The borderline spectrum
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THE BORDERLIINE SPECTRUM: CLINICAL AND NOSOGRAPHIC MATTERS

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SUMMARY

This paper analyses the main guidelines of borderline personality disorder, historically reviewing the nosographic, clinical tradition to reach a better definition, alongside the psychoanalytical understanding of the problem.

The conclusion takes its cue from the characterization of borderline personality disorder as a personality disturbance and affective disorder.

SUMMARY:

Key words: borderline, nosological

The work analysis the principal guide-lines of the borderline disorder going through the historical clinical nosological tradition. The work is also directed to improve the disorder's definition adding to it a psychoanalytic comprehension.

The conclusions take for granted the characterization of the borderline disorder between the personality and the mood disorders.
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INTRODUCTION

The term borderline was used for the first time by Hugues (1884) to indicate subjects who oscillate between "normality" and "dementia" on the "borderline of insanity".

As psychiatric studies were carried out over the years, the term took on various meanings, often causing confusion and reflecting the difficult definition of this disorder. Difficulties in understanding and the overuse of this concept have brought many authors to consider borderline personality disorder to be an artefact, an "artificial creation that does not correspond to reality", that could be used for those cases in which the diagnostic definition was problematic and uncertain.

The continuous research into this matter contrasts the scepticism of some authors.

The skepticism of some authors is opposed by the continuous research on the subject.The observation of these pictures difficult to ascribe to known diagnostic categories and the antithetical tendency on the one hand not to make nosographic innovations, on the other to fragment into small entities the structural essence of marginal syndromes have been reflected in the nosographic disintegration to which borderline disorder was submitted by the editors of the various editions of the DSM. The work proposes a review of the diagnostic problems of borderline disorder, highlighting its aspects of closeness / continuum with schizophrenic pathology, with affective psychoses to conclude with the new model proposed in the III section of the DSM5.

Borderline personality disorder in clinical-nosological tradition: schizophrenia and psychopathy

Historically, borderline personality disorder represented a psychopathological concept that was difficult to define, due to the symptomatic polymorphism that the descriptive clinical model couldn't' provide with precise limits. The difficult in identifying a pathognomonic organiser made this disorder oscillate between the large nosographic entities of the

Kraepelinian system, manic-depressive psychosis and schizophrenia on the one hand and in the borderline area between psychosis and neurosis on the other hand, and finally in the realm of patho-characterology.

At the end of the nineteenth century, European psychiatry involved two schools of thought: the German one, that – influenced by Kraepelin's nosographic rearrangement (1883) – included mental illnesses in a solid category system based on the observation of psychic functions, etiopathogenesis and progress, and was anchored to the classic concept of the natural illness; and the French school, that – influenced by Magnan (1891), Morel (1852-1857), both loyal to the Lamarckian evolutionary views (degeneration theory) – formed a nosological system based on the juxtaposition of types, connected to cerebral physiology where disturbances are a secondary phenomenon of degeneration.

With regard to the first school of thought, borderline personality disorder is first attributed as a minor form of schizophrenia.

Here several development paths can be seen, hinged on analysing progress and on the concept of latency and the coexistence of schizophrenic symptoms with neurotic or affective manifestations.

In 1883, Kraepelin was the first person to speak of diluted forms of dementia praecox, when observing schizophrenic-like, psychotic symptoms on the one hand and a relatively favourable path on the other.

Based on the observation of favourable progress, subsequently insidious, other authors associated adjectives to the definition of schizophrenia that were intended to soften the impact, such as "minor", with "favourable evolution", "abortive", "attenuated" and "out-patient".

The nosographic criterion based on progress, however, gave rise to criticism about the boundary of these descriptions for schizophrenia simplex, a paucisymptomatic form with an insidious onset described for the first time by Diem (1903) and later included by Bleuler (1911) in the classic clinical forms.

A second line of research began with the concept of latency: with the notion of schizomorphism and latent schizophrenia, in 1911 Bleuler spoke of medical cases that were difficult to interpret where the latent schizophrenic disposition affected the symptomatic expression of neurotic or disturbed forms.

