The Treatment of Female Borderlines

Edward Teitelman, Joel B. Glass, Charlotte Blyn, and Donald Jennings

Abstract

Failure to complete needed operations in the separation-individuation process during early childhood development is increasingly suspected of being a major source of borderline pathology. Building on Mahler’s descriptions of this process as an interpersonal operation between child and mother, we have directly intervened in the patient-mother relationship in a small group of adult female borderlines. All patients displayed rapid and apparently complete clearing of borderline symptoms following limited conjoint therapy. Although neuroses remained, the criteria for a borderline diagnosis were no longer met.

Treatment results with six women who had pretreatment and posttreatment psychological testing are reported. Testing confirmed clinical impressions of significant shifts in psychological defenses as well as perceptions of self and others. Fundamentals of this approach are discussed briefly, and observations regarding possible borderline pathology, mother-daughter interactions, family dynamics, and therapeutic philosophy are made. This approach appears not only to be effective but offers promise of simplifying both the role of the therapist and the therapy itself.

Our experience with six severely disturbed female patients suggests that there is a rapid and effective method to treat the borderline syndrome. Based primarily on Mahler’s (Mahler 1974; Mahler and Furer 1968) observation that separation-individuation is an interpersonal, as well as an intrapsychic, process actively involving both child and mother, we have undertaken direct renegotiation of the patient-mother relationship in brief conjoint contact. In so doing, we have allowed significant shifts in their interactions, apparently freeing the patient to proceed with separation and individuation. This approach led, through stages to be described elsewhere, to disappearance of clinical manifestations of the borderline syndrome within months of completion of the conjoint renegotiation.

All patients showed improvement in the diagnostic criteria for borderlines proposed by Gunderson and Singer (1975). All became more settled and secure in interpersonal relationships. Intense affect and impulsivity were decreased, while social adaptiveness remained. There have been no more brief psychotic experiences, and psychological testing revealed significant change. Although for a short time after conjoint treatment some sense of transient stormy interpersonal relationships remained, these stabilized with the passage of time. Beyond the criteria, and important to our formulation, all became less ambivalent toward their mothers and moved toward mutual support.

Rorschach criteria of Schafer (1965), Weiner (1968), and Goldfried, Strichler, and Weiner (1971) were used to establish a diagnosis of borderline on psychological

* A shorter version of this article was presented at the International Conference on Borderline Disorders, Topeka, Kans., March 20, 1976.

Reprint requests should be addressed to Dr. Teitelman, Cooper Street Psychiatric Group, 301 Cooper St., Camden, NJ 08102.
testing. These criteria included a combination of a color stress system, deviant tempo, low reality contact scores, perseveration, and restricted content. On retesting, none of the patients could be diagnosed borderline. Other levels of significant change in testing were noted with the four patients for whom complete pretreatment, as well as posttreatment protocols, were available. Generally, these indicated freer capacity to cope with the protocol and greater ability to organize in creative and meaningful ways, with decreased anxiety.

Although all patients remained neurotic and frequently required further treatment for later developmental or family system problems, they were no longer borderlines.

Method

All patients initially fit the diagnostic criteria of Gunderson and Singer (1975). Five were from 22 to 28 years of age; one was 40. The husbands of the five married patients were actively involved in the treatment process.

Treatment contacts since December 1973, when we undertook our new approach, have ranged from 15 to 94 hours, with most about 30 hours. Between 9 and 14 hours have been required in direct conjoint therapy, although this may have been spread over a period as long as 18 months.

These women had all attempted pseudo-autonomous character adaptations, but could not maintain these because of severe anxiety and periodic disorganization. All complained of acute feelings of emptiness and helplessness, and five required hospitalization at some point in treatment. One of the patients had been in individual psychotherapy with us (54 hours), and three more had had considerable individual contact before adequate family involvement could be secured. One had an extensive history of individual therapy elsewhere. In all cases, individual treatment resulted in a poor therapeutic response and was marked by wide fluctuations of symptoms, intense ambivalent transference reactions, and acting out, none of which were tempered by medication.

