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Historical review of the borderline personality disorder concept

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Introduction. The concept of borderline syndrome is the subject of current debate because of its ambiguity and lack of homogeneity. Furthermore, the concept is rejected by many authors as a common category for atypical and non-specific disorders that cannot be classified elsewhere. The current use of the term borderline seems to be more a consequence of its historic use than its true clinical meaning. There is discrepancy on whether this term determines a level of severity, an organization of personality or a defined syndromic entity. In 1938, Stern was the first author to use the term borderline, and it was not introduced in the DSM III until 1980.

Objective. This work makes a historical review of the use of the term borderline and also of those terms that have been used to define patients with the same characteristics.

Conclusion. The different schools (psychoanalytic, biological, eclectic and biosocial) have different concepts on the term borderline. There is still no concise and exact definition for the diagnostic criteria of borderline and it is even possible the best term for this group of patients has still not been determined. It will be important to consider the contributions of the DSM V or ICD 11 in the next years.

Key words:
Disorder. Personality. Borderline.

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Revisión histórica del concepto de trastorno limítrofe de personalidad *(borderline)*

Introducción. La utilización del término *borderline* sigue generando incertidumbre por su inespecificidad y ambigüedad. Además, múltiples autores opinan que quizás es el término más desafortunado para designar a este tipo de pacientes, y muchos otros consideran que se usa como cajón de sastre para pacientes que no pueden ser clasificados en otros diagnósticos. El uso del término *borderline* actual parece ser más una consecuencia de su uso histórico que su verdadero significado clínico. Hay discrepancia sobre si este término determina un nivel de gravedad, una organización de personalidad o una entidad sindrómica definida. Stern en 1938 fue el primer autor en utilizar el término *borderline* y no se incluyó en el DSM-III hasta el año 1980.

Objetivo. Este trabajo realiza una revisión histórica de la utilización del término *borderline* y también de aquellos términos que se han usado para definir pacientes con las mismas características.

Conclusión. Las distintas escuelas (psicoanalítica, biológica, ecléctica y biosocial) tienen concepciones distintas del término *borderline*. Aún no se ha llegado a una definición concisa y exacta para los criterios diagnósticos del *borderline* y quizá, incluso, no se ha llegado a determinar cual es el mejor término para este grupo de pacientes. Será importante tener en cuenta las aportaciones del DSM-V o CIE-11 en los próximos años.

Palabras clave:
Trastornos. Personalidad. *Borderline.*

INTRODUCTION

The first author to use the term borderline was Stern in 1938 in a psychoanalytic publication[28]. At that time, the term borderline described a «borderline group of neurosis». The psychoanalytic studies favored the use of the term and its subsequent inclusion in international classifications. The term borderline appeared for the first time in the 1980 DSM classification (DSM-III)[50], and in the 1994 ICD classification (ICD-10) as unstable personality disorder[51].

In spite of this, it was still considered an ambiguous and diffuse term. Millon considered that the contribution of the DSM on including the personality borderline disorder was very appropriate, since it described a very important population that had lacked official diagnosis up to then. However, at the same time, he made an important criticism on the term borderline because he considered that it was not the best term[1]. For Millon, the term borderline refers to a

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level of severity and not to a description, so that he proposed other names, such as ambivalent disorder, unstable disorder, impulsive disorder, Quixote disorder, etc.

Finally, the term borderline was maintained, but its evolution course in the deliberations of the DSM-III committee reinforced the notion that it dealt with a diagnostic entity that describes an advanced level of dysfunction and that its clinical characteristics are not those of a personality syndrome but those corresponding to an affective spectrum disorder, according to Millon. In this sense, it would be similar to the schizotypal syndrome that is currently included within psychotic disorders in the ICD-10.

Vicente Rubio Larrosa[2] has recently defined the term borderline disorder as the «most unfortunate» to name this disorder. He considers that the name borderline is a historic sequel of when this disorder was considered the border between psychoses and neuroses. On the other hand, he considers the name emotional instability disorder of the personality better. This author has sometimes defended the use of other names, such as global personality disorder, generalized personality disorder, morbid personality disorder or deteriorating personality disorder.

