BORDERLINE PERSONALITY DISORDER AND DEAFNESS

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Abstract

This paper provides a fundamental understanding of borderline personality disorder in persons who are deaf. Symptoms and treatment directions are discussed. Additional factors related to deafness in the etiology of borderline traits and in treatment concerns are mentioned.

Estimates regarding mental health disorders in the deaf population have been considered proportionally equal to mental health disorders in the hearing population (Myers & Danek, 1989). In the case of borderline personality, it is estimated that as much as 3 to 5 percent of the general population and up to 20 percent of the population in psychiatric treatment facilities experience this disorder (Grinspoon, 1987). Since clients who are deaf have less accessibility to mental health services (Langholtz & Heller, 1988; Sussman, 1988; Myers & Danek, 1989), the proportion of persons who are deaf with a diagnosed borderline disorder is probably less than in the hearing population. However, there is no reason to believe that the proportion of borderline personality is any less in the total deaf population than in the hearing population.

When working with clients who are deaf, communication is an essential consideration (Anderson & Rosten, 1985; Glickman & Zitter, 1989). However, as Glickman and Zitter (1989) found in an in-patient psychiatric faculty for clients who were deaf, good communication skills and an understanding of deafness was not sufficient for effective therapeutic work. Therapists must also have expertise in theoretical foundations of psychiatric disorders and expertise in effective treatment modalities. This paper will address the psychiatric issues associated with a borderline personality disorder, treatment directions for the disorder and the implications of the additional variables brought to the disorder because of deafness.

Borderline Personality Disorder

The borderline personality disorder is one of 13 personality disorders listed by the Diagnostic and Statistical Manual of Mental Health Disorders (DSM III-R), (1987). Although this diagnosis is officially reserved for persons who are over 18 years of age, it is not uncommon for the literature to refer to the borderline syndrome in adolescents (Kernberg, 1963; Masterson, 1972; Palombo and Feignon, 1984; Egan, 1986). The dramatic factors associated with this disorder suggest the importance of becoming familiar with borderline features. Many young people who self-mutilate by superficial slashing of arms or legs may be suffering from a borderline personality (Schaffer, Carroll, Abramowitz, 1982). Other behavioral symptoms include repeated overdosing, sexual promiscuity, addiction and other self-destructive acts (Gunderson and Singer, 1975).

A personality disorder implies a more profound and ingrained pattern of behavior than

adjustment or developmental issues. Personality implies attitudes and traits that persist in differing situations over a long period of time (Millon, 1981). A personality disorder exists when the traits of a personality are inflexible to the point of seriously impairing a person's capacity for love and work (Millon, 1981). A personality disorder is generally a life-long relatively stable handicap even though treatment can achieve significant change.

The intransigent nature of severe personality disorders is related to developmental experiences very early in life (Gunderson and Singer, 1975). Specifically the source of borderline pathology is thought to be related to an overly frustrated relationship with parent figures during the first year of life (Kernberg, 1967; Shapiro, Zinner, Shapir, and Berkowitz, 1975; and Masterson 1973). At this age all children begin to integrate the "good" parent and the "bad" parent into a unified concept or object. Since the child who develops borderline traits is thought to experience a highly frustrating relationship with the parents, anxiety about the relationship becomes overwhelming. As a defense, the child splits the experience of the parent into an internalized "good" parent and a "bad" parent. The child is then able to feel secure in the relationship with the "good" parent; however it is a precarious security that protects the self from an ever-present threat of parental retaliation (Shapiro, et al. 1975). What follows is a developmental pattern where the person often experiences others as either all good or all bad and is unable to integrate the complexities of external relationships and internal representations. These difficulties become evident in symptoms that include an inability to meet separation and individual developmental demands.

