Birth of a Self in Adulthood

SUPPORTING LITERATURE

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THE DIAGNOSIS OF BORDERLINE

For many years the term *borderline* has been a catchword diagnosis in psychiatry and clinical psychology, describing a wide range of people who appear to be suffering from neither neurotic nor psychotic processes. There has been a flood of articles and books attempting to describe this kind of personality organization and to create a form of effective treatment (Balint 1968, Boyer and Giovacchini 1967, Chatham 1985, Giovacchini 1984, 1986, Grinker and Werble 1977, Grotstein 1981, Hedges 1983, Kemberg 1980, 1984, Masterson 1972, 1976, 1981, 1983, 1985, Masterson and Rinsley 1975, Miller 1981, Rinsley 1981, 1982, 1984, 1985, Searles 1986, Stone 1980, 1986). The existing literature is replete with controversy regarding both diagnosis and treatment. There have been countless attempts to review the literature of the borderline. It is not necessary to repeat this exhaustive task here (Chatham 1985, Hedges 1983, Masterson 1976, Rinsley 1982, Stone 1980, 1986). Instead, a few brief comments on some of the literature that has influenced the development of the ideas presented in this book will suffice.

Part of the difficulty in agreeing upon a defining set of characteristics

and a treatment plan appears to be that mental health professionals are talking about a wide range of functioning within the broad rubric *borderline,* that necessitates flexibility in treatment approaches.

Hedges (1983) speaks to the same issue:

> Borderline developmental limitations do not lend themselves to categorizations by “symptom” or “syndromes” because the array of behavioral and dynamic possibilities is literally infinite since the ways a child reacts to mothering are infinite.
>
> Reluctance [by baby] to relinquish the immediacy of the dyadic experience in favor of separation and individuation results in highly idiosyncratic developmental arrests which subsequently undergo a series of adaptive convolutions. The specific area(s) of arrested development, depending on how crucial or how pervasive they are, may have only minor consequences for future development of the child or may have massive implications for development, [pp. 134-35]

Despite these obvious complexities within the profession of psychology and psychiatry, theorists and clinicians have now generally agreed upon certain characteristics describing borderline functioning (Grinker and Werble 1977, Gunderson and Singer 1975, Kemberg 1980,1984, Masterson 1976,1981, Rinsley 1982, Stone 1986):

1. A superficially high degree of sociability coupled with difficulty being alone.

2. Unstable interpersonal relationships.

3. Instability because they see themselves and the world in terms of extremes of good and bad.

4. The predominance of anger and depression.

5. Anhedonia, or an inability to feel and enjoy pleasure.

6. A poorly developed sense of self.

7. Impaired achievement in completing the life steps of profession, marriage, and family.

8. Unusual access to creativity, although they may have difficulty organizing it.

9. Self-destructive behavior, including self-mutilation.

10. Drug and alcohol abuse.

11. Sexual promiscuity and confusion.

12. Brief psychotic episodes.

13. Primitive ecstatic experiences, such as being drunk or "high."

Additionally, some theorists have attempted to create discernible subtypes within the broader category of borderline. Experts such as Kemberg, Masterson, and Rinsley speak at workshops and conferences of "higher-level" borderline and "lower-level" borderline.

The first eight characteristics seem to fit the higher-level borderline, or persons who are functioning closer to the neurotic level. These patients are motivated to seek treatment, keep their appointments regularly, and are relatively consistent in the behavior they manifest. They are seeking out psychotherapy in increasing numbers and are achieving successful results with once- or twice-weekly outpatient treatment. The patients who have provided vignettes for this book are higher-level borderline.

A relatively high percentage of such patients demonstrate disciplined, successful, and integrated creativity in music, poetry, and writing. Creativity appears to be born out of internal conflict and the borderline’s greater access to the layer of experience where primitive thoughts and emotions reside (Balint 1968, Sass 1982). Many of these patients show “special faculties and particular ways of reacting both to internal and external milieu that make possible the expression of the creative urge” (Giovacchini 1986, p. 430).

