Work in Progress

Borderline Personality Disorder and Childhood Abuse: Revisions in Clinical Thinking and Treatment Approach

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Abstract

In this paper, we consider the implications of new research on childhood abuse for our understanding of people diagnosed with borderline personality disorder. We begin by reviewing and reframing core features of the diagnosis: primitive defenses, unstable relationships, identity disturbance, inability to be alone, and self-destructiveness. In addition, we examine the treatment implications of the data on childhood trauma in the context of our reframing of these diagnostic markers. Finally, we address the question of the borderline diagnosis itself in light of these reformulations.

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Introduction

The nature, etiology, and treatment of borderline personality disorder have been actively debated for several decades. In the 1970s, Mahler (1971) noted a similarity between certain psychological vulnerabilities of the borderline adult and separation issues of young children. She hypothesized that the central developmental underpinnings of the borderline personality are psychological derailments during the rapprochement subphase of the separation-individuation process. These derailments lead to an enduring inability to modulate aggression as well as to integrate "good" and "bad" perceptions of parental figures. Her theory has had a major impact on psychoanalytic writers, who have also viewed separation-individuation impasses as the developmental cornerstone of the borderline disorder (Kernberg, 1975, 1976, 1984; Masterson, 1972, 1981; Masterson & Rinsley, 1975). However, this view has not held up in empirical analysis. In carrying out longitudinal studies, even Mahler and her colleagues (1971, 1977) have observed some toddlers with rapprochement phase difficulties who did not develop borderline personality disorder and others who did, but who had not manifested problems at the rapprochement stage.

Other empirical investigations from a psychodynamic and developmental perspective have focused on either the quality of parenting in the family of origin or the history of early losses and separations. Parents of people diagnosed as borderline have been described as neglectful (Frank & Hoffman, 1980; Frank & Paris, 1981; Gunderson, Kerr, & Englund, 1980; Gunderson & Englund, 1981; Walsh, 1977), over-involved (Soloff & Millward, 1983a; Walsh, 1977), or engaged in a rigid marital bond, which disallows

support and protection of the children (Gunderson et al., 1980). Early losses and separations from important figures have been noted to be high in some studies (Bradley, 1979; Paris, Nowlis, & Brown, 1988; Soloff & Millward, 1983a, 1983b) and less significant in others (Zanarini, Gunderson, Marino, Schwartz, & Frankenburg, 1989). Overall, no single compelling pattern has emerged in any of these attempts to clarify questions of etiology, although there are consistent indications of generally disturbed relationships with both parents (Gunderson & Zanarini, 1989).

Over the past few years, however, studies have begun to supply strong evidence of a highly significant correlation between the diagnosis of borderline personality disorder and a history of chronic childhood trauma associated with sexual abuse (especially incest), physical abuse, and the witnessing of severe domestic violence (Bryer, Nelson, Miller, & Krol, 1987; Herman, Perry, & Van der Kolk, 1989; Westen, Ludolph, Misle, Ruffins, & Block, 1990; Zanarini et al., 1989). In an investigation that attempted to look at both separation and abuse issues, Zanarini and colleagues (1989) found that a history of childhood sexual abuse more consistently differentiated people diagnosed as borderline from other clinical groups. They conclude:

> The results of this study suggest that both physical neglect and the more subtle forms of emotional neglect thought to be of etiological significance by authors such as Mahler and Masterson, are common but not necessarily discriminating features of the childhood histories of borderline. (p. 23)

Since the incidence of childhood abuse has ranged from about 55 to 80 percent in these studies, it may be close to filling the role of a necessary (even if not sufficient) condition for the development of this clinical picture.

In this paper, we wish to consider the implications of these important findings in some detail by reviewing and critiquing standard developmental and psychoanalytic theories about the diagnosis. As noted, these have considered losses and separation-individuation issues to be causally central and have explained core problems of ego weakness, identity diffusion, unstable relatedness, affective storminess, and impulse control with reference to these roots. However, the framework offered by data on traumatic early histories tends to shift the terms of the discussion. Rather than understanding many of the observed difficulties with separations as primary, we believe they may be secondary to the long-term impact of childhood trauma and its relational context. At the outset, we want to acknowledge that our reframing of ideas about the diagnosis owes a great deal to two theoretical positions: recent literature about the aftereffects of trauma (Figley, 1985; Kluft, 1985, 1989; Putnam, 1989; Van der Kolk, 1984, 1987) and about women's development as represented by the Stone Center's perspective (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991; Miller, 1986, 1988; Stiver, 1990a, 1990b).

Defences

Splitting

For many psychoanalytically-inclined clinicians, it is the intrapsychic or structural, not the symptomatic or descriptive, aspects of the disorder that are of greatest significance in making and understanding the diagnosis. One of the most important delineators of this view is Kernberg (1975, 1976, 1984), according to whom splitting is a critical diagnostic feature. He defines it as a central defense mechanism and a primary determinant of self-concept and object relations in these patients. In its defensive function, splitting protects the ego from intrapsychic conflict by "actively keeping apart contradictory experiences of the self and significant others . . . As long as these contradictory ego states can be kept separate from each other, anxiety related to these conflicts is prevented or controlled" (Kernberg 1984, p. 15).

In Kernberg's view, splitting begins as a normal, though primitive, cognitive strategy that allows an infant to construct a rudimentary organization of her experiences of self and other. It only turns into a pathological and growth-preventing defense when the infant is chronically flooded by an excess of instinctual aggression or chronically overwhelmed by anxiety and frustration because of skewed maternal responses to her age-appropriate strivings for autonomy. At this point, splitting can become defensive in order to prevent the aggression-tinged, "all bad" representations of self and other from contaminating the idealized, "all good" representations. Thus, it can save the infant (or the adult with a borderline level of pathology) from experiencing unbearable levels of rage or anxiety in an ongoing way. However, it also imposes serious costs. Splitting blocks the development of differentiated self and object representations, in which good and bad aspects of experience can be integrated and an awareness of the good endure over time, despite transitory frustrations or empathic failures. In essence, this integration permits the achievement of object constancy.

