

## **Do You Know Someone Like This: The Borderline Personality Disorder**

*by Joel Bruce Douglas*

It is common to joke that someone has a personality disorder. But personality disorders are no joking matter. Try having a close relationship with someone with a personality disorder—particularly of a narcissistic or borderline variety—and it is likely you will be in for a roller coaster ride...and worse, you will be blamed for it!

The Diagnostic and Statistical Manual (DSM) catalogues and defines psychopathology. The first two axes on its five-axis diagnostic formulation consists of Axis I, for mental disorders such as anxiety, depression, spectrum disorders of childhood, etc., and Axis II for personality disorders (PD). Often mental health care clinicians in completing their DSM list of differential diagnoses will “defer” or simply leave an Axis II diagnostic impression blank, irrespective of whether a personality disorder exists. However, those therapists who under Axis II simply identify borderline, histrionic or narcissistic *traits*—in contrast to a full blown borderline, histrionic or narcissistic personality *disorder*—ain’t necessarily telling the truth, the whole truth and nothing but the truth, or more worrisome, may not fully appreciate precisely the dynamics of the patient they have. The reason many psychotherapists are loathe to list Axis II personality disorders is 1) the condition is often directly associated, if not the cause of the Axis I symptomatology; 2) PDs—though clearly a disease—are usually not compensable by the patient’s insurance; 3) the label is pejorative, speaking volumes about the individual; and 4) someone so branded with this diagnosis bears a social stigma, however well-deserved. Indeed, though many shudder over the more commonly understood Axis I psychiatric diagnoses of bipolar disorder (manic depression) or schizophrenic—truly topping the worse psychiatric conditions—at least there are pills which can mediate the symptoms of bipolar disease and schizophrenia, dealing with neurotransmitters gone afoul, or even shock therapy. As bad as these conditions are, they are eminently treatable and there is reasonable hope to achieve some degree of functionality notwithstanding the import of these dreaded diseases. Not so with someone with a personality disorder.

The DSM defines a personality disorder as “an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress and impairment.” A disorder is distinguished from personality traits where the traits “are inflexible and maladaptive and cause significant functional impairment or subjective distress.”

The DSM groups the different types of personality disorders into three clusters. Fundamentally, they can be thought of as the weird, the wild and the wacky. Cluster A includes the Paranoid, Schizoid and Schizotypal Personality Disorders. “Individuals with these disorders often appear odd or eccentric,” the DSM observes. Antisocial, Borderline, Histrionic and Narcissistic Personality Disorders fall within Cluster B. “Individuals with these disorders,” it says, “often appear dramatic, emotional, or erratic.” Cluster C personality disorders consists of Avoidant, Dependent and Obsessive-Compulsive Personality Disorders, marked by individuals who “often appear anxious or fearful.”

While one can’t catch a personality disorder—it is developmental, reflecting the individual’s experiences and response patterns, mindset and peculiar ideas, thinking and behaviors arising from childhood and etched in proverbial stone by adolescence or early adulthood—one can become agitated, conflicted,

depressed and distressed when in a relationship with or simply around someone like this. It is said that you can't have a personality disorder on a deserted island. It takes someone to conflict with. Yet, even without someone to find fault or make miserable, the person with a personality disorder has enough going on to make him or herself miserable. This is especially true of the Cluster B, or "wild" category of personality disorder individuals. Unfortunately, it often takes a while into the relationship before a doctor or other person in relationship with such individual starts—if ever—to realize precisely what is going on amid the tumult. It is easy to think that there may be some rational basis for their conduct and charges, however pathognomonic that behavior is as a manifestation of their disease. Often times, these individuals present as very attractive, bright and engaging people. The same can be said of many poisonous plants, snakes and spiders.

Perhaps the most notorious PD is the borderline. A borderline personality disorder (BPD) is characterized by instability in self-image, instability in mood and instability in relationships, marked with impulsivity, usually historically traceable to early adulthood—notwithstanding the excuses and explanations the patient may give for their seeming hard luck experiences with others.

