ON CONSTRUING A DISORDER: AN UNUSUAL CASE OF BORDERLINE

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A young man came to psychotherapy, claiming that he had Borderline Personality Disorder. The problem was his lifelong emotional reaction to rejection. As a child he was diagnosed as having enuresis, encopresis, ADHD and depression. When well, he acted as an able person who had worked in many capacities. Did he really suffer from BPD? Was he now, at the age of 35, acting as 'borderline', as 'normal', or both? We investigated his many roles comprising his dominant narrative, and tried to find out ways for him to break the cycle.

Keywords: *DSM-IV; personality disorder; personal construct psychotherapy; constructivism*

INTRODUCTION

Peter was a client who made me think, and in this paper I want to address several questions: Most important from the viewpoint of theory and therapy is how an identity is formed, given his personal history and his current and important relationships. What was the role of several psychiatric diagnoses that had been given to him throughout his life, from early childhood? Apart from making him a person with a disorder, did these diagnoses provide a framework, a container for his fragile self?

I made an effort to understand fine layers, nuances in his behaviour in therapy, and to get a better picture of what was happening during our work together. The analysis of our relationship provided a basis for understanding this young man who demonstrated pathology, but who, at the same time, in his good phases, was successful in a number of things.

Here was a fine line between normality and pathology and I will try to demonstrate it by presenting Peter's story. *Clearly*, I wanted to understand what was happening in this 3-month long encounter with Peter.

One evening, there was a terrible storm with thunder and lightning. The rain came down hard as the wind howled. Suddenly, someone knocked at the castle door and the old King went out to open it. A young woman stood outside. She said she was a princess who had been caught in the storm. But what a sight the rain and wind had made her look! The water ran down from her hair and clothes. It ran into the toes of her shoes until they overflowed. Still, she said that she was a real princess. 'We'll soon find out', thought the Old Queen (Hans Christian Andersen: The princess on the pea).

THE PRINCE WITH NO MEANS

Peter was a 35-year-old man from Croatia who came for psychotherapy with the hope that he would beat his depression. It struck him after his relationship with a lady friend broke down: he was feeling devastated due to the fact that he was rejected. He did not have psychotherapy at this stage, and when he saw a psychiatrist on one occasion, the doctor gave him antidepressants. You would need years of therapy, said the doctor, if you could afford it.

He came over as polite, well spoken, good looking, and spontaneous, with a good sense of humor. He accepted everything I offered such as coffee. He was living on his savings, but they would soon run out. His problem was lack of energy and inability to put any effort into doing anything. At that time, he did not have any sig-

nificant person around as he had not lived in Croatia for years.

The trigger for his depression was a breakdown in his relationship with a lady friend, who said he had to find a place to live on his own and a job or else the affair was over. When we met, he could not think of doing anything, although, over the years, he had worked in many capacities. Somehow, for one reason or another, he would quit the jobs and continue living on his girlfriend's money.

DEVELOPMENTAL HISTORY

Peter was born and raised in Croatia, and later obtained American citizenship. He travelled all around the world. His short stay in Croatia was due to the breakup of his relationship. His parents divorced, after a series of fights, when he was seven. Up until the age of 18 he depended on the care of his mother, and claimed that he could hardly remember his father. The household consisted of his grandfather, his mother, and himself.

The mother was an extremely energetic and powerful woman who kept him out of school because he had many psychiatric diagnoses. The 'disabled' child was her weapon against his father, with an aim to get the ownership of the flat they were living in. The risk was real; they might lose the place where they lived, as his father had kicked out his first wife with their two children. Over some years Peter was diagnosed as having enuresis, encopresis, ADHD and depression. He also told me that he had night terrors when he was a child. A repetitive theme was an evil character, the IT from Steven King's movies; although, at the time, he claimed he had not seen the films.

For some time, his mother was moving him around in some sort of a wheelchair, claiming that he could not walk. He was allowed to walk while at home when nobody could see him. When he was 11 years old, she let him attend dancing classes. He still enjoys dancing tango, claiming '*I am the best'*.

HIS MANY ROLES

As a child, he said that he was *his mother's slave*. He had been cleaning, cooking, and working to earn some money. At the same time, he was living in his own world of imagination ('*a hero; powerful'*). One of his other roles was a '*skillful, imaginative manipulator'*. Similar to his mother, he was good at inventing and creating a world of his own, but not quite a liar, as that had been his mother's expertise.