If we both recognize the reality of the clinical phenomena that prompted Kernberg's theorizing and acknowledge the role of early childhood abuse, it becomes crucial to reexamine the genesis and significance of splitting. We would like to challenge several central assumptions about the timing of its development, about the relational context in which it emerges, and even about its categorization as a defense. First, instead of viewing splitting as a defensive fixation at a developmental stage occurring in the first year or two of life, it may be seen as arising at any point through the latency period, by which time approximately 70-80% of these patients have been seriously abused or have witnessed significant familial violence (Herman et al., 1989; Westen et al., 1990). This suggestion contrasts with the psychoanalytic assumption that the so-called primitivity of splitting indicates an origin at an archaic developmental stage. Such an assumption ignores the devastating impact of chronic abuse, especially when it occurs within the family environment that is supposed to be a child's source of safety.

Second, rather than pinpointing the mother-infant dyad as the pathological relationship which generates splitting, data about abuse suggest that the critical relationship is far more likely to be with the father or other male perpetrator who, by virtue of his age and role, ought to have a protective responsibility toward the child (Herman et al., 1989; Saunders, 1991; Westen et al., 1990). We do not mean to deny the existence of mother-child abuse nor to minimize the impact of the absence of maternal protection, even if based on her ignorance or powerlessness. However, without the actuality of the abuse by predominantly male perpetrators, the mother's unresponsiveness might not have had the same significance or contributed to so devastating a sense of betrayal. Moreover, the abuse often occurs within highly dysfunctional families, permeated by serious relational distortions and emotional neglect (Stiver, 1990a, 1990b). In comparison to a theory recognizing the combined impact of a pathological family system and traumatic sexual abuse and violence during much of childhood, the explanation of borderline pathology by reference to disruptions in the mother-infant dyad during early separation-individuation seems obviously inadequate.

Finally, a question might even be raised about splitting's presumed intrapsychic origins as a defense against drive-related conflicts. Against a background of severe abuse and neglect, splitting might well reflect an internalization of the child's actual experience, thereby representing more of a repetition phenomenon than a defense per se. The abused child is, for example, faced with a father who tells her that she is special or that he is doing something to make her feel good, yet who touches or hurts her in ways that directly contradict the meaning of his words; with a mother who does not see the signs of the trauma and often fails to respond to her daughter's nonverbal or even direct attempts to disclose it; with a family that contains chaos and violence inside its walls, but insists that no one outside can be trusted, that nothing is really wrong, or that you deserve what you get. In hearing of the chronic trauma that many of our patients have survived, even we, as adults and mental health professionals, are daunted in our efforts to integrate a picture of someone capable of perpetrating such violations on a child. How, then, does the child develop a coherent sense of herself or of others, if she is a victim of such situations, and how does she tolerate the intensity of the feelings they generate so as to allow "aggressive drive derivatives to integrate with libidinal drive derivatives" (Kernberg 1975, p. 26)?

Once we understand splitting in relation to actual experiences of incest or violence, we may come to see it less as a defense than as a learned template, superimposed on contemporary experience in a manner analogous to *any* anticipated repetitions of early and central relational dynamics. When these sorts of basic templates are activated in adulthood, they may produce extreme reactions, which seem quite disproportionate to or distorting of the situations which precipitated them. Without understanding their original adaptive function — i.e. to help the child deal with real world dangers that threatened psychic and even physical survival — they are simply labelled pathological. Therapists and hospital staff members feel frustrated or manipulated because of repeated failures to establish a solid treatment alliance, and the patient often feels blamed when her splitting is confronted. If the etiology of splitting is accurately identified, the patient may feel pain in recognizing that, but she may also experience the relief of being understood and of herself understanding reactions which previously may have made no sense to her either. In turn, this awareness can potentiate the development of greater ego strength, increased capacity for self-observation, and improved relational abilities (Stiver, 1990a, 1990b).

It must be acknowledged that Kernberg's (1975, 1976) rationale for interpreting splitting involves a very similar goal of ego development. The crucial difference has to do with the kinds of explanatory concepts and interpersonal experiences that can be

internalized when the approach suggested here is used. A person's splitting is no longer simply a pathological or primitive characteristic about which she may experience shame or defensiveness, and the therapist's intervention is less apt to inflict further narcissistic injury on a self already massively injured.

Projective identification

Alongside splitting, a second key defense associated with the diagnosis is projective identification. As typically defined, projective identification entails an "unconscious attempt to evoke feelings or behavior in the other that conform with the projection and the willingness (conscious or not) of the recipient of these projections to accept these attributes as part of himself" (Shapiro, 1978, p. 1307). In contrast to pure projection, this defense is quintessentially relational in its push to engage with someone so as to shape his or her emotional states and behavior to conform with the content of the projections. This understanding also assumes that the content of the projections corresponds to unbearable aspects of the self, which the person wishes to be rid of. Overall, these projections are seen to be connected with aggressive drive-derivatives, i.e., with the "all bad" constellations formed from interpersonal experiences having a negative affective tone or charge. Because of the borderline patient's poor boundaries, the explanation continues, she ends up reidentifying with the person onto whom she has thrust these unwanted parts. Thus, she is forced to manage the very things she hoped to avoid in relating to the holder of her projections and may feel an urgent need to control him or her.

However, when we think of the impact of early abuse, a reformulation is suggested, analogous to what we have said about splitting: that projective identification is another repetition phenomenon, involving the reactivation of powerful intrapsychic representations based on actual events. Insofar as these are encoded in memory, even if not consciously identified as such by the individual, they certainly arise from within the person. Nonetheless, it is very different to define the projection as one of an early model of traumatizing self/other interactions rather than of an individual's own rage or sadism caused, perhaps, by a constitutional excess of aggressive drives. In this context, it makes no phenomenological sense to tell the patient that she is projecting her own aggression onto you and, for that reason, sees you as frightening. If anything, this kind of interpretation confirms the inner sense of badness, which so often plagues victims of trauma. In addition, it increases the patient's very real fear of her own anger, when a goal of treatment is to help her learn that anger is fundamentally an emotion, not a violent action or a cause for abandonment or retaliation. The kinds of interpretations typically associated with the traditional concept of projective identification not only fail from the perspective of accuracy, but also may decrease trust, intensify anxiety, and increase resistance to the very painful work that the treatment actually entails.

Summary and illustrations

At this point, we have suggested that the psychoanalytic, especially Kernbergian, conceptualizations of splitting and projective identification need to be revised, given the important role of actual trauma. It is not necessary to hypothesize that splitting must originate at an archaic developmental stage nor that problems in the mother-infant dyad are essentially responsible for this developmental derailment. Furthermore, the cognitive structures associated with splitting and projective identification may be described more convincingly as internalizations of actual experiences rather than as defenses against intrapsychic conflict. This viewpoint leads to clarifications and interpretations, generally experienced by patients as less blaming than the traditional confrontations about splitting or projection. Moreover, while furthering ego development, these types of interventions also tend to promote the internalization of positive relational ties, thereby enhancing the safety of the therapeutic environment as a place from which the awful realities of childhood can be acknowledged and mastered.

