and spent his vacations primarily with his father. During adolescence, Mark became further withdrawn, disclosing his feelings to no one. He often felt empty and alienated from others, and developed a defensive sarcasm and cryptic wit with which to distance from his peers. He had shown no interest in romantic involvements until the start of college, when he was rebuffed by a woman he liked. This seemed to increase his sense of aloneness and abandonment and precipitated his suicide attempt and subsequent
hospitalization.

Hospital course. In his brief hospital stay, Mark was alternately rageful and sullen. He had recurrent violent images and thoughts that were extremely frightening to him, in part because he feared that he would not be able to distinguish between those thoughts and destructive actions. It seemed that when these images and fears became too intense, he would dissociate. At those times, Mark would drift into a withdrawn state where he could not speak to others or concentrate on any task. Mark developed a strong attachment to his therapist, although the relationship was characterized by vascillations between idealization and devalument. When his therapist was on vacation, Mark stopped eating and caring for himself; he deteriorated into a regressed, withdrawn state. His regressions and dissociations seemed both to express his sense of abandonment and alienation from the world as well as to serve as a way of not experiencing the rage that he feared would be destructive.

Observing ego. The treatment team thought that Mark had the capacity to be quite insightful, given his intelligence and ability to distance from things. He was seen as the "perfect observer" in milieu therapy groups, yet he participated from a stance of the intellectual, detached observor. When he was called upon to self disclose, he found the group intrusive and refused to participate.

Success of the treatment. The treatment had as its goal to enable Mark to verbalize some of the intense feelings that he had
experienced at a preverbal level for most of his life. As the treatment progressed, he was able to relate anger toward his parents for emotionally abandoning him at various times throughout his childhood. Individual psychotherapy was quite helpful, since it was through a discussion of his sense of abandonment by his therapist that Mark was able to verbalize similar feelings about his parents. As Mark became more verbal and dissociated less, he became more openly rageful. He would storm the halls of the inpatient unit, yelling and, on a few occasions, turning furniture over. It was the task of the milieu team to contain his rage by firm limit setting. Mark began to internalize this sense of containment, which enabled him to be less afraid of his feelings and to replace his dissociative experiences with the more positive experience of intimacy with others.
A Comparison of the Borderline Subtypes

When reading over the cases which have been presented, the similarities among them may stand out more than any differences. This is to be expected: all of these individuals have been chosen for the study by virtue of the fact that they display similar symptomatology. For example, all the individuals displayed some sort of separation anxiety, a symptom of and issue central to borderline personality. Connected to this was a mention, in almost all the cases, of a profound longing, neediness and sense of deprivation that these patients manifested. However, there are qualitative differences in how and why borderlines express their separation anxiety. Although longing and a sense of deprivation are at the core of separation anxiety for all borderlines, variability in defensive structure and developmental level means that separation anxiety will be stirred up and expressed for different reasons in different borderlines. It was the aim of this study to explore differences in how and why borderline pathology is expressed across individuals, and these differences became apparent through an examination of variabilities in precipitants to symptom expression across a borderline sample. In order to make this clearer, the cases will be contrasted in terms of how and why separation anxiety was manifested and expressed based
on developmental vulnerabilities and defensive structure of each subgroup.

Relational borderlines

For the relational borderlines, separation anxiety centered around a fear of abandonment. This fear was expressed as a need to merge with another person, and it was exacerbated by a fear of losing the self through the loss of another.

The loss of an important object was comparable to self-annihilation for Shirley and Rosanne. Whenever Shirley's husband threatened to leave her, it would precipitate a serious decompensation. She had gotten married at an early age, and had not been alone in adulthood. Separation was worse than death for her. Similarly, Rosanne's suicide attempts followed threats of the loss of her aunt, her boyfriend and the hospital, to which she had formed a strong institutional transference. Like Shirley, Rosanne had formed serious attachments at an early age to ward off the fear ofaloneness and abandonment. Employment as a prostitute is not unusual among many young borderline women, who defend against their fear of being undesirable, unwanted and abandoned by sexual promiscuity.

For the relational borderlines, separation anxiety was seen as more prominent than in the other subgroups. This was probably because of how their separation anxiety was expressed, as opposed to the actual intensity of it. Since separation anxiety was expressed in the context of a relationship for these borderlines, its expression was more public for these individuals than for others. For example, when
Shirley's therapist cancelled an appointment, she ran down the hallways crying uncontrollably. When Rosanne feared that she would be discharged from the hospital, she slashed her wrists and walked down the hallways displaying the injury. In both cases, there was a display and almost a theatrical quality to the expression of the separation anxiety. This is one example of a type of behavior that gets labelled as manipulative in reference to the borderline. However, by considering why these patients were theatrical, one becomes more sensitive to their genuine distress as opposed to callous to their flamboyant expression of it. Both Shirley and Rosanne were communicating their distress to an audience and were doing so because, for them, the maintaining of a relationship or a connection to another person was essential to their sense of survival.

Protective borderlines

Like Shirley and Rosanne, Peter and Debra also manifested significant separation anxiety. For the protective borderlines, however, separation anxiety centered around a fear of engulfment. It was exacerbated by, and they became symptomatic due to, a fear of being robbed of their autonomy or sense of separateness. Therefore, separation anxiety was expressed as a need to protect oneself, to remain in control so as to ward off intrusions from others and to assert a sense of separateness from another.

It is important to emphasize the defensive nature of this expression of separation anxiety. Through projective identification, they left others feeling as unwanted as they often felt. Although
these borderlines often minimized the importance of others, it was clear that underneath the fear of engulfment was a sense that others were essential for their own survival. For Debra, her experience of losing her father to the younger siblings in childhood, and the upcoming separation from the family to go to college in adolescence, were precipitants to her becoming self-destructive. Although the specific events are less clear, Peter became symptomatic around the developmental transition of late adolescence. His provocative and rageful behavior on the unit was often documented as being due to his needs not being met, or due to a sense of abandonment.

Whereas Shirley and Rosanne were often seeking closeness and actively displaying their neediness, Peter and Debra were characteristically private and oppositional in response to their separation anxiety. Peter refused to participate in milieu activities and Debra would isolate herself in her room when feeling abandoned. Although they both longed for attention from others, an assertion of a sense of separateness and control was essential to them. Therefore, in contrast to Rosanne and Shirley, there was not an actual emphasis on maintaining relationships as a way of minimizing separation anxiety. Perhaps the protective borderlines had as intense an internal sense of separation anxiety as did the relational borderlines, but their external striving for closeness was not comparable. One might say that externally, they defended against their separation anxiety by minimizing the importance of relationships. Both Debra and Peter escalated into more rageful, oppositional and self-destructive
behavior as they became more needy and internally abandoned.

**Primitive borderlines**

For the primitive borderlines, separation anxiety centered around a fear of disorganization. They became symptomatic when they feared their needs would not be met, thereby threatening their survival. Their separation anxiety was expressed as a flight from intense affect and was expressed as a need for containment. Whereas the relational borderlines readily and actively engaged with others and the protective borderlines engaged in an oppositional and defiant manner with others, the primitive borderlines maintained a minimal level of engagement. To the extent that they interacted in the milieu, it was to get their needs met. Like all the borderlines studied, separation anxiety was central in this subgroup as well. Mark's impairments were reflective of a profound sense of abandonment from early on, given the possible identification with his sibling who died and the impact of frequently moving in combination with his parents' divorce. His sensitivity to separation became clear in the hospital when his therapist went on vacation and Mark stopped caring for himself. Similarly, Cheryl's early history of a sexualized and enmeshed relationship with her father shed some light on why she became symptomatic at the time of separation from home.

However, Cheryl and Mark expressed their separation anxiety in a much different manner than either the relational or protective borderlines. Contrast Cheryl's explosive behavior on the unit with that of the relational borderlines. Whereas both Rosanne and Shirley
reacted to the anticipated loss of a meaningful relationship and became symptomatic in order to communicate distress to the parties involved, Cheryl did not seem to be aware of an audience at all. When she would race down the hallways screaming and attempting to hurt herself, it was in response to an internal sense of disorganization and was not externally linked via a relationship with another individual. Separation anxiety was experienced by her as a flooding of intense affect from which she had to escape, or as a fear of her needs not getting met therefore pulling her to regress to a state that would ensure caretaking. Similarly, Mark would experience separation anxiety as a sense of being flooded by intense affect. In response to this, he would dissociate or become more isolative and withdrawn from others. Mark and Cheryl shared a basic sense of alienation from others. Whereas for Shirley and Rosanne, being with someone was essential, for Mark and Cheryl closeness was highly anxiety-provoking. This subgroup was the least social; neither Cheryl nor Mark had had an intimate or sexual relationship and neither had any close friends.

