BORDERLINE PERSONALITY (OR BORDERLINE SYNDROME)

Papageorgiou G. E. [1], Triadafyllidou S. [2]

1.Dr., Med.,Neurologist, Psychiatrist, Psychotherapist,Professor of Psychiatry at the Technological Educational Institute of Athens

2.Dr., Psychologist, Staff - member of the Social Counseling Service, Technological Educational Institute of Athens

ABSTRACT

It concerns a psychodynamic explanation of the term 'Borderline Personality which is based mainly on the way and the quality of the sentimental investments and the use of the defense mechanism of the individuals who are characterized from borderline elements in their personality. This explanation is necessary for the understanding of the phenomenological image of the behavior and the ways of communication of these individuals.

Key words: borderline, borderline personality

Corresponding Author:
Papageorgiou G. Evangelos

Technological Educational Institute of Athens

12210, Agaleo

INTRODUCTION

Over the recent years, the term "borderline personality" has gained increasing popularity in psychiatric practice, at the same time being the source of a great amount of confusion for many clinicians. The term is often used in order to conceal the inability to provide a definite diagnosis, as well as to characterize a condition that resembles psychosis or neurosis, while being neither the first nor the second.

Originally, the terminology as well as the main description of the so-called BORDERLINE syndrome, derives from psychoanalysis. As early as 1903, Kraepelin referred to some intermediate conditions (ein "Zwischengebiet") between the pathological psychological conditions and the subtleties of personality. This observation was the starting point for the creation of the English term "BORDERLINE STATES", or "BORDERLINE". In the eighth edition of his psychopathology (1909), Kraepelin refers to the special character of some psychopathetic personalities that he characterizes as "non developed cases of dementia simplex", i.e., as "latent schizophrenias" (Bleuler, 1911).

The first descriptions of personalities that were thought of as being located in a "borderline land" (Borderland), come from much earlier. These descriptions mainly refer to borderline cases of psychotic or neurotic patients. The psychoanalyst Stern (1938), coined the term in order to characterize and describe a specific category of neurotic borderline conditions.

The descriptions and definitions of this borderline "space", locate it in the boundaries between the psychotic and the neurotic condition. It is in this sense that Hoch and Pollatin (1949), describe a non-typical schizophrenic condition in the context of "psychoneurosis", characterized by **autism, ambivalence, thought disturbance and disorder of affect**. Implicit in the current use of the term is the concept of a border between psychosis and neurosis. This linear conceptualization of the syndrome is also evident in the notion of a boundary line between the first (narcissistic) and the second (anal) stage, simplistically implying the passage from psychotic to neurotic attachment. However, clinical reality is different. Clinical practice indicates that borderline syndrome consists of a quite broad spectrum of pathological formations that are actually related to both psychosis and neurosis and are also characterized by non homogenous nature that demands a corresponding classification of relative but different categories and groups.

The natural question to raise, then, is whether there is enough cohesion among the elements of these groups, so as to justify the use of a single term for their description. Most authors agree that this is actually the case and that the problem consists in proving that there is an "internal cohesion" in the structure of all these conditions that would permit us to classify them under the generic term of "borderline syndrome" in clinical practice. In other

words, if this term is to have any clinical usefulness, it must characterize psychopathological conditions that present phenomenological differences, but do have relevancy and common features in their structure.

2. Phenomenological Image

The symptoms that characterize the phenomenological image of borderline disorders refer to the quality and configuration of emotional investments and to impulse control, as well as to contact with reality, personal identity and way and form of interpersonal relationships. Consequently, the phenomenological image of the borderline disorders includes a wide range of behaviors and symptoms, so that in order to characterize a specific personality as borderline, at least five among the following characteristics must be present:

1. Impulsivity or irresponsible behavior in at least two areas that are potentially self-damaging (e.g., spending, sex, games of chance, psychotropes substances abuse, shoplifting, binge eating, self – destructive behaviours).
2. A pattern of unstable but very intense interpersonal relationships characterized by harsh shifts in attitudes, idealizations, devaluations, exploitation and use of other people (e.g., the chronic use of other persons to meet the patient's aims is the main axis of relating to them).
3. Boundless, intense anger outbursts, or insufficient control of anger (e.g., frequent displays of temper, constant readiness to burst in aggressive behaviours, constant anger).
4. Identity diffusion, expressed as difficulty in various domains that relate to identity, i.e., self image, sexual identification, pursuit of long term goals, career choice, friendships and values concerning legitimacy (e.g., "Who am I?" "When I'm good I think that I am like my sister").
5. Affective instability, i.e., obvious shifts from normal affective state to melancholia, irritability or phobia, typically lasting a few hours and only rarely more than a few days, then return to the normal affective state.
6. Frantic efforts to avoid real or imaginative abandonment. Patients with a borderline personality are intolerant to being alone, to such a degree that they make spasmodic efforts to avoid it. When they are left alone, their affective state deteriorates.
7. Suicidal behaviour, e.g., suicide, self-mutilating behaviour, recurrent accidents or physical fights.
8. Chronic feelings of emptiness (the patients may feel empty and bored).

It should be noted that the criterion of identity disturbance does not apply to patients below 18 years of age.

According to this diagnostic system, the presence of at least five from the above characteristics permits us the diagnosis of borderline disorder. However, in clinical practice things are never as simple as this. The clinical picture of borderline disorders ranges in an array that extends from the psychotic up to the neurotic end. In fact, differential diagnosis between these two ends is not necessary. Furthermore, phenomenological observation is insufficient for the purpose of differential diagnosis, since practically there are many cases of borderline disorders that display the features of neurosis or psychosis. Obviously, then, these borderline conditions include a wide range of patterns rather than constituting a single entity. Hence the differential diagnosis should proceed beyond phenomenological symptomatology, to the recording of the defense mechanisms, the ways, the quality, the form and the intensity of their use by the borderline patient, resulting to experience, emotional investments and behaviors that characterize his/her clinical image.

3. Psychodynamic Interpretation

A psychodynamic interpretation of borderline disorders demands that we employ our knowledge of narcissistic disorders in order to understand the former. This does not mean to say that borderline disorder and typical narcissistic disorder are one and the same thing: the characteristic image of the borderline patient is not the one of an individual that constantly "revolves" around him/herself showing little or no interest in others.

The psychodynamic interpretation is necessary for the development of treatment strategies and for planning the way of relating between the patient and the therapist, as well as evaluating the possible influence of disappointments and traumatic experiences that the patient could tolerate. It comes naturally that all of the above are important criteria for treatment procedure and that it will be easier to define these criteria after speculating about issues related to differential diagnosis.

A neurotic structure of personality implies the existence of object relations, defense mechanisms and psychic abilities that correspond to the oedipal or post-oedipal phase of psychological development.

Contrary to this, the defense mechanisms employed in the narcissistic disorder of personality or in the borderline syndrome, are not similar to the ones of

the neurotic structure, while its object relations are not identical with the ones of the neurotic structure and they have not reached the kind of "maturity" that they display in neurotic patients.

Let us begin with the defense mechanisms:
- hysterical neurosis is characterized by intense "repression", rationalization, idealization and identification.
- obsessive neurosis is also characterized by "repression", but it also presents
- reaction formation and isolation

All of the above mechanisms are weaker or less useful in the narcissistic personality. On the contrary, in the narcissistic personality disorder the mechanism of "**denial"** is more profound. In most cases it has to do with denial of specific fantasies and desires, as well as of their sexual content. It is a denial of fantasies and desires and not of reality, the latter being a characteristic of psychotic disorders.

An important clarification should be made at this point. In every psychopathological structure there exists a degree of distortion and consequently of denial of several elements of reality. However, this kind of denial is apparent only to a restricted degree in borderline and narcissistic disorders, as compared with the high degree of denial that takes place in psychoses or in the psychotically structured personalities and the much smaller degree of denial in neuroses.