All patients had psychological testing done before conjoint contact, four by D. J. or an associate. All were retested by D. J. in October 1975. This represented a point from 1 to 17 months after the end of mother’s direct involvement. Protocols for the two who had testing done elsewhere were not available, although diagnostic findings were. We thus had two groups of patients for comparison on the basis of psychological testing—six patients for whom at least a diagnosis based on preconjoint treatment testing was available, and four patients on whom complete pretreatment and posttreatment testing protocols were available.

The testing battery used by D. J. consisted of a clinical interview, Wechsler Adult Intelligence Scale, and Rorschach Inkblot Test. The diagnosis of borderline was based on fulfillment of the Rorschach criteria of both Schafer (1965) and Weiner (1968; see also Goldfried, Strickler, and Weiner 1971). Our psychologists were ultimately aware that testing was involved in a clinical research project on borderlines, but neither of them had specific information as to the clinical approach. Patients were told that testing was part of the treatment program, and no further explanations were given. The institutional setting and the diagnostic criteria were the same throughout testing by us.

Treatment

The significant treatment involved a limited number of joint sessions with the patient and her mother, sometimes with the patient’s husband present. This contact involved no more than 14 hours of office time, frequently as weekly 2-hour therapy sessions. Interaction between family members between visits was encouraged. Most actual treatment was performed by E. T.

The patient’s mother was frequently found to be a somewhat rigid but basically caring person who often was a victim of circumstances. She had become locked into increasingly mutually frustrating interactions with her daughter. The patient was frequently suspicious of her mother’s support when expressed and resisted closeness while suffering from its lack. Contact was directed to nurturing and the development of behavioral and verbal expressions of basic trust, mutual closeness, and need. This represented clarification and amplification of elements present, but denied or lost in confusion. Our basic position was nurturing of the mother; we supported all expressions of closeness, ventilating but playing down anger. We reinforced the idea that the daughter’s difficulties were the result of circumstances for which no one was to blame. Within this context, issues of independence and dependence were addressed, but from the position that the daughter could not be comfortably independent without a
sense of the mother’s good feelings and support within her. This was now possible because they could finally bring to the uncompleted process a mutual warmth and capacity to concentrate on mechanics that had not been possible in their initial attempt or at any time since.

Once issues seemed to have been resolved enough for mother and daughter to deal with each other in new ways, the extent of further treatment contacts was based largely on the degree of patient and family interest in further exploration. Three patients left treatment shortly after the end of maternal involvement, apparently satisfied with the relief experienced. With married patients, however, further change had to occur in treatment or outside of it to adapt the marriage to the patient’s changed perceptions of herself and thus the relationship. Three patients did want further psychotherapy. Now uncomplicated by the chaos resulting from splitting, individual treatment could proceed with relative ease. Treatment was usually oriented around Oedipal issues and focused on sexual and interpersonal ambivalence with men. This was dealt with by eclectic analytically oriented psychotherapy, although conjoint treatment with spouse or group therapy was also used.

Illustrative Case

A 24-year-old woman was seen in acute depression; her mind was “racing,” and she wished to be hospitalized. The patient admitted to being “scared inside” most of her life, but said, “I let people think that I was happy-go-lucky.” Feelings of increasing disorganization, isolation, and “emptiness” had disturbed her, especially over the last 6 months. Her affect was flat. The patient displayed depersonalization, amnesia, and tension headaches. She had a stormy marital relationship. Intense ambivalence and guilt focused around a sexual contact at age 8, which had re-emerged to consciousness several months before during pastoral counseling; she now felt the minister was rejecting her in fear. Her employer was making sexual advances, stimulating her fantasies. She was fearful to share with her husband, and felt her parents did not care.

She felt her mother had shown a lack of interest in her and two older brothers by going to work when the patient was 4 years old. She idealized her father but also stated, “He’s too busy with television to care about me.” Her parents had fought a great deal, often about the maternal grandmother who lived with them. The patient was hospitalized briefly after crisis intervention treatment failed to settle her psychotic panic. She feared the mother would “swallow” her if they got too close. A history of intense prepubertal and pubertal sexual preoccupation and confusion became evident, including a “rape” at age 8 by a newsboy, whom she stated blandly, “could have been my brother.”