This study perspective was continued by Rorschach (latent schizophrenia 1921), Stern (hidden schizophrenia 1938), Schaffer (schizophrenic nature 1954**), Meehl (schizotypal personality disorder** 1962).

There was confusion in this field too, mostly due to the fact that there were debates regarding these marginal types about the relationship between a pre-pathological personality and schizophrenia, that can be outlined in Bleuler's stance (that identified the pathological process in the origin of primary symptoms, and a deficit compensation mechanism resulting from the pre-existing personality structure in the origin of secondary symptoms), which contrasted with that of Claude (1926) who identified a schizo-semiogenetic progression from the pre-pathological personality to schizophrenia where schizoidia, schizomania and schizophrenia would be the various stages.

The medical differentiation of typical, nuclear, atypical or attenuated forms of schizophrenia, depending on progression, with their benign catastrophic evolution was challenged due to the complex nature of the somatic and psychic, social and ecological factors used in determining prognosis of the psychopathological cases.

The co-existence of polymorphous neurotic symptoms and psychotic manifestations, before psychoanalysis managed to clarify the limits between the two entities, brought about hybrid definitions such as "pseudopsychotic schizophrenia, pseudocharacterial or polymorphous pseudoneurotic schizophrenia".

Literature from the start of the twentieth century particularly considered hysterical and obsessive symptoms when looking at relations between schizophrenia and neurotic symptoms.

In his essay in 1908, Bleuler wrote "alongside the anomalies in character, we find hysterical and neurasthenic symptoms, precursors of manifest mental illness. Many sufferers of schizophrenia, especially young women, go from one doctor to

another with these diagnoses. The periods of improvement found in many cases would seem to confirm the diagnosis of "neurosis".

Wolfsohn (1907) stated that there was a neurotic overlapping (nevrotisk blastung) on the primary clinical situation in 29% of his case studies of dementia praecox but did not compare the evolution of these forms with typical situations of schizophrenia.

Mayer Gross (1932) referred specifically to schizophrenic situations with a neurotic aspect (neuroseahnliche bilder) that he identified as masked pathoplastic clinical forms (athpathoplastische verschleierte bilder).

Bornstayn (AA.VV 1985) stated that some forms of schizophrenia could initially appear to be obsessive neurosis.

Helbromer AA:VV: 1985) spoke of "progressive obsessive psychosis", Jarrheiss (AA:VV 1985) of "systematic chronic obsessive disease", Carp (AA.VV. 1985) of "obsessive malignant neurosis".

The relationship between schizophrenia and hysteria were highlighted by Kraepelin (1896), when describing hysteroid and hysteriform onsets. Claude and Baruk (AA.VV 1985) reported the need to distinguish between hysterical movement crises and the automatic paroxystic movements of sufferers of schizophrenia.

Generally-speaking, literature from this period highlights the lack of "psychologicity" in the pseudohysterical manifestations of schizophrenia sufferers.

The French school's line of development was expressed around the concepts of polymorphous *bouffée delirante* by Magnan (1893), acute hallucinatory psychosis by Gilbert (1910), essential imaginatory psychosis by Duprè and Longrè (AA.VV. 1985), schizophreniform psychosis by Lagenfeld (1939), psychogenic, oneiroid states by Gillet and Follin (AA.VV. 1985), recurring, atypical, schizoaffective, and cycloid with thought content (polymorphous delirium, irrational perceptions and intuitions), thought process, self-awareness (depersonalisation and derealisation) and affective disorders in cyclical and benign patterns as a common denominator.

Behavioural, affective elements permanently organised and the fragile sense of self as the basis of possible psychotic development were categorised as pathocharacterial cases such as Magnan's (1983) and Morel's (1852-1857) degenerates, Duprè's (AA.VV, 1985) psychopaths and mythomaniacs, with an interface in psychiatry of the period to Kahlbaum's (1874) eboidophreny, Kurt Schneider's (1955) psychopathic personalities, and Kretschmer's (1950) sensitive paranoid personalities, clearly separated from schizophrenia and representing prototypical models of understanding for delirium and behavioural disorders, seen as an extension of pre-existing traits.