The early relationship between the deaf child and the parent faces a number of special challenges without the added factor in borderline dynamics of a particularly abusive or unavailable parent. Kampfe (1989) describes the potential for parental frustration, guilt, disappointment, confusion, overprotection and even punitive reaction directed toward the deaf child. She also points out that others (Mindel & Feldman, 1987) believe parents with greater personal resources will be better able to cope with their own feelings and provide adequate parenting to their deaf offspring. In addition, Zalewdska (1989) describes confounding factors in personality development from the perspective of the deaf child. She describes the inability to use sound as a differentiating measure between self and others, the inability to stay in contact with the parent by voice when out of the line of vision and the potential tendency to need greater close contact with the parental love object. When a deaf child is born to parents who do not cope well with the demands of any parent-child relationship, the additional factors associated with deafness and early development can only lead to greater pressures on an already strained parent-child relationship. These conditions have the potential to lead to the kind of abusive or unavailable parenting that may result in a borderline personality disorder.

The term borderline personality disorder has only been uniformly established since the DSM-III included the categories of personality disorders in 1980 (Millon, 1981). Previous to that time, references to borderline characteristics were found in diverse authors as far back as the 1930's when referring to a type of client that was considered severely disturbed but not psychotic (Stern, 1938; Deutsch, 1947; Ekstein and Wright, 1952; Frosch, 1964). Each writer recognized a relatively stable psychological character which differed from the more fluid and profound disruption of normal functioning as seen in schizophrenia.

Kernberg (1967) was among the first to state that the borderline personality was a stable and predictable personality structure. He described many of the symptoms currently associated with the disorder including chronic anxiety,

prepsychotic aspects of paranoid, schizoid and hypomanic disorders, impulse control problems, narcissistic and depressive behaviors, and a number of defenses, such as splitting, projective identification, idealization and devaluation. Projective identification, idealization and devaluation are among the more frustrating symptoms for the counselor, since these defenses often invite counter-transference (when the counselor "transfers" a personal issue or need into their work with a client). Splitting is a process where the client "splits" the counselor into an idealized counselor and later into a devaluated or "bad" counselor. Projective identification is the process by which the client projects some aspect of self behaving as if the characteristic or behavior is part of the counselor. Devaluation is simply removing "value" from the perception of the counselor often leading to a negation of the counselors efforts. Each of these defenses can be particularly difficult and frustrating for the counselor.

Since individual clients differ in specific symptoms and degree of severity, clinicians should not review the borderline diagnosis in a rigid categorical manner. Grinker, Werble and Drye (1968) described four types of borderline groups. Group I was the most severely affected. They had great difficulties establishing positive relationships with others. They did not actively seek out relationships. They were lonely, depressed and angry at others. They had periods of transient psychosis mixed with periods of inappropriate, maladaptive behaviors. Group II was considered the most typical of the borderline style. They actively searched for companionship and affection but in an approach/retreat fashion. As they moved toward the development of a relationship they became anxious and angry, retreating from the relationship and developing feelings of loneliness and depression. They seemed to have little real affection for anyone. They did not show any psychotic episodes. Persons in Group III were isolated and withdrawn. They seemed to wait for others to define their identity, behaving in a complementary fashion to the particular person to whom they attached. Group IV has a wider range of affect than the other groups and was able to develop relationships. However, they still lacked a consistent identity and did not have the capacity to give to others. Their relationships were self-oriented and were characterized by whining, crying and dependency.

When thinking about persons who are deaf and the descriptions of borderline behavior by Grinker, et al. (1968) many of these behaviors could be thought of as normal reactions to being deaf in a hearing world making diagnosis particularly difficult. However, it can be seen through the following excerpt from DSM III-R that reactions to deafness which fall into the normal personality range differ significantly in context and degree from those behaviors classified as borderline:

> A pervasive pattern of instability of mood, interpersonal relationships, and self-image, beginning by early adulthood and present in a variety of contexts, as indicated by at least five of the following:
>
> (1) A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of over-idealization and devaluation.
>
> (2) Impulsiveness in at least two areas that are potentially self-damaging, e.g., spending, sex, substance use, shoplifting, reckless driving, binge eating (Do not include suicidal or self-mutilating behavior covered in [5]).
>
> (3) Affective instability: marked shifts from baseline mood to depression,

irritability, or anxiety, usually lasting a few hours and only rarely more than a few days.