Another mechanism of defense that keeps a fundamental function for the behavior of borderline personalities is the one of **projection.** Projection is a defense mechanism that constitutes one of the central elements of the normal psyche. This is the main reason why it often remains unrecognized or under-evaluated. The neurotic patient appears to make special use of the mechanism of projection, as well as not to have any inhibitions concerning the recognition of this projective behavior, which renders the possible "correction" of this behavior a relatively easy task. However, this correction is not equally easy in respect to the projective behavior of borderline personalities, while it is unfeasible in respect to the behavior of psychotic patients.
An analogous difference is obvious in the relieving function of this mechanism. The neurotic character finds is easy to quit from this relieving function, throughout corrective interventions to his/her relation with reality. On the contrary, the patient with narcissistic disorders faces more difficulty in this respect.

The most often mentioned defense mechanism, that is considered to be a pathognomonic sign of borderline syndrome, is **"splitting".** Due to relevant confusion surrounding this concept, we shall begin from an attempt to elucidate the exact meaning of the term.

When splitting occurs, it is possible for the patient's environment to recognize psychic elements that the patient's EGO can not see. That is, those psychic elements **are not repressed**, which would render their recognition impossible, rather they are offered to observation from the environment and they characterize the individual's behavior, while, at the same time, they remain non recognizable by the individual itself. More specifically, borderline personalities are possessed by narcissistic fantasies of omnipotence that are expressed without fail both verbally and behaviorally, so that in no case will they remain hidden from the environment. However, they remain completely unknown, or hardly recognizable by the individual who presents them, even when someone else attempts to sensitivize the individual towards this direction. This equals to an absolute splitting in the realization of the world.

There are also **"splittings"** that do not present this absolute character, i.e., splittings between subjective experience and behavior towards the environment, but at the same time they constitute intrapsychic elements whose relation presents the same characteristic splitting.

For example, while an intrapsychic element A, or a drive A and an intrapsychic element B or a drive B can be potentially experienced by the individual, in no case can these two elements be experienced simultaneously, as structural elements of the psyche –and yet they are not being repressed. This is a case of intrapsychic splitting. The result is that there is no inner conflict that would lead to repression of one element by the other, but rather a splitting that renders their simultaneous identification impossible.

The main difference between the splitting of a borderline personality and the one of a psychotic personality is considered to lie in the fact that while a borderline personality splits objective reality, a psychotic person splits both objective reality and the EGO itself. All in all, it is obvious that we should avoid all clear cut dichotomies, since borderline individuals are also characterized by a degree of splitting of their EGO, although in quantitative terms this splitting is much more restricted than the one of

the psychotics and, in final analysis, it does not lead to the complete disorganization of EGO, which is the case for the psychotic individuals, since the EGO of borderline individuals preserves its form.

As long as splitting constitutes a defense mechanism that characterizes the EGO of a borderline person, it will also determine his/her object relations with the environment. Actually, the distinction between defense mechanisms and object relations is much less clear for a borderline person, compared to a neurotic individual. This is due to the fact that for the borderline person, the autonomy of the object has not yet been completed, at least not to the degree that this has been done for a neurotic or a normal person, the latter having a psychic structure that is more stable and limited against the objects of the environment. That's why the relationship of dependence on the objects of the environment is significantly smaller for the neurotic and normal persons, as compared to borderline personalities. In other words, the same fact, the "loss of an object" will be experienced by a borderline personality in a much more traumatic way, since the "representations" of the object in his/her psyche will constitute part of its structure, so that its loss or even its short-term absence will lead to a much more severe disorder of his/her autonomy, or, as one might say, of EGO functioning. This is a very important point for the understanding of the disorganization that a borderline individual presents after a traumatic inner experience, while the neurotic person who presents a more stable and less dependent psychical structure, reacts to a traumatic experience such as the loss of the object, by means of enforcing his/her defense mechanisms.

