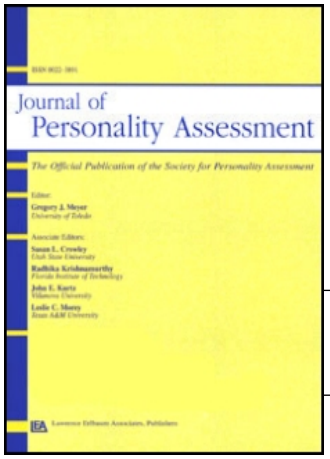

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Psychodiagnosis of Personality Structure II: Borderline Personality Organization

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The borderline conditions have been the focus of considerable debate and controversy for over 30 years. This article, second in a series of three articles focusing on Kernberg's (1975, 1984) psychostructural diagnosis of personality organization, examines Rorschach contributions to the description and diagnosis of borderline personality organization. Rorschach approaches integrating nomothetic and idiographic data are applied to borderline personality functioning and appraised in light of the Rorschach's contribution to the clarification of the controversial and poorly delineated borderline diagnosis.

Perhaps no single diagnostic category or type of patient has consumed more attention from theoreticians, diagnosticians, and therapists than the so-called "borderline" cases. Although borderline cases have been variously described in the clinical literature for over four decades (Stone, 1980), the attention focused on these demanding and perplexing cases has been intense since the early 1970s. Questions about the nature of borderline conditions—whether they represent a personality disorder (Spitzer, Endicott, & Gibbon, 1979), a stable personality configuration or syndrome (Grinker, Werble, & Drye, 1968; Gunderson & Singer, 1975), a mild form of schizophrenia (Kety, D. Rosenthal, Wender, & Schulsinger, 1968; Kety, 1985), a variant of affective disorder (Akiskal, Djenderedjian, T. Rosenthal, & Khani, 1977; Akiskal et al., 1984; Jacobson, 1953; Klein, 1977), a range of severity or functioning (Kernberg, 1975; Millon, 1981), or an unvalidated wastebasket diagnosis (Widiger, 1982)—have been and continue to be vigorously debated. Even the choice of the designation borderline has been subject to disagreement (Millon, 1981).

The history of the borderline concept is too familiar to be outlined in detail here, so a brief exposition will suffice. Descriptions of borderline cases, at least where the term *borderline* is formally used, date from the 1930s (Stern, 1938), although

even earlier (e.g., Kraepelin's "excitable personality," 1980; Schneider's "labile personality," 1980). Various theoreticians and clinicians delineated the borderland between psychosis and neurosis: Zilboorg's (1941) "ambulatory schizophrenia" (1941), Rapaport, Gill, and Schafer's "preschizophrenic character" (1945/1946), Schmideberg's "stably instable" patients (1947), Hoch and Polatin's "pseudoneurotic schizophrenia," (1949) Bychowski's "latent psychosis" (1953), and Knight's (1953) further popularization of the borderline term. From early on, two trends were noted in the definitions of the borderline conditions: those describing clinical pictures on the border of schizophrenia and those on the border of the psychoneuroses (Stone, 1980). For the most part, these early descriptions were anecdotal. Lack of agreement of definitions, mixed picture of clinical symptomatology, character pathology, and poor response to traditional—psychoanalytic—treatment confused attempts to delineate the disorder.

Three early contributions to the borderline literature deserve a brief consideration. Stern's (1938) description of the borderline is clinically astute, instructive from a definitional point of view, and remarkably prescient with respect to later formulations. He listed 11 characteristics of the borderline disorder: narcissism, psychic bleeding, inordinate hypersensitivity, psychic rigidity, negative therapeutic reactions, feelings of inferiority, masochism, wound-licking, somatic anxiety, projection mechanisms, and difficulties in reality testing.

