Chapter 70

The borderline personality structure in adolescents - a clinical case report

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1 INTRODUCTION

It is important to define the concepts of structure and structural diagnosis, considering views with some differences and many complementarities, in the Psychopathology that one intends to discuss and study. In fact, it can also be observed that there are several levels of dIgnosis in Psychopathology. Fiorini (1986) describes at least nine distinct types of diagnosis in Psychopathology: (1) clinical, (2) evolutionary, (3) adaptive and prospective, (4) group, (5) psychosocial, (6) communicational, (7) health potentials, (8) body issues, (9) therapeutic bonding

Clinical diagnosis, which is based on the traditional categories of psychopathology, for many professionals and researchers is fundamental for the definition of pharmacological and clinical approaches, multidisciplinary psychotherapeutic approaches, and short- and long-term prognostic criteria. And, in fact, it also allows this dialogue with researchers from all over the world. However, one can raise relevant criticism about the manuals (International Classification of Diseases 10th Edition (WHO 1994), with the 11th edition under study, and the DSM that was released in its fifth edition (APA, 2014). The main criticism lies in the excessive standardized categorization.

In this way it can also be mentioned that there is more than one Psychopathology. Just to focus on two of these, one can mention the descriptive, for which the form of the psychic alterations is fundamentally important, the symptom that characterizes the pathological experience. For Dynamic Psychiatry, the interest lies in the content of the experience, in the affections, desires and fears, in a particular experience, where the symptoms have a meaning (Dalgalarrondo, 2008). This same author advocates a skillful combination of the descriptive approach and a dynamic approach of the person presenting an alteration.

This is also Gabbard's (1998) proposal for Diagnosis, that is, that two objectives should be contemplated: to reach a descriptive and a psychodynamic diagnosis. The descriptive diagnosis can be the basis for medication planning, but the dynamic diagnosis allows the patient to understand the meaning of the medication itself, and is fundamental for the team's professionals to deal with problems in treatment

compliance as a whole. On the other hand, as will be pointed out later, the dynamic structural diagnosis is important not only for the indication of psychotherapy, but in all therapeutic planning.

With respect to DSM IV (APA, 1996) and DSM IV - TR (APA, 2002), Kernberg (1995) considers that understanding the intra-psychiatric characteristics of patients together with criteria derived from the descriptive diagnosis can result in a great improvement in diagnostic accuracy.

On the other hand, Kernberg is one of the authors of a very interesting article that brings a concern and a criticism, worth mentioning, with respect to the DSM-V (APA, 2014). This is a paper written by senior researchers working in various theoretical lines, who have experience in personality disorders (Shedler; Beck; Fonagy; Gabbard.; Gunderson; Kernberg; Michels and Drew Westen, 2010). These researchers aim, with this manifesto, to ensure that personality assumes a more important place in psychiatric diagnosis and treatment. They bring the concern that a characteristic dimensional approach may not work for real-world clinical diagnosis. They recommend that a diagnostic system should be clinically relevant, cover the spectrum of personality syndromes seen in practice, facilitate their recognition, and most importantly should focus on people, not types of classifications. The aforementioned researchers acknowledge an improvement in DSM V over DSM-IV in that a diagnostic assessment should also recognize gradations of severity, as DSM V does. But the authors question and criticize a trait-based system, such as the one proposed in this latest revision for persondality disorders.

The diagnosis discussed here is the structural and evolutionary, which, as pointed out by Davoglio (2011), is an important indicator of the extent and achievement of the stages of psycho-emotional development reached by the individual. Relationships are sought with what unfolds from childhood experiences and development.

About the structural approach to differential diagnosis, and referring specifically to the borderline personality organization, Kernberg (1995) emphasizes the importance of diagnosing the patient as a total individual and evaluating his internal life of objective relations in terms of self and other aspects. The same observation applies to patients with other manifestations, with the focus always being on the total individual.

Vaisberg and Machado (1999) bring a relevant contribution to this debate in an article in which they discuss and present the notion, the relevance and mainly the meaning of structural diagnosis, which the authors have done based on Bergeret's (1992) conceptions. They consider that one must deal with a conception of personality structure as "history transformed into psychic structure", since Psychoanalysis is a "genetic structuralism" as Goldmann (1974) points out, quoted by the authors. They point out that structural, in this context, does not mean detached from history, but, "on the contrary, that which crystallizes from infantile emotional history" (pp3). Even following the structural diagnosis proposed by Bergeret, Vaisberg and Machado (1999) state that in clinical practice, structures can be maintained, but their

functioning can be transformed. And they consider, on the other hand, that borderline organizations may come to be truly structured, such organizations will be addressed in this presentation.

Another conceptualization of structure that can underlie an understanding of psychopathological aspects can be highlighted, which refers to Conduct Structures, a concept by the Argentine psychoanalyst Jose Bleger (1975) which, studied at the psychological level, is an organized totality, functioning as a unit of experience and unit of meaning. To diagnose behavioral structure is to study the patient in situation, including the diagnosing professional. From this point of view, every behavior is a specific pattern of interpersonal or object relations, and each individual has his or her own repertoire of behaviors, modes or privileged structures of behavior (Kusnetzoff, 1982).

Two fundamental conceptions arise here: according to Bleger and taken up by Kusnetzoff (1982), that every conduct, at the moment it manifests itself, is the "best", in the sense that it is the most ordered and best organized that the organism can manifest at that moment and is the one that can regulate the tension as much as possible for these conditions. Kusnetzoff (idem) defines and differentiates levels of Integration, which refer to a certain progressive and increasing development of improvement in psychological organization. This development implies a greater complexity in the structure and functioning of the psychological apparatus, as well as a growing differentiation of the same. In this sense, following Bleger's conceptions, he also establishes two levels of integration: Neurotic and Psychotic.

