

Dynamics and Treatment of Borderline Schizophrenia from the Adlerian Viewpoint¹

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The *Handbook of Individual Psychology* published in 1926 included a paper by Ilka Wilhelm (10) on "Schizophrenia from the Viewpoint of Individual Psychology." In many other papers and books written by Adlerians we find a few sentences or paragraphs on this subject. These publications mention schizophrenia in passing to show how Adler's concepts fit in with the symptomatology of psychoses. Ilka Wilhelm's contribution is a thorough and scientific description of five cases of schizophrenia, their development and their treatment according to Individual Psychology. If we study her paper published twenty-seven years ago, we can either be proud of how sound her ideas as an Individual Psychologist were, or we can be disappointed about the limited and slow progress we have made since then in regard to etiology and psychotherapy of schizophrenia.

We have to apply Adler's concept of the human being as a totality of body and mind to understand the etiology of schizophrenia. There are certainly many etiological factors to be considered, such as heredity, constitution, and somato-type which form the premorbid personality. This personality may respond with a schizophrenic type of psychosis to various environmental stimuli, to physical or especially to emotional strains. This concept of totality is substantiated by most of modern scientific research, as for instance Kallmann's studies on identical twins.

Among the etiological factors, we have to mention not only those within the individual, but also those within his environment, his family and his society. Here again we follow Adler in visualizing

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the person as a part existing within the field of his relationships, reacting to his environment and acting on it.

According to this viewpoint we state:

1. Heredity and constitution may predispose an individual to a schizophrenic reaction, possibly due to some organic inferiority.

2. A specific influence of the family, as the earliest environment leads to certain attitudes toward life problems which constitute the premorbid or prepsychotic, so-called schizoid personality, a personality that develops a pattern of withdrawal and avoidance in the face of difficulties; that responds with helplessness and confusion to any challenging situation and feels isolated and alone in a world without friends.

3. This person cannot meet the demands of adult life, of society represented by school or work situation.

The outbreak of the psychosis occurs under pressure of the environment, to which the individual who has neither social feeling nor a life goal is unable to respond with a healthy or even with a neurotic adaptation.

Lewis Way says in *Adler's Place in Psychology* (9): "While the neurotic's refusal to adapt is only conditional, only a protest against some special aspect of life, the psychotic's is a total refusal, an unrelieved failure in every direction at once."

Ilka Wilhelm in her above mentioned paper explains some of the symptoms of schizophrenia: "The dissociation of affects originates in the need to exaggerate natural expression of affects and serves the trend of the patient to move out of group living. His pathological need for power explains some features of his behavior: search for originality, mannerism, grimacing, the repetition of apparently meaningless phrases and verbigerations, and his negativism. His catatonic features serve to separate him from the community, in the same way as his aggressiveness, only that the latter shows more courage. Compulsions and obsessions are a 'side-show' to evade responsibility, an expression of the low self-esteem of the patient."

Alexandra Adler, however, states in *Guiding Human Misfits* (3): "In a psychosis the connections between the individual life goal and the symptoms are less logical and less clear than in a neurosis."

At this point I want to define the concept of "Borderline Schizophrenia" and to explain the reason for limiting this paper to the discussion of this disease entity.

The "borderline patient" shows many signs and symptoms of the psychotic schizophrenic without having completely withdrawn from reality and without overt irrational behavior. This patient hovers as it were on the borderline separating neurosis from psychosis.

Nolan Lewis (6) says: "In the early schizophrenic there are apt to be shyness, seclusiveness, timidity with marked mood fluctuations and with anxiety that becomes activated by all environmental changes, indicating generalized sensitivity. There is blurring of the borderline between reality and unreality. The phenomenon of depersonalization, complaints of not being able to reach people emotionally or to be reached, feeling of being alone in a crowd are characteristic. There are all kinds of neurotic symptoms, like obsessive, compulsive or phobic or psychosomatic in large variety; for these symptoms the term *pan-neurosis* seems adequate. There is a deeply seated conviction that something fundamental, dangerous and threatening is at the core of the situation." Besides the term "borderline schizophrenia" or "*pan-neurosis*" we also find the term "pseudoneurotic schizophrenia."