Undoubtedly, the peculiarity of object relations has to do with splitting and from a phenomenological perspective, it appears as an inability of borderline personalities to tolerate contradictory emotions towards the same object, i.e., to accept the object as an integrated whole that comprises both positive and negative elements. Thus, objects are experienced as if they were split, with a complete splitting corresponding to the psychotic conditions and a different quality of splitting found in borderline cases. The latter is not a splitting into all - good or all - bad elements, but rather a splitting into acceptance and negation, i.e., into qualitative elements of the potential relation with the object. So, whereas in the case of psychosis we have the all - good element that leads to the symbiotic relationship with the object, in borderline cases we find an element of unrestricted acceptance that does not reach the symbiotic psychotic quality of the relationship, but it also requires a great degree of **idealization** to take place. This is because no real person would actually possess the protective qualities or be able to offer the kind of care that is asked by the impulsive tendencies of the borderline person.

Another pervasive feature, or, so to say, the other side of the coin, is the negative relationship with the object, without this being equal to the psychotic negation that turns the object into a persecutor. The object is represented by its negative elements, thus it is a "bad" object, though not to the degree it reaches in the case of psychosis, which is the reason why the object is not experienced as having the qualities of a "persecutor".

Also, another element that characterizes the object relations of borderline personalities is the **fantasies of omnipotence.** It is noteworthy that these fantasies are invested both in the "being" of the borderline person and in the object, that's why they may appear in a misleading way. In the patient's language, this is translated into: "It is not only me who is omnipotent, but you too", i.e., "both of us", which is expressed through corresponding behavior. The idealization that accompanies a position like this, exerts a major influence on the relation with reality that is preserved by borderline persons, as explained above. It is a fragile idealization, since it depends on the potential corrective influences of various experiences and disappointments. However, almost as a rule disappointment prevails, so that the case of a stable or long lasting idealization in a relationship is very rare. We commonly have the change of object, in varying pace, depending on various factors. The inability to quit from an idealized relationship will have pervasive effects on the psyche of the borderline person, who loses his/her psychological equilibrium and is induced to depressive disorganization. This depressive disorganization results from the discharge of narcissistic investment of the very being of the borderline person, due to the ending or the failure of the pre-depressive idealization. This fact has been known for decades. In his interpretation of melancholia, or endogenous depression, Abraham observed that any object relation that triggers a melancholic phase after its ending, had a narcissistic character from its very beginning. This clinical observation has a major significance, since it permits us to explain why some conditions that do not appear to be depressive, e.g., especially ecstatic and at the same time narcissistic forms of love or object relations, most often result in

disappointments and demystifications that, in turn, lead to depression.

An additional element that plays a determining role in the formation of borderline personality, is the **"ideal EGO".** The "ideal EGO" is an element formed very early in the course of psychomotor development, closely related to the development of "Narcissism" in the individual and obtaining its energy from it. For this reason, the fantasies of "ideal EGO" are directly related to the "ideal – object". Disappointment concerning the object will easily result in a collapse of the "ideal EGO" and thus in depressive disorganization.

The significance of this element is indicated through the comparison with the neurotic structures where the prevalent structural element is the SUPEREGO. In the present context, the term SUPEREGO carries its Freudian underpinnings that differentiate it from the meaning attributed to the term by Melanie Klein. That is, we refer to the mature post-oedipal SUPEREGO that appears to be independent from any object relation, contrary to the early SUPEREGO that is directly dependent on object relations and formed in analogy with the object by introjecting it. The mature SUPEREGO brings forth guilt and self-blame, while the early one takes a persecutory character causing delusions of persecution, auditory illusions, or hallucinations with persecutory content. So, when we use the term SUPEREGO in reference to borderline persons, we always imply its mature form. A SUPEREGO as evidence of processing the oedipal problematic, is not observed to borderline individuals. One might say that although the borderline patient passes through the oedipal phase and confronts its problematic, this problematic has no influence on the formation of his/her personality. In other words, the borderline patient, or the child-to-be a borderline patient, in final analysis, has "understood" nothing from the oedipal situation he/she went through, neither any intense attractive drive towards one of his/her parents, nor any potential frustration due to inability to satisfy such an impulsive need. It seems as if the borderline patient says to him/herself: "So what, this is something I've known for a long time, some people are good and kind to me, while others are negative. So I have to see how I'll get along with the kind people around me".