Finally, as a definition of structure that underlies these reflections, we cite Kernberg's (1995) definition: structures are relatively stable configurations of mental processes (p.6). Still according to this author, the concept of mental structure was formulated for the first time by Freud (1976) in 1923, when he refers to the division of the psyche into ego, superego, and id. The superego and id are structures that dynamically integrate substructures, such as the cognitive and defensive configurations of the ego.

In a later work, devoted to describing the way Kernberg and his team recommended on the Treatment of Patients with Borderline Organizations of Persondalide, written with Clarkin and Yoemans, Kernberg (2006) maintains and extends the conception of psychological structure as being a stable and enduring pattern of mental functions that organize the individual's behavior, perception, and subjective experience (p.2).

Caligor and Clarkin (2010) also maintain the definition established by Kernberg and make it even more explicit, clarifying that Other examples of psychological structure are motivational systems, coping mechanisms, relationship patterns, and the processes that regulate the function of mood and impulses. The nature and organization of psychological structure are characteristics of the individual and tend to be stable over time, although they can be modified as a result of maturation, life experience, and successful treatment, conceive Caligor and Clarkin (2010).

Caligor and Clarkin (2010) further aim to discriminate structures from descriptive personality traits, as psychological structures are conceptualized within a psychodynamic frame of reference, and may not be

directly observed by the clinic nor reported by the patient. Instead, at the level of clinical observation, the nature of psychological structures can be deduced and also systematically assessed based on their impact on describing aspects of psychological functioning, in particular on an individual's behavior, interpersonal relationships, and subjective experiences.

It is still worthwhile, to bring into discussion the meaning of diagnosis. Vaisberg and Machado (1999) state that since the beginning of Psychoanalysis, Freud (1900/1976) recognized the importance of establishing a provisional diagnosis before the effective beginning of treatment. Freud revealed this concern in his work based on his vast clinical experience and on the theoretical concepts developed until then in Psychoanalysis. Thus, according to the same authors, Freud establishes criteria for the selection of patients, based on this initial diagnosis.

Kusnetzoff (1982, p199) , regarding diagnosis, says: "

The problem of diagnosis has always been, for any school of psychology and psychotherapy, an extremely complex problem. There is no diagnosis "in itself" without the subject that makes the diagnosis and above all without the purposes for which it is being instrumentalized.

Thus, it is very important to know how to diagnose, but more importantly for what purpose. A diagnosis has to have a why and a for whom, and so, circumscribing the theme of this text, one can say that the diagnosis has the meaning of favoring the understanding of the suffering expressed by the person, in its context; to favor the most indicated therapeutic indication. However, the themes raised here have always been the object of investigation. In the team coordinated by Kernberg, studies have been made for decades, always with the purpose of improving knowledge in order to help the human being.

The International Society for Transference Focused Psychotherapy (ISTFP) was founded in 2011 by Otto Kernberg and is composed of members from many countries. On the Society's website2 it is clearly evident that one of the most challenging aspects of working as therapists specializing in the treatment of personality disorders is the process of sharing with patients the impression of their diagnosis, and outlining for them the type of treatment proposed. Although difficult, this process is essential. It is generally recommended to start with an explanation of the term: personality disorder, which can sound negative and prejudiced, and it is important to have a clear understanding with patients about what is going on with them . All these issues are worked through, but the emphasis in this form of treatment is on helping patients understand the changes in their experience of themselves and their experience with others, instilling hope even in very difficult cases.

The Structural Diagnosis according to Kernberg - the Neurotic, Psychotic and Borderline Organizations

Kernberg (1995) uses the term structural analysis to describe the relationship between the structural derivatives of internalized object relations, which constitute hierarchically organized substructures of the ego, and the various levels of organization of mental functioning.

In the same work, Kernberg (1995) refers to structural analysis as the permanent analysis of the content of unconscious conflicts. For the author, this conception of mental structures refers to internalized object relations. This concept, so present in Kernberg's work, is based on the contributions of M. Klein (1943- 1963/1997) and M. Mahler (19681). And the author adds that the structural organization performs the function of stabilizing the mental apparatus by mediating etiological factors and the direct behavioral manifestations of the disease. The factors: genetic, constitutional, biochemical, familial, psychodynamic or psychosocial contribute to the etiology of the disease, and the effects of all these factors are present in the psychic structure of the individual, which then becomes the underlying matrix from which the behavioral symptoms develop. Still considering the relevance of structural analysis and structures, Kernberg (1995), citing Hartman, Kris and Loewenstein (1946) and Rapaport and Gil (1959), conceptualizes the ego as changing little by little from "structures" or configurations that determine the channeling of mental processes; the mental processes or functions themselves; and even "thresholds" of these functions and configurations.

Kernberg presents in the 1995 work a characterization of neurotic, borderline, and psychotic organization types, which are reflected in the dominant characteristics of the patient, particularly in relation to: (1) Degree of identity integration; (2) Types of defensive operations; (3) Ability to test reality.

Seeking to understand this picture, in the same work, Kernberg's (1995) conceptions are summarized. In a more recent work written 25 years later (Clarkin Yeomans and Kernberg, 2006) this characterization is broadened and deepened.

Thus, on the above framework, the neurotic structure in contrast to the borderline and psychotic implies an integrated identity, and the neurotic structure presents a defensive organization centered on recalcitrance and other high-level defenses. The identity diffusion syndrome and the predominance of primitive defenses allow structural differentiation between borderline personality organization and neurotic one; the reality test allows differentiation between borderline organization and the major psychotic syndromes. Borderline and psychotic structures are found in patients who show a predominance of primitive defensive operations centered on the splitting mechanism (Kernberg, 1995).

