Interview with Dr. M. Gerard Fromm on Borderline Personality Disorder

created by former Erikson Scholar Joshua Wolf Shenk in 2009

Dr. Fromm, borderline personality disorder is often regarded as a controversial diagnosis and many people have a hard time grappling with it. Just what does BPD mean?

That's a good question, and one that has intrigued me for some time. In the late 1980s and 90's, the term became prominent in psychiatry - and it quickly became embedded in set of pejorative ideas and attitudes toward very difficult patients. I found this troubling, and joined the conversation with a paper called "What Does 'Borderline' Mean?" (Psychoanalytic Psychology, Vol. 12, No. 2, Spring. 1995, pp. 233-45.)

You wrote in that paper that "borderline" - and you put in quotations marks - "is not an entity, but rather a vast developmental territory of severe personality disturbance."

Yes, it occurred to me that no patient has ever come into a doctor's office and said, "I feel borderline today." You do hear people say, "I feel anxious," or "I feel depressed," or "I'm obsessing all day." But the diagnosis of borderline doesn't come from the patient's experience of emotion or any kind of action referent. It is applied to sufferers, rather than coming from them. I would argue that the term actually applies to the clinician, who often feels a dilemma facing certain kinds of patients who really get under our skins. So we ask ourselves, "Is this neurosis? Is it psychosis? Is some kind of need coming at me that I need to address, or is there a demand that I need to set boundaries on?" It's really the clinician at a borderline of some sort, asking, "Is it this or is it that?"

That said, both a person who "has" something called borderline - or is in relation to it - will experience profound interpersonal trouble. The person who gets the diagnosis, and those around them, feel a kind of instability relating to their sense of themselves. We could also call this an intense and sustained identity crisis. This might be expressed through their work or other aspects of their daily life. But most often it comes through in their relationships, which flame up, and die out just as quickly.

People with borderline are often associated with intensity and extremes.

Yes. Another way to describe the intensity issue is what we would think of as "affect regulation," which means the person's trouble controlling emotions, particularly the emotion of anger around loss. The emotional temperatures of these patients shoot up, and wreak havoc, and then fall just as rapidly, but often leads to other people withdrawing from them. People we call borderline often leap into an intense relationship, and want to interpret it as more much more serious than it is, and cannot stand either the humiliation of potential loss or, more seriously, the actual sense of rejection and abandonment. The "borderline" position is a highly relational one - it's in relation to one other person.
In terms of assessing the line between neurosis and psychosis, the psychoanalyst Otto Kernberg, MD, who directs the Personality Disorders Institute of the New York Hospital-Cornell Medical Center, argues that there are three relevant categories. First, the ability to test reality - to know what's real from what's fantasy. Second, the ability to integrate oneself so you have a sense of being a distinct, whole human being. And third, the ability to differentiate oneself from others, so you can tell what's you and what's them. A neurotic person can do all three. A psychotic person is vulnerable in all these areas. A borderline person's troubles begin at a point in life when they've matured enough to see themselves as a whole person, but remain very vulnerable to a loss of boundary between themselves and other people.

What do you suppose is happening for the suffering person, under the skin?

I would argue that the fear of abandonment is absolutely key, and that it's that fear that provokes so much instability in work life and, especially, in personal life. Usually when people break out into something called borderline, their sense of themselves in relationships tends to have a deep contradiction. They simultaneously feel that they are way too much for another person - that no one can stand the intensity of their feelings or the idiosyncrasies of their inner life - but also that they're not enough. They feel a weakened sense of self. They're dependent on another person's presence to avoid isolation and abandonment, and yet they feel they're not enough to hold the other person with them, and then that their anxiety-driven emotions will drive away the person they most need. It's an impossible spot.

In short, they're terrified of being left alone. Just terrified. And when that comes up, they can become easily enraged, and frantic to do something about it. It's such a terror that they don't actually allow the feeling to happen. It's so hard to sit with this feeling. In some ways, to feel lonely is an advance for this kind of person, because it allows them to tolerate aloneness without feeling overwhelmed. Our effort in treatment is to help people sit with painful feelings and learn to tolerate them without feeling it is the end of the world. In these frightened states, there's no time frame, everything is now. It is a revelation for a person to see it's not always going to feel this way, feelings are feelings, they do not condemn a person to a permanent and terrible fate.

And they pass rather quickly if one lets them?

