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SOME BORDERLINE PSYCHIATRIC CONDITIONS

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The borderlines to be discussed are those between schizophrenia on the one hand and normality, personality disorders and neurosis on the other, leaving out affective disorders, mental retardation, brain syndromes, and psychophysiological reactions.

No books have been written on this subject and it is the rare textbook which does more than nod acquaintance with one or several of the terms to be mentioned. The commonly used diagnostic and statistical classifications are equally unhelpful, as are Psychiatric dictionaries. Thus we are dealing with a vague and complex area which seems to have provoked over the years an astonishing terminological inventiveness. To illustrate this and with some satisfaction I list the following:

Borderline, - state, - patient, - case, - schizophrenia, - psychosis, - neurosis;

Abortive, - ambulatory, - attenuated, - benign, - chronic undifferentiated, - incipient, - latent, - marginal, - masked, - potential, - prepsychotic, - pseudoneurotic, - pseudo-psychopathic, - residual, - subclinical, - transitional, - under-active, ever controlled, - schizophrenia;

Schizophrenia mitis, - schizophrenia in remission, - hysterico - schizophrenia, - pre-schizophrenia, - overideational preschizophrenia, - schizophrenic character, - oneirophrenia, - bipolarphrenia, - diegophrenia;

Decompensated schizotype, - schizoidism, - schizoid psychopath, schizoid personality, hebephrenoid personality, - schizoid compulsion neurotics, - pseudoschizophrenic neurosis, - compulsion neurotic delirium, - neuropsychoses, - psychotic character, - prospective and larval psychosis, - mixed manic-depressive psychoses and static and transitional borderline cases.

The total is forty-nine terms and one might without embarrassment add "pseudonormal schizophrenia" for the sake of completeness.

I do not propose to discuss each of these terms in turn: the majority are synonymous. A number of writers have attempted to establish a clear-cut group from among the borderline cases and these will be discussed shortly.

In reading the literature one of the most frequent issues mentioned was the point of contact, if any, between neurosis and psychosis. I have no evidence that there was any great concern about differentiation between insanity and neurosis from the time that CULLEN coined the term "neurosis" in 1769 until FEUCHTERSLEBEN introduced, in the mid-eighteenth century, the word "psychosis" with its rather scientific and professional ring (although intended to mean all disorders of personality). Certainly since the beginning of this century controversy has raged, and in most instances admission has been delinquency, perversion, and addiction (4) an arrested psychosis posing as psychopathy and (5) psychosis provoked by therapeutic or didactic psychoanalysis. He modified this in 1956 and described two groups - one which shows an abortive or arrested psychosis, may have

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had an earlier acute brief psychotic phase and subsequently stabilized at their best possible adjustment; the second including those with prospective psychosis who harbour a psychotic core dissociated from the rest of the ego; the healthy part struggles to keep the psychotic nucleus covered up by various defences. The outcome depends on life circumstances and other factors.

SANDOR RADO conceived of "schizotypal organization" and its possible types of adaptation. In his article "Theory of Schizotypal Organization", 1953 he wrote "Through its interaction with the environment, the inherited predisposition (genotype) causes the schizophrenic phenotype to develop an organization significantly different from that of all other human types. This actual expression of the inherited predisposition we call schizotypal organization." Schizotypes have two inherited defects - an integrative pleasure deficiency (anhedonia) and a proprioceptive diathesis (or disturbance of self-concept and body image). Four modes of adaptation are available to the schizotype (1) compensated - the schizoid personality (2) decompensated - the pseudoneurotic schizophrenic (3) disintegrated - the overt schizophrenic and (4) deteriorated - the deteriorated schizophrenic. Thus the decompensated and possibly the compensated schizotype fall within our category of borderline conditions.

