The Borderline Personality and Transitional Relatedness

BY PAUL H. ARKEMA, M.D.

Borderline patients may be distinguished from patients with personality disorders through the former's use of transitional objects. The transitional relatedness of the borderline patient is generally rigid and maladaptive. By comparison, transitional relatedness, both past and present, is essentially absent in patients with severe character disorders. The borderline patient's capacity for transitional relatedness indicates achievement of a developmental level that has implications for diagnostic classification and psychotherapeutic strategy.

The distinction between the borderline syndrome and personality disorder has been poorly defined. The purpose of this paper is to show that, by virtue of their capacity for transitional object relatedness, "borderline" patients are differentiable from those with other forms of character pathology. My survey of 45 borderline patients (reported later in this paper) supports this hypothesis.

Personality disorders, as defined in the standard nomenclature (*DSM-III*, pp. 305-330), are a heterogeneous group of deeply ingrained, usually lifelong maladaptive patterns of behavior in which there is an absence of true neurotic or psychotic symptoms. Although these persons cause themselves (and others) much unhappiness, their behavior is usually ego syntonic, and there is little motivation for change.

Historically, the diagnosis of borderline personality emerged from an effort by psychoanalysts to understand character pathology, a trend beginning as early as 1919 (1). (This is perhaps the main reason why patients with personality disorders and those with borderline syndrome are so often thought to suffer from the same disorder.) Efforts have been made, especially by Kernberg (2) and Frosch (3), to determine the specific ego pathology that permits delineation of the borderline entity as discrete, relatively stable, and internally consistent. Other attempts to demonstrate a clear borderline syndrome have used a descriptive approach. For example, using cluster analysis Grinker and associates (4) arrived at four discrete borderline types within the borderline syndrome. Gunderson and Singer (5) surveyed the literature, discussed methodological issues, and identified features that included themes of affect, behavior, social adaptation, reality testing, performance on psychological testing, and interpersonal relationships. Their formulation of criteria for the borderline syndrome includes *both* descriptive and psychodynamic issues and is the one on which this study is based.

Using semistructured interviews, Gunderson and Kolb (6) could distinguish borderline patients from schizophrenic patients and neurotic depressed patients. However, that study excluded patients with a primary diagnosis of alcoholism or drug abuse, a limitation they recognized: "A potentially more difficult control group would be made up of patients with personality disorders not considered borderline." Indeed, Grinker and associates (4) noted the high frequency with which personality disorder and borderline syndrome are confused by diagnosticians.

Although many ambiguities surround the diagnosis (1, 7-9), the concept of borderline personality has proved useful in determining clinical approach (7, 10, 11). Accepting the core symptoms and signs that Gunderson and Kolb (6) described as defining the borderline patient, I will focus in this paper on discriminating the borderline patient from the patient with a severe personality disorder. The features of the borderline syndrome are impulsivity, manipulative suicide attempts, heightened affectivity, mild psychotic experiences (with an absence of severe widespread psychotic experiences), high socialization, low achievement, and disturbed close relationships (6). Space does not permit a discussion of these diagnostic features; the case histories that appear later in this paper are intended to highlight these symptoms and signs of the borderline syndrome.

In the current survey the concept of transitional relatedness is used to provide a clinical technique for clarification of the diagnosis of borderline personality as a specific and discriminable type of personality disorder, as well as to aid in formulating a basis for therapy.

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From the Department of Psychiatry, Boston University School of Medicine, and Westwood Lodge Hospital, Westwood, Mass.

Address reprint requests to Dr. Arkema, 44 Hill Top Rd., Weston, MA 02193.