He did not go to school from the age of 7, but being *able and intelligent* he passed the exams all the way through to college. He said that when he reached 18 he let himself be free, but that his energy was lost. He started to study, but felt totally out of place. He had several relationships with women that all broke down. I asked, how did that happen? The same scenario occurred; he was rejected, with the same periods of feeling helpless, worthless, and desperate. "I have these periods of going up, feeling excited about life, and then falling deep down, to nothingness".

DIAGNOSIS

Did he really suffer from BPD? According to the DSM-IV, the essential feature of Borderline Personality Disorder is a 'pervasive pattern of instability in interpersonal relationships, self-image and affects, and marked impulsivity that begins by early adulthood, and is present in a variety of contexts'. DSM-IV-TR lists 9 additional criteria for diagnosis, including "dysphoric mood, often disrupted by periods of anger, panic or despair that reflects extreme reactivity to interpersonal stresses" (DSM-IV, pp 706-708).

Why DSM–IV? Can we do without it? Yes and no:

In some respects, constructivists position themselves as the "loyal opposition" to mainstream trends in the discipline: oppositional because they contend against its more dehumanizing aspects, but loyal, because they generally strive to work within the system to secure services for their clients, and an audience for their efforts. At times, it may require postmodern practitioners to be 'multilingual', speaking a language of medical necessity and measurable outcomes with managers, second a conceptually richer discourse with fellow psychotherapy theorists, and third a more metaphoric and personal idiom with clients whose world of meaning they seek to enter (Neimeyer & Raskin, 2000, pp 9-10).

A pluralistic perspective is being advocated. DSM-IV does not give tools, or a design, for psychotherapy treatment, but provides a good and thorough description of the syndromes. Therefore, we introduce the theme of this paper using a concept that is well recognized by both professionals and lay people, and continue elaborating it from the perspective of PCP and constructivism.

Peter did not have the most damaging characteristics of BPD, such as problems with extreme angry outbursts, impulsivity that is potentially self-damaging or risks of self-harm. He had received no psychiatric treatment, except for one contact with a doctor and no psychotherapy so far.

A PCP PERSPECTIVE ON BPD

Winter et al. (2003) and White (2014) proposed a set of characteristics as an alternative to the DSM construing of BPD, conceptualizing it from a PCP perspective. This no doubt opens up a space for therapy work. I will list those characteristics that are relevant for the case under consideration here.

First, there is his feeling of emptiness as an emotional reaction to major invalidation. The failure to invest in anything, let alone to take a job he badly needed. In Kellian terms, this can be described as the failure to be aggressive and complete a new experience cycle. However, this is not the whole story, as we had seen areas of aggressiveness quite early in the therapy.

His dramatic emotional reaction to rejection points toward undispersed dependency, a dependency path that is characterized by threat (Chiari & Nuzzo, 2010, p 129). His current relationships were construed in the same terms as early relationships, namely, as a problem with insecure attachment. Given his early history, this is something that might be expected.

What is in DSM-IV described as a "pattern of unstable and intense relationships characterized by alternating between extremes of over-idealization and devaluation" in PCP is addressed as "tendency to preemptive construing; slot-rattling; superordinacy of constructs concerning valuation of self and others; fragmentation and low sociality" (White, 2014, pp. 30-1) . Winter et al. (2003) suggested that the value of self and other and self in relation to others forms an important focus of how those with BPD organize their world psychologically. These issues were elaborated in the therapy.

Stojnov & Procter (2012, p. 12) accentuate this even more, citing Kelly's claim that a "person is an intersect of many personal construct dimensions, as well as that personality is our abstraction of the activity of other persons. Kelly made otherness a prerequisite of our existence". Actually, "Kelly was trying to outline the theory about people in relation – which was clearly the reason why he also used to call personal construct theory a role theory" (ibid). Stojnov & Procter further elaborate the idea of distributed self, presenting techniques that help in investigating the *relational self*.

Peter's valuation of self presented as extremely split, due to his fragmented self. When low, he was *worthless, not able to move in any direction*; others *did not exist*. It was a major constriction in the service of self-protection; arguably, a consistent sense of self-awareness is an essential precondition for the ability to regulate and/or control emotions. It seems obvious that inconsistency in this area would lead to problematic interactions in relationships with significant others.

