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The Predictive Validity of the Millon Adolescent Personality Inventory to Assess Borderline Conditions in Adolescents

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THE PREDICTIVE VALIDITY OF THE MILLON ADOLESCENT PERSONALITY INVENTORY TO ASSESS BORDERLINE CONDITIONS IN ADOLESCENTS

by

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Juan Mario Herakovic

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INTRODUCTION

The Diagnostic and Statistical Manual (DSM-III) (APA, 1980) describes the Borderline Personality Disorder as follows: Diagnostic criteria for Borderline Personality Disorder. The following are characteristic of the individual's current and long-term functioning, are not limited to episodes of illness, and cause either significant impairment in social or occupational functioning or subjective distress:

A. At least five of the following are required:

1. Impulsivity or unpredictability in at least two areas that are potentially self-damaging, e.g., spending, sex, gambling, substance use, shoplifting, overeating, physically self-damaging acts.

2. A pattern of unstable and intense interpersonal relationships, e.g., marked shifts of attitude, idealization, devaluation, manipulation (consistently using others for one's own ends).

3. Inappropriate, intense anger or lack of control of anger, e.g., frequent displays of temper, constant anger.

4. Identity disturbance manifested by uncertainty about several issues relating to identity, such as self-image, gender identity, long-term goals or career choice, friendship patterns, values, and loyalties, e.g., "Who am I?, "I feel like I am my sister when I am good."

5. Affective instability: marked shifts from normal mood to depression, irritability, or anxiety, usually lasting a few hours and only rarely more than a few days, with a return to normal mood.

6. Intolerance of being alone, e.g., frantic efforts to avoid being alone, depressed when alone.

7. Physically self-damaging acts, e.g., suicidal gestures, self-mutilation, recurrent accidents or physical fights.

8. Chronic feelings of emptiness or boredom.

B. If under 18, does not meet the criteria for Identity Disorder. (p. 322-323)

To understand the issues surrounding the diagnosis of Borderline Personality Disorder, there should be an understanding of the evolution of the concept. For that purpose, a brief introduction to the concept is presented.

While the first references to the borderline condition can be traced to the nineteenth century, its contemporary inception arises from the psychoanalytic theoretical framework of the 1930's (Stone, 1980, p. 5). References to the term borderline appear as early as 1884 when Hughes made reference to a condition that seemed to border between the schizophrenic and the neurotic.

Psychoanalysts working in the clinical field at the turn of the century noticed "a large number of patients who were not ill enough to warrant a clear-cut psychotic diagnoses yet who were too ill to benefit from, or even withstand, unmodified psychoanalysis" (Stone, 1980, p. 6). In the view of the early pioneers of psychoanalysis, these persons presented a series of pathological indicators that represented a "borderline" between psychotic and neurotic states. In some in-

stances, references to the symptoms were made, without labeling them "borderline." This appears to be the case with the description that in 1918 Freud made of the "Wolf Man." (cited in Stone, 1980, p. 6).

In 1925, Wilhelm Reich wrote a monograph, The Impulsive Character, where he described serious character disorders. The patients experienced a "splitting" in their feelings that led them to bizarre ideations. As Reich stated "The compulsive thought of killing one's child, as conceived by the simple neurotic, appears trite and innocuous in comparison to the compulsive urge of an impulsive individual to roast his child slowly over a fire" (cited in Stone, 1980, p. 7).

During the 1930's other pioneers in the field, such as Oberdorf, also made reference to this condition, and placed importance on the hereditary variables that may contribute to the development of borderline symptoms. (cited in Stone, 1980, p. 7).

But the research undertaken by different scientists, yielded different outcomes. Since the early stages of the development of this concept, there was little agreement over what it was and what caused it. There was a sense of an ill defined cluster of symptoms that defied categorization. Some psychoanalysts started grouping these symptoms in relation to each other and chronologically, and gave rise to the concept of a borderline

syndrome. But it wouldn't be until later on in the twentieth century that this cluster of signs would be described as a disorder.

Not all the professionals in the field agreed that "borderline" symptoms should be regarded as transient states in route to a more generalized schizophrenic state. This was the case with Glover who argued against a separate transitional phase describing a pre-psychotic state. He believe that every person could potentially become psychotic, but numerous variables could induce or prevent the development of psychosis (cited in Stone, 1980, p. 9).

In Zilboorg's (1941) view some schizophrenics may not have any overt characteristics that would make them easy to differentiate from non-schizophrenics; "The individual may appear normal in all respects, even suave and almost worldly; he may sometimes give the impression of a warm personality." Further more, these individuals have adequate intellect, and possess "dereistic thinking" (thinking away from things), need to seek excitement, conflictual interpersonal relationships, and lack of stability in emotional and life affairs (pp. 149-155).

An important leap forward in the conceptual categorization of the term borderline was achieved in 1938 when Stern outlined a set of ten diagnostic criteria to describe patients that were "too ill for classical

psychoanalysis." His set of criteria included:

1. Narcissism.
2. Psychic bleeding.
3. Inordinate sensitivity.
4. Psychic and body rigidity.
5. Negative therapeutic reaction.
6. Constitutional feeling of inferiority.
7. Masochism.
8. Organic insecurity.
9. Projective mechanisms.
10. Difficulties in reality testing. (cited in Stone, 1980, pp. 10-11).

Stone (1980) points out that until Knights reformulation of the concept in 1954 there was little progress made past Stern's criteria. Furthermore, Stone suggests that two mostly exclusive main trends of conceptualization emerged: "On one side there were those who categorized borderlines as a 'border between schizophrenia and nonschizophrenia,' and the other one, which considered it to be a 'border between psychoneurosis and the deeper disturbances'" (p. 11)

Another important work in this area was achieved by Zilboorg (1941) when he labeled a number of patients as suffering from "ambulatory schizophrenia" (pp. 149-155). According to Zilboorg theses patients experienced problems in their interpersonal relations, social

adjustment, and thinking processes. Stone (1980) makes a point of stating that "the ambulatory schizophrenic of Zilboorg is, in any case, a sicker patient with a poorer prognosis, though some had a 'good recovery', than Kasanin's schizoaffective patient, and in a different realm altogether from Stern's patients." (p. 12).

In 1942, Helene Deutsch described a condition in which patients did not fit the traditional conception of neurotics and yet did not have a reality disorientation commonly seen in psychotics. She considered these patients as suffering from:

1. A curious kind of depersonalization that was not ego-alien or disturbing to the patient.
2. Narcissistic identifications with others which are not assimilated into the self but repeatedly acted out.
3. A fully maintained grasp on reality.
4. Poverty of object relations, with a tendency to adopt the qualities of the other person as a means of retaining love (hence the "as if," rather than genuine, nature of their own personality).
5. A masking of all aggressive tendencies by passivity, leading an "air of mild amiability, which is, however, readily convertible to evil"
6. Inner emptiness, which the patient seeks to remedy by attaching himself to one after the other social or religious group, no matter whether the tenets of this year's group are diametrically opposed to those of last year's. (cited in Stone, 1980, pp. 12-13).

From the psychologist's point of view, a very important task was undertaken in 1945 by Rapaport, Gill

and Schafer. It was a systematized effort to use psychological testing for the diagnosis of psychotic states. Among their findings, they encountered a group of thirty-three individuals that presented schizoid personalities with schizophrenic traits. Rapaport et al., labeled this group as "preschizophrenic." In their view, for these individuals, "Any stress or strain could precipitate a schizophrenic psychosis, but under favorable chance conditions, they might continue with such preschizophrenic behavior or ideation without an acute break." (p. 21)

In 1947 Melitta Schmideberg identified patients that did not appear to have clear cut symptoms of neurosis or psychosis. She tended to consider them as cases of "near-schizophrenia."

> Such patients are unable to stand routine and regularity. They transgress every rule; naturally they do not attend treatment regularly, are late for their appointments and, when they do appear, are unreliable about payments. They do not associate freely and often do not talk at all. They refuse to lie on the couch. They often come for analysis only under persuasion or pressure and even when they come on their own, their insight does not last nor carry them through difficulties. Even when they try to cooperate, they cannot sustain the effort. In their lives something always "happens," usually on the spur of the moment, entirely out of the blue. If they are poor, they are likely to become criminals. In general, if they belong to the upper classes they manage not to break the law too flagrantly or, at least, not to get caught. Money and background provide a greater latitude for abnormality so that people merely describe their behavior as "erratic." Yet in many cases their antisocial tendencies are only too obvious and, either by omission or

> commission, they hurt those who become associated with them. (p. 45)

In 1949 Hoch and Polatin attempted to redefine the concept of "borderline patients" by making its diagnosis more clear. They attempted to move away the concept of the borderline from a nebulose criteria of an undefined state lying somewhere between neuroses and psychoses and spoke of the borderline syndrome as a variant of a schizophrenic state. However, they recognized neurotic traits in these patients in a variety of areas, including sexual and social maladjustment, depressive states, compulsions, phobias, hypersensitivity to criticism, proneness to violence and rage. Hoch and Polatin labeled these traits "panneurosis," further labeling the anxious traits of these individuals as "pananxiety" and the sexual patterns of promiscuous sexual behavior and perversions as "pansexuality." These patients seemed to vary somewhat from classic forms of thought disorder in that their ideations were not erratic and bizarre thought processes and hallucinations, but rather a thinking pattern characterized by concrete, allusive, and condensed forms. They termed this pattern: "Overvalued ideas." (cited in Stone, 1980, p. 17).

Beginning with the second half of the twentieth century, the concept of "borderline disorder" begins to gain momentum.

A major landmark was the publication of a set of criteria outlined by Knight (1953). It presented a major step in objectively defining the clinical obser-vations from purely subjective inferences. Although a good deal of his work still remained very much open to subjective interpretations, it was a major attempt to establish some degree of objective criteria. Perry and Klerman (1978) summarized Knight's criteria for borderline states as follows:

I. Neurotic symptoms present.

II. Macroscopic evidence of ego weakness.
   A. Lack of concern over predicament.
   B. Absence of observable precipitating stress.
   C. Symptoms viewed as ego-syntonic or externally precipitated.
   D. Lack of achievement over time.
   E. Unrealistic planning.
   F. Relating of bizarre dreams.
   G. Insufficient contrast between dreams and waking life.

