Emotional Hypochondriasis, Hyperbole, and the Borderline Patient

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The authors define a new defense mechanism, emotional hypochondriasis, that is hypothesized to be central to borderline psychopathology. The behavioral manifestation of this defense—the hyperbolic stance of the borderline patient—is also defined and related to the complex phenomenology of borderline personality disorder. Borderline patients are seen as making an active attempt to maintain a tolerable, if tenuous, adaptation in the face of tremendous subjective emotional pain that has been shaped in large measure by traumatic childhood events that have never been validated. Twelve treatment implications and three expectable, if overlapping, stages of treatment stemming from the use of this defense and its behavioral sequelae are detailed.

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Three major psychodynamic theories have been proposed to explain the development, phenomenology, and treatment course of borderline personality disorder. Briefly, in the first of these theories Kernberg[1] suggests that excessive early aggression has led the young child to split his positive and negative images of himself and his mother. This excess aggression may have been inborn or it may have been caused by real frustrations. In either case, the pre-borderline child is unable to merge his positive and negative images and attendant affects to achieve a more realistic and ambivalent view of himself and others.

In the second of these theories, Adler and Buie[2] suggest that failures in early mothering have led to a failure to develop stable object constancy. Because the pre-borderline child's mothering was inconsistent and oftentimes insensitive and nonempathic, the child fails to develop a consistent view of himself or others that he can use in times of stress to comfort and sustain himself.

[*Note:* In this article masculine pronouns are used inclusively.]

In the third of these theories, Masterson[3] suggests that fear of abandonment is the cen-

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tral factor in borderline psychopathology. He believes that the mother of the future borderline patient interfered with her child's natural autonomous strivings by withdrawing emotionally when the child acted in an independent manner during the phase of development that Mahler[4] has termed "separation-individuation." Later experiences that require independent behavior lead to a recrudescence of the dysphoria and abandonment panic that the borderline patient felt as a child when faced with a seemingly insoluble dilemma (either continue to behave dependently or lose needed emotional support).

Each of these theories has helped clinicians to better understand and treat borderline patients. However, each theory has also unnecessarily pathologized the borderline patient by focusing on what are perceived to be structural defects and/or functional deficiencies. In this regard, Kernberg[1] sees the borderline patient as having too much of a basic human drive or instinct—aggression. Adler and Buie,[2] although deeply empathic to the subjective suffering of the borderline patient, see him as having too little of a basic ego function needed for adult functioning—libidinal object constancy. Masterson,[3] although also holding a warmly empathic view of the borderline patient's emotional plight, sees his primary fear as being left alone, a fear that recent research has shown is not specific to the borderline patient.[5] Each theory, as initially formulated, also focuses on early and relatively subtle failures in mothering as being of primary etiological significance.

In contrast, we believe that borderline psychopathology can best be seen as an active attempt to maintain a difficult adaptation in the face of relationships with people—both real and internal—who can neither be loved comfortably nor left gracefully. We also believe that such pathology develops in response to serious, chronic maladaptive behaviors on the part of immature and emotionally incompetent, but not necessarily deliberately malevolent, caregivers.

EMOTIONAL HYPOCHONDRIASIS

We believe that emotional hypochondriasis is the primary defense of borderline patients. G. E. Vaillant[6] originally defined hypochondriasis as "The transformation of reproach toward others, arising from bereavement, loneliness, or unacceptable aggressive impulses, into first self-reproach and then complaints of pain, somatic illness, and neurasthenia." He also believed that "The mechanism may permit the individual to belabor others with his own pain or discomfort in lieu of making direct demands upon them or in lieu of complaining that others have ignored his needs (often unexpressed) to be dependent" (p. 384). In this view, hypochondriasis underlies the subjectively real but objectively untreatable disease and discomfort with which hypochondriacs plague their intimates and family physicians. The feelings of helplessness and rage that this type of situation engenders in physicians have been well documented in the clinical literature.[7-9]

Building on Vaillant's[6] definition, we believe that emotional hypochondriasis is best defined as the transformation of unbearable feelings of rage, sorrow, shame, and/or terror into unremitting attempts to get others to pay attention to the enormity of the emotional pain that one feels. These attempts are usually indirect and involve a covert reproach of the listener's "insensitivity," "stupidity," or "malevolence."

We believe that paying attention to the presence of this defense has three important functions or consequences. First, it helps to identify borderline patients accurately. Second, it provides a different view of their dynamics. Third, it provides clear implications for their treatment.

