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A history of borderline: disorder at the heart of psychiatry

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This article suggests that to appreciate some of the conundrums that surround 'borderline personality disorder' (BPD), we need to understand more about its history and the contexts and cultures in which it arose, consolidated and proliferated. Previous work on the development of personality disorder diagnoses (Jones, 2016) points to their emergence and shape being determined by the interaction of a multiplicity of forces including the needs of distressed individuals and communities; the manoeuvring of professional groups seeking to provide solutions to that distress and the cultural, public and media representations and responses to those problems and the proposed solutions.

This single article can only begin to outline some of the key issues and will focus on the emergence of the diagnosis within the discourses of psychiatry. As we will see in the case of BPD, like other, so-called, disorders of personality, there are connections to major social changes; in particular to some of the anxieties raised by urbanisation and industrialisation and later processes of deindustrialisation and their impacts on people's lives and identities.

The article argues that significant roots of the diagnosis can be traced back to major fault lines in the discipline of psychiatry and unresolved questions about its own borders. Is psychiatry a branch of the medical profession or is it a cross-disciplinary endeavour that centres the mind as an object of study and treatment, which cannot merely be located in the individual but is instead immanently connected to the social and cultural world?

Introduction

The article is motivated by the idea that to appreciate some of the conundrums and puzzles that surround 'borderline personality disorder' (BPD), we need to understand more about its history and the contexts and cultures in which it arose, consolidated and proliferated. Previous work on the development of personality disorder diagnoses

(Jones, 2016) point to their emergence and shape being determined through iterative interaction of several forces:

1. The perception of distress, or problems, occurring at individual, community or social levels.
2. The manoeuvring of professional groups seeking to provide solutions to that distress or those problems.
3. The impact of cultural, public and media representations and responses to those problems and the proposed solutions.

While this single article can only begin to outline some of the key issues and will focus on the emergence of the diagnosis within the discourses of psychiatry, it needs to be held in mind that while the diagnosis is clearly the product of 'psychiatry', it is insufficient to simply focus on the appearance of the diagnosis within the textbooks and manuals of the profession. Its emergence has also to be understood within the various social and cultural contexts in which the diagnosis has arisen and been maintained. As we will see in the case of BPD, like other, so-called, disorders of personality, there are connections to major social changes; in particular to some of the anxieties raised by urbanisation and industrialisation and later processes of deindustrialisation and their impacts on people's lives and identities.

Stories of the emergence of BPD usually attribute the formal recognition to the paper by the American psychoanalyst Adolf Stern (1938), and the substantial consolidation of the diagnosis to the appearance of BPD in the 3rd edition of the *Diagnostic and Statistical Manual* (DSM) published by the American Psychiatric Association in 1980. This article will suggest that there are complicated tales around these events and that the 'problem' with borderline is that it falls on territory that has been subject to considerable dispute within psychiatry. Borderline can only really be properly understood as what might be termed a transdisciplinary disorder that formed in the territory that is subject to substantial epistemological dispute.

The formal diagnosis emerged at a point in time and in places where there was explicit belief within the field of mental health and psychiatry that its endeavours were necessarily transdisciplinary in nature. The problem is that since then this transdisciplinary diagnosis has gone on to survive within disciplinary contexts that have little capacity to comprehend let alone respond to such a multidimensional 'disorder'. Debate over the status of the 'personality disorders' runs to the heart of conflict over the nature of the subject matter of psychiatry, and BPD has come to be at the centre of the battle over where the boundaries of the discipline lie.

The article is divided into four chronologically ordered sections, each outlining the significance of a particular era. We begin at the birth of the formal profession of psychiatry in the early decades of the 19th century amidst the turbulence of industrialisation and urbanisation, when claims for new forms of 'mental' disorder were being made within the context of emergent modern European national states. These new forms of disorder were distinct from the insanity that was understood to involve a loss of reason (that would be understood to be visibly manifest [Loughnan, 2012]) that had been understood for many centuries (Walker, 1968). They were also distinct from forms of 'unhappiness' or 'distress' (such as melancholia, for example) that had both been recognised for centuries (for example, Burton, 1638).

These new disorders can be considered under the general heading of 'moral insanity' and were associated with antisociality, criminality and even violence, and were understood to exist, hidden away, within 'the mind' of the sufferer. The claim

of expertise in the detection of such disorders was one of the central planks of the appeal made by the emerging profession of psychiatry. This proposal that 'the mind' should be at the heart of the psychiatric endeavour quickly became contested within the profession, and 'borderline' falls precisely on this disputed territory.