Initial testing revealed a verbal IQ of 92, performance IQ of 94, and full scale IQ of 93. She showed little energy in performance and required maximum supervision and instruction, responding poorly to support. Rorschach testing resulted in a diagnosis of borderline. There was much alienation and overintellectualization. The reality contact score reflected in F% was 29 and F+-% was 60. She stabilized after 8 days in the hospital; family contact began after discharge. She felt the most immediate need for closeness and validation from her father and did not want her mother to attend the therapy sessions. Several hours of therapy with the patient, father, and husband provided a history of the patient’s mother having promised to care for her own mother after the death of her father. This was discussed objectively. The patient’s father attributed his wife’s lack of closeness with her children to the burden of caring for the grandmother.

The patient’s parents pulled back at this point, and the minister came with the patient to the next session. Family patterns of denial were noted, and problems they all had with dependency were discussed. The patient overdosed several days later on a small amount of Librium and Codeine, feeling that the minister had abandoned her.

Immediately following a brief rehospitalization, she again felt, “I’ll never get better.” A family meeting focused on the patient’s anger and consequent inability to accept her mother’s love and support. A 3-hour session with the patient, mother, and husband followed, in which their resistances to closeness were explored and interpreted. These included a significant stubbornness, as well as masochistic excitement. The mother needed help not to become too guilty. After a total of 6 hours of conjoint treatment with her mother, the patient was feeling more stable. She persisted with headache and some sleep disturbance, but noted, “Mother hasn’t swallowed me.” Her mother
was less defensive and more effectively emotionally available.

During the remaining 10 sessions, the focus was on the patient's relationship with her husband and her employer. Residual anger limited the patient's capacity to use her mother as a stabilizing person. Following much turmoil, the patient had a brief affair with her employer. She told her husband, who was initially supportive, but later had a fistfight with his rival. The patient still resisted giving up old fantasies, and more working through of aspects of anger at her behavior by the therapist, mother, and husband was required before things gradually settled down. The patient and her husband dropped out of therapy after 28 hours of outpatient treatment, 5 months after initial contact.

The patient wrote a month later, indicating that she had quit work. She and her husband had been renegotiating marital roles to give her a greater feeling of self-worth. A call 5 months later (11 months after initial contact) revealed that the patient and her husband had separated for 3 months, but were now reunited. She stated, "I got myself together over a period of time."

Followup testing 17 months after initial contact revealed verbal IQ of 90, performance IQ of 115, full scale score of 101. Projective testing showed no borderline signs, although neurotic trends in the area of sexuality remained. Reality contact score F% was 60 and F+-% was 80. The patient handled testing easily, displayed appropriate energy levels, and did not resort to over-intellectualization.

Comparison of pretreatment and posttreatment testing showed a significant upward shift in performance IQ of 21 points. As verbal IQ remained essentially the same, full scale IQ improved 8 points, a significant change. Projective testing showed disappearance of borderline signs. There was a shift in shading responses in reference to form from 2FC to 3FC. In the area of color responses, testing shifted from 2C responses with poor form to 4CF or FC responses with good form, suggesting more organized and structural handling of stimuli. Total responses increased from 17 to 22. Human responses increased from 12 to 27 percent, while animal responses went from 53 to 27 percent. Color naming, present twice on pretesting, disappeared on posttesting. Reality contact scores, as represented by F%, increased from 29 to 60, and as shown by F+-%, increased from 60 to 80. The patient dealt more creatively with the testing situation and appeared better integrated, both in the testing protocol and in her clinical behavior.

Results

Patients showed clearing of Gunderson and Singer's behavioral and affective indicators of borderline state within several months of completion of brief conjoint treatment with their mothers. Symptoms have not reappeared with followup as long as 36 months. Our impressions were reinforced by the results of followup psychological testing, which indicated disappearance in all six patients of the Rorschach signs used by us as diagnostic of borderline.

Beyond this, psychological change in the four patients with complete pretreatment and posttreatment protocols could be documented in the following four areas: (1) improved performance on the WAIS; (2) significant shifts in certain Rorschach parameters; (3) change in Rorschach association content; and (4) subjective change in attitude toward aspects of the testing experience. Test-retest phenomena did not appear involved.