The remaining five characteristics seem to more adequately describe the lower-level borderline, whose functioning is closer to psychotic. These patients demonstrate unpredictable behavior and often require treatment in a hospital setting. Most of the literature about the borderline is actually about the lower level borderline or hospitalized patients (Boyer and Giovacchini 1967, Giovacchini 1984, Kemberg 1984, Searles 1986, Stone 1986).

Some estimates indicate that the borderline personality represents 10 percent of the population and 25 percent of the patients in treatment (Sass 1982). Searles (1986) seems correct in suggesting that the borderline population is probably much larger:

> I have found that there is no lack of borderline psychopathology among... highly qualified and effective persons. Another way of putting it is that I know that I am far from alone, among mental health professionals, in carrying around my own share of proclivity for the use of borderline defenses, [p. xii]

THE NATURE AND ORIGIN OF THE BORDERLINE PSYCHOPATHOLOGY

There are two developmental tasks that young children should accomplish during the preoedipal period. The first is to develop a sense of separateness from significant caretakers. The second task is to develop a sense of constancy or feeling of integration and unity regarding both self and others. The literature supports the thesis within this book that the borderline patients have difficulty with these tasks because their parents' psychological needs have prevented them from developing independent and separate selves (Brown 1986, Chernin 1985, Masterson 1976, Peck 1978,1983, Rinsley 1982). Instead, the parent has, in unconscious ways, sabotaged the borderline patients' growth by threatening them with the loss of the relationship whenever they take a step away from the family. Therefore, to avoid abandonment, children remain enmeshed or symbiotically attached as an

extension of their parents and fail to develop autonomous separate selves (Masterson 1976,1981, Rinsley 1982).

As a result of this difficulty in parental relationships, borderline patients do not grow out of the primitive defense of splitting and fail to integrate the good and bad experiences of self and others. Therefore, their sense of self-identity and their perception of others tend to fluctuate from moment to moment according to their unintegrated perceptions.

Borderline patients have not achieved a stable sense of object constancy. Kaplan (1978) speaks of the necessity of object constancy for effective interpersonal relationships:

> Our emotional acceptance of the idea that we are neither saints nor demons but whole persons who are capable of ordinary human love and ordinary human hatred. By uniting our loving emotions with our emotions of anger and hatred, constancy confirms our sense of personal wholeness. ... When constancy is weak, the only way to protect the cherished parts is to split them apart and to keep them fenced off. When the good and the bad are split apart, the wholeness of the self fragments and disintegrates. And then it becomes impossible to appreciate and respect the wholeness of others, [p. 30]

Much theoretical work has centered on trying to locate a stage of development in which borderline difficulties begin, in an effort to identify a fixation point. Masterson (1976) and Rinsley (1982) believe that the problem begins very early in infancy and reaches a peak in the period of 16 to 36

months.

As Giovacchini (1986) and Chatham (1985) have argued, it is not particularly useful to declare a fixation point because parents' failure to allow the child to become a separate person starts at the beginning of the child's life and continues indefinitely until the child interrupts the process. As Chatham (1985) says,

> The therapist should avoid hunting for the "right stage" ... [because] borderline adults regularly reveal distortions that arose from more than one stage. These distortions, after all, are influenced by the previous stage. Early developmental pathologic problems are played out again in the Oedipal period, with perhaps a subsequent distorting of this process, and yet again during the second individuation process that occurs in adolescence, [p. 159]

UNDERSTANDING THE PATIENTS' PARENTS

In his best seller, *People of the Lie,* Peck (1983) recommends that psychiatry recognize a new personality disorder called *evil.* Although the word *evil* may be too pejorative and connotative of religion to be clinically useful to patients examining their parental relationships, Peck's criteria are useful in describing the parents of borderline patients:

1. Consistent destructive, scapegoating behavior, which may often be quite subtle.

2. Excessive, albeit usually covert, intolerance to criticism and other

forms of narcissistic injury.

3. Pronounced concern with a public image and self-image of respectability, contributing to a stability of life-style but also to pretentiousness and denial of hateful feelings or vengeful motives.

