SOME ASPECTS OF THE PHENOMENOLOGY OF BORDERLINE PERSONALITY DISORDER

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SUMMARY

Borderline Personality Disorder has received diagnostic respectability with its inclusion in DSM III. Unfortunately, its popularity has outstripped its clarity. It is receiving widespread clinical attention, yet its phenomenology remains unclear. This paper describes a study of brief psychotic and depressive symptoms in inpatients with narrowly defined Borderline Personality Disorder. Almost all the cases present with evidence of brief psychotic symptoms, most common symptoms being the dissociative type (derealisation/depersonalisation); some patients also experience non-drug induced psychotic symptoms mainly hallucinations which are brief and appear only in stressful circumstances. Depressive symptoms are observed in almost all cases at the time of admission but are usually transient; antidepressants are not of much therapeutic value. The brief psychotic and depressive symptoms are described in detail and their diagnostic implications are discussed.

Borderline personality disorder (B.P.D.) achieved diagnostic respectability with its inclusion in D.S.M. III (1980). Doubts concerning the validity of the diagnosis nevertheless remained, provoking extensive research aimed at resolving the validity question.

The recent review by Tarnopolsky and Berelowitz (1987) has examined the literature on borderline personality published since the review of Liebowitz (1979) in terms of the Robins and Guze (1970) validity criteria. These authors have concluded that the balance of current evidence favours the validity of the disorder, when the diagnosis is made according to the new research criteria particularly Diagnostic Interview for Borderlines (D.I.B.) (Gunderson et al. 1981) and DSM III criteria.

In spite of the growing body of evidence favouring validity of the borderline diagnosis, the place of psychotic and depressive symptoms in the phenomenology of the disorder remains uncertain.

Psychotic Symptoms in Borderline Personality Disorder

The question to be answered concerning the clinical importance of psychotic experiences in borderline personality disorder is whether they are part of the main pathology, or manifestations of some independent morbid phenomenon. Kolb and Gunderson (1980) claimed the "one clinical aspect of borderline patients that could appear to remain a valuable discriminating feature is the regressive potential, especially their vulnerability to transient psychotic symptoms". A similar observation was made by Tarnopolsky and Berelowitz (1984) but psychotic episodes are considered an accessory feature of borderline personality disorder in the D.S.M. III definition. A
revision of the D.S.M. III definition was suggested by Gunderson (1982) because the existing empirical evidence seemed to support the inclusion of "the psychotic experiences or episodic lapses in reality testing".

Some studies have questioned any association between borderline personality disorder and psychotic symptoms. Jonas and Pope (1984) have suggested that

(a) "narrowly defined" psychotic symptoms such as clear cut delusions are rare in borderline personality disorder.

(b) Psychotic symptoms may be attributable to a concomitant possibly independent disorder suffered by the patient such as substance abuse, or major affective disorder.

(c) "Broadly defined" psychotic symptoms such as derealization and depersonalization which are often reported in borderline personality disorder, are also reported in patients with non-psychotic disorders.

(d) Psychotic symptoms in borderline personality disorder may be factitious.

Depressive Symptoms in Borderline Personality Disorder

The prevalence of depressive symptoms in the presentation of patients with B.P.D. has been noted many times since first reported by Grinker et al. in 1968. The different quality of the depressive experience in borderline patients has been stressed, with complaints of loneliness, emptiness and boredom predominating over the usual depressive guilt and remorse. Kernberg (1967) emphasizes the inner sense of badness, deprivation and rage, which seem to be distinctive components of depression in borderline patients. Impulse action patterns and quality of interpersonal relationships have been found to distinguish borderline patients with depression from the non-borderline depressed group (Gunderson & Kolb 1978, Krol et al. 1981).

Several authors in the last twenty years have postulated that borderline patients have a primary affective disorder. They suggest that an affective illness occurring during adolescence or early adulthood may distort behaviour patterns and disrupt personality growth in such a way that borderline characteristics emerge.

Klein (1977) has described sub-groups of affective disorder "hysteroid dysphoria" and "emotionally unstable character disorder" whose presentation resembles that of Borderline Personality Disorder, but whose symptoms are said to be responsive to mood-regulating drugs (imipramine, Monoamine Oxidase inhibitors and Lithium Carbonate).

Akiskal (1981) suggests that two-thirds of his borderline patients represent "atypical chronic and complicated forms of affective disorder". He cites family history data, response to medication and presence of biological markers to support his case.

There is no doubt of the extent of overlap between B.P.D. and depression. The question is which is the primary disorder or do they co-exist independently?