Due to its phenomenological fluctuations, previous generations of psychiatrists have not recognized it as a diagnostic entity. Borderline patients may appear as defenseless, pleasant and depressed individuals who seek the compassion of others or who may appear as patients with substance abuse disorders, eating behavior disorders or depressive symptoms. When they feel threatened, they may experience situations of real life risk and become furious and desperate to avoid abandonment. They have important feelings of self-loathing against themselves that may lead to self-injurious behaviors, acts that serve to punish themselves, or they may simply be requests for help. If they receive subsequent protection due to these self-injurious behaviors, they will momentarily lose the fear of abandonment, but they tend to repeat themselves. If these behaviors requesting help do not occur, the patient may abuse alcohol or other drugs, and under this influence, bind to other persons perversely. The psychotic episodes are generally short and there may also be dissociative or derealization symptoms. For the borderline patient who performs suicidal acts, the belief that life does not merit being lived if there is no one to rescue him/her is present. Thus, most suicidal gestures generally take place when rescue is possible[3]. Prevalence in the general population is in a range between 0.6% and 3.5%[4].

In 1938 Stern used the term borderline to classify patients who tested the limits of therapy. Ten years later, Knight called this diagnosis «a catch all term»[5]. In 1970 Kernberg and Masterson proposed the label borderline personality and formulated the development processes and intrapsychic structures that helped to explain these patients. In the same period, Grinker made the first efforts to empirically define the components of the syndrome and later Gunderson continued with the task and described some more reliable criteria that were adopted by the APA in 1980, which is when the term borderline personality disorder became official.

Even though it is an official diagnosis, the concepts continue to be diffuse. A first proposal was that it was an atypical form of schizophrenia (due to the episodes outside of reality, the benefits that are obtained with neuroleptics, etc.) although this is currently discredited because the attempt to demonstrate a relationship with schizophrenia failed. The ideas also arose that it was an atypical form of affective disorder (most of the patients have some comorbid affective disorder and have family members affected by affective disorders) and this possibility continues to be viable at present. They are patients who often respond to antidepressants and mood stabilizers and coincide neurobiologically with the affective disorders. The third proposal showed that most of the borderline patients had a background of serious traumatic experiences during childhood and this has lead to the thinking that it could be an atypical form of post-traumatic stress disorder (but not all individuals with traumatic background develop borderline symptoms and there are also borderlines without traumatic backgrounds). Another viable possibility is that it is within the spectrum of impulsivity disorders.

In the last decade, several genetic studies have placed this disorder within the medical model and this has inspired more research on its biogenetics. The fact that there are increasingly more specific treatments for BPD stresses the different character and clinical relevance of this diagnosis[6].

The heterogeneity that the picture has always had in its presentation and conceptualization has lead to the search for the characteristic or essential characteristics of what we call borderline personality over the years. In 1978, Perry and Klerman pointed to the enormous amount of terms used and the significant lack of agreement among the different authors regarding the attributes that characterize this entity and that hinder the integrating study of the historical backgrounds of this disorder[7].

Although some theoreticians have formulated the borderline concept as if it represented a personality organization level (Kernberg) or severity level (Millon, Stone), the DSM-III work group chose this name to indicate a defined syndrome entity.

An historic review that provides better understanding of the term and its context is made in the following.

HISTORIC REVIEW OF THE CONCEPT BORDERLINE

The historic review of the term borderline presents several problems. The first is that the borderline syndrome has very extensive historical and theoretical precursors and the

argument cannot be limited only to proposals that use the term «borderline». Much literature exists on syndromes that are not called «borderlines», but they have the clinical characteristics that clearly represent the pattern of affective and interpersonal instability characteristic of this personality type. Another one of the problems is the amount of terms and extensive lack of agreement that exists among the theoreticians in regards to the fundamental attributes of the syndrome that are different in the different psychoanalytic schools (Frosch, Kernberg, Knight, etc.) or biological orientation (Akiskal, Rosenthal and Khani, Klein, etc.).