Variations in Observational Capacities and Effectiveness of Milieu Treatment

Since the notes in the chart concerning observational capacities centered around the patient's use of the milieu, these two areas will be combined into a general discussion of the strengths and needs of the patients and how they were addressed in the hospital. The milieu
treatment in the hospital where this study was done consisted of formal and informal groups on locked, inpatient units consisting of fifteen to twenty-five patients. The patients in this study stayed on any one of about ten units and there were differences in the way these units were run. However, all of the units had nursing staff who offered either mandatory or voluntary talks on a daily basis with the patients. In addition, meetings with all patients and staff were held on at least a weekly basis. Many units had mandatory and voluntary groups such as a women's group, activities group, adolescent group, orientation group and cooking group. In addition to the hall milieu, there was a hospital milieu; several groups were offered through the rehabilitation department and were available to all hospital patients.

Before looking at differences in terms of milieu effectiveness and observational capacities across subgroups, the commonalities will be addressed. In general terms, the hospital was a place where a borderline's pathology could emerge and be confronted in an intensive manner. Given the constant interpersonal contact in the milieu, the borderline patients readily displayed their defense of splitting between patients, staff, family, therapist or whomever. Since the staff was trained to confront such splitting, the patients were forced to examine their varying, inconsistent, "all or nothing" perceptions of others. Over time, this fostered an increase in the patient's ability to tolerate ambivalence as well as a strengthening of the patient's awareness of his or her perceptions of others.
Much of the dynamics of borderline personality disorder involves a failure of the ego functions to modulate or neutralize instinctual impulses and primitive anxieties. The ego buckles under the power of primary process material which overpowers the borderline patient. The milieu strived to strengthen the ego functions of the borderline, such as ability to delay impulses, reality test (distinguish feelings from actions), contain anxiety rather than act out around it, form more stable, integrated views of others and oneself and take an active role in one's life. Milieu treatment was effective in strengthening ego functions to some degree in many of the borderlines who were studied. It seems that the milieu succeeded by "lending an ego" to the patients, which through identification and separation, was eventually internalized by the patient. The milieu provided containment for the borderline through constant limit setting and confrontation. In addition, containment was provided through the structure offered in the milieu; borderlines have been known to modulate more successfully in structured rather than unstructured settings and situations.

Again, the success of the milieu seemed to be due both to its consistent offering of an ego in combination with its offering of a relationship to the patient. Some more specific examples may help to clarify this point. Upon admission to a unit, each patient was assigned a coordinator, who was a member of the nursing staff. The patient usually had daily staff talks with this mental health worker or nurse. Events of the day were consistently addressed in terms of how the patient might have handled something differently (sublimation),
how the patient expressed a feeling through an action (increasing insight and ability to tolerate anxiety resulting from intrusion of primary process material), and how a patient may more actively intervene in the treatment course (discouraging regression). The coordinator is a role model for the patient and, over time, the patient identifies with and internalizes the persistent questioning and examining that the coordinator provides.

**Relational borderlines**

The specific subgroups of borderlines will now be contrasted with an emphasis on how their needs were addressed in the milieu. The relational borderlines were often described as passive, dependent upon others, prone to rapid regression and compliant in order to be liked. The milieu was helpful to these patients by thwarting the extreme regression to which they were prone. This was encouraged by providing a structured treatment program that stressed activity rather than passivity; in order to be discharged, the patient was required to complete certain tasks that demanded that the patient be active and responsible for him or herself.

Since the relational borderlines expressed their pathology in the context of relationships, and since contact with others was essential for their maintaining a sense of themselves, they were more readily engaged in the milieu than were the other subgroups. Their ability to depend on others was often a positive sign in the milieu, strengthening staff contacts and resulting in a successful internalization of the milieu after discharge. However, relational borderlines
were often compliant, engaging in a superficial manner to ensure that their needs would be met. The staff commented that due to Shirley's compliant stance in the milieu, the genuineness of her insights could not be trusted. For Rosanne, an ability to depend on others had both advantages and disadvantages. The staff found her ability to engage with them very positive, however, in the end, Rosanne formed the strongest attachment to the person she felt could gratify her the most: her boyfriend on the unit. Her attachment to him strengthened each time a staff member terminated with the unit. It was clear that her fear of abandonment ruled her actions even though it led to an undermining of her treatment.

Protective borderlines

Whereas the relational borderlines were rated highest among the subgroups in observational capacities, the protective borderlines were rated the lowest and did the poorest in the milieu. The fact that this subgroup needed privacy, control and a sense of separateness directly conflicted with the group emphasis of the inpatient milieu. Peter was a treatment failure due to his oppositionalism and deficits in the area of self-reflection. The staff was unable to form a working alliance with him. In contrast Debra, although initially private and withholding, was eventually able to verbalize her feelings of abandonment and sadness rather than to act out around them. In the beginning of her hospital stay she refused to tell staff when she was upset, but through the constant emphasis on verbalizing one's feelings in the milieu, Debra came to make use of the staff. For the protective
borderlines, the milieu had to stress the containment of acting out behavior through limit setting and the importance of seeking out others for support in times of distress.

**Primitive borderlines**

The primitive borderlines were distinguished by their schizoid, isolative interpersonal style and the severity of their ego deficits. Their ability to tolerate anxiety was poor and they were often overwhelmed by unintegrated instinctual material. For these borderlines it was particularly important for the milieu to stress its ability to contain their impulses. The failure to communicate this was likely to result in a decompensation on the part of the patient. This was the case with Cheryl, who frequently became symptomatic when the unit was in a chaotic state. Whereas the relational borderline was able to engage with other patients or friends when the milieu was in turmoil, and the protective borderlines were not as attuned to or invested in the milieu, the primitive borderline depended on the stability of the milieu in order to feel grounded. Concrete interventions on the part of the staff were most helpful to these borderlines, such as the use of the seclusion room. Since these patients were particularly deficient in reality testing, it was important for the staff to help them distinguish frightening images or impulses as internally based. Much of the work with Cheryl centered around reassuring her that the snakes and spiders she saw would not hurt anybody, and that they may have come to mind in response to a stressful day.
In contrast to the relational borderlines who could not modulate their strivings to be close to others, and the protective borderlines, who withdrew from others as a defense against engulfment, the primitive borderlines seemed to lack the ability to engage with others. It was important for the milieu to teach them how to interact more positively by offering them frequent staff contact. In addition, it was helpful for these borderlines to learn to verbalize their internal state, since they were often both isolated and overwhelmed by intense and disorganizing affect. This was true of Mark, who dissociated and withdrew when faced with intense affect. By aiding him in labelling and verbalizing his rage, he dissociated less and sought more contact with people. At this point in his treatment, he displayed his rage more directly, such as by kicking over furniture and yelling. The staff needed to keep stressing the importance of verbalizing feelings while maintaining firm limits on his acting out behavior.

Methodological Considerations and Limitations of the Study

Before beginning a final discussion of developmental differences across borderline patients, some of the limitations and methodological considerations of the project will be mentioned. First, before any conclusions can be stated, it is important to define what population has been drawn upon in this sample. As is apparent, the category of borderline personality disorder is a large one, including those who can function in society and those who are more severely disturbed. By using patients in a private, inpatient psychiatric hospital as
the sample, it is possible that the individuals represented are borderlines on the severely disturbed end of the continuum. The average hospital stay of these patients was 11 months, although there was a bimodal distribution divided between stays of a few months and admissions of a year or more. Many of the brief admissions returned to their occupations after discharge. Thus, the sample did draw upon a range of borderlines in terms of functioning. The borderlines who were hospitalized during a crisis which had been precipitated by movement in psychotherapy often returned to a high level of functioning after a brief admission. In contrast, there were others who had never been high functioning and who required a several year hospital stay in order to make some gains. Others had had multiple admissions and lived a roller coaster existence, with periods of adequate functioning and periods of deep regression.

Not only were all the individuals chosen for the study from a hospitalized population, but the sample of borderline patients was further refined by the use of the selection criteria of both the discharge diagnosis and the DIB. There were many patients with discharge diagnoses of narcissistic, schizoid, schizotypal and mixed personality disorder who had been given ratings of nine or ten on the DIB. These patients were excluded from the sample because of their discharge diagnosis. Had they been included, they may have expanded the range of borderlines represented; however, they also may have contaminated the sample with individuals who were not borderline. Interestingly, many males with high DIB scores had a diagnosis of narcissistic
personality disorder and could not be included in the study. This has implications concerning gender differences in diagnosis that are worth further exploration.