These remarks may clear the meaning of the term. Though the definition is not a strict one, those of us who have dealt with patients of this kind will know what we are talking about. Alexandra Adler's remark of "less logical and less clear connections between life goals and symptoms in psychosis" explains why *Borderline Schizophrenia* was chosen as the topic of this paper. By presenting three cases of this kind and their dynamics, I will try to trace these connections before the outbreak of the full-blown psychosis and before deterioration has taken place. Another point which I hope to make concerns treatment. The pathological changes in the borderline patient are to a great extent reversible. Though the heredity and constitutional factors remain, like the great sensibility or low threshold to all kinds of stimuli and a tendency to introspection, the psychological factors and the symptoms can be remedied, if and when the patient can establish a direction toward a social life goal.

Rose, a girl of twenty-two, came for treatment after a suicidal attempt with sleeping pills and a short stay at Bellevue Hospital. The attractive girl, pretty, intelligent, with a talent for poetry and for painting, could not get along with anybody, neither within her family nor with friends or at work. She seemed lost in contradictory feelings and inconsistent actions, and was full of anxiety and guilt

feelings. Delusional episodes contributed to her confusion. Once, for instance, she saw a little boy with both legs amputated and bleeding, sitting on the baggage rack of the Long Island Railroad. The image disappeared in a few minutes. Rose became aware of its unreality, but she had to leave the train in a panic. She also felt a compulsion to throw herself in front of onrushing cars. She was unable to keep a job or to attend school.

Her childhood had been a disturbed one. She was the oldest child, had one brother five years younger. Her father was an extremely possessive, domineering person who ruled the house, including his dependent, submissive wife. Rose was the father's absolute favorite and strongly tied to him. He humiliated and ridiculed her weak and fearful mother and openly preferred the attractive, premature adolescent daughter. The mother tried to get on good terms with Rose, flattered her, wanted to prove that she was as good a parent as the father. At the same time she competed against her daughter for the father's attention and approval. In this triangular struggle the son was nearly forgotten. This case report may sound like a typical history of the pampered child. As always, life is not typical. In spite of all the favoritism and spoiling which surrounded Rose like a queen's court, her parents' attitudes were of an opposite, conflicting nature as well. Her father was extremely demanding, and became critical and rejecting when Rose did not live up to his expectations, whether it meant success in school or in any other respect. He wanted her to be popular and successful with boys, but became destructive of any relation which could lead to even a limited independence of his daughter. The mother had uncontrolled outbreaks of rage against Rose. The girl showed from early adolescence some delinquent behavior, such as truancy, stealing, and later on, sexual promiscuity as a result of a confused rebellion against all these pressures.

Her emotional disturbance was first diagnosed as hysteria and counseling was advised to help her to a better adjustment. It was pointed out to her that she contributed to her parents' unhappiness, that she acted like a spoiled princess, that she should try to live up to social responsibilities. She felt worthless and rebellious at the same time, broke off counseling, had a few delusional episodes and attempted suicide. Then she started psychotherapy with me.

After reporting on two other cases as briefly as possible I will discuss the dynamics and treatment of all three patients.