How about his valuation of others? Loose construing and an inability to predict made him retreat from relationships. His predictions were pretty much clustered around the *me good-me bad* dichotomy, seen through role relationships as *me accepted-me rejected*. I asked, 'how come that his good relationship in his affairs with women after a period of time deteriorate to the point of breakdown? How do they start arguing? What about? How come that this *polite, well-behaved man* can possibly become *unpleasant and angry*? Is this a case of objectification of the other as opposed to intimacy, as Leitner et al. (2000, p. 184) would put it? Does the terror and potential injury experienced in his childhood lead him to find ways of retreating from genuine ROLE relationships and experience of person-to-person engagement, and with him using people to fill in the gaps, his sense of emptiness? His retreat from a ROLE relationship (if he ever engaged in one) can be seen as a self-protective move in which the aim is to maintain integrity of the core self. We found out more about this in the course of therapy.

Fragmentation is clearly one of the main mechanisms at work. According to the Fragmentation Corollary, "A person may successively employ a variety of construction subsystems which are inferentially incompatible with each other" (Kelly, 2005, vol. 1, p. 58). Here, we could see fragmentation of the self as a survival response to childhood invalidation and trauma. In the therapy, together we identified him as a desperate child – seeing himself as *my angry child*, *almost autistic* versus *selves that are doing well*. The two systems are incompatible with each other, with no connection between them. His *miserable child* does not have any contact, let alone support, from this *mighty guy* who is capable of finding jobs and persuading others to satisfy some of his needs.

Here is some of the material that came out using PCP techniques. At the beginning of therapy, he saw himself in the following terms:

'Who are you?' "*I do not know who I am – an empty soul*".

'How about making a drawing that would represent you now?' His drawing contained a small circle scribbled with blue, and a big one in pink surrounding the small one. *"This inner circle represents my angry and* scared *child. The outer circle is me – how I act in the world outside. This one is not real me; the real me is this angry child. The child is almost dead; he is Peter's heavy burden. He has been creative once, now he is sick and sad. Occasionally he appears full of energy, and after a while he just leaves me".*

'Can you try to talk to him?'. "*He won't talk to me...he sits on the sand; I can see him from behind. If he* turns *around, I am afraid I might see his ugly face full of hate. Like a character from my childhood nightmares".*

'How about the outer circle'? *"It's just a façade, a mask.* He *is kind of manipulator; the polite, skillful guy, but fake".*

Using the ABC model (Tchudi, 1977) for the construct *me empty, depressed – me normal,* we got the following:

'What would be disadvantages of feeling empty and depressed?' "*Immobilized, not able to move or do anything…"* 'How about advantages of feeling empty and depressed?' *"This is real me, here I am in contact with my real self. True to myself".*

'What are the advantages of being 'normal''? "*It may feel good, but would not be real me".* 'Disadvantages of being 'normal''? *"As I said, not the real me. Average, boring… Eventually, 'normal'* people *end up in a bad way, like my grandfather, who had been a successful owner of a restaurant, but for years did not go out of the house – another 'disabled' person in my mother's household!"*

As 'his mother's slave' he was productive, and in his private world a child full of imagination. Once he set himself free, all this energy was lost. 'Does it mean that it is risky to be free, to do things for yourself, rather than being part of somebody's project?' *"No, the risk is to be enslaved again, now in the world of grown-up people. The norms, regulations, hierarchies...competition. It is scary. I want to remain free".*

To understand this person better I had to pay more attention to his, as well as my own behaviour while we worked together. I expressed some doubt about the effects of psychotherapy for BPD, but he knew better. Peter found on the Internet that psychotherapy for BPD works. The sessions should last one and a half hours and be held twice a week, he said. We agreed on it. He was extremely punctual and polite all the time. However, the tasks I asked him to do were not done, except in the sessions. He worked in therapy in the way that suited him, tending to ignore my suggestions in the sessions and outside the sessions.

When feeling low, he was true to himself. 'Why not writing poetry, or just writing, to give the space to these deeper layers that are feeling like *true me*?' "Good poets talk about despair, dark sides of their personality, sharing it with the audience". He did write; one of his stories was about *Mark, the guy who did not like to sleep in his own bed, changing beds all his life*. He did not share the whole story with me, although I had the privilege to be the audience for the time being.