III. Microscopic evidence of ego weakness.
   A. Impaired integration of ideas.
   B. Impaired concept formation.
   C. Impaired concept formation.
   D. Occasional blocking.
   E. Peculiarities of word usage.
   F. Obliviousness to obvious implications.
   G. Contaminations of idioms.
   H. Inappropriate affect at times.
   I. Suspicious-laden questions and behavior.
   J. Lack of recognition or embarrassment over peculiarities of speech. (p. 142)

In the 1950s Rado classified four syndromes that could be found in an area lying between normal behavior and psychopathology. He labeled these syndromes as: (1) depressive, (2) extractive, (3) paranoid, and (4)

schizotype. His "extractive" disorganization had many of the features that now days are considered characteristic of borderline personality disorder. These included bouts of depression, unpredictable and irresponsible behavior, hedonism, low frustration tolerance, impulsivity and excitability resulting in numerous angry outbursts. Stone (1980) equates these features outlined by Rado with the description that Kernberg later on makes of the borderline personality "with narcissistic and antisocial features" (p. 19). Rado also made significant contributions to his area, by refining the concept of "schizotypal disorder." Individuals with schizotypal traits seem to possess various forms of anhedonism and to be prone to experience "emergency emotions" such as fear and rage. The individuals seemed to lack capacity of attachment and experience different levels of anguish. Furthermore, Rado organized the level of adaptation of the schizotype along a continuum:

1. The compensated schizoadaptation, where the schizoid personality does not experience major breakdowns.

2. The decompensated schizoadaptation where panic states lead to distortions of awareness leading to thought disorder.

3. Schizotypal disintegration resulting in a full blown schizophrenic process. (adapted from Stone, 1980, pp. 18-19).

The concept of latent schizophrenia introduced by Federn (1947) was further developed by Bychowski (1953) when he described patients as presenting "latent psychosis." According to Bychowski, latent psychosis could be diagnosed if the patient presented:

1. Character neuroses of a sort that, under stress, burst into psychosis.

2. Neurotic symptoms with the same outcome.

3. Socially deviant behavior (perversion, addiction, delinquency).

4. An "arrested" psychosis destined later on to reveal its true nature.

5. Psychosis provoked by psychoanalysis. (adapted from Stone, 1980, p. 21).

In general, reports of a border between neurotic and psychotic states were unprecise and subjective. As Aronson (1985) states:

> These reports were mostly anecdotal, based on a limited number of patients. They reflected the experience of the second generation of psychoanalytic authors with patients who initially appeared neurotic and analyzable but proved highly resistant to psychoanalysis and at times became worse on the couch. Each author struggled to describe a relatively sick, heterogeneous, non-psychotic population stressing slightly different patient characteristics that reflected differences in clinical experience, therapeutic style, and theoretical framework. Though different terms were devised, they all stressed a connection with schizophrenia. (p. 210)

Furthermore, Aronson (1985) states that: "The clinical descriptions of the first twenty years emphasized its schizophrenic-like features. Those of the last twenty have emphasized the affective: the rage, emptiness, chronic depression, suicidality, self-mutilation, emotional lability, and secondary alcoholism." (p. 211)

In 1968, Grinker, Werble, and Drye pursuing an ego-psychological approach identified four subgroups of patients at the Chicago Psychoanalytic Institute. This was the first serious attempt to make the diagnosis of borderline disorders more objective and scientific. They subgrouped them making use of the following criteria:

I. Common Characteristics.

- A. Anger is main or only affect.
- B. Defect in affectional (interpersonal) relations.
- C. Absence of consistent self-identity.
- D. Depression characterizes life.

II. Characteristics of the Four Subtypes.

- A. Type I: The Psychotic Border.
  1. Behavior inappropriate, nonadaptive.
  2. Self-identity and reality sense deficient.
  3. Negative behavior and anger expressed.
  4. Depression.
- B. Type II: The Core Borderline Syndrome.
  1. Vacillating involvement with others.
  2. Anger acted out.
  3. Depression.
  4. Self-identity not consistent.
- C. Type III: The Adaptive, Affectless, Defended, "As If" Persons.
  1. Behavior adaptive, appropriate.
  2. Complementary relationships.

3. Little affect; spontaneity lacking.
4. Defenses of withdrawal and intellectualization.

D. Type IV: The Border with the Neuroses.
1. Anaclitic depression.
2. Anxiety.
3. Resemblance to neurotic, narcissistic character. (cited in Stone, 1980, p. 29).

In general, there are four main approaches that contributed to the present conception of the Borderline Personality Disorder. The first one is a continuation of the psychodynamic approach. The salient work in this area belongs to Kernberg (1975). It is Kernberg who can be truly credited with the popularization of the term "borderline." Like psychoanalysts before him, Kernberg placed the concept of the borderline along a continuum between the neuroses and the psychoses. He relied heavily on object relations theory and attempted to construct an integrated and cogent theory of the borderline personality organization. He stressed the pre-oedipal conflicts with more primitive character disorders.

Kernberg (1975) stresses the prevalence of ego weaknesses represented primarily by "primitive mechanisms of defense." These ego weaknesses are: "(a) lack of anxiety tolerance, (b) lack of impulse control, and (c) lack of developed sublimatory channels." (p. 22)

In addition, Kernberg (1975) postulates that other mechanisms used by borderlines include: (1) splitting,

(2) primitive idealization, (3) early focus of projection, and especially projective identification, (4) denial, and (5) omnipotence and devaluation. (p. 94-103)

Furthermore, Kernberg (1975) states that "contradictory introjections and identifications is what gives the 'as if' quality to these patients [borderlines]." (p. 38) This "chameleonlike" adaptability is what allows borderlines to relate superficially to others and prevents them from establishing meaningful interpersonal relationships.

Influential in this area was also the work of Mahler, Pine, and Bergman (1975) on separation-individuation of infants, and the contributions from the psychology of the self made by Kohut (1971). Kernberg views the borderline "as representing a level of psychostructural functioning. It is distinguished from the neurotic and psychotic levels by specific ego strengths and weaknesses." (cited in Aronson, 1985, p. 215).

Kernberg (1975) differentiates between borderlines and psychotics in that the borderline maintains a relatively intact ego strengths, thought processes, and the ability to adapt to reality. Furthermore, Kernberg (1975) separates the borderline from the neurotic by considering the ego weaknesses of the borderline as a function of use of primitive ego defenses, affective

instability, low frustration tolerance, identity diffusion, and poor impulse control.

Emphasis is made by Kernberg and other psychodynamic theorists on the superficial way in which borderlines relate to others. The clinging and pushing away, lack of depth, tension, and generalized pattern of unstable relationships, are some of the most observable characteristics of borderlines.

The research-oriented approach attempted by several professionals, such as Gunderson and Singer (1975) is the product of the necessity to attempt to unify criteria when defining borderline syndromes. These researchers attempted to bring together a variety of sources and methodologies and unify them into a clear concept. To a larger extent, they succeeded at providing a cogent description and definition of the borderline syndrome. A good part of the results of their research was employed in the present classification of the Borderline Syndrome in the DSM-III. Gunderson and Singer (1975) identified a set of six distinct features that seem to characterize the majority of borderlines. These are:

1. Presence of intense affect (depressive or hostile).

2. Impulsive behavior.

3. A degree of social adaptiveness.

4. Brief psychotic experiences under stress.

5. Loose thinking in unstructured situations.

6. Interpersonal relationships that vacillate between transient superficiality and intense dependency (adapted from Goldstein, 1983, p. 319).

Based on their findings, Gunderson and his colleagues developed the Diagnostic Interview for Borderlines (DIB).

Using the DIB as a research tool, Gunderson and Kolb (1978) were able to identify essential characteristics of borderlines that separated them from both neurotic and schizophrenic patients. The essential areas of differentiation included: (a) low achievement, (b) impulsivity, (c) manipulative suicide, (d) heightened affectivity, (e) mild psychotic episodes, (f) high socialization, and (g) disturbed close relationships. (cited in Goldstein, 1983, p. 319).

Goldstein (1983) points out that essentially the features that Gunderson and his colleagues identified are very similar to the ego strengths and weaknesses that Kernberg presented.

A somewhat less important work, because of its outcome, was undertaken by researchers, who searched for a genetic linkage between borderline and schizophrenia. In their view, a borderline personality could have schizophrenic genetic traits. However, there seems to be an inherent contradiction, since in its modern inception,

the borderline is a level of personality organization and not the result of possible chemical imbalances in the individual. To assume that a borderline individual has a cluster of symptoms as an expression of a biochemical deficiency, would be to assume an organic linkage, which under the DSM-III conceptual framework would be incompatible with a personality disorder, more subjected to environmental variables.

The last group of researchers and theorists that contributed to the present conception of the borderline personality were those who assumed that there was an affective component to this disorder. Their major expression can be found in Klein's (1977) approach, where he treated this disorder with the use of antidepressant medication. He argued that borderline patients seemed to react in a positive way to antidepressants. There seems to be quite a controversy surrounding this idea, since other researchers state categorically that borderlines do not respond to medication, e.g., Freed, 1984. In reviewing this controversy, Gunderson and Elliot (1985) analyzed three hypotheses: "that borderline disorder arises from affective disorders; that affective disorder arises from borderline disorder, or that the two are independent and overlap coincidentally" (p. 277). They feel that none of these hypotheses satisfactorily explains the existing data. Instead, they suggest an

hypothesis where borderline disorders, and affective disorders can have a variety of etiological factors and that a good segment of the population may actually have both. They acknowledge that the data are not clear and that further research is needed.

As it can be noticed, the concept of the borderline has gone through many mutations and changes, both cosmetic and conceptual. As Wong (1980) states:

> Many who accept the term borderline disagree about whether it refers to a patient, a state, a personality organization, a character, a pattern, a subgroup of schizophrenia, a condition, or a syndrome; and there remains a confusing overlap and discrepancy among authors' descriptive attempts to define borderline disorder. (p. 102)

The basic notion remains that there is a cluster of signs that may defy easy categorization.

