

Borderline personality disorder from a psychopathological-dynamic perspective

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Summary

As is well-known, borderline personality disorder is a highly variegated clinical constellation, so that it might be better pictured as an area rather than a line. It is in this clinical area that we encounter particularly difficult patients who, subject to emotional dysregulation and tendency to impulsive action, cause much trouble to clinicians and health workers committed to their treatment. The contribution of psychopathology becomes essential whenever it allows the clinician to move from the level of symptoms to that of lived experience. When this shift is not attempted, the clinician's gaze remains dominated by the triad

of stigmatisation, intractability and chronicity. To ask "what is it like to be a person with BPD" means, for example, to identify the characteristics of a perpetually dysphoric mood condition that forces the subject to look for ways to quickly reduce such uncomfortable state. Psychopathology allows us to shed light on the dynamics of dysphoric mood and the transformation of dysphoria into anger: this knowledge can also help reduce the risk of emotional mirror-involvement in the clinician.

Key words

Borderline personality • Disorder • Dysphoria • Anger

Introduction

As is well-known, the clinical constellation of borderline personality disorder is highly variegated, so that it might be better pictured as an area rather than a line. This area resembles a kind of condominium (the "borderline condo") whose tenants can display very different characteristics. This should not be seen as a static metaphor. In fact, there is the possibility of changing apartments within the same building or even abandoning it for another building. The latter is indeed the goal of every therapeutic enterprise. According to Clarkin, Hull and Hurt's¹ clinical typification, we can imagine a ground, first and second floors. The ground floor is occupied by borderline patients characterised by an uncontrollable drive to act (impulsivity, acting out). The first floor is dwelled by borderline patients with an affective impairment that can take the form of atypical depression. The second and top floor is inhabited by "quiet borderline" patients²: these people live in a condition of identity diffusion and suffer from chronic states of emptiness and despair, but do not display serious self-harming behaviours such as those characterising the borderline patients living on the ground floor.

While those inhabiting the first and second floors are generally able to ask for help, the borderline patients who

live on the ground floor are in a far more problematic condition: they are imprisoned in a mechanism that finds a temporary "solution" to their chronic suffering in the impulsive discharge towards the outside world. Unable to formulate a more or less explicit request for help, these patients end up trapped in situations in which the low level of mentalisation and the frequency of acted-out behaviours (impulsive behaviour, acting out, self-harming behaviour, provocative or antisocial behaviour) conspire with each other, causing the endless repetition of traumatic or even catastrophic interpersonal events. This type of borderline patients is usually taken care of by Community Mental Health Services.

Relationship: the stage of the disorder

In the area of personality disorders, borderline personality disorder (BPD) has always enjoyed a privileged position, so that it represents the most diagnosed condition; it is also the main object of study, research and both theoretical and clinical reflection. This attentional bias is certainly related to the complexity of the disorder and its multiple possibilities of expression, but also and foremost to the serious difficulties experienced by clinicians and Community Mental Health Services in dealing with it. The main obstacle to treatment is represented by the type

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of relationship that the borderline patient establishes with others, and especially with those who deal with him or her from a clinical point of view (psychiatrists, clinical psychologists, nurses, psychosocial nurses). The therapeutic relationship invariably becomes emotionally turbulent or even fiery because of the intensity of the emotions involved. It also becomes highly addictive, very discontinuous, stormy and constantly on the verge of rupture or interruption. This relationship is highly traumatic for both the patient (who follows a relational pattern with the clinician that repeats itself cyclically in its life story) and the clinician (who needs to maintain his therapeutic attitude under the pressure of events).

In fact, one of the fundamental features of borderline personality disorder is that, on the one hand it has serious effects on the sufferer and severely restricts his lifestyle, and, on the other, it also plagues those who interact with the subject: parents, relatives, friends and partners, as well as clinicians. The symptoms of BPD, in this sense, do not simply belong to the psychopathological disorder, but "flood" the relationship. This explains why, paraphrasing Winnicott, it is possible to argue³ that there is no such a thing as an *isolated* borderline person: each time there is one, there must be somebody else interacting with him or her. In brief, one cannot be a borderline person all by oneself: those who interact with a borderline personality are inevitably at risk to be dragged into borderland territory. Thus, being a borderline also means *disturbing* someone: that is, it means to force the other to bear and share one's own subjective states (especially when the other is a clinician who adopts a therapeutic point of view).