That's right, though the relationship issues that lead to the bad feelings need to be grasped and changed. The Lacanians talk about three orders of experience: First, real order: the raw, emotional experience that borders on actual trauma. Second, the imaginary order: for the person in the borderline spot, they feel attuned to one other person and they are in heaven in that brief moment when they can talk themselves into the illusion that the other person will always be with them, and they are in hell when that falls apart. That is a kind of imaginary bubble the person is constantly caught up in. And third, there is the symbolic order: everyday laws, roles, and language, putting things into a perspective that includes a reality larger than both people and that situates the person in an ordinary understanding of how people work. That stage is very hard for a person in this borderline state to get to, so in the midst of a breakdown moment of such intense experience, you see behavior that feels so outrageous, so apart from ordinary ways people might operate that it tips you off that an extreme condition is in front of you. In a state like this, the person seems shameless, but when it's over, the sense of reality returns and, along with it, a deep sense of shame.
In addition to relationships, how does borderline manifest?

Well, we’re talking about instability, and the basic instability has to do with one's sense of self. Often, a borderline person tries to play out a role, or a variety of roles, but can never settle fully into one. The psychoanalyst Helene Deutsch, PhD, considered this the "as if" aspect of the person's personality - so we have person who acts "as if" they are this or that, but never really occupies a place of depth or substance. With borderline, you see people who may try to be one sort of person, but it doesn't fit as a true identity, and so they look for another, and on and on. They identify with certain roles and environments. And they can be, at times, competent in those contexts. Their adaptation seems solid, but also brittle, because real identity is a deeper process than performance or behavior, where our daily actions and roles flow from a consolidated and durable sense of self. Donald Winnicott saw the borderline problem as related to what he called the "false self," where you have a social self that feels completely alien from a more spontaneous or perhaps chaotic inner self. The person with BPO sometimes adopts a chameleon-like way of being.

This makes me think of the famous cases of Borderline Personality Disorder - like Marilyn Monroe, someone who can adopt roles, be what she is asked to be.

Yes, and the paradox is that there can be quite a creative capacity to shift and adapt, depending on the moment and the circumstance. And the person's creativity is not only used defensively. There is such emotional intensity in people with this trouble, coupled with so little capacity to put it into language, that the arts can be an enormously important expressive outlet. And genuine art can come of it - work in which some form can be given to what is otherwise experienced as simply chaotic intensity.

But the borderline problem presents a real threat to creativity, too. You see this in psychotherapy when patients become too anxious to free associate. Letting your mind go can arouse anxiety in anyone, to some degree, but most people can notice these emotions and still use the experience as a kind of deep play for the purpose of getting in touch with oneself. But a person who is very concerned about losing control - and losing one's mind - will be terrified by the invitation to free associate. I think you can actually measure progress in treatment by the increasing ease people have in just speaking their thoughts. And that relates to creativity, openness to taking a chance, spontaneity and so on.

What do people suffering from this condition, look like and talk like? How would a doctor or a family member recognize borderline?

There's a tremendous range, and it partly depends on what defense is in play. In other words, is a person suffering in the moment from their solution or are they suffering from the problem? Often people will develop an eating disorder or harm themselves by cutting or burning. You might say that these behaviors condense the struggle between expressing a strong feeling and controlling it. The behaviors are, in their peculiar way, "solutions." Remember, part of the trouble here is emotional disregulation. And cutting oneself, paradoxically, is an organizing experience. It focuses you in one direction and it distracts you from the more chaotic, emotional pain. Often it punishes you - for some crime you feel you

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have committed - but it brings both the company and absolution of somebody coming and taking care of you. So it then becomes a tool - sometimes used manipulatively - to get people to stay with you. It solves lots of problems at once. And very often, people who are starving themselves or cutting themselves - they don’t feel it. They’ve managed to develop a kind of psychic numbing capacity, so one of the interesting things you notice when people get better is that the cutting starts to hurt.

Of course, these so-called solutions deepen the problem. We’ve discussed what happens in relationships, when a person gets in the bind of needing another person (say, a romantic partner or parent) and pursuing it to the extent of living in a very false way of being — being “good” or thin enough to make another person like you. We often see a person with borderline chasing after love and using sex to try to get love, so there can be these bouts of promiscuity — and this leads to a vulnerability to sexual abuse and abusive relationships.

Sometimes people’s solutions break down completely. They might enter a phase that looks manic, making frantic efforts to find a new partner or dull the pain through substance abuse or buying things. Sometimes, suicidal behavior occurs as a response to a sense of total breakdown into desperation. I see a close link between what can look like a bipolar condition and the ups and downs of an underlying sense of chaos, of desperation about being alone in the world and of rage at the person who left you alone. The caricature of this is the Glenn Close character in Fatal Attraction, who will go to whatever extremes necessary to get the attention of her lover; she is determined to vengefully right a wrong and, even more so, to undo a rejection, at the cost of destruction to everyone’s life.

Clearly, BPD can be accompanied by other diagnosable disorders.