The very fact that the core of the oedipal phase is the sex difference, as well as the inability to gain impulsive satisfaction out of this difference or out of the representatives of the sex in the environment, will never become part of the experience of the borderline-to-be child. It will never become a structural element of his/her present or future world. Thus the problem of sexuality is attenuated in a very special way for the borderline individual. This does not mean to say that there will be no sexual problems, rather that the sexual problematic of the borderline person will be mainly related to the feeling of acceptance or rejection from the partners, than with the specific sexual problems that are usually attributed to the experiences of the oedipal phase. In clinical practice, the existence of such an emotion is a major determinant of differential diagnosis. The fact that a patient narrates his/her personal problems with his/her partner does not necessarily mean that he/she is a neurotically structured individual, as it might seem to be at a superficial observation. It is especially important to continue the investigation in order to discover both the fundamental characteristics of the partner and the decisive causes for the patient's complaints.

The neurotic patient usually complains about failures in his/her sexual life, or about the relevant failures of his/her partner, as well as about the special qualities of his/her partner that are thought of as leading to failures of this kind, about his/her sexual inhibitions etc. On the other hand, the narcissistically structured person, as well as the borderline person, most often complains about the potential abandonment by a partner, about his/her inability to "become one" with him/her, to feel as if they were "one", or, on the contrary, about his/her fear to become "one" with his/her partner, to totally lose his/her boundaries. Here we have two diametrically different emotions, on the one hand the impulsive desire for unification and, on the other hand, the intense anxiety caused by this very desire; the desire for a fundamental dependence on the "object" and the existential anxiety about the possibility of experiencing this dependence, since this is more than a dependence of a sexual nature: It is a dependence on an object that simultaneously constitutes part of the very psychical structure of the borderline person. In the inner world of the borderline person, the representations of the object i.e., what the objects stands for, constitute part of his/her psyche and due to this fact the patient can not separate from this object without intense pain and reorganization of his/her inner structure. The quality of anxiety is a further element that should not be overlooked. It is important to recognize the source of the patient's anxiety, according to all of the preceding remarks.

From this multifactorial perspective, five major questions are raised in order to differentiate and define the formation of the patient's psychic structure. These questions can be summarized as follows:

- What is the prevalent structural element?
- What is the form of the problem (the intrapsychic conflict)?
- What is the quality of anxiety?
- What are the prevalent defense mechanisms?
- In what form do the interpersonal relationships occur (relations with the primary object of love)?

The borderline person's EGO is not experienced as "decomposed". The intense anxiety crises that accompany situations of real or symbolic loss of object are prevalent in the psychic structure of the borderline or narcissistic personalities. However, this is not experienced as a loss of EGO or as an explosion of EGO, which is the case for the psychotic patient. Of course, there is a similarity between these two conditions as well as a difference with both qualitative and quantitative dimensions in the person's psyche. The borderline patient's anxiety is simultaneously the result of the loss of control over his/her EGO, as well as the result of the experienced potential loss. Of course, we also observe that many of our patients have experienced in the past "various kinds of loss of control over EGO" and the anxiety that characterizes them is the anxiety of a potential repetition of this situation. However, this anxiety is actually related to a weakness of defense mechanisms, rather than to a potential full loss of EGO, or of the individual's existence in general, which is described by many psychotic individuals. Certainly, most psychotic individuals are not able to process their delusional crises, however, there are also some patients who can describe these situations, their relevant emotions and their anxiety concerning a potential repetition. This is what they often characterize as a "disorganization" of their personality, apparent in some borderline persons too, depending on the amount of anxiety they experience.