In other serious disorders, gravely depressed or delusional subjects, for example, withdraw and shut themselves into a private world hardly accessible to the others. Something very different happens to people with BPD. In this case, the relationship with the other becomes the stage on which the disorder unfolds and keeps re-enacting those highly problematic or destructive relational patterns that "burn out" one relationship after the other: one partner after the other, one friend after the other, one employer after the other – and even a psychiatrist, or a clinician, one after the other. Thus, BPD takes the form of what Kurt Schneider⁴ would have called a true "disordering disorder". By the middle of the twentieth century, Schneider had come up with this quite acute definition by arguing that the abnormal and psychopathic personalities are those that, because of their abnormality, suffer or cause suffering: today we could say with greater precision that they are those who "suffer *and* cause suffering".

Since the relationship with the other becomes the stage on which the disorder is enacted, it is very difficult to build, develop and maintain a therapeutically-oriented relationship with these patients. In the absence of the clinician's continuous monitoring and rethinking of the

status of the relationship, the course of events inevitably leads to the discharging of the patient (*prise en décharge*) rather than the "taking charge" of him or her (*prise en charge*). In addition, it is well known that severe personality disorders have a bad reputation among healthcare workers. According to the title of a 1988 article by Lewis and Appleby⁵, borderline patients are "patients psychiatrists dislike". This mere nosographic diagnosis seems to trigger negative emotions and thoughts^{6,7} among clinicians, so that it has been regarded as a "diagnosis of exclusion" – which means a diagnosis employed *not* to deal with a problem. In this sense, the old adage that diagnosis of borderline personality psychopathology is a sort of waste basket needs to be rethought. Rather than a container for all those cases that are difficult to match with established nosological models, it is a trash bin in which to throw everything one does not want to deal with: the waste of the clinic. The vague clinical symptoms elicit unpleasant responses in healthcare workers and tend to be dismissed. Many studies⁸⁻¹² have emphasised that the negative perception of borderline patients affects healthcare workers' ability to develop a good therapeutic relationship. The negative perception of the patient (starting with diagnosis) often leads to a problematic or negative interaction. Once assigned to a patient, diagnosis of BPD becomes "sticky" and often triggers a chain reaction that leads to a real stigmatisation. This depends on the fact that often these patients unleash a "destructive whirlwind"¹³ – an image used by many healthcare workers to describe the effect of their encounter with patients suffering from the most severe cases of BPD.

BPD patients frighten, bewilder and worry healthcare workers; they cause emotional problems and trigger intense emotional reactions that are sometimes uncontrolled and in any case difficult to contain in the context of the therapeutic process. In the absence of any understanding of the true nature of these phenomena and of training that can prepare one to deal with their effects on the therapeutic group, the most likely outcome results in the triad: stigmatisation-misunderstanding-intractability. This situation triggers another vicious circle: due to the tendency to stigmatise, the vindicating, challenging and sometimes violent attitudes of these patients are not seen as partial data to be processed and integrated into a broader clinical context, but rather as symptomatic elements that preclude and compromise any therapeutic process. In essence, faced with the inability to understand the workings of the borderline mind, the healthcare worker quickly develops the tendency to objectify and stigmatise – and the paradigm of chronicity-intractability resurfaces. Eventually, the low level of mentalisation typical of the borderline functioning is reflected in a similarly low level of mentalisation in healthcare workers, leading to impairment of therapeutic function.

These serious difficulties in establishing a therapeutic relationship with the most severe borderline patients (most likely to be encountered in a Community Mental Health Service rather than in private practice) highlight the limits of a diagnostic system which – due to its non-theoretical character – does not provide any help in the planning and implementation of therapeutic intervention. Once a diagnosis of BPD is reached according to the criteria of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the Clinical Manual abandons the clinician to his destiny: how is it possible to convert the identification of symptoms from a categorical-nosographic perspective into a therapeutic intervention that will not be compromised by the emotional-relational disturbances described above? In the history of borderline psychopathology, the nosographic phase (inaugurated in 1980 by the DSM-III) put an end to a pioneering, pre-nosographic first phase. The third historical phase, still on-going, has seen the attempt to introduce distinctions within such a complex and elusive clinical area: traits that remain stable over time have been distinguished from acute symptoms and the main core dimensions of the disorder have been identified. The most important of such dimensions are: impulsivity, identity diffusion, cognitive impairment and emotional instability^{14,15}. In particular, emotional instability plays a fundamental role because it is perhaps the best discriminant between borderline personality psychopathology and normality¹⁶. In what measure did (and does) psychopathology contribute to the understanding of the borderline condition? Its contribution should go beyond the description of the symptoms or the structural functioning of the disorder (as with Kernberg's model of Borderline Personality Organization) and, instead, should emphasise the lived experience and the lived world of the borderline person. Is it possible to highlight the subjective character of the experience, namely what it feels like to be a borderline person? Is it possible to develop at least a vague and problematic idea of the borderline person's perspective on himself, the others and the world? *What is it like to be a bat?* – Thomas Nagel asked in his famous 1974 essay¹⁷. The point was not to try and imagine what it would feel like *for us* to be a bat, but, rather, what it feels like *for the bat*. Similarly, we could ask what it feels like for a borderline to be a borderline. This question, however, implies a shift from the level of the description of the psychiatric symptom to the dimension of lived experience. The scope of this effort will be represented by the dysphoria and the dysphoria-rage sequence.