While these individuals are persistent if not needy in seeking certain relationships perceived as critical, and equally quick to idealize the object of their insatiable attention, paradoxically they are unconsciously fearful of commitment and dependence, and when not insufferably testing the relationship and their object's purported caring or love, these individuals will frantically act in ways way to avert real or imagined fear of rejection or abandonment, even if that means sabotaging the relationship themselves and devaluing their hitherto idealized object. These frantic efforts to avoid their heightened sensitivity over abandonment in the very relationship they desire may include raging (anger disproportionate to the reality of the circumstance) and impulsive acting out behavior, such as self-mutilation, suicidal threats, behavior or other attention-getting negative conduct. They also employ risky behavior, including promiscuity or sexual acting out, excessive spending, drug abuse and eating disorders, to combat their sense of profound emptiness and boredom when not in a satisfying relationship, or simply to prime an uncertain relationship or test the limits of someone's caring and love. Self-gratification is aspired through such macabre and negative ways. The term sado-masochism may be apt.

While most of these individuals with BPD diagnoses statistically tend to be women, it is believed that many men actually suffer from it as well. The reason, it is felt, their population is not more proportionately represented among the ranks of this diagnosis, is that they may be less likely to seek professional help, or they may have been written off as criminals, alcoholics, druggies. or simply suffering from an antisocial personality disorder.

Psychoanalyst Otto Kernberg is one of the pioneers in the study of this personality syndrome, which at one time was thought to reflect people suffering from borderline or marginal schizophrenia. For sure, the disorder has all the negative and obnoxious features of the other formulations—the callous recklessness, impulsivity and deceit of the antisocial personality disorder; the histrionic personality with its self-dramatization and attention-getting behavior, self-absorption and demandingness; and the self-centeredness, lack of empathy toward others, envy and delusions of grandeur and self-importance seen in someone with a narcissistic personality disorder. In describing the BPD, Dr. Kernberg discussed the borderline personality organization, thought to be the core source of not only borderline, but narcissistic and other personality disorders. This organization is characterized by immature defense mechanisms, such as splitting (either the person is all good or all bad), inability to make sense of contradictory aspects

of oneself and others, poor reality testing, etc., along with the primitive raging, a telltale marker of the primordial wound over which the patient has failed to grieve, incorporate and move beyond a fundamental narcissistic slight—one which has remained probably from infancy as an ever vigilant button of immense sensitivity and outrage over an unrequited if not insatiable baby need.

Psychoanalytically, these individuals remain stunted in infantile ideas and reasoning. This includes notions of central importance, entitlement, intolerance when needs are not met, coupled with a lack of empathy and respect for the feelings, needs, life and separateness of others. Either their baby needs were not met by their parents, the needs were jeopardized or traumatized early in their development, or as a child they were simply insatiable, insufferable and intolerant, and that created the self-fulfilling prophecy. These patients possess an infant's level of appreciation of object relations. Principles of object constancy have not been embraced or incorporated in their maturation process. Consequently, they perceive their life in relation to others as uncertain if not chaotic. In this primitive way of thinking, objects or other people are either gratifying or not, either good or bad, with no in between. They lack appreciation or tolerance to a complicated and imperfect world of grays, especially which does not dedicatedly and unconditionally focus on them and service their needs. As a result, in adulthood this infantile thinking persists, and undersurface anger over these needs unfulfilled pervades their being, expectations, thoughts, emotions, behavior and relationships—even though packaged in an adult body of, on the surface, a seemingly accomplished, articulate and rational individual.

Despite such individuals' accomplishments and facade, they are nevertheless deeply insecure. They are needy if not demanding of attention and rescuing relationships. At the same time they are ultimately fearful of abandonment and rejection, and thus they are frequently fussing, fretting and testing over issues of commitment and dependency. This frustrating and chaotic mindset influences their affect or mood, which can be hypomanic when they believe they have found the person who can save them, or agitated, angry, anxious and/or depressed when fear of dependence and rejection enter into their thinking, causing them to challenge and frequently disrupt even a healthy or stable relationship. The process is insidious and often unwittingly to the object of their attention. Indeed, BPD patients always have an excuse or explanation, and the blame is inevitably at the doorstep of the other person, who soon finds him or herself on the defensive, if not apologetic and bargaining.