Second, this article surveys the emergence of the borderline diagnosis itself through the 1930s and into the post–Second World War period. It will be argued that the diagnosis, born formally at this point, needs to be understood as a transdisciplinary disorder. Like the earlier conceptions of moral insanity, it supposed a form of interiority, but one that was conceived within fields of enquiry that assumed an intimate connection between psychic states and the surrounding social world. Third, the article looks at the publication of BPD in DSM III in 1980. While doubtless a milestone in the establishment of the disorder, this official recognition glossed over underlying battles between different factions within psychiatry who understood the discipline in very different terms. One group were clinicians, strongly influenced by psychoanalytic ideas, who wanted to defend their expertise in the exploration of interiority and to provide treatment to those who attended their clinics. Ranged against this view were those who saw the job of psychiatry, as befitting of a branch of medicine, to observe symptoms and identify syndromes that could be associated with organic lesions. The resulting version of BPD that made it into DSM was recognisable in terms of symptomatology to the version that emerged in the 1930s but was largely shorn of the conceptualisation of BPD as a transdisciplinary disorder located both within the individual and within the environment. The fourth section looks at the explosion of BPD in the mainstream in the past few decades.

Moral insanity in the 19th century: the rise of the hybrid and paradoxical profession

Up until the early decades of the 19th century the territory upon which new profession of psychiatry emerged (Porter, 1987; 2002) could be understood as made up of two distinct areas. First, there were the various forms of unhappiness and distress (as the popularity of work such as Burton [1638], Mandeville [1711] and Cheyne [1733] can testify; and also see MacDonald [1981]). Second, there were also more overt and dramatic forms of insanity that rendered the sufferer without reason. This distinction has been largely carried through into the contrasting categories of neurosis and psychosis as they emerged through the first half of the 20th century (Beer, 1996), such that Laplanche and Pontalis (1988) could dryly note that the former might indicate a visit to your doctor, while the latter more likely suggested accommodation in an asylum.

It is less well recognised that it was the 'discovery' of a set of disorders that do not fit into either category that was a crucial factor in the emergence of psychiatry as a formal professional body. It was the proposal of diagnoses such as 'moral insanity' in the early decades of the 19th century that staked out this third territory. The fundamental idea of 'moral insanity' (and the related diagnoses of the various monomanias and partial insanities) was that there were forms of insanity that could affect the mind of the sufferer in very particular ways that might impact on the emotions or morals of the individual, thus allowing for highly antisocial behaviour to occur. It was this conceptualisation that allowed the new profession to make claims for expertise in the criminal justice system to arbitrate on matters of insanity or criminal responsibility

(Goldstein, 1987; 1998; Jones, 2016). The diagnoses were used in the criminal justice system to defend those accused of serious crime, even when the defendant was evidently not suffering from obvious manifest forms of insanity that might have left them bereft of reason. These new forms of insanity were developed initially in French psychiatry through the notion of the 'monomanias' (Esquirol, 1845; Goldstein, 1987); forms of insanity that might impact only on one very particular aspect of the mind and taking precise shapes such as kleptomanias and homicidal monomanias, for example (for example, Georget, 1826). At this point, they were distinctly psychological concepts, requiring professional expertise to detect them hidden away in the mind of the suffer often using what we now think of as a clinical interview (Jones, 2017). With some success in the courtrooms around the middle of the 19th century (notably in Britain), this thinking was taken beyond the world of criminality, with the work of British medic James Cowle Prichard a landmark as he formally proposed the diagnosis of 'moral insanity' in the 1830s (for example, Prichard, 1835). He was interested in the more general antisocial tendencies that might be the consequence of this form of mental disorder. He argued that 'moral insanity' affected only the 'feelings, temper, or habits' of an individual, rendering them 'incapable … of conducting himself with decency and propriety in the business of life'. Meanwhile their capacity to talk or reason was left intact (Prichard, 1835: 4).

As we will see, it is onto this 'new' territory that borderline was to be born some years later. The problem is that this is highly contested territory scarred by battle between those that would want the profession to be true to its medical roots and those that wanted to celebrate the hybridity of the profession (Berrios, 2019).[1] The former assumed that disease resided in the organs of an individual and that treatments would ultimately need to intervene at the level of the body. The latter viewed the territory as encompassing 'the mind' which not only drew in the world of subjective experience but also raised many questions about where the borders of the mind might lie. Could the mind simply be considered as a function of the brain, or does it encompass the wider world of experiences that might include social and cultural matters?

For reasons discussed thoroughly elsewhere (Jones, 2016; 2017), the organicist view of psychiatry triumphed from the middle of the 19th century, becoming entangled with eugenical thought whose catastrophic consequences became clear in the 1930s through the rise of Nazism. The clarity provided by this moral catastrophe strengthened those branches of psychiatry that were committed to social and psychological frameworks of understanding, and renewed interest in forms of 'moral insanity'.