Intelligence testing function changes were most pronounced on performance testing, which showed universal improvement. Patients integrated and processed information with less ambivalence and confusion, and there was less deviation between verbal and performance scores on the posttreatment protocols.

Changes in the Rorschach parameters were mainly in the areas of anxiety (sharing responses FC) and emotions (color responses). There were significantly fewer color naming responses after conjoint treatment. An increase per protocol of human responses relative to animal responses was noted. Although one patient did present with fewer total responses on retesting, there was a trend toward an increase in total responses per protocol in the others. The reality contact scores (F% and F+-%) were improved in all cases, and the patients' language was richer in both quality and amount.

Less clear but still notable were references to struggles with the daughter-mother relationship in posttesting Rorschach response discussion, often with a sense of optimism. At the very least, it could be inferred that issues of separation and individuation were now more a major focus.

A change in the way patients dealt with Rorschach stimuli was also noted by the psychologist. There had been a high level of anxiety on initial testing, with a
great deal of fidgeting when patients were presented with testing demands; this was much less evident on followup. The patient seemed to accept the protocol as it was presented and tried to integrate it, putting the protocol together in a meaningful way so that she could give subjectively positive responses. However, there was a persistence of neurotic patterns. These showed primarily through the inability of the patient to display new techniques for problem solving when initial attempts proved unsuccessful. However, the application of these patterns was more consistent on posttreatment testing. The end result was greater coping capacity, as there was a lessening of submissiveness, giving up, or scatter of approaches that had appeared as part of the pretest behavior.

In those patients tested by the same psychologist before and after conjoint treatment, clinical change was also noted subjectively. The patients appeared to be more outgoing, verbalized more with the examiner, and made more requests for feedback than on the initial contact. There were also more signs of humor.

Further results include new thoughts about the treatment of borderlines. Abandonment depression, often an intense and painful phenomenon complicating individual therapy of borderlines, can be largely avoided, as the mother does not have to be accepted as an abandoning, nonloving object.

In addition, many borderlines do not desire extensive working through of all psychopathology. Although followup testing suggested that significant neurotic patterns persisted after limited conjoint treatment, the patients universally felt a degree of psychological freedom that may have been sufficient for their expectations of personal happiness. Patients remained in treatment with us from 7 to 60 hours after completion of work directly with the mother, but three left treatment within 14 hours. That pan-neurotic patients retained some of their neuroses should not be surprising. What was surprising was their relative ease in coping with residual neurotic conflict once the relationship with the mother was resolved.

After mother and daughter have established themselves in conjoint treatment, interactions between them are fairly predictable, although further resistances are frequently strong. Stubbornness on the part of both mother and daughter appears to be the prime problem, before and after conjoint contact, and can only be dealt with by appropriate patient work. The crisis seems to come at the point of sharing. When mother and daughter can become mutually emotionally supportive, the daughter seems able to make intrapsychic changes that cause disappearance of splitting as a primary mental mechanism. There is rapid clearing of the sense of helplessness as she can correct her previous impression of the mother as a primarily uninterested, absent, nonsupporting object. Clinical manifestations of the borderline syndrome clear as these central changes allow further intrapsychic and interpersonal shifts toward integration and stabilization.

Attempts were made with two male borderlines early in our work with this method, but the issue of homosexual weakness and fear of regression forced both to avoid openly asking the mother's involve-
level of function the daughters displayed, as well as our good results, but it also calls into question preconceptions about borderlines' mothers.

This is further underlined by the phenomenon of "grandmothering," which is often present. The patient's mother could show open love and holding to her grandchildren, but not to her child. In several cases, the patient's mother could relate this pattern to her own experience of being "grandmothered" and thought that even her own mother had been treated in like manner. Thus, "grandmothering" presented as a three-generational phenomenon, which was repeated possibly as often as four times over six generations.

In all of these cases, the fathers were deceased, chose not to be significantly involved, or were excluded by the women. One variation was occasionally present, in which the patient initially looked to her father for nurturing she felt could not be obtained from the mother. As in the case illustration, the fathers lost their apparently key role when the mother became obtainable. Assuming that the father should serve a role as mediator in the mother-daughter relationship—supporting his wife in letting go and at the same time helping his daughter to grow—the effective absence of fathers may be one etiological factor in psychopathology. Treatment demonstrates that outside support, especially of the mother, is frequently needed for the complicated process of separation-individuation to proceed to a degree of completion.