From emotional instability as a symptom to dysphoria as lived experience

The psychiatric literature has emphasised how emotional instability, emotional disorder and poor emotional

awareness are all aspects of the same pathogenetic core, which has strong and specific ties with the borderline symptomatology^{18,19}. The various, if not infinite, facets of the borderline personality psychopathology might well be just the superficial manifestation – in the context of relationships – of an instable and disordered emotional core, which functions as the true *driving force* behind the borderline existence.

Emotional instability, however, is a construct that needs clarification. What does emotional instability mean exactly? Koenigsberg²⁰ has shown that this label hides several different phenomena: sudden and rapid shifts from one emotion to another; high levels of emotional intensity; sudden eruptions of emotions; long recovery time to return to the state *quo ante*; high reactivity to interpersonal stimuli; unpredictability; dramatic display of emotions. The typical patterns of emotional instability are at least two: 1) strong reactivity to psychosocial stimuli; 2) mood fluctuations that develop autonomously. While this last pattern is typical of mood disorders, the first belongs specifically to the borderline area and consists of the three following additional elements:

a) Emotional specificity

Does the emotional instability typical of the borderline personality involve all emotions or is it limited to specific ones? The borderline emotional instability has no generic emotional features, but is emotion-specific, meaning that it generally concerns emotional states that fluctuate between fear and rage. Goodman et al.²¹ have identified the core of the borderline emotional instability in the oscillation between dysphoria and rage²²⁻²⁴ – an oscillation that is particularly sensitive to the variables that pertain to the interpersonal context. What happens here, then, is different from what happens with mood disorders, where the emotional instability, if present, is less dependent on the context and the fluctuations concern the polarities depression/euphoria, euthymia/depression, and euthymia/euphoria²⁵.

b) Dependence on the context

The borderline emotional instability is strongly dependent on the context (environmental, relational, interpersonal) and is characterised by a distinct reactive component. This resembles what has been called “interpersonal sensitivity”: an extraordinary sensitivity to detect flaws and imperfections in the relationship with others and the environment. Such sensitivity can detect even minor atmospheric changes. This reactivity is triggered primarily by negative stimuli (Gratz et al. 2010) and is not confined to occasional mood episodes, but, on the contrary, forms a constant element in the way the borderline personality functions. Some impulsive conducts develop on this

ground as an attempt to “cleanse” – at least momentarily – a state of permanent internal tension.

c) *Poor emotional awareness*

Emotional instability goes together with a scarce awareness of one's own emotions: confusion, dissociation, denial, avoidance and episodes of emotional cutting off are all typical features. Every process of emotional self-regulation presupposes some form of emotional awareness. An impairment of this function severely interferes with the process of feedback regulation of the intensity of emotions. In this way, in the borderline personality, emotions are experienced as autonomous physical and mental states that cannot be easily modulated, mitigated or oriented in one direction rather than another. In this condition, the person easily loses the sense of being the agent and source of his emotional states: the awareness that a particular emotion originates within the self, belongs to it and has much to do with it and with the vicissitudes of its internal and the external world, is lost. When the borderline patient is not able to see himself as an active agent, such emotional states start fluctuating like vague and menacing entities in search of a place to settle.

Together with poor awareness of his emotional involvement (which tends to be experienced as overwhelming), the borderline person has the ability to capture – with incredible sensitivity – micro-variations of the emotional atmosphere in the context of human relationships. Equipped with this sensitivity, he or she seems to look for objects, individuals or situations to which to “attach” his or her emotions, thereby trying to give such emotions a limited and therefore accessible meaning. This way, however, the objects end up playing the modulating function that the borderline lacks – as if the patient's wellbeing depended on what the object does (an object often charged with an overwhelming amount of responsibility). Every clinician who has dealt with a borderline patient is familiar with this kind of feeling. As one of such clinicians said: “Those patients make you feel worn out, they suck up your energy. They're like leeches: if you keep them on you, they suck your blood. If you take them off, they die”.