Morty, a boy of fourteen, was referred to me as schizophrenic by the school psychologist after a diagnostic evaluation at the Psychiatric Institute of Columbia University Medical School. Because of his youth, psychotherapy was attempted before referring him to shock treatment. He had not attended school for two months in spite of all kinds of threats and punishment; he appeared withdrawn, frightened and hardly talked to anybody. His passive and withdrawn attitude had been interrupted by wild temper outbursts. When, for instance, his younger brother borrowed his bike, he had tried to strangle him. The family was poor, his father had been alcoholic and had beaten his wife and abused her in front of the children. Finally he deserted her and his three children. Morty was the middle child between an older sister and a younger brother. His mother had remarried, had a baby in this second marriage. Morty's stepfather could not control the boy, had once tied him for hours to the bed for punishment. Finally the boy refused to go to school. Punishment or threats remained unsuccessful when Morty did not budge from his room and stopped answering or defending himself. The truant officer called the school psychologist; finally the community and the parents realized that the boy was sick. Treatment with him and his family started then.

The last case concerns a young man, Paul, twenty-two years old, the youngest son of a domineering, overprotective mother and a weak, dependent, though impulsive father. Paul had always been a shy, withdrawn youngster, but had been able to finish college and to hold a job as technical laboratory assistant in spite of many delusions and ideas of reference. He came for treatment because of his inability to concentrate, his complete lack of companionship or friendship, his fears which made walking on streets or riding in the subway an ordeal. Only by a heroic effort to overcome these fears was he able to get to his job. His leisure time was spent secluded in his room, reading, making attempts to paint, day dreaming and masturbating. Because of his unhappiness he went to a vocational guidance service and was referred to psychotherapy.

What has happened to these three people? Without denying the importance of hereditary predisposition, we will attempt now to trace the influence of their early and later environment.

Alfred Adler (1) says: "Man's behavior is determined by his interpretation of his environment. My conviction credits the child with a free path for its striving for achievement, perfection, fulfillment, su-

periority, indeed for evolution itself, as developing its inborn capacities. This striving and the influences of the child's environment and upbringing, all serve as building material out of which the child, a playful artist, forms its style of life."

We ask: "What has gone wrong with Rose, Morty, and Paul?" Adler answers (2): "Mother is the first cooperater, she stands on the threshold of social feeling." And again: "Spoilt children, once outside the circle in which they are spoilt, forever feel their safety to be threatened, as though they had entered enemy country. The result is unlimited self-love and self-absorption." I want to add: If this is the result of pampering, the result of neglect can be similar or worse. The child grows up in enemy country, there is no circle of safety. There is only confusion, contradiction, overwhelming danger in the environment.

In our three cases, Rose, Morty, and Paul, and probably in most, if not all cases of borderline schizophrenia, we find pampering and neglect. The confusion becomes even more destructive if one and the same person, mother or father, is alternately and incomprehensibly pampering to the degree of squelching the child's "creative power" and rejecting and humiliating to complete the destruction of his personality. The child, the patient later, has no self esteem, no feeling of security, no feeling of belonging. Human relationship for this person, who perceives himself as utterly weak, defenseless, at the mercy of everybody and everything in his environment means only dependency on a superior, strong, powerful figure who can either destroy him or demand extreme symbiotic renouncement of self assertion for the price of protection and love. Schilder says (7): "We have to discover to what extent the symptoms of psychotics represent weapons employed by them in their struggle to assert themselves."

The schizophrenic feels anticipatory anxiety and dread in most situations. He has hardly ever experienced any social feeling towards him; therefore he has had no opportunity to develop it. For him the world is a chaos, a threatening jungle; he is either a victim or he shows irrational outbreaks of hostility and to defend himself attacks others. The response to his attempts of aggression are defeat and discouragement, a point which will be stressed again, when we discuss therapy. We understand the schizophrenic's withdrawal as an attempt to hide, to be left alone in his chaotic environment, his temper tantrum and occasional violence as a hopeless and undirected attempt of self assertion, his mood swings and depression as a result of his constant failures

and discouragement, his fears, suspicion and secretiveness as weapons against further destruction by his hostile environment. Unpredictable and unfounded attacks from one of his parents, changing suddenly to outpourings of so called "love," lack of protection by the other parent, do not lead to any consistent style of life. It seems to be safest to expect mutual hostility and hatred, to be prepared for it toward everybody. Every person is a potential enemy and ideas of reference result, with projection of one's own feeling of hostility on to the environment. Usually members of the opposite sex seem more dangerous and threatening; therefore Freudian interpretation finds latent homosexuality in all paranoid patients. Magical thinking, inability for testing of reality and consequent delusions are the result of the constant feelings of helplessness and anxiety.

Goldstein and many others studied the disturbance of abstract thinking in schizophrenics; a disturbance which we can also observe in borderline cases and which improves under therapy. Abstract thinking develops in man as a socialized being. An atmosphere of security and social interchange is essential for the child's proper intellectual development. Social learning, imitation, explanation, verbalization are all prerequisites to the development of abstract thinking. The chaotic environment of the schizophrenic does not give an opportunity to acquire abstract thought processes.

At this point I want to make a short remark on the question of causality versus finality.

Adler's concept stresses the purpose of the patient's symptoms and disease. You may have noticed that in my presentation I could not avoid assuming causal connections in the development of the schizophrenic's personality. In this I do not see a contradiction to Adler's viewpoint but a logical consequence of his holistic approach to life as a growth process conditioned by past experiences and by an outlook towards the future. Our personality changes with time; each moment is a link in the change of individual development connected to the past by causality and to the future by purpose. What goal can a schizophrenic strive for, since he has lost or never had a sense of direction?

Lydia Sicher writes in her paper on the "Individual in Society," (8): "The mentally sound individual asks: 'How do I stand in relation to the world?' while the mentally sick questions: 'How does the world stand in relation to me?' As for the answer to this rhetorical question, the neurotic always expects the world to be inimical; for he seemingly

justifies his attitude toward life by anticipating defeat." He develops his life style to avoid the area of anticipated defeat.

The psychotic perceives the world not only as inimical, but as chaotic, incomprehensible, ruled by chance, contradictory. The borderline patient still attempts to test reality; he hopes to find a goal and a purpose to orient himself, but goal and purpose shift and change, come and go in the same whirlpool of experiences (in the meaning of *Erlebnis*) as the unpredictable and contradictory experiences in his childhood. Lewis Way (9) writes: "The aim of the psychoses appears to be to do away with all restrictions binding on the personality, even if this can be achieved by way of a mental suicide. Schizophrenia may attempt to kill all sense of purpose through a fragmentation of the whole personality."

Rose, Morty, and Paul had to re-experience their childhood in the secure and consistent relationship with the therapist. The establishment of this relationship can only succeed if slowly the past traumatic and destructive experiences are balanced against the new ones. I cannot go into detail of this reconstructive work. It is difficult, because the patients are dependent, clinging and demanding in one moment, hostile and provoking in the next. The therapist needs flexibility, patience and understanding, but also a firm sense of values and direction to enable him to give support and guidance to his patient.

What the therapist should strive for and try to communicate to his patient is expressed in a beautiful booklet *Religion and Individual Psychology* by Alfred Adler and the Reverend Ernst Jahn in regard to the principles of human motivation (5): "In monotheistic religions every individual forms a picture of the working and embodiment of the supreme being different by a thousand shadings from the conception formed by others. Whether you term the highest moving principle God, or Socialism or, as we do, the pure idea of social feeling, or as others do—clearly borrowing from the community concept—the ideal ego, it always reflects the dominating goal of self-conquest that promises perfection and blesses."

Rose was under treatment for only six months; some of her attitudes improved so that she was able to attend college regularly and to have less confusing interpersonal relationships. Suicidal actions and phantasies and delusions did not reoccur. Slowly therapy seemed to make her independent from her father. We attempted to work with the parents, but unsuccessfully. Rose's growing independence moti-

vated her father to remove her from treatment by sending her to another country.