Since the beginning of medicine, the authors recognize the coexistence in a single person of intense and different emotions such as euphoria, irritability and depression. If we go back to the classical period, we find that Hippocrates or Areteo de Capadocia listed humors, classifying them in yellow bile, black bile, blood and phlegm, that also corresponded with a serious of temperaments such as choleric, melancholic, sanguine and phlegmatic. Logically a balance between them was normality. They very vividly described impulsive fury, mania and melancholy, indicating that these «spells» were changeable and that the personalities were probably subject to them[8]. In the year 180 a.C., Areteo probably made the first distinction between neurosis and psychosis, describing a type of patient capable of seeing things as seen by a healthy person, but who erred in their opinions due to a lack of critical sense. Theophrastus, disciple of Aristotle, responsible for the work titled «characters» in which 30 descriptions of other psychological types are presented, gives a more clinical type description of the alterations of the subjects according to their way of being or behaving[9]. Ovid, in his work *Ars amandi* recommends a type of psychotherapy for the «easily infatuated and unstable», in order to «put out the cruel flame and free the heart from shameful slavery».

In the Middle Age, the prefreudian theories of San Agustín, on intrinsic perversity of the child, fruit of the original sin, stand out.

With the onset of the Renascence came the works of Erasmus of Rotterdam *(Praise of folly,* 1508) and Luis Vives *(De anima et vita,* 1538), in which the explanations of the way of being, characters and temperament are studied in depth. Juan Huarte de San Juan also contributed in this period with his work *Examinations of men's wit* in 1575[10]. Years later, in 1621, the work *Anatomy of melancholy* of Robert Burton appeared. It described affective pictures compatible with affective emotional instability and the sensations of emptiness of borderline patients.

The term «manico-melancolicus» described by the Frenchman Bonet in 1684, joins impulsiveness and unstable mood conditions into a single syndrome for the first time.

After, in the XVIII century, Schacht and Herschel reinforced the idea suggested by Bonet that this mood instability followed a periodic pattern of elation and depression. A periodicity of the manic-depressive covariation was unavoidable.

Pinel, in 1801, described mania without delusion (mane sans délire): patients who were influenced by a furious instinct and by bloody cruelty but who did not show intellectual dysfunctions[11]. After, Pritchard, in 1835, described the concept of «moral insanity», giving a moral connotation to these pictures and leaving a mark that still continues in our days[12].

A few years later, Baillarger and Falret, in 1854, summarized his works of 30 years with depressive and suicide patients, stressing that most of the patients showed an intermittently interrupted depressive picture due to periods of irritability, rage, euphoria and normality, calling the syndrome «folie cirrulaire» and «folie à double forme» (circular insanity)[13]. These descriptions would be precursors, above all, of the bipolar disorder, but also of the borderline disorder.

In 1882, it was Kahlbaum who suggested the current belief on the relationship between mania and melancholy. He saw them as aspects of a single disease, that manifested in different ways (sometimes euphoric, sometimes melancholic, other time excitable or choleric). However, in spite of this, it was the primacy of the first two, that made the future concepts of the syndrome more rigid and reoriented thinking towards different horizons of the so characteristic affective instability and unpredictability. This author distinguished a milder variant of the disease, in which periods of normality, «cyclothymia» and another more severe and chronic one of the same disorder were typical. This was called «vesania typica circularis»[14].

From a different approach, in 1884, Hughes spoke of a borderline of insanity and persons who spent all their lives on one side or the other of this line. He wrote «the borderline of insanity is populated by many persons whose life passes close to this line, sometimes on one side, sometimes on the other»[15]. Shortly after, in 1890, Rosse described «borderline insanity» in patients who moved between «reason and despair»[16].

Modern formulations

In 1921, Kraepelin conceived irritable mood as a mixture of fundamental conditions that he described as «irritable personality», and that gathered the criteria presently included in the DSM IV classification of BPD, especially impulsivity, affective instability and interpersonal relationships, intense and inappropriate fury and self-injurious acts. Kraepelin described its four mood variants that he called abnormal or morbid[17].