4. Intellectual deviousness, with increased likelihood of a mild schizophrenic-like disturbance of thinking at times of stress, [p. 129]

Peck then speaks poignantly regarding the task that the children of such parents face.

> If evil were easy to recognize, identify, and manage there would be no need for this book. But the fact of the matter is that it is the most difficult of all things with which to cope. If we, as objectively detached mature adults, have great difficulty coming to terms with evil, think what it must be like for the child living in its midst.
>
> To come to terms with evil in one's parentage is perhaps the most difficult and painful psychological task a human being can be called upon to face. Most fail and so remain its victims, [p. 130]

Brown (1986) speaks of the same kind of parenting but chooses to use the softer phrase “innocent evil” or “the unintentional thwarting of the growth and independence of the child” (p. 115). Coincidentally, in this book she uses the analogy of a broken leg with a slightly different emphasis. She describes a parent with a crippled leg threatening death if the child does not take the crippled leg and give the parent the child's healthy one. “So both

parent and child then hobble along together. Neither becomes whole” (p. 31).

A patient, Marie Cardinal (1983), in recounting her analysis speaks of the relationship with her mother from the patient’s point of view.

> What can even a willful child do in the face of an impervious, seductive, secretly crazy adult who is, furthermore, her own mother? Hide as much as possible her falcon feathers, transforming herself into a dove in order to preserve her true nature. I had played the game so early and so long that I had forgotten my appetite for competition, for victory and freedom. I had believed I was a dutiful daughter and I was a rebel. I had been one from birth. I existed There was in me an independence, a pride, a curiosity, a sense of justice and pleasure which didn’t square with the role which fell to me in the society of my family, [p. 200]

All caretakers inevitably fail their children in some respects. However, it is important to say that deficiencies in the ability to love and parent stem primarily from psychological limitations within the parent rather than from intentional malice. It is also important to note that some children come into the world with difficult personalities (Gardner 1985). Thus, “internal object relations, concerning both ‘bad’ and ‘good objects’ are generated out of the intensity of infantile passions as well as parental character pathology” (Mitchell 1981, p. 396). Therapists do better psychotherapy when we approach origins of psychological difficulty in terms of accountability without blame.

THEORETICAL FRAMES OF REFERENCE

Object Relations Theory

The object relations theory focuses on the earliest stage of life, when children acquire an awareness of the difference between the self and others in their external world and achieve a basic sense of object constancy. The ideas presented in this book are more closely related to this theory than to any other.

Similar conclusions reached separately by Masterson and Rinsley and first published in 1975 concerning the role of mothers in the psychological development of their children seem to explain the tendency of patients to sabotage repeatedly their own steps forward. The most valuable part of Rinsley and Masterson's approach encompasses their explanation of mothers' need to reward for regression and threaten abandonment for growth, and their children's resulting abandonment depression (Masterson 1976, Rinsley 1982). Rinsley (1984) describes the "push-pull" conflict:

> What is discovered in the case of the borderline personality is a maternal injunction to the effect that to grow up is to face the calamitous loss or withdrawal of maternal supplies, coupled with the related injunction that to avoid that calamity, the child must remain dependent, inadequate, symbiotic-the depersonifying "push-pull" tie that binds. [p. 5-6]

In terms of the Masterson-Rinsley approach, I have developed my own vocabulary of *commands* and *permissions* that details the specific ways in which parental sabotage is carried out and encompasses both parental

rewarding and abandoning behavior.

Masterson (1983) advises confrontation as the primary intervention for borderline patients whenever they are unable to do the psychotherapy work themselves. This intervention avoids rescuing patients who are already used to having their parents do for them. This advice to therapists seems sound but occasionally limiting, if the total re-parenting needs of patients of this kind are considered. Sometimes patients stop the therapeutic work for reasons other than a wish to be rescued. Overuse of confrontation can lead to an hour that lacks richness and focus (Masterson 1983). Contributions from other theorists, explained in the following sections, provide a wider range of options in treating borderline patients.