Observing such cases that were difficult to attribute to known diagnostic categories and the antithetical tendency on the one hand to not make nosographic definitions and on the other to break up the structural essence of marginal syndromes into tiny entities, resulted in the nosographic disintegration of borderline disorder by the editors of DSM I and subsequent editions (DSM IV TR).

The Automatization of Borderline Personality Disorder in the Evolution of Psychoanalytical Thought

The contribution from psychoanalysis was decisive in understanding and outlined borderline personality disorder, finding the organising criteria for a clinical and therapeutic definition of this pathology in the therapeutic situation and the transfer and counter-transfer dynamics.

Stern's (1938) work was particularly important. He was among the first to establish specific diagnostic criteria for borderline personality disorder, defining the characteristics of a group of patients who were "too ill" to undergo classical psychoanalysis (narcissism, flight under mental stress, excessive behaviour, rigidity, negative reactions to therapy, sense of inferiority, masochism, the use of obsolete mechanisms, a bad examination of reality).

In turn, Eisenstein (1949) used this terminology and brought the concept of borderline personality disorder back on top.

Like the previous author, he was struck by a growing number of patients for whom there was no indication for psychoanalytical treatment and who could not be classified as neurotics or as psychotics, and who had the following characteristics:

- high anxiety triggered by all the interpretive interventions experienced as disapproval, a symptom of higher inner insecurity;
- defensive rigidity, closely related to this interior insecurity and destined to come into action each time these patients' narcissistic equilibrium is endangered;
- hyperesthesia each time there is a breakdown in self-esteem.

In agreement with the previous authors, Wolberg (1952) highlighted the nosographic distinction of the limits, in particular for psychotic structures, stating the repetitive mechanisms that such subjects use in their compulsive, everlasting search for gratifications, that are needed to increase self-esteem and resulting in megalomaniac apparitions if frustrated.

In this same period, thanks to Hoch and Polatin's (1949) study and in accordance with psychoanalytical contributions, classic psychiatry offered its first consistent contribution to the study of this marginal pathology, stating precisely the semeiological characteristics that were required to make a diagnosis.

When using the term "pseudoneurotic schizophrenia" the two authors are not indicating a transitional state towards the classic forms of schizophrenia, or a neurotic onset of the disorder, but rather a crystalized form, with low development tendencies of the illness. In this sense, patients remain "stable-unstable" for their entire lives and in cases where the psychotic phenomenology erupts totally, it is restored within a short period of time.

While agreeing with the progression stability in these patients and providing an accurate symptomatologic and structural analysis, M. Schmiderberg (1949) considered these non-schizophrenic patients but on the borderline with neurosis, psychosis, psychopathy and normality as having severe personality disorders as their essential characteristic.

From this point on, psychoanalytical literature on the matter can be divided into two lines:

1. study of non-specific manifestations of the self and regression to primitive functioning structures relating to primary thought processes, in reference to transferral and psychotherapeutic problems in general;
2. consideration on specific defensive operations of borderline organisation, in particular focusing research on splitting processes, intended as an active defence mechanism rather than an impairment of the self.
3. Grinker (1948) completed an essential clinical study for isolating borderline personality disorder as a nosological entity that is separate from neurosis and psychosis, by highlighting
4. 4 essential elements:

- anger, intended as a dysphoric, explosive crisis;
- flawed, seriously disturbed interpersonal relations;
- identity disturbance;
- depression "not in its typical form with guilt, self-accusation and remorse, but the sensation of emptiness and futility".

The same author distinguished 4 subgroups:

– *psychotic aspect:*

- inappropriate behaviour;
- problems in examining reality;
- negative behaviour and expressed anger.

- *Borderline personality disorder nucleus*

- pervasive negative affectivity;
- unstable involvement with others;
- Agitated anger;
- Identity disturbance.
- *Group as itself*
- tendency to imitate the identities of others;
- reduced affect display
- more adaptive behaviour;
- non-genuine relationships.
- *Neurotic aspect*
- anaclitic depression;
- anxiety;
- neurotic and narcissistic aspects.