Identification of Borderline Patients

The borderline diagnosis was originally a "wastebasket" term used to identify any patient who was not obviously psychotic or

clearly neurotic in character structure and level of functioning.[10] Research has outlined four areas of psychopathology that are most characteristic of borderline patients: 1) intense, dysphoric affects; 2) cognitive distortions, especially dissociative experiences and transient stress-related paranoid experiences; 3) impulsivity, especially self-mutilative acts and manipulative suicide efforts; and 4) intense and unstable relationships, marked by such problems as devaluation, a sense of entitlement, and demandingness.[11–13] However, research has also shown that many other types of Axis II patients exhibit one or more of these kinds of symptomatology.[5] Furthermore, research has shown that borderline patients manifest a variety of Axis I disorders, especially unipolar depressions, substance abuse, eating disorders, and anxiety disorders.[14–21] However, none of these disorders is specific to or pathognomonic for borderline personality disorder.[16–21]

We believe that being able to recognize the defense of emotional hypochondriasis at work allows the clinician to accurately identify the borderline patient. Such a patient may present with a bewildering array of symptoms and/or Axis I disorders; recognizing emotional hypochondriasis allows the clinician to organize this plethora of clinical data in a meaningful way. This ability to diagnose accurately is particularly important with borderline personality disorder; we believe that the borderline diagnosis is both overused to describe angry, impulsive, interpersonally difficult patients[5] and underused to describe patients who present with seemingly intractable Axis I disorders or symptoms that clinicians may mistake for one of these disorders.[22]

Keys to Identifying Emotional Hypochondriasis

The outward manifestation of this defense is the hyperbolic stance of the borderline patient. To put it most succinctly, nothing that can be stated dramatically is said simply and nothing that can be stated once goes unrepeated. In other words, much as Willie Loman's wife in *The Death of a Salesman*[23] believed that "attention must be paid" to his deteriorating situation, borderline patients insist that attention be paid to the enormity of their subjective emotional pain—pain that is often consciously perceived and openly discussed as "the worst pain anyone has felt since the history of the world began."

There are three keys to recognizing the presence of emotional hypochondriasis.

1. The patient presents a series of unremitting complaints or one major but perhaps shifting lament. These complaints or laments can be about almost anyone or anything. Particularly common, however, are complaints about the lack of understanding that others display and/or the presence of various Axis I symptoms.
2. These complaints do not yield to reason, reassurance, or angry confrontation. In fact, they tend to increase in intensity or undergo a transformation into something equally maladaptive when inappropriately and nonempathically confronted.[24]
3. Real-life conflicts soon take on a transferential quality. The patient who complains about her mother's gross insensitivity will soon complain about her therapist's gross insensitivity. Likewise, the patient who complains about her old psychopharmacologist who could not cure her dysphoria and insomnia will soon complain about her new psychopharmacologist's lack of ability to do the same. This transferential stance of being completely miserable and passively expecting a treater or team of treaters to remove this misery will soon engender rescue fantasies that will eventually be replaced with countertransferential feelings of exasperation, helplessness, and exhaustion.[25–27] These feelings are a

particularly helpful guide to the presence of the defense of emotional hypochondriasis.

Dynamics

Again, the defense of emotional hypochondriasis represents an unremitting cry that attention must be paid. Hyperbolic speech and behavior are characteristic of the borderline patient when this defense is operative. ("No one knows how much I am suffering and the misery I feel. I'm in agony and no one knows or cares.") The etiology of this defense remains unclear. Psychodynamic theories have tended to focus on the role of maternal failures during the separation-individuation phase of ego development.[1-3] The first wave of research on the childhood experiences of borderline patients pointed to the role of early separation experiences[28-31] and relatively subtle forms of emotional neglect.[28,30,32-36]

We believe that the crucible for the development of this defense is the situation where the child has been repeatedly and deeply hurt or brutalized by one or both parents, but the validity of this experience has never been acknowledged. In this view, the borderline patient is not suffering from a constitutional problem with aggression, as Kernberg[1] has suggested, but is simply completely furious that he has been left to bear someone else's anger, depression, or helplessness that was unjustly taken out on him. Thus, unlike Adler and Buie,[2] who believe that the borderline patient has failed to develop libidinal object constancy as a result of relatively subtle failures in parenting, we believe that borderline patients have trouble comforting themselves because they have such troubling images, affects, and memories inside—images, affects, and memories that are more accurate than not reflections of their pathogenic childhood experiences. This conceptualization also differs from that of Masterson,[3] who believes that borderline patients are terrified of being abandoned and left with profound feelings of aloneness and emptiness. In contrast, we believe that borderline patients are not so much afraid of being left alone as completely fed up with being left with other peoples' pain that inconveniently inhabits their bodies. To put this another way, we believe that borderline patients are not so much afraid of staying in an empty house as they are terrified of being trapped in a haunted house—a house haunted by the memories of what others have done to them and what they, in turn, have done to themselves and others.