The work of Bowlby (1969,1973,1980) explains the affect and behavior that accompanies separation and loss. Kaplan (1978), Kemberg (1972), Mahler (1974, 1975), and Winnicott (1965) provide an understanding of the infants' normal developmental process. Gould (1978), Sheehy (1976, 1981), and Vaillant (1977) shed light on the stages of development that borderline patients are missing. My creation of the permissions represents a condensation of this knowledge.

Family Research and Therapy

There is a considerable body of research on family dynamics, family

therapy, and the etiology of schizophrenia that has been helpful and validating in the conceptualization of this book (Nichols 1984). In recent years object relations theorists and family therapists have been sharing overlapping concepts (Slipp 1984).

Bateson and colleagues (1956) introduced the concept of the *double-bind.* In this situation patients have a relationship with a significant other where a response is mandatory and escape is not possible. They receive two contradictory but related messages, usually at two different levels in a subtle manner in which it is difficult to realize the inconsistency. A double-bind, not to be confused with simple contradiction, has six characteristics:

1. Two or more persons are involved in an important relationship.

2. The relationship is a repeated experience.

3. A primary negative injunction is given.

4. A second injunction, often nonverbal, is given that conflicts with the first, also enforced by punishment.

5. A third injunction is given that demands a response and prohibits escape (necessary part of the bind).

6. Once the victim is conditioned, any part of the double-bind is enough to evoke rage or panic.

In the case examples within this book, the permissions and commands are delivered simultaneously as contradictory injunctions with many of the elements of the double-bind.

Two other concepts come from the work of Wynne's study of schizophrenic families (Wynne et al. 1958). He introduced the concept of *pseudomutuality,* or the family facade that gives the impression that family members have good relationships. They present an image of fitting together so uniformly that there is no room for separate identities or differences of opinion. Their pseudomutuality keeps conflicts and intimacy from emerging. The second of Wynne's concepts is that of the *rubber fence.* The rubber fence is employed to keep family members from gaining separateness. It is an invisible barrier that precludes any meaningful contact outside the family. It may be stretched to allow such activities as going to school or work, but it pulls back hard if the involvement goes too far. The members of the family most in need of outside help are the ones most restricted. Bizarre behavior on the part of patients may be the only way to get around these restrictions, but such behavior evokes total rejection by the family so that pseudomutuality can be restored.

These two concepts are similar to the myth of self-sufficiency, the myth of perfection, and mother commands 1,2,3, 8,9, and 10 set forth in preceding chapters in this book. However, since I was not acquainted with Wynne's

concepts until after I created the commands, permissions, and myths, my work may be regarded as an independent corroboration.

A fourth concept is Lidz's *marital skew* (1973), in which there is serious psychopathology in one marital partner who dominates the other. This is the most frequent manner in which patients' parents accommodate each others psychological needs.

Although Lidz has written primarily about schizophrenia, the same but less severe family dynamics seem to create the borderline condition. As Lidz has suggested, both schizophrenia and borderline disorders appear to originate in the interpersonal relationships within the family. The pattern of psychopathological interaction can be defined, and improvements within the family can be satisfactorily made. His definition of parental sabotage is similar to that of Rinsley (1982,1984) and Masterson (1976).

Transactional Analysis

Like Berne (1961,1974), I like to draw from fictional and nonfictional literature as one way of understanding human interaction. I like to speak in modem, updated, simple terms understandable to both patients and therapists. Berne speaks about the broad "scripts" for life that children receive from their parents by the age of 6, whereas I speak of many different parental messages. Both of us hold an optimistic view that patients can

actively change their situation. Berne writes with a sense of humor and with a gimmickry that is not present in this book, however. On the contrary, some of the commands evoke a quiet and serious mood in many people.