Yes, we see a great deal of co-morbidity with things like substance abuse, eating disorders, manic behaviors, major depression. These troubles can be immediately devastating for the patient and the people around them — for family and friends and colleagues. We also see a great deal of post-traumatic stress disorder. It often turns out that in the early history there has been an abusive relationship, perhaps even childhood sexual abuse, and often trouble in the early maternal relationship. There are a variety of ways a bad fit can develop in early attachment relationships, which then have consequences for the child’s development, including the ways emotional events are processed by the mind of the child. One problematic consequence can be turning to male figures, and if it introduces the problem of premature sexuality, it becomes a disaster. So behind “borderline” is often trauma, and empirical data show this.

I don’t mean to blame the parents. People generally do the best they can. One of the things we have seen so regularly here at Riggs is an intergenerational transmission of trauma. So, for instance, our parents’ parents may have survived the Holocaust, which can produce devastating effects on what they can let themselves feel, what they can talk about and how they raise their children.

In the face of competing diagnoses, what moves borderline to the top of the list?

You work with what’s most acute. So, for example, if substance abuse is the most acute problem, you have to find a way of helping the person become sober. And it helps a lot if you've been able to put the underlying problem in a clearer
perspective - to help the patient see that this is a false - or temporary and costly - solution, and to examine the contours of the real problem. This isn't easy, because feelings have gotten so distorted. What's often in the background for people with eating disorders is that all feelings - loneliness, fear, anger - get channeled into hunger.

These feelings become concretized in terms of hunger for food, which is then reacted against and so on. You get a loss of boundaries around discrete feelings, and sometimes when a person is growing up, their feelings have been regularly misinterpreted in such a way as to confuse them and also to fit a parents' needs for them to be one way and not another. It sounds fancy, but it's really very simple: How many times do parents: feed the child when the child is upset about something else entirely? The child wants to be recognized as angry about something and is bought off with a sweet instead.

Once a person has gotten some control over a chronic acting out solution - and we've talked about all the ways that can manifest - you can move into a substantive treatment, in which, hopefully, the patient will feel a little freedom from the impulse to act and will have gained a little insight, so that, when they find themselves in a red zone, they know it, and we know it, and we can work with it.

How do you work with BPD at Austen Riggs?

A person in a borderline state has had trouble in their primary relationship of dependency in life. Setting up an intensive psychotherapy invites them to depend on their therapist, thereby creating a situation, a charged situation to be sure, where the problems can be felt first hand and talked about. We can connect what happens in the therapy to the therapeutic relationship itself, and to other people in the patient's life. So you have a way of working with the trouble in the immediacy of the therapeutic relationship, including sorting out what's the patient and what's the therapist and a building of what some theorists call "reflective functioning or "mentalization." By that we mean the capacity - often not achieved in a chaotic home life - to think about what might be going on in the mind of the other person. Who is bringing what to the dynamic? Where is the reality, and where are there distortions in thinking? What we often see are spikes of feeling at boundary moments, including the end of the therapy hour, and those are major opportunities to sort out what the patient has done with this in their mind and where that comes from.

But this kind of relationship trouble is a precarious and sometimes life-threatening experience for people - and something they've been living with for a long time. So it's important that we also have people here the patient can go to after the therapy hour, so that they don't have to be alone. The nursing staff is critical, as is the patient community. At some level, a borderline person feels troubled all the time - unstable, insufficient - but the patient community invites you into alternative roles, where, say, you're putting together an evening of some activity, or voting on something in a community meeting. Also, when the person's feelings break out into action rather than language, it happens in a context of others and in our program, a group of patients meets with you about that.

Say a person really loses it, and cuts himself. At Riggs, we have a series of patient-run work groups. One is called the Task Group, which gets referrals about troubled or troubling behavior. So now this person sits down to discuss with a small group of their peers what happened, the effect of what happened on the rest of the community, how other people have dealt with that impulse, what was going on in the social situation that upset the person, and so on. This can really
change a person's perspective, because he or she has let loose with something very angry, without a second thought that there are other people who will feel the effect of it.

And now you have those other people speaking back, saying things like, "When you did that, I was reminded of what happened in my home when my father got drunk, fell on the floor and was bleeding all over the place. It really got to me - then and when you did it." For people who are caught up in their own minds, it comes as a huge surprise to see how other people are affected. This creates a tension, but I think a healthy tension. It humanizes the target, so to speak, and reminds people that there is something - a human community - there for them, that they actually care about, and that they have a responsibility to, something larger than themselves.