So, what is the difference between these two cases?

These cases are thought of as located at the threshold between psychosis and neurosis, as well as the proof that a differential diagnosis based solely on the symptoms is very difficult or even impossible.

Most of the times the observed symptoms permit diverse interpretations (mutli-symbolic symptoms), so they can not be considered determinants of the psychic structure. For this reason, most psychodynamically oriented clinicians suggest that the symptoms are not completely decisive for the psychic structure, as well as that the whole of symptoms that constitute "a syndrome", is not a determinant of the psychical structure, or of the person's disease, in the more restricted meaning of the term. Undoubtedly, professionals who are used to working within the perspective of the "psychiatric syndromes", solely based on phenomenological observations, will oppose such a position. From our perspective, even if a syndrome was identified via the use of a P/C program, or any other mechanistic composition of elements, this would not be enough to determine the deepest structure of the psyche. To avoid misinterpretations, the above observation does not attempt to diminish the major importance of phenomenology in psychiatrics, which constitutes the fundamental psychiatric practice, but rather that it implies that this practice is not adequate for providing the patient with an appropriate treatment. Especially in cases with a symptomatology that permits multiple interpretations, a diagnosis of the psychical structure is more helpful in order to proceed to individualized observations for prognosis and treatment, that would not be feasible by means of a mere description of the syndrome.

The differential diagnosis from psychosis is rendered feasible only through this process. Another criterion deriving from clinical observation, is the fact that, differently from psychotic patients, the social contacts of these patients remain largely stable. Whereas this kind of stability might appear in some psychotic cases too, in borderline disorders this comes as a rule.

Finally, one more difference between the psychotic and the borderline individual lies in their synthesis of the ideal EGO. The ideal EGO (ICH IDEAL) of the psychotic person, represents an earlier archaic structure that is more dependent on the primary narcissism of childhood, whereas the ideal EGO of the borderline person is to a greater degree a more mature psychic structure. This means that while the ideal EGO of a borderline patient is characterized by the absence of sexual drives, in the psychotic patient's ideal EGO it appears that whole parts of reality are missing. So, the ideal EGO of the psychotic patient is identified with the immature primary narcissism of childhood, while the ideal EGO of the borderline patient will have a narcissistic form, as a result of some process of maturation.

In the first case, the ideal EGO corresponds to a stage of independent and archaic (immature)

narcissism, while in the second, to a stage of mature narcissism. This more mature expression of the ideal EGO of the borderline individual corresponds to an also more mature expression of SUPEREGO, that appears to be closely related to it. This is a "symbiotic" relationship of mutual dependence, so that SUPEREGO, rather than having the role of an inner "gendarme", represents a composite of values that the person can be identified with, to such a degree that it constitutes a determining element of his/her behavior.

4. Etiopathogeny

In the background of borderline disorders we usually find intense disappointments in the relationship with the primary object of love (mother). We also find emotional deficiencies in this relationship, deficiencies in the affirmation and evaluation of behavior in childhood. Quite often, this is due to an unstable, splitting relation of the mother towards her child, who functions at times in a dating manner and at times in a rejecting way, so that the child is not helped in the formation of an integrated maternal image. As far as the borderline-to-be-girl is concerned, her mother usually cultivates mainly addictive elements through her behavior towards the child, while in the borderline-to-be-boy she enforces his expansive – narcissistic aims. The fixation of psyche in this stage of development, results to deficient EGO maturation and while the girl acquires from her mother only superficial strategies for the experiencing and processing of the everyday problem situations that are typical of this age, the boy does not reach a complete identification with his father, having as a result either his submission, or the avoidance of competition with him.