It is worth noting the definition of reality testing as the ability to differentiate between self and non-self, between internal and external origins of perceptions and stimuli, and the ability to realistically evaluate one's affect, behavior, and thought content in terms of usual social norms. Clinically the reality test is recognized as: absence of hallucinations and delusions; absence of bizarre or obviously inappropriate affect,

thought content, and behavior; ability to empathize with and clarify other people's observations of what seems to them to be affective. It is maintained in the neurotic and borderline organization but is strongly diminished in the psychotic organization (Kernberg, 1995).

Kernberg (1995) warns that it is necessary to differentiate the Reality Test from alterations in subjective experience that may be present for a moment in any psychologically tormented patient; and from the altered relationship to reality that is present in all character pathology, as well as in more regressive conditions such as psychotic ones (pp. 18)

These structural criteria can supplement the common behavioral or phenomenological descriptions of the patients and intensify the acuity of the differential diagnosis of mental illness, especially in cases of difficult classification. Additional structural criteria helpful in differentiating between borderline organization and neurosis include the presence or absence of nonspecific manifestations of egoic fragility, lack of anxiety tolerance, impulse control, and capacity for sublimation; and for purposes of differential diagnosis of schizophrenia - the presence or absence in the clinical situation of primary process thinking (Kernberg, 1995).

With respect to the superego, Kernberg (1995) clarifies that this relatively well-organized structure, although extremely austere, characterizes the neurotic organization of personality. On the other hand, borderline and psychotic organizations reflect failures in superego integration and are characterized by nonintegrated precursors of the superego, particularly primitive object representations, sadistic and idealized. The author adds that superego integration can be assessed by studying the extent to which the patient identifies with ethical values and has normal guilt as a regulator. The author establishes that the quality of object relations and the quality of superego functioning are probably the two most important prognostic criteria derived from structural analysis.

Clarkin, Yeomans and Kernberg (2006) in the Handbook of Treatment of Borderline Personality Disorders, bring contributions to the understanding of personality types and development, based on Object Relations Theory. They build on contributions by Klein (1997) and Mahler (1971) and emphasize notions about the drives described by Freud - libido and aggression.

The term object relations, clarify Caligor and Clarkin (2010), refers to the quality of the subject's relationship with others. Transformed from the external world, to the internal world of the subject, the term internal object is used with reference to the representations or presence of another within the subject's mind. Object relations theory comprises a group linked psychodynamically and psychoanalytically to psychological models of motivation and functioning in which the internalization of early patterns of relationships is seen as the central feature of psychological development and functioning.(p. 3)

Clarkin,Yeomans and Kernberg (2006) consider that these internal Object Relations are the building blocks of psychological structures and serve as organizers of motivation and behavior. Such building blocks, in fact, are units composed of a representation of the self, an affect related to or representing

a drive, and a representation of the other (the object of the drive). These units: the self , the other, and the affect that connects them; are the dual relations (or dyads). It is important to note that the self and the object in the dual (dyad) relationship are not complete accurate internal representations of the self or the other, but are representations of the self and the other as they were experienced at specific moments in time in the course of early development.

Kernberg and Caligor (2005) suggest that internal object relations arise from an interaction of innate dispositions of affection and attachment relations; from the earliest days of life. Constitutionally, certain affect states are activated and linked to interactions with caregivers. Over time, these interactions are internalized with relationship patterns, which are gradually organized in the form of enduring, affection-laden psychological structure to which they refer as internal object relations.

Thereafter, in this work, there are characteristic descriptive and structural descriptions about the normal personality. It is worth noting that normal has more of a sense of evolution and development. It is a concept more related to practice (without going into the complex issues surrounding what is called "normality"). Descriptions are always made in a comparative way, in order to favor clinical understanding.

Thus, Clarkin, Yeomans, and Kernberg (2006) establish that pathological personality is brought into focus when contrasted with a clear conception of normal personality functioning. That is, the individual with a normal personality organization has an integrated concept of self and the other signifiers, which is embedded in the concept of identity. This is a coherent sense of self that is basic to self-esteem, pleasure, and the ability to derive pleasure from relationships with others and commitments to work

A coherent and integrated sense of self contributes to the long-term realization of the person's capabilities, desires, and objects. Also, a coherent and integrated conception of others contributes to realistic evaluation involving empathy and social tact. The combination of an integrated sense of self and others contributes to the capacity for mature interdependence with others, which involves the ability to make emotional commitments to others while maintaining a sense of autonomy.(Clarkin,Yeomans and Kernberg, 2006).

Another structural feature of normal personality organization is the presence of a wide range of affective experiences. The individual with normal personality organization has the ability to experience a range of complex and well-modulated affections without losing impulse control. A third structural feature of normal personality organization is the presence of an integrated internalized value system. Despite its roots in the development of parental values and prohibitions, the mature internalized value system is not rigidly linked to parental prohibitions, but is stable, individualized, and independent of external relations with others. This internalized value structure is reflected in a sense of personal responsibility, a capacity for realistic self-criticism, and decision making that is flexible and related to commitment to norms, values, and ideals.(Clarkin,Yeomans and Kernberg, 2006).

Clarkin, Yeomans, and Kernberg (2006) refer, like other psychoanalysts, to infant development. Thus, they relate Object Relations Theory to personality structure, suggesting that in the course of child development, various internal pairs (dyads) are created based on early experiences. Object relations theory posits that as the child develops, the nature of his or her moment-to-moment experience differs in terms of affective intensity.

Clarkin,Yeomans and Kernberg (2006) address the importance of affect-laden memory structures that influence the development of the individual's motivational system. With respect to object relations, the child's satisfying experiences involve an ideal image of a loving and perfect other and a satisfied self, whereas frustrating experiences involve an entirely negative image of a deprived or even abusive other and a needy and helpless self.