Schmideberg (1947, 1959) employed the term borderline during the late 1940s, a term she used to describe individuals who could not tolerate routine, were incapable of insight, were inclined to lead chaotic lives, and were deficient in empathic capacity. Her description is quoted at length:

> It is not just quantitatively halfway between the neuroses and psychoses; the blending and combination of these modes of reaction produce something qualitatively different ... One reason why the borderline should be regarded as a clinical entity is that the patient, as a rule, remains substantially the same throughout his life. He is stable in his instability, whatever ups and downs he has, and often keeps constant his pattern of peculiarity. Borderlines should be broken down into major subgroups, such as depressives, schizoids, paranoids ... Borderlines suffer from disturbances affecting almost every area of their personality and life, in particular, personal relations and depth of feeling. (1959, p. 399, quoted in Millon, 1981)

Finally, Knight's (1953) work description of borderline patients anticipates the current work of Kernberg, which emphasizes "ego weakness" as a crucial element of borderline personality structure. Knight wrote,

> We conceptualize the borderline case as one in which normal ego functions of secondary process thinking, integration, realistic planning, adaptation to the environment, maintenance of object relationships and defenses against primitive unconscious impulses are severely weakened. (1953, p. 5)

Like many theorists, Knight emphasized the value of psychological testing in illuminating borderline dynamics, specifically macroscopic and microscopic

evidence of borderline ego functioning (Knight, 1953; Perry & Klerman, 1978).

More recently, sophisticated and methodical efforts at description and delineation of the borderline conditions have been undertaken. The work of Grinker and his colleagues (Grinker, Werble, & Drye, 1968) is particularly useful to the diagnostician. Using an empirical, ego psychological approach, they described a borderline spectrum with four clusters of patients falling along a continuum from psychosis to neurosis: on the psychotic border, the core borderline and "as if" characters falling in the middle, and a lesser disturbed group falling on the border with neuroses. Spitzer and his colleagues (1979) have refined and described two diagnostic criterion sets for borderline personality: the "schizotypal personality," demonstrating similarity to "borderline schizophrenia" (odd use of language, ideas of reference, magic thinking, and social detachment; cf. Kety, 1985), and the "unstable borderline," with a much stronger affective component to their illness (Stone, 1980). D. Klein (1977) has emphasized the dimensions of affective disorder in his "hysteroid dysphoria." He describes overly sensitive individuals who demonstrate "crash-like," depressive symptoms following personal rejection, self-abusing and self-defeating behaviors, including substance abuse, self-mutilation, overidealization of love objects, and a personal style that is histrionic in nature. Gunderson's borderline personality disorder (Gunderson, 1978; Gunderson & Singer, 1975), which closely resembles the diagnosis in DSM–III (American Psychiatric Association, 1987), highlights the poor work capacity, impulsivity, manipulative suicide gestures, intolerance of being alone, and predominantly angry affects. Gunderson stresses (discussed later) the notion that these individuals will show good performance on structured psychological testing but will demonstrate the emergence of primitive ideation on unstructured psychological testing.

The latest version of the *Diagnostic and Statistical Manual* (3rd ed., rev. *[DSM–III–R];* American Psychiatric Association, 1987) has not improved the situation, because over 90 different variants of the disorder can be derived from the 8 diagnostic criteria. To the *DSM–III–R*'s credit, however, the borderline disorders were split into two separate personality disorder categories: schizotypal personality disorder, based on the borderline schizophrenics of D. Rosenthal, Kety, and Wender, and borderline personality disorder, an integration of the formulations by Gunderson, Kernberg, Stone, and Rinsley (Widiger & Francis, 1985). A recent study by Gacono, Meloy, and J. L. Berg (1992) suggests that the *DSM–III–R* Cluster B disorders (the dramatic, impulsive, emotional, erratic, and egocentric behavioral styles) are consistent with Kernberg's lower range of character pathology or borderline personality organization (Kernberg, 1984). In summary, despite numerous attempts to define and delineate what constitutes borderline psychopathology, the diagnosis continues to elude the sort of definitional clarity, reliability, and validity that is ideally demanded from a diagnostic category.