In general, there has been a clear lack of good research methodology; hypothesis and conclusions are drawn based on a limited number of patients. Grinker, et al. (1968) suggest that clinicians may use this category when they are uncertain of the clinical diagnosis.

The salient characteristics of borderlines, those on which most authors would agree, seem to encompass feelings of emptiness, loneliness, isolation, and lack of empathy. There is a constant need to be given recognition and love, but they fail to reciprocate. They tend to be reckless in their behavior, showing little concern for others. While some may engage in punitive or

destructive behaviors such as alcoholism and drugs, others have the capacity of higher functioning, but seem to lack the capacity to establish and maintain meaningful emotional relationships.

On first appearance, borderlines seem to be concerned only with themselves; however, it does not take long for the observer to realize that they lack a cohesive sense of themselves, and have little self-worth and self-esteem. It is believed that these disorders originate in the narcissistic developmental period of object relations.

When borderlines experience high degrees of stress they tend to alternate between dependency and self assertion, and at times even develop symptoms that closely resemble transient psychotic states. Their major problem or conflict is their inability to adapt negative introjections and identifications. It should be remembered that it is their object relations which is the one that is impaired, and not their cognitive abilities. Their rage seems to be primitive in nature and in that way they tend to develop intense relationships with others, as a way of defending against these rages. These excessive intense feelings lead them most often than not to disappointments.

Kernberg (1975) traces the origin of borderline conditions to the span encompassing the fourth month and

the end of the first year, a time when a child begins to differentiate objects from self.

Another theorist who dealt with the development of borderline characteristics is Winnicott (1965). His primary emphasis was the environment where the child grows, especially the relationship that develops between the mother and the child. He places the foremost responsibility on the bonding that the mother has to have towards the child. If the mother is perceived as rigid, uncaring, and not nurturing, the child will attempt to develop patterns of closeness that may not be reciprocated, resulting in traumatic early experiences that may reflect later patterns of difficulty in establishing relationships. This has also been fairly established by experimental psychologists working with animals, as is the case with Harlow (1962, 1971) and his research in bonding between monkeys. If during the early stages there is not a nurturing relationship, abnormal behavior patterns are likely to result.

In a similar theoretical framework, but disagreeing with object relations theorists, Arlene Wolberg (1982) stresses the attachment and bonding, to the family milieu as a whole, and not only the mother, where borderline characteristics originate. In this regard, several authors attempt to de-emphasize the role of the mother and place extended responsibility on the family. It

should be noted that these theories originate, at times, as a response to shift blame from the mother to other family members. In that way, these theories tend to follow social tensions and conflicts associated to such issues as feminist movements, etc.

With the appearance of the Diagnostic and Statistical Manual (DSM-III) of the American Psychiatric Association (1980), there has been a shift in emphasis, from perceiving the borderline syndrome in general theoretical terms, mostly related to the psychoanalytic conceptual framework, to a more behavioral description of the overt features, using a behavior checklist.

While the DSM-III is a way of attempting to simplify diagnosis, it also gave away with important theoretical considerations. As Goldstein (1983) points out "there is an obvious overemphasis of affective disturbance, thus creating a potential overlap diagnostically between the borderline and affective disorders." (p. 324).

This point is further expanded by Nuetzel (1985) who stated:

> The criteria-based DSM-III borderline personality disorder is a valid entity, but is improperly named. Unstable personality disorder seems more descriptive of the traits delineated for borderline personality disorder in DSM-III and therefore is more suitable as a criteria-based descriptive psychiatric diagnosis. As a designation for a theoretical structural level of psychological organization, borderline is uniquely meaningful. In its psychoanalytic context the term has referents and adds a dimension to clinical discourse. This

> psychodynamic dimension is lost in the purely descriptive use of DSM-III, but it could be added in a psychostructural axis of assessment to future editions of the Diagnostic and Statistical Manual of Mental Disorder. (pp. 132-133)

Undoubtedly, the controversy is bound to continue. As Stephen Appelbaum (1980) stated: "Borderline is, to some extent, in the eye of the beholder" (p. 366). Perhaps one of the main problems in using and categorizing borderlines is the lack of knowledge and/or understanding of the conceptual framework where this theory originates. It would not be too risky to venture that one cannot understand a borderline personality unless one has a clear idea of the theory where it originates. Practitioners in the field, coming from diverse theoretical orientations, will have problems in grasping the concept due to their own orientation, e.g., behavior, client centered, etc. To describe, or to attempt to diagnose a borderline solely on the basis of the DSM-III description, would lead to an overuse of this diagnostic term, since it would overlap significantly with other disorders such affective. In general, it is interesting to observe, by reviewing chronologically the literature how the concept of the borderline has evolved from a psychoanalytic concept to an almost purely behavioral description.

Can a borderline patient be identified by means of a check list description, even when there is sufficient

knowledge of the theoretical framework? According to authors such as Berkowitz (1983), there are therapy related phenomena which may aid the clinician in diagnosing borderlines. Berkowitz suggests for the clinician to be aware of three clues:

1. You find yourself giving your patient special handling.

2. You find in the course of your work with this new patient that no matter how "friendly" the sessions seem, you cannot joke around.

3. The third one, although difficult to define, deals with the capacity of borderlines to make a significant impact in the personal life of the therapist, that makes them unforgettable (pp. 405-406).

Other authors such as Briggs (1979) also stress the importance of countertransference as a diagnostic tool. He places importance on the necessity to accurately diagnose borderlines, so that negative transference factors could be planned for and dealt appropriately. Briggs recommends that therapists, especially novice therapists, should not use techniques similar to those used when treating neurotics; do not allow or set the occasion for borderlines to express angry and hostile feelings; do not use unstructured "Rogerian" techniques, nor passive ones in general. Briggs suggests setting

firm limits and boundaries as a way of reducing their anxieties.

Mental health professionals should be aware of the negative implications of the borderline diagnosis. As Reiser and Levenson (1984) view it:

> The borderline diagnosis is commonly abused to express countertransference hate, mask imprecise thinking, excuse treatment failures, justify the therapist's acting out, defend against sexual clinical material, and avoid pharmacologic and medical treatment interventions. . . . These abuses are seen not only in trainees; they also occur in the professional community as a whole. (p. 1528)

To avoid as much as possible this state of affairs, the authors suggest:

1. The borderline diagnosis should never be accepted without critical challenge. One should always demand a logical defense of the diagnosis. The defense of the diagnosis can be descriptive, based on the Gunderson-Singer criteria (5), or it can be psychodynamic, based on a coherent understanding of the major pertinent theoretical works on the subject. Regardless of the theoretical starting point, however, a logical and comprehensible explanation should be expected one that points toward a suitable treatment strategy.

2. It should be recognized that many patients, by virtue of their inherently tragic plight, their complexity, and their great rage, may evoke intense feelings of countertransference fear and hate. Such emotions are understandable, but they should not be allowed to become disguised by being dressed up with pseudoscientific jargon.

3. Educators should be alert to the tendency of trainees to label all complicated material as "borderline" and should regard such lumping with great skepticism.

4. Whenever a therapist has a patient in treatment and the treatment is not going well, one should question very skeptically any use of the term "borderline" to explain the problem. Too often problems within a treatment are passed off and rationalized in this manner.

5. Educators should pay particular attention to unusual attitudes or atypical behavior displayed by therapists who are treating patients labeled "borderline". It may signal acting out in the countertransference.

6. Supervisors and educators should always have a high index of suspicion for the presence of neurotic, including oedipal, issues in patients diagnosed as borderline. Many people wonder whether the incidence of classic neurosis is declining. Some neurotic patients may not have disappeared but have been misdiagnosed.

7. Educators should apply suggestions 1-6 to themselves, in their own work, as well as expecting as much from their students. "Teacher, teach thyself." (pp. 1529-1530)

We believe that increased attention to abuses of the borderline diagnosis will ensure its continuing theoretical and clinical utility and prevent it from becoming a waste-basket term. Supervisory skepticism about the use of the borderline diagnosis will help elucidate the complex issues involved in becoming a psychotherapist and thereby improve the educational experience.

And finally, as Aronson (1985) points out, borderline is used as a pejorative label and as a level of denigration. It has become one of the most misused and abused of all psychiatric labels. The patient is thus blamed who makes life difficult for the therapist or does not get better.

However, regardless of the number of false positives, there is a segment of the psychiatric population who has a set of symptoms that can be described as fitting the borderline label. Many of these patients require hospitalization, mainly as a result of being perceived as a threat to themselves or others. Borderline patients are characterized by patterns of unstable and unpredictable behavior. These patterns seem to be cyclical in nature, a characteristic which Nurnberg and Suh (1978) refer to as "chronic stable instability."

When borderlines enter a crisis phase, hospitalization may be recommended and/or necessary. Nurnberg & Suh (1978) describe the following as indications for hospitalization:

1. Minipsychosis - In addition to the characteristics described in the section on diagnosis, psychosis may show: duration from minutes to weeks; high affective volatility; sudden onset related to a precipitant; absence of social isolation; absence of Schneiderian criteria; sharply circumscribed thought disorder; unstable paranoid type delusions and/or hallucinations; marked depersonalization and/or derealization; initially ego alien, with retrospectively viewed ego syntonic characteristics.

2. Suicidal or assaultive threats, attempts or dangerous behavioral equivalents - These behaviors when persisting make meaningful outpatient treatment virtually impossible. Severe antisocial behavior involving police may be included here.

3. Diagnostic evaluation or consultation. Differentiation from other psychoses may not be possible in the predominance of a chaotic life or family situation. A patient may be unable or unwilling to provide meaningful or essential data necessary for a diagnosis. A persisting or unremediable chronic negative therapeutic reaction in which lengthy periods of stalemate or active devaluation/destruction of the therapeutic relationship might necessitate a period of structured separation and psychiatric multidisciplinary team evaluation and consultation.