We would like to conclude this section on defenses and ego structures with an example that illustrates many of these points:

Ms. J. is a single woman with multiple psychiatric hospitalizations associated with severe suicidality and depression, impulses to self-mutilate, and post-traumatic stress symptoms. She was aware of a history of extreme family violence perpetrated by her explosive alcoholic father throughout her childhood; she also suspected sexual abuse by another relative without having very clear memories of this. Even when not acutely symptomatic, her moods could be erratic and often fluctuated in response to her very polarized way of viewing situations, other people, and herself (i.e., splitting). Treaters had typically described her as histrionic, manipulative, or hostile dependent. She so infuriated the staff and psychiatrist at one hospital that they barred her from further admissions.

In her fourth inpatient hospitalization, she not

only expressed confusion and shame about her excessive reactivity to current events, but also felt that she was overreacting to the events of her childhood. However, as she allowed herself, within the safety of the hospital, to re-experience the terror she lived through when her father was drunk as well as the fury she felt because no one in the extended family did anything to stop him, she finally recognized her minimization of childhood events for what it was — a view developed from her parents' angry labelling of her as "always making too much of everything" and as "opening her mouth when she should keep it shut." Furthermore, she realized that her current disproportionate reactions had to do with her displacement into the present of all these early feelings, but with a combination of urgency and drama that made them seem artificial.

Until she accomplished this piece of work in therapy, she had remained dissociated from the source and depth of her emotions. She had also both desired and feared to speak about her terror and desperation, but had learned from her family to expect hostility and rejection whenever she tried. The combination of her internal conflict with the direct anticipation of retaliation if she did manage to express herself contributed to the misfiring of her present-day attempts to find empathic listeners. In essence, this is an excellent example of projective identification. A traditional interpretation would focus only on her own fury being disowned and projected onto others who, in turn, became angry at her, leaving her alone and scared. An understanding based on trauma reconstructs a far more complex relational matrix in which a combination of internal conflict and transferential replay of an old schema (i.e., hostile rejection in response to her attempts to communicate her feelings) produced a repetition of abandonment by treaters when she tried to work on the same childhood issues.

While no miracle cure followed from this insight, it did represent an important step in her recovery. Her own experience of her internal life became more authentic and grounded. In turn, others also experienced her as a more genuine person, thereby responding to her with more empathy and enabling her to form healthier connections.

Interpersonal relationships

Just as splitting and projective identification are viewed as fundamental ego-structural features defining borderline personality organization, so maladaptive patterns of relationships are seen as central descriptive features. As Gunderson (1984) notes, "The major clinical characteristics of patients with borderline personality disorder can be understood as reactive to the presence and nature of the borderline person's major interpersonal relations" (pp. 29-30). Moreover, it is the unleashing of these powerful reactions in the transference and countertransference that often makes the therapeutic relationship so difficult for both parties. In order to contrast traditional formulations with the revisions made possible by data linking the diagnosis with early childhood abuse, we shall review two aspects of the interactive patterns frequently noted in the literature: first, the tendency toward enmeshment or overinvolvement in relationships and, second, the frequently stormy nature of interpersonal connections.

One type of relational distortion, both quite relevant to the first of these patterns and quite specific to the aftereffects of abuse, has been labelled *traumatic bonding* by Dutton and Painter (1981). The phenomenon involves attachment behavior, which arises as a result of chronic victimization in an emotionally powerful relationship. Like learned helplessness, it has been noted across species as well as across types of trauma, from wife-battering to the so-called Stockholm syndrome, in which hostages develop affection and concern for their captors. What seems to be crucial to its formation is the combination of intermittent maltreatment with either intense dependency or loving connection. Experimental analogues have been created in research with dogs and primates. For example, Fischer (1955) placed young dogs in one of four experimental conditions: isolation, friendly play, rough handling and punishment, and, finally, intermittent play and punishment. Using a measure of approach behavior, she found that the dogs in the intermittent play and punishment group showed about two and a third times more human orientation than did those in the pure play group. A similar pattern of results has been reported by Harlow and Harlow (1971) in an experiment involving monkeys in which, again, the key to the relational dynamic was the intermittence of positive and negative responses, a reinforcement schedule which generates behavior extremely resistant to extinction.

The familial context in which early childhood abuse occurs generally conforms to the critical conditions for traumatic bonding. What clinicians pejoratively term *enmeshment* in borderline families may be analogous to the kind of clinging observed across species when individuals are treated with alternating comfort and abuse. Thus, difficulties of this sort should not be seen as simply the derailment

of a normal developmental process but, at least in part, as the aftereffect of an abnormal dynamic that develops when abuse occurs in pivotal relationships.

Another diagnostic hallmark involves a tendency toward intense, unstable relationships. Most psychodynamically-inclined clinicians see these sorts of relational patterns as the consequence of fluctuations produced by splitting and projective identification along with their associated, often stormy affective states. What is remarkable about these discussions is the frequency with which they contain terminology connoting victimization and trauma without ever conjecturing that such experiences might have actually occurred in their patients' lives (Gunderson, 1984; Nadelson, 1976; Pine, 1986; Shapiro, 1978). For example, Nadelson (1976) writes about the borderline patient's reactive rage and the resultant fluctuations of transference and countertransference, using the phrase "victim/victimizer interactions." Pine (1986) directly cites "very early trauma" (p. 451) as one of three critical components in the development of the "borderline-child-to-be." However, he explicitly defines it as the subjective experience of being overwhelmed, not as an identifiable objective event, and states that its occurrence can only be judged by its effects on development.

Underlying many discussions of this sort is an allusion to so-called borderline manipulativeness. Treaters often react to these victim-perpetrator repetitions with implicit anger or blame because of their own frustration at feeling objectified, controlled, and helpless. By understanding the degree of abuse and the loss of control these patients anticipate in close relationships, it becomes possible to respond differently. Instead of confronting manipulativeness in an accusatory manner, something which is guaranteed to compound treatment difficulties by triggering shame and associated rage, one can speak about the history and impact of abuse, which together create these dynamics. In fact, we would like to suggest that Kernberg's (1975, 1976, 1984) and Gunderson's (1984) recommendations about the early interpretation of the negative transference be reframed in terms of the need to address problems with basic trust that result from chronic abuse and trauma. Identified as such, a therapist has a more accurate and empathic way of addressing the issues within the therapeutic relationship as they arise.