The use of the DIB and GUND-R also served to narrow the continuum of borderlines by excluding the most seriously disturbed. The interview demands that the patient have some awareness of his or her symptomatology, as is apparent by questions such as, "In the last two years, have you feared losing a sense of yourself as a separate person?" or "Were you ever afraid that you would be abandoned?" (Gunderson and Zanarini, 1982). Unless the interviewer draws upon staff input or his or her own clinical judgement, the reliability of the patient is essential in the scoring. More severely disturbed borderlines might rate lower because of their lack of awareness of what has transpired in the last three months. By stressing social adaptation and interpersonal dynamics such as a pattern of intense and unstable relationships, the GUND-R and DIB select out those borderlines who are too disturbed to have any relationships.

For example, I came across a patient who had been hospitalized for seven years in various psychiatric facilities; every professional who had treated her had given her a diagnosis of borderline personality disorder with no diagnosis on Axis I. This woman was so suicidal that she had to be maintained in lock door seclusion and four point restraints on a continual basis, allowing for the periodic breaks mandated by the law. During these breaks, she had to be watched by four or five nursing staff members because of the facility with which
she could be self-destructive. When I rated this woman's behavior using the GUND-R, she did not score in the borderline range due to the fact that her functioning was so regressed that it was not tapped by the social adaptation or interpersonal relations categories. This may be why the Primitive subgroup, who were less interpersonally oriented than the other groups, had slightly lower DIB and GUND-R scores than the other subgroups.

There were some disadvantages and limitations which resulted from using medical records as opposed to direct patient contact. Each chart varied in terms of the amount of detail and elaboration it contained. Several subjects had to be excluded from the study due to insufficient data available in the charts. The content of any given chart was reflective of the theoretical stance and counter-transference reactions of those who wrote in it. This was particularly problematic in the coding of the observational capacities, which depended on the judgements of the treatment team. Also, descriptions of observational capacities were not easily gleaned from the charts; they seemed to be addressed infrequently and indirectly. In contrast, the precipitants to symptom expression were addressed more directly and could be coded from concrete events, such as a patient's suicide attempt after the documentation of a difficult family meeting.

To compensate for the inevitable subjectivity and selectivity of information, I looked for the repeated mention of a symptom or precipitant by different sources, such as the nursing staff and the psychologist doing the assessment. The minutes of the mandatory
sixty and ninety day treatment reviews were helpful in this regard since they made note of the input from nursing staff, administrators, therapist and psychological assessor. If there were major inconsistencies in how the patient was viewed, they emerged in these reports. This occurred a few times, and in such cases the piece of information was not recorded as data for the study.

As can be seen on Coding Sheet C in the appendix, input from primary care providers like the nursing staff was recorded separately from the input of administrators as well as psychological testers. This was done to leave room for possible discrepancies in the data resulting from professionals who had different types of contact with the patients. Thus, by separating types of input on the coding sheets, it was easy to detect discrepancies among staff members. Although there were a few discrepancies between recommendations of the psychological testers and those of the nursing staff, the majority of the charts revealed consistent perceptions across the various members of the treatment team. Again, the input was discarded from the analysis if it did not represent the opinion of all staff members.

Also important was the need for consistency in types of documentation across all charts. Such consistency was achieved in the study since all of the hospital charts included certain structured reports. The sixty and ninety day treatment summaries, which addressed precipitants to illness and hospital course, were found in each patient record. Each chart also contained the
administrator's weekly progress notes, which commented on specific symptoms and events that emerged in the patient's treatment course. Since the progress notes of administrators and nursing staff had to follow a certain format, the same questions were asked about and addressed for each patient.

In coding for borderline symptomatology, the fact that the patients were hospitalized made some of their symptoms hard to detect. This was most apparent for the borderline symptom of an intolerance of being alone, which only showed up for one of the twenty subjects. This is an example of a symptom that would not be mentioned by staff because inpatients are rarely alone on a milieu therapy unit. However, if staff members were interviewed and asked if a patient had this symptom, they might be more likely to cite it as a probability.

There were definite limitations in this project stemming from the small sample size and the analysis of the data. Certainly twenty subjects were not enough from which to justify the drawing of conclusions about the borderline patient population. In addition, in the data analysis, certain results were confusing because they were based on concepts which should have been more clearly defined from the outset. For example, the question of differences in observational capacities across subgroups was clouded by the fact that "observational capacities" were loosely defined in the study. Information about insight, ability to perceive one's actions from an outside perspective, ability to separate feelings from actions, ability to use feedback and any other related comments were coded from the
charts. This category became loosely defined because of the small sample size in combination with the fact that very little was written about insight or one's observing ego in the charts. As a result, there was a wide range of information coded under this category which then had to be contrasted across a small number of cases. The question of how to define and assess a patient's capacity for insight remains a problematic one and merits continued investigation.

The other area of difficulty was in defining the primitive borderline subgroup. Whereas borderline clusters resembling the interpersonal and the protective subgroups had been hypothesized prior to the study, the features of a third subgroup were not as well defined. The relational and protective subgroups did not display much variability in terms of ratings within the groups; five of the relational borderlines were rated AE, one was rated ADE; one of the protective borderlines was rated B, four were rated BC and one was rated BCD. In contrast, the primitive group all had F precipitants in common, but the ratings ranged from one BF, one CF, one DF, one CDF, one BEF to one EF. Therefore, this category, although tied together by one common feature, was more loosely defined than the other two categories. Although I decided to group these cases together based on their similarities, it was with the understanding that they had more differences across them than did the cases in the other subgroups. Since B and C ratings were common to the primitive subgroup, some of the cases might have been grouped as protective/primitive. The implications this has in the interpretation of the
results will be discussed later in this section.

To conclude this discussion of the limitations, it is apparent that the qualitative nature in which the data has been analyzed left room for distortions due to the subjectivity of the examiner. However, I felt that well-informed clinical judgement, although subjective, was still an important tool in case analyses. This seemed particularly true in the study of borderline personality disorder, which, because of the abstractness of its definition, often proves to be a slippery fish in the sea of quantitative research. The initial exploration of the disorder and the further refining of it has largely evolved from the perceptions of astute clinicians. It was felt that the subtle differences in borderlines that this study hoped to detect would be most readily discernible through the use of clinical judgements shaped by specific guidelines and criteria for the selection of the cases.

A Consideration of Developmental Differences in Borderlines and Possible Treatment Implications

By studying the variabilities in precipitants to symptom expression, several distinct subcategories of borderlines emerged. The question to be raised, however, is what these subgroups signify both diagnostically and in terms of treatment implications. In particular, do the subgroups reflect some sort of developmental continuum across the borderline personality disorders and how might this continuum be defined? To begin to shed some light on these questions, some of the most relevant aspects of the literature already reviewed in the
introduction will be highlighted and discussed in the context of the results of the present study.

Noam (1985) considered the interaction between stage, phase and style in striving to make sense of the developmental differences among borderline patients. His model is very useful when applied to the patients in this study. The contrasting relational and boundary interactional styles which Noam has described were comparable to the styles employed by the relational and protective borderlines. Whereas the relational borderlines sought closeness with others, the protective borderlines' interactions were in the service of establishing autonomy or maintaining a sense of separateness from others. Unfortunately, given the methodological limitations of the study, it is difficult to assess ego developmental stage for all the patients. It was hoped that the construct of observational capacities would tap differences in stage of meaning organization. However, there was not consistent data available on this from all charts. The data was not analyzed for phase considerations, and I suspect this would have been a useful addition to the study.

The psychoanalytic literature has discussed several developmental variations in the borderline, as was noted in the introduction to this thesis. Theorists such as Masterson (1976) suggest a continuum of borderline pathology which is based on the onset of the arrest in the separation-individuation period. Masterson divided borderline patients into two levels of pathology based on their specific vulnerabilities and corresponding defensive style. There are similarities
between his two subgroups and the relational and protective borderline subgroups described in this study. The similarity is best illustrated by quoting Masterson:

The upper-level borderline's clinical picture is most often neurotic-like . . . his principal fear is abandonment, and his principal form of defense is clinging, not distancing. The reverse can be said of the lower-level borderline, . . . whose principal fear by far is that of engulfment and whose principal defense is distancing. The lower-level patient is prone to temporary psychotic attacks under separation stress, as well as to feelings of depersonalization, unreality, and paranoid projections (1976, pp. 37-38).