The hypothesis that affective disorder is primary received little support in Gunderson & Elliott's (1985) careful review of the interface between B.P.D. and affective disorder. They concluded that "the stability of the borderline diagnosis over time argues against it, as does the fact that antidepressants are not the treatment of choice for even the majority of such patients. Also, borderline patients have an
increased frequency of relatives with personality disorders compared with patients with affective disorder, suggesting that the disorders can run independently in families. Furthermore, many borderline patients never display a symptom picture of major depression. Those affective disorders with which the borderline syndrome seems to have the greatest overlap - unipolar non-melancholic depression - have the weakest evidence for biogenetic determinants and are relatively unresponsive to drugs”.

The recent review of Kroll and Ogata (1987) concludes that depressive disorders which occur in borderline personalities are atypical and distinct precisely in having borderline features.

This present study of psychotic and depressive symptoms in Borderline Personality Disorder was undertaken by the authors in order to examine the local experience with these aspects of the phenomenology, and to compare this experience with the findings from other centres.

The detailed results have been described by the authors elsewhere (Chopra & Beatson 1986, Beatson & Chopra 1988). A brief description of methodology and summary of the result follows.

**Material and Methods**

The study was carried out at Footscray Psychiatric Hospital, (56 bed inpatient unit) Melbourne, Australia, on narrowly defined hospitalised cases of B.P.D. fulfilling D.S.M. III criteria. Any doubtful case in which there was a possibility of concomitant schizophrenia, major affective disorder, organic mental disorder or substance abuse disorder (as per D.S.M. III criteria) were excluded. The Diagnostic Interview for Borderline patients was administered to all patients by a trainee psychiatrist who had been trained in conducting this interview. All patients were examined by one of the authors (H.D.C.) to confirm the diagnosis and main clinical findings.

Thirteen inpatients (11 females and 2 males) fulfilled the study criteria. Psychotic and depressive phenomena in these patients were examined during the period of the index admission. Depressive symptoms were examined during the index admission and over a follow-up period ranging from 2-42 months. One of the thirteen patients was lost to follow-up within two months of discharge, and was excluded from the depressive symptom section of the study; ten patients were followed for a minimum of 12 months. The patients were followed up either by one of the authors or by a trainee under the supervision of one of the authors.

Psychotic symptoms were elicited and categorised according to the “psychosis” subsection of the Diagnostic Interview for Borderlines (Table 1).

Depressive symptoms were elicited and categorised according to the ‘affect’ subsection of the Diagnostic Interview for Borderlines (Table 1). The course of depressive symptoms was monitored during admission by a trainee psychiatrist under the supervision of one of the authors. Details of follow-up were obtained by retrospective examination of the case notes by one of the authors (J.A.B.).

**Results**

All the cases presented with evidence of brief psychotic symptoms (11 definite, 2 probable). More definite and severe symptoms were seen in females.

The most common psychotic
Table 1
Diagnostic Interview for Borderlines (DIB)

| SECTION                  | ITEMS                                                                 |
|--------------------------|----------------------------------------------------------------------|
| I. Social Adaptation     | 1. Stability in work or at school                                    |
|                          | 2. Special achievement effectiveness                                 |
|                          | 3. Active social life                                                 |
|                          | 4. Appearance appropriate                                             |
| II. Impulse Action Patterns | 5. Self mutilation                                                    |
|                          | 6. Manipulative suicide threat or effort                              |
|                          | 7. Abuse of drugs                                                     |
|                          | 8. Sexually deviant practice                                          |
|                          | 9. Other impulse pattern                                              |
| III. Affects             | 10. Depression                                                        |
|                          | 11. Anger                                                             |
|                          | 12. Demanding, entitled                                               |
|                          | 13. Chronic dysphoria, anhedonia, or emptiness                         |
|                          | (-) 14. Flat or elated                                                |
| IV. Psychosis            | 15. Derealization                                                     |
|                          | 16. Depersonalization                                                 |
|                          | 17. Brief psychotic depressed experiences                              |
|                          | 18. Brief paranoid experiences                                         |
|                          | 19. Psychotic experiences with drugs                                  |
|                          | (-) 20. Hallucinations; nihilistic, grandiose, or hallucinations       |
|                          | (-) 21. Mania or widespread or persistent delusions or hallucinations |
|                          | 22. Transient psychosis in therapy or regression in hospital          |
| V. Interpersonal Relations | 23. Avoids being alone                                                |
|                          | (-) 24. Loner                                                          |
|                          | 25. Caretaker role or conflict about care                             |
|                          | 26. Unstable one-to-one relationships                                 |
|                          | 27. Devaluation, manipulation, hostility                              |
|                          | 28. Dependency and masochism                                           |
|                          | 29. Staff splits, "special" relationships, noteworthy countertransference |

Note: (-) indicates the item is given negative score.

