Psychopathological Study on Borderline Case

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INTRODUCTION

Attempts have been made to create a clinical entity in the borderline area between neurosis and schizophrenia since the end of the 1800's. After going through transition periods of first being defined as latent psychosis (Federn [1]) and later as ambulatory schizophrenia (Zilboorg[2]), this entity is now generally accepted as the pseudodeurotic form of schizophrenia (Hoch et al.[3]).

And it may now be said that the idea of a borderline state (Knight[4]) has settled in the domain of psychiatry. Symptoms of neurosis are found mainly in the obsessional state. Excellent reports by Sullivan[5] and Kasahara and Kato[6] are available, which study the affinity between such obsession and delusion.

Here in Japan, such borderline cases have recently tended to increase in number, which is attracting the attention of psychiatrists. A report on four cases the author examined and treated is presented here along with a psychopathological discussion.

CASE REPORT

Case 1: Male university student, 23 years of age

As a second-year student in junior high school, he began to shun social contact, suspecting that he had bad breath. Subsequently, his grades went from the best in his class to the worst.

Complaining that his friends would frown at him when they met him in class, he became certain that a bad smell was emitting from his mouth. He saw several dentists for examination, and was told there was nothing abnormal in his mouth. Not satisfied with the diagnosis, he, independently, saw a psychiatrist. Diagnosed as having obsessional neurosis, he received medication, but began persistently complaining that his chin receded after taking the drug.

When his mother reminded him about the fall in his grades, he attempted to run away from home. Thereafter, his hypochondria and obsessive symptoms were dormant. After graduating from senior high school he entered the university.

Shortly after he began commiting to school from home, he started to complain that other train passengers nearby were turning their faces away from him and holding their noses. After his second year, he withdrew from the university, and shut himself up in his room. He spend his time playing the guitar and listening to records. From around that time, he developed delusions of persecution and delusions of reference. He then started complaining that his neighbors were speaking ill of him, and that they were watching his behavior. He was then admitted to a psychiatric ward.

In the ward, he showed a strong dependency, which was accompanied by childish speech and easily hurt feelings in his personal relations with others. He also showed an ambivalent vacillation, fawing on the physician or nurses in charge in one instance, and taking a defiant and agressive attitude toward them in another.

Meanwhile, obsessional behavior was also conspicuous. He would go to the nurse's station repeatedly during the day for confirmation of the menu. This behavior continued for some time. Suspicious that this condition resulted from uncertainty of his male sexual identity, it was decided that his parents and the physician in charge assume a rigid attitude toward the patient. In line with this decision, he was made to engage in horticultural work with a certain production quota imposed. As a result, delusions of persecution disappeared, and his obsessional state began improving.

Two years later, he was discharged, and he made the decision to attend a driving school. He believed that an instructor there, who knew past psychotic history, treated him with contempt. He began to show behavioral abnormalities such as writing over one-hundred letters proposing marriage to a certain TV actress and using violence against his father and younger sister. He was then readmitted and, administrated neurotropic drugs. One month later, the patient regained placidity.

Life history: He is the eldest of two siblings. His younger sister was cheerful and sociable. His father was a public servant, holding a managerial position. He was strict exclusively with his son, and showed leniency only to his daughter. This exclusiveness was also apparent in the education of his children. The patient's mother had often meddled in

almost all of his activities since his childhood, and demanded academic excellence from him. Although a strict disciplination, she indulged the children in any material request made of her. The patient was rather timid about seeking acquaintances with the opposite sex, which resulted in a negative outlook toward women. He began to masterbate at approximetely the same time that obsessive symptoms developed.

The patient's uncle, on his father's side has a typical affective disorder, and has been receiving medical treatment for from three to five years.

Case 2: Male junior high school student, 17 years of age

While taking a test at school, he started showing signs of queer behavior. He became overly concerned about time, and consulted his wrist-watch repeatedly. Not satisfied with that, he would leave his seat without permission and would check the watches of his friends and his teacher during the test period.