'Those others': the emergence of borderline – the 1930s and the Second World War

While theorisation of 'moral insanity' in the 19th century laid the ground for the emergence of this 'other' category of mental disorder, which were to become known as 'personality disorders', it was not until the 1930s that the borderline diagnosis began to take shape. We can see the phrase 'borderline' beginning to be used in clinical literature (for example, Glover, 1932) and a formal description was published by Adolf Stern in 1938. It will be suggested here that the concept emerged through these periods of social crisis – the economic and social crises of the 1930s followed by the turmoil of war. The Second World War itself had considerable significance, as the full horror of the Holocaust revealed the twisted and dangerous logic of eugenics and

pushed psychiatry away from the biological path it had been on for many decades. It was psychoanalysis that offered the most obvious alternative paradigm and it is here that borderline disorder begins to be conceptualised. As we will see, however, the concept fell within contested territory here as well.

Stern's formal definition

The paper by psychoanalyst Adolph Stern, published in 1938, is often referred to as the first formal attempt to distinguish 'borderline' as a particular disorder. Stern reported gathering his data from the histories of his patients and his reflections on the experience of psychoanalytic therapy with them. Some of the features of the disorder that were to become established as characteristic of the diagnosis are here in Stern's description. There are mentions of 'hypersensitivity', 'deep rooted insecurity', 'dependent attitudes' and 'demands for pity, sympathy', and the possibility of negative therapeutic reactions provoking 'suicidal ideas' or 'suicidal attempts' (Stern, 1938: 58–59). Besides this, there is no direct reference to self-harm, although Stern does claim that patients would 'hurt themselves in their business, professional, social, in fact in all affective relations' (Stern, 1938: 61).

Stern was a significant figure in the formative decades of American psychoanalysis, at various times being president of the American Psychoanalytic Institute and president of the New York Psychoanalytic Society (Eisendorfer, 1959). His 1938 paper appears on the face of it to be light on theory, with only two authors referred to (Sigmund Freud and David M. Levy).[2] Nevertheless, it is apparent that Stern's work can be located within what was becoming contested territory in psychoanalysis, with two prominent battles shaping the paper. These were, first, the significance of childhood trauma and abuse as salient causes of mental illness (and borderline issues in particular). Second, there was dispute over the intervention style: should the psychoanalyst actively provide emotional support to the patient rather than simply rely on the interpretive method of psychoanalysis? Both points came to be viewed as transgressive within orthodox psychoanalysis, and were both associated with the work of Sandor Ferenczi. This was the Hungarian psychoanalyst right at the heart of psychoanalytic endeavours, and a friend of Freud in the early years of psychoanalysis, until falling out of favour thanks to his views. Stern would have been very aware of Ferenczi's work, notably attending the 6th Psychoanalytic Congress in The Hague in 1920 when Ferenczi was president of the International Society. Stern, attending as president of the American Psychoanalytic Society, was on the committee that approved the publication and adoption of the *International Journal of Psychoanalysis* founded by Ferenczi. At the same conference, Ferenczi presented a paper on the importance of the 'active technique' to work with some patients as an alternative to the blank screen of free-association (Ferenczi, 1980 [1920]).

Stern declared that 'at least 75%' of his 'borderline' group had experienced at least one negative family factor in early childhood. Separation and divorce were described as commonly occurring before the age of seven. The mothers were described as 'decidedly' neurotic or psychotic types, who inflicted psychological injuries on their children as they lacked the 'capacity for simple spontaneous affection'. Further, 'actual cruelty, neglect and brutality' were often found in the background operating 'more or less constantly over many years from earliest childhood' (Stern, 1938: 56). This latter theme was developed in a follow-up paper in 1945 that emphasised that it was not

so much specific experiences of abuse that were the problem but that the 'traumata were practically continuous' such that 'their environment was in itself traumatic' (Stern, 1945: 190–191).

Although highly critical of 'mothers', the tone of sympathy directed at the patients is particularly striking as this is often not obvious in later descriptions of borderline. For example, in raising the issue of dependence that might emerge during therapy, Stern suggests that when dependence is 'bestowed' upon the analyst:

> [I]t should be welcomed and responded to with whatever parental capacity the analyst has. Support, assurance, understanding, respect, consideration, and unflagging interest are all necessary. The assurance of being wanted, of belonging, helps materially to develop self-assurance and a strong ego structure. Since these are so lacking in the borderline group, they must be developed in and by the treatment. (Stern, 1945: 196)

Stern's paper directly describes some of what were to be become regarded as the outward symptoms of borderline, but also what were to become enduring controversies concerning what might underlie such symptoms and what might provide help. Stern is aligned with Ferenczi's plea both for 'active therapy' and the identification of the significance of environmental trauma. Both claims place him quite far from what had become psychoanalytic orthodoxy, which emphasised the significance of unconscious fantasy rather than actual abuse and the adherence to the classical technique.

Of course, although Stern's paper appears as the first formal description, ideas of borderline conditions were already cropping up in clinical literature and elsewhere. The next section will consider the significance of an important example where the concept of borderline was being used in a way that was to prove influential. We see here how at least one version of the diagnosis was formed in circumstances far beyond the psychiatric clinic, encouraged by a highly cross-disciplinary understanding of the nature of mental distress.