HOCH and POLATIN described the clinical entity "pseudoneurotic schizophrenia" in 1949, having observed, like Freud, that many patients treated unsuccessfully for neurosis proved eventually to be unrecognized schizophrenics. The basic features of this condition are (1) an autistic life approach, (2) withdrawal from reality, (3) gross ambivalence in many areas, (4) some emotional imbalance, but no gross affective changes, (5) pan-anxiety (the term used to designate the all-pervading anxiety which may vary markedly in intensity, but "leaves no life-approach free from tension" despite the massive defensive manoeuvres used), (6) par-neurosis (indicating the presence of several or many different forms of neurotic manifestations, and may include obsessions, compulsions, phobias, hysteria, depression, hypochondriasis, depersonalization phenomena and neurasthenia, successively or simultaneously), (7) no gross thinking disorders, but minor ones discovered by psychological testing, (8) vagueness of elaboration of symptoms, (9) occasional presence of micropsychotic episodes with hypochondriasis, ideas of reference, and feelings of depersonalization, otherwise absence of so-called accessory schizophrenic symptoms, (10) dramatising, antisocial, drug dependent behaviour may be present, (11) chaotic infantile or perverse psychosexual organization. These patients are anxious and suffer, but their contact with reality and social adjustment are well preserved so that often they maintain a precarious existence, and usually they have enough anxiety or insight to seek help spontaneously.

R. P. KNIGHT, whose views are most consistent with those of this reviewer, describes the "borderline state" as "one in which normal ego functions of secondary process thinking, integration, realistic planning, adaptation to the environment, maintenance of object relations and defenses against primitive unconscious impulses are severely weakened." As KNIGHT points out, the concept of borderline states has no official status; it conveys the idea that the patient is quite sick, but not frankly psychotic, and is used where features of both neurosis and psychosis are present and where there is a reluctance to classify him as psychotic since he has "not yet broken with reality" but on the other hand the severity and ominous clinical signs preclude a diagnosis of neurosis. Thus "borderline state" conveys more about the uncertainty and undecidedness of the psychiatrist than about the patient's condition. Many of these patients, present at the office or open unit as failures of usual treatment, have previously been diagnosed as severe neurosis: obsessive - compulsive, phobic, hysterical, anorexia nervosa, depressed, paranoid or character disorder. Thus many diagnostic errors occur. Preferred as an approach to understanding this condition is Freud's metaphor of the retreating army--various detachments made, albeit rather reluctantly at first, that all cases can not be fitted into a classical or typical framework and that atypical or borderline cases occur.

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GREGORY ZILBOORG, who coined the term "ambulatory schizophrenics" in a paper on this topic in 1941, gave the following lurid description: "The ambulatory schizophrenic may appear normal in all respects; suave, warm, even worldly; he thinks more than he talks (the first sign of autism); he is rarely brilliant or successful and has frequent changes of occupation and interests. They are literally suffused with hatred which is usually seen in two guises: (1) physical tension and (2) anxiety - an inner, violent helplessness rage that they are often not aware of. They carry out the motions of living, have acquaintances but no intimate friends; they do not confide. Very often alcoholic, they are pathologically jealous. Sensations are experienced in a "pure" form with no emotional component. They are just as apt to kill someone else as to kill themselves." ZILBOORG stated that his observations included extremely few females of this type, that these people are rarely hospitalized, mostly on the loose - thus the term "Ambulatory schizophrenics" - and constitute the "difficult or problem people," "poor personalities" or "psychopathic personalities." Although usually hypochondriacal, they often actually do have many minor ailments. Unconscious homosexuality plays an enormous role but is seldom overt. "Not infrequently (they) are sexual perverts, transvestites or fetishists or both, or criminals, mostly impulsive murderers." Almost invariably they get into trouble with the law unless they suicide. ZILBOORG stated: "I have in mind men who are apprehended for exhibitionism, for cutting women's hair, for stealing their fur-pieces, or for masturbating on women's clothes while standing in line in post-offices, or railroad ticket offices or theatres." From this description, one would probably agree that these people may well be schizophrenic.

MELITTA SCHMIDEBERG has described "the borderline patient." For her "the borderline" represents a clinical entity bordering on normality, the neuroses, the psychogenic psychoses and psychopathy, and contains elements of any or all of these. This blending produces not merely a quantitative but a qualitative difference. She stresses that these patients usually remain substantially the same throughout life, are stable in their instability and show a constant pattern of peculiarity.