His grades, once the highest in his class, rapidly worsened where upon his mother scoled him severely. He then developed general convulsions accompanied by a clouding of consciousness over hours. He was then taken to the Department of Psychiatry and admitted there at his mother's request.

At home he was listless, rigid in posture and almost expressionless except for occasional facial distortions, but in the psychiatric ward his behavior was animated and relaxed, and his rapport with the physician in charge was good.

Pathological experiences, for instance, such as his belief that classmates were grinning meaningly at him, that teachers were telepathically controlling his thoughts, and that persons around him were reading his thoughts through mezmerization, were vocalized as the patient, crying, clung to the physician in charge pleading for help. Pathological experiences disappeared rapidly following the administration of neurotropic drugs, but obsessional symptoms persisted in different forms, such as his occasional indecision over which sock to take off first.

Due to his mother's opposition to the patient's projected length of stay in the hospital, he was discharged home three months after and started attending school. But he was readmitted due to persistent hypochondriadic complaints such as fatigue, abulia and headaches. His ambivalent attitude was expressed when he would react positively to the approaches of female patients, while to his parents and physicians he showed resistance and rejection.

Life history: He is the eldest of two siblings. His younger sister

does well in school and, by nature, is unaffected by inconsequential matters. The patient seems to feel somewhat inferior to her. His father is a public servant, holding a managerial position. He is reticent and has a strong sense of responsibility, but does not have a sociabe nature. The children's entire upbringing has been strict in nature, but the father, encouraging education for his children, frequently helps them with their homework in the evenings.

The patient is subservient to his father in every respect. His mother, an able jewlery saleswoman takes the initiative financially at home. But she is constantly at odds with her husband over how the children should be raised. She tends to use money, given freely on demand from the children, as a justification to demand exemplary behavior from them.

Hereditary history is not remarkable.

Case 3: Male senior high school student, 16 years of age

The trauma of one of his teacher's death, immediately before the entrance examination for senior high school, created a feeling of apathy in the patient. He would say things like, "I'm at a loss as to how to study" or "It's not worth entering a senoir high school because there is no one who will be pleased with my entrance". The patient developed insomnia and was absent from school about once every three days. He would shut himself up in his room and would masturbate. When confronted, he would throw dishes at, or strike his sister.

He received medical examination at his own request. He had a dejected attitude, and complained of "indescribable" abulia. He would make confused and hostile complaints such as, "I would like to attend the school, but my classmates say I am pale. That seems to me to be reproaching my masturbation indirectly. They treat me as if I were a sex maniac, so I don't like to attend the school". Upon returning home from school, he would divest himself of all clothes and throw them into a washing machine.

As soon as he successfully passed the entrance examination for a senior high school, his obssessional symptoms disappeared, but he would sometimes take a domineering attitude toward his mother.

Life history: He has a younger sister. His father holds a managerial post in a prestigious firm, and due to the nature of his work, he must spend much of his time overseas. As a result of this, the patient has lived in a fatherless home for most of his life. He complains that his father is a "target out of reach" as an example of identity for him. He has never taken a defiant attitude toward his father. His mother meddles in the patient's life excessively and is not satisfied unless she brings her

children under her total control.

Hereditary history is not remarkable.

Case 4: Male junior high school student, 15 years of age

From the time when he was a fifth year student in elementary school, he thought something unfortunate would happen if he took the same way to school twice, so he would make a circuit of routes, requiring much time to go to school. This obsessional symptom later disappeared. When he entered a junior high school, however, he became increasingly tense as the date of each test approached, and started saying, "When the body of a classmate touches me by chance in a corridor at school, I become restless unless I touch the classmate back", or "I feel uncomfortable if I stand on tiptoe in taking down something from a high place". He admits that it is odd of him to think such things, and he tries to hide it carefully from his family and friends.