(4) Inappropriate, intense anger or lack of control of anger, e.g., frequent displays of temper, constant anger, recurrent physical fights.

(5) Recurrent suicidal threats, gestures, or behavior, or self-mutilating behavior.

(6) Marked and persistent identity disturbance manifested by uncertainty about at least two of the following: self-image, sexual orientation, long-term goals or career choice, type of friends desired, preferred values.

(7) Chronic feeling of emptiness of boredom.

(8) Frantic efforts to avoid real or imagined abandonment (Do not include suicidal or self-mutilating behavior covered in [5]) (pp. 194-195).

Directions for Treatment

Approaches to working with the borderline client generally have a psychoanalytic orientation. There are two distinct approaches within that orientation. Chessick (1982), Zetzel (1971) and others have advocated a supportive approach to working with borderline clients concentrating on limit-setting and the client's ability to adapt to reality. Confrontations and interpretations are primarily reserved for later phases of therapy. Kenberg (1975), Masterson (1974) and others believe that an approach based on early confrontation and clarification of the client's defenses, especially splitting, will ultimately encourage more positive behaviors from the client.

There are a number of factors that develop in establishing a counseling relationship with a person who is deaf and has a borderline personality disorder. Awareness of these factors is probably the most critical dimension in effective counselor intervention. As previously stated, the defenses of splitting, projective identification, idealization and devaluation can lead to a good deal of counter-transference when working with this kind of client. Indeed it has been likened to an "emotional roller coaster ride" for the counselor (Shick-Tryon, DeVito, Halligan, Kane and Shea, 1988). The person with a borderline personality brings many symptomatic defenses into all significant relationships including a counseling relationship. In the process of projective identification the client projects distorted internal representations onto others and expects them to conform to that project. If the counselor does not conform to the projection, the client may devalue the counselor or engage in a behavior that is likely to achieve the expected response from the counselor. For example, if the client expects the counselor to be alternately loving and rejecting, the client may encourage rejecting behavior by coming to the office without an appointment or at a time when the counselor's duties would conflict with providing the desired attention. Subsequent anger at the counselor could range from verbal devaluation to a severe acting out behavior such as a suicidal gesture. That behavior, in turn, may further distance some counselors further from the client.

Often the counselor, as well as friends, relatives or other significant relationships, are seen as either all good or all bad (splitting), making the counselor's efforts to work with the client stressful at best. Numerous writers have warned of the intense counter-transference difficulties that can arise when working with this type of client (Schaffer, 1986; Masterson, 1974; Simon, 1984). Feelings of anger, hostility, pity, helplessness and

frustration are not uncommon for the counselor due to the self destructive and projective behaviors of the client (Kernberg, 1975). Westerland (1990) warns of the additional possibilities of a rescuing counter-transference by a hearing therapist when working with particularly needy deaf clients. Recognition of these factors allows the counselor to manage many of the countertransference issues that can undermine successful intervention. Sometimes supervision may be necessary due to the pervasive transference and countertransference phenomena associated with this disorder.

Working with Deaf Clients

There are a number of barriers that deaf persons who have a borderline personality disorder face when confronted with the mental health treatment community. The foremost of these barriers is the difficulty of finding a competent therapist who also knows sign language (Lange, 1989). Due to the severity of symptoms associated with this disorder, deaf persons with borderline symptoms are often sent to an in-patient psychiatric hospital. Assuming that the problems of communication are solved in the hospital, the patient would be referred for long term out-patient therapy; hopefully, to a therapist with good communication skills. Some clients who are deaf still present communication difficulties even for the competent signer due to their poor use of abstractive signs even in ASL (Glickman & Zitter, 1989). The issue of trust is also a particularly difficult issues for the client with borderline qualities and therefore is a potential barrier to developing a trusting counseling relationship. Many of the defenses associated with this disorder are related to trust issues, and many deaf persons have an inherent caution if not mistrust of hearing persons (Lane, 1989), which many compound the development of a counseling relationship.