Psychoanalytic and Psychodynamic Theory

I am indebted to Kaiser’s book *Effective Psychotherapy* (1965). His chapter entitled “Emergency” highlights the valuable and respectful interchange of learning between patients and therapists. Kaiser’s book provoked my early thinking regarding the issues of inappropriate fusion, separateness, aloneness, and responsibility. He defines the patient’s fundamental problem as the *universal symptom:* the attempt to achieve the delusion of fusion (to incorporate him- or herself into another person and lose one’s own personality, or to incorporate and destroy the other person’s personality). Kaiser (1965) defines the *universal conflict* as stemming from the reality of separateness and aloneness.

> Closeness as it is accessible for an adult illuminates more than anything else could the unbridgeable gap between two individuals and underlies the fact that nobody can get rid of the full responsibility for his own words and actions, [p. xix]

He sees therapy as “an attitude on the part of the therapist which emanates naturally from his interest in making possible a relationship where the equality and the autonomy of the patient are respected" (Kaiser 1965, p.

xvi).

My relationships with patients have also been influenced by the work of Sullivan (1956) and Chapman (1978). His approach to psychotherapy is based on observable human relationships, with the sole purpose of psychotherapy being to help patients to become aware of interpersonal relationships and their concomitant feelings and thoughts. This is accomplished by dialogues in which patients and therapists actively work together, speaking without psychological jargon. Sullivan's concept of *parataxic distortion* appears to be a broader and therefore more effective concept for borderline patients than Freud's concept of transference. Parataxic distortion is not just the reliving of a past relationship within the therapeutic relationship; it is the "repeating of a pattern of feeling and behavior developed gradually during the formative years" (Chapman 1978, p. 116).

In addition, the works of Angyal (1965), Greban (1984), Miller (1984), and Taft (1962) have encouraged me to provide a real relationship for patients in addition to the working alliance.

Short-term Therapy

My study and teaching of short-term therapy techniques (Davanloo 1978, Mann 1973, Small 1979, Wolberg 1980) has influenced me to

consolidate a central focus for borderline patients. The short-term therapy model highlights and actively works out the central issue. This model forces therapists to consider the ways in which therapists and patients can interact with each other around issues of dependency, therapeutic ritual, and laziness. The short-term therapy and life stages are both finite, highlighting the need to provide help as speedily as possible to borderline patients, who have already lost so much time in the service of their parents.

The short-term therapy model sanctions giving advice for the purpose of expanding patients' range of possible choices once the resistance and the historical material have been worked through.

TREATMENT CONSIDERATIONS

Mental health professionals have recommended a wide range of treatment options:

1. No treatment because borderline patients are untreatable, certainly unsuitable for psychoanalysis.

2. Medication for depression and variable behavior.

3. Hospitalization to curb the self-destructive behavior of the lower-level borderline (Masterson 1972, Rinsley 1982).

4. Supportive therapy (Masterson 1976,1981).

5. Long-term intensive treatment (Giovacchini 1984, Masterson 1972).

6. Once- to twice-weekly out-patient confrontational treatment (Masterson 1972).

7. Short-term focused treatment (Davanloo 1978, Mann 1973, Small 1979, Wolberg 1980).

8. Individual therapy in conjunction with family therapy (Lidz 1973).

Higher-level borderline patients can definitely benefit from a once- to twice-weekly time-limited psychotherapy of one to two years' work with a clearly understood focus on commands, permissions, myths, and general knowledge concerning separation-individuation issues. In addition, successful therapy requires that therapists hold two basic assumptions:

1. It is the mental health professionals' responsibility to provide a supportive response to growth to replace the inadequacies of parenting at various developmental sub-phases. Some basic form of real, honest, direct relationship is required that has the components of re-parenting.

2. Patients are the only ones to assume responsibility for their present limitations and future plans unless they are acting dangerously toward themselves or others. Therapists must always respect and expect patients to take on this responsibility. This attitude of respect is one of the cornerstones supporting growth and creates a reality around

which patients' behavior can be examined, evaluated, confronted, and supported (Masterson 1972,1976).

THE BORDERLINE DILEMMA IN LITERATURE AND THE ARTS

Issues of separation and individuation are now appearing regularly in popular literature, magazines (Sass 1982), and television, indicating the public's need for a greater understanding of separation-individuation issues.