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TRANSITIONAL RELATEDNESS

Winnicott introduced the concept of transitional objects and transitional phenomena in his study of the "first 'not me' possession" (12). Winnicott described the sequence of events that leads to an attachment to various transitional objects, such as a blanket or stuffed animal, and to less tangible phenomena, such as a favorite tune. Originally, the choice of the treasured object or phenomenon emerges from the child's diffuse "somatic affective" experience of the mother.[1] It is in this way that the child chooses and comes to own the "felt presence" of a good enough mother (13). Thus the object (or phenomenon) stands for the mother in her absence. Winnicott emphasized the soothing function of the transitional mode and compared it to the "substance of illusion . . . which in adult life is inherent in art and religion" (12). As he pointed out,

> the task of reality-acceptance is never completed, . . . no human being is free from the strain of relating inner and outer reality, and . . . relief from this strain is provided by an intermediate area of experience which is not challenged (arts, religion, etc.). This intermediate area is in direct continuity with the play area of the small child who is 'lost' in play. (12, p. 96)

The exact meaning of transitional relatedness will become clearer in the illustrative cases to follow.

Coppolillo (14, 15) made a clear and useful distinction between use of transitional objects, fantasy, and transference and described the role of transitional phenomena in maturation. Horton (16, 17)[1] presented transitional object usage from a developmental point of view and gave examples of normal use of transitional objects at all stages of life, showing how the undifferentiated soother of childhood may be replaced by the intangible, often complex soothers of adult life. Other authors, too numerous to cite, have shown the existence of transitional relatedness at all stages of life and in various phases of psychotherapy and psychoanalysis.

Observations also have been made on use of transitional objects and psychopathology. Modell (18) applied Winnicott's observations on transitional relatedness to the borderline individual's transference response. He compared the involvement of a child and his or her transitional object to the borderline individual's experience of the therapist and inability in the therapy situation to recognize and accept reality. He noted that some self-object discrimination exists in a borderline patient, but it is imperfect. The comforting, protective illusion often shatters in a way that accounts for some of the borderline patient's intense, chaotic transference patterns. The borderline patient experiences the therapist in the "intermediate area" as an illusion combining qualities of an outside object and projections of his or her internal subjective state. In contrast, the neurotic patient is able to discriminate consistently the perceptions that originate within himself or herself (18, 19).

Horton and associates (16) demonstrated that a hospitalized group with an assortment of personality disorders (antisocial, inadequate, hysterical, explosive, passive-aggressive, passive-dependent, and schizoid) gave no history of the use of transitional objects. In a controlled study, those researchers investigated the ability of a group of patients with personality disorders and a group of normal subjects for transitional relatedness, both past and present. The results were remarkable: "None of the individuals with personality disorders gave evidence of ability for transitional relatedness in the present, and 84% gave no evidence of childhood transitional object usage." In the normal group, 93% gave evidence of transitional relatedness in childhood and in the present.

As will be shown, the absence of transitional relatedness among a group of well-defined personality disordered individuals (16) contrasts sharply with the findings among a group of diagnosed borderline patients.

PROCEDURE AND FINDINGS

The subjects included in this clinical survey consisted of patients admitted to Westwood Lodge, a small private psychiatric hospital, over a 36-month period and diagnosed as borderline based on evaluations by two psychiatrists and on psychological testing.

The initial diagnosis of borderline personality was made by 1 of 29 admitting psychiatrists, diagnosticians who did not participate in the study. I made the second psychiatric diagnosis of borderline personality on the basis of interviews and 10 days of observation, using the criteria set forth by Gunderson and Kolb (6). The diagnosis of borderline personality by the 4 psychologists who did the psychological testing was made independently of the first and second diagnoses. Only after the diagnosis was fully established did I investigate transitional phenomena in these borderline patients.

The procedure for gathering information for these case studies included open-ended questions designed to elicit the subject's description of early attachments to inanimate objects and to avoid problems, such as embarrassment, evasiveness, or lack of cooperation, that might relate to the subject's attitudes. I first asked very general questions, such as, "Tell me what you were like as a child. Did you like to play or pretend? Did you have a favorite toy? Did you ever have anything you liked to carry around with you? Did you ever

[1] P.C. Horton: Transitional relatedness as a developmental line. Presented at the meeting of the American Psychoanalytic Association, Atlanta, Ga., May 1978.

have anything you liked to take to bed with you or on trips away from home?" *Every one of the 45 patients reported past and present use of transitional objects.* Rarely was specific inquiry required. It is highly significant that information about use of transitional objects frequently appeared spontaneously and always emerged easily, with little effort on my part. The contrast between the use of transitional objects for this group and the personality disordered individuals studied by Horton and associates is sharp indeed and suggests that transitional phenomena may be useful as a diagnostic indicator to differentiate borderline patients from patients with personality disorders.