There are a variety of counseling modalities that have been recommended in the literature for working with the borderline client. Individual psychotherapy is generally the modality of choice (Kernberg, 1975; Masterson, 1972 and Chessick, 1979), although Horwitz (1980) has advocated a group approach and Shapiro, et al. (1975) have advocated a comprehensive approach including individual therapy, couples therapy, and parents and family meetings. Regardless of the approach used, it is generally agreed that therapy for a borderline client is a long-term effort. It is not uncommon for the borderline client to be in therapy for 5 to 10 years or more.

Masterson (1974) offers a four stage guide for working with borderline clients. In stage one, the counselor's task is to develop a trusting relationship with the client. Since the borderline client has profound fears of abandonment, there is often a lengthy period of testing and acting out. This stage is marked by intense transference issues. This stage can last several months or even years (Frances & Katz, 1986). During the phase of work with the borderline client, the risks of negative counter-transference are probably the greatest since client behaviors can include repeated suicide attempts, episodic psychotic regression, or simply continued repetition of previous negative relationship patterns (Egan, 1986). Most writers seem to agree that a balanced ability to provide both limit-setting and positive affirmation is the counselor's most useful strategy at this stage of treatment (Simon, 1984; Masterson, 1974).

During the second stage of treatment the focus of therapy is on the depression, anger and loneliness felt by the client. Because of the establishment of a solid relationship between the counselor and the client in phase one of treatment, the client is better able to tolerate the intensity of those emotions with less defensive acting out. By phase three the client begins to develop a more consistent sense of self and others. The ability to integrate both positive and negative qualities in

others is increased. Finally, the client starts to be able to separate from significant people without the overwhelming fear of abandonment which is often at the root of the symptoms shown by the borderline client. The final stage of treatment is termination: a stage where the counselor must be aware of the possibility of regression due to the fear of ending the counseling relationship.

Treatment of a client with borderline qualities is a long term and difficult process. When the additional factors of communication and general social accessibility associated with deafness are added to the therapeutic puzzle, the therapist may be hard pressed to find the resources to meet the challenge. A starting place in developing these resources includes the ability to identify borderline clients, to understand appropriate strategies, and to understand the implications of deafness as related to the borderline disorder.

References

Anderson, G. & Rosten E. (1985). Towards evaluating process variables in counseling deaf people: A cross-cultural perspective. In Anderson, G. & Watson, D. (eds.), *Counseling Deaf People: Research & Practice*. Little Rock, Arkansas: University of Arkansas.

American Psychiatric Association (1987). *Diagnostic and Statistical Manual of Mental Health Disorders* (3rd ed. rev.).

Chessick, R. (1979). A practical approach to the psychotherapy of the borderline patient. *American Journal of Psychotherapy, 33,* 531-546.

Chessick, R. (1982). Intensive psychotherapy of a borderline patient. *Archives of General Psychiatry, 39,* 413-419.

Deutsch, H. (1942). Some forms of emotional disturbance and their relationships to schizophrenia. *Psychoanalytic Quarterly, 11,* 301-321.

Egan, J. (1986). Etiology and treatment of borderline personality disorder in adolescents. *Hospital and Community Psychiatry, 37,* 613-618.

Ekstein, R. & Wright, S. (1952). The space child. *Bulletin of the Menninger Clinic, 16,* 211-224.

Frances, A. & Katz, S. (1986). Treating a young woman with a mix of affective and personality disorders. *Hospital and Community Psychiatry, 37,* 331-333.

Frosch, J. (1964). The psychotic character: Clinical psychiatric considerations. *Psychiatric Quarterly, 38,* 81-96.

Glickman, N. & Zitter, S. (1989). On establishing a culturally affirmative psychiatric in-patient program for deaf people. *Journal of Rehabilitation of the Deaf, 23,* 46-59.

Grinker, R., Werble, R. & Drye, R. (1968). *The borderline syndrome: A behavioral study of ego functions.* New York: Basic Books.

Grinspoon, L. (1987). Personality and personality disorders - Part I. *Harvard Medical School-Mental Health Letter, 4,* (3), 1-4.

Gunderson, J. & Singer, M. (1975). Defining borderline patients: An overview. *American Journal of Psychiatry, 132,* 1, 1-10.