Two years later, in 1923, Schneider described the «labile personality», characterized by rapid and sudden mood state changes with violent reactions to insignificant stimuli and

to which a constitutional component was attributed. In 1934, he wrote the work *Psychopathic personalities,* that could be considered the most important work on personality disorder classifications[18].

In 1925, Kretschmer wrote about patients with a temperament that he called «mixed cycloid-schizoid», and that consisted in a hostile attitude toward the world with an insufficient affective response, with abruptness, nervousness and spasmodic restlessness[19]. Kretschmer is considered one of the main precursors of current BPD even though consistency and adequacy with Kraepelin may be lacking.

In this same year, Reich spoke about patients with «impulsive characters» and stressed the intense ambivalence and rapid mood state changes of these patients. He placed these patients between the mild and serious levels of the disease. He described the patients with impulsive characters as subjects with childhood aggressions, primitive narcissism and super-ego alterations. He considered the intense ambivalence and rapid mood state changes of these individuals as a «borderline» group of disorders situated between middle and serious levels of disease[20].

The contribution of Kasanin (1933) is also important, because he was the first to coin the term «schizoaffective». He considered that many of the cases of young psychotics initially hospitalized with the diagnosis of acute schizophreniform episode really had the social dispositions and typical affective inclinations of the manic depressives[21]. His descriptions are somewhat tangential to the borderline formulations, but somewhat comparable.

The first time that the term borderline was used was in 1938, by Stern, in a psychoanalytic publication[22]. He called «borderline group of neuroses» those patients who could not clearly be placed in the psychotic or neurotic categories and who did not respond satisfactorily to psychotherapeutic interventions. He described a «borderline neurosis» that was characterized by ten symptoms, character traits and «reactive formations», as narcissism, psychic bleeding (control impossibility) inordinate hypersensitivty, psychic rigidity, negative therapeutic reactions, masochisms, inferiority feelings, projection mechanisms, difficult to evaluate reality and intense somatic anxiety. He considered that these patients had the permanent feeling of being wounded or harmed. At that time, two tendencies arose that sometimes overlapped. Psychoanalysts such as Stern were concerned with the problem of identifying the border between neurotic characters or disorders and the more serious forms of disease. The analysts' concern lead to the gradual evolution of his idea towards the formulation of the DSM III, which described it as «borderline personality». The hospital clinicians tried to differentiate the manifest forms of schizophrenia of the borderline variants, characterized by names such as «latent», «ambulatory», or «incipient». The last line was that which finally shaped the syndrome and the criteria for the «schizotypal» personality of the DSM-III.

In 1942, Helene Deutsch stated that these personalities are incapable of having real feelings and interests or developing true ego and superego identifications, but act «as if» they had them[23]. This type of person never had a true internalized superego, being, however, dependent on external controls that limit and control us in their external behavior. Deutsch compared the hysteric personality (emotional repression) with borderline personality (emotion deficiency).

In 1945, a Spanish author, Merenciano, wrote the book called *Psicosis mitis* in which he described patients with pictures that could not fit into psychosis[24].

Contemporaneous proposals

The first author who used the term borderline in publications after the Second World War was Schmideberg in 1947. This author stated that the characteristic traits of borderline are not its symptoms but the deep personality disorder that affects almost all the areas of life: interpersonal relationships, depth of feelings, identification and empathy, attitude towards society and reality, will and self-control, sublimations, work, capacity to enjoy and need for pleasure, sexual life, etc. describe the object relationships of these patients as superficial and weak. She does not consider it a single clinical entity, but rather that the term borderline includes different combinations of traits and a complete group of symptoms. For this author, the concept borderline represented a high functioning level in which characteristics of normality, neurosis, psychosis and psychopathy were combined. For Schmideberg, the borderlines should be divided into subgroups, such as depressive, schizoid, paranoid[25].