Given this background of betrayal and gross insensitivity, the rage of borderline patients is understandable. No one wants to wear somebody else's dirty clothing. Equally important in understanding their anger is understanding the frustration of never having those who have hurt you acknowledge in a meaningful way that your pain is justified. Nothing can ever take away the pain of being run over by a car, but an apology can go a long way toward warding off endless efforts at legal reparations.

Recent research supports this view of borderline dynamics. Studies have consistently found that borderline patients are more likely than those with other forms of personality disorders or nonpsychotic affective disorders to have a history of physical or sexual abuse.[20,37-39] In addition, three-quarters of borderline patients report a chronic childhood history of severe verbal abuse.[38] All told, about 80% of borderline patients report a history of one or more forms of childhood abuse.[37,38] Studies have also found that borderline patients are likely to have a parent with a serious psychiatric disorder—most often unipolar depression, substance abuse, or character pathology.[40,41] In addition, a series of studies has shown that the parents of borderline patients are often reported to have been neglectful of both their emotional and physical needs.[38,42]

Thus, recent research supports our clinical impression that borderline patients are often mistreated by their caregivers—and in

gross and dramatic rather than subtle ways.[20,37–39] Recent research is also consistent with our belief that this mistreatment was not directed solely by personal malevolence toward the child but rather arose from the general immaturity and psychopathology of the parents.[40,41] Additionally, the results of studies concerning serious forms of neglect are consistent with our belief that borderline patients are expected to bear their pain in silence and/or deny its existence.[38,42] However, more research is particularly needed in this last area because the results of existing studies are only suggestive. They do not directly assess the issues of secrecy and denial in the families of borderline patients.

Caveats

Our belief in the centrality of emotional hypochondriasis does not blind us to the importance of other defensive operations. Plainly, the impulsivity of borderline patients can be linked to their reliance on the defense of acting out.[6] Similarly, the hypervigilance of borderline patients can be linked to the defense of projection, and their seeming mood swings to the use and failure of dissociation and denial.[6]

Our belief that the pain of borderline patients has been hard earned also does not blind us to the possible etiologic significance of constitutional factors.[43–46] Clearly, some children can be and have been exposed to similar environmental failures and have not developed borderline psychopathology. Some have developed other types of serious character pathology, such as antisocial personality disorder;[47] others have gone on to lead productive lives unmarred by serious psychopathology.[48]

TREATMENT IMPLICATIONS

Conceptualizing emotional hypochondriasis as the core defense of borderline personality disorder leads to 12 treatment implications. Although none of these treatment implications is entirely new, taken together they suggest ways for a therapist to deal with both of the key elements that we believe are associated with the development of and reliance on this defense: the presence of intense but inchoate inner pain and an almost absolute insistence that others empathically acknowledge this pain regardless of how awkwardly and indirectly it is expressed.

1. Frame the patient's situation in terms of felt pain rather than symptoms or symptom clusters. Most borderline patients will feel better understood when told, "You are in terrible pain" than when told, "You have an affective disorder."
2. Validate the enormity of the pain the patient feels. Acknowledging that he is in tremendous pain reflects the patient's subjective experience. We have found that using powerfully emotional language is particularly useful in this validation process (e.g., "Growing up for you was like living in an emotional concentration camp.").
3. Try to help identify the constituent elements of the patient's pain. Chronic feelings of anxiety and/or terror, rage, intense frustration, shame, and sorrow are often found when the clinician is genuinely interested and willing and able to listen. In this regard, a particularly articulate patient described her most common inner state as "exasperated dysphoria," which she went on to describe as an agonizing admixture of rage, anxiety, and sorrow that she felt as an alien entity throughout her entire body.
4. Try to help the patient place his pain in a meaningful historical context. Although borderline patients want their pain acknowledged, they often cannot immediately identify the reasons for this pain. This inability may be due to dissociation, shame, or habituation to abusive experiences that would seem

catastrophic to the objective observer.