In addition to viewing the borderline subgroups in terms of their specific defenses and vulnerabilities, they may be viewed along a continuum of predominant character traits, such as hysterical and schizoid. Many of the psychoanalytic theorists found this grouping useful in discussing the borderline patient. Meissner (1984) used a hysterical-schizoid continuum of borderline pathology which included many subcategories. Unlike the results of this study and the work of the majority of the other theorists, Meissner's hysterical group included some patients more disturbed than those in the schizoid group. For example, under the schizoid category, he listed as-if personalities and false-self organized patients, whose reality testing was good and potential for regression was minimal. In contrast, the hysterical continuum included groups such as the pseudoschizophrenias and psychotic characters, who displayed evidence of thought disorder, regressed easily and had severely impaired object relations. However, the hysterical continuum also included the primitive hysterics, who had the best prognosis of all the borderline subtypes.
Most significant in Meissner's work is the fact that he found his subdivisions useful in making treatment recommendations, including types of medication and types of psychotherapy. For example, he advised that supportive or expressive psychotherapy in conjunction with hospitalization would be the treatment of choice for the pseudoschizophrenias and psychotic characters. Psychoanalysis or intensive psychoanalytic psychotherapy would be best suited for the primitive hysterics, false-self and as-if personalities. His work supports the assertion in this study that making distinctions, such as those described, among hospitalized borderline patients may prove useful in recognizing the varying needs these patients may have in the milieu treatment program.

Like Meissner, Kernberg (1975) urges clinicians to consider the type of character pathology present in the borderline. Since his definition of the borderline personality is as a level of organization, however, it is more likely to encompass a greater variety of character types than would be seen when following the DSM III definition of borderline personality, as was done in this study. Still, the work of Kernberg is applicable to the hospitalized sample of DSM III borderlines in this study, who had many differences across them. Kernberg points out that:

Different types of character pathology involve difference levels of instinctual development, superego development, defensive operations of the ego, and vicissitudes of internalized object relationships (1975, p. 113).

He goes on to say that taking into account both the level of character pathology and the constellation of character traits, "has direct,
intimate relevance to prognosis and treatment" (p. 113). Whereas hysterical personalities have a good prognosis, schizoid personalities have a prognosis which is more guarded.

Now that the borderline subgroups have been contrasted in terms of relational and defensive style as well as character pathology, we can look at them in terms of strength of ego functions. An important ego function, and one discussed extensively by many theorists, is the quality of object relationships or the relational strengths of the patients. According to Meissner (1984), Grinker (1977) and Kernberg (1975), the more severely disturbed or developmentally impaired the borderline, the more chaotic, unstable and impaired is his or her relationships. This held true for many, but not all of the cases in this study. For example, the relational borderlines were, as a whole, the least impaired in terms of object relations. They were comparable to the higher order borderlines about whom Meissner speaks; they are primarily primitive-hysterics or depressive-masochistic character types. These borderlines are able to maintain relationships without losing perspective on reality; their projections onto others are usually not delusional. This was true of most of the relational borderlines in the study, however, some did have more delusional and fragmented object relations. The same held true, in the reverse, for the primitive subgroup. This group was, on the whole, comparable to the schizoid and psychotic core groups that were discussed in the literature (Meissner, 1984; Grinker, 1977). Their relationships were the most severely impaired and prone to delusional
projections. None of the cases in the primitive group were involved in an adult, intimate relationship.

Developmental differences have also been discussed in terms of other ego functions, such as impulse control, reality testing and social adaptiveness. It does seem that impulse control was most severely impaired in the primitive borderlines, as was reality testing. Many of the patients in this subgroup would act on their impulses quickly and in response to a rapid breakdown of their defensive structure. An important measure of ego strengths is the person's ability to function in society, whether it be in an occupation or as a member of a family. Although it might be expected that the primitive subgroup would be the most impaired in functioning, this was not always the case. Although they were isolative and most impaired in relationships, they often used their cognitive skills to maintain relative success in professions. This is in contrast to the protective borderlines, who were not as successful in terms of overall functioning. The relational borderlines were the most successful in both their relationships and their occupations.

The three borderline subtypes have been contrasted in terms of various types of developmental impairments. To conclude this discussion, we will turn back to the differences in relational and defensive style which were discussed earlier. The results of this study make most sense when they are viewed in terms of the variations in how borderlines express their vulnerabilities, such as through fears of disorganization, abandonment or engulfment across the three subgroups.
This reflects differences in defensive style and relational style and may also suggest a continuum based on the phase of the life-span in which the person is developmentally fixated. This is in contrast to Noam's use of phase to describe the actual environmental task that the individual is struggling to negotiate. The three subgroups in this study express issues of different functional life-span developmental levels: the wish for a relationship in early adulthood; the wish for privacy in adolescence; and the egocentric position of needing total caretaking in early infancy. Again, these issues were apparent regardless of the actual life-span phase that the person was in; there were several late adolescent borderlines in the study (i.e.: Cheryl, Debra, Rosanne, Mark), and some of them experienced the separation of adolescence in terms of a threat of abandonment while others, for example, experienced it as a failure to have their immediate needs met, which brought with it the threat of disorganization at a primitive level.

Further work in the area of establishing borderline subtypes is important for the treatment of these individuals. By recognizing the various limitations of each subtype, a therapist will be more aware of how to modify his or her therapeutic approach based on who is being seen. The specific data on responsiveness to the milieu has been discussed earlier in this chapter. Whereas the primitive subgroup needed the firmest limits and most containment, the relational subgroup needed to be discouraged from regressing and needed to learn to modulate the intensity of their interactions. The defensive style
of the protective borderlines, such as the importance of privacy for them, needed to be respectfully challenged. Based on the data, this group is able to make the least use of the milieu, perhaps because the treatment team does not recognize and respect the particular defenses of these patients. In summary, the three subgroups did vary in terms of what they needed from the milieu, suggesting that research such as this may be significant in modifying treatment approaches.
REFERENCES


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Frosch, J. (1964). The psychotic character: clinical psychiatric considerations. Psychoanalytic Quarterly, 38, 81-96.


Zilboorg, G. (1941). Ambulatory schizophrenias. Psychiatry, 4,
APPENDIX A

The Coding Sheets
CODING SHEET A

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Family status/background (family configuration when growing up, date left home, presently lives with whom, contact with family or origin):

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Precipitants to hospitalization:

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CODING SHEET B

Part 1 - Symptoms and their Precipitants

**IMPULSIVITY**

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# CODING SHEET B

**Part 1 - Symptoms and their Precipitants**

**UNSTABLE AND INTENSE INTERPERSONAL RELATIONSHIPS**

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Part 1 - Symptoms and their Precipitants

IDENTITY DISTURBANCES

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CODING SHEET B

Part 1 - Symptoms and their Precipitants
INAPPROPRIATE OR INTENSE ANGER

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## CODING SHEET B

### Part 1 - Symptoms and their Precipitants

**INTOLERANCE OF BEING ALONE**

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### CODING SHEET B

**Part 1 - Symptoms and their Precipitants**

**OTHER COMPLAINTS**

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### Part 2 - Ego Strength and Response to Treatment

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<tr>
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<th>Social Perspective Taking Ability</th>
<th>Response to Milieu</th>
<th>Response to Psychotherapy</th>
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## Coding Sheet C

**Guidelines for rating type of information**

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<tr>
<th>Code</th>
<th>Type of Information</th>
<th>Examples</th>
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<tbody>
<tr>
<td>A</td>
<td>any descriptive info such as those found in the nursing notes-any passage that states a behavior or symptom and the events which preceded or followed it.</td>
<td>Joe threw furniture after finding that his privileges were placed on hold. He was sent to open quiet room.</td>
</tr>
<tr>
<td>B</td>
<td>any interpretive piece of information based on direct clinical observation- often found in therapist progress notes and treatment reviews.</td>
<td>Joe has a hard time seeing his own role in events and feels that others have picked on him unjustly.</td>
</tr>
<tr>
<td>C</td>
<td>any interpretive piece of information based on abstract material rather than direct clinical observation-most common source will be psychological testing reports.</td>
<td>The wish for approval becomes fused with aggressiveness and poor judgement as evidenced by his approach to the test material.</td>
</tr>
</tbody>
</table>
APPENDIX B

The Diagnostic Interview
for
Borderlines
February, 1982

DIAGNOSTIC INTERVIEW FOR BORDERLINES
(2nd Edition)

John G. Gunderson, M.D.
&
Mary C. Zanarini, Ed.M.