The development of borderline in the post-war period

There is little doubt that BPD has entered popular discourse thanks in considerable part to its inclusion in DSM III in 1980. This is the same edition that gave considerable boost to the use of the personality disorders by giving them their very own axis; inviting clinicians to assign their clients to a personality disorder alongside other conditions. This article will look at some of the debates that surrounded the inclusion of BPD in DSM a little closer, after exploring a little of the groundwork that led to some acceptance of the categories of personality disorder that took place in the pre-war years.

Borderliners: Winnicott, Hawkspur and the Institute for the Study of Delinquency

Andre Green (1977:24), at a conference organised to facilitate the entry of borderline into DSM III (discussed later), reviewed various theoretical approaches to the problem and then proclaimed Donald Winnicott as 'the analyst of the borderline'. As Winnicott had not published explicitly on 'borderline',[3] the connection might not have been obvious. Winnicott had, however, described the 'character disorders' as 'a third category … the in-betweens' that he viewed as distinct from either the psychoneuroses or

psychoses. He also echoed Stern's earlier work in suggesting that these were 'individuals who started well enough, but whose environment failed them at some point, or repeatedly, or over a long period of time' (Winnicott, 1984a: 235). However, Green's justification for lauding Winnicott as the analyst of the borderline was deeper than this. It is important to understand that Winnicott's stance was nurtured within the object relations school of psychoanalysis, that came to dominate psychoanalytic thought and practice in Britain and to a considerable extent in the United States and was widely acknowledged to have influenced those who had a strong hand in the entry of borderline into DSM. It is worth spending a little time understanding this perspective, and the way that it asks questions about the borders of the mind.

While it is only a certain amount of teleological hindsight that can identify 'a school' of object relations thinking,[4] at the core of the movement was a shift from early Freudian theory that supposed that human beings were only motivated towards relationships by the need to meet drives (whether of hunger, or of a sexual nature). Instead, it was assumed that individuals have a fundamental need to relate to others and this itself drives much human behaviour. Developmental processes are therefore embedded in social relationships. While, in keeping with the work of Melanie Klein, the mainstream world of psychoanalysis gave considerable emphasis to the fundamental importance of the relationship with the mother, there was significant scope for work that emphasised and theorised the significance of wider social and cultural relationships (notably in the work of Ian Sutie [1935] and John Macmurray [1939], for example).

The significant move here is that it became possible to question the idea that many forms of 'psychopathology' could be understood in terms of individual psychology, but were instead better understood as 'relational'; existing in an intermediate territory between the internal world of the individual and the surrounding social world. It was Winnicott who was to become the best-known channel for this line of thought as he developed the idea of the importance of transitional phenomena and space (Winnicott, 1984b [1970]). As Green (1977: 24) notes, this work emerged from a significant shift in Winnicott's perspective away from the typical psychoanalytic focus on the intrapsychic towards the 'interplay of the external and the internal'. The cause and radical nature of the shift in Winnicott's thinking is perhaps not as well-known as it should be, but it is also very relevant to the question of 'borderline'. Towards the end of his life Winnicott (1984b [1970]) paid credit to the influence of the experience he had with working with children in the context of what was effectively an experiment in community living in the early 1940s. He had provided consultative support to a war-time children's home that provided shelter for children, from troubled backgrounds, who were evacuated from the threat of bombing in London. Their behaviour and distress meant that they could not be accommodated in ordinary families and were instead billeted to institutional care. Once such home was organised by the Q-Camps committee who had run Hawkspur camp, an experimental intervention for young men between 1936 and 1941 who were considered at risk of falling into lives of delinquency (Wills, 1941). There is no space to fully describe the principles of the camp here but suffice to say that it emerged from an eclectic mix of influences that included a commitment to community activism, an interest in the dynamics of democracy, belief in the benefits of a pioneering lifestyle that were all stimulated by the social and political changes wrought by economic depression, mass unemployment alongside some excitement at the democratic possibilities created by the emergence of full suffrage in 1928 (Jones and Fees, 2024b). Added to this was an

interest in group processes and object relations psychoanalysis. The camp was directly supported by the Institute for the Study and Treatment of Delinquency (ISTD) (itself psychoanalytically informed but a highly cross-disciplinary organisation that went on to nurture the emergence of British criminology as well as the 'Psychopathy Clinic', that became the Portman Clinic). The Hawkspur work itself informed the development of group and community therapies that occurred in the post-war period (Harrison, 2000).