Eschewing descriptive approaches based on symptomatic presentation and history, Kernberg (1975, 1976, 1980, 1984) approached the borderline conditions utilizing a combination of ego psychological and object-relations concepts that view the borderline conditions as a range of psychological functioning, which

reveals itself in underlying structural characteristics of personality organization. Kernberg's view is clearly described in his 1984 formulation:

> Neurotic, borderline, and psychotic types of organization are reflected in the patient's overriding characteristics, particularly with regard to (1) his degree of identity integration, (2) the types of defenses he habitually uses, and (3) his capacity for reality testing. I propose that neurotic personality structure, in contrast to borderline and psychotic personality structures, implies an integrated identity. Neurotic personality structure presents a defensive organization centering on repression and other advanced or high level defensive operations. In contrast, borderline and psychotic structure are found in patients showing a predominance of primitive defensive operations centering on the mechanism of splitting. Reality testing is maintained in neurotic and borderline organization but is severely impaired in psychotic organization. These structural criteria can supplement the ordinary behavioral or phenomemological descriptions of patients and sharpen the accuracy of the differential diagnosis of mental illness, especially in cases that are difficult to classify. (1984, pp. 5–6)

In this framework, a number of psychological functions are arrayed across a tripartite continuum of functioning, from psychotic on the low functioning end, through the intermediate borderline conditions, to neurotic functioning on the high functioning end (see Table 1).

In differentiating level of personality organization, the psychodiagnostician has a large number of theoretically derived indices reflecting developmental lines (Freud, 1965), including ego functions, stages of defensive organization, affect development, and self and object concepts (Acklin, 1992). Kernberg pays particular attention to three of these: identity integration, defensive operations, and reality testing (see Figure 1).

Kernberg proposes, further, that borderline structure is characterized by nonspecific manifestations of ego weakness (Kernberg, 1975), reflecting poor anxiety tolerance, poor impulse control, absence of sublimatory channels, and shift toward primary process mentation, especially in situations of low structure, like psychoanalysis or projective psychological testing (Kernberg, 1967, 1975; Knight, 1953).

While Kernberg does not postulate a superordinate construct for understanding borderline structure, in psychoanalytic terms, an underdeveloped, regressive, or chronically regressed ego accounts well for the borderline clinical picture (cf. Schmideberg's 1959 description of the borderline personality as "stably instable"). The borderline's weak ego and tenuous ego balance reflect tendencies for regression in the face of stress, that is, a propensity to shift to developmentally earlier modes of adaptation and relatedness. In fact, the borderline individual's clinical history is typically characterized by erratic functioning and episodic, chaotic regressions, a tendency that is replicated in their projective test protocols.

A borderline designation as a broad measure of severity is not a sufficient diagnostic classification. Psychodiagnosis from Kernberg's structural point of view distinguishes between personality organization, a broad range of functioning sharing common structural characteristics, from personality style: histrionic, para-

TABLE 1
Kernberg's Differential Diagnosis of Borderline Personality Organization

Area	*Neurosis*	*Borderline*	*Psychotic*	*Diff*
Ego development	High	Moderate	Low	N/B/P
Reality testing	Generally intact	Good in distant relations, poor in intimate relations	Generally poor	N/B/P
Defenses	Predominantly high-level	Predominantly low-level	Predominantly low-level	N/B
Affect	Modulated, stable, appropriate	Unmodulated, intense, unstable, inappropriate	Unmodulated, intense, unstable, inappropriate	N/B
Impulsivity	Highly selective, infrequent	Moderately selective, frequent	Unselective, frequent	N/B/P
Anxiety tolerance	High	Low	Low	N/B
Sublimatory channels	Yes	No	No	N/B
Superego integration	Contemporary, integrated, depersonified	Archaic, unintegrated, personified	Archaic, unintegrated, personified	N/B
Dynamics	Oral, anal, phallic, genital	Oral aggressive	Oral aggressive	N/B
Object relations	Contemporary, depersonified, abstract	Archaic, personified, concrete	Archaic, personified, concrete	N/B
Object constancy	Constant	Inconstant	Inconstant	N/B
Self–other differentiation	Good in most relations	Good in superficial relations	Poor in most relations	N/B/P
Identity	Intact	Diffusion likely	Diffusion	N/B/P
Interpersonal relationships	Stable with symptoms, anxiety, inhibitions	Superficially stable, intimate relations chaotic	Unstable in all relations	N/B/P