For further information concerning the DIB, contact Dr. Gunderson at McLean Hospital, 115 Mill Street, Belmont, MA 02178
DESCRIPTION

The DIB is a semistructured interview that collects information in five areas considered to be of diagnostic importance for Borderline Personality Disorder: Social Adaptation, Affect, Cognition, Impulse Action Patterns, and Interpersonal Relationships. It contains 141 questions and judgments concerning the way that the patient has felt, thought, and behaved during the past two years. The patient is the sole source of information for the vast majority of these items, but a small number require the use of an additional data source as well. The interview is further divided into numerous subsections, and the information gathered from each of these subsections is used to rate one of twenty-five capitalized statements called SUMMARY STATEMENTS. Each of these statements represents an important diagnostic criterion for Borderline Personality Disorder and is used to assess the presence or absence of this condition.

INSTRUCTIONS

1. Probe further if a specified inquiry provides insufficient information to answer a question or make a judgment.

2. Circle the number that represents the best answer for each question, judgment, or Summary Statement. Unless otherwise specified, all questions and judgments are rated: 2=YES, 1=PROBABLE, and 0=NO. All Summary Statements are also rated: 2=YES, 1=PROBABLE, and 0=NO. If a question or judgment is not applicable, write N.A. to the right of its scoring set.

3. For each section, add the Summary Statement Scores to obtain a SECTION SCORE.

4. Convert the Section Score to a SCALED SECTION SCORE of 0, 1, or 2 by following the directions provided for that section.

5. Total the Scaled Section Scores to obtain an overall DIB SCORE of 0-10.

6. Use the following guideline when making a diagnostic assessment at the end of the interview: a DIB Score of seven or more is considered indicative of Borderline Personality Disorder, while a score of six or less is considered indicative of another clinical syndrome.
BACKGROUND INFORMATION

1. Patient's Code Number: 
   (Patient's Name: __________________________) 

2. Status at Time of Interview: 1. Inpatient  
   2. Outpatient  
   3. Other Patient  
   4. Nonpatient  
   (Date of Interview: __________________________)  
   (Institution: __________________________)  
   (Interviewer's Name: __________________________)  
   (Relationship to Patient: __________________________) 

3. Age: 

4. Sex: 1. Male 2. Female 

5. Marital Status: 1. Never Married 2. Ever Married 


   2. Other DSM-III Disorder  
   (Other DSM-III Disorder: __________________________)  
   (Diagnostician's Name: __________________________)  
   (Relationship to Patient: __________________________) 

9. Degree of Certainty: 1. Uncertain  
   2. Somewhat Certain  
   3. Moderately Certain  
   4. Very Certain
Before we begin, I want to point out that all of the questions in this interview pertain to the past two years of your life or in other words, the period since (APPROPRIATE MONTH, DAY, AND YEAR).

1. **SOCIAL ADAPTATION**

   During the past two years, have you ...

   **Occupational Record**

   1. ... worked, gone to school, or been a homemaker? What's your work record (school history) been like? (2=erratic or failing, 1=steady but nonprogressive, 0=steady and progressive)

   2. ... had any periods when you were particularly effective at your job (studies)? (2,1,0)

   3. ... been able to work (study) effectively even if you've been so upset that you weren't functioning well in the other areas of your life? (2,1,0)

   4. **5.1 THE PATIENT HAS HAD AN ERRATIC OR FAILING OCCUPATIONAL RECORD.**

      (Occupation: ____________________________ )
      (Instability: ____________________________ )
      (Stated Reason: ____________________________ )

   **Social History**

   5. ... been extremely sensitive to criticism? (2,1,0)

   6. Rejection? (2,1,0)

   7. ... had a lot of trouble relating to people because of being distant or withdrawn? (Judge whether the patient has been unable to establish adequate interpersonal rapport because of constricted or inappropriate affect. Observations made during the interview should also be used in making this judgment.) (2,1,0)

   8. ... often tried to avoid getting together with other people or felt uncomfortable in social situations? (2,1,0)

   9. ... tended to withdraw from people when you're upset? (2,1,0)
10. ... had a lot of people in your life? (2,1,0)

11. ... found it easy to meet new people? (2,1,0)

12. ... regularly gotten together with friends or acquaintances? About how many times a week? (2=3/wk, 1=2/wk, 0=≤1/wk)

13. ... often spent your free time with more than one person? (2,1,0)

14. ... gotten along well in social situations involving groups of people? (2,1,0)

15. S.2 THE PATIENT HAS HAD AN ACTIVE SOCIAL LIFE OUTSIDE HIS IMMEDIATE FAMILY.

SECTION SCORE: _______________________

Social Adaptation
Scaled Section Score: 2 if the Section Score is 3 or more
1 if the Section Score is 2
0 if the Section Score is 1 or less, or if the patient has been a socially isolated loner

16. _______________________

SCALED SECTION SCORE: _______________________

II. AFFECT

During the past two years, have you ...

Depression

17. ... felt rather down or depressed a lot of the time? (2,1,0)
18. ... had any periods when you were very depressed for two weeks or more? Did you move and talk much more slowly or much less than usual? (Discrete Depressive Episodes) (2,1,0)

19. ... felt helpless for days or weeks at a time? (2,1,0)

20. Hopeless? (2,1,0)

21. Worthless? (2,1,0)

22. Very guilty for things that you've done or failed to do? What were you feeling so guilty about? (Nondelusional Guilt) (2,1,0)

23. S.3 THE PATIENT HAS HAD A CHRONIC LOW-GRDE DEPRESSION OR EXPERIENCED ONE OR MORE DISCRETE DEPRESSIVE EPISODES WITHOUT PSYCHOMOTOR RETARDATION.

24. S.4 THE PATIENT HAS HAD SUSTAINED FEELINGS OF HELPLESSNESS, HOPELESSNESS, WORTHLESSNESS, OR NONDELUSIONAL GUILT.

Anger

25. ... felt cranky or irritable a lot of the time? (2,1,0)

26. Angry or hostile? (2,1,0)

27. Furious or enraged? (2,1,0)

28. ... often been negative? (2,1,0)

29. Sarcastic? (2,1,0)

30. Impatient? (2,1,0)

31. Argumentative? (2,1,0)

32. Quick tempered? (2,1,0)
33. S.5 The patient has chronically felt angry or chronically given frequent vent to his anger (i.e., has often been negative, sarcastic, impatient, argumentative, or quick tempered).

Anxiety

34. ... felt nervous or anxious a lot of the time? (2,1,0)

35. Scared or frightened? (2,1,0)

36. Terrified or panic-stricken? (2,1,0)

37. ... often had tension related physical symptoms such as headaches, butterflies or tightness in the stomach, excessive sweating, rapid heartbeat, or attacks of shortness of breath? (2,1,0)

38. ... been troubled a lot by any fears or phobias? (2,1,0)

39. ... had any panic attacks? (2,1,0)

40. S.6 The patient has chronically felt anxious or chronically suffered from frequent physical symptoms of anxiety.

Other Characteristic Affects

41. ... often experienced shifts from your usual mood to feelings of depression, anger, or anxiety that lasted only a few hours or days? (2,1,0)

42. ... had times when you enjoyed yourself? (2,1,0)

43. ... felt very alone a lot of the time? (2,1,0)

44. Lonely? (2,1,0)

45. Dissatisfied? (2,1,0)

46. Bored? (2,1,0)
47. Empty? (2,1,0)

48. S.7 THE PATIENT HAS EXPERIENCED CHRONIC FEELINGS OF LONELINESS, DISSATISFACTION, BOREDOM, OR EMPTINESS.

Nonborderline Affects

49. ... often been told that it's very difficult to tell what you're feeling because you show little or no emotion on your face or in the way that you talk? (Judge whether the patient has been flat. Observations made during the interview should also be used in making this judgment.) (2,1,0)

50. ... had any periods when you felt high or elated for no good reason? (Judge whether the patient has been elated. Observations made during the interview should also be used in making this judgment.) (2,1,0)

SECTION SCORE: 

Affected Scaled Section Score: 2 if the Section Score is 5 or more (2 each from S.5 and S.7)
1 if the Section Score is 3 or 4, or any other combination of 5 or more
0 if the Section Score is 2 or less, or if the patient has experienced psychomotor retardation or been flat or elated

51. SCALED SECTION SCORE: 

III. COGNITION

All items, except where noted, and all Summary Statements in this section pertain to substance-free experiences. Determine whether the experiences described by the subject occurred naturally or took place under the influence of alcohol or drugs. Those experiences that were substance-induced, if any, should be rated and described only where specified.
During the past two years, have you ...