Summary and illustrations

We have looked at two major characteristics of relational patterns commonly found in individuals with borderline diagnoses. In place of the traditional psychodynamic explanations referring to separation-individuation, we have suggested that the phenomenon of traumatic bonding may be more specifically relevant to problems of enmeshment or overinvolvement. In addition, many aspects of the negative transference as well as the broader relational impact of splitting, projective identification, and associated affect states can be reframed with respect to the traumatic childhood history. This reconceptualization of interpersonal issues suggests corresponding shifts in treatment strategies.

Two illustrations conclude this section of the paper. They highlight the contrast between treatment based on earlier ideas about the confrontation of so-called borderline manipulativeness and of the negative transference and the approach suggested here, based on an understanding of the etiological importance of trauma. For heuristic purposes, the examples have been chosen to describe clearly contrasting treatment responses, one representing poor handling and the other good handling of situations that occur frequently.

Illustration 1

Ms. P., a married woman, mother of three children and a professional, was hospitalized at an unfamiliar institution for longer term treatment than was available closer to home. She had vague memories of sexual abuse by her adoptive father. On admission, she became quite fearful, especially because of the distance from her family and friends. The admitting doctor, who was familiar with the issues of incest survivors, suggested that she submit a three-day notice to have more of a sense of control and to guarantee that she could leave if she decided that the hospitalization was a mistake. Since the patient was not acutely suicidal or homicidal, the notice represented a genuine option. She felt very relieved by this suggestion and followed through on it.

When she met her inpatient psychiatrist later that day, he immediately confronted her, stating that no work could begin until she had retracted the three-day notice and that he would not engage in a treatment founded on threats. The patient then explained how the admitting doctor had suggested the three-day, whereupon she was accused of lying. The therapist did not believe a staff psychiatrist would make such a suggestion. Ultimately, she decided to retract and stay because she was desperate to resolve her chronic problem with suicidality and to return to her previous functional level as a wife, mother, and professional.

During the early part of her stay, brief dissociative episodes caused her to have memory

problems. On one occasion, she applied for and received a higher privilege level than should have been the case, based on the unit's system of privileges and passes. It was, in essence, the staff's mistake to have granted her request. Moreover, because of her memory and concentration problems, the patient seemed genuinely to have overlooked the discrepancy. However, she was confronted by staff for misleading people — read manipulation — because "she knew how things worked." After six weeks, during which a few similar incidents recurred, the patient felt her degree of mistrust was so heightened that she could not accomplish any productive work. Fortunately, her husband and outpatient therapist supported her, and together with them, she arranged a transfer to a different institution. The patient's husband was told by the psychiatrist that he was undermining his wife's treatment, and the patient herself was said to be splitting.

Illustration 2

Ms. N. is a divorced mother of two teenage children, hospitalized for acute post-traumatic stress symptoms and suicidal ideation. She had been sexually abused by a male friend of the family from about age 5 to age 10, when he moved away. Furthermore, her alcoholic mother was often out of control and forced her to be a caretaker from a very early age, for example, she was doing the laundry, shopping, and cooking by the time she was 8 or 9. Neither parent was able to provide reasonable caretaking nor to listen to her needs or distress. This dynamic continues to the present day.

Her inpatient therapist and the nursing staff focused on her sense of abandonment and her difficulty trusting caretakers because of both the abuse and the general level of neglect and parentification. During the first three or four weeks of hospitalization, she was able to process some very painful memories and learn how to control previously debilitating flashbacks. As she prepared for discharge, she began to worry about how she would deal with her parents because even their current relationship was very destructive to her sense of self-esteem and empowerment.

One evening, after receiving an upsetting and guilt-inducing phone call from her parents, she became overwhelmed and wanted to speak with the nursing staff member assigned to her, someone who happened to be an on-call worker unfamiliar with the unit. He said that he would meet her in the TV room, but he became absorbed in a program and did not respond to her when she entered. After about ten minutes of waiting in silence, she began to feel enraged, finally leaving the TV room and having an angry outburst in her bedroom. The anger was accompanied by an abrupt escalation in her suicidality. A regular staff member intervened at that point, but the level of rage was such that it was difficult for the patient to regain her equilibrium, except by taking a PRN medication and going to sleep.

The next day, her therapist and regular staff validated her anger at having been ignored in a moment of need. Following this acknowledgement, she could move beyond her reactive anger to recognize her own inability to speak up for herself when the staff member did not address her. She also was able to accomplish vital work on the connection between her parents' chronic unresponsiveness to her emotional needs and her current suicidal ideation. Within a few days, she decided to ask them forthrightly for something to help with her treatment. Although a simple request, they would not satisfy it, and, instead, turned it into a potentially guilt-inducing complaint against her. For the first time, she was able to feel justifiable anger at them without it escalating into rage and suicidal ideation. Moreover, she began to recognize with conviction her need to set limits on their demands in order to protect herself. Along with the progress on processing memories and controlling flashbacks, this represented a major step in her treatment.

Aloneness

Many authors have described the difficulties with loneliness and being alone experienced by individuals diagnosed as borderline (Adler & Buie, 1979, Adler 1985; DSM III-R, 1987; Gunderson, 1984). With the publication of DSM III, an inability to be alone became a formal diagnostic criterion of borderline personality disorder. Although writers vary in their understanding of this problem, most have viewed it as the result of early separations, losses, or empathic failures in the mother-child relationship. For example, Adler and Buie (1979) have suggested that such early failures can result in an inability either to evoke a soothing and sustaining image of another person or to comfort oneself when faced with being alone or with the loss of a relationship.

However, the compelling data on childhood abuse suggest an alternative explanation for these difficulties with self-soothing. For the abused individual, aloneness becomes associated with either a terrifying state of submission to the abuser or a state of shock in which everyone else in the world is walled

off. The victim's loneliness and inability to be alone may stem from repeated disconnections from other people as well as from her own internal experience, as these occur within the context of chronic trauma. Although early empathic failures, losses, and separations may be important, more relevant causal factors may include dissociation, secrecy, and isolation — all central aspects of abusive situations.