Morty's story has a happier ending. His therapy lasted for about one and a half years and consisted mainly in playing monopoly, chess, and checkers. From the first session on he seemed to enjoy his relationship with me; he slowly became more secure. He talked about his unhappy past experiences and about everyday happenings within his family and later on with friends. He accepted and integrated into his own thinking interpretations given in words to fit his intellectual and age level. He became free of anxiety. His confusion cleared up to the point that with some guidance he could move towards renouncing his destructive family environment. At sixteen he made the decision to live in an institution, the George Junior Republic. After ups and downs there which did not belong to the symptomatology of schizophrenia, but to delinquent behavior, he returned to his family. He now has a job and a girl friend and seems to be doing well.

Paul has been in treatment for one year and is continuing therapy. According to my experience and others working with borderline cases who have, as he does, insight into their emotional upheaval, extreme anxiety about it and a desperate wish not to lose hold on reality, his treatment may last from three to five years.

The prognosis as far as functioning normally is a good one. According to statistics more than fifty percent of these cases can lead a normal life, with jobs, family, and friends. There is no doubt that some personality traits, like great sensitivity, remain. Scars resulting from the psychotic experiences show up in different ways; for instance, difficulties in making decisions, exaggerated intellectualizations with lack of spontaneity. Further research and follow up on these cases will teach us more.

The borderline schizophrenic responds to treatment, if we as therapists are able to substitute for him as a parent figure who shows him the first steps in cooperation, the first experience with social feeling and who interprets society to him as a place of relative safety, as a world which is not chaos, but has rules and regulations, though sometimes inadequate ones. Treatment is an emotional process in which the borderline patient experiences security without overprotectiveness, help without being overwhelmed or threatened by dependency, guidance without being forced or coerced, encouragement and approval for every attempt to grow up, no punishment or humiliation

for failures, but renewed encouragement and guidance for a new effort to do better the next time.

The fear and confusion of the schizophrenic, comparable to the fear of a hunted animal, has to be relieved step by step. The relief from fear should be attempted gradually by the therapist. A starved person cannot stand too much food in the beginning. Haste or too intensive reassurance can either confuse the borderline patient or make him more distrustful, or may lead to delinquent acting out. Especially the adolescent patient like Morty seems to vacillate between overwhelming anxiety and withdrawal on the one side and, if the anxiety is relieved, the feeling that everything is permissible, that there are no limits for his anti-social acts on the other. The therapist never should be provoked into frightening the patient by a rejecting or threatening attitude, but he has to interpret and explain why we all have to accept limits to fit into society.

The adult borderline patient usually has tremendous anxiety about losing control. As long as his perception of reality is not destroyed and his judgment partly preserved he will rather attempt to be destructive to himself than to others. But the problem remains to help him to gain courage, to assert himself and to develop social feeling not only in the dependent relation to the therapist, but also as an equal in the community. Dreikurs says (in the *Fundamentals of Adlerian Psychology* (4): "The psychotic's attitude toward community more or less decides whether the illness can be cured or will become more serious," and he recommends group therapy.

Many psychiatrists feel that about one-third of the patients who come for psychotherapy belong to the borderline schizophrenics. We do not know whether we are better able to diagnose these cases or whether more come for treatment because they can be helped. Freud saw in society mainly a restrictive, inhibiting influence. Even Freudian analysts agree now that the borderline patient develops an open psychosis and has to be hospitalized, if the psychoanalyst "removes defense mechanism" and sets free "libidinal drives." The Adlerian will be aware that it would be a mistake to explain to the borderline patient that his symptoms have an asocial purpose, before the patient has gained enough basic trust in himself and in other people to develop social interest. The patient's own "creative power" will be liberated and he can function to his own satisfaction and be useful within society. As a result of psychotherapy as positive emotional experience,

a style of life can develop which is directed toward a social goal and which replaces "unlimited self-love and self-absorption."

Alfred Adler (5) says: "Thus not the intellect has the power to divert our drives, only the altered goal, the changed style of life has such power."

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