5. Try to help the patient see his life as a unified narrative with a beginning, a middle, and an end. Knowing that life unfolds and that one has some control over the direction and pace of change will help to alleviate panicky feelings that the pain will never end or will end too soon. It will also help to instill hope in these patients, in whom hope is often quite tenuous.
6. Try to show the patient that his pleas for help are so indirect and disguised that only a fellow traveler will be sure to recognize them. This will be difficult, for borderline patients are sure they are accurately communicating the depth of their suffering and that most other people are knaves, abusers, or both. In this regard, we have found that practicing helps. For example, one might say, "Try to tell people that you are very angry because you are remembering the many times that your parents told you that you were ugly and stupid and then went out and received praise for their charitable efforts. Don't call your friends at three in the morning and say you are going to overdose on your antidepressant if they aren't more understanding in the future. This only makes people feel angry and helpless." Although this may seem self-evident, often it will be a revelation to the borderline patient, who has been taught the language of desperation and hyperbole as a child. Clearly, no one is going to bother to shout if he believes that a normal conversational tone will suffice.
7. Try to help the patient see that those who have hurt him so are limited people rather than simply deliberately withholding or sadistic. Both clinical experience and recent research findings[49] suggest that borderline patients tend to believe that their parents are selfish and/or evil. This belief seems to us only partially correct and ultimately self-defeating. If you believe that someone has something good and just will not give it to you, you may well persist in trying to get it, endlessly lament that you do not have it, or engage in some exhausting combination of both. Acknowledging that those who have hurt and denigrated them gave them what they could is difficult for borderline patients but necessary for their recovery. Few people will try to break into a store that is obviously empty. Additionally, it is useful for the borderline patient to learn that the world responds better to a tearful person than one with a clenched fist.
8. Try to demonstrate to the patient that you can be most helpful by bearing with him while he learns to bear his pain. Efforts to distance yourself from his pain or even silence him, such as desperate attempts to medicate what is actually his "dis-ease," will only lead to a regressive spiral or the premature termination of treatment. In contrast, being patient, calm, and genuinely emotion ally available in the face of true suffering will begin to teach the borderline patient that the unbearable can be borne and the unspeakable can be spoken.
9. Try to frame the borderline patient's use of interpersonal maneuvers (such as manipulation, demandingness, and devaluation) as helpful attempts to teach you about his chaotic early experiences and his resultant intense feelings of worthlessness and inner badness, instead of criticizing these maneuvers as forms of misbehavior or sadistic attempts to control your behavior. It makes no more sense to chide a starving person for his poor table manners than it does to chastise a borderline patient for holding on to these outmoded survival strategies. Additionally, the reframing approach will serve both to protect the patient's already low self-esteem

and demonstrate your faith in his ability to collaborate, albeit in a somewhat unusual way, in the therapeutic work.

10. Never attack the borderline patient's parents or other loved ones. No matter what they have done or failed to do, they are loved and needed by the patient. In our experience, hypochondriasis is typically a defense of the inconsistently loved but not the unloved person. If the borderline patient did not have some hope about relationships, he would not keep seeking them out. Rather, he would join the antisocial person who is without hope and continually flee from the pain of honest intimacy through seemingly mindless acting out.[50] There is another reason to avoid such attacks: the patient will be quick to perceive that his chances of being forgiven for the many times that he has inadvertently and/or deliberately hurt others are slim if his therapist cannot forgive those who have hurt him.
11. Try to remember that the affect borderline patients dread most is sorrow. Although they often have trouble directly expressing their anger and they fear the destructive power of their rage, they frequently come from families where angry conflict was the norm. In contrast, they have never had any help in learning to bear their sorrow. Furthermore, sorrow acknowledges that the struggle is over, that one's life could only have unfolded as it has and now it is time to mourn and move on. The borderline patient, like any reasonable person, is reluctant to give up this struggle until a clear alternative way of thinking, feeling, and behaving is firmly in place. Plainly, no one leaves a foxhole until given reassurance that the shelling is really over.
12. Be prepared for the borderline patient to resist getting well and for the treatment process to be prolonged. The borderline patient resists giving up his pain for three reasons. First, it has formed the core of his identity and thus represents what is known and to some degree safe. Second, it represents lost loves that have gone awry and is thus cherished. Third, any hint that the therapist believes that progress is being made brings about an affective recrudescence of the patient's early experiences of having his pain belittled or denied, which, in turn, gives rise to overwhelming feelings of desperation, rage, and panic.