Dissociation occurs as a common adaptive defense to trauma. When faced with physical or sexual violation, the child may use trance-like states to protect the self from physical pain and overwhelming emotional confusion. In cases of repeated violation and frequent dissociation, the feelings and meaning attached to the trauma — and sometimes the memory for the event itself — become split off and removed from any protective relationship. In essence, this is a terrible aloneness; "condemned isolation" may be a better term for it, as Jean Baker Miller has suggested (1988). Frequently, dissociation continues into adulthood, and the victim of trauma withdraws dissociatively rather than bearing feelings or turning to other people when faced with either intense emotion or aloneness. Finally, adult experiences of isolation and dissociation can trigger flashbacks and other post-traumatic responses, which again make aloneness unbearable and seemingly unchangeable.

Secrecy, a characteristic response to trauma for the victim and her family, leads to loneliness and the inability to be genuine with other people. Without a history of solid friendships and love relationships, people usually cannot experience peaceful solitude or bear being alone when life imposes it. Abuse, particularly incest, occurs in isolation from other family members, and then is distorted and kept secret by both victim and perpetrator (Courtois, 1988; Gelinas, 1983, 1986; Goodwin, 1985; Herman, 1981; Reiker & Carmen, 1986; Summit, 1983). If the child attempts disclosure, she is often met with a response that minimizes or invalidates her cry for help, especially when the perpetrator is a close family member or friend (Courtois, 1988; Russell, 1984; Summit, 1983). As a result of secrecy, the child feels shamed and cut off from caregivers as well as from everyone else, and typically fears that telling will lead to either more violation or to the break-up of the family. In adulthood, the survivor may feel controlled by her belief that pivotal experiences and emotions cannot be revealed. Moreover, the family's isolation and mistrust of the outside world (Gelinas, 1983, 1986) may force the victim to remain dependent on the abusive environment, further impairing her ability to seek relief from outsiders or to develop healthy friendships.

At best, the end result of dissociation, secrecy, and family isolation is that survivors experience themselves as inauthentic or playing roles in their relationships (Stiver, 1990a, 1990b). Less optimally, they may feel entrapped by their isolation. Frequently, aloneness becomes associated with loneliness because of an inability to find relationships outside the context of abuse. In any of these situations, aloneness produces deep pessimism about either finding someone who can bear to know about the abuse or pessimism about developing a relationship in which most aspects of the self, including what is considered shameful, can be shared.

Illustration

The following is a composite clinical example which illustrates the ways in which a survivor's isolation and disconnection make being alone an intolerable experience.

Ms. S. was sadistically abused, both physically and sexually, by her father from infancy until her teens. Using dissociation, she would put herself into a trance by concentrating on a crack in the wall until she experienced herself going into "a tunnel," where she was protected by a decrease in sensitivity to her surroundings. After these traumatic and violent episodes, Ms. S.'s father appeared to be "a different person," adding to her sense of unreality. Sometimes the abuse would be followed by family mealtimes or other family activities, without anyone recognizing what was happening. She would hide all physical injuries and would be silenced by her fears of further abuse or her fears of the disintegration of her family. Her experience of being alone included hiding in order to avoid abuse or being left unprotected by some family members, while being abused by others.

Later in adulthood, Ms. S. had profound difficulty being alone as well as feeling genuine in relationships. When isolated, she often dissociated and experienced memories or flashbacks of the abuse. In addition, she could not bear either feelings of anger or vulnerability, which were associated with the abuse. In order to develop friendships, she used rituals and self-hypnosis to block out trauma-related memories and feelings and to become a "different person," who could succeed in the outside world.

In her psychotherapy, Ms. S. and her therapist analyzed her responses to separations from important people in her life. Understanding the connection between her difficulty with aloneness (including her inability to self-soothe) and her past experiences of

abuse helped to mitigate her difficulties with being alone. She became increasingly able to differentiate her abuse-related panic, anger, and sense of humiliation from the reality of current separations. This had not occurred in her previous therapies, in which her inability to be alone had been interpreted only in light of early maternal absence. Finally, her difficulty being alone lessened as her therapy focused on how she kept herself from fully engaging with other people. Gradually, Ms. S. became more emotionally connected and, in fact, less alone. She realized that selected self-disclosing, as well as depending on others, need not lead to humiliation. In addition, she became able to be with herself in periods of both ordinary solitude and aloneness imposed by the loss or absence of important relationships.

Self-destructiveness

Self-destructiveness has been considered a quintessential feature of the diagnosis of borderline personality disorder (DSM III-R, 1987; Gunderson & Kolb, 1978; Perry & Klerman, 1980). As Gunderson (1984) puts it, it is "the behavioral specialty" other authors have looked for as a diagnostic marker. Traditionally, it has been understood as an act of anger and desperation designed to control or manipulate primary persons when they are frustrating, absent, or rejecting (Gunderson, 1984). Self-injury has also been viewed as an attempt to manage the fear and panic triggered by aloneness (Gunderson, 1984).

Recent research suggests a strong correlation between a history of early childhood abuse and ongoing or later self-destructive behavior (Briere, 1989; Briere & Runtz, 1986; Bryer et al., 1987; Courtois, 1988; Graff & Mallin, 1967; Goodwin, 1989; Pattison & Kahan, 1983; Van der Kolk, 1989). Such behavior may take many forms, including suicide attempts, self-mutilation, recklessness of a potentially self-damaging sort, and impulse disorders like substance abuse and bulimia. Given this correlation, we shall reconsider the meaning of the self-destructiveness specific to the borderline diagnosis in light of three types of experiences associated with trauma: (1) rage and humiliation secondary to helplessness, (2) the repetition compulsion, and (3) the frequency of actual revictimization.

First, within a framework of early childhood trauma, the anger, fear, and efforts to control others that have been noted to induce self-destructive behaviors become more comprehensible. For example, efforts to control others by self-abuse in the present may be understood in the context of the overwhelming powerlessness which characterizes early abusive interactions. As adults, survivors are primed to feel massively helpless and humiliated, and also to expect loss of emotional and even physical control in relationships. Self-mutilation may be an effort to control both these internal and interpersonal experiences, in the hope that others will respond to acts of such desperation and with the recognition, for some individuals, that self-injury may provide relief from unbearable emotional states. In addition, it may be an expression of reactivated rage at victimization and abandonment, which can be triggered by adult situations.