4. Crisis intervention - A severely deteriorating social situation or collapse of supports beyond the extent of the minimal supportive environment. This may also involve the avoidance of a situation that may have damaging consequences.

5. Malingering or other manipulation of the environment - Social agencies may arrange or be manipulated into arranging hospitalization so as to make available resources such as welfare because of medical disability. Though not a psychiatric indication for admission, treatment facilities may in fact be confronted by this situation. Nadelson has reported on Munchhausen syndrome (hospital hoboes) as a form of borderline pathology. Inpatient unified multidisciplinary evaluation and approach may be required to intervene in this situation. (p. 422)

In concluding this introduction, a clarification regarding the use of the term borderline with different populations is needed. The Diagnostic and Statistical Manual of Mental Disorders, recommends the label "borderline" only for those people over the age of eighteen. Patients with the same range of symptoms under the age of eighteen are labeled as identity disorders. However, as Egan (1986) points out: "While for statistical and research purposes this distinction is usually

adhered to, in general clinical practice the terms identity disorder and borderline personality disorder are used interchangeably." (p. 613).

PURPOSE OF THE STUDY

Beginning in the nineteenth century, but mostly in the twentieth century, there was a tendency to regard adolescence as a period of stress and turmoil. Pivotal to this view of upheaval were the writings of G. Stanley Hall (1904) who characterized adolescents as experiencing physiological and mental transformations that led to rebellious and chaotic behavior. Although there are many opposing views to this characterization, e.g., Stinchcombe (1964), Offer, D. and Offer, J. (1975), Offer, D., Ostrow and Howard (1981), the persistence of this "myth" continues to be widespread.

This view of adolescence as being necessarily rebellious, tumultuous, and chaotic may have led to an overdiagnosing of identity disorders and/or borderline conditions, in the general population. As stated before, these conditions are on the eye of the beholder. However, this overemphasis should not preclude the fact that some adolescents indeed suffer from this personality disorganization. As Egan (1986) views it:

> The adolescent with borderline personality manifests an inordinate amount of aggression, difficulty in separation, use of splitting mechanisms, incomplete individuation, and weakly established libidinal object constancy, a combination that easily leads to regression. The clinical picture that emerges is one of an adolescent carrying out angry, defiant acts in his attempts to maintain ego integration.

> They might include frenetic attempts at establishing intimacy, which result in intense anxiety about the loss of boundaries. This in turn mobilizes desperate efforts to separate.
>
> Thus, the object relations of the adolescent with borderline personality are chaotic, fluctuating, tempestuous, and frequently sadomasochistic. The adolescent's own efforts to reduce these primitive anxieties frequently result in self-medication with a variety of drugs. Impulse disorders may be manifested in eating disorders, antisocial acts, sexual promiscuity, and aggression toward self or others.
>
> In summary, because of the developmental defects noted, adolescents diagnosed as having borderline personality manifest some combination of poor anxiety tolerance, fears of being alone or being too close, deteriorating academic work, serious substance abuse, chaotic and often coercive interpersonal relationships, and disorders in the regulation of eating and sexual behaviors as well as defiant-oppositional acts toward authority figures and, often, antisocial acts. (p. 615)

For some of these adolescents hospitalization in a psychiatric ward is recommended. As Egan (1986) recommends:

> Hospitalization of adolescents for borderline personality disorder is indicated when the adolescent's behavior is sufficiently destructive to himself, to property, or to others. Rinsley suggests hospitalization when the patient's conduct is seriously disruptive or bizarre; when his ability to use home, school, or community supports is severely compromised; when the patient shows progressive psychosocial deterioration despite all efforts at outpatient treatment; or when the family is severely pathogenic or dysfunctional.
>
> Frequently upon hospitalization these patients stabilize, accommodate rather well to the ward, milieu, and routine, and then after one or two months are discharged as improved. Then, to the dismay of the ward staff, the parents, and the adolescent, rehospitalization is often necessary. In such instances it seems that the brief

> hospitalization interrupts the pathological interactions between the adolescent and the parents but that the 'parentectomy' carries with it no substantial reorganization of the psyche. This is not to suggest that brief hospitalizations are unwarranted. Very often they are indicated to let the family situation relieve tension and allow the therapist to try to help the family regroup, thus improving the likelihood that the adolescent will be able to continue treatment while living at home.
>
> But when this outcome is not achieved, borderline adolescents will require long-term hospitalization, often in a very structured setting that incorporates considerable behavioral components within the ward milieu. Long-term hospitalization should be primarily aimed at reducing and ultimately stopping the adolescent's acting out and increasing certain ego strengths, especially the capacity to tolerate frustration, delay gratification, restrain aggressive impulses, and tolerate ambivalence. (p. 617)

Adolescent borderlines, as well as adult borderlines, present an unusual challenge for the staff in a psychiatric ward. The impact of borderlines on psychiatric staff cannot and should not be underestimated. This author discussed this issue with a variety of psychiatrists, psychologists, social workers, nurses, and mental health technicians, in several psychiatric units in the state of Michigan, and found a great deal of concern for the disruption that borderlines can cause in a psychiatric milieu.

One of the major concerns is the splitting that borderlines can cause on staff members. As Gallop (1985) explains it:

> 'After a brief honeymoon period,' newly admitted borderline patients quickly lapse into predictably unpredictable behavior. Labile in affect, these patients perceive staff alternately as villains or heroes. Acting out behaviors occur often in rapid order: slashing; verbal abuse; suicidal gestures. Other evidences of psychological regression. (p. 8)

For many instances, this splitting of staff into villians or heroes is considered as a signal that the patient may have borderline features. This polarizes the feelings of staff members regarding a patient.

> Main found the same pattern among staff doctors and nurses who treated those "special" patients. Believing that they alone understood the patient, they used more and more drastic therapies, from occasional sedation to sleep induction and electro-convulsive therapy, with little success. One nurse went so far as to recommend brain surgery. The staff members resentfully blamed one another for the failure. Only when they began to discuss these patients among themselves did they realize how they were being split into two contending factions (Kramer & Weiner, 1983, p. 70).

> This splitting characteristic causes dissention within a hospital. One group, drawn to the borderline patients, is seen by other doctors and nurses as "collusive, unrealistic, and over-indulgent". In turn, they consider the others suppressive, insensitive to the strains on an immature ego, and lacking in proper feelings (Kramer & Weiner, 1983, p. 72).

But the splitting does not occur only between staff members, it extends to the administration as well. As Kramer and Weiner, (1983), furthermore explain.

> Such a division can grow until it disrupts an entire institution. Borderline patients have a tendency to split clinicians from administrators: They write letters of complaint to the hospital director, complain to their therapists' supervisors, and sometimes threaten the hospital with ruin in the form of a malpractice suit.

> Faced with a bureaucracy they can't comprehend, rules they don't understand, and staff who 'never seem to care enough', borderline patients use every means at their command to call attention to themselves and create the illusion of being in control. (p. 72)

Another major concern is the projective identification that borderlines create; they project disliked aspects of themselves onto others, especially their treatment teams. While this may reduce their anxieties it has a considerable effect on their caretakers:

> Therapists find themselves fulfilling patients' expectations, as if they were compelled to behave according to a distorted perception. Main and others have said that borderline patients intuitively choose the therapist most likely to respond this way. Psychiatrist Leon Grinberg suggests that the relationship between such a patient and a therapist is like that between hypnotist and subject. The patient projects a "parasitic" superego that can cause the therapist to act just as the patient knows or fears that all authority figures will act.
>
> One seasoned clinician experienced with borderline patients and their families tells of a nightmare in which she sees herself standing in front of her childhood dresser. Peering into the mirror, she sees the reflection of her own face and body, but her hair is that of one of her borderline patients. Another therapist says she had an argument with her husband one day and found herself sulking on her front step, thinking, "I'll get him by getting a kitchen knife and scratching my wrists." Startled, she realized that she might be "catching" her patients' habitual responses.
>
> The phenomenon is common enough that some therapists use it as a diagnostic criterion. They talk of a characteristic borderline "feel," a pull toward fusion. "If you schedule a 45-minute session and end up spending twice that long with the patient," one says, "the fact that you've gotten sucked in should be a warning" (Kramer & Weiner, 1983, p. 72).

One of the most important changes that has taken place in recent years in mental health is the movement to very short periods of hospitalization. While this topic is the subject of heated dispute between clinicians and insurance companies, the trend continues to keep people out of hospitals, or to be admitted for short periods of time.

Based on the factors listed above, the need for a rapid screening instrument was established. Since clinical interviews, which involve a lengthy and cumbersome process, as well as the need for an experienced and skilled clinician, are not always effective in rapidly determining the borderline personality, alternate methods were explored. One of these alternate methods involved the use of the Millon Adolescent Personality Inventory (MAPI) (Million, et al., 1982).

THE INSTRUMENT

According to Millon, et al., 1982, "The MAPI (Millon Adolescent Personality Inventory) was designed to be used by school counselors, guidance personnel and other mental health service professionals as an aid in identifying, predicting and understanding a wide range of psychological attributes characteristic of adolescent." (p. 2). The intended use of this test, according to the authors is "For vocational and academic advising, as well as in mental health service settings as an instrument for adolescent clinical assessment." (p. 2).

The recommended age range for this test is thirteen through eighteen years old, for both males and females. The instrument consists of 150 items that the adolescent must answer as true or false. The questions are clear and concise, written at the sixth grade level, (see Appendix A). The authors recommend that the person taking the test "should be reasonably comfortable, free of distractions or excessive fatigue" (p. 11) and advise against administering the test when "severe anxiety, confusional states, drug intoxication or sedation" (p. 11) are present.

Scoring is performed in an automated way. This can be accomplished by use of a personal computer and a hook-up to National Computer Systems, Inc., with instant interpretation provided, or by sending the sense sheet by mail. There are no hand scoring templates available. The reason offered for this lack of availability is the number of errors that hand scoring can produce, as well as continuous refinements in correction scores and norm adjustments that are continuously added to the computer interpretation.