What is dysphoria?

What do we mean by dysphoria? ^{22 26-28} To what extent does dysphoria differ from, on one side, anxiety and depression and, on the other, from rage? In the psychiatric and clinical-psychological literature, the term “dysphoria” appears quite frequently. In the context of mood disorders, the term “dysphoria” is used mostly as synonymous of sadness, to indicate mild forms of depression (subthreshold) or to describe a mixture of negative and

unpleasant emotions: a kind of general dissatisfaction or a mixture of experiences of anxiety and depression that lack specificity ^{29 30}. In short, dysphoria is a so-called “as if” term: it is often used as *if* one could rely on some implicit shared meaning, so stable and reliable that there is no need to make it explicit. In order to better understand the nature of dysphoric mood, it is essential to describe its fundamental characteristics: one is a general characteristic, while the other three are specific.

From a *general* point of view, dysphoria is a mood condition that is experienced as unpleasant, uncomfortable, negative and oppressive, with all the features of mood states (an enduring state, devoid of an intentional object, unmotivated, rigid, difficult to articulate, encompassing the whole horizon of the subject and affecting his relationship with the world, the others and himself). In this sense, the term “dysphoria” indicates an emotional state that is hard to endure: while euphoria is an emotional state comparable to the feeling of wearing a comfortable dress that fits the body like a glove, dysphoria points to the exact opposite feeling. In this case, the subject experiences a state that, literally, does not suit him. This is the meaning of the term in many psychiatric conditions, where the subject experiences a state of uncomfortableness, distress and discomfort with respect to: 1) the body that it is forced to inhabit (gender dysphoria); 2) a body condition that hinders his life and must be dealt with (premenstrual dysphoria); 3) a feeling of unease and discomfort related to a sense of mental and motor awkwardness, which the patient sees as an effect of the intake of neuroleptics (neuroleptic dysphoria). In short, the mood condition typical of dysphoria has to do with the perception of something that is askew – something that went wrong and hinders one's life. Indeed, in dysphoria, *everything* goes wrong. It is difficult for most of us to imagine a condition in which this emotional state does not represent an isolated experience (whether temporary or transient), but, rather, a stable and enduring one. One of the best examples of dysphoric mood can be found in Herman Melville's *Moby Dick* ³¹. Ishmael – the narrating voice – is describing the kind of mood that periodically forces him to get to the sea:

“Call me Ishmael. Some years ago—never mind how long precisely—having little or no money in my purse, and nothing particular to interest me on shore, I thought I would sail about a little and see the watery part of the world. It is a way I have of driving off the spleen and regulating the circulation. Whenever I find myself growing grim about the mouth; whenever it is a damp, drizzly November in my soul; whenever I find myself involuntarily pausing before coffin warehouses, and bringing up the rear of every funeral I meet; and especially whenever my hypos get such an upper hand of me, that it requires a strong moral principle to prevent me from deliberately

stepping into the street, and methodically knocking people's hats off—then, I account it high time to get to sea as soon as I can”.

We could consider what Ishmael calls spleen and hypochondria as parts of the dysphoric mood state typical of the borderline person. However, insofar as he is able to identify his mood condition, to come to terms with it and also to find effective coping strategies, Ishmael has nothing of the borderline personality. In the borderline functioning, the subject, utterly incapable of recognising his discomfort, to make sense of it and to find a way to modulate it, is overwhelmed by what Ishmael is able to describe with such precision and, desperate to find ways to reduce the tension, is dragged into the abyss of impulsive actions, (step into the street and display aggressive behaviours, take drugs, develop self-harming behaviour, etc.). The pervasive mood condition that Ishmael describes as episodic is merely a fraction of the borderline condition, which is durable and devoid of an intentional object (in the sense that the subject cannot ascribe it to a specific situation). This condition dominates the borderline existence, an existence in which dysphoria envelops the subject like a thick fog.