Obvious psychotic symptoms are lacking, there are no delusions, hallucinations, extreme disorganization, regression, elation, depression, true paranoid, dramatic hysterical or marked obsessional features. They may have depressive, anxious or other feelings and one may "often find various offenses, sex-perversions, homosexuality and prostitution, alcoholism, drug addiction, hypochondriasis, eccentricities, peculiar behaviour, querulousness and vegetarianism, but they may occur in other conditions and even normals under stress." SCHMIDEBERG'S concept thus resembles somewhat ZILBOORG'S earlier description of "ambulatory schizophrenics," the difficulty, however, is to differentiate the borderline from the milder forms of simple schizophrenia, from character disorders and from normal but disliked people under stress.

DUNAIF and HOCH described "pseudopsychopathic schizophrenia" as a clinical concept in HOCH and ZUBIN'S book "PSYCHIATRY AND THE LAW" 1955, the main features being pan-neurosis, pan-anxiety, and chaotic sexuality along with psychopathic behavior and often micropsychoses. This clinical entity seems to be more clear cut, the underlying schizophrenia always present, flaring up occasionally and only to be missed if the eye catching psychopathic features alone are concentrated on.

GUSTAV BYCHOWSKI outlined his concept of "latent psychosis" in a paper in 1953 entitled "THE PROBLEM OF LATENT PSYCHOSIS." He listed in his descriptive definition five conditions (1) character neurotic difficulties becoming a psychosis under appropriate provocation (2) neurosis with the same outcome (3) deviant behaviour e. g. make a stand against opposition and conduct holding or delaying operations at various points where the terrain lends itself to such, while the main force retires much to the

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rear. Thus the forward defensive operations protect the bulk from disaster. But they may not be able to hold out and may have to retreat at any time, or, the main army may be able to regroup, add reinforcements or new leadership and recapture its morale, then the forward positions may hold long enough for the main forces to move to or well beyond the stubbornly defended outposts. This picture indicates the psychoeconomy and indicated treatment of borderline states. The outposts which may be obsessive, hysterical, compulsive, phobic, etc., must not be attacked while the ego is laboring badly because of constitutional, earlier traumatic or recent precipitating stress factors. It is most important to assess the TOTAL EGO-FUNCTIONING by means of several interviews (necessarily structured situations), a history from another source, and psychological testing (unstructured situations in which the ego-alienness of unusual responses can be determined), situations in which the ego-alienness of unusual responses can be determined).

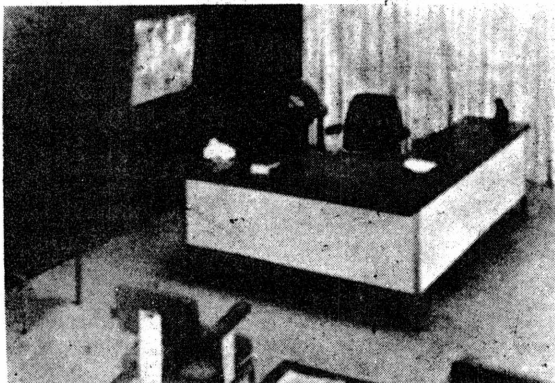
MILTON H. MILLER in an important article has described the frequent appearance of borderline patients in medical and surgical practice, as marginally adjusted patients preoccupied with somatic complaints, and he points out that even if diagnosed early they are often looked after by non-psychiatric personnel who may maintain them for many years in fair adjustment without realizing it since the patients' somatic complaints remain unchanged.

A statement concerned with incidence of borderline conditions seems more appropriate at the end of such an article as this, since its usefulness and validity can be better judged after determining the fairly diverse nature of the group of conditions under consideration. PIOTROWSKI and LEWIS state that 50 per cent of patients discharged from the New York Psychiatric Institute with a diagnosis of "neurosis" subsequently became schizophrenic. EISENSTEIN -- 30 percent of 250 private practice patients seen in consecutive consultations fell within the borderline category, as did 30 percent of WOLTMAN'S diagnostic referrals of private adult patients. These are high percentages regardless of the inevitable differences in diagnostic criteria. The present unofficial classification of these conditions is obviously unsatisfactory; perhaps "the group of borderline schizophrenias" would be an appropriate term, subdivided according to the predominant "non-schizophrenic" symptomatology. Perhaps, as LANGFELDT has suggested, much of aetiology is to be discovered on careful nosological subdivision.

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