Clarkin,Yeomans and Kernberg (2006) employ the concept of affections defined as innate dispositions that emerge in the early stages of human development. This constitutionality is genetically determined and affections are gradually organized into impulses that are associated and integrated into the initial object relationship. Pleasurable gratifying affections are organized as libido; aversive, painful, and negative affections are organized as aggression. Affects, then, are building blocks of impulses and signal the activation of impulses in the context of a given internalized object relation.

In the course of infant development, multiple affectively charged experiences are internalized, such that one segment of the psyche is constructed with these idealized images based on experiences of satisfaction and another segment is constructed with the negative affect and devalued images of the other. An active separation of these segments develops within the psyche (Clarkin, Yeomans and Kernberg, 2006).

These authors establish that in normal child development, there is a gradual integration of these extremes, the good and bad representations of self and others during the first years of life. This integration results from internal representations of the self and others that are more complex and realistic and that recognize the reality of people; they are a mixture of good and bad attributes and are able to satisfy at some times and frustrate at others.(Clarkin,Yeomans and Kernberg ,2006)

In children who evolve toward borderline personality disorder, the integration process does not evolve and a more permanent division between the idealized and persecutory sectors of peak (highly charged) affective experiences remains and remains as a stable pathological intrapsychic structure. This separation of functions protects the idealized representations (loving feelings toward the object perceived as perfectly satisfying), from the negative representations (associated with affections of anger and hatred toward the object perceived as harmful and persecutory). Because hatred is defined as the desire to destroy that which is perceived as dangerous, the separation of the good from the bad is necessary in this primitive psychic organization to protect the good representations of self and others from the danger of destruction by the hatred associated with the bad representations. This separation is the internal mechanism of splitting,

which is the paradigm of primitive defense mechanisms and is central to borderline personality pathology (Clarkin, Yeomans and Kernberg, 2006).

In the course of normal development, patterns of behavior are eventually established; and the motivational system of intense splitting and projection of negative affect is modulated and is integrated into the individual's adaptive mechanisms and general aspirations, thus improving adaptation to the complexity of the real world. However, individuals with borderline personality have difficulty doing this because they develop a non-integrated sense of who they are and their relationships with others are seriously distorted. These individuals cannot acquire an integrated sense of self that could allow them to accurately assess their specific mental state and that of others in light of an overall positive view of the self and of human interactions. The intensity, type and range of affect exhibited by children in development are important in understanding patients with Borderline Personality Disorder.

Clarkin ,Yeomans and Kernberg (2006) call attention to the importance of care in the relationship between child and caregiver in the development of personality, and the presence of trauma has a profound effect on the development of the conception of self and others.

In this regard, authors warn about effects of early sexual abuse on the history of borderline patients, and add that the neglectful, indifferent, and empathy-deficient caregiver also constitute additional factors that have profound destructive effects on development (Cicchetti et al,1990) (Clarkin,Yeomans and Kernberg, 2006; Tardivo and Pinto Junior, 2010; Manfre, Tardivo and Pinto Junior, 2014).

Normal development is disrupted by the environment characterized by physical and emotional neglect and physical or sexual abuse. In these cases, the child demonstrates negative affect, poor self-regulation disruptions in conceptions of self and others, and disturbed peer relationships. This emerging picture resembles that of adults with Borderline Personality Organizations with identity diffusion,with a preponderance of negative affect, poor self-regulation of the self, and difficulty in engagement relationships with others (Tardivo, 2014; Pinto Junior, Tardivo, & Althanat, 2016)

At the behavioral level, personality pathology manifests itself in the inhibition of normal behaviors or in the exaggeration of certain behaviors, and also from the oscillation between contradictory behaviors. At the structural level, personality can be organized, with a coherent and integrated sense of self and others or without this coherent sense of identity; which constitutes in diffusion of identity. (Kernberg and Caligor 2005, p.6).

By considering the concept of identity, along with related concepts such as defense mechanisms, reality testing, object relations, aggression, and moral values, one can conceptualize levels or degrees of personality organization: progressing from healthy to dysfunctional organization. These levels range from normal to neurotic to borderline

An important element in this differentiation concerns the evolution of defense mechanisms. Individuals with Borderline Personality Disorders are under the influence of primitive and intense emotions

that are not integrated and over which they have no control; these emotions become active in conjunction with corresponding cognitive systems. These individuals not only get angry, but also think there are good reasons for their anger. This type of response reflects not only dysregulation of affect but also dysregulation of cognition .

Patients with Borderline Personality Disorders are characterized by fuzzy identity, the use of primitive defenses, usually intact yet fragile reality testing, impairments in affect regulation and sexual and aggressive expression, inconsistent internalized values, and poor quality of relationships with others .

The pathological structure of Borderline Personality Disorders consists of a lack of integration of the positive and negative segments of the primitives of early object relations that were established as memory traces throughout the initial intense affective experiences. This lack of internal integration constitutes the syndrome of identity diffusion - and the opposite , of a normal identity and sense of self. This syndrome, which is at the center of Borderline Personality Disorders is characterized by the absence of an integrated concept of self and significant others.

Clinically, the lack of integration of these internal representations of self and others becomes evident in patients' non-reflective, contradictory, or chaotic descriptions of self and others and their inability to integrate, or even become aware of, these contradictions. This lack of integration has a fundamental impact on the individual's experience of the world.

Correlated behaviors of this Borderline Personality structure include emotional lability, anger, interpersonal chaos, impulsive self-destructive behaviors, and a propensity to fail the reality test.A typical manifestation specific to this diffuse and fragmented identity is the oscillation between mild helplessness and a tyrannical angry aggression directed at self or others.