It is also striking that Hawkspur was organised to provide a service for what the leading protagonist called 'those others', or 'misfits' who were not being served by mental health services as they existed at that point, often with challenging early experiences (Franklin, 1971). The ISTD provided psychological assessments of the camp members, and we can see the language of character disorder and even 'borderline' itself being used (Jones and Fees, 2024a). For example, the psychiatrist Dennis Carrol at the ISTD described one of the very first admissions as 'a borderline schizophrenic' and that 'his tendency to decide what is best for him and worry people to do it is characteristic of people in this state'.[5] More strikingly there is also evidence of this language of 'borderliner' being picked up the young men themselves. Indeed, the same young man wrote a letter after he had left referring himself as 'a person who is called a "borderliner" by doctors and who is made continuously wretched by his ailment'.[6]

Fuelled by the experiments in group and community therapies that aimed to work with this new client group there was considerable interest in treatment and policies aimed at the problem of psychopathy (that was at this point being used as a version of what was to become 'antisocial personality disorder') (Ramon, 1986). In the UK psychopathy was to be an important part of the 1959 Mental Health Act, and the US witnessed a whole series of polices directed at the treatment of sexual psychopaths in the post-war period (Swanson, 1960). It was this post-war period that saw the rise of the 'personality disorders'.

The *Diagnostic and Statistical Manual* and 'personality disorder'

The DSM itself arose from post-Second World War dissatisfaction with previous nosologies that appeared to only serve the needs of those who worked in the asylums (and dealt with cases of insanity) or those who worked with the neurotic and unhappy in private clinics (Harper, 2020). The Second World War and mass mobilisation brought military psychiatry into contact with a wider array of the population, particularly those who had experienced trauma and whose difficulties might be characterised as struggling to fit in with the demands of military life (APA, 1952). The significant 'new' category were the 'personality disorders'[7] that were described in terms that clearly occupied the territory opened up by the notion of 'moral insanity': 'characterized by developmental defects or pathological trends in the personality structure, with minimal subjective anxiety, and little or no sense of distress. In most instances, the disorder is manifested by a lifelong pattern of action or behavior, rather than by mental or emotional symptoms' (APA, 1952: 34).

The DSM went on to describe various forms of personality disorder under three headings. The first pattern of 'personality disturbance' described what were assumed to be inherited personality types, unlikely to be amenable to therapy (APA, 1952: 35). The second, 'personality trait disturbance', included those viewed as 'unable to maintain their emotional equilibrium and independence' and appeared as a more

psychological conceptualisation and included a description of the 'emotionally unstable personality'. The third category of 'sociopathic personality disturbance' was to become the most significant at this point as it contained the root of what was to become 'antisocial personality disorder' and the description bore the fingerprints of Cleckley's (1941) descriptions of psychopaths. It is a strikingly social diagnosis at this point. Those in this category were described as 'ill primarily in terms of society and of conformity with the prevailing cultural milieu, and not only in terms of personal discomfort and relations with other individuals' (APA, 1952: 38). Within the second grouping we see 'emotionally unstable' (APA, 1952: 36) and here we can see some associations with the later 'borderline diagnosis':

> **Emotionally unstable personality** In such cases the individual reacts with excitability and ineffectiveness when confronted by minor stress. His judgment may be undependable under stress, and his relationship to other people is continuously fraught with fluctuating emotional attitudes, because of strong and poorly controlled hostility, guilt, and anxiety.
> This term is synonymous with the former term 'psychopathic personality with emotional instability'. (APA, 1952: 36)

The use of the male gender here, of course, is consistent with writing conventions in a society that saw masculinity as the norm. It is fair to say, however, that there is no reason to think this was a diagnosis aimed at women at this point. Meanwhile, the language of 'hostility, guilt and anxiety' is indicative of the influence of psychoanalysis, although there is no particular reference to Stern's description, nor to the idea of being close to 'psychosis'.

The second edition of DSM (APA, 1968) represented a shift to a more 'psychological' approach and the influence of psychoanalysis is clearer. According to the appendix the equivalent of 'emotionally unstable' is now 'hysterical personality disorder', which was described as 'characterized by excitability, emotional instability, over-reactivity, and self-dramatization. This self-dramatization is always attention-seeking and often seductive, whether or not the patient is aware of its purpose. These personalities are also immature, self-centered, often vain, and usually dependent on others' (APA, 1968: 43: 301.5). The linguistic assumption of male gender has now disappeared and, given the historical association of the term hysterical with femininity, this now seems to be a gendered diagnosis. There is brief mention of 'borderline schizophrenia' (APA, 1968: p34) but there is still no notable entity of borderline even at this point. The entry of borderline was to take place in 1980, and was one of the most controversial topics dealt with by the committee dealing with the new edition.