Recent development in the characterization of borderline personality disorder: personality disturbance and affective disorder.

The conceptualisation of borderline personality disorder as a specific personality disorder in the DSM dates back to its third edition, where it was included after the considerable amount of literature on the matter in the 1960s and 70s.

There was no mention of it in its previous edition, DSM II, and borderline patients, consistently with the predominant position of that period, were mostly placed in the category of latent schizophrenia.

Its inclusion in the DSM III was largely affected by the descriptive study by Gundeson and Singer (1975), who, further to reviewing literature, highlighted six essential characteristics for diagnosing a patient:

- intense, mainly depressive or enraged affectivity;
- impulsiveness;
- superficial adaptation to social situations;
- temporary psychotic episodes;
- tendency to lose associative connections if subjected to projective tests;
- unstable, dependent but fleeting interpersonal models.

When writing up the items, reference was also made to Kernberg's structural study (1978-1985-1987).

The psychopathological aspects, in particular thought disturbances, were instead included in schizotypal personality disorder, that was separated from schizoid personality disorder in the 3rd edition of the DSM.

One controversial subject included in the criteria in DSM III and IIIR for borderline personality disorder was the non-inclusion of temporary psychotic episodes, which were later included in the 4^{th} edition.

Other problematic areas concerned the diagnosis overlaps between some axis II disorders and borderline personality disorder, which pressed the DSM III R writers to eliminate the items idealisation, devaluation of histrionic personality disorder and outbursts of anger from Histrionic Personality Disorder, in order to define the various cases better.

Another point that was the cause of much debate was the comorbidity of borderline personality disorder and other axis I disorders, in particular affective ones.

The observation of the multitude of symptoms with which borderline personality disorder manifests itself led many authors in the early 1980s to draw conclusions which contrasted with the ones contained in the DSM III.

Observations made show that the clinical characteristics of borderline personality disorder often did not originate from character disorders, but instead hid an axis I illness.

The required differential diagnosis often involved affective disorders. The main studies aimed at a better definition of borderline personalities with a consequent distinction from mood disorders focused on this line of research.

Research conducted had to address previous observations that brought to light the connection points between the two different pathological situations: Klein (1975) found a good response from borderline patients to pharmacological treatment with antidepressants, Stone (1981) recorded another incidence of affective psychopathology in his longitudinal observation of these patients, even going as far as highlighting “contemporary shift of the borderline concept from a subshizophrenic disorder to a subaffective disorder”. Grinker and coll (1968), Gunderson and coll (1975) highlighted the characteristics of depressive episodes in patients diagnosed as borderline as a “anaclitic-type depression and temporary states of solitude”, “a predominance of anger and depression and several levels of anxiety and anhedonia”.

Several other studies have considered the overlapping between the two different psychopathological situations, evaluating various aspects and using neurophysiological, neuroendocrinal and drug-responsiveness tests.

The various considerations that came from these evaluations led several authors to theorise on a primary position of affective disorders in characterological illnesses.

Two studies which stand out for the amount of consensus are the ones by Akiskal and coll. (1981) and Andrulonis and coll. (1982), carried out using the additional evaluative criteria of DSM III for diagnostic analysis (biological markers, response to treatment, progress, familial history). The use of external parameters has provided an alternative analysis model for the disorder to the descriptive one in the manual.

Akiskal and coll (1985) studied a sample of 100 patients selected on the basis that they satisfied at least five of the six DSM III criteria. The patient cohort was evaluated in a semi-structured interview, a follow-up (6-36 months), evaluating the presence of affective disorders and family medical history. Based on the results they obtained, the authors summarised a heterogeneous set of disorders that included the entire range of the psychopathology.

The evaluation criteria for affective disorder diagnosis were met in at least half the sample, and the affective component was found to the extent that they stated that “borderline personality disorders are mainly placed on the border of affective psychosis, rather than on that of schizophrenic psychosis”.