THERAPEUTIC PHASES

Numerous authors have presented their views concerning the phases that constitute the effective psychotherapy of the borderline patient.[3,51–54] In our experience, which was informed by the work of these previous authors, the successful therapy of the borderline patient is roughly divided into three separate but often overlapping phases.

Reframing

During the first phase of treatment, which we have termed the reframing phase, the defense of emotional hypochondriasis will be fully operative, and the patient will repeatedly attempt to communicate his pain to his therapist in indirect but maddening or frightening ways (seemingly endless complaints about the therapist's incompetence and/or lack of caring, deliberate self-mutilative efforts, repeated suicide gestures). Regardless of the patient's initial style of presentation, the primary task of the therapist is to repeatedly reframe the patient's words and actions as efforts to express his deep inner pain. Despite the patient's seeming indifference to or contempt for these efforts, our experience suggests that he is inwardly appreciative that someone is trying to understand and give voice to his inchoate concerns.

The end of this phase of treatment, which is similar to Masterson's testing phase,[3] is usually marked by three important changes. First, there will be a noticeable decrease in the frequency and intensity of the patient's hyperbolic behaviors (reliance on indirect means of communication such as self-destructive behaviors and complaints of others' insensitivity). Second, the patient will begin to admit that he is in pain, although he will usually be unable to articulate the reasons for this pain or to detail its elements. Third, the patient will usually have returned to work or school if he began treatment as an inpatient or will have begun to stabilize his occupational or academic functioning if he began treatment as an outpatient. This will both enhance his self-esteem and provide him with a range of opportunities for real-life reparations that will make further progress possible.

These changes will be neither initiated nor maintained, however, unless the patient's therapist engages in an iterative process whereby the patient is encouraged in his efforts to make progress but is continually reminded by his therapist that his pain has not been "forgotten" and that his therapist does not believe that he is now "all better."

Validation

During the second phase of treatment, which is similar to Masterson's working-through phase,[3] the patient will begin to explore the nature and etiology of his pain. The therapist has two primary tasks during this phase. The first is to help the patient examine the often chaotic childhood experiences that have led to the development of his pain; the second is to validate the reality of these experiences and the reasonableness of the patient's emotional response to them. This latter task will be difficult because borderline patients, like other trauma survivors,[55,56] often alternate between intense experiences of reliving agonizing past events and denying that they ever occurred. This task will also be difficult because the therapist must validate the patient's emotional response to his chaotic childhood experiences while at the same time pointing out the self-defeating nature of his behavioral responses to these events.

Two self-defeating patterns, actually the flip sides of one another, are particularly important to address. First, the therapist needs to help the patient differentiate between the experience of others either placing reasonable expectations on him or disappointing him in expectable ways, and the experience of being reabused. Second, the therapist needs to help the patient differentiate between appropriate expressions of anger and assertiveness and actually being cruel toward those with whom he is close. In both cases, we have found that an educational approach concerning the general "rules" of life and the fact that they apply to everyone is helpful. In the former situation, one might say, for example, "Being asked to get up by nine in the morning is not the same as being tortured as a child. It may feel the same, but getting up is for your benefit, while being hurt and abused was for theirs." In the latter situation, one might say, for example, "No matter how much you have suffered, it doesn't give you the right to take it out on someone else. This kind of behavior only makes you feel even worse about yourself and may lead to your getting rejected again." We believe that this approach is helpful because it allows the therapist to empathically join with the patient in trying to deal with the inevitable frustrations of everyday life, while at the same time it holds the patient accountable for behaviors that he intuitively knows are self-defeating.

Additionally, it is important to remember that the pain engendered by an alternating pattern of emotional abuse and neglect may well be as excruciating as the pain engendered by physical and sexual abuse; thus, this kind of pain needs and deserves to be treated with as much respect as the more clearly traumatic experiences. In fact, recent research has shown that these more subtle failures usually serve as the background against which these more dramatic failures occur.[57]

The end of this phase of treatment, which we have termed the *validation* phase, will be marked by two important changes. The first change is that the patient will begin to direct his anger at those who have truly disappointed and hurt him rather than at those who are trying to help him. This in turn will allow him to begin to work through his feelings of worthlessness as he realizes that he is carrying the rage and hopelessness of others with him through a combination of habituation and identification. As one chronically dysphoric patient put it, "All this time I've thought I was a really angry person and for no reason. Now I see that I'm carrying my father's rage around. He abused me, and I've spent most of my life being a psychiatric patient. This rage is his, not mine. If I only could get rid of it, I would feel so much better." This process of reclaiming the true self has been well described by authors as varied as Winnicott[58] and Alice Miller.[59]