The Diagnostic and Statistical Manual III (1980): the appearance of borderline

Published in 1980, DSM III is widely recognised as representing a remarkable shift in psychiatric nosology (Kutchins and Kirk, 1997). It is considerably longer, consisting of almost 500 pages and 265 diagnoses, compared to DSM II of around 130 pages and 182 diagnoses. Planning for DSM III began only five years after the publication of DSM II (Decker, 2013). As the APA acknowledged, there was an urgency driven by a sense that psychiatry faced crisis, besieged by an array of critics (Mayes and Horwitz, 2005). One wing of the attack took a broadly sociological stance that viewed the concepts of psychiatry as mere social constructions designed to oppress

and coerce those whose behaviour and thoughts did not fit the expectations of rational Western modernity, or who otherwise railed against the observed injustices or negative experiences of the average patient. This view was consistent with the various counter-cultural movements of the 1960s that questioned conventional institutions and their assumptions. Surveyed under this harsh light, psychiatry was not just failing to ameliorate the misery of mental suffering, it was often one of the causes. The other major attack came from a very different angle; from those who saw psychiatry as failing to carry out its promise to become a full and proper branch of medicine. To them its concepts were already too woolly, based on clinical intuition and deductive logic (that at this point was often following well-trodden psychoanalytic theoretical tropes). Scrutinised under the microscope of conventional medicine, psychiatry was systematically failing to identify syndromes and pin their aetiology down into identifiable lesions within the organs of the body (Kutchins and Kirk, 1997).

This battle was to be played out most explicitly over the terrain of the personality disorders. Decker (2013) describes Robert Spitzer, appointed to lead the transformation of DSM, as 'pre-occupied' from the outset with this 'contentious' and 'mine strewn grouping' that exemplified the battle between researchers and clinicians (Decker, 2013: 196). As a psychoanalyst and quantitatively minded researcher he was well placed to bridge between the researchers who loathed these seemingly amorphous categories, and the clinicians who found the diagnoses usefully described forms of distress that they encountered in their clinics.

The positivistic minded researchers styled themselves as 'neo-Kraepelins' after Emil Kraepelin, the influential German psychiatrist who pushed hard for psychiatric diagnoses to be more objectively tied to symptom manifestations that were assumed to represent underlying lesions of the nervous system (Kendler et al, 2009). While this group were generally sceptical about the concepts of personality disorder, they could accept the idea that there were disorders that were not fully manifest versions of more identifiable mental illnesses (such as schizophrenia). In this view the concept of borderline could be understood to be referring to a disorder that was merely on the borderline with psychosis, and not an entity in its own right.

The shape of the immediate battle that led to the inclusion of BPD can be seen in a major conference on borderline that was hosted by the Menninger Clinic in Topeca in March 1976 (leading to a collection of papers edited by Peter Hartocollis [1977]). Andre Green's paper that emphasised the significance of Winnicott was given at this conference and has already been discussed. While the nature of the host venue ensured that the interests of clinicians were well represented, it brought protagonists from both sides of the divide together. Kafka (1981) later observed that despite 'some genuine attempts at communication', there was huge distance between the philosophical approaches taken by the groups and 'massive resistances' were mobilised against venturing into shared terrain. The clinicians were generally followers of psychoanalytic theory and those that had direct influence on DSM such as Otto Kernberg (1977) and Donald Rinsley (1977) both gave papers at the conference and pressed for a version of object relations theorisation. Researchers and medical psychiatric perspectives were represented by papers that promoted psychometrics (Singer, 1977), described links to 'borderline schizophrenia' (Gunderson, 1977) and proposed the familial links between schizophrenia and borderline (Goldstein and Jones, 1977).

Despite scepticism from the positivist perspectives, Spitzer appeared to acquiesce to the clinicians and favoured the inclusion of borderline as a particular entity. As part of

a strategy for clearing the way for this, he, and researchers Jean Endicott and Miriam Gibbon, published a technical paper in the *Archives of General Psychiatry* on the eve of the publication of DSM III (Spitzer et al, 1979). They reported on their efforts to tease out the two different ways that the concept of borderline could be understood. Was 'borderline' best construed as a specific clinical entity as favoured by the clinicians or as simply as a word that signalled a milder form of another diagnosis such as schizophrenia (using the term schizotypal)? Spitzer et al (1979) operationalised a set of criteria for both versions and tested both on a sample of patients.[8] They argued that their findings provided evidence for both forms of disorder – schizotypal and borderline. Throughout the paper, however, the authors emphasised their negative feelings about the term borderline and their hope to replace it with 'unstable personality disorder' (similar to that previously used in DSM I). They acknowledged, however, that the clinicians they consulted would 'never abandon the term "borderline"' as it better described what they saw as a rather stable condition. Spitzer conceded on the term 'borderline', and the argument that BPD should be recognised as a distinct clinical entity was won. At the point of publication there were three clusters of personality disorder. BPD was found in cluster B, alongside narcissistic, hysterical and antisocial personality disorders. The categories of borderline, narcissistic and hysterical all have obvious connections to psychoanalysis and an underlying theoretical link to all four is provided by Kernberg's notion of borderline organisation (Kernberg, 1985 [1975]), itself rooted in object relations psychoanalysis (Klein and Tribich, 1981). However, the DSM process meant that this version of borderline bore little relationship to the more complex, cross-disciplinary disorder that was construed as existing in a form of transitional space (to use Winnicott's language) between the world of individual psychology and the social world. Instead, the chosen criteria focused on observable behaviour and thus this squeezed out the knotty problems concerning where the boundaries of the mind might be judged to lie, let alone how 'it' might be observed and measured. Of the eight criteria, five clearly emphasise the location of the pathology within an individual (impulsivity/unpredictability, inappropriate anger, affective instability, physically self-damaging acts, chronic feelings of emptiness or boredom), while three are perhaps a little more suggestive of the significance of social dynamics: identity disturbance, unstable and intense interpersonal relationships, and an intolerance of being alone (APA, 1980: 321). Just over a single page of the manual is devoted to BPD, in contrast to the four pages devoted to 'antisocial personality disorder'. There is little sense here of just how significant this diagnosis was to become in the following decades.