Mr. Rogers' Neighborhood aired a fascinating presentation surrounding the issue of separation and independence for the preschool audience. A policeman in the "land of make-believe" wanted to leave the town to go away to study opera. Another character tried to prevent his departure by surrounding him with a large paper chain. The policeman breaks the chain and explains that trying to hold someone back will not enhance but only hurt the relationship. If instead he is allowed to go freely, he will return with his new talent to entertain the community from time to time. The community then expresses their sadness at his departure but allows him to leave freely.

The popular dramatization of *Brideshead Revisited* by Evelyn Waugh (1945) studies the gradual demise of an attractive young man, Sebastian, whose life was constantly directed for him by his mother to benefit her psychological needs. Lady Marchmain is a skillfully drawn character who masks her inner turmoil with iron control, unbending manipulative demands,

extreme propriety, and a total absence of love. Sebastian's most supportive companion is his teddy bear. Sebastian ends up as a drunken derelict in North Africa having achieved only a physical distance from his family.

Anne Tyler's novels, such as *Dinner at the Homesick Restaurant* (1982), are filled with characters attempting to make a separation from family. Ben Joe, in *If Morning Ever Comes,* is a young man in college who "can't seem to get anywhere, nowhere permanent" (Tyler 1964, p. 43) from a family who "were a set of square dancers coming to clap the palms of their hands to each other only their hands missed by inches and encountered nothing" (p. 20).

Ben Joe leaves college to return home for a visit to see his family. Anne Tyler writes about his call to his mother to ask permission to return home, and describes a beautiful example of his lack of object constancy.

> Ben Joe waited, frowning into the receiver, twining the coils of the telephone cord around his index finger. He tried desperately to picture what she looked like right now, but all he came up with was her hair, dust-colored with the curls at the side of her face pressed flat by the receiver. That was no help. Give him anything-eyes, mouth, just a stretch of cheek, even-and he could tell something, but not hair, for goodness' sake. He tried again, [p. 17]

Superficially, his mother frowns upon his need to return home, but Ben Joe also understands her nonverbal underlying communication rewarding his dependency.

> Ben Joe shrugged and pulled his pillow up behind him so that he could sit against it. The sheets smelled crisp and newly ironed; his mother had smoothed them tight on the bed herself and turned the covers down for him, and he could hold that thought securely in his mind even when she scolded him for returning. You had to be a sort of detective with his mother; you had to search out the fresh-made bed, the flowers on the bureau, and the dinner table laid matter-of-factly with your favorite supper, and then you forgot her crisp manners. Ben Joe was still watching mother with those detective eyes even though he was a grown man and should have stopped bothering, [p. 54]

Finally, the self-help literature is also aiding people with borderline problems. *August* (Rossner 1983), *My Mother, My Self* (Friday 1977), and *Mommie Dearest* (Crawford 1978) are best sellers. The popular *Women Who Love Too Much* by Norwood (1985) describes fifteen characteristics of women who stay too long in dysfunctional relationships. Eight of these examples are characteristic of the patients described in this book.

1. Having received little real nurturing yourself, you try to fill this unmet need vicariously by becoming a care-giver, especially to men who appear in some way needy.

2. Because you were never able to change your parent(s) into the warm, loving caretakers) you longed for, you respond deeply to the familiar type of emotionally unavailable man whom you can try to change, through your love.

3. Terrified of abandonment, you will do anything to keep the relationship from dissolving.

4. Accustomed to lack of love in personal relationships, you are

willing to wait, hope, and try harder to please.

5. You are willing to take far more than 50 percent of the responsibility, guilt, and blame in the relationship.

6. Your self-esteem is critically low, and deep inside you do not believe you deserve to be happy. Rather, you believe you must earn the right to enjoy life.

7. By being drawn to people with problems that need fixing or by being enmeshed in situations that are chaotic, uncertain, and emotionally painful, you avoid focusing on your responsibility to yourself.