Any attempt to imagine the dysphoric mood condition inevitably leads to a delimitation of it: our instinct is to provide it with some intention, some content and a specific reference, thereby explaining its manifestation by reducing it to a particular set of events. This is how a patient tried to describe the condition with which she had to cope every day: “It's like getting up in the morning and banging your toe against the bed!”. Those who are fond of *bricolage* will be reminded of a somehow similar situation: the screw that, under the pressure of the screwdriver, refuses to be driven vertically – or the nail that gets twisted on the first hammering. From then on, everything goes wrong. Not only is it almost impossible to straighten the nail, but any attempt to improve the situation leads to further disasters. The twisted nail becomes an obstacle to implementing the whole project of hanging a picture on the wall. Instead of a picture, there seems to be a bottomless pit on the wall. Each one of these examples, however, allows us to taste only a small portion of dysphoria, and does not portray dysphoria as a *general* mood. In the above examples, in fact, it is tempting to identify a triggering event (the bed, the screw, the nail) and focus all our attention on it. This way, however, the emotion, far from being experienced as something that permeates the world of the patient, is circumscribed, contained and explained.

In order to get an idea of what the dysphoric mood means for a borderline patient, we should think of a condition in which such an emotional state cannot be traced back and confined to the feelings experienced before a twisted screw or a hurt toe. Events such as these, if they ever

happened, must have fallen into oblivion: it is as if the toe, once and for all, had banged against the bed in some kind of primeval and forgotten condition, but the emotional experience related to this event had settled deep in the subject and conditioned his emotional barometer irreversibly. In dysphoria, so to speak, the name of the object went lost: what is left is only the background emotion. Detached from its possible objectual referents, this emotion expands in the air like a gas, poisoning the entire emotional life of the patient and overflowing into its relationships with the others.

Once the ties with its original source are lost, dysphoria becomes a pervasive, unintentional and unjustified emotion, thereby resulting as overwhelming, tormenting and inescapable. This condition becomes so unbearable and widespread that one is forced to look for an object (any object) to which to trace back one's mood in order to modulate and circumscribe it in space and time. In this sense, dysphoric mood is in permanent search of a twisted screw – and if the screw doesn't twist by itself, one can always lend a hand. In Florence, we have an expression for this particular condition: “What is it? Did you wake up *twisted*?” To be twisted or askew means to endure this painful condition. In dysphoria, however, it is not the screw that is twisted, but, rather, the mood itself. From this perspective, dysphoric mood is an emotional state close to depersonalisation: here the mood is not just the implicit and unproblematic background on which our experience as human beings rests; this tacit background has turned into a condition in which one's mood has lost its air of familiarity and has given way to a feeling of suspension and estrangement. This is one of the reasons why dysphoria is a state of discomfort.

The condition described by Zanarini et al.³² as “psychic pain” closely recalls, on the one hand, the general characteristics of the dysphoric mood and, on the other, some aspects of the sense of painful incoherence that Wilkinson-Ryan and Westen³³ identified as the essential component of the borderline personality disorder. This latter perspective, however, involves a shift from the level of emotions to that of personal identity (with respect to the outside world) or to the state of the self. This was one of the key points on which Clarkin et al.³⁴ based their analysis of the borderline constellation. Such a change in perspective, however, is likely to divert the attention from the level of pain and emotional involvement – a level that (insofar as mood is concerned) is *closer to the experience of both the patient and the clinician*, and is therefore essential to the therapeutic process. The clinician has to deal with a borderline patient and feels invariably affected, if not “flooded”, by the dysphoric mood. Such direct, less mediated and almost contagious aspect of dysphoria (conceived as mood) strongly calls for an analysis of dysphoria as one of the key elements of the

borderline condition – something that, clinically speaking, must be dealt with. A better understanding of both dysphoria as mood and the experiences that characterise it would surely prove very useful, whether one is facing a borderline patient or dealing with the mood condition normally triggered by the encounter with a borderline patient.

Alongside these general features, dysphoric mood is characterised by at least three specific elements: *tension*, *irritability* and *urge*.

a) *Tension* refers to a state of great inner tension, underlying bad mood, chronic and nameless unhappiness and widespread and tenacious discontent. It is like being permanently “on edge”, together with a tendency to anxiety, apprehension and intensification of reactivity and vigilance in a state of persistent *dysphoric alertness*.