The inclusion of BPD as a specific clinical entity in DSM might have looked like a victory for the clinicians and psychoanalysis. However, the avowedly positivistic stance and the reliance on simple descriptions of behaviours meant that in many ways this was a major defeat. The diagnosis was shorn of its connections with the exploration of interiority, and certainly with the idea that it might be a disorder existing within a transitional space that existed neither solely within the borders of the individual, nor simply within the social world. The DSM definition is an individualised diagnosis, with little trace of the transdisciplinary understanding of borderline that was apparent in the work of Hawkspur, and that of Winnicott. Neither is the more sympathetic account of Stern and his emphasis on the significance of environmental damage apparent here either.

DSM III was in its own terms a considerable success. It became the accepted textbook in US psychiatry and then more globally. Medical students were taught

to learn and use its criteria, academic and professional journals expected authors to refer to it (Mayes and Horwitz, 2005). As Mayes and Horwitz (2005: 264) argued, 'the historic shift from a psychosocial to a symptom-based view of mental health was complete'. A few years after the publication of DSM III, Morton Reiser, responsible for training psychiatrists in the United States, worried that psychiatry was 'losing the mind' (Reiser, 1988), as the trainees he was coming across were 'astoundingly unpsychological'. They used DSM III to diagnose and decide on the 'pharmacotherapy', at which point 'meaningful communication stopped' and so did the 'curiosity about the patient as a person', with no interest in their mental life and experiences (Reiser, 1988: 151).

Post-*Diagnostic and Statistical Manual*: borderline hits the mainstream

Almost 50 years after becoming a recognisable syndrome among psychoanalytically orientated clinicians, the concept of 'borderline' made it into the third edition of DSM. It survived subsequent revisions of DSM and was still present in DSM 5 despite a concerted campaign to remove the distinct categories of personality disorder. Indeed, borderline received further recognition in the 11th edition of the International Classification of Diseases (ICD) produced by the World Health Organization in 2019. BPD had been removed from ICD 10 (1990), to be replaced by Emotionally Unstable Personality Disorder (EUPD) – the diagnosis that appeared in the very first edition of DSM in 1952. EUPD itself was then removed in ICD 11 as the manual steered towards a dimensional approach to PD that distinguished according to the severity of symptoms (mild, moderate or severe) rather than categories. The general description emphasised disturbances of affect and identity, as well as difficulties in interpersonal relationships characterised by persistent conflict alongside patterns of withdrawal and dependency. Nevertheless, the term borderline actually reappeared as it was used to describe a 'Borderline Pattern (ICD-11)', that strongly echoes and reinforces the DSM version of BPD.[9]

It is also fair to say that BPD has not only survived in the diagnostic manuals, it has positively flourished in the outside world becoming a common facet of everyday discourse (Cariola, 2017). A number of studies have found that only the BPD and Antisocial Personality Disorder (ASPD) diagnoses are used very much at all in practice and have become *the* PD diagnoses (Newton-Howes et al, 2021).

The idea that BPD could be understood in behavioural terms was strongly promoted by one of the most influential treatment models that emerged in the late 1980s called Dialectic Behaviour Therapy (for example, Linehan, 1987). This has been driven mainly by Marsha Linehan's work that has construed BPD in what she has termed a 'biosocial' model, which appears to very deliberately exclude the psychological realm. Issues of self-harm and parasuicidal behaviours are foregrounded as BPD is understood as a disorder that is characterised chiefly by emotional dysregulation which is understood in terms of a biological pre-disposition that leads to a range of behaviours that are viewed as ultimately self-damaging and self-defeating. The social dimension of the disorder is not entirely excluded but attention is focused on the failure of the developmental environment to adequately 'train' the individual to regulate their emotions. This can occur through lack of attention and support, so that 'often they learn that extreme

emotional displays are necessary to provoke a helpful environmental response' (Linehan, 1997: P265).