8. You are not attracted to men who are land, stable, reliable, and interested in you. You find such “nice” men boring. [Norwood 1985, pp. 10-11]

I Only Want What’s Best for You by Brown (1986) speaks clearly to parents about not using their children to solve their emotional problems, and Halpern’s *Cutting Loose* (1976) and *How to Break Your Addiction to a Person* (1982) are self-help guides for adults about becoming independent both from their parents and from dysfunctional love relationships. Lerner (1985) addresses ways in which women can use anger to effect a separation from the behavioral problems of significant others.

Public Television’s *Masterpiece Theatre* aired D. H. Lawrence’s *Sons and Lovers,* originally written in 1913. The story of Paul Morel’s strong tie to his

mother is said to parallel Lawrence's own experience. The last page of the novel details Morel's confusion yet determination to separate psychologically from his dead mother. He had just left his lover.

> There was no Time, only Space. Who could say that his mother had lived or did not live? She had been in one place, and was in another, that was all. And his soul could not leave her, wherever she was. Now she had gone abroad into the night, and he was with her still. They were together. But yet there was his body, his chest, that leaned against the stile, his hands on the wooden bar. They seemed something. Where was he? ... She was the only thing that held him up, himself, amid all this. And she was gone, intermingled herself. He wanted her to touch him, have him alongside with her.
>
> But no, he would not give in. Turning sharply, he walked towards the city's phosphorescence. His fists were shut, his mouth set fast. He would not take that direction, to the darkness, to follow her. He walked towards the faintly humming, glowing town, quickly, [p. 420]

The ending leaves one feeling sad because Morel, despite his determination, did not have the necessary understanding and working-through of his emotions to break away.

ADDITIONAL WAYS TO STUDY THE BORDERLINE PATIENT

Theorists and clinicians are often guilty of speaking about the borderline population in impersonal, theoretical, pejorative, condescending, and overly dramatic terms. Perhaps this is a way of releasing feelings about a too wide continuum of patients who have been baffling, variable, and

frustrating to treat because there is not a sufficient frame of reference from which to respond to them (Johnson 1985, Reiser and Levenson 1984).

For a time, during my ongoing study of the borderline patient, I decided to stop reading and just listen to my patients and record and study what they told me. Out of this experience came a clear frame of reference-the subject of this book-from which to respond to their dialogue with me. This respectful stance with them, not so surprisingly, aided the psychotherapy process.

It is admittedly difficult to make valid inferences about childhood from adult behavior. Since it is not possible to go back and research the childhood of adult patients, it is necessary to listen, share, and learn from material contributed by patients themselves (with, of course, the patients' permission). The works of Brown (1986), Cardinal (1983), Lindner (1955), Norwood (1985), and Yalom and Elkin (1974) have provided valuable information from the patients' perspective to therapists' accumulated knowledge.

We have preferred to write about the borderline condition from an adult perspective. However, there are borderline children currently seeking therapy with separation and individuation problems. Gardner (1985) in *Separation Anxiety Disorder* writes about school-phobic children. His description of the parents and the psychodynamics correlates very closely

with the material in this book. The children and their families currently seeking therapy will become a rich source of additional information for therapists' clinical understanding.

THE SOCIETAL CONTRIBUTION TO BORDERLINE PSYCHOPATHOLOGY

To understand the borderline dilemma, it seems necessary to consider societal changes, especially for women, as a contributing factor in the development of borderline pathology. Authors of articles in popular magazines speculate about whether the lack of a nuclear family or the greater number of professional choices for women are contributing factors in the borderline problem (Sass 1982).

Many patients currently in treatment have parents who reached maturity during the Second World War. The men went off to fight leaving the women as single parents and as occupants of the jobs that the men vacated. Many women were suddenly presented with work opportunities previously denied them. They thrived under these new, temporary circumstances and came away from the experience with a new sense of their "professional" definition. At the same time, psychologists began articulating early developmental stages, the developmental aspects of intelligence, and the importance of mothers' staying at home. Society designed more organized ways for mothers to be involved with their children. Those who continued in,

or returned to, full-time homemaking may have wished that their “career” as parents could last longer. They were not ready to retire after eighteen to twenty years, especially when jobs for women were not yet plentiful. Perhaps some mothers vicariously lived through their children and unconsciously found ways to keep their children dependent for a longer period of time. Many patients speak sympathetically of intelligent mothers who never got to do what they really wanted in terms of a career.