Second, self-destructive behavior may be motivated by the unconscious compulsion in victims to repeat or re-enact components of past trauma. On a biological level, Van der Kolk (1989) has hypothesized that self-destructive behavior is linked to neurophysiological processes, which may create an addiction to retraumatization. A range of authors has suggested that early childhood abuse may be encoded in the sensorimotor system rather than in language (Freud, 1896/1962; Janet, 1889; Van der Kolk, 1989). Thus, past abuse may be re-enacted literally or symbolically at the behavioral level without conscious recall of the original trauma. In addition, many survivors experience their bodies as split-off and inanimate both because of the psychologically dehumanizing impact of abuse and their own dissociative numbing. For some of the latter, self-destructive behaviors make the body as well as the self feel more real, while concretely expressing prior experiences of debasement and feelings of self-loathing (Goodwin, 1989).

Third, in addition to intentional self-injury, patients diagnosed as borderline, like other survivors, often show impaired judgment and engage in behaviors or interactions that are potentially self-damaging. This impairment leaves them vulnerable to harm from accidents, battering relationships, and rapes or assaults. As survivors of chronic abuse, they are often unable to gauge dangerousness accurately and have never been taught to attend to self-protection and self-care. Moreover, the heightened anxiety evoked by threatening situations can trigger dissociation which, in turn, reduces the ability to monitor risk or pain.

Serious suicidality needs to be understood differently from self-mutilating behavior. For many survivors, it represents the ultimate and only reliable solution to an enduring sense of entrapment, isolation, and self-hatred (Courtois, 1988, Summit, 1986). Originally, suicide may have been viewed as an escape from or means to end chronic abuse (Summit, 1986).

Later, it may be seen as a way to escape victimization-related feelings. In addition, suicide may be tied to the survivor's identification with the perpetrator: The survivor may feel she must be "bad" or "evil" to have deserved such abuse, and she may lack self-empathy for the impact of her victimization. Here, suicide may be a way to kill off aspects of self that are unacceptable.

Summary and illustration

An understanding of the dynamics central to childhood trauma may not only enhance our conceptualizations about self-destructiveness, but may also suggest some revised and more empathic treatment strategies than those provided by the traditional approach to limit-setting and confrontation. Without clear parameters and limits, a person may continue to act self-destructively and may run the risk of repeating past traumatic interactions without psychological growth, even in the therapy relationship. However, limit-setting can be framed in terms of self-protection, self-care, the development of self-soothing, and the impact of the therapist and patient on each other — all of which may have been absent or distorted in the survivor's family of origin. The therapist's active role in educating the patient and pacing the treatment, particularly the processing of memories or, when necessary, the setting aside of memories, can significantly reduce self-destructiveness during therapy. While self-destructiveness associated with the re-enactment of victim-victimizer dynamics may at times feel intolerable to both patient and therapist, a more accurate and empathic formulation can lessen transference- and countertransference-based deadlocks.

The following composite clinical example illustrates these points.

Ms. C., who was physically and sexually abused by both parents, was repeatedly hospitalized for self-mutilation, particularly during the early phase of her psychotherapy. Initially, her therapist understood this behavior as both enactment of Ms. C.'s anger about his unavailability and evidence of her wish to manipulate him. After she disclosed her abuse history, another formulation became apparent. Experiences of either shame, neediness, or flashbacks of the abuse would typically lead to cutting and burning, particularly early in the therapy and at times when she could not communicate these experiences to her therapist with some degree of comfort. At first, her verbalization of memories of abuse either triggered more flashbacks or evoked humiliation. At a loss, she would turn to self-mutilation as a way to re-establish self-control, and to diminish shame through self-punishment.

Once the centrality of the abuse was acknowledged, Ms. C. and her therapist could reconstruct the relational patterns which resulted in her self-destructive behavior. Her therapist maintained treatment parameters and limits by avoiding over-reactions, such as excessive phone contacts or enactment of angry countertransference, and also by encouragement of Ms. C.'s own exploration of re-enactments in current relationships. However, her therapist's openness about his concern, and even his frustration, with her repetitive self-harm and enactment of victim-victimizer dynamics was helpful because it indicated to her that she had an impact on him. She developed strategies to achieve self-soothing when alone, using grounding and imaging techniques. For example, she would imagine lying in a field of grass, which was tactile but not contaminated by the conflicts evoked by human intimacy. With careful pacing of treatment, particularly around the processing of memories, and with slow, repeated exploration of her feelings, her humiliation diminished, as did her flashbacks and her relentless re-enactment of her past. In addition, she became more engaged in her treatment, experiencing it as a secure holding environment in which to do her work. Finally, Ms. C. became less self-hating, less rageful, and more tolerant of her needs, even those that could not be fulfilled.

Identity diffusion

Significant problems with identity formation have been associated with the diagnosis. Early descriptions pertinent to the borderline category have included references to "as if" personalities who are unable to integrate their identifications (Deutsch, 1942), "imposters" (Greenacre, 1958; Greenson, 1958) and persons with "multiple identities" (Fast, 1974). More recent literature has viewed "identity stasis" (Meissner, 1988), "identity diffusion" (Kernberg, 1975, 1984), or, as in DSM III-R (1987), "identity disturbance" as central differentiating features of the diagnosis. Descriptions of difficulties related to identity typically have included the following characteristics: contradictory self-perceptions (Kernberg, 1975, 1976), a disturbed self-image (DSM III-R, 1987; Kernberg, 1975, 1976), an extreme sense of either badness or equally unrealistic specialness (Gunderson, 1984; Waldinger & Gunderson, 1987), and radically different levels of ego-functioning (Deutsch, 1942; Fast, 1974; Knight, 1953; Kernberg,

1975, 1976). In addition, identity disturbance has been linked to a lack of resolution and commitment regarding choice of friends, love relationships, and long-term goals or career (Meissner, 1988; DSM III-R, 1987).

As with the other features we have examined, a reconsideration of identity diffusion in light of the long-term effects of child abuse enhances the meaning of this concept and offers it a developmental context. Years of dissociation, splitting (as we have redefined it in this paper), and interpersonal dilemmas, such as secrecy and shame, can derail identity formation. Because the concept of identity diffusion is broad, we shall limit discussion to three areas which have particular importance for survivors of chronic abuse: identity fragmentation, deficits in self-knowledge, and impaired self-image.