Note. Adapted from Kernberg (1975, 1976, 1980). Diff = relevant differential diagnosis. N/B/P = neurotic, borderline, and psychotic personality organization, respectively.

noid, narcissistic, obsessive–compulsive, hypomanic, and so forth. Consequently, diagnostic formulation is two-tiered; for example, a patient may be diagnosed as demonstrating an histrionic personality disorder organized at the borderline level of personality functioning.

Similar attempts to provide a definitive conceptualization of the borderline conditions have emerged from the psychological assessment literature. These attempts at discovering the borderline Holy Grail (Murray, 1992) have, similar to other conceptual approaches, foundered on definitional issues (Widiger, 1982). The role of psychological testing has been affirmed from early on. In 1953, Bychowski emphasized the importance of the Rorschach in detecting "schizophrenic disposition." In 1954, Knight

	Neurotic	Borderline	Psychotic
Identity integration	Self-representations and object representations are sharply delimited.		Self-representations and object representations are poorly delimited, or else there is delusional identity.
	Integrated identity: contradictory images of self and others are integrated into comprehensive conceptions.	Identity diffusion: contradictory aspects of self and others are poorly integrated and kept apart.	
Defensive operations	Repression and high-level defenses: reaction formation, isolation, undoing, rationalization, intellectualization.	Mainly splitting and low-level defenses: primitive idealization, projective identification, denial, omnipotence, and devaluation.	
	Defenses protect patient from intrapsychic conflict. Interpretation improves functioning.		Defenses protect patients from disintegration and self-object merging. Interpretation leads to regression.
Reality testing	Capacity to test reality is preserved—differentiation of self from nonself, intrapsychic from external origins of perceptions and stimuli.		Capacity to test reality is lost.
	Capacity to evaluate self and others realistically and in depth.	Alterations in relationship with reality and in their feelings of reality.	

FIGURE 1 Kernberg's differentiation of personality structures.

noted the value of including both structured and unstructured stimuli in the psychological assessment of borderline patients. Kernberg (1975) similarly noted that the detection of primary process thinking "through the use of projective tests makes sophisticated psychological testing an indispensable instrument for the diagnosis" (p. 25).

Psychological evaluation studies have outlined a number of the presumably cardinal, but controversial, psychological assessment features of the borderline conditions (Gartner, Hurt, & Gartner, 1989). These include adequate functioning on high structure tests (e.g., the Wechsler Adult Intelligence Scale [WAIS] or WAIS–R) and deteriorated performance on projectives, especially the Rorschach (Rapaport, Gill, & Schafer, 1945/1946; Kernberg, 1967; Knight, 1953; Singer, 1977), evidence of loosened thinking, boundary disturbance and thought disorder (Singer & Larson, 1981), malevolent object relations (H. Lerner & St. Peter, 1984; Stuart et al., 1990)), dysphoria, poor stress tolerance, and labile emotionality (Exner, 1986). Although these studies have done much to describe the range and quality of functioning of borderline patients, the "shifting aliases and category boundaries" (Widiger, 1982, p. 227) have weakened empirical support for definitive understanding of psychological test performance by borderline patients.

A number of studies have examined borderline personality functioning on psychological tests. In their definitive study, Gartner, Hurt, and Gartner (1989) noted that approximately 40 articles had been published since 1977 aimed at identifying test characteristics found in borderline test records. Although some of the findings have become points of controversy and share the same flaws as attempts to clarify what defines borderline (Widiger, 1982), they have become part of the clinical lore relating to borderline patients and are useful to the diagnostician. A selective review follows.