5. Treatment

In general terms, the ability for psychotherapeutic processing of an individual as well as the prognosis of the psychotherapeutic effort, depend on the still existing healthy elements of EGO. Thus, the analysis of the specific structure of the personality as well as of the quality and the pattern of the defenses being used by the borderline patient, will determine the way and the form of psychotherapeutic intervention.

Since patients with borderline personality are severely stressed and mistrustful, a period of preparation aimed at the investigation of the possibilities of psychotherapeutic cooperation with them must always precede. The therapeutic intervention must be structured without the mediation of big intervals of silence that may enhance the tendency to regress and may be experienced as oppressive by the patient.

The general aim of treatment should be the change of the patient's defence mechanisms. This is not feasible by means of an associative process and any therapeutic intervention should be aimed at the correction of the relation with reality, the elaboration of the specific situations that trouble the patient and the amelioration of his/her communication with the environment. The enforcement of the defence mechanisms will permit the patient to cope more efficiently with various situations and with his/her relationships with other persons, to better tolerate his/her various intrapsychic problems and to enhance his/her emotional control.

The inability of the borderline patient to engage in timely experiential processing of the psychotherapeutic material as well as his/her inability to use this material in order to differentiate the ways he/she confronts everyday problems, may put the therapist into distress. The therapist must be very efficient in processing his/her own aggressive emotions, as well as able to preserve stable interpersonal relationships without the involvement of evaluative elements or criticism. Throughout the course of therapy in borderline patients, we often notice the disappearance of the therapeutic relation so that the therapist is transformed into a friend or an enemy of the patient, or even into a parental figure, resulting in a pathological perpetuation of the relationship of dependence.

The therapist must be prepared to undertake the role of the representative for all the deficiencies of the borderline individual in his/her relation with the environment, to present them to the patient and help him/her experience them according to the reality principle. So, contrary to what applies to neurosis, the therapist must necessarily offer the patient a real "idol", in realistic and stable human dimensions, aimed at hindering the potential projective distortions made by the patient. This is because the final aim of the therapy is rendering the patient able to accept him/herself as well as others, without feeling threatened by this acceptance.

Bibliography

1.Bauer, S., Hunt, H., Gould, M., Goldstein, E.: Borderline Personality, Organization, Structural Diagnosis and the Structural Interview. *Psychiatry,* 43:224-233, 1980.

2.Benedetti, G.: Psychopathologie und Psychotherapie der Grenzpsychose Praxis. *Psychotherapie,* XII I:1-15, 1967.
3.Benedetti, G.: Das Borderline – Syndrome. *Nervenartz,* 48:641-650, 1977.
4.Bleuler, E.: *Dementia Praecox oder Gruppe der Schizophrenien.* Leipzig und Wien: F. Deuticke, 1911.
5.Braudigam, W. Von: *Reaktionen – Neurosen. Abnorme Personlichkeiten,* 4 Auflage, Thieme Vrig. Stuttgard 1978.
6.Hoch, P. & Pollatin, J.: Pseudoneurotic Forms of Schizophrenia. *Psychiat. Quart.* 23: 248-276, 1949.
7.Jaspers, K.: *Allgemeine Psychopathologie,*4 Aufl., Springer Vrlg., Berlin, 1946.
8.Kraepelin, E.: Psychiatrie: Ein Lehrbuch für Studierende und Ärzte, 8th ed., vol. I, Leipzig: J.A.Barth, 1909.
9.Gerd, R.: *Krankeheiten im Grenzen von Neurose und Psychose.* German Book, 1977.
10.Leichsenring, F.: *Borderline – Stile: Denken, Fuhlen, Abwehr und Objectbezienhugen. Eine Ganzheitliche.* Sichtweise Huber Vrlg., Berlin, 2003.
11.Stern, A.: Psychoanalytic Investigation and Therapy in the Borderline Group of Neurosis. *Psychoanal Q.,* 7:467-489, 1938.