Perhaps most central to identity diffusion are the repeated use of dissociation and splitting and the repeated experience of abuse-related interpersonal dynamics which can result in severe intrapsychic fragmentation and radically different levels of self-functioning. Individuals with borderline diagnoses characteristically shift from achievements requiring competence and high levels of functioning to sudden and major regressions. Considering the impact of severe trauma, such fragmentation is a predictable outcome. Typically, a survivor's sense of self includes a multitude of contradictory, unintegrated feelings, memories, and self-perceptions. In cases of severe dissociation, the survivor may experience distinctly separate affective and memory states, which may border on the multiple identities found in multiple personality disorder.

Even if the damage does not result in independent identity fragments, survivors of chronic abuse often do not have consistent or stable self-perceptions. Secrecy, distortion of reality, and dissociation can produce major gaps and inconsistencies in the survivor's sense of her own history (Courtois, 1988; Goodwin, 1989; Reiker & Carmen, 1986; Summit, 1983; Terr, 1979). Trance-like states of dissociation can cause vagueness about even non-traumatic and current experiences. In addition, action and enactment can replace self-reflection in some traumatized individuals, discouraging self-knowledge. This lack of self-knowledge can become problematic for treaters. Indeed, individuals with long histories of dissociation and impulsive acting-out may be viewed as manipulative and uncooperative or as having a factitious disorder because of an inability to provide a consistent history (Chu, 1990). Furthermore, such persons may actually confabulate and distort in an attempt to cope with contradictions and memory gaps. Even when survivors have memory for traumatic events, their emotional and cognitive understanding of these events may seem deficient or inconsistent because of their difficulties integrating these intolerable experiences.

Finally, survivors struggle with an impaired self-image of being either unduly bad and dirty or unrealistically special (Courtois, 1988). Either extreme may be experienced by the survivor as shameful and unacceptable. In addition, both may create the illusion for the survivor that she possesses heightened powers of either destructiveness or invulnerability. The survivor's impaired self-image may be explained by several relational experiences, central to childhood trauma. First, children who are abused by their caregivers typically believe that they have been "bad" and that that is why they are abused (Courtois, 1988; Summit, 1983). Second, abused children and, later, adult survivors often experience profound humiliation and shame. Over years, these repeated emotional reactions may lead to the survivor's belief that she is "bad," or even "evil." In some cases, it may not be possible for an individual to change her sense of "badness" without an understanding of her shame and its source. Finally, an identification with the abuser may underlie both the survivor's "badness" and her sense of being powerful and special, especially if the abuser has also been an important, perhaps even nurturant, caregiver.

Illustration

Ms. A., an articulate, witty businesswoman and a survivor of violent father-daughter incest, was prone to radically different levels of functioning. She viewed herself as a Jekyll-and-Hyde character and experienced a terrible, destructive power inside her, which she believed could cause disease and death. Her initial attempts to explore her history made her feel unreal, self-doubting, and fragmented as she could only recall contradictory pieces of her past. Over the course of therapy, she connected her self-image to a sense that her father actually existed inside her and that she and her father, or the internalized father-part, had a Bonnie-and-Clyde-like partnership. As she pieced together memories, she suspected that she had enjoyed the specialness of her relationship with her father, but that this relationship had included witnessing or passively participating in violent acts toward others. She struggled with her own impulses to harm others, finding this the most shameful secret of all and the most difficult to disclose in her therapy. The more she addressed her special identification with

her father, the sadder she became, realizing that this imagined connection had helped cover her vulnerability and the absence of parental love in her childhood. Reviewing her past therapies, she believed her early attempts to deal with her "badness" had been misguided because of suggestions to "get in touch with her anger," without comprehending the intensity and complexity of this issue as it related to her abuse history. Initial efforts to address her shame were painful and unsettling as Ms. A. experienced such exploration as a humiliation in itself. As her treatment progressed, however, the exploration of her shame as well as her grief became central to relieving her sense of "badness" and omnipotence.

Conclusion

Having argued that chronic childhood abuse explains many of the key features better than previously articulated developmental theories do, it seems inevitable to raise the question of the utility of the borderline diagnosis itself. Is the term "borderline" too weighted down by inaccurate and pejorative implications to convey these new meanings? Does the syndrome as reframed really fit within the category of the personality disorders as generally understood? Would it be more accurate to think of a diagnostic label that directly conveys the etiological centrality of trauma?

The diagnosis has a long history, including a series of major attempts to define core features of the borderline syndrome from the 1950s on (Grinker, Werble, & Drye, 1968; Gunderson & Singer, 1977, Gunderson & Kolb, 1978; Kernberg, 1975, 1977; Knight, 1953). However, as Perry and Klerman (1978) have noted, the individuals selected by these early diagnostic systems form a very heterogeneous group. Even with the advent of standardized DSM III and III-R (1987) criteria, 93 combinations of symptoms can result in a borderline diagnosis, producing a collection of individuals who again bear only minimal resemblance to one another. Other authors note that the borderline diagnosis co-occurs with various Axis I and II diagnoses, but without necessarily showing any consistent pattern of interrelationships (Angus & Marziali, 1988; Hurt & Clarkin, 1990; Zanarini et al., 1989). All of these factors raise serious questions about the diagnosis and its validity, as it is currently understood.

Moreover, in light of new etiological data, another significant issue is added to the discussion. One has to decide whether the Axis I diagnosis of post-traumatic stress disorder may better fit this population, given the striking parallels between core features of post-traumatic stress disorder and borderline personality disorder that have been noted in the literature (Brende, 1983; Donaldson & Gardner, 1985; Gelinas, 1983; Herman & Van der Kolk, 1987; Lindberg & Dystad, 1985; Parson, 1984; Sedney & Brooks, 1984). Research results have been mixed, with one study finding both diagnoses co-existing (Goodwin, Cheeves, & Connell, 1990) and others finding either inconsistent or non-significant levels of post-traumatic stress disorder (Herman et al., 1989; Saunders, 1991). Therefore, although trauma may be etiologically important for the development of the personality diagnosis and may lead to clearcut post-traumatic stress disorder in some individuals, not everyone with a borderline diagnosis actually meets the Axis I criteria, even at acute points in his or her clinical course. In addition, the post-traumatic stress disorder diagnosis does not capture adequately the important differences between the impact of one traumatic experience and chronically traumatic life circumstances or between trauma occurring in childhood and in adulthood. Finally, studies consistently show a significant minority of people diagnosed as borderline who do not report abuse histories. It is unclear whether this is a specific, characterizable subgroup within the general diagnosis or whether these are individuals who have remained amnestic for their experiences of abuse. Thus, it is difficult to imagine post-traumatic stress disorder replacing borderline personality disorder, given all these inadequacies and unanswered questions.