In contrast to Borderline Personality Disorder, individuals with Neurotic Personality Organization have an integrated identity (that is, an integrated sense of self and others), generally use mature operational defenses, which are organized from repression rather than splitting.

These defensive operations lack behavioral characteristics that immediately distort the patient's interpersonal relationships. Neurotic defenses, in contrast to schism, involve ego-syntonic integration, deep and secure dyadic relationships, and definition of a self-consistent concept, which provides a stability that patients with Borderline Organizations lack. Neurotic Personality Disorders are the less severe disorders, especially hysterical personality disorder, obsessive-compulsive personality disorder, depressive and masochistic personality disorder

Clarkin; Fonagy and Gabbard, (2010) also bring a contribution that further extends this differentiation of personality disorders by classifying pathological personality based on the nature of the major psychological processes or structures. (This classification is set up as structural diagnosis.)

The authors establish this structural approach by examining the aspects:

1) Identity (sense of self and others)

2) Predominant level of defensive operations (habitual way of dealing with external stress and internal conflict)

3) Reality test (valuing conventional notions of reality)

4) Quality of object relations (understanding the nature of interpersonal relationships)

5) Moral functioning (ethical behavior, ideas and values)

On a conceptual level, the structural approach to pathological personality is consistent with an emerging consensus among personality disorder researchers who state that these patients faced difficulties in relation to a sense of self, or identity, and chronic interpersonal dysfunction, these being the essential elements in personality disorders (Livesley, 2001; Pincus, 2005, cited by Caligor and Clarkin, 2010).

Describing these Organizations, Clarkin; Fonagy and Gabbard, (2010) refer that in the less severe, neurotic level of personality organization there is : 1) normal identity; 2) the predominance of high level repression-based defenses, as already mentioned and; 3) intact reality testing, also already pointed out in this text .

Individuals organized as neurotic organizations generally function well in many domains; with typical maladaptive personality traits interfering predominantly in focus areas of functioning and/or causing more specific distress, for example in inhibiting the expression of emotions, but not interfering with the formation of deep attachments (Clarkin; Fonagy and Gabbard, 2010).

In borderline personality disorders, patients exhibit a rigid maladaptive personality in: 1) clinically significant identity pathology; 2) predominance of low-level schism-based defenses; and 3) reality testing may vary but is usually grossly intact, but the more subtle abilities to appreciate social conventions and to accurately perceive the internal states of others are compromised. Individuals organized at the borderline level have pervasive difficulties that very negatively compromise their functioning, in many domains and exhibit maladaptive traits that are more extreme and more rigid than those individuals with Neurotic Personality Organizations.(Clarkin; Fonagy and Gabbard, 2010).

A continuum is observed, where the healthiest on the spectrum, are individuals with normal identity, predominantly high level defenses, and stable reality testing, while at the most pathological end, are those individuals with severe pathological identification, predominantly low level defenses, and doubtful reality testing. However, the demarcation between the organization of neurotic and borderline personality levels is not categorical, and there are patients with milder pathological identity who exhibit mixed characteristics.

Kernberg (1995) presents a classification of defenses divided into three groups: 1) mature defenses, 2) repression-based or neurotic defenses, 3) defenses based on splitting or low-level mechanisms - also referred to as "primitive"

Kernberg (1995) suggests that defenses based on splitting mechanisms are intimately connected with identity pathology, and splitting is the most striking defense in cases of patients with severe personality

disorders. In patients with borderline organizations, the most common splitting involves, on the one hand, the separation of the experiences associated with positive affections in conjunction with idealized representations of the self and the "other"; and on the other hand, with the representations of devalued negative affections and paranoid (also called persecutory) object relations.

With regard to identity pathology, schism-based defenses are responsible for polarized experiences with "others" (of the "black or white" type), as if everything is either "too good" (idealized) or "too bad" (paranoid or devaluing). They are linked on the one hand to feelings like love, gratitude and trust, and on the other hand to frustration, intimidation and contempt. These polarized experiences about the self and the "other" are superficial and unreal, for example, a position of gratification in contrast to unbearable frustration; an experience of protection or destruction of the objects of the self; an omnipotent self in contradistinction to a fragile and powerless self.

Split-based defenses, in the context of identity pathologies, are typically unstable, and can lead to abrupt and chaotic shifts between idealized and persecutory experiences between the self and the other (Kernberg, 1984). In individuals with borderline personality organizations, schism-based defenses cause severe personality rigidity, and are responsible for a remarkable distortion of interpersonal reality. In this scenario, these defenses result in typical manifestations resulting in disruptive behaviors.

Individuals classified as high-level borderlines make use of a combination of repression-based and split-based defenses. This defensive organization is typically characterized by stable functioning and relatively well-integrated experiences most of the time. However, in a stressful situation or in areas of psychological conflict, these individuals are exposed to an abrupt intrusion into consciousness caused by a splitting of internal object relationships that disrupts the repression-based defenses.(Clarkin ; Fonagy, and Gabbard, 2010).

Substantial loss of the ability to test reality is not a feature of personality disorders. However, a transient loss of this capacity may be seen in some more severe cases of personality disorders, especially in highly stressful or affectively charged situations, as well as in contexts of alcohol or other substance abuse. When a patient presents with a frank loss of the ability to test reality, the assessment and treatment of psychosis becomes the highest priority, and the pathological aspects of personality are deferred until the psychotic symptoms are properly treated.(Clarkin ; Fonagy, and Gabbard, 2010).