We have been struck by the violent and unpredictable turmoil in the patient's marital relationship that frequently occurred at some point in treatment. The women tended to have husbands who were superficially passive, in many cases almost completely uninvolved or overwhelmed. In each case, there was a significant shift in the wife's expectations for her spouse. As she came to feel differently about herself, negotiation and renegotiation of the marriage was necessary.

Using an open family therapy contract, we intervened as needed to help the husband and patient resolve emerging as well as old differences. By involving the husband as a participant and positive male figure in the patient-mother interaction, we hoped to minimize these marital difficulties and help the patient find him again on a new basis when her turmoil from early developmental issues had settled. Still, during the process, some families had to go through acting out, including separation; in two cases, divorce occurred. In the three other instances, a more stable marriage has gradually developed, frequently with a strengthening of the husband's role.

Discussion

While students of therapy have focused on splitting and narcissism as core issues in borderlines (Kernberg 1975), family theory suggests that these patients are not emotionally free or autonomous. For change to occur within the family system, the mother, who at first appears rejecting and controlling, must assume alternative behaviors. Our experience suggests that such changes may not be so difficult to achieve as has been frequently assumed.

In addition to its influence on homeostatic family systems (Jackson 1957), we see family intervention as blending with analytic concepts by appreciating the mother's pivotal role in meeting the developing emotional needs of the child as outlined in Mahler's practicing and rapprochement subphases. This is a preverbal, interpersonal operation of mother and child in the context of family and the outside world. Use of direct conjoint renegotiation of the separation-individuation process with mother and daughter is rapidly effective because it focuses economically on an essential process that is incomplete in borderline adults. Change occurs in the patient's perception of the mother, leading to a degree of object constancy and a disappearance of splitting. We consider this central to the range of clinical changes seen. The importance of the actual confrontation of the real object with the introjects from the past cannot be stressed too highly.

Indirect intervention through individual psychotherapy may be helpful and at times successful. However, integration of infantile maternal introjects exposed in the transference reaction with the real object of the therapist must contain an element of fantasy which limits its strength—for as much as the therapist can be like the mother, he cannot be the mother herself. There can always be doubt that the mother could behave as the therapist behaves, taking abuse and still being emotionally available. Likewise, recollections of warm and loving fantasies of mother lack the strength of the presence of a real interacting person and are open to conscious and unconscious doubt. It is likely that successful treatment of borderlines by individual therapy involves
some capacity of the patient and the mother to complete a parallel confrontation and testing of infantile introjects with real objects, assisted by the process between patient and therapist. By bringing such key transactions within the confines of treatment, rather than allowing them to take place beyond, we gain a control that is critical to success in many of these cases.

Beyond this, information about the mother's role in the mother-daughter relationship comes direct and not by way of the patient's perceptions, which are often distorted or emphasize one aspect of a complex character. Family resistances and actions are also more open to the therapist's notice and intervention. But perhaps most important from the therapist's point of view is that unlike regression to dependency in individual treatment, here the weight of support is borne by the natural object, mother, and its ultimate quality—once ambivalence is tempered—is totally without equal. Maintaining the ambivalence about dependency as an issue between patient and mother and not between patient and therapist also allows a degree of clarity and therapeutic effectiveness that those who have struggled with the confusion and anger of a borderline in individual treatment will find refreshing.

References


The Authors

Edward Teitelman, M.D., is Adjunct Assistant Professor of Psychiatric Nursing, Graduate School of Nursing, University of Delaware, Newark, Del. Joel Glass, M.D., is an Assistant Professor, Department of Psychiatry, University of Pennsylvania School of Medicine, Philadelphia, Pa. Charlotte Blyn, M.D., is a Clinical Instructor, Department of Psychiatry, Medical College of Pennsylvania, Philadelphia, Pa. Drs. Teitelman, Glass, and Blyn are in practice as the Cooper Street Psychiatric Group in Camden, N.J. Donald Jennings, D.Ed., is an Instructor, Department of Psychology, St. Joseph’s College Evening Division, Philadelphia, Pa.