References (continued)

Horwitz, L. (1980). Group therapy for borderline and narcissistic patients. *Bulletin of the Menninger Clinic, 44,* 181-200.

Kampfe, C. (1989). Parental reaction to a child's hearing impairment. *American Annals of the Deaf,* Oct., 255-259.

Kernberg, O. (1967). Borderline personality organization. *Journal of the American Psychoanalytic Association* 15, 641-685.

Kernberg, O. (1975). *Borderline conditions and pathological narcissism*. New York, Aronson.

Kernberg, O. (1963). The Diagnosis of Borderline Conditions in Adolescent. *Adolescent Psychiatry, VI,* 292-292.

Lane, N. (1989). Substance abuse among the deaf population: An overview of current strategies, programs & barriers to recovery. *Journal of Rehabilitation of the Deaf,* 22, 79-85.

Langholtz, D. & Heller, B. (1988). Effective psychotherapy with deaf persons: Therapists' perspectives. In D. Watson, G. Long, M. Taff-Watson, & M. Harvey (eds.), *Two decades of excellence: A foundation for the future* (pp. 54-67). Little Rock, AR: American Deafness and Rehabilitation Association.

Masterson, J. (1972). *Treatment of the borderline adolescent: A developmental approach.* New York: John Wiley and Sons.

Masterson, J. (1973). Maternal clinging, separation-individuation, and the borderline syndrome. *International Journal of Child Psychotherapy,* 2, 331-345.

Masterson, J. (1974). Intensive psychotherapy of the adolescent with a borderline syndrome. *American Handbook of Psychiatry,* Silvano Arieti, ed. New York: Basic Books, 250-263.

Millon, T. (1981). *Disorders of personality DSM-III: AX's II.* New York: John Wiley & Sons.

Mindel, E. D. & Feldman, V. (1987). The impact of deaf children on their families. In E. D. Mindel & M. Vernon (eds.), *They grow in silence: Understanding deaf children and adults* (2nd edition).

Myers, P. & Danek, M. (1989). Deafness mental health needs assessment: A model. *Journal of Rehabilitation of the Deaf,* 22, 72-78.

Palombo, J. & Feignon, J. (1984). Borderline personality development in childhood and its relationship to neurocognitive deficits. *Child and Adolescent Social Work Journal 1,* 18-33.

Schaffer, C., Carroll, J. & Abramowitz, S. (1982). Self-mutilation and the borderline personality. *The Journal of Nervous and Mental Disease, 170,* 468-473.

Schaffer, N. (1986). The borderline patient and affirmative interpretation. *Bulletin of the Meeninger Clinic, 50*(2), 148-162.

Shapiro, E., Zinner, J. & Shapir, R. L., et al. (1975). The influence of family experience on borderline personality development. *International Review of Psychoanalysis,* 2, 399-411.

Shick, Tryon, G., DeVito, A. J., Halligan, F., Kane, A. & Shea, J. (1988). Borderline personality disorder and development: Counseling university students. *Journal of Counseling and Development, 67,* 178-181.

Simon, J. (1984). The borderline syndrome in adolescents. *Adolescence, 75,* 505-519.

Stern, A. (1938). Psychoanalytic investigation of and therapy in the borderline group of neuroses. *Psychoanalytic Quarterly, 7,* 467-489.

References (continued)

Sussman, A. (1988). Approaches in counseling and psychotherapy revisited. In D. Watson, G. Long, M. Taff-Watson, & M. Harvey (eds.) *Two decades of excellence: A foundation for the future* (pp. 54-67). Little Rock, AR: American Deafness and Rehabilitation Association.

Westerland, E. (1990). Thinking about incest, deafness, and counseling. *Journal of Rehabilitation of the Deaf, 23*, 105-107.

Zalewska, M. (1989). Non-verbal psychology of deaf children with disorders in personality development. *Journal of Rehabilitation of the Deaf, 22*, 65-71.

Zetzel, E. R. (1971). A developmental approach to the borderline patient. *American Journal of Psychiatry, 127*, 867-871.