Normal personality is associated with a commitment to values, ideals, and a "moral compass" that is consistent, flexible, and fully integrated with the sense of self, put Clarkin; Fonagy and Gabbard, (2010). In neurotic personality organizations, commitment to values, ideas, and the absence of antisocial behavior, reflect an integration and internalization of values and ideas. However, a moral rigidity and a tendency to hold unjustifiable high standards for oneself, being overly critical of oneself and feeling distressed are common aspects in neurotic personality organizations.

Borderline personality organizations, on the other hand, are characterized by varying degrees of pathology in moral functioning. At one end of this spectrum, one can find moral functions with relatively well-developed but rigid and excessively severe levels, characterized by severe anxiety and subjective distress, which manifest themselves in the form of self-criticism or anticipatory criticism of people who do not share one's inner values. At the other end of this spectrum can be found the absence of any internal moral mediator, and the lack of an ability to feel guilt, aspects characteristic of patients with low-level borderline organizations, also present in antisocial personality disorder or severe cases of narcissistic disorders. (Clarkin; Fonagy, and Gabbard, 2010).

2 ADOLESCENCE AND THE BORDERLINE DIAGNOSIS

With respect to considerations of Borderline Personality Organizations in adolescence, many considerations made in the previous paragraphs, can be noted here.

Jordão and Ramires (2010) present a review article and present results that suggest the relationship between affective bonds of adolescents with indicators of borderline personality. The studies found were discussed in three groups: adolescence and contemporary culture, characteristics of the borderline organization in adolescence, and affective bonds of these adolescents.

The authors point out the controversies regarding the definitions of "psychopathological conditions" in the adolescent period, since the separation between the "normal" and the "pathological" in this phase of life is tenuous. There are some authors who are categorical in characterizing personality disorders in childhood and adolescence (Terr and Kernberg,P. 1990); others, such as Giovachinni (1993), Masterson and Outeiral (1993) define pathological situations in adolescence as "states" or "organizations".

There are studies that point to the diagnostic possibility of borderline personality in adolescence such as those of (Bleiberg, 1994; Bradley, Zittel, & Westen, 2005; Chabrol, Chouicha, Montovany, & Callahan, 2001; Crick, Murray-Close, & Woods, 2005; Paris, 2005, cited by Jordão and Ramires, 2010). The authors suggest that further studies be conducted, especially in the Brazilian context. They discuss the importance of insecure attachment bonds, the issue of maternal psychopathology, and the role of traumatic experiences in the life history of these patients.

Seeking to understand the borderline personality organization in adolescence, we begin with a brief discussion about this phase of life, which can only be understood by considering at the same time the psychological and sociological factors involved, as well as the biological ones (Tardivo, 2007). The relationship between personality and socialization is essential in any study or reflection about human beings and their behavior, which occurs in the three fields, mind, body and environment, in the model proposed by Pichon Rivière apud Bleger (1975).

Ajuriaguerra (1985) states that on the one hand, adolescence can only be understood through the knowledge of drives and defenses, blockages and identification processes that evolve towards the search

for identity. And, on the other hand, it is also indispensable to understand the role that the adolescent has in a given society, in a given historical and political moment. Many times, according to the same author, the difficulties that occur in this phase of life have to do with a devaluation of the identifying images that are offered to adolescents. According to Ajuriaguerra (idem), this does not stem only from the lack of value that the adolescent attributes to family and society figures, but also from the devalued image offered to him by his parents and society.

There is also agreement among several authors (Aberastury and Knobel, 1971; Carvajal, 1993; Levisky, 1998; Tardivo, 2008) that the harmony between ego ideals and the environment is disrupted in puberty, with a resurgence of aspects of pre-genitality. The search for an adult identity (sexual, cognitive, and social) disrupts the balance of the relationship between ego and superego, creating an extensive area of conflict. The conflicts present will be more intense in adolescents who have "fixation points" and regressive characteristics during childhood. The greater the attachment points and regressive characteristics have been, the greater the likelihood that conflicts in adolescence will be more intense (Aberastury, 1971).

This stage of life is often described as a contradictory, confusing, ambivalent, painful period, full of conflict with the adolescent's environment. It is possibly the most vulnerable stage of all human development. And, possibly, this vulnerability may be more intense according to the environment in which the adolescent is inserted (Tardivo, 2007).

It is fundamental to reflect about this period that is strongly marked by losses, which are basically of three types. The first type refers to the loss of the child's body, which brings about many difficulties and strong anguish. It is as if the teenager doesn't know himself, and some even experience moments of strangeness. Also related to this process of loss, another fundamental characteristic of the teenager is ambivalence, on one hand he/she feels proud of his/her new body, even though it is very unknown, and on the other hand, he/she denotes strong feelings of shame. The second type is related to the loss of the parents from childhood, this process is related to the image that the children made of them, and can be very painful for the teenager himself/herself, as well as for the parents. This experience is also necessary, since adolescents need to move away from their parents, emotionally, in order to seek connection with new objects and ideals; and mainly to devote themselves to the primary function of the adolescent, which is the formation of their own identity. And the third type of loss, is the loss of childhood condition; which, besides grief, brings conflict and anguish. Adolescents are too big for some things, like playing, doing things they used to do; and they are children for others, like going out, coming back late, drinking, smoking, having sex life (Tardivo, 2007).