Some aspects of a narrative approach seemed to be useful at this point. During our encounter it was me who was listening to his stories. According to a number of authors (Musicki, 2017), the two practices, PCP and narrative approach, can

amalgamate. The narrative can be seen as an organizing principle. "In an attempt to explain the world, people will employ their imaginative powers to produce meaning by making causal links which are embedded in stories they tell" (ibid, 2017, p. 362). The stories are not just explanations; people live their stories. As McLeod would put it, "there is implicit power in 'authoring', in having a voice. Being powerful requires other people to listen, to hear; to be influenced by what that voice has to say" (McLeod, 1997, p. 93).

What has been the role of understanding others in his construing of self? He clung to his intimate relationship(s), while some relationships with men were cut short at some point due to his withdrawal. 'Is the world of grown-ups poorly understood', I asked? "*No, I understand people well, but...I do not do anything with my pretty sound understanding"*.

He had been doing his own therapy for years, talking to himself. 'Borderline' is his explanation about what was happening to him. Looking at his behaviour in the long term, he is more an *avoidant person*, and this has been recognized in therapy. Also, there is a lot in terms of *obsessive-compulsive* behaviour, (more attitude than behaviour). His basic need was to understand himself, his highs and lows, and he was putting a frantic effort into analyzing himself to the smallest details. This took more energy than his investment in others, which calls for a *narcissistic character trait*.

His resistance to change is easy to see as a legitimate attempt to protect his core. As Winter & Procter (2013) advise, clinicians should not challenge core constructs during therapy too early, at least not until a trusting therapeutic relationship has been established. Resistance to change occurs as a result of attempts to preserve certainty. In some areas he is getting a substantial validation for his sense of self. He takes good care of his physical condition...diet, exercise: "*Good looks are my only assets"*. 'How about his other roles?' "*One of them is being a good housekeeper, a person who takes care of money; of the household. What's wrong with it? I have been trained this way, and I am doing it well'*.

Also, there is Peter who *corrects and teaches others*. He did it as a child to his mother. He found it as part explanation for his trouble with his girlfriend. He was helping her to understand her shortcomings, her psychological problems; his *psychologically minded* self at work. Once he identified this role as *me, control freak* the space was opened to work on the construct *no control— control freak*

As for his need to lead and control me, I asked on one occasion: 'Are you patronizing me?' "*No, doctor, I am listening to you very carefully* (smile)". When asked how it feels talking to me, he said: "Y*our place feels good and you are normal".* He has to be his own person, independent and free. But he kept forgetting things after leaving, once even his rucksack was left in my office. He was getting involved in therapy more than he liked to admit. He had been giving the most intimate details about himself, but at the same time keeping a sort of distance, as a deeper attachment to a therapist might be a risky business.

At the end of the last session, he said: "*I would like to* give *you a little present, but deep down I do not feel like doing it".* There was no time to ask him elaborate, but I respected his honesty.

The therapy had to stop here, as he was leaving the country. The reason for termination was clear; he wanted to go back to US and was happy to tell me that he had been '*taken back'* by his girlfriend. It was he who closed the story in terms of therapy. He did not want to continue on Skype, but said he would like to stay in contact with me over the telephone.

'So, anxiety and depression reduced; what next?' At the end we made a little summary of our work together. His question was about his childhood experience. "*How do I resolve childhood traumatic experience, and fear of abandonment?"*

My main question was about his social position and social functioning. Why did he abandon people and quit jobs one after another? "*People are weak, not interesting, or strong, they do not want me"*. He saw people as either *strong* or *weak*, in his view the strong ones did not want him, and he had no interest in the weak. This response seemed far below his ability to see others in their complexity; it is a repetition of an old pattern.

At the end of therapy, he said he was feeling content. He started collecting and reading old copies of the journal that was meant to entertain children (aged 7-77). It seemed to me that his

inner child was coming to life again. 'What kept him in the role of a person who did not have a job and was living on somebody else's money?' His need *to remain free*…this was identified. Also, I suspected that he liked, in a way, to remain *special.* A child within is taken care of. And, maybe, this life is a *payoff* for years of being his mother's slave.

He actually denied all previous DSM diagnoses; they were his mother's inventions. However, he told me that, as a child, on one occasion he was holding faeces for six days, feeling good about it (control?), while eventually soiling the bed. He did not try to find an explanation of encopresis on the internet.