In the 1980s, many young women have established a professional career before starting their families. They have been given the chance to experience mastery and build their own sense of identity in a way that is separate from the career of parenting their children. It is therefore less painful for working mothers to have their children leave home because their careers and identities as professionals will continue.

Some of the children of the eighties have, and will, become “latch-key kids,” growing up with a new problem called neglect, until society learns to accommodate women with good child care on the job site, leaves of absence, and adjusted work schedules to accommodate both raising children and working. Many of these children are having to separate too early, assuming adult responsibility in caring for themselves while their parents are at work.

Glossary

Clarification: those dialogues between patients and therapists that bring the psychological phenomenon being examined into sharp focus. The significant details are highlighted and carefully separated from the extraneous material.

Entitlement: rights given at birth to decide what to do and what to share or withhold.

False self: the patient's facade of compliance and accommodation created in response to an environment that ignores the patient's needs and feelings. The patient withholds a secret real self that is unrelated to external reality (Hedges 1983).

Impingement: the obliteration of psychological and sometimes physical separation between individuals without obtaining permission.

Insight: the ability to perceive and understand a new aspect of mental functioning or behavior.

Interpretation: the therapist's verbalizing to patients in a meaningful, insightful way material previously unconscious to them (Langs 1973).

Introjection: the taking into oneself, in whole or in part, attributes from another person (Chatham 1985).

Object: a psychoanalytic term used to represent another person, animal, or important inanimate object (Chatham 1985).

Object constancy: the ability to evoke a stable, consistent memory of another person when that person is not present, irrespective of frustration or satisfaction (Masterson 1976).

Object relations theory: a theory that focuses on the earliest stages of life when children become aware of the difference between the self and the external world. This theory describes accompanying developmental tasks and also explains the difficulties that result if these tasks are incompletely accomplished.

Observing ego: the ability to stand outside oneself and look at one's own behavior.

Oedipal: a stage of childhood development that begins at about 3 years of age. After a stable differentiation of self, mother, and father has been achieved, children engage in a triangular relationship with their parents that includes love and rivalry.

Preoedipal: the period of early childhood development, ages 0 to 2, which occurs before the oedipal period. The developmental issues are the formation of constant internal memory of others and a separate sense of self.

Projective identification: fantasies of unwanted aspects of the self are deposited into another person, and then recovered in a modified version (Ogden 1979).

Reframing: the therapist's description, from a different perspective, of an event in the patient's life, providing new insight.

Separation-individuation: separation includes disengagement from mother and the creation of separate boundaries, with recognition of differences between mother and self. Individuation is ongoing achievement of a coherent and meaningful sense of self created through development of psychological, intellectual, social, and adaptive coping (Chatham 1985, Rinsley 1985).

Splitting: the holding apart of two opposite, unintegrated views of the self or another person, resulting in a view that is either all good and nurturing or all bad and frustrating. There is no integration of good and bad (Johnson 1985).

Symbiosis: an interdependent relationship between self and another in which the

energies of both partners are required for the survival of self and other (Masterson 1976).

Transference: the inappropriate transfer of problems and feelings from past relationships to present relationships (Chatham 1985).

Transitional object: a soft or cuddly object an infant holds close as a substitute for contact with mother when she is not present. A transitional object aids in the process of holding on and letting go and provides soothing qualities. It represents simultaneously an extension of self and mother (Chatham 1985).

Working through: the second phase of therapy involving the investigation of origins of anger and depression through transference, dreams, fantasies, and free association. Patients satisfactorily relate elements of past and present relationships. As a result, patients risk giving up old behaviors no longer needed in order to adopt new behaviors.

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