The normative population for the test consists of two main groups. The first one, considered to be a "normal" group consisted of 1071 males and 1086 females, totaling 2157 subjects. They were drawn from " a variety of public and parochial junior and senior high schools encompassing different socioeconomic levels and located in a number of cities across the country (Millon et al., 1982, p. 14). The second group, or "clinical" group, consisted of 242 males and 188 females, totaling 430 subjects. Of this total, 325 were drawn from outpatient settings, and 105 from inpatient settings. These settings included "programs of psychological assessments or psychotherapy." The difference between the number of total subjects in the "normal" group when compared to the "clinical" groups is substantial, giving a ratio of 5:1. Some questions can be made regarding the validity of the

norms with the use of such small "clinical" group.

The scales of the MAPI are grouped under three basic dimensions: Personality Styles, Expressed Concerns, and Behavioral Correlates. The first dimension, Personality Styles, encompasses eight scales addressing the personality traits that an adolescent characteristically displays. This personality profile is based on a profile configuration.

Scale 1:	Introversive	(31 items)
Scale 2:	Inhibited	(41 items)
Scale 3:	Cooperative	(35 items)
Scale 4:	Sociable	(29 items)
Scale 5:	Confident	(42 items)
Scale 6:	Forceful	(37 items)
Scale 7:	Respectful	(29 items)
Scale 8:	Sensitive	(46 items)

The second dimension addresses the issue of Expressed Concerns and encompasses eight scales. These scales indicate voiced perceptions regarding feelings and attitudes of the adolescent.

Scale A:	Self-Concept	(36 items)
Scale B:	Personal Esteem	(36 items)
Scale C:	Body Comfort	(21 items)
Scale D:	Sexual Acceptance	(28 items)
Scale E:	Peer Security	(23 items)
Scale F:	Social Tolerance	(26 items)

Scale G: Family Rapport (25 items)

Scale H: Academic Confidence (30 items)

The third dimension, Behavioral Correlates, indicates actual observable behaviors rather than feelings and attitudes. It encompasses four scales:

Scale SS: Impulse Control (35 items)

Scale TT: Societal Conformity (39 items)

Scale VV: Scholastic Achievement (41 items)

Scale WW: Attendance Consistency (36 items)

Clinical profiles are based on a profile interpretation of the preceding 20 scales. Millon et al., (1982) suggests that "profile interpretation is the primary method of evaluating MAPI results," (p. 18). Single scale interpretation may be feasible only if a particular scale in any dimension is 20 base rate points or higher than any other scale.

In each scale, an elevated base rate score indicates a greater probability of the adolescent having the traits measured by the scale. Millon et al., (1982) indicates that base rates "cutting lines at 75 and 85 should be used to identify 'presence' and 'prominence' [of a particular clinical characteristic]" (p. 19).

Validity of this test, according to Millon et al., (1982) followed the "developmental validation" process developed by Jane Loevinger. That process involves three main phases: substantive, structural, and external.

Therefore, "validation of the MAPI became an integral element at each step of development rather than an afterthought" (p. 41).

The first phase of this validation process involves a Theoretical-Substantive approach. During this stage the focus is on deriving items on the scales from an explicit and accepted theoretical framework. For this purpose Millon et al., (1982) based the scale items on his own work on personality theory. In that regard, Millon's theory seems to have a widespread acceptance, including providing part of the theory upon which the DSM-III rests.

The second phase deals with the Internal-Structural validation, that is, "the model to which the instrument's items are expected to conform," Millon et al., 1982 (p. 41). Therefore, items included in each scale enhance the "homogeneity" of the scale, overlap with "other theoretically congruent scales, and demonstrate satisfactory levels of endorsement frequently and temporal stability," Millon et al., 1982 (p. 41).

The third phase addresses the issue of external-criterion validity. External criteria, such as relevant behavior, are correlated with test scales.

In addressing the issue of reliability, Millon et al., 1982, cautions that dealing with adolescents may pose a more significant problem than other populations,

since this age group is subjected to greater changes due to growth and rapid change. This then may be more difficult to separate from measurement errors that may be present in the instrument. Data is presented on two distinct "clinical" populations of adolescents. One group (Group A) consisting of 105 adolescents was tested-retested at a five months interval. The coefficients for this group range from .53 to .82, with the majority in the mid-seventies range.

The second group (Group B) consisted of 59 "clinical" adolescents, and was tested-retested at one year interval. The coefficients obtained were lower than those in Group A, ranging from .45 to .75, with the majority in the sixties range. The authors clarify that the data may be "contaminated" since these adolescents were exposed to psychotherapeutic treatment, as well as natural changes.

Millon et al., (1982) also provide test-retest coefficients for the "normal groups." According to the authors, "these figures vary from group to group, but on the average range about .08 to 1.0 higher across the board compared to data for clinical populations over equal time spans," (p. 50).

Millon et al., (1982) also provide coefficients between the MAPI and other widely used tests such as the 16 Personality Factors (16 PF), California Personality

Inventory (CPI), and the Edwards Personal Preference Survey (EPPS). Coefficients were drawn between scales in the different tests and scales in the MAPI. Both positive and negative coefficients were obtained when comparing all the scales reflecting a great variability.

As stated before, the MAPI provides personality profiles of adolescents based on configurational scale elevation. At the end of each report, the MAPI includes a DSM-III parallel diagnosis that is based on these configurational profiles. The authors of the test have not provided, so far, a publication that would outline how these profiles and diagnoses are made. This seems to be a closely guarded secret and the clinician or counselor has to rely, on faith, on the automated interpretation. Catherine T. Green (1986), co-author of the test, provided this author, in personal correspondence, with the high point profiles that are employed to generate a Borderline Personality profile:

If profile is 26, or 286 and either 2, 6 or 8 are 85 or above then: 301.83 Borderline personality disorder also consider: 313.81 Oppositional disorder mixed with 313.00 Over-anxious disorder.

If profile is 28 and both 2 and 8 are 85 or above then: 301.83 Borderline personality disorder also consider 212.21 Avoidant disorder.

If profile is 38, or 83 and 8 is 85 or above the: 313.00 overanxious disorder mixed with 313.81. Oppositional disorder and 301.83 Borderline personality disorder.

If profile is 48, or 84 and 8 is 85 or above then: 313.00 Overanxious disorder mixed with 313.81. Oppositional disorder and 301.83 Borderline personality disorder.

These diagnostic decisions were created on the basis of both empirical data involving several studies and theoretical considerations. Therefore, the key scales utilized in diagnosing Borderline Personality Disorders are: Scale 2 (Inhibited); Scale 3 (Cooperative); Scale 4 (Sociable); Scale 6 (Forceful); Scale 8 (Sensitive). Following, is a description of the Personality Styles for each scale as described in the MAPI Manual (Million, et al., 1982):

> Scale 2: Inhibited (41 items)
> High scorers tend to be quite shy or socially ill-at-ease with others. These individuals would like to be close to people but have learned it is better to maintain one's distance and not to trust the friendship of others. Although they often feel lonely, they avoid close interpersonal contact, often fearing rejection and tending to keep their sometimes very strong feelings to themselves.
>
> Scale 3: Cooperative (35 items)
> High scorers tend to be soft-hearted, sentimental and kindly in relationships with others. They are extremely reluctant to assert themselves, however, and avoid taking initiative or assuming a leadership role. They are inclined to be quite dependent, preferring to let others take the lead and give direction. It is typical of them to 'play down' their own achievements and to underestimate their abilities.

> Scale 4: Sociable (29 items)
> High scorers are talkative, socially charming, and frequently dramatic or emotionally expressive. They tend to have strong but usually brief relationships with others. These adolescents always look for new excitements and interesting experiences. They often find themselves becoming bored with routine and long-standing relationships.
>
> Scale 6: Forceful (37 items)
> High scorers are strong-willed and tough-minded, tending to lead and dominate others. They frequently question the abilities of others and prefer to take over responsibility and direction in most situations. They are often blunt and unkind, tending to be impatient with the problems or weaknesses of others.
>
> Scale 8: Sensitive (46 items)
> High scorers tend to be discontented and pessimistic. They often find themselves behaving unpredictably; sometimes being outgoing and enthusiastic, then changing quickly to the opposite. These people often feel guilt about their moodiness, apologize to the people involved, but soon are just as moody as ever. (pp. 3-4)

One final word regarding this instrument. The MAPI consists of 150 questions that are answered true or false. An examination of the three basic dimensions reveals that the Personality Styles, Expressed Concerns, and Behavioral Corre-lates dimensions combined amount to 666 items. Therefore, each question is used for more than just a single purpose, averaging 4.44 uses across the three dimensions and twenty scales.

METHODOLOGY

Subjects were nineteen adolescents housed in an inpatient unit in a private psychiatric hospital in Michigan. Ten were males and nine were females. Their ages ranged from fourteen years old to seventeen years old. Only three had a prior history of hospitalization for psychiatric reasons.

The subjects chosen for this study were selected randomly. The following criteria was established: the number of subjects that would be part of this study would continue to be added until a minimum of six subjects labeled Borderline, by the Millon Adolescent Personality Inventory, were obtained. This would be irrespective of the total number of subjects. A delay in obtaining the MAPI reports, due to mechanical failure, resulted in obtaining more diagnosis of Borderlines, nine of them, in excess of the six originally established as a criteria.

The nineteen subjects were chosen on the basis of consecutive admissions to the adolescent unit, irrespective of sex, age, diagnosis, or any other personal characteristics.

Each adolescent admitted to the inpatient unit was evaluated by a hospital clinical treatment team to determine suitability for admission, and given a

psychiatric diagnosis based on the classifications established by the Diagnostic and Statistical Manual for Mental Disorders, (APA, 1980). This diagnosis was not taken into account for choosing the subjects since the consecutive admissions criteria was established.

Upon admission, each adolescent was administered the MAPI. This procedure is a standard one for adolescents in this hospital's adolescent unit.