Things ordinarily start off famously well for both parties in the relationship with a borderline. Again, these individuals not uncommonly present as attractive, engaging and even intelligent. These individuals will appear to have attached deeply to the major object of their attention, say a physician who reminds them of the positive attributes which existed or were wished in a parent. They feel they have found home, and the relationship becomes oceanic. They are quick to idealize the doctor with traits and values beyond that which may be objectively present. Naturally the object of this adoration and attention, say a physician or the patient's psychotherapist, is flattered. They are at risk of being manipulated, particularly if not recognizing with whom they are dealing and the pathogenesis of what will all but certainly occur. These individuals may appear depressed, bored or lonely, and long for more of the object of their attention. However, they telltalingly bristle when they sense controls are being exerted. They resent boundaries or limit setting, and exhibit extreme sensitivity to rejection even under the rubric of healthy autonomy. This is the honeymoon period, and many clinicians do not recognize the history which preexisted in their patient, or that what they are encountering and experiencing as genuine is really symptomatology of the patient's underlying disease. Despite the purported admiration, respect, idealized wonderment and avowed love

being directed at the clinician or object of their attention, under the surface is surely a yet to be released incredible anger for the very object of their attention and affection.

Phase two in the relationship happens when the patient begins to perceive frustration of their demands and expectation in the relationship, or when the patient senses the prospect of loss. This may be due to reservation or unavailability of the object, limit setting, not responding or simply saying no to attention-getting behavior amid the patient's unremitting effort to challenge or test the caring, love and commitment of their object. Even acquiescing to the patient's accusations or demands or testing is only buying time before the patient's frustration manifests. The borderline will eventually ratchet up the behavior, employing biting sarcasm, belligerent argumentation, extreme demands and uncontrolled anger (borderline rage), all calculated to manipulate, control or coerce their object to acquiescing or staying. The patient is angry, manipulative and now devaluing of the doctor or major object of his or her aspiration.

In the final level of the relationship, the borderline feels the object is absent. Not surprisingly, the patient's behavior has in fact brought on the very situation he or she feared. They panic, become impulsive and can even become psychotic—the sense of loss they experience being so profound and primitive. The once all-good, wonderful savior, now becomes the all-bad anti-Christ. This is called splitting. Borderlines are notorious for defensively and aggressively marshaling their story so as to convince and enlist others, such as subsequent treating health care providers, to buy into their tale of woe and lay blame on the object against whom they are now raging—to provoke or join in their campaign to attack, denigrate and destroy their former object of attention whom they sense rejected them. The rage (vs. normal anger or disappointment) reflects the core hurt in childhood. It is often a projection (or transference) onto the once adored doctor of the undersurface, ungrieved anger stemming from the perceived failure of the parent to meet the individual's childhood needs. The doctor represented both the idealized parent and hope the patient never had, but at this stage is seen as the bad parent who ran roughshod over his or her need for attention and unconditional love. The rage is very much like a baby tantruming when it does not get its way. This prompted Melanie Klein to analogize the rage seen in such adults as tantamount to angry baby wanting to kill the “bad mommy” for not getting what it wants. It is that borderline rage, narcissistic wound from childhood, which animates and energizes the patient's determination to now wish destruction of the object of their ire, the person they adored who did not make them number one, whom they perceived rejected and abandoned them. In that pursuit, the end justifies the means, and pseudologic fantastica along with distortion and selective memory are fair game “in love and war” when remembering and telling their story.

Unfortunately, we have seen it all too often in life. He or she who tantrums best and loudest get the undeserved attention, credibility and sympathy of well-intended, however clueless individuals trying to judge from this one-sided account what is going on. More often than not, the unsophisticated naturally concludes that for someone to be so upset, the prior treating therapist must have done something egregious, “mishandled the transference,” etc. It's far easier to side with the “victim” *qua* patient, even though in reality 1) the victim ironically is the prior treating doctor; and 2) what may be viewed as damage stemming from the prior relationship is in fact nothing more or less than symptoms of the patient's underlying disease. In addition to confusing disease for cause, the uninitiated subsequent treater will just as readily compound the problem and promote the patient's psychopathology by siding with him or her and, more importantly, missing a teaching opportunity to discuss with the patient principles of boundaries, empathy, respect and self-responsibility—the elements of mental health and mature functioning. Unfortunately, even if the prior psychotherapist was hip to the patient's disorder, confronted and

interpreted the behavior and set firm boundaries, nevertheless the common knee jerk—and absolutely wrong—reaction for most will be to assure someone like this, weeping their crocodile tears, that it is not their fault, and blame is justly placed at the doorstep of the earlier therapist who should have known better...*just as the patient thought!*