b) *Irritability* refers to a state of constant and annoying underlying irritability, restlessness, worry and insistent anxiety. It is like a chronic and irritating thorn that torments the patient and gives him no respite: a general state characterised by aversion, unfriendliness and tendency to quick temper. The main attitude here is that of aversion towards the entire world: this renders the patient ill-disposed, irritated, distrustful - if not even suspicious – intolerant, resentful and hostile: “Rage – a patient clarified – rests on a cause. Me, I’m left with just rage, without any cause”. This dysphoric irritability expands across the board. Such an emotional condition is the mark of the psychopathology of the borderline personality and expresses itself in the form of an extraordinary sensitivity to relational vicissitudes and their atmospheric micro-disturbances³⁵.

c) *Urge* refers to an aspect of dysphoria that is characterised by a kind of impatience and intolerance that develops into an urge to action. This is a condition that precedes the discharge into action, as when, after a certain point, a loaded spring snaps, violently releasing all the stored energy. The action is always “violent”, not necessarily in the sense of physical violence, but rather in that of a great intensity of the emotions involved; the idea is that through action one will be able to shatter and break through the sort of shell one feels trapped in. The underlying fantasy is that of getting rid of such a shell through action. Action responds to the need of cleaning up, lowering the tension and the irritability, thereby somehow modulating the dysphoric mood state. This element of dysphoria has strong connections with rage: it is the outcome of the oscillation between dysphoria as mood and rage as an affect. The emotional urge must find a relief valve – it doesn’t really matter how: “*I cut myself, I take drugs, I get a fix...I skip a red light, I insult a traffic warden, I punch in the face the first person I bump into... in other words, I just do something!*”. The important thing is to stop, at least for a moment, the dysphoric agony. From

this point of view, it is as if at this stage the borderline patient is searching for a twisted screw that can serve as a target for his rage and as an explanation of his suffering – and most of the time the patient does find such screw.

Precisely because dysphoria as a mood cannot be easily modulated, the only possible modulation is sought outside of the mind, on the surface of a body on which to inscribe one’s own emotional state. Borderline self-harm is a way to find relief from the torment of inner tension. The self-inflicted lesion of the skin provides a temporary oasis of peace and relaxation. It is a way to take a rest from dysphoria. This relief, however, can also be achieved by targeting the outside world, that is, by acting on the environment and transforming it even with violence. For example, to ruin and destroy things, to create a messy and deteriorated environment around oneself may be a way to try to lower the inner tension and irritation by using the environment as a regulating mechanism: such inner tension and irritation are experienced when one has to acknowledge the difference between the drama that unfolds internally and the indifference, the tranquillity, or (even worse) the beauty of the surrounding environment. In one of the very few studies that have tried to give a specific connotation to dysphoria, Starcevic³⁶ has divided the additional secondary features characterising dysphoria as a mood into two groups: the first is a cognitive type and the second a behavioural one. The features included in the first group range from a tendency to suspiciousness and to blame others to feelings of bitter disappointment and injustice, which can easily turn into genuine paranoid ideas. Such a cognitive structure organises itself around a “borderline attributional style”³⁷ – an idiosyncratic style, made of malevolent expectations towards the world and human relationships and directed primarily to the immediate satisfaction of one’s needs.

The behavioural features of dysphoria, on the other hand, concern the dimension of impulsivity and actions: these actions are generally parasuicidal and are aimed mainly at “naming” and “localizing” dysphoria. One example of such behaviour is the attempt to engrave, so to speak, dysphoria on one’s own skin by engaging in self-mutilation acts such as incisions, cuts, burns, etc. Precisely because dysphoria as a mood is scarcely flexible, the only chance of modulating it – as we have already noted – can only be sought on the outside. The cutting/burning of the surface of the body, in fact, is systematically described by self-mutilators as a way to alleviate the torment of dysphoria: this appears to be the borderline way to take a rest from dysphoria. The high levels of *harm avoidance* and *novelty seeking* detected by Korner et al.³⁸ and Cole et al.³⁹ in their studies of borderline patients strongly challenge the idea that the aim of self- and hetero-destructive behaviours is simply to inflict pain and cause damage to oneself or others. On the contrary – and paradoxically –

even when the behaviour clearly appears harmful to the subject, the goal is to avoid greater damage. In the words of a self-mutilating patient: "It is like staunching one kind of pain with another kind of pain".