He exaggerated his complains of abulia, lack of perseverance and difficulty in concentrating his attention. His parents confirmed such exaggeration, but his grades in school are not low enough to necessitate his excessive worrying. He says that, "My idea seems to be leaked out to my friends…". Because of this we suspect that he is suffering from "egorrhoae symptoms" (Fujinawa[7]).

Life history: He is the youngest of two children. The school records on his older brother, a senior high school student indicate that he is an excellent student. The patient's father is a public servant holding a manegerial position. He has a gentle character and is never stern or severe with his children. The patient frequently states that, "I would like to be what my father is, but it is by no means possible". He plans to take an entrance examination for the department of low.

The patient's mother forces her expectations on him and takes an empathic attitude toward her children's problems. She has recently developed insomnia.

Hereditary history is not remarkable.

DISCUSSION

The following are characteristics common to the four cases presented here.

1. All cases are males comprised of 3 eldest children and 1 youngest child.
2. Each disease developed as the patient was going through puberty. Degeneration began with multiple forms of obsessional symptoms

followed by delusions of persecution, and delusions of reference or "egorrhoae symptoms".

3. Obsessional symptoms, though fluctuating in intensity, tende to persist. By contrast, positive signs suggestive of schizophrenia are transient in many cases. In this respect, it may be referred to as micro-psychosis.
4. Ambivalent or polyvalent tendencies, over a wide range are present.
5. Somewhat related to observation 4, the patient, on the one hand, attempts to escape from the actuality while he shows adaptability actual life on the other.
6. Hatred or violence to family members are common.
7. Impairment of identify as a male is present, but this may be considered one of the common characteristics of puberty.
8. They share a type of father who is an able, and active member of society, but an outsider at home, and a mother who is "symbiotic" with her son.

Item 1 to 7 enumerated above are in agreement with the criteria for the diagnosis of pseudoneurotic forms of schizophrenia set by Hoch et al.[3] Today cases situated between the neurotic sphere and the schizophrenic sphere are treated borderline cases. This concept of regarding such cases as clinical entities is gaining acceptance.

Studies in this field have given rise to diagnostic names such as "Latent schizophrenia" (Bleuler, E[8]), "Ambulatory schizophrenia" (Zilboorg[4]), "Borderline state" (Knight[4]) and "Averted schizophrenia" (Arieti[9]).

When the world of the normal and that of the abnormal are positioned in a linear perspective, the world of the neurotis is considered standing closest to that of the normal, while the world of the schizophrenics is lying most removed from that of the normal.

Limited to such a linear perspective, the existence of an intermediate zone between neurosis and schizophrenia is conceivable, but Doi[10] proposed spectra on a circle instead of spectra on a straight line, thus admitting the existence of a case bestriding the border between schizophrenia and normal psychology.

One of the principal symptoms of pseudoneurotic forms of schizophrenia is the presence of an obsessional state. Eggers[11] advocated that obsessions similar to those mentioned above are the chief symptoms of the type of schizophrenia peculiar to juveniles. The obsessional state and schizophrenic state can easily be shifted and have an affinity to each other. The obsessional state is believed to have protective significance

against the disruption of personality, one of the chief symptoms of schizophrenia (Arieti[9], Stangel[12], Rosen[13]). Obsessional symptoms are characteristic, and stereotyped, and include tepid recognition of irrationality. They take the form of ego-syntonic impulsion, and later develops into delusions of reference (Rosen[13], Kasahara et al.[6]).

By nature, the patients are often impulsive, aggressive, masochistic and sadistic. These tendencies are especially conducive to outward actions in various forms. Such impulses are not expressed though symbolic or substitutional actions, but are presented in their most brutal and crude forms.

Delusions subsequent to obsessional symptoms are reactive and understandable in many cases. The patients become prone to delusions, resulting from a vulnerability of self-esteem (Sullivan[5]) and shameful imperfection (Kretschmer[14]). Puberty increases the momentum of such degeneration (Kato et al.[15]).