A fundamental characteristic of adolescence is the search for identity, the main task of the adolescent in Erikson's (1972) conceptions. In this search, the "group tendency" is fundamental. In the process of searching for identity, the adolescent resorts to uniformity with his peers as a defensive behavior, which provides him with security and personal esteem. It is interesting to note this phenomenon, where a process

of massive identification is perceived, that is, everyone identifies with each other. Many times this process is so intense that separation from the group seems impossible, and the adolescent seems to belong more to his group than to his family. In fact, one can also identify in the actions of the group and its members an opposition to the parental figures, at the same time that it is the active way to go on determining an identity different from the family environment. In this way, the peer group represents for the adolescent reinforcement and support necessary for the aspects of the ego changes that are occurring in this period of life. There are the fundamental and healthy aspects of this group tendency, which can even be understood as group identity. However, there are groups that are structured in a pathological way, which can even be a risk, such as "tribes" and "gangs"; a phenomenon that is often already related to the development of delinquency and antisocial behavior (Tardivo, 2007; Tardivo and Moraes, 2016).

The borderline adolescent thus has problems in identity development, with significant weaknesses in the representations of self (identity) and others (Jordão and Ramires, 2010). Thus, the diffusion of identity defined by Kernberg is essential to detect personality disorder in adolescents.

Foeschl; Odom, and Kernberg,P. (2008) conducted a work where they present a form of Psychotherapy for severe cases of adolescents (with Identity Diffusion), and make clear that there are elements that allow discussing the presence of borderline personality organization characteristics in these cases.

Clarkin, Yeomans and Kernberg on the Society for Transference Focused Psychotherapy website (2011) recommend an initial phase in treatment that includes "boundary setting with respect to the patient's destructive behaviors and further exploration phase of the patient's mind and sense of self. They further recommend that observation of the boundary continue throughout the time in treatment.

Jordão and Ramires, 2010) suggest that further studies should be conducted, especially in the Brazilian context . They discuss the importance of insecure attachment bonds, the issue of maternal psychopathology, and the role of traumatic experiences in the life history of these patients.

3 CLINICAL CASE

The case to be illustrated is that of a 14-year-old adolescent, who presented intense suffering and self-mutilation behaviors, and it was a great challenge to understand and treat her, beyond the diagnosis of Borderline Disorder, which today is the consensus for those who attend her.

Maria, fictitious name, was referred to psychotherapy by the director of the shelter where she had been living since she was 10 years old. Previously, she lived with her mother in northeastern Brazil (where she was born). The Council of Guardianship states that her mother is a drug addict and prostitute, and there is evidence that she led Maria into prostitution. Thus, the mother had lost custody of her to the father, whom Maria met when she came to São Paulo. So she started living with him, but due to the violence committed against her by her stepmother, Maria decided to run away. She would have returned to her hometown in

search of her mother, and, not having found her, returned to São Paulo on her own, living on the streets until she was supported at the shelter. Such data is in her history, and with the report that the teenager made these trips hitchhiking.

Her legal guardian (Director of the foster care institution) had decided to refer Maria for psychotherapy treatment after an episode of violence, when Maria threatened to kill a roommate after they had an argument. In the first session, when the psychologist asked about her daily activities (school, leisure, etc.), she said that everything was "very boring". She said that she misses her mother very much and would hear her voice at night. She stated that nobody likes her and that she is considered "crazy" by her classmates. She stated that her mother told her (from the voice she hears) that these opinions do not matter and that she should not pay attention to them.

After months of care, Maria went to a family's home for a vacation period. This is a project in which families are willing to receive children from the institution for vacations and year-end festivities. Maria was aware that this stay would be temporary, and wanted to go to this home. The lady, a volunteer at the institution, often took her by car to the care sessions. Maria had a very pleasant Christmas, receiving presents at Christmas and having a very good relationship with the couple that received her. A relevant fact was that during the period in which she was in this family, the adolescent witnessed the birth of a baby that the couple had been waiting for a long time, Maria also expressed happiness with this birth, and returned to the institution.

However upon her return in a session after the vacations, Maria revealed feeling very depressed. She expressed her desire to commit suicide, in her wish, saying she didn't want to live anymore because no one liked her. She also stated feeling very angry with herself at this time. In this same session, she had a crisis of self-aggression, pulling her hair violently. She had similar problems in the institution and went through a brief hospitalization .

After returning to the institution, she had other crises, in which she tried in many different ways to commit suicide (such as cutting her arms with glass or drinking perfume). She was then transferred to a nursing home for elderly women, where she received a lot of attention from the residents. After two weeks in this place, when she was calmer, receiving a lot of affection and attention from the ladies, she had another crisis in which she attempted suicide with a knife, stolen from the kitchen during a meal and hidden in her room. During this episode, she verbally offended the religious sisters and the doctor who tried to stop her from hurting herself by trying to attack him. Thus, she returned to the host institution.

In the second session after this return to the host institution, in the Clinic, she had a crisis, throwing chairs and the table in the assistance room, and tried to hurt and bite an employee of the host institution, who was her caregiver. The psychotherapist tried to reassure her, with some interpretations. Maria calmed down, but remained silent, alternating with intense crying. The therapist then said that her pain had become so great that it had become unbearable. Maria remained silent until the end of the session,

Maria returned to psychotherapy and asked for help to leave the institution because she said that her treatment there would not have adequate effects. When asked by the psychologist, Maria said she had done this with a shard of glass extracted from a broken glass. And she drew during the session (pictures 1 and 2 at the end).

At this point she was crying, saying that she had been hurt, but no one at the foster care facility called a doctor or an ambulance Maria replied that she was fine in the house with the elderly religious women, since the crisis happened after two weeks that she arrived there. She joked with the psychotherapist and smiled during the games.

A month later on a holiday, the therapist received a call from the foster care facility because Maria was crying a lot, very desperate, refusing to take her medication correctly. She was saying that she wanted to die. The psychotherapist went to the foster care facility and she begged the therapist to help her get out of there. Maria again tried to cut herself with a piece of glass that she had hidden in her bra. She then locked herself in the bathroom and tried to break the toilet in order to use the pieces to cut herself. The bathroom door was kicked in, at which point she tried to hurt and bite four caregivers. She had shards of glass in her mouth, handing two of them to the psychotherapist (after she was once again asked firmly) and reporting that she had swallowed one of them, which was later not confirmed after medical examination. Maria then reports that she was seeing a very ugly figure, who told her that she deserved to die and that her mother was already dead.