Conclusions

BPD and ASPD have become *the* diagnoses of personality disorder. The personality disorders themselves have been at the centre of heated debate about the nature of mental illness and distress. Part of the problem with borderline is that it lies on a significant fault line within the discipline of psychiatry. On one side of this line are those forces that have sought to establish a discipline that is unambiguously a part of the now established field of medicine. This entails the privileging of positivist scientific methods to identify diseases that can be associated with lesions and disorders within the organs of the body. On the other side are those forces that have sought to locate 'the mind' as a central concern of the discipline. While this allows for a wider array of human experience to be drawn into the analytic frame, it also provokes many unresolved questions; to what extent is it possible to draw boundaries around the individual mind or instead is it necessary to draw elements of not only the corporeal but also of the social and cultural worlds into this analysis? The inclusion of the subjective world of experience and its relationship to culture as a historical and shifting phenomenon is deeply challenging for those who want to see psychiatry joining the epistemic ranks of the natural sciences.

As reviewed in this article, it was diagnoses associated with the idea of moral insanity that initially put the exploration of the mind within the modern psychiatric project. This controversial territory has played a key role in the development and growth of psychiatry. In the post–Second World War period it was the personality disorders that were responsible for considerable growth in the expanse and reach of the psychiatric realm. Since its inclusion in DSM in 1980, the borderline diagnosis has grown enormously and is now well established in Western culture, well beyond the clinic.

The reference to 'borders' is perhaps no mere oddity but does perhaps explain something of the longevity of the diagnosis as it hints at the marginalisation of individuals who are viewed as, or experience themselves as, on the edge or outside of the norm. The reference to borders perhaps also refers to questions about the boundaries of the discipline of psychiatry and where they lie. This article has only been able to touch upon the wider social and cultural issues that have also driven the 'popularity' of the diagnosis. There is little doubt that the emergence of psychiatry itself was fuelled at least in part by feelings of anxiety about social change in the 19th century. The emergence of borderline itself occurred in the middle of the 20th century; initially in 1930s Britain, which was being transformed by social change and industrial decline, fear of what would become of young men left under-employed and disconnected. This association with young men at that point is noteworthy. The diagnosis became more associated with women in the latter decades of that century. There was no borderline in DSM II (1968) but there was hysterical personality – a diagnosis clearly highly gendered. It is notable that hysterical survived as a separate category even when borderline made its appearance in DSM III where it perhaps operates as the sister diagnosis to 'anti-social personality disorder' that was very much associated with men.

The big question that needs far more exploration is why did borderline explode in popularity in the latter decades of the 20th century? Christopher Lasch (1979)

suggested that it was post-industrial American culture that led to the emergence of a culture of narcissism and it is noteworthy that he based his analysis on an understanding of Kernberg's theorisation of borderline personality organisation.

Meanwhile, borderline remains a tortured and paradoxical diagnosis – it falls into territory that has been key to the emergence and the popular spread of psychiatry as a profession – ushering many contemporary forms of human misery within the psychiatric ambit. But this territory remains highly contested with many within the profession regarding it as alien territory that does not belong within the boundaries of a properly medicalised discipline.

Notes

1. Berrios (2019: 111), for example, suggested that at birth, the project of psychiatry was a hybrid that drew on fragments of 'philosophy, history, psychology, rhetoric, the nascent sociology and the neurosciences'.
2. Levy was another New York psychiatrist who theorised that emotional deprivation or 'affect hunger' was deeply damaging to child development (Levy, 1937).
3. He did explicitly discuss 'borderline' cases in his correspondence, for example, to Robert Rodman in 1969 (Rodman, 1987).
4. The work of a group who largely worked in Britain that included Melanie Klein, Donald Fairburn and Donald Winnicott came to be viewed as at the forefront of object relations ideas.
5. Letter from Carrol, ISTD, to Frankling, 1 February 1936, Planned Environment Therapy Archives: https://mulberrybush.org.uk/mb3/archives/ SA/Q1/HM 31.131.5.
6. Letter from Walker to Mr Thompson – Solicitors Jermyn Street, 29 August 1936, Planned Environment Therapy Archives: https://mulberrybush.org.uk/mb3/archives/ SA/Q1/HM 31.131.5.
7. It is noteworthy that the more obvious language of 'psychopathy' was not adopted at this point. This is despite the popular success of the term following Cleckley's work (however ironic this is, as Cleckley himself was critical of the term). It is likely that the APA were concerned to avoid association to the eugenical work on 'psychopathy' in the previous decades (Breggin, 1993) and the by then discredited policy initiatives aimed at the control of 'sexual psychopaths' (Lave, 2009).
8. The sampled 'borderline group' used in the study was 68 per cent female, showing gender was significant at this point – although not exclusive.
9. A 'pervasive pattern of instability of interpersonal relationships, self-image, and affects' and marked with impulsivity in a number of areas, including 'frantic efforts, efforts to avoid real or imagined abandonment', 'self-damaging' and rash behaviour, 'self-harm', 'chronic feelings of emptiness, inappropriate intense anger'. There is also some nod to the idea that this was a disorder close to the border with psychosis with reference to '[t]ransient dissociative symptoms or psychotic-like features in situations of high affective arousal' (ICD11: 2019).

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