Parallel diagnosis were provided by five professionals. These included an American Board of Psychiatry certified child psychiatrist with admitting privileges in that unit, a doctoral (PhD) level psychologist who was a staff member of the adolescent unit of the hospital, a psychiatric clinical social worker (ACSW), also a staff member of the adolescent inpatient unit. These professionals were required to furnish a psychiatric diagnosis without knowledge of the purpose or the content of the study. They conducted their own individual evaluations and arrived to an independent diagnosis. They received no other directions than to provide a diagnosis based on their best clinical judgement and experience.

In addition, a masters level psychologist and a clinical social worker (ACSW) were asked also to furnish a diagnosis for the subjects. These two professionals were instructed to use, in addition to their professional judgement, the Diagnostic Interview for Borderline

Patients developed by John G. Gunderson, M.D. They were also instructed to conduct individual evaluations and to arrive to an independent diagnosis.

All of the clinicians were trained in different graduate programs and had a variety of theoretical orientations. This is clarified to prevent misconceptions that diagnoses were similar or dissimilar based on shared theoretical educational backgrounds.

The data obtained were correlated using the Kendall-Tau-b statistic which is considered to be a suitable measure of association or measure of strength of a relationship.

RESULTS

As evidenced by Table 1 there is little agreement between the Millon Adolescent Personality Inventory (Millon, et al., 1982) and the different professionals regarding the diagnosis of Borderline Personality Disorder. Agreement over Borderline diagnosis between the MAPI and the clinicians occurred on only one occasion, with Social Worker I, and only over one subject, Subject 11 in Table 1.

According to the parallel diagnosis generated by the computerized report furnished by National Computer Systems, the MAPI identified nine of the subjects are Borderlines. These are subjects number 1, 2, 4, 10, 11, 16, 17, 18, and 19. The clinicians involved in this study did not diagnose these subjects as Borderlines, with the exception of the only agreement, that between the MAPI and Social Worker I on Subject 11.

The MAPI identified nine out of nineteen subjects as Borderlines, while the five clinicians singled out only three of nineteen, with different degrees of agreement.

Two clinicians agreed on Subject 3, while the MAPI disagreed with them. On Subject 11, only one clinician agreed coinciding with an agreement from the MAPI.

It is interesting to note that on Subject 12 there was unanimous agreement by the five clinicians. All of

Table 1

Borderline/Non Borderline Diagnoses For All Subjects

SUBJECT	MAPI	PSYCHIAT.	PSYCHOL. I	S. WORKER I	PSYCHOL II	S. WORKER II
1	YES	NO	NO	NO	NO	NO
2	YES	NO	NO	NO	NO	NO
3	NO	NO	YES	YES	NO	NO
4	YES	NO	NO	NO	NO	NO
5	NO	NO	NO	NO	NO	NO
6	NO	NO	NO	NO	NO	NO
7	NO	NO	NO	NO	NO	NO
8	NO	NO	NO	NO	NO	NO
9	NO	NO	NO	NO	NO	NO
10	YES	NO	NO	NO	NO	NO
11	YES	NO	NO	YES	NO	NO
12	NO	YES	YES	YES	YES	YES
13	NO	NO	NO	NO	NO	NO
14	NO	NO	NO	NO	NO	NO
15	NO	NO	NO	NO	NO	NO
16	YES	NO	NO	NO	NO	NO
17	YES	NO	NO	NO	NO	NO
18	YES	NO	NO	NO	NO	NO
19	YES	NO	NO	NO	NO	NO

them diagnosed this subject as Borderline. However, the MAPI did not assess this subject as having a Borderline Personality Disorder.

As illustrated in Table 2 the correlations among the different raters, regarding the Borderline diagnosis only, ranged from -.12 to +1.

Table 2

Correlations Among Raters For Borderline Diagnosis

	MAPI	PSYCHIATRIST	PSYCHOLOGIST I	SOC. WORKER I	PSYCHOLOGIST I	SOC. WORKER II
MAPI						
PSYCHIATRIST	-.22					
PSYCHOLOGIST I	-.32	.69				
SOC. WORKER I	-.12	.54	.79			
PSYCHOLOGIST II	-.22	1.00	.69	.54		
SOC. WORKER II	-.22	1.00	.69	.54	1.00	

Perfect correlation regarding agreement of Borderline/Non Borderline diagnosis for all subjects was found between the Psychiatrist and Psychologist II; between the Psychiatrist and Social Worker II; and between Psychologist II and Social Worker II. The lowest correlation was found between Psychologist I and MAPI.

In general terms it can be said that regarding the diagnosis of Borderline/non Borderline only there was greater agreement among the clinicians than between the clinicians and the MAPI.

The lack of agreement between the clinicians and the MAPI was not only noticeable regarding the Borderline/Non Borderline diagnosis, but extending to the other diagnoses as well.

There were 23 different diagnoses assigned by the clinicians and the MAPI (see Table 3).

Each one of these diagnostic categories was assigned a code for comparison purposes (see Table 4).

As Table 5 indicates, there was a great diversity of diagnoses by the instrument and the clinicians.

As it was the case with the lack of agreements on Borderline/Non Borderline diagnoses, Table 6 indicates the lowest number of agreements, for all diagnosis, between the MAPI and the different clinicians.

Agreement for the different diagnoses was higher among the clinicians especially between the Psychiatrist and Psychologist I.

Table 3

Diagnoses for all Subjects

Subject	MAPI	PSYCHIATRIST	PSYCHOLOGIST I	S. WORKER I	PSYCHOLOGIST II	S. WORKER II
1	Borderline Personality Disorder	Dysthmic Disorder	Dysthmic Disorder	Histrionic Personality Disorder	Dysthmic Disorder	Major Depressio Single Episode
2	Borderline Personality Disorder	Dysthmic Disorder	Identity Disorder	Dysthmic Disorder	Adjustment Disorder of Adolescence	Personality Disorder N/S
3	Adjustment Disorder	Identity Disorder	Borderline Personality Disorder	Borderline Personality Disorder	Dysthmic Disorder	Major Depressio Single Episode
4	Borderline Personality Disorder	Dysthmic Disorder	Conduct Disorder	Identity Disorder	Conduct Disorder	Conduct Disorder
5	Avoidant Disorder	Dysthmic Disorder	Separation Anxiety	Separation Anxiety	Conduct Disorder	Avoidant Personality
6	Conduct Disor. Socialized/ Aggressive	Conduct Disor. Socialized/ Aggressive	Conduct Disor. Socialized/Non-Aggressive	Conduct Disor. Undersocialized Aggressive	Conduct Disor Undersocialized Non-Aggressive	Impulse Disorder
7	Adjustment Disorder	Major Depression Single Episode	Major Depression Single Episode	Major Depression Single Episode	Dysthmic Disorder	Obsessive Perfectionistic
8	Adjustment Disorder	Major Depression Single Episode	Major Depression Single Episode	Major Depression Single Episode	Major Depression Single Episode	Adjustment Disorder
9	Adjustment Disorder	Schizo-affective Disorder	Schizo-affective Disorder	Schizophrenia Schizoaffective Type	Schizo-affective Disorder	Manic-Depressive
10	Borderline Personality Disorder	Schizo-affective Disorder	Oppositional Disorder	Schyzotypal Personality Disorder	Schyzotypal Personality Disorder	Major Depressio Single Episode

Table 3--Continued

Subject	MAPI	PSYCHIATRIST	PSYCHOLOGIST I	S. WORKER I	PSYCHOLOGIST II	S. WORKER II
11	Borderline Personality Disorder	Major Depression Single Episode	Major Depression Single Episode	Borderline Personality Disorder	Unspecified Not Borderline	Major Depression Single Episode
12	Oppositional Disorder	Borderline Personality Disorder	Borderline Personality Disorder	Borderline Personality Disorder	Borderline Personality Disorder	Borderline Personality Disorder
13	Identity Disorder	Schizophrenia of Adolescence	Schizophrenia Undifferen-tiated	Schizophrenia Undifferentiated	Schizophrenia	Schizophrenia
14	Avoidant Disorder	Conduct Disor. Socialized Aggressive	Conduct Disor. Socialized Non-Aggressive	Narcissistic Personality Disorder	Passive-Aggres-sive Personality Disorder	Conduct Disorder Socialized/Non Aggressive
15	Adjustment Disor. w/Mixed Disturb. of Emotions & Conduct	Conduct Disor. Undersocial. Aggressive	Conduct Disor. Undersocial. Non Aggressive	Conduct Disor. Undersocial. Aggressive	Conduct Disor. Socialized Non/ Aggressive	Conduct Disorder
16	Borderline Personality Disorder	Atypical Impulse Control Disor.	Overanxious Disorder	Dysthmic Disorder	Adjustment Reaction of Adolescence	Major Depression Single Episode
17	Borderline Personality Disorder	Schizophrenia	Schizophrenia	Schizophrenia Paranoid	Schizophrenia	Psychosis
18	Borderline Personality Disorder	Major Depression Single Episode	Major Depression Single Episode	Avoidant Personality Disorder	Major Depression Single Episode	Major Depression Single Episode
19	Borderline Personality Disorder	Dysthymic Disorder	Conduct Disor. Socialized Non Aggressive	Avoidant Personality Disorder	Atypical Personality Disorder	Major Depression Single Episode

Table 4

Codes for the Different Diagnoses for all Subjects

01	Borderline
02	Dysthymic
03	Histrionic Personality
04	Major Depression
05	Identity Disorder
06	Adjustment Disorder
07	Personality Disorder N/S
08	Conduct Disorder
09	Avoidant Disorder
10	Separation Anxiety Disorder
11	Impulse Disorder
12	Obsessive Disorder
13	Schizoaffective Disorder
14	Manic Depressive
15	Oppositional Disorder
16	Schizotypal Disorder
17	Schizophrenia
18	Unspecified
19	Narcissistic
20	Passive-Aggressive
21	Atypical Impulse Control
22	Overanxious Disorder
23	Atypical Personality Disorder

Table 5

Codes for all Diagnoses

SUBJECT #	MAPI	PSYCHIATRIST	PSYCHOLOGIST I	SOC. WORKER I	PSYCHOLOGIST II	SOC. WORKER II
1	01	02	02	03	02	04
2	01	02	05	02	06	07
3	06	05	01	01	02	04
4	01	02	08	05	08	08
5	09	02	10	10	08	09
6	08	08	08	08	08	11
7	06	04	04	04	02	12
8	06	04	04	04	04	06
9	06	13	13	17	13	14
10	01	13	15	16	16	04
11	01	04	04	01	18	04
12	15	01	01	01	01	01
13	05	17	17	17	17	17
14	09	08	08	19	20	08
15	06	08	08	08	08	08
16	01	21	22	02	06	04
17	01	17	17	17	17	17
18	01	04	04	09	04	04
19	01	02	08	09	23	04

Table 6

Number of Agreements in any Diagnoses
Over the 19 Subjects

	MAPI	PSYCHIATRIST	PSYCHOLOGIST I	SOC. WORKER I	PSYCHOLOGIST II	SOC. WORKER II
MAPI						
PSYCHIATRIST	1					
PSYCHOLOGIST I	1	12				
SOC. WORKER I	2	8	9			
PSYCHOLOGIST II	1	9	10	7		
SOC. WORKER II	2	7	8	4	6	

For comparison purposes the different diagnoses were grouped together under four major diagnostically related groups: Personality Disorders, Mood Disorders, Psychoses, and Anxiety Disorders, (see Table 7). The fifth group was unspecified.