Symptoms were of the dissociative type; derealization was present in 12 cases (four severe, four definite, four probable), and depersonalization was present in 11 cases (two severe, five definite, four probable). The 13 patients' other symptoms, in order of frequency, were brief paranoid experiences ($N = 10$; six definite, four probable), brief psychotic depressive experiences ($N = 10$; four definite, six probable), hallucinations or delusions ($N = 7$; four definite, three probable), transient psychosis in therapy or regression after hospitalization ($N = 6$; one definite, five probable), and drug-induced psychotic experiences ($N = 5$; two definite, three probable).

No change in the clinical picture was observed in any of the cases during the follow-up ranging from 2 months to 3 years.

All the cases also reported depression and anger for much of the time in the past 3 months. The depression was characterised by chronic feelings of emptiness and loneliness, reported in all cases. Sleep problems were reported by all patients, and half of them reported early morning waking. Two of the 12 patients reported diurnal variation of mood. Loneliness and a sense of inadequacy and failure were reported to produce depression in 9 of the 12 patients. Nine of the twelve patient's behaved in a demanding and entitled way.

**Course of Depressive Symptoms During Admission**

1. In the majority of patients (10 out of 12 cases) depressive symptoms remitted fairly quickly (within 14 days) after admission in response to supportive management and environmental manipulation. The fairly frequent fluctuations in the mood state occurred in response to the patient's perception of the current state of significant relationships.

2. In two cases, antidepressants were initiated during the course of admission because of the persistence of depressive symptoms. Both cases had reported early morning waking at the time of admission but denied diurnal variation of
mood. In one case dramatic improvement occurred within 24 hours of the commencement of Amitriptyline, while in the other, no clear response was observed with Amitriptyline 150 mgm. per day, continued for 6 weeks. Eventual improvement followed increased environmental support.

Findings of Follow-up

Ten of the cases were followed for a period of 12-42 months. In 9 of the 10 cases, depressive symptoms recurred, but in six of these the symptoms were transient and emerged in response to environmental stresses. In the remaining three cases where depressive symptoms recurred, a diagnosis of unipolar non-melancholic depression was considered during the follow-up period, but no significant correlation between treatment with therapeutic doses of anti-depressants and clinical improvement was found.

Discussion

As is obvious from the results, all the patients had some kind of brief psychotic experience, but the most common symptoms were derealization/depersonalization. These symptoms, which were of varying frequency and of brief duration, were experienced by the patients in stressful situations and intensified their resting levels of anxiety.

An unexpected but significant finding was the experience of non-drug induced psychotic symptoms in the form of hallucinations. Seven out of thirteen cases experienced hallucination only, no-one experienced any delusion. Five cases experienced auditory hallucinations alone, while two cases had both auditory and visual hallucinations (visual hallucinations were complementary to the auditory ones). It was observed during the initial assessment that these hallucinations appeared to be manifestations of the intense anxiety resulting from the patients' inability to cope with their stresses, particularly in unstructured situations. The main characteristics of these hallucinations were as follows:

(a) Brief, lasting usually for a few hours, responding to symptomatic measures, disappearing after the alleviation of anxiety.
(b) Clear and vivid but appearing only in stressful circumstances.

Hallucinations without drugs, as described above, receive a negative score on the Diagnostic Interview for Borderlines, but they could be part of the phenomenology of B.P.D., and might be of some diagnostic value. They could not be attributed to a concomitant independent disorder because the follow-up of most of the cases, ranging from two months to three years, did not reveal any change in their clinical picture.

The possibility of psychotic symptoms being factitious, as suggested by Jonas & Pope (1984) appeared to be remote because the main driving force behind these psychotic symptoms was intense anxiety which appeared quite genuine.

The quality and prevalence of depressive symptoms in this group of borderline patients is consistent with findings reported by several authors. The fluctuation in the level of depressive symptoms according to the perceived state of significant relationships was striking. There was lack of any clear response to antidepressant medication in this group, but the small sample size renders this finding of little significance.

This study is based on a small, select groups of inpatients. The authors are
aware of the limitations of the present study and recommend further investigation with a larger group and rigorous methodology.

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