A new option is currently being investigated in clinical trials for DSM-IV, called Disorders of Extreme Stress Not Otherwise Specified (DESNOS). Like a personality diagnosis, it captures characteristic and enduring patterns, in this case reflecting the aftereffects of chronic trauma, but it does not require the specific symptoms of the flooding and numbing phases of post-traumatic stress disorder. Because the clinical reliability and validity of this diagnosis has yet to be verified, it is difficult to know whether it will provide a workable solution to the diagnostic dilemmas for at least those individuals meeting borderline criteria who also have knowledge of a history of childhood abuse. Given our reservations about the pejorative implications of the term "borderline," about its poor specificity, and about much psychodynamic literature on the subject, we certainly hope that a viable substitute will become available. However, this substitute must make sound conceptual and clinical sense. Otherwise, it will risk

becoming simply a covert and less offensive way of indicating "borderline personality disorder."

Discussion Summary

After each colloquium presentation a discussion is held. Selected portions are summarized here. At this session Drs. Judith Jordan, Jean Baker Miller, and Irene Stiver joined Drs. Eleanor Saunders and Frances Arnold in leading the discussion.

Question: What about the effects of intermittent reinforcement patterns on battered women? What can clinicians do to help battered women with their dysfunctional relationship patterns?

Saunders: In fact, the article that I was referring to, on traumatic bonding by Dutton and Painter, is about wife battering. Concerning what a treater does to deal with this relationship pattern, it's something that one has to have a lot of patience with and not be judgmental about. Treaters must try to understand, and help the person understand, what's going on.

I suspect that some of what Fran said about trying to set limits or trying to bring up issues about self-care and self-protection would be very important. But it's a very difficult pattern to change.

Stiver: I don't think there's anything magical. I wish there were. I do think that group treatment, mutual-help groups, and the more informal networking do work. They provide empowering strength to the women so they can begin to recognize their relationship patterns themselves. I think this occurs in the group process. I think it's that growing awareness of doing it without feeling ashamed of the fact that they keep going back and going back to that situation which is so shameful. When they hear that other women go through that too, and begin to see that in context, I think then there's more chance of some kind of shift, or getting out of that stuck, repetitive pattern.

Arnold: I think, traditionally, it's been understood as simply a character flaw and it sort of stopped at that. People would just say to the patient, "look, you're being masochistic and there's something just wrong with you," without understanding the relationship pattern in a larger context. It does shift the work for both the treater and the patient to put it back in its context.

A client I was working with said it is horrible to get the borderline diagnosis and that she prefers the diagnosis of post-traumatic stress disorder. It's not that she didn't think she had some of the symptoms that are described in the borderline diagnosis, but that with post-traumatic stress disorder one has some kind of context and explanation for why one is left with such effects.

Jordan: I really appreciate the reworking that Eleanor and Fran are doing on this, but I really think we ought to get rid of the diagnosis. I know there is a rich literature, but I think most of it's wrong. And I think most of it leads to a profound misunderstanding and a judging and punitive attitude. There actually was a study done that indicated simply by giving the diagnosis of borderline personality you automatically decrease the empathic responsiveness of the treater. If there's anything survivors need, it's an empathic response from the treater. I don't have an alternative either, but I think that we really ought to strike it from the books.

Miller: I, too, think it would be much better to have a totally open attitude and just try to understand what's going on, and I think Eleanor and Fran have done a tremedous job of unraveling it and trying to understand what's going on. We're in an age of diagnosis and it's pushed forcefully on all of us and reinforced by the social and economic structures of medicine. You have to have a diagnosis to have public or private insurance pay for any kind of treatment.

I think the history of this story involves the relationship between the treaters and the so-called borderline. It's very hard to separate who is doing what to whom and how, which you've alluded to in many ways.

I want to come back to the question about battered women. I think it makes a difference to a lot of the women who work in shelters to know that many battered women have to try several times in order to be able finally to leave a very bad relationship. So you then begin to recast it. Rather than feeling either that they are failures, or that the clients are disparaging their work, treaters can see it almost like practicing, that clients have to go through this two, three, four times. It has been said about giving up smoking, the best predictor of giving up is failing three or four times, and that gives you a different viewpoint.

Question: Do you think for some of these individuals long-term, inpatient hospitalization would help? I know there are some studies showing that self-injurers — cutters — do poorly with inpatient hospitalization, although it's been a reason to prolong their stays. I wondered what thoughts you had on that.

Arnold: Prolonged hospitalization, with a hospital and staff that doesn't understand the context of the borderline diagnosis, can be one of the worst things, and it can be very lengthy and very costly, and sometimes fosters a repetition of the troubled, earlier relationship patterns. I think that clinicians are trying to work for shorter stays. At McLean Hospital, we still

have a number of people who have longer admissions after a series of failed, shorter hospitalizations. In these instances, it' s hard to get a clear understanding of the hospital course because some trauma patients have repeated, failed hospitalizations in which treaters have not understood the trauma history.

Saunders: I don't think the question is simply about long-term hospitalization versus short-term. In general, the literature on outcome of treatments with borderline patients suggests that there is very poor outcome — whether it's outpatient treatment or inpatient treatment. I suspect that a lot of the problem in figuring out how to have a good treatment with this group of people has to do with such a profound misunderstanding of what the actual problems are. So it's hard to answer a question like that because it seems to me that there's been pretty much the wrong treatment, whether it's inpatient or outpatient. Maybe from this point forward we have a good chance of revising our notion of how to work with people who have had the kinds of histories which produce this range of symptomology and painful life problems. As stated in reviews of treatment outcome studies, many patients actually get worse as a result of the interventions of the mental health field. That's very serious and should make people stop and reflect carefully about what they're doing.

Stiver: I really think we have to take a stand. I think you two did a wonderful job of reframing, restating, and reorganizing it all so powerfully. However, by working in hospitals, it's almost as though we still get tied to the establishment. I think it's terribly important that we make the stand even though we're small in number in the struggle. I kept listening to you and every time I heard "borderline" I found myself feeling that it's just not right. It just feels so off. As long as we use the term "borderline," we contribute to poor treatment. I know that that doesn't solve the problem either because there's going to be poor treatment and there's going to be devaluing of women patients regardless of what labels you use. But I think it is really important to raise awareness and to start taking a stand more actively.

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