She was taken to a general emergency room, where she was kept under observation, and from there was referred to and admitted to the child psychiatric ward of a hospital. There were meetings with the whole team, psychotherapist, psychiatrist, doctors, caregivers from the shelter, and members of the Guardianship Council. After Maria left the hospital, she continued to receive care despite the difficulties. The Tutelary Council managed to contact the Council of the city where Maria lived, and it was confirmed that the mother was well, without manifesting drug addiction, but integrated and welcomed by the family. Work was done with the family of origin and Maria returned to live with her mother, and the local Guardianship Council recommended the continuity of treatment for Maria, who felt better when she was finally supported by her mother.

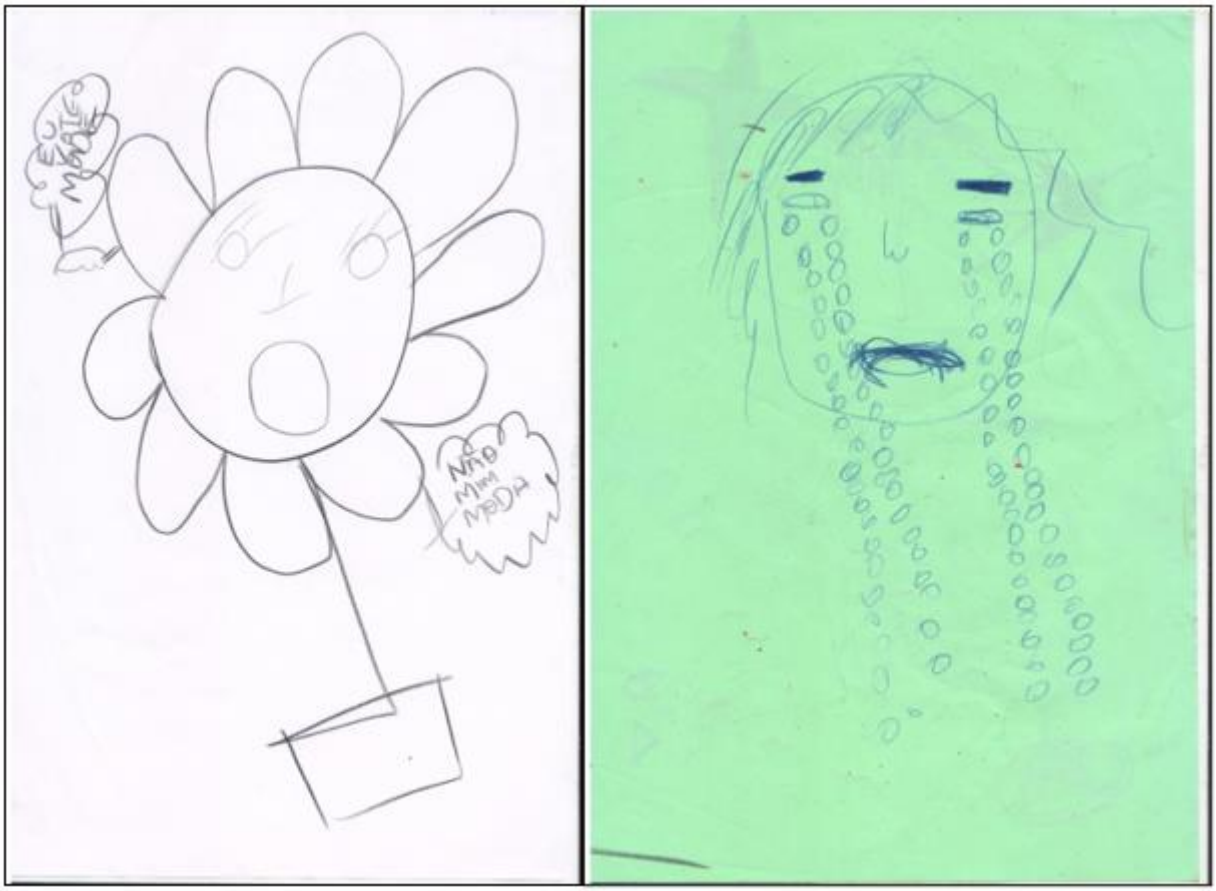
With respect to the brief account given, the characteristics pointed out throughout the text can be observed. Maria maintains idealized relationships, especially with the mother figure. On the other hand, the host institution is considered a very bad place, with people who do not like her. She denotes exacerbated anger, with difficulty in containing it, and generally converted into acts against her own physical integrity, with recurrent episodes of self-aggression, with significant suicidal acts. In this case, the experience she had with the family that took her in, and having witnessed how a child can be expected and loved, seems to have favored the feelings of intense lack throughout her development.

Very relevant is the presence of primitive defense mechanisms, such as idealization, splitting, splitting. There are moments in which Maria behaved as understanding and caring, and in others very aggressive and hostile. Maria lived intense feelings of helplessness and hopelessness, with much suffering with all the flaws in her development, which resulted in the condition.

The case illustrates the possibility of care and treatment of adolescents with borderline manifestations. In Maria's case, a joint work between health professionals, psychiatrist, psychotherapist, the caregivers of the host institution and the Guardianship Council was necessary. We also emphasize the relevance of environmental factors in triggering the difficulties presented by Maria. f

It is necessary to develop effective treatments and preventive programs that include families, focusing on the relationship between parents and children, and the entire social environment.

Figure 1 - Figure 2



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