Tension, irritability and urge are just *static* characteristics of dysphoric mood. To complete the picture, we should visualise them within a dynamic progression that structures itself as a real sequence. Such a "dysphoric sequence" might progress from an inner psychological condition (*tension*) to a condition that surfaces on the skin, which is perceived as a shell for the self and as a membrane that functions as a contact point with the world (*irritability*); finally, the subject can reach a state of dysphoric aversion towards the world, the environment, the relationships and even the skin (*urge*). The product of the dysphoric sequence, however, can take at least two different forms: a disorganising one and an organising one. The first form (*disorganising*) coincides with a state of disorganisation and confusion with respect to personal identity. This is the basic condition of borderline psychopathology described by Kernberg as identity diffusion. Tension, irritability and urge cannot break down the dysphoric mood so to structure it and orient it towards a specific object. On the contrary, the mood condition intensifies and leads to a disorganisation of the self by a "centrifugal" effect⁴⁰. Such state of disorganisation does not belong just to the patient, but can also affect the clinician in the therapeutic relationship: this might give the clinician serious trouble or force him or her to try to "organise" the dysphoric sequence. Such an organisational attempt often results in acts that are symmetrical to those of the patient, which in turn leads to the expulsion of the patient and breakdown of the relationship. On the other hand, however, the state of disorganisation can represent a guiding tool in the therapeutic relationship. In the fluctuations of one's *own* sense of identity occurring during sessions, Searles⁴¹ sees an important and unexpected source of data to understand what is happening in the therapeutic relationship, so much as to propose to use this as a sort of clinical organ of perception.

In the second form (*organising*) of the dysphoric sequence, instead, we see – downstream of the dysphoric aversion – a behaviour that possesses a specific content or an emotional condition characterised by a dominant affect: fear or rage. Self-mutilating behaviours^{42 43} represent a typical expression of this organising mode. By means of a precise ritualisation, these behaviours position dysphoria into a behavioural circuit that has a constant effect: invariably, the skin lesion leads to a state of lowered tension. It is a momentary oasis of peace. The act of providing dysphoria with a shape by means of an objective, concrete and visible skin lesion allows a kind of "emotional discharge to the ground". In the words of a patient: "There was such tension inside my head – it is so strong that it goes away

only if I do something bad, like cutting myself [...]. For me, cutting is the only medicine". The cuts are a way to stop a dysphoric state of mind: "The cuts – another patient says – are my air vent". Cutting the flesh represents an attempt to modulate or staunch a dysphoric mood condition, precipitating dysphoria in a place that has a name, is concrete, visible, objectifiable, delimited and also "curable". Another organising sequence takes place when an affect gains a prominent position, imbuing the entire emotional field. The emotional field verticalises itself and takes on an "affective" character, orienting itself toward a specific object. An object is recognised by an affect and becomes the focus of the patient's rage or fear.

From dysphoria to rage

Along this path, the oscillation between dysphoria and rage occupies a privileged position. Kernberg^{44 45} has tried to sum up the main functions of rage, from the most primitive to the most evolved:

1. eliminate a source of irritation or pain by means of a violent reaction;
2. remove an obstacle to gratification;
3. restore – by an extreme and desperate attempt – a sense of autonomy in the face of very frustrating situations, trying to recreate a state of narcissistic equilibrium;

The first two functions gravitate around an object that acts as a "source" of pain or as an "obstacle" to gratification. In this sense, rage – unlike dysphoric mood – presupposes the identification and focalisation of an object as a target for one's own arrows. The third function identified by Kernberg, instead, concerns the self and the effect that rage has on the state of the self. Keeping in mind these three different functions, I would like to try to characterise rage as an affect as opposed to dysphoria as a mood by taking into account the following areas:

a) Rage and the object

What is the best way to elicit the characteristic rage of the borderline person? According to Adler⁴⁶, this can be achieved by not playing a holding function (or by not playing it at a particular moment with the required intensity). Rage is the way the borderline patient responds to every fracture or even micro-fracture of empathy: rage emerges when the patient feels that the person in front of him or her is not willing to perform the function he or she is in desperate need of. Each affect that – as such – has an object, is intentional and motivated. In a state of rage, the object is clearly visible, strongly characterised and stands out very distinctively. Such an object is certainly far from being vague, blurred and confused, nor are its features difficult to focalise. To get angry with someone (or with

something) means to make the object present, to take it out of ambiguity and to delineate some of its features very clearly: these are negative features that work as “handles” to which rage clings to. In this sense, rage allows one to switch from the state of dispersion and “centrifugal force” typical of dysphoric mood (where the object’s outlines and features are blurred, vague and ambiguous), to a condition in which the boundaries and characteristics of the object stand out with great clarity.