Two years later, Hoch and Polantin (1949), introduced the term of pseudoneurotic schizophrenia in which the primary symptoms of schizophrenia are behind the neurotic ones. They presented pan-anxiety, pan-neurosis and pan-sexuality as secondary and also more visible symptoms of the clinical picture[26]. They state that there may also be psychotic episodes of variable characteristics that have a short duration and complete restitution.

Wolberg (1952) described the situation of a child who, on the one hand, wanted to continue obeying his parents and continued to be their «child», and on the other resisted obeying them. This situation created a state of anxiety and depression in the child, a continuous need for confirmation of love, hypersensitivity to anticipated rejection of others, feelings of personal failure, loneliness and emptiness, hostile projections towards others followed by regret and guilt, self-injurious behaviors and self-destructive behaviors (consumption of alcohol and other drugs that increase anxiety and depression), which began the vicious circle again[27].

In 1953 Knight focused on the episodes of schizophrenia and other psychoses but essentially contributed in the im-

portance of «ego weakness», considering it a crucial element in the structure of borderline personality[28]. He concluded that psychotic episodes may occur on borderline structures. According to this author, the ego of the borderline patient operates defectively as a result of constitutional tendencies and traumatic events with disorders in human relationships. In these same dates, Frosch named the "impulse control disorders"[29].

The term borderline according to the different schools

The conception of borderline personality varies according to the different personality theories. From a psychoanalytic perspective, the idea is maintained that it consists in a structural configuration or an organization of character half way between neurotic and psychotic disease. From a more biological perspective, the hypothesis is maintained that the syndrome should be considered as a combination of variants of personality within the spectrum of affective (Akiskal) or impulsive disorders. For other authors, it would deal with a stable and moderately serious functioning level that combines a variety of personality subtypes (Grinker). In spite of the different conceptions of the concept, it is still difficult to define and categorize a nucleus of elements as indicators of the diagnostic entity.

Psychoanalytic model

The psychoanalytic model has tried to find common traits that are in the basis of this condition. Beginning in the 60's, the defense mechanisms, maturation levels of the Ego and object relationships of these patients were studied.

In 1953, Knight used the term borderline to describe a syndrome between psychosis and neurosis[28]. He gave importance to Ego weakness, considering it an essential element in the borderline personality structure. In the same year Jacobson called these patients «borderline cyclothymic» and tried to interpret their behavior in psychoanalytic terms[30].

The first empiric study in which explicit criteria were used to include a sample of the borderline population was done by Grinker in 1968[31]. He questioned if there was a borderline condition that could be described and if there were several subtypes within this. The patient's data were subjected to a cluster analysis and the main common and differential characteristics were grouped into four subgroups: that closest to psychotic («psychotic border»), going through the «core» group («fundamental border»), the group «as if», that represented a group similar to the DSM schizoid personality one, and the group closest to neurosis («border with neurosis»). The four groups coincided in the following characteristics: fury, defects in emotional relationships, absence of indications of identity and depressive loneliness.

In 1965, Easser and Lesser described the emotional symptoms of the so-called «hysteroid» borderlines[32]. They presented the typical behaviors of the classical hysterical personality but in a much more altered variant. They are patients who are similar to those that Kernberg called «infantile personality».

According to the different schools, emphasis is placed on different aspects. The American school emphasizes ego or self-lability and the diffusion of identity. The English school gives importance to psychotic anxiety and neurotic characterologic mechanisms that arise against this and a special way of living the relationship with the object. One of the most important authors of the British school is Winnicott who, in 1968, defined the term borderline when referring to the patients in whom the core of the disturbance is psychotic but who have sufficient psychoneurotic organization. He focused his studies on the importance of the transitional objects of the first infancy and on the fact that the borderline patients do not have a history of the presence of these objects[33]. The French school considers depression symptoms the most important fact and that the disorder appears due to a lack of neurotic or psychotic structuring to become oriented towards one of these two poles

Another author of the British school Modell (1963) described several borderline cases that were characterized by a tendency to the «transitional relationship», an inclination to attribute a magic omnipotence to those who they idealize[34].