The second change is that the patient will gradually cease many of the desperate interpersonal strategies that have served him so poorly as an adult (e.g., clinging, demanding, being devaluative). In our experience, this constitutes true character change even though the patient is likely to stop these behaviors first and only afterward to discuss the reasons why he so vigorously maintained them; he is unlikely to stop them as a result of discussing them. This change seems to be partly facilitated by the support offered by therapy and partly by the reparations offered by life (such as finding a concerned mentor, being admired by a close friend, or being cherished by a romantic partner). Plainly, it is easier to be direct with people about one's needs when one feels well loved than when one has managed to inadvertently anger and alienate everyone one knows.

Mourning

During the third phase of treatment, which we have termed the *mourning* phase, the patient will focus on his sorrow at how others have hurt him and how he has hurt himself and others. The primary task of the therapist is to bear with the patient while he mourns for the lost years of his life. Plainly, it is difficult to admit that years of one's life were wasted in an empty, angry pursuit of a type of reparation that will never be forthcoming. A secondary but crucial task for the therapist is to help the patient achieve the many subtle but essential changes detailed by Buie and Adler in their article concerning the definitive treatment of the borderline patient.[51]

Throughout these three stages, the patient has been moving along a continuum that starts with inchoate suffering and ends with genuine mourning over the heartache of his life. As noted above in disparate places, we believe that three factors are responsible for this process: 1) validation of and help in articulating his inner pain; 2) true achievements in the real world that help both to foster self-esteem and to disprove the erroneous belief that autonomous behavior is sure to be punished by abandonment; and 3) a genuinely sustaining relationship that allows the patient to get sufficient distance on his feelings of inner badness and distrust of others so that he can begin to bear the pain of facing his past and letting it go. Both hope and gratitude are essential if the chronic suffering of the borderline patient is to be transformed into genuine respect and true sorrow for the unfortunate, even horrific, events of his life.

Clearly, our approach has much in common with the empathic approaches advocated by Adler and Buie[2] and Masterson.[3] In its emphasis on the subjective experiences of the patient, our approach also owes much to the self psychology of Kohut,[60,61] the object relations theory of Winnicott,[58,62] and the childhood observations of Bowlby.[63] Additionally, our formulation has been enhanced by the work of those concerned with the characterological effects of trauma.[55,56,59,64] However, our approach owes the most to the adaptational approach advocated by G. E.

Vaillant,[6,65] which implies that therapy can be most effective by facilitating change rather than by actually effecting it. To put this another way, borderline patients will mature in their own time if we are patient and hold them accountable for their behavior, but they will not be helped by taking a superego approach (as many frustrated therapists do) and forcing them to admit the error of their ways.

Directions for Future Research

The presence and specificity of emotional hypochondriasis have yet to be assessed empirically. Luckily, as Vaillant[6] has pointed out in regard to other immature defenses, outward behaviors can be studied as markers of this new defense.

Currently, there are three main techniques for studying defense mechanisms. The first is the self-report measure of Bond and J. S. Vaillant,[66] the second is the longitudinal clinical vignette method of G. E. Vaillant et al.,[67] and the third is the videotaped clinical vignette method of Perry and Cooper.[68] The hyperbolic behaviors associated with borderline personality (unremitting complaints of dysphoria, intractable Axis I symptoms, deliberately physically self-destructive acts) can be studied using any of these paradigms.

We have recently developed a series of questions to append to Bond's self-report measure. Using this modified instrument, we are currently assessing the specificity of this series of hyperbolic behaviors in a sample containing both carefully defined borderline patients and near-neighbor Axis II control subjects. We are also planning to assess, in a naturalistic study of the longitudinal course of borderline personality disorder, whether paying attention to the presence of this defense mechanism reduces the high dropout rate found in most studies of the psychotherapy of borderline patients.[69–71]

Conclusions

In our experience, the borderline patient has suffered enormously in his childhood, and the resulting pain has been ignored or belittled. This situation has led both to the reliance on the defense of emotional hypochondriasis and the development of the hyperbolic stance of the borderline patient. We suggest that rather than viewing such patients with anxious dread, one can admire the integrity with which they have dealt with their pain. After all, not many people remain so loyal to and so respectful of such disheartening and demeaning experiences.

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