Nonpsychotic Experiences

52. ... been very superstitious? (Marked Superstitiousness) (2,1,0)

53. ... believed that your thoughts, words, or actions could cause things or prevent them from happening? (Magical Thinking) (2,1,0)

54. ... thought that you had a sixth sense about things? (Sixth Sense) (2,1,0)

55. ... believed that you could tell what other people were thinking or feeling even if you weren't given the usual clues or that other people could know your thoughts or sense your feelings in some special way? (Telepathy) (2,1,0)

56. ... thought that you could perceive things happening around you that other people couldn't or that you could foretell the future? (Clairvoyance) (2,1,0)

57. ... had any beliefs that you knew might be untrue but were unable to completely give up? (Overvalued Ideas) (2,1,0)

58. ... repeatedly sensed the presence of a force or person who wasn't really there or misinterpreted things that you've heard or seen (e.g., thought that you heard someone talking when it was really the sound of the wind in the trees)? (Recurrent Illusions) (2,1,0)

59. ... repeatedly felt that you were unreal? Like your body or a part of it was strange or changing size or shape? As if you were physically separated from your feelings or were viewing yourself from a distance? (Depersonalization) (2,1,0)

60. ... repeatedly felt that things around you were unreal? Like they were strange or changing size or shape? As if you were in a dream or something like a window was between you and the world? (Derealization) (2,1,0)

61. ... had these experiences (SPECIFY) naturally or when you were under the influence of alcohol or drugs? (Judge whether the patient has developed ideational or perceptual disturbances after using alcohol, marijuana, or hashish.) (Ideation/Perception: ), (Substance-induced Ideational or Perceptual Disturbances) (2,1,0)
62. **THE PATIENT HAS BEEN PRONE TO ODD THINKING (E.G., MARKED SUPERSTITIOUSNESS, MAGICAL THINKING, OR OVERVALUED IDEAS) OR UNUSUAL PERCEPTUAL EXPERIENCES (I.E., RECURRENT ILLUSIONS, DEPERSONALIZATION, OR DEREALIZATION).**

   (Ideenation/Perception: )
   (Frequency: )
   (Severity: )

63. ... felt quite distrustful or suspicious of other people? (Undue Suspiciousness) (2,1,0)

64. ... thought that other people were giving you a hard time or were out to get you? Have taken advantage of you or blamed you for things that weren't your fault? (Other Paranoid Ideation) (2,1,0)

65. ... thought other people were taking special notice of you or staring at you? Talking about you behind your back or laughing at you? Things happening around you had a special meaning meant just for you or that people were trying to send you messages in a special way? (Ideas of Reference) (2,1,0)

66. **THE PATIENT HAS HAD BRIEF, NONDELUSIONAL PARANOID EXPERIENCES (I.E., UNDE S.UPSICIOUSNESS, OTHER FORMS OF PARANOID IDEATION, OR IDEAS OF REFERENCE).**

   (Paranoid Experience: )
   (Frequency: )
   (Severity: )

67. ... had times when you felt so desperate, overwhelmed, or out of control that you weren't able to think clearly or lost perspective on what was going on? What were you usually feeling when this happened? (Feeling State: (Transient Loss of Perspective) (2,1,0)

68. On these occasions, were you afraid that you were going to be abandoned? (Fear of Abandonment) (2,1,0)

69. Lose your sense of yourself as a separate person? (Fear of Engulfment) (2,1,0)

70. Die or be destroyed? (Fear of Annihilation) (2,1,0)

71. That something else bad would happen? What were you afraid of? (Stated Concern: ) (Other Intense Fear) (2,1,0)
72. S.10 THE PATIENT HAS REPEATEDLY LOST HIS PERSPECTIVE DUE TO THE INTENSITY OF HIS AFFECT AND EXPERIENCED FEARS OF ABANDONMENT, ENGULFMENT, AND ANNihilation. (Cognitive Impairment: _____________________________ )
(Frequency: _____________________________ )
(Severity: _____________________________ )

73. ... been in any (other) therapies? How many? Why did you enter treatment? (Reason for Treatment: _____________________________ )
(Number of Primary Therapies) (2=2, 1=1, 0=none)

74. How many months out of the past twenty-four have you been in therapy? (Time Spent in Primary Therapy) (2=21 yr, 1=<1 yr, 0=none)

75. Was there a period when you got worse? In what way? (Primary Therapy Regression) (2,1,0)

76. ... had any (other) psychiatric hospitalizations? How many? Why were you hospitalized? (Reason for Hospitalization: _____________________________ )
(Number of Psychiatric Hospitalizations) (2=2, 1=1, 0=none)

77. How many months out of the past twenty-four have you been hospital-ized? (Time Spent in Psychiatric Hospital) (2=6 mos, 1=<6 mos, 0=none)

78. Was there a period when you got worse? In what way? (Psychiatric Hospital Regression) (2,1,0)

79. S.11 THE PATIENT HAS UNDERGONE A CLEAR-CUT BEHAVIORAL OR SYMPTOMATIC REGRESSION DURING THE COURSE OF PSYCHOTHERAPY OR PSYCHIATRIC HOSPITALIZATION (E.G., HAS BECOME INCREASINGLY SUSPICIOUS, ANGRY, OR DEMANDING; DEVELOPED NEW SYMPTOMS; OR EXPERIENCED AN EXACERBATION OF CHRONIC SYMPTOMS). (Regressive Experience: _____________________________ )
(Frequency: _____________________________ )
(Severity: _____________________________ )

80. ... been unsure of who you are or what you're really like? Your values or goals? Who you really care about or whether you're actually a man or a woman? (Serious Identity Disturbance) (2,1,0)

81. ... often been told that your speech is vague or overelaborate? That you include far too many details or go off on tangents? Leave out important pieces of information or contradict yourself a lot? (Judge whether the patient has exhibited odd but nonpsychotic speech. Observations made during the interview should also be used in making this judgment.) (Odd Speech) (2,1,0)
Psychotic Experiences

82. ... believed that thoughts were being put into your mind that weren't your own? (Thought Insertion) (2,1,0)

83. Thoughts were being taken away from you by some external force? (Thought Withdrawal) (2,1,0)

84. Your thoughts were being broadcast so that other people could hear what you were thinking? (Thought Broadcasting) (2,1,0)

85. Your feelings, thoughts, speech, or actions were being controlled by an external force? (Delusions of Passivity) (2,1,0)

86. You could hear what other people were thinking or that they could actually read your mind? (Delusions of Mind Reading) (2,1,0)

87. Other people were plotting against you or trying to hurt you? (Delusions of Persecution) (2,1,0)

88. Other people were spying on you or following you? Things were specially arranged for you or that you were being sent special messages through the radio or television? (Delusions of Reference) (2,1,0)

89. You'd hurt someone, committed a crime, or deserved punishment for something terrible that you'd done? (Delusions of Guilt/Sin) (2,1,0)

90. You were an extremely important person or that you had very special abilities or powers? (Delusions of Grandeur) (2,1,0)

91. Something terrible had happened or would happen in the future? (Nihilistic Delusions) (2,1,0)

92. Something was wrong with your body or that you had a serious disease? (Somatic Delusions) (2,1,0)

93. Something else you thought was true even though no one else agreed with you (e.g., believed that a loved one was considering having an affair or had already cheated on you even though he or she repeatedly denied it)? (Other Delusions) (2,1,0)
94. ... heard any voices or other sounds that no one else heard?  
   (Auditory Hallucinations) (2,1,0)

95. ... seen any visions or other sights that no one else saw?  
   (Visual Hallucinations) (2,1,0)

96. ... had any other sensory experiences that no one else shared  
   (e.g., smelled something that wasn't really there)? (Other  
   Hallucinations) (2,1,0)

97. ... had these experiences (SPECIFY) naturally or when you were  
   under the influence or alcohol or drugs? (Judge whether the  
   patient has developed simple, transient delusions or halluci-  
   nations after using alcohol, marijuana, or hashish.) (Delusion/  
   Hallucination:  
   (Substance-Induced "Quasi" Psychotic Experiences) (2,1,0)

98. ... had these experiences (SPECIFY) naturally or when you were  
   under the influence of drugs? (Judge whether the patient has  
   developed well-organized, enduring delusions or hallucinations  
   after using LSD, PCP, mescaline, or another psychotomimetic.)  
   (Delusion/Hallucination:  
   (Drug-Induced "True" Psychotic Experiences) (2,1,0)

99. S.12 THE PATIENT HAS BEEN PRONE TO "QUASI" DELUSIONS OR HALLUCINA-  
   TIONS (I.E., INTENSELY "IMAGINED" EXPERIENCES THAT CAN BE DIF-  
   FERENTIATED FROM "TRUE" DELUSIONS OR HALLUCINATIONS BY THEIR  
   SIMPLICITY AND TRANSIENCE).  
   (Delusion/Hallucination:  
   (Frequency:  
   (Severity:  