The theories of Mahler and coworkers contribute greatly to the understanding of the borderline disorder pathogeny. In 1975, Carlos Paz found disorders in relationship with reality, defensive disorders (defectuous repressions), thought disorders, aggression regulation disorders, sexuality disorders (sadomasochistic fantasias, promiscuity, perverse fantasies), typical body movements and expressions (pulling on the fingers and knees), presence of confusional anxieties, characteristic transferencial and contratransferential bonds, etc. in the borderline disorders.

Currently, one of the most important and relevant authors is Kernberg (1979). His investigations have been influenced by the theories of Stern and Knight, Klein and Winnicott. He writes on the «organization of the borderline personality». He considers that the borderline subjects have certain common, stable and long-lasting structural characteristics that are somewhere in between the psychotic and neurotic organization[35]. They are patients who have a specific and stable pathological organization of personality. Ego weakness is characteristic. For this author, the main defense mechanism is splitting that he defines as an active process of keeping introjections and identifications of opposite quality separated. Kernberg divides the borderline organization into two levels: the most neurotic organization (sadomasochistic, cyclothymic, dependent, hystrionic and narcissistic personalities) and the most psychotic organization (paranoid, hypochondriac, schizotypal, hypomanic, an-

tisocial and malignant narcissistic personality). As a result of his studies, increasing mention has been given to «borderline personality structure» as something stable and differentiable, both of the neurosis and psychosis, which therefore has begun to acquire its own identity.

Focusing the problem on the relationship with the mother is the contribution of Masterson (1976) who explained that all separation attempts of the child caused feeling of depression and reproach in the mother. Following the evolutive classification of Mahler, he makes a division between well adapted borderline states that generally are not seen in the consultation and borderline clinical syndromes in which the basic fear of being gobbled up or abandoned by the mother and there is no profound regressions or delusion[36]. For the author, the picture is a stoppage of the development established in the cordial meeting, moment of infant separation-individuation.

For Rinsley the pathogeny of the borderline disorder is focused on a very deficient maternal presence. On the contrary, Stone (1993) focuses the adolescence period as the origin of the conflict[37]. He considers that these patients have an innate predisposition to affective diseases and a history of parental abuses. Gabbard (1994) also contributed his descriptions of the intrapsychic processes of the disorder, above all, those that are observed during the therapeutic interviews[38].

Eclectic-descriptive model

It is the model followed by the DSM that considers Gunderson as the most important author. In 1989, Gunderson and Zanirini considered that there was a clear personality disorder that may be clearly described and diagnosed outside of schizophrenic syndromes and neurotic conditions. They focus on five areas: impulses and actions (alcohol, self-aggression, promiscuity, bulimia), affects (depression, rage, anxiety and despair), psychosis (short episodes and not very serious) and social adaptation (apparently without difficulties). They characterize this syndrome in the following way: intense affectivity, incapacity for pleasure, impulsive behaviors and alterations in identity that may be associated to brief psychotic episodes. The following distinctive characteristics are proposed: self-mutilation, parasuicidal behaviors, excessive concern of neglect and loneliness, very demanding attitude, quasi-psychotic thinking, therapeutic regressions and difficulties in contratransference[39]. Zanarini contributed to these studies the opinion that the borderlines are within the spectrum of the impulse disorders instead of being a variant of the spectrum of the affective disorders[40]. Gunderson developed the diagnostic interview of the borderline disorder.

Biological model

It is considered that the disorder represents a combination of clinical syndromes, each one with their own origin, course and prognosis. It proposes three subtypes: that related with schizophrenia, that related with affective disorders and that related with organic brain disorders.