Another aspect of Riggs that's extremely helpful for the borderline patient is the openness of the setting. This isn't just a physical fact: that patients can come and go as they wish, and that there are no locked doors and no privileging system. It is also a structuring value. The openness of the setting represents a foundational recognition of the independent authority of the patient. Patients like this are so vulnerable to a kind of regression that can become a chronic way of being. They're so likely to say, in effect, "I will trade my capacities for your care." And that's just deadly. The open setting requires people to take up their authority for their daily lives and to hold onto their strengths, at the same time that they are getting in touch with their vulnerabilities. In an open setting, patients are invited collectively to contribute to the running of the hospital - holding elected leadership positions, running meetings, weighing in on the issues. They keep the place going. People, especially with the kind of relational instability we're talking about, are desperate to belong. They want a community, and that tempers things when times get tough.

A borderline person can look really bad and then bounce back and look really good. You've got to have a setting that allows for that range. A corollary to this aspect of the community program is the activities department. Many of these patients are enormously creative, but they haven't acquired a real ability to use language to master and express emotion. So the Shop, where there are materials, where it's non-verbal expression, is hugely important.

The last important piece here is family work. What's really interesting is that very often the person who becomes the patient has been carrying this intensive feeling forever, but has never talked with their family about it. If you're lucky, and you can get the family to come and feel supported enough themselves, they can have some conversations about what went on between them that become really helpful in the long run.

*When it comes to borderline patients, what are the challenges for the therapist and the staff?*

The big challenge is survival. You have to survive in your role. With people who are so passionate and so chaotic, the intensity of feeling toward the person who is supposed to help is dramatic and overwhelming. Often, in outpatient settings, these therapies become an endless series of managing crises. Very commonly, a borderline person is so distressed at the end of the hour that the therapist will agree to call later in the evening or see them later in the day. Pretty soon, you've devolved into almost an emergency room way of thinking, a 24-hour availability. But, in order to really be of help, therapy has to have a stable, reliable structure, and that gets easily undermined when borderline storms occur. So therapy never gets down to the person's inner experience, how they grew up, what their real troubles are. To some extent, avoiding that more unknown pain is a function of the acting out in the first place.
Of course, with every patient, a therapist has to negotiate boundaries. But for a borderline person, the risks are especially acute. The invitation to call the therapist - or to come again for an extra session - excites a feeling that, "I won't have to be alone. I have a person who will love me." And in the background of course there is the inner sense that, "Nobody can really love me because I have so much hate in me."

We see many patients at Riggs who are here because a therapy went very badly awry - not necessary a full boundary violation, but a relationship that slipped into chronicity and futility. Often, in early assessments, someone with a borderline trouble brings a false demeanor. They're on their best behavior. So you start a therapy without knowing what you're getting into. Then something goes wrong, and they need an extra session. And then another. The therapist sees it's too much, but doesn't know what to do. And sometimes they just go with it. But more becomes much less. There is an escalation of the craziness but nothing useful happens. It's as though the therapist is supposed to meet every need, and of course, they can't and shouldn't.

If one person in the patient’s life has become so important that you're going to feel so devastated when they leave you, you’re always in danger of destroying the relationship you most need, as these escalations often do. In therapy, that’s transference — transferring to the present something about the critical relational moments from your past. We’re fortunate here in that the intensity has a chance of being managed through the clinical team. Eventually, if things go well, the feelings do get centered on the therapist, but the therapist must have help with this. For a while, the intensity of the transference can be distributed — to the nurse, who bridges the gap between therapy sessions and manages troubles between peers; to the internist, who manages the patient’s physical health; to the patient community. And the patient’s psychopharmacologist is also helping to take the edge off of the most intense feelings. So you have many people bearing bits of the feeling, and the patient begins to feel safe. The eggs are not in one basket, so to speak, and if one part of the human environment is endangered by the patient’s intensity, there is always another, who can help both the patient and the other staff member.

Therapists need this support, or else you wind up with too much intensity inside you and, meanwhile, you need to be looking at the situation clearly, not only in terms of the patient’s past but in terms of what you might have done to precipitate an attack or outburst. The potential demand from the patient can seem so unrealistic, even outrageous, that there can be a tendency in both people to write it off as simply craziness, but that is never the real deal. The real learning comes from finding what might have actually happened between patient and therapist that ignited the patient’s attack and that might relate to failures in the patient’s early relationship life.

Basically the challenge of a borderline person comes in depending on somebody — with all that that brings up, the hunger, the anxiety, the anger and the deep mistrust as to whether you can actually put your weight on the other person’s reliability. This kind of trouble challenges both people to try to sit with painful feelings, to try to put them into words. Primarily it’s the challenge of depending on somebody, somebody you can’t control. That’s where the stability of the structure and of the therapist plays a huge role.

And the therapist needs people around him to stay stable himself, because it’s going to be a passionate piece of work and a very interesting one. Many patients like this are very appealing. They’re often quite passionate people. They feel things strongly — that’s part of the problem but also part of the potential. If those feelings can be gotten hold of and sorted out, this person can bring a lot of life.