100. S.13 THE PATIENT HAS REGRESSIVELY DEVELOPED "QUASI" DELUSIONS OR  
    HALLUCINATIONS DURING THE COURSE OF PSYCHOTHERAPY OR PSYCHI-  
    ATRIC HOSPITALIZATION.  
    (Delusion/Hallucination:  
    (Frequency:  
    (Severity:  

101. ... had any periods when you felt extremely energetic and confident  
    as well as high or elated for no good reason? Did you sleep a lot  
    less than usual or do any thing impulsive that got you into trouble?  
    (Manic Episodes) (2,1,0)
102. ... often been told that your speech is very difficult to follow or that it's almost impossible to understand what you're trying to say? (Judge whether the patient has exhibited psychotic speech. Observations made during the interview should also be used in making this judgment.) (Psychotic Speech) (2,1,0)

SECTION SCORE: ___

Cognition Scaled Section Score: 2 if the Section Score is 4 or more (2 each from S.9 and S.10)
1 if the Section Score is 2 or 3, or any other combination of 4 or more
0 if the Section Score is 1 or less, or if the patient has had "true" psychotic experiences or a full-blown manic episode

103. SCALED SECTION SCORE: ___

IV. IMPULSE ACTION PATTERNS

This section pertains to patterns of acting out. Include only those behavioral episodes that are attributable to the patient's poor impulse control or lack of foresight. For all items except Sexual Orientation, which doesn't constitute an impulse action pattern, the following is applicable: 2=definite pathological pattern, 1=probable pathological pattern, 0=no pathological pattern.

Score except where noted: 2=3/2 yrs
1=2/2 yrs
0=1/2 yrs

During the past two years, have you ...

Substance Abuse/Dependence

104. ... used alcohol at all? What's your drinking been like? (Alcohol Abuse) (2=definite abuse, 1=probable abuse, 0=no abuse)
105. ... had to drink more than you used to to get high or felt really sick if you've cut down or stopped drinking? (Alcohol Dependence) (2=definite dependence, 1=probable dependence, 0=no dependence)

106. ... used any prescription or street drugs? What's your drug use been like? (Drug Abuse) (2=definite abuse, 1=probable abuse, 0=no abuse)

107. ... had to use more (APPLICABLE DRUG OR DRUGS) than you used to to get the desired effect or felt really sick if you've cut down or stopped using it (them)? (Drug Dependence) (2=definite dependence, 1=probable dependence, 0=no dependence)

108. S.14 THE PATIENT HAS HAD A PATTERN OF SUBSTANCE ABUSE OR DEPENDENCE. (Substance Disorder: __________________________) (Frequency: __________________________)

Sexual Deviance

109. ... been sexually attracted to men or to women? (Sexual Orientation) (2=primarily heterosexual, 1= bisexual, 0=primarily homosexual)

110. ... had sexual relations with anyone of the same sex? (Homosexuality) (2,1,0)

111. ... impulsively gotten sexually involved with anyone or had a brief affair with anyone who you didn't know very well? (Promiscuity) (2,1,0)

112. ... engaged in any unusual sexual practices (e.g., enjoyed being humiliated or hurt while having sex)? (Paraphilias) (2,1,0)

113. ... had sex with any relatives or family members other than a spouse? (Incest) (2,1,0)

114. S.15 THE PATIENT HAS HAD A PATTERN OF SEXUAL DEVIANCE (I.E., HOMOSEXUAL EXPERIENCES, PROMISCUOUS RELATIONSHIPS, OR PARAPHILIC OR INCESTUOUS EPISODES). (Sexual Deviance: __________________________) (Frequency: __________________________)
Self-mutilation

115. ... deliberately hurt yourself without intending to commit suicide? (Self-mutilation) (2=2/2 yrs, 1=1/2 yrs, 0=none/2 yrs)

116. S.16 THE PATIENT HAS HAD A PATTERN OF MUTILATING HIMSELF (E.G., WRIST SLASHING, BURNING, OR HEAD BANGING). (Mutilative Effort: ________________________________________) (Frequency: ________________________________________) (Stated Reason: ________________________________________)

Suicidal Efforts

117. ... threatened to kill yourself? (Suicide Threats) (2=2/2 yrs, 1=1/2 yrs, 0=none/2 yrs)

118. ... made any suicide attempts, however minor? (Suicide Gestures/Attempts) (2=2/2 yrs, 1=1/2 yrs, 0=none/2 yrs)

119. S.17 THE PATIENT HAS HAD A PATTERN OF MANIPULATIVE SUICIDE THREATS, GESTURES, OR ATTEMPTS (I.E., THE SUICIDAL EFFORTS WERE PRIMARILY DESIGNED TO EFFECT A "SAVING" RESPONSE). (WRIST SLASHING MAY HAVE BEEN THE METHOD THREATENED OR USED.) (Suicidal Effort: ________________________________________) (Frequency: ________________________________________) (Stated Reason: ________________________________________)

Other Impulsive Patterns

120. ... accidentally taken any overdoses? (Accidental Overdosing) (2,1,0)

121. ... had any personal or household accidents? (Accident Proneness) (2,1,0)

122. ... gone on any eating binges? (Compulsive Overeating) (2,1,0)

123. Spending sprees? (Compulsive Spending) (2,1,0)

124. Gambling sprees? (Compulsive Gambling) (2,1,0)

125. ... lost your temper and told anyone off or shouted, yelled, or screamed at anyone? (Verbal Temper Displays) (2,1,0)
126. ... been in any physical fights? (Physical Fights) (2, 1, 0)

127. ... threatened to hurt anyone? (Threatened Physical Assaults/Abuse) (2, 1, 0)

128. ... shoved, slapped, or punched anyone, or been physically violent with anyone in another way? (Physical Assaults/Abuse) (2, 1, 0)

129. ... deliberately damaged, broken, or destroyed anything? (Property Damage) (2, 1, 0)

130. ... driven far too fast or while you were drunk or high on drugs? (Reckless Driving) (2, 1, 0)

131. ... run away or escaped from any place? (Running Away) (2, 1, 0)

132. ... done anything that's against the law or committed any crimes? (Antisocial Actions) (2, 1, 0)

133. S.18 THE PATIENT HAS HAD ANOTHER PATTERN OF IMPULSIVE BEHAVIOR (E.G., COMPULSIVE OVEREATING, VERBAL TEMPER DISPLAYS, OR RECKLESS DRIVING).
   (Impulsive Behavior: ________________________)
   (Frequency: ________________________)

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SECTIONS SCORE: ______

Impulsive Action Patterns
Scaled Section Score: 2 if the Section Score is 6 or more
                      1 if the Section Score is 3-5
                      0 if the Section is 2 or less

134. SCALED SECTION SCORE: ______
V. INTERPERSONAL RELATIONSHIPS

During the past two years, have you ...

Intolerance of Aloneness

135. ... voluntarily spent most of your time with other people? (2,1,0)
136. ... felt a need to be around people most of the time? (2,1,0)
137. ... tried to avoid spending more than brief periods of time alone? (2,1,0)
138. ... had times when you went to great lengths to be with other people? (2,1,0)
139. ... tended to feel depressed when you're alone? (2,1,0)
140. Upset or troubled in another way? What way? (Other Dysphoric Affect: __________________________) (2,1,0)
141. S.19 THE PATIENT HAS TYPICALLY CHOSEN TO SPEND MOST OF HIS TIME WITH OTHER PEOPLE, TRIED TO AVOID BEING ALONE, OR FELT DYSPHORIC WHEN ALONE.