Two main authors of this school, Costa and Widiger (1993), describe a five factor dimensional model that determines the neurotic factor (hostility, impulsivity, vulnerability, depression and anxiety). For the authors, the borderlines score high on this neurotic dimension. They have tried to reword the different personalities of the DSM-IV[41]. In turn, Akiskal uses «cyclothymia» for a borderline or subclinical disorder of the personality in relationship with the bipolar spectrum. In 1985, this author considered that borderline was an «adjective in search of a name»[42]. He supported the idea that what they called «cyclothymia» is a borderline personality disorder that is found in biological parents of the manic-depressive, that predisposes them to the clinical form of the disease. The association between borderline and serotoninergic dysfunction was described by Siever and Davis in 1991: serotonin is decrease and norepinephrine hyperactive[43].

Biosocial model

Authors such as Linehan stand out. In 1993, he considered that the borderline personality disorder was a dysfunction of emotional regulation that occurred as a result of a genetic tendency plus an invalidating setting in which the parents failed to help the child to manage emotion. Linehan developed the dialectic theory: most of the borderline behaviors can be explained as a result of dialectic errors among the opposite poles in which borderline often moves[6]. Paris (1994) considers that the risk factor of the borderlines is the social disintegration, this referring to the fact that the current society expects that the subject functions independently, decreasing support and restraint, and generating an increase of the characteristic borderline behaviors: impulsive behaviors, substance abuse and parasuicidal behaviors. He proposes what he calls «multidimensional approach», and recommends taking the «social risks» into account[44].

In recent decades, Millon has significantly contributed to the studies on personality disorders. In 1985, he described a biosocial learning model and indicated that together with constitutional disposition and early life experiences, they play a very important role in social and cultural factors. In 1996, he divided the borderline pattern into several subtypes: humiliated borderline, impulsive borderline, arrogant borderline, self-destructive borderline. The rupture of the social rules is creating an increased risk of borderline disease and the rapid social change interferes in intergenerational transmission of values, reducing the importance of the family and the community. The borderline pattern is a result of the deterioration of the not so serious previous patterns. In 1975, Millon described the so-called «cycloid borderline»: «they have intense instability of the mood state, irregularities of activation, self-condemning conscious, anxiety for

dependence and cognitive-affective ambivalence»[1]. This text was subsequently revised and this was changed to the name «unstable personality disorder». After, Spitzer, Endicott, and Gibbon, in 1979, added criteria of several clinicians who had specialized in this disorder and it was called «borderline personality» by the DSM III. Spitzer and co-workers wrote an article after making a review of the literature and decided that there are mainly two ways of understanding what is called «borderline»[45]. The first would form a part of the circle of the personality and the second that of schizophrenia. In the first, Gudnerson and Kernberg would be the representatives, defining the patients with relatively stable characteristics of the personality, that have a treatment and course that support the vulnerability and instability characteristic of them. The second one would include Kety and Rosenthal as representatives, and it would describe the patients with relatively stable psychopathological characteristics over time that are presumed to be genetically determined and would include chronic schizophrenia in the pathological spectrum. Authors such as Zanarini, in 1993, relate the borderline personality disorders with impulsive ones instead of being a variant of the affective ones[46]. On the other hand, Kroll related them with the post-traumatic stress disorders[47] and studies of Carrasco and co-workers show findings of a possible hypersensitivity of the feedback systems of the hypothalamic-pituitary adrenal axis in the borderlines, as in the post-traumatic stress disorders[48].

Cognitive model

The maximum representative of the cognitive model is Beck (1990). It considers the disorder as a result of the cognitive-dysfunction patterns and schemas[49]. In his studies, his contribution to improve the understanding of the dysfunctional belief that control the emotional responses and pathological behaviors of these patients stands out. «The most characteristic are the intensity of their emotional reactions and variability of their mood states. These patients are generally discovered in cognitive therapy».

CONCLUSION

There have been many names for that which we now call borderline personality disorder and also many meanings of the concept. In spite of its inclusion in the DSM, many authors criticize this concept and question the adequacy of its classification within personality disorders. Some of its phenomenological characteristics, such as impulsivity, affective instability and course of the disorder would support the suggestion of some authors to place this disorder within the spectrum of affective or impulsive disorders. In a future time, the advance in the research on this disorder and the new classification models will help to make a better definition and perhaps name of the borderline personality disorder.

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