Exner's (1986) Rorschach study differentiating the two types of borderline disorder described by Spitzer et al. (1979; the schizotypal and emotionally unstable personality) tended to validate Spitzer's observations. Schizotypal personalities bore a strong resemblance on the Rorschach to schizophrenics with tendencies toward introversion, problems with odd or divergent thinking, and passive, social detachment. The borderline group was described as "very different from the other two [schizophrenics and schizotypal personalities] in both organization and functioning" (p. 468). They were described as more likely to be extratensive *(EB),* affect-oriented *(Afr* and *FC: CF + C),* self-centered *(3r + (2)/R),* and immature individuals who are easily overwhelmed by stress *(es* and *D),* with problems with dysphoria and affect modulation (shading and *FC:CF + C*). Exner noted that "the differences [between the two groups] are so extensive that it seems reasonable to question the DSM–III notion that the diagnoses of both borderline and schizotypal personality disorders could be used to identify the same patient" (p. 468). He concludes that "the current label borderline seems overly general and potentially misleading. Quite possibly, by reverting to an older category of inadequate personality, the label would be more appropriately descriptive" (p. 470).

With respect to reality testing and perceptual accuracy, borderline records have been shown to be distinguishable from both neurotics (Singer & Larson, 1981) and

schizophrenics (Exner, 1986). Overall, borderline patient's good form responses generally make up 65% to 70% of the record (Gartner, Hurt, & Gartner, 1989), with a higher level of weak or unusual form quality, indicating idiosyncratic rather than distorted reality perception.

Rorschach (1921/1942) and, later, Rapaport and his colleagues (1945/1946) described the oddities of thought in the Rorschach records of latent or ambulatory schizophrenics. Rapaport, Gill, and Schafer also were the first to note the borderline's intact performance on the WAIS and deterioration on the Rorschach. The work of Margaret Singer (Gunderson & Singer, 1975; Singer, 1977; Singer & Larson, 1981) on the psychological testing of borderlines has attracted significant attention in this regard. Singer asserted that the test records of borderlines demonstrate significant deterioration of thinking (revealed through a predominance of fabulized combination special scores). She asserted further that good performance on the "structured" WAIS and poor performance on "less structured" Rorschach is "almost axiomatic" in the diagnosis of borderline psychopathology (1977, p. 194). Singer asserted, further, that Rorschach protocols of borderline individuals are "more openly filled with primary process associations" and "schizophrenic thinking" than are the Rorschach records of most schizophrenics" (pp. 193–194). The seasoned Rorschach examiner, especially in the inpatient psychiatric setting, cannot help but validate the observation that borderline individuals demonstrate highly disturbed or florid records.

Observations about the role of structure in testing borderline patients have been subject to considerable debate and attempts at replication (Carr, Goldstein, Hunt, & Kernberg, 1979; Forer, 1950; Weiner, 1966; Zucker, 1952), including a well-reasoned review by Widiger (1982) that criticizes these assertions as being without empirical support. M. Berg's excellent review of borderline psychopathology on psychological tests (1983) notes that the absence of disturbed thinking on the WAIS or WAIS–R may be an artifact "of the typical practice of summarizing intelligence test responses to comply with the narrow space on the test forms, in contrast to the verbatim records made during projective testing," (p. 121) a point that bears consideration.

As an aid to diagnosis and means to test Kernberg's hypothesis that "low level" defenses characterize the functioning of borderline individuals in comparison to neurotics, P. Lerner and H. Lerner (1980) developed a scoring manual for borderline defenses. Human content *(H)* responses are scored for splitting, devaluation, idealization, projective identification, and denial. Preliminary findings for reliability and discriminability have been good.

Cooper, Perry, and Arnow (1988) developed a scoring manual for Rorschach defense scales across three broad categories: Neurotic (denial, intellectualization, isolation, reaction formation, repression, rationalization, and pollyannish denial), Borderline (splitting, primitive idealization, devaluation, omnipotence, projective identification, and projection), and Psychotic (massive denial and hypomanic denial). Suitable levels of interrater reliability have been obtained, and the scales have demonstrated preliminary validity.