Counterdependency

142. ... often tried to help or take care of other people or animals? (2,1,0)
143. ... found doing this distressing in some way or actually disliked it? (2,1,0)
144. ... wished that you had someone who would help or take care of you? (2,1,0)
145. ... had a hard time asking for or accepting help or care from others? (2,1,0)
146. ... actually resisted it? Even if you needed it? (2,1,0)

147. S.20 THE PATIENT HAS BEEN STRONGLY COUNTERDEPENDENT OR SERIOUSLY CONFLICTED ABOUT GIVING AND RECEIVING CARE.

Unstable Close Relationships

148. ... had any close relationships? How many? Which one was most important to you? (Most Important Relationship: ___________ ) (2=≥4/2 yrs, 1=2-3/2 yrs, 0=≤1/2 yrs)

149. Have these relationships tended to be intense? (2,1,0)

150. Brief? (2,1,0)

151. Troubled by frequent arguments? (2,1,0)

152. Numerous breakups? (2,1,0)

153. S.21 THE PATIENT HAS TENDED TO HAVE INTENSE, UNSTABLE CLOSE RELATIONSHIPS.

Recurrent Problems in Close Relationships

154. ... tended, in close relationships, to ignore people's faults and see only their good traits? Think of them as unusually good or caring? Exceptionally important or powerful? Indestructible or maybe even perfect? (Idealization: the patient has repeatedly exaggerated the strengths and minimized the weaknesses of others) (2,1,0)

155. Feel very dependent on others or need a lot of emotional support or actual help in order to function? (Dependency: the patient has repeatedly been overly dependent on others) (2,1,0)

156. Let other people force you to do things that you don't want to or treat you cruelly? Victimize or abuse you? (Masochism: the patient has repeatedly allowed others to coerce or hurt him) (2,1,0)
157. S.22 THE PATIENT HAS HAD RECURRENT PROBLEMS WITH DEPENDENCY OR MASOCHISM IN CLOSE RELATIONSHIPS.

158. Ignore people's good traits and see only their faults? Think of them as mean or uncaring? Weak or incompetent? Bad or maybe even worthless? (Devaluation: the patient has repeatedly exaggerated the weaknesses and minimized the strengths of others) (2,1,0)

159. Try to get others to do what you want them to without actually asking or telling what to do (e.g., by using threats, complaining of physical ailments, or throwing temper tantrums)? (Manipulation: the patient has repeatedly used indirect means to get others to do his bidding) (2,1,0)

160. Try to force others to do things that they don't want to or treat them cruelly? Been told that you're bossy or mean? (Sadism: the patient has repeatedly tried to coerce or hurt others) (2,1,0)

161. S.23 THE PATIENT HAS HAD RECURRENT PROBLEMS WITH DEVALUATION, MANIPULATION, OR SADISM IN CLOSE RELATIONSHIPS.

162. Ask people for things that they couldn't or shouldn't give you? (Demandingness: the patient has repeatedly made inappropriate requests) (2,1,0)

163. Act as though you had a special right to things or that people owed you things? (Entitlement: the patient has repeatedly exhibited unrealistic expectations) (2,1,0)

164. Feel good about people one day and bad about them the next or have negative feelings toward those you're no longer involved with? (Marked Shifts of Attitude: the patient has repeatedly changed his opinion of others) (2,1,0)

165. S.24 THE PATIENT HAS HAD RECURRENT PROBLEMS WITH DEMANDINGNESS OR ENTITLEMENT IN CLOSE RELATIONSHIPS.

Troubled Psychiatric Relationships

166. ... been the focus of any staff conflicts or problems on an inpatient unit? (Judge whether the patient has been the focus of a notable staff countertransference problem. Therapist's report or chart material should also be used, when available, in making this judgment.) (2,1,0)
167. ... been told by a therapist that you're difficult to treat or that you might do better work with someone else? Had a therapist actually refuse to continue to see you because of your behavior? (Judge whether the patient has been the focus of a notable therapist countertransference problem. Therapist's report or chart material should also be used, when available, in making this judgment.) (2,1,0)

168. ... developed a "special" relationship with an inpatient staff member? (2,1,0)

169. A therapist? (2,1,0)

170. S.25 THE PATIENT HAS BEEN THE FOCUS OF A NOTABLE COUNTERTRANSFERENCE PROBLEM ON AN INPATIENT UNIT OR IN PSYCHOTHERAPY OR FORMED A "SPECIAL" RELATIONSHIP WITH A MENTAL HEALTH PROFESSIONAL. (2,1,0)

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Interpersonal Relationships

Scaled Section Score: 2 if the Section Score is 6 or more
1 if the Section Score is 3-5
0 if the Section Score is 2 or less

171. SCALED SECTION SCORE: ___
CONCLUSIONS

1. Approximate Length of Interview: 1. 30 Minutes  
   2. 45 Minutes  
   3. 60 Minutes  
   4. 75 Minutes  
   5. 90 Minutes

2. DIB Score: 0-10

3. Diagnostic Assessment: 1. Borderline Personality Disorder  
   2. Other DSM-III Disorder  
   (Other DSM-III Disorder: ______________________________)

4. Degree of Certainty: 1. Uncertain  
   2. Somewhat Certain  
   3. Moderately Certain  
   4. Very Certain

5. Agreement with Clinical Diagnosis: 1. Yes 2. No  
   (Reasons for Disagreement: ______________________________
   ______________________________
   ______________________________
   ______________________________)

APPENDIX C

The Borderline Diagnosis - Retrospective

(GUND-R)
BORDERLINE DIAGNOSIS - RETROSPECTIVE (BORDER-R)

(Adapted from the Diagnostic Interview for Borderline Patients)

I. Social adaptation (2 year framework)
1. School work achievement: lack of stability in work or at school during the past 2 years
2. Special abilities/tauent: areas or periods of special achievement effectiveness
3. Social activities: active social life involving groups of people
4. Appearance/manners: generally appears appropriate and conventional in a group of socioeconomic peers

Section Total

II. Impulse/action patterns (2 year framework)
5. Self-mutilation: slashed his/her wrist or otherwise mutilated self
6. Manipulative suicide: manipulative suicide threat or effort (any suicide attempt or gestures made than someone probably would know of the effort, i.e., designed to affect a swing response: can include wrist slashing)
7. Drug abuse: pattern of serious drug or alcohol abuse
8. Sexual deviance: pattern of promiscuity, homosexuality, or repetitive sexually deviant practices
9. Antisocial or impulsive pattern not included above (e.g., runaway, assaults, trouble with the law)

Section Total

III. Affects (3 month framework)
10. Depression: appears depressed or reports recent or chronic
11. Hostility: angry, hot tempered, or sarcastic
12. Demanding/entitled
13. Dysphoria/anhedonia: complain
14. Flat or elated affect

Section Total

(If section total 2, if 3-5, score 1; if 0-2, score 0) Scaled Section Total

(If section total 2, if 3-5, score 1; if 0-2, score 0) Scaled Section Total

(If section total 2, if 3-5, score 1; if 0-2, score 0) Scaled Section Total

2 = Yes
1 = Probably
0 = No
IV. Psychosis* (3 month framework, except as noted)
15. Derealization: things are unreal, changing shape, separated by window 2 1 o
16. Depersonalization: feels unreal, outside self 2 1 o
17. Depressive: drug-free, brief psychotic depressed experiences 2 1 o
18. Paranoid: drug-free, brief paranoid experiences 2 1 o
19. Drug-induced: ever had psychotic experiences on marijuana or alcohol or persisting psychotic 2 1 o
delusions, or grandiose delusions, or bizarre delusions
20. Hallucinations/bizarre, nihilistic, grandiose delusions*: drug free hallucinations, or nihilistic 2 1 o
delusions, or grandiose delusions, or bizarre delusions
21. Mania/widespread delusions*a, b: ever had manic episodes or periods of persistent widespread 2 -2.1 o
delusions or hallucinationsb
22. Past therapy regressions*: ever had transient psychotic experiences that developed in psycho 2 1 o
therapy or a clear behavioral regression after hospitalizationb

Section Total

(If section total ≥ 4, score 2; if 2-3, score 1; 0-1, score 0) Scaled Section Total [2 1 0]

* If there are psychotic experiences which are well-organized, stable
enduring, widespread, the scaled score in this section is automatically 0.

V. Interpersonal relations (2 year framework, except as noted)
23. Aloneness: almost always with people or actively avoids being alone 2 1 o
24. Isolation*: socially isolated: a "loner" -2 1 o
25. Anamnestic: actively seeks a relationship taking care of others (e.g., nurse, veterinarian 2 1 o
housekeeper) or is in active conflict about giving and receiving care
26. Instability: forms intense unstable one-to-one relationships 2 1 o
27. Devaluation/manipulation: devaluation, manipulation, and hostility recur in close relationships 2 1 o
28. Dependency/masochism: dependency and masochism recur in close relationships 2 1 o
29. Past therapy relations*: ever involved staff splitting, formed "special" relationships, or evoked 2 1 o
noteworthy countertransferance problems by a therapistb

Section Total

(If section total ≥ 6, score 2; if 3-5, score 1; 0-2, score 0) Scaled Section Total [2 1 0]

Total Score (Sum of the 5 scaled section totals) = [2 1 0], if score 7, patient probably has Borderline Personality
Disorder.

a Characteristic discriminates against the diagnosis of borderline
b Score on basis of whether patient has had these symptoms ever in past
1 Gunderson, GJ, Koll RJ, and Austin V: The Diagnostic Interview For Borderline Patients: