THE INTERACTION OF PSYCHOPHARMACOLOGY AND PSYCHOANALYSIS IN THE BORDERLINE PATIENT
Scott Snyder, M.D.

An analysis of the interplay between psychoanalysis and psychopharmacology in the borderline patient is presented. The importance of affect in developing definitions of the borderline syndrome is discussed. The effects of medication on the affect of the borderline is seen as a technique for better delineating the syndrome and dividing the syndrome into subtypes.

INTRODUCTION

The psychiatric community has witnessed a veritable explosion of the use of the term borderline during the last decade. The student of the borderline finds new terminology, elaborate psychoanalytic formulations, and a vast array of information on the syndrome appearing regularly. Yet for many the term remains somewhat vaguely defined and even enigmatic. Some even believe the borderline is an illusion.¹

Most definitions of the borderline have stressed psychoanalytic formulations. Scant attention has been paid to descriptors such as prognosis, and response to medication, to biometrics, and to a host of other factors which have proved their value over time in psychiatric classification. No comprehensive definition of the borderline patient has emerged by coalescing knowledge from such fields as developmental psychology, epidemiology, and psychopharmacology. This is largely due to a lack of adequate knowledge in these areas on which to base such a definition. Perhaps a more fundamental reason is the formidable ability of attempting to fuse these diverse bodies of knowledge into a somewhat cohesive unit.

This work is intended as a step toward the coalescence of the psychoanalytic psychology and what is known of the psychopharmacology of the syndrome. The purpose of the paper is two-fold: (1) to explore the interrelationships between psychoanalytic and psychopharmacologic perspectives as they aid us in unifying our concepts and definition of the borderline patient and (2) to define the role of medication in the treatment of the borderline patient.

Clinicians have come to recognize certain central dynamic and developmental issues in the borderline. Indeed, these issues may form the core of the borderline’s pathology and be more valid and reliable than the descriptive one.
diagnosis of the syndrome itself. Therefore, we begin with a brief review of the most widely accepted psychoanalytic conceptualizations of the borderline. Then the central role of affect in the syndrome will be traced. Next we shall review the sometimes controversial use of response to medication as an aid in diagnosing the borderline. Then an examination of the content of the medication administered will be presented. It will be seen that certain types of medication may affect different subtypes of the borderline selectively and that response to medication may aid us in delineating the syndrome.

MAJOR FORMULATIONS OF THE BORDERLINE PATIENT

Within recent years, the borderline syndrome has attained an ever-increasing recognition. A variety of ways of conceptualizing the entity has been introduced, ranging from descriptive characterizations to formulations based on psychoanalysis and ego-psychological perspectives. Numerous names abound for the syndrome: the "as if" personality, pseudoneurotic schizophrenia, the borderline personality organization, and the borderline syndrome being among the most popular. This section shall briefly outline some of the most significant descriptions of the syndrome. It will emphasize the dynamic issues which seem to be basic to most descriptions of the borderline and is not intended as a comprehensive review of the syndrome.

Knight was the first to describe ego weakness as being central to the "borderline state". He described "microscopic" evidence of ego weakness such as reduced integration of ideas and concept formation, impaired judgment, intermittent blocking, occasional inappropriate affect, suspiciousness, and a singular lack of concern for the above symptoms. Neurotic symptoms, especially hysterical, psychosomatic, phobic, or obsessive-compulsive, were often noted. The "microscopic" ego weaknesses were marked by an absence of a particular stress which brought the patient to therapy and a view of his symptoms as caused by outside circumstances. His concept was time limited and described an interval in a patient's life in contrast to other descriptions which are more chronic and long lasting.

Kernberg separates three sets of criteria for his "borderline personality organization." The first set includes standard descriptive features such as diffuse, free-floating anxiety, polymorphous perverse sexual trends, polysymptomatic neuroses, and classical prepsychotic personalities such as the schizoid and cyclothymic personality.

The second set is the structural analysis of ego weaknesses. Deficits occur in areas such as impulse control, the development of sublimatory channels, and anxiety tolerance. The patient has pathologic internalized object relations and a shift toward primary process thinking. Specific defensive operations of the ego such as splitting, primitive denial, idealization, projective identification, and alternating omnipotence and devaluation are also characteristic. This second set is the most innovative and serves as his definitive criteria.

A genetic-dynamic viewpoint forms the final set of criteria. Kernberg believes there is an excessive development of oral aggression in both sexes. This results in a pathological amalgamation of pregenital and genital strivings under the influence of aggressive needs.

Grinker et al. uses empirical research to devise his concept of the "borderline syndrome." His group identified four characteristics that are central