CASE REPORTS

Case 1. Ms. A, an 18-year-old college student, was admitted to the hospital after a drug overdose. She had participated in an unstructured group experience lasting several days; it included much talking, sharing sleeping quarters, and a sense of cohesiveness from a common cause. At the end of this event she experienced intense loneliness, emptiness, and anger. On admission, she complained of an inability to give enough to her new friends. In the hospital she exhibited regressive behavior and sought special consideration. She was hypersensitive, mistrustful, anxious, and despondent, and she denigrated the staff. Her anger was directed only at staff and not at other patients or visitors. She began to break windows and frequently cut herself, something she never had done before admission; this behavior continued until effective limits were set.

The patient perceived herself as a special child, her father's "special little girl," although she was always fearful of his anger and avoided him. She also felt isolated, envious of the only two childhood friends she could recall, and continuously lonely. She was angry with both of her parents for not knowing her fears as a child and was angry with her mother for working and not being home after school. Her parents, an engineer and a mathematician, often sent Ms. A to her grandparents for the weekend or when she was ill. The family placed a premium on manners and good behavior, on Ms. A's being "special or superior" to other children.

As a child she developed the habit of talking to her stuffed animals, who "understood" her hurt feelings. She felt better when she played with them. However, she said that immediately before admission, she found that talking with the stuffed animais no longer "worked" to soothe her. The animals no longer "sympathized" with her as she wished, and she felt they were hypersensitive, jealous, envious, suspicious, and resentful. It had been her practice since second grade to turn to her transitional objects for soothing whenever she was disappointed in a relationship, frustrated in filling her emotional needs, dealing with separation issues, or angry with her care givers, especially her parents, for not satisfying her demands. She attempted to "squeeze warmth" from them, and when they failed to comfort her she became enraged and self-mutilative. She cut one of the animals to increasingly smaller pieces. She brought another animal to the therapist's office for protection. A breakdown in this mode of self-soothing led to attacks on herself and to subsequent hospitalizations.

Case 2. Mr. B, a 31-year-old man, was admitted for his first psychiatric hospitalization after expressing suicidal ideas. The patient's girlfriend had decided to take a teaching position in another city rather than remain in a junior academic position and in an uncertain relationship with the patient. He had lived with her for a year, essentially denigrated her, and had not planned to marry. He wondered if he loved her, talked about how injured he felt, and vacillated between ideas of killing himself by carbon monoxide poisoning or of finding a position at another university immediately. While on a pass, he sought reassurance from his girlfriend, drank excessively, and took an overdose. He was returned to the hospital by the university police and several friends. He pleaded with his therapist that if only he could listen to music and return to work, he could obtain relief. He denied being depressed. He elaborated that when he felt an "aimless dread or emptiness" he would listen to certain string quartets over and over.

Mr. B recalled spending hours with a phonograph as a child listening to his father's records. His father had died when Mr. B was 2 years old; except through the music, he could not remember his father. Family sources reported that the father was an affable, unpredictable person who had inherited a significant amount of money, did not work regularly, and often had small groups at the house to play chamber music with him. The patient's mother remarried, traveled frequently, and turned over his care to a variety of governesses. He described her as "diffident and ceremonious." His main memory of her was formal meetings with her on specific days when his behavior would be reviewed. The emphasis was on educational achievements. After the meetings, he would be returned to his room. He stated, "I was alone and the room was empty until I turned on my phonograph." He never learned to play an instrument. The family had been puzzled that he had destroyed two string instruments, and his mother stopped his lessons without inquiry. He reported, "I don't remember what happened. I just wanted to listen to music. I wanted it given to me." (This illustrates the essential nondemanding quality of anything—animate or inanimate—that comes to serve as a transitional object.)