These conclusions were contested by various authors who found themselves in antithetical positions.

In clinical practice, it is extremely difficult to clearly distinguish the various components of the disorder, however it is important to identify and include each symptom within a diagnostic hypothesis.

The plasticity of borderline disorder symptoms would, according to Akiskal (1985), mainly be based on a weak self structure, a hypothesis that would allow us to include a wide range of manifestations, from neurotic to psychotic, without it being possible to identify a purely characterological origin.

Borderline Spectrum: clinical and nosographic considerations

Analysing nosographic, symptomatologic, evolutionary and therapeutic data in the realm of borderline personality disorder shows the validity of it being separated from the field of schizophrenia and affective pathology, where initially it was thought to be included. Its systematisation in character disorders also appears to be valid, after observing both familiarity and follow-ups.

The clinical and nosological study of this disorder must however be addressed in the more general context of all personality disorders. The current reducing systematisation within Axis II of DSM IVTR is still a controversial point.

The crux, as Kernberg (1981) and Millon (1981) point out at the time when DSM IV TR was written, was the distinction and identification method for disorders in axis II, not based on severity, therefore distinguishing criteria were never finalised, but based on totally arbitrary descriptive pathognomonic organisers.

On the other hand, the many diagnostic overlaps in axis II bring to the fore the problem of the existence of several spectra: in DSM IVTR (1984) many spectra are interrupted in their continuum, through the exclusion of some character disorders (e.g. hysterical personality, masochistic-depressive personality etc) or through their inclusion in axis I as occurred, for example, for some affective disorders (e.g. cyclothymic and hypomaniac personalities) and for impulse control disorders, including explosive personality (intermittent explosive disorder) and various impulsive personality disorders.

The situation is made even more confusing by the narrowing of the field of schizophrenia, by the expansion of the field of affective disorder and on the dispersion of neurotic disorder excluded from DSM III.

One idea for future studies comes from the Kernberg proposal (1978-1981-1989) of representing personality disorders according to both clinical and dynamic parameters along a continuum, including hysterical, obsessive and depressive masochistic personalities at a higher level, high performing narcissistic personalities, higher-level infantile personalities (histrionic) and passive-aggressive personalities at an intermediate level, and more regressive narcissistic personalities, low-level infantile personalities (histrionic) and severe affective personalities (hypomaniac and cyclothymic), schizoid, paranoid and antisocial personalities at a low level, all included in homogeneous spectra. The DSM5 try to resolve this controversia by the althenative model of personality disorders proposed in the Section III.

The DSM5 proposed in the section III a new model for the diagnosis of personality disorders as an alternative to the established diagnostic criteria. The proposed model incorporates impairments in personality functioning as well as pathological personality traits. The specific personality disorders diagnosis that may be derived from this model included only six disorders (antisocial, avoidant, borderline, narcissistic, obsessive compulsive and schizotypal and personality disorder trait specified). The essential features are

1. Level of personality functioning Self and interpersonal functioning evaluated on a continuum

For the Self : Identity and Self direction

For the interpersonal functioning :Empathy and Inthimacy

1. Pathological Personality traits are organized into five broad domains

-negative affectivity

-detachment

-antagonism

-disinhibition

Psychoticism

1. D) Pervasiveness and Stability as well as the definition on DSMIV TR
2. F) G) alternative explanations for Personality Pathology (Differential Diagnosis).

However, even this model, despite being a very suggestive proposal, which has tried to take into consideration the criteria of Kernberg, Millon, Cloninger still leaves open issues despite both PD borderline and trait specified disorder.

Even the dimensional optics proposed by the DSM5 still seem unsatisfactory at the moment. In fact within the same diagnostic framework can present very different psychopathological distress pictures and this has decisive implications for the treatment. In fact, the same diagnosis may require different therapeutic projects. Despite this the diagnostic moment

remains a fixed point in the organization of the psychopathological nosography especially for the construction of individualized therapeutic projects, respectful of the complexity of each individual patient

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