There were 114 diagnoses assigned to 19 subjects by the instrument and the five clinicians. Of the 114 diagnoses, 54 were considered to be Personality Disorder diagnoses; 19 were considered to be Mood Disorders; 17 were considered Psychosis; 2 were considered Anxiety Disorders; the remaining one was an unspecified diagnosis.

The purpose of this comparison was to see if the rate of agreements and disagreements would be altered by placing the different diagnoses under more general and encompassing diagnostic categories. If the MAPI and the clinicians disagreed among themselves on particular diagnoses, there could be more agreement within larger diagnostic categories. Table 8 gives a comparison of how the instrument and the clinicians compared when diagnosing across larger diagnostic categories.

As it can be seen on Table 9, the number of agreements between the clinicians, and between the MAPI and the clinicians increases notably by diagnostic categories when compared to individual diagnoses.

Table 7

Diagnosis Grouped Under Categories

PERSONALITY DISORDERS
Borderline Personality Disorder
Histrionic Personality
Identity Disorder
Personality Disorder N/S
Conduct Disorder
Avoidant Disorder
Impulse Disorder
Obsessive Disorder
Oppositional Disorder
Narcissistic Personality
Passive Aggressive Personality Disorder
Atypical Impulse Control
Atypical Personality Disorder
MOOD DISORDERS
Dysthymic
Major Depression
Adjustment Disorder
Manic Depressive
ANXIETY DISORDERS
Separation Anxiety Disorders
Overanxious Disorders
SPECIAL CATEGORY
Unspecified

Table 8

Comparison of how the Instrument and the Clinicians Compared When Diagnosing Across Larger Diagnostic Categories

SUBJECT #	MAPI	PSYCHIATRIST	PSYCHOLOGIST I	SOC. WORKER I	PSYCHOLOGIST II	SOC. WORKER II
1	PERS	MOOD	MOOD	PERS	MOOD	MOOD
2	PERS	MOOD	PERS	MOOD	MOOD	PERS
3	MOOD	PERS	PERS	PERS	MOOD	MOOD
4	PERS	MOOD	PERS	PERS	PERS	PERS
5	PERS	MOOD	ANX	ANX	PERS	PERS
6	PERS	PERS	PERS	PERS	PERS	PERS
7	MOOD	MOOD	MOOD	MOOD	MOOD	PERS
8	MOOD	MOOD	MOOD	MOOD	MOOD	MOOD
9	MOOD	PSYCH	PSYCH	PSYCH	PSYCH	MOOD
10	PERS	PSYCH	PERS	PSYCH	PSYCH	MOOD
11	PERS	MOOD	MOOD	PERS	SP.CAT	MOOD
12	PERS	PERS	PERS	PERS	PERS	PERS
13	PSYCH	PSYCH	PSYCH	PSYCH	PSYCH	PSYCH
14	PERS	PERS	PERS	PERS	PERS	PERS
15	MOOD	PERS	PERS	PERS	PERS	PERS
16	PERS	PERS	PSYCH	MOOD	MOOD	MOOD
17	PERS	PSYCH	PSYCH	PSYCH	PSYCH	PSYCH
18	PERS	MOOD	MOOD	PERS	MOOD	MOOD
19	PERS	MOOD	PERS	PERS	PERS	MOOD

Table 9

Number of Agreements Increases Notably by Diagnostic Categories When Compared to Individual Diagnoses

	MAPI	PSYCHIATRIST	PSYCHOLOGIST I	SOC. WORKER I	PSYCHOLOGIST II	SOC. WORKER II
MAPI						
PSYCHIATRIST	7					
PSYCHOLOGIST I	10	13				
SOC. WORKER I	11	12	13			
PSYCHOLOGIST II	10	13	13	14		
SOC. WORKER II	10	11	11	9	13	

DISCUSSION

As evidenced by the Results section the rate of accordance between the MAPI (Millon, et al., 1982) and the clinicians is minimal.

This study seems to indicate that there is a tendency by the MAPI to overdiagnose Borderlne Personality Disorders. This can be the result of several factors. In first place this particular diagnostic category appears to be more subject to personal interpretations than is the case with other diagnostic categories. A major contributing factor may be the diverse theoretical orientation of different clinicians and assessment instruments.

As stated in the Introduction section the concept of a "borderline condition" originated within the work of early psychoanalysts. It had a place within that theoretical framework between neurotic and schizophrenic states. It was a state characterized by rage, bizarre ideations, conflictual interpersonal relationships, high degree of emotional instability, covered at times, by a patina of normalcy.

It is important to remember that many of these conceptual categorizations were made at a time when knowledge about the functioning of the brain, and the

role of biochemistry in behavior were considerable less present knowledge. Therefore they are rooted in intangible intrapsychic states that are the cornerstone of psychoanalytic theory.

This lack of tangible concepts, that is, those that can be measured in by objective means e.g. centimeters, grams, seconds, is evidenced in the jargon used to describe the disorder. Examples of this can be seen in terms such as social adaptiveness, poverty of object relations, psychic bleeding, inner emptiness, and others, that were presented in the Introduction section.

This author does not dispute that there may be a range of behaviors, or "inner experiences" that are defined by these words. What is stated is that these words and concepts are intangible enough to allow for considerable subjective interpretations. These subjective interpretations do not allow for a standardization of terms or concepts, resulting in considerable differences in the topography of behavior that they describe.

It is interesting to note that the development of new concepts and terms, most of which come from the field of psychoanalysis, did not clarify the issue, since the new terms were just as obscure as the old ones.

The use of this jargon poses a special problem since the field of mental health is far from being a unified field. What this means is that there is a considerable

number of theories and systems in psychology and psychiatry, and professionals do their training in one main theory with little knowledge of the other ones. However, many professionals seem to use concepts and terms from different theories without a precise understanding of the terms. Furthermore, some of these terms seem to be so vague, e.g., psychic bleeding, that understanding of the concept and the parameters by people from even the same theoretical orientation seem difficult at best.

The concept remained largely unchanged for over half century staying almost exclusively within the domain of psychoanalysis. It wasn't until the second half of this century that attempts were made to redefine and describe the cluster of symptoms in concrete, observable, and somewhat measurable terms.

This can be construed, perhaps, as the result of the influence, and gaining of momentum, that behavioral mental health professionals had through the 1960s, 70s, and 80s. It can be best exemplified by the overall movement in the field of mental health towards setting treatment plans and goals in terms of observable and measurable criteria. This may be the result of professional attempts to standardize criteria, while at the same time represents economic realities that do not allow for protracted treatments with dubious results.

However, by attempting to blend elements from conceptually diametrically opposed theories, the field produced a hybrid that in its present inception continues to defy categorization. This has also produced diverse approaches to treatment over which there is little agreement. This hybrid concept has enough elements of diverse theories to make it appealing to diverse professionals.

Another factor to be considered is that in many cases symptoms of disturbance within mental health are not always easily categorized. A Borderline Personality diagnosis combines enough behavioral and personality characteristics to make it a tempting residual category when the clinician is not sure of the diagnosis.

It appears that even if the DSM-III (APA, 1980) attempts to provide a more precise description of the Borderline Personality Disorder, clinicians may approach this diagnostic category in a lackadaisical manner. In that way many clinicians seem to draw more meaning from the connotative aspects of the classification than from the denotative aspects. It is as if the concept of Borderline in itself overrides the boundaries of its definition and description. Practitioners and instruments seem to rely more on their own interpretations of this concept than on established criteria. It is possible that once an opinion is formed about a patient

following the concept, then particular behaviors are matched to the DSM-III diagnosis.

Another factor that cannot be disregarded is the tendency of the field of mental health to create diagnostic fads. This is not to say that there are no people who would fit this category, but, the tendency to create large numbers of false positives. This is an area that seems to afflict the field of mental health perhaps more than other fields.

Mental health tends to be a very normative concept. It creates in many areas an ideal concept of a person and then tends to label deviations from that norm. As the field grows and expands its concepts and terminology, it should be remembered that it tends to become more inclusive of criteria and more prone to find concepts that represent deviations to the norm. The growth of the mental health field is undeniable, as expressed by the total output of professionals and by the culture in which it is centered, to become what Gross (1978) termed "The Psychological Society".

But the concepts and terminology that the mental health profession comes up with, are not always clear, precise, and easily identifiable as it may be the case with other sciences, e.g., biology, medicine, etc. In the latter the evidence of deviations from health and norms are more readily observable than in the former.

The growth of diagnostic categories has also been undeniable. Evidence of this can be found in the almost geometric increase of diagnostic categories observed when comparing the DSM-I (APA, 1952) and the DSM-III (APA, 1980). As the mental health field expanded its power base, it also multiplied its concepts and jargon. This dramatic increase in diagnostic categories did not always face critical challenges or, as Reiser & Levenson (1984) stated, "demand a logical defense of the diagnosis" (p. 1532). It is interesting to note as a side comment that efforts at curbing this growth did not come, for the most part, from within the field. It came from other interested parties, mainly the health insurance companies.