Building on Mahler's (1971) theoretical notions of separation–individuation as important etiological factors in borderline psychopathology, Kwawer (1980) pro-

posed a scoring system for Rorschach content that focuses on boundary disturbance and symbiotic modes of relatedness. In this framework, Rorschach percepts are scored for engulfment, symbiotic merging, violent symbiosis, separation and union, malignant internal processes, birth and rebirth, metamorphosis and transformation, narcissistic mirroring, separation–division, boundary disturbance, and womb imagery.

A series of studies by Gacono, Meloy, and their colleagues have demonstrated the robustness of the P. Lerner and H. Lerner, Kwawer, and Cooper, Perry, and Arnow scales in discriminating levels of character pathology (Gacono, 1990; Gacono & Meloy, 1991; Gacono, Meloy, & J. L. Berg, 1992; Gacono, Meloy, & Heaven, 1990).

Consideration of the borderline diagnosis cannot be complete without reference to emerging data that link borderline conditions to sex abuse trauma. Recent studies have demonstrated a high incidence of sex abuse histories in individuals carrying the borderline diagnosis (Brown & Anderson, 1991; Bryer, Nelson, Miller, & Krol, 1987; Herman, Perry, & van der Volk, 1989; Ludolph et al., 1990; Ogata, Silk, Goodrich, Lohr, & Westen, 1990). Individuals with histories of sexual abuse present with posttraumatic symptoms (intrusive phenomena, nightmares, sensory numbing), disturbances in affect regulation and expression, dissociative control of awareness, identity disturbance (impaired self-concept and self-reference), and problems in tension reduction, often associated with substance abuse, sexual acting-out, and self-mutilation (J. Briere, notes from Sexual Abuse Trauma Workshop, Honolulu, HI, May 7, 1992; Cole & Putnam, 1992). The overlap between these clinical features and the clinical history and presentation of borderline personalities is now well recognized (Landecker, 1992), and as further studies of the overlap emerge, questions of etiology are likely to undergo rapid and perhaps dramatic change.

Given these considerations, what then can the diagnostician expect in viewing the Rorschach of a borderline individual? The first question is what kind of "borderline" are we talking about? Broadly speaking, one would anticipate a protocol that reflects ego weakness, general instability of psychic functioning, and easily provoked regression. The borderline Rorschach is typically, but not always, raw in content, in both affective and content spheres; it also offers a mixture of human percepts ranging from cooperative to malevolent. It demonstrates the following: a wide and unstable range of functioning, including rapid deterioration and recovery; loss of distance from the blots; well-developed but malevolent representations of humans, including primitive relational modes. It yields structural data that reveal labile emotionality (in the case of the emotionally unstable borderline); poor stress tolerance; high percentage of unusual over minus form quality; boundary disturbance without the sort of arbitrary distortion observed in overtly psychotic records (e.g., fabulized combinations over contaminations); and primitive defensive operations focused on splitting, including devaluation and projective identification. Test-taking behaviors may, but do not always, demonstrate the borderline patient's problems in dealing with unstructured situations, where their own lack of internalized structure infiltrates the ambiguity of the test situation

(Arnow & Cooper, 1984). Characteristic storminess and regression and problems with the inquiry may be noted.

The Rorschach is unable to clarify the definitional issues related to the borderline diagnosis, likely an impossible task given the heterogeneity of the patient population and theoretical points of departure. Nevertheless, when used in a manner that integrates empirically based nomothetic and theory-saturated idiographic analysis (Acklin, 1992), the test is unparalleled in graphically assessing and displaying the underlying structural, affective, and representational features of the borderline's inner world. Despite the controversies and unanswered questions surrounding the borderline diagnosis, the Rorschach's unique role and value in elucidating borderline dynamics assures its pre-eminent place in the diagnostician's tool box.

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