Mr. B could not recall being loved by anyone throughout his childhood. He attended boarding schools after age 8. To others he seemed shy and sensitive. When he dated in college and graduate school, if he felt a woman showed interest in him, he kept the relationship going only as long as the woman seemed to tolerate his lack of commitment. He acted "as if" he were in a relationship (one pattern of the borderline syndrome) (7). He admitted that he had a secret hostility toward all people. Sometimes he felt relieved when a visiting acquaintance would leave his apartment and he could listen to music. He was aware that one function of the music was to help relieve the strain of holding in check his hostility toward people around him. He felt entitled to homage from others because of his superior intellect and academic prowess. He saw his intellectual "discussions" as covert arguments filled with violence. In psychotherapy, he defended his withdrawal from people into music: "If I become a burden on anyone, I'd have to kill myself. Music helps me to be alone with myself."

Case 3. During the night before being brought to the hospital by her parents, Ms. C, a 22-year-old unemployed woman, was assaulted by her boyfriend and had cut both of her forearms. Her parents were concerned that her behavior would

deteriorate and blamed the boyfriend, a known drug abuser and pusher. Ms. C and her boyfriend had been at a nightclub the previous evening. He felt she was dancing too seductively, they argued, and he slapped her in the face. She ran from the club, later cut both arms, became fearful something terrible would happen to her boyfriend, and spent the rest of the night looking for him, damaging her car in the process. He went to another bar, got into a fight, and was arrested for assault and possession of illegal drugs. She described the situation, "He didn't understand. I need to dance. I'm a gypsy." In the hospital, with much support, she appeared to understand the advisability of terminating the destructive relationship. As soon as she was free on a pass, however, she would become "desperate" and seek him out again. She observed, "If I have someone else right away I can do it; I can leave him. But it's the only way."

At home the patient had a doll, a ballet dancer, carefully wrapped in clear plastic; she would take the doll out and touch it each day. She observed,

> It makes me feel so good. I remember seeing a movie with a dancer who had a ribbon on one ankle. It reminded me of the one on the doll. I want to dance with a ribbon. I keep touching it. I don't care if anyone watches. My boyfriend was wrong to accuse me of flirting. I got my doll from my grandmother. She never hurt me or used me. Even up to the time she died—I was five or six then—she would play music and ask me to dance. But sometimes, like that night, I dance until I'm exhausted, and it doesn't help.

The patient described her emptiness, intermittent overwhelming anxiety, impulsivity, wrist cutting, self-burning, sense of victimization, and fear of sexual abuse. She had no direction in life. She wondered if dancing lessons would help make her life more meaningful. Yet she was not interested in putting dancing to practical use. She feared that with lessons, "something would be changed, that [she] would lose something [she] needed."

This case illustrates a patient's use of more than one transitional object—the doll, a tangible object, and the experience of dancing, an intangible activity, that usually led to a sense of a soothing psychological reunion with her maternal grandmother.

DISCUSSION

The patients described are typical of the entire group of 45 patients in their use of transitional objects (and phenomena). Their experience in the transitional mode was ubiquitous, obvious, and easily accessible to inquiry. Generally, they used transitional objects rigidly and maladaptively. They returned repetitively to a potentially soothing world, wrung from it everything they could get, and occasionally, when the transitional object failed them, they experienced rage and demonstrated tantrum-like or self-destructive behavior. The transitional object relationship may be seen to fail in its adaptive role as mitigator of badness extruded upon the external world (20). The rigidity is also apparent in the borderline patient's inability to shift back and forth between the "intermediate area" and reality. In contrast, the well-functioning adult makes use of the intermediate area of experience for self-soothing at times of intrapsychic stress and shifts, in a truly timely and appropriate way, to awareness of crucial internal and external realities.