There is also a fallacy in many mental health professionals who tend to regard their own feelings and countertransference issues as a diagnostic tool. By doing so, they just seem to add more confusion to a diagnostic category that has problems of its own. This tendency to evaluate countertransference also ties with the issue of norms, since it makes it even more subjective.

An interesting point that arises from this countertransference issue is the possibility of this diagnosis being used as a punitive consequence. When clients do not respond to expectations of therapists this may lead to an increased sense of frustration on the

therapist's part. The mental health professional may then, in turn, react in a punitive manner and label the person a borderline.

It should be restated that there are a number of people whose unstable and unpredictable behavior makes it difficult for others. If the Borderline Personality Disorder diagnosis can effectively identify them is the subject of great controversy; especially when looking at the prevalence of the term in the field.

Leaving aside the theoretical dimensions of the Borderline concept and focusing on the results of this study, there appears to be a tendency, by the MAPI, to diagnose as Borderlines more adolescents than it is the case with clinician generated diagnoses.

This can be the result of several possible factors that should be considered.

In first place, it is not clear from the description given by Millon et al., (1982) of the validation process of this instrument, especially in its applications regarding automated interpretations. Millon (1982) states that:

> The foundation of the MAPI system is, in part, an actuarial one, resting on the results of descriptive ratings that were obtained in empirical studies. However, it also depends heavily on the hypotheses of a systematic clinical theory. Not only did the theory guide the empirical studies, but it synthesized the findings so as to produce coherent interpretative assessments. For these reasons, the MAPI program is best viewed as a mixed system, both

> actuarial and theoretical. Where substantial and clearcut data exist, the system of predictor-descriptor relationships was determined largely by actuarial results. However, where such data were insufficient to cover the broad domain of possible predictor profiles, the theory provided a deductive framework of hypotheses by which these deficits could be 'filled in'. As a result of the power of the theory to bridge these deficiencies, 100 percent of all possible MAPI profiles can be interpreted. It is in this regard also that the MAPI program should be considered both actuarial and theoretical. (p. 30)

It is not clear from the information available in the manual the exact boundaries of the interplay of actuarial and theoretical systems. In other words, it is unclear how much do the authors use the theoretical framework to bridge the gap in actuarial data.

The second major question that arises from the validation process is the size of the normative population, especially the clinical group. For a test that is commercially available to professionals, and used not only for research purposes, a clinical population of 430 seems to be a small number; this paucity is even more noticeable when compared with the normal group of 2157.

Very little information is given about the parameters and overall composition of the clinical population. No reference is made in the manual to reasons why these adolescents were placed in inpatient or outpatient treatment programs. In addition, more than three-fourths of the adolescents were placed in outpatient programs, indicating the possibility that, at

least some of them, did not present "serious" clinical manifestations. The remaining one-fourth were drawn from inpatient settings, but again, there is little description of why these adolescents were institutionalized. A number of concerns can be expressed regarding the validity of this instrument which relies on narrow clinical norms.

Compounding the validity problem, there is the issue of changing perceptions and values within our society. As stated in the Introduction section, it wasn't until the twentieth century that adolescence was defined as a separate stage of development. It wasn't until the writings of G. Stanley Hall, that this expectation of adolescence being tumultuous was "officialized". With this expectation in place in society, the base rate of adolescent defiance and oppositional behavior increased. It appears that it became quite normal to expect that adolescents would go through a period of emotional instability, social defiance, and erratic and unpredictable behavior. This may have led to a self-fulfilling prophecy effect, leading adults and adolescents to believe in it and expect disorganized patterns of behavior.

By raising the expectations society also narrowed, in direct proportion, the perceptual distance between what was considered "normal" and pathological. What this

means is that it increased the number of children whose behavior could be described as "abnormal" or "pathological". It made it much more difficult to differentiate clear cases of abnormality from those where adolescents are allowed or expected to act out their frustrations. As the buffer zone separating these groups narrowed, the number of cases requiring some form of intervention increased.

If in addition to the above stated problems we add a confusing terminology and concept, then there is a natural progression to the increased number of people that can be labeled Borderline.

Another concern that can be expressed regarding the validity of the instrument is the use of 150 questions to construct twenty scales. Therefore, on the average, each question is used 4.44 times. By comparison, another major instrument such as the Minnesota Multiphasic Personality Inventory uses 566 questions to construct three validity and ten clinical scales. In addition, a simple visual examination of the questions in the test (see Appendix A) seems to indicate the vagueness of some items. This is compounded when these questions are administered to adolescents, especially young ones, whose cognitive and emotional skills are being developed. No premature judgments should be made regarding this overlap of items; however, data should be provided to help

understand how and why this overlap occurs. More important, how single questions can answer different dimensions of personality remains to be explained.

The instrument seems to be able to identify general deviations from what can be considered "normal behavior". When individual diagnoses were grouped under larger diagnostic categories (Table 9) the rate of agreements between clinicians and the instrument increased substantially. However, when these diagnostic categories were broken down into individual diagnosis the rate of agreements decreased. It is in this area, of individual categories, that the instrument seems to overidentify a particular diagnosis, that of Borderline.

This study focused only on comparing diagnosis between the instrument and the clinicians. It does not make a statement regarding the intrinsic validity of either one. The purpose of this study was to establish the effectiveness of the MAPI for a quick screening of potential Borderline Personality Disorders when these are admitted to inpatient psychiatric units. In that regard, the MAPI seems to identify many more than it could be expected. This seems to be supported when comparing it to clinician's diagnoses.

One major issue that needs to be clarified is that there is a lack of standardization of criteria by which clinicians and the MAPI develop the Borderline diagnosis.

It may be the case that the MAPI overdiagnoses borderlines, when compared to clinicians, but it does so not because it is an unreliable or invalid instrument but because it uses a different criteria from that of the clinicians. However, it appears that at least the MAPI would use a consistent criteria as opposed to the high variability that may exist among the professionals.

It is quite unlikely that the present state of affairs will change significantly in the immediate future. While the DSM may try to redefine the concept in present and future editions it still has to contend with pressures from opposing theoretical views. Adopting a more middle of the road position may placate some tempers but it may not further clarify the concept in a substantial way.

The problems associated with the diagnosis of borderlines are symptomatic of larger problems present in the field of mental health. Creating new diagnostic categories may not only not solve any needs but actually divide the field even more at a time when unification seems to be more imperative. In that way, the diagnosis of borderline may stand as an example of an "impossible" diagnosis.

The risk of generating a false diagnostic impression is great. For one, once a label is applied to an adolescent it may be hard to eliminate, even when

contradicted by evidence later on. This may lead to a self-fulfilling prophecy effect where the staff may treat the adolescent as a Borderline, under the impression that the youngster may be trying to engage in "impression management" and try to mislead them. In that sense, the risks of using this instrument, for that purpose, may outweigh its benefits. Finally, it should be remembered that these results suggest a tendency by the MAPI to overdiagnose Borderlines. However, the number of cases used in this study is limited and this should caution against definite statements. To prove or disprove these results other studies may be needed, including a replication of this study with a larger number of cases.

Appendices

Appendix A

Millon Adolescent Personality Inventory (MAPI)

Appendix B

Human Subjects Institutional Review Board Approval and Other Consent Forms

WMU

Western Michigan University
Kalamazoo, Michigan 49008-3899

Human Subjects
Institutional Review Board

TO: Juan Herakovic

FROM: Dr. Ellen Page-Robin EPR

RE: Human Subjects Review

DATE: August 4, 1986

This memo will serve as confirmation that your research protocol "The Predictive Validity of the Millon Adolescent Personality Inventory to Assess Borderline Conditions in Adolescents" has been approved by the HSIRB.

cc: Fred Gault

Enclosed is a consent form which, if you agree to sign, would allow my access to the medical record of

Access to the medical record is necessary in order to assist in a research project that I am conducting. The study is intended to compare the effectiveness between the stated results of a psychological test and a practitioner's diagnosis. Access will consist of a brief review of the chart and consultation with Hospital Staff regarding diagnosis.

I assure you that complete confidentiality of patient information will be observed. Identifying information (ie; name or any type of information that would distinguish the patient) will not be used in any manner in order that the patient's identity will be protected. Also, please understand that your consent is purely voluntary and that no consequences will occur to your child if you decide to refuse consent. If you change your mind, the consent may be revoked at any time.

Please read the attached consent form, sign at the bottom if you wish to give your permission, and return it to me. A stamped self-addressed envelope is enclosed for your convenience. If you have any questions, please call me at

Your prompt attention would be appreciated.

Sincerely,

Juan Herakovic, M.A., L.L.P.

PERMISSION FOR ACCESS TO PATIENT INFORMATION

I, _____ authorize
Name of Parent/Guardian

Juan Herakovic, M.A., L.L.P., to review the medical record of my child,

_____. Review of the record is
Name of Patient

for research purposes.

I understand that access will consist of a brief review of the record and consultation with Hospital Staff regarding my child's diagnosis.

I understand that identifying information will not be used and that my child's name or any other type of distinguishing information will be protected.

I understand that there will be no consequences to my child if I refuse to sign this consent.

I understand that this consent may be revoked at any time.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Witness Date

P.O. Box 1416, Minneapolis, MN 55440 / Phone 612-933-2800

NATIONAL COMPUTER SYSSYSTEMS 80

PROFESSIONAL ASSESSMENT SERVICES

June 14, 1989

Mr. Juan M. Herakovic
Psychology Department
Western Michigan University
Kalamazoo, MI 49008-5052

Dear Mr. Herakovic:

Thank you for your attention to copyright issues.

Permission is hereby granted to exhibit a copy of the MAPI Test Booklet for use in your dissertation.

Upon completion of your dissertation, we would appreciate receiving a copy of your work.

Sincerely,

Mary F. Spilles

Mary F. Spilles
Contracts Specialist

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