In "délire pubère" (Uemoto et al.[16]), the pattern of clinical symptoms is said to be simple, and in this respect it differs from this disease that shows a variegated development.

According to studies on the prognosis of this disease, two types are present: one that is favorable to a normal recovery and one that is not. Cases with a relatively good prognosis are considered resultant of a delayed breakaway from the period of puberty. With this in mind, an attempt is being made to classify borderline cases into two types, one akin to neurosis, and the other akin to schizophrenia (Kasahara et al.[17]).

An interesting question common to all of the four cases presented here is the peculiaity of the relation between a mother and her son. In the cases mentioned in the above, the relationship was one of symbiosis in a fatherless environment. The two feel strong sympathy toward each other, and each uses this sympathy to take advantage of the other's psychological weaknesses.

This may be considered a reflection of social and cultural influences, such as rapid urbanization and the proliferation of the so-called "nuclear family" (smallest familial unit) in present-day Japan (Yasunaga[18]).

It is understandable that a son, overwhelmed by his mother, would not be able to establish his identity as a male. This phenomenon becomes more prevalent in the father-absent home. Such a mother-son relationship is out of the influence of the father, and is closed off from society.

Doi[19] believes that this mother-son relationship can be understood by a 2-fold structare of consciousness, "omote" (face) and "ura" (reverse),

which he maintains is peculiar to the Japanese. "Omote" refers to the label and "ura" to the content, the two being similar to the relationship between open and ulterior, public and private, and rational and irrational. In this correlative structure the two, "omote" and "ura", are supplement to, and dependent on each other. Because of this dependence, the two cannot form an ambivalent symmetry, but are harmonized and integrated into one personality.

"Omote" signifies adaptation to the actual and is concerned with "superego", while "ura" means the defense of instinctive impulses, being concerned with "es". The relation between "omote" and "ura" is undifferentiated and not integrated in schizophrenia, while in neurosis the "ura" invades the "omote", and is contaminated. From this viewpoint, it may be deduced that Case 1 and Case 2 are closer to schizophrenia, and that Case 3 and Case 4 are more akin to neurosis.

In the cases cited above, the patients have attempted to establish their sexual identity through psychological treatment with the father on the premise. The father's presence is especially important due to the abnormally strong influence of the mother in each case. It may be said that the psychopathology of the borderline case, includes the psychopathology of the mother. This concept of involving the mother is extremely difficult to deal with because it can further confuse and complicate the psychological condition of the mother, as well as prompt acting out on her part. It did, however, prove somewhat effective in cases 1 and 3.

In case 1, the effect of paternal discipline in a predominantly maternal environment was evidenced when the patient in a minor state of hysteria, told a physician in charge, "When my father slapped me in the face and said, 'You lack perseverance. A man who makes no effort cannot be considered as a man with his manhood', I was delighted, because that was the first time in my life that I was hit by my father. I will hold out and do it over again at the university". His condition improved after this paternal discipline.

Pathology of such borderline cases lies in the abnormality of the mother–son relationship. In other words, if it is understood that this condition is due to an abnormality in the psychopathology of the mother, it would become somewhat easier to understand the fact that this disease usually develops in puberty and is often found in males.

SUMMARY

We have presented four cases which started with obsessional symptoms, followed by the appearance of symptoms within the sphere of

schizophrenia, delusions of reference, and "egorrhoae symptoms".

The most severe cases are found in patients that are: 1) male and 2) going through puberty.

The mother-son relationship in these cases is symbiotic, and the paternal influence is such that this relationship continues uninterrupted.

The relationship between "omote" (face) and "ura" (reverse) peculiar to the Japanese is not integrated well in the mother and son relationship. In this sense, psychopathology of the borderline case is considered to be that of the mother.

We have experienced a case in which psychotherapy administered to the patient and psychotherapy administered to the mother, using the same approach, simultaneously has proven effective.

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