The borderline individual's use of transitional objects (and phenomena), as represented by the stuffed animals, the music, and the dancing, lacks evolution to more mature expression (12, 21). The music is not sung or played. Little self-esteem or exploration is derived from the stuffed animals, music, or dancing (22). The second and third patients did not pursue formal training in music or dance. To have studied these art forms would have introduced an external reality, challenging their use as transitional objects (12). The transitional object of the borderline patient is used in a passive regressive perceptual mode that has the qualities of a first transitional object (23). The subtle evolution from tangible soothers of children to abstract transitional relationships of adults, seen for example in artistic or religious expression, is missing in the borderline patient (14, 15, 24).[2]

IMPLICATIONS

Developmental Theory

The borderline individual clearly exhibits the use of treasured "possessions" that serve a soothing function. In contrast, the individual with a personality disorder may have some rudimentary ways of dealing with anxiety, other than direct expression of impulses, but they are not effective and do not provide neutralization of instinct as do true soothers or transitional objects (25, 26). Studies of institutionalized children (27) have shown impaired development of relationships to inanimate objects. Horton and associates (16) demonstrated the total inability for transitional experience in adults with severe personality disorders. The implication of these observations is that defects in the development of the severe personality disorders antedate the separation-individuation phase described by so many authors (1, 2, 5, 11, 18, 19, 28) as the phase wherein the focal dynamics of borderline psychopathology appear. Of course, controlled studies are needed to further elucidate the role of transitional relatedness as a selection criterion for the borderline personality as compared with the broad group of personality disorders.

Psychotherapeutic Strategy

Psychotherapy has to be designed with an understanding of the patient's capacity and need to form a soothing illusion. The borderline individual requires assistance with gradual separation and individuation

[2]See footnote 1.

and with ability to tolerate affects. Any disruption in the "illusion" of the therapist, any suggestion that he or she exists as a separate individual or is not in accordance with certain infantile and magical fantasies, is met with anxiety, rage, and dysphoria (18). Management of the intense, frequently chaotic transference, as well as impulsive self-destructive behavior, has been well described in the literature (11, 28).

In contrast to the borderline patient, the individual with a personality disorder finds therapy meaningless. Such an individual cannot lend personal meaning to the world around him or her (16, 29). External objects cannot be psychologically internalized. Horton (17) has proposed that good treatment results are possible with personality disordered patients by facilitating the patient's awareness of the use of transitional objects and exploration of various interactions that require the ability to experience transitionally.

Classification

Attempts to establish the borderline category as a clear and separate entity have been too all-encompassing or too intricate to be clinically useful. An example of a too broad, "wastebasket" categorization, on the one hand, is Schmiedeberg's description of the "borderline personality" (30), which includes patients with severe character pathology and "psychopathy." Within the "borderline" category she includes individuals with antisocial personalities, sexual perversions, and alcoholism. On the other hand, Kernberg's proposed psychoanalytic classification of three levels of character pathology (31) places the borderline individual in the lowest group along with individuals with alcoholism, addiction, sexual deviations, and inadequate personalities and individuals with impulse-ridden characters. Kernberg further stated that the borderline individual may also be grouped at the intermediate level, a "more broad and complex level," which he suggested may require subclassification. This intricate classification, which depends so heavily on the mechanism of splitting (and it is well known that splitting is found in other conditions) (7, 32), lacks the clinical effectiveness and simplicity of a history of transitional object relationships in determining a patient's level of organization of character pathology.

The capacity for transitional relatedness may be a pivotal developmental criterion for the classification of character development. The commonly accepted basis for the definition of personality disorder is the habitual inflexibility of behavior patterns and the lack of subjective distress or symptoms. It is difficult to measure or standardize the degree of inflexible maladaptive behavior in making a diagnosis of personality disorder. Horton and associates (16) suggested that the inability to relate in a transitional mode is the common phenomenological root that encompasses the more ingrained heterogeneous behavioral disorders known as personality disorders. Therefore, to sort out the borderline patient from the patient with the well-defined personality disorder—the condition with which it is most readily confused—the criterion of past and present transitional relatedness is a simple and effective addition to a total assessment.

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