CONCLUDING COMMENTS

Peter was an emotionally abused child, who struggled with his mother's seductive stance of seeing him as 'special' and her rejection while treating him as a 'scum'. I assume that both of them were powerful characters, fighting for dominance. As a child, he had the lower hand. Still, his strength was the leading force throughout his life. I believe that he had enuresis and encopresis as a child. The question remains was this his acting? Was it his way of complying with the expectations, that is, with his mother's need to present him as a disabled child? Was this an oversensitive and imaginative child able to produce symptoms of psychopathology? And later in life, just be able to repeat a scenario that he was at ease with?

After the therapy was over, he telephoned to let me know that he had two good job offers, and was thinking about accepting them. One was based on his good communication skills, another on his practical skills – like refurbishing an old house for good amount of money. I suggested that, this time, he might act as a *tight negotiator*.

Some things in his relationship changed as well. He hoped it could improve, but at the same time he was ready to accept the end of it. He found that his lady friend was an extremely possessive person; she wanted to control every aspect of his life, and was angry when he found some interesting people to socialize with. At this point the relationship became less important, which was real improvement in comparison to the time of his big crisis.

As mentioned before, I have been the audience; his voice was heard in a nonthreatening, accepting atmosphere. The issues of power and control were elaborated in a new way. It remained open whether he might put bits and pieces together, not giving up on a precious *true self*, but acting within a *continuous sense of self.* This also assumes that he might distribute his dependencies in a more functional way with new people in his life and act as an *adult.*

At this point we are closing the story. What was the Old Queen's verdict?

1. Peter did not appear to have BPD: more likely, he suffered from some form of character disorder or style (pattern), as Lingiardi & McWilliams, (2017) would put it, talking about dimensions of disorder. Distinct categories of personality disorders are "increasingly viewed as problematic, because personality disorder categories are highly comorbid, they often overlap with each other (and with other mental disorders), resulting in many patients meeting criteria for multiple diagnoses" (Raskin, 2019, p 386). A new way of conceptualizing diagnostic categories was also suggested in DSM-5, with the idea of continuity rather than dichotomy. The proposed (but not official) DSM-5 alternative model of personality disorders (*sometimes called a hybrid model, or hybrid trait model*) combines both dimensional and categorical assessment in diagnosing personality disorders' (ibid, 2019, p 392). It requires, among other things, assessment of the patient's level of personality functioning …that ranges from 'little or no impairment' to 'extreme impairment'. I believe that Peter does not come across as a person with a disorder in social contacts; it was only when he went through his many failures (in particular in interpersonal and occupational, and less so in social functioning), that the impairment become obvious. It seems that *avoidant personality disorder, or style*, would be the most accurate description of the Peter's case at this time. After the therapy was formally over, Peter asked, for the first time "*What am I afraid of "?* This might be the beginning of a new cycle for him, with or without therapy.

2. His numerous diagnoses were the organizing principle. His personal development was organized on several levels; some of his identities were functional, others less so. His 'disabled self' served a purpose; he collaborated with his mother's efforts, helping her organize their life around the idea of 'having a disabled child'. Later on, he found a diagnosis of 'borderline' to be an explanation for his dramatic reactions to abandonment. At some level he was playing with the idea of having a disorder; as if 'this was just pretence, an act of playing the role'.
3. His resistance to change was obvious. This is to be expected in people with a particular character style, or disorder. Once he was feeling better ("*I am content now"*) he wanted to go on with his life; he did not feel he needed further psychotherapy.
4. The relationship to the therapist was ambivalent. He kept forgetting things in my office, yet carefully protecting himself from becoming dependent on me. The relationship, I believe, was as good as it could be; there was mutual respect, but his 'selfish self' was representative of an old pattern. This is the way I understood his comment of '*not wanting to give me a present'*. This was an issue of a ROLE relationship, or intimacy, he was hungry for attention and love (whatever that means) but was not ready to give something in return. There was not enough space to elaborate on this.
5. This therapy is not the story of success, rather it is a story of an unusual encounter. At the beginning the therapist was an audience. Later, Peter's need to control the process was recognized, and the controlling self became the main topic of our exchange. This let him feel better about his relationship with his lady friend, understanding his role in it, and finally, give her the space to go (and let himself free).
6. We are still in contact. The news is that he moved to his own flat, accepted the job that was well paid, although not permanent. However, feeling tired and sick all the time, but not having enough money to go to see a doctor. Psychosomatic? In a good PCP tradition (tolerating uncertainty), I feel free to admit, I do not know.

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