The rage-affect has a “centripetal” role: it coagulates emotional dispersion by identifying, in each occasion, an object/interlocutor. All those vague emotions that floated around in dysphoric mood converge and plunge on such an object. Now those emotions have an interlocutor – somebody (or something) who can be held accountable for what happens at that particular moment, but also for *everything* else that happened in the past – and the list of the unpaid debts is huge. This explains the violence with which the object is invested with rage and the feeling that, in each occasion, everything is at stake, as if it were a matter of life or death. Dysphoria turns into rage each time it can be directed towards a specific object that has been identified as the source and cause of one’s suffering. In this sense, dysphoria resembles a widespread and unsaturated magmatic state in search of an object on which to converge. Instead of getting lost inside a dysphoric cloud, rage hunts out the object, forces it out of a state of vagueness, inconsistency and anonymity and turns it into the target of a sniper rifle. This is also how the clinicians and healthcare workers feel when they become the target of borderline rage: they feel loaded with an amount of responsibility that often exceeds their understanding and ability to endure.

b) Rage and hope

At some level, the expression of rage implies the existence of a dimension of hope. In other words, it implies the belief that under the blows of rage, the object, the environment, or reality itself can react and respond to the violence of the stimulus, thereby gaining the role it had never played or had lost. Rage, therefore, is not resignation or annihilating despair; rather, it is a desperate vital reaction that presupposes both an interlocutor to be held accountable and the possibility of a response. At the same time, rage also plays a defensive role with respect to the pain caused by the separation and the irreparability of the loss: a mind kept busy by angry fantasies somehow is still clinging to what it has lost.

c) Rage and the self

Rage makes the object present and allows a clear focalisation of it, but, at the same time, it consolidates and gives consistency to the self. As the rage-affect gains ground,

the object of rage stands out as the true cause of pain, while the subject adopts a clear and consistent accusatory role towards such an object and focuses on what it perceives as its faults. At the same time, this unambiguous focalisation of the object gives the subject the chance to perceive his own self as cohesive and, to some extent, as powerful. From this point of view, rage clarifies things and gives them consistency: in this state, the person presumes to see things clearly and to know the reasons of his suffering. These reasons are identified in a precise object that is held responsible for his condition. The transition from dysphoria to rage contributes to preserving or recovering a precarious cohesion of the self. Edward Bunker⁴⁷, who spent most of his life in jail, describes how, when a man has no other identity left, the ability to arouse fear in the others succeeds at least in fulfilling his need for one. The chance to observe the effect of one’s own rage on another person can contribute to the development of this sense of increased vitality and cohesion too. To the extent that I am able to scare others, I am and exist as an acting and powerful subject.

d) Rage and authenticity

Rage does not only clarify the outlines of the object and gives the illusion of having identified it as the source of all evil: it also reaches for the object, shakes it and subjects it to a great stress. This way, rage verifies the true nature of the object – it is a bit like when a child, smashing a new toy on the ground, tries to see how it is really made and what its true inner nature is. In a very similar way, borderline rage brings the object out of the shadow, opens it like a can opener would do and forcibly extracts its true nature. This is a sort of load test whose aim is to see how the object reacts under pressure and stress: it is a bit like what happens in those stress-tests made to test the soundness of banks. The intention here is to test the soundness of the other person, but also to lay bare the true features of him or her. As if only by putting people in a traumatic situation can one see how they really are. In order to see what the other person is made of and “bring the soul out of him”⁴⁸, the borderline patient needs to see the other bleeding. Touching on this issue, Stone⁴⁹ writes: “Borderline patients reduce us to our final human common denominator”. They force us to go beyond our defensive asset in order to see what we are really made of, what we are as people. In a way, they peel us like onions.

Conclusions

In conclusion, we can say that while dysphoria is characterised by a mood condition where the subject falls prey to the mists of an all-pervasive and all-assimilating mood (a mood that absorbs both the subject and the other), rage

as an affect leads to a clarification of the situation: the object emerges as what is responsible for one's suffering and the self gains cohesion by facing such object. In this sense, rage helps to dispel the fog and allows to better focalise both oneself and the other.

Borderline emotional functioning seems to be rooted in the need to modulate the vagueness of dysphoric mood (a mood that envelops the person like a *crust*, influencing his vision of the world, his perception of the self, the others and his relationships), and to avoid this condition by focusing its emotions on an affect (rage) that identifies, from time to time, an object to be held responsible. The borderline existence, therefore, is in constant search, in the context of its relationships, for an object to be held accountable – which means accountable *for everything*. In a temporality dominated by the absorption in the immediacy^{50,51}, where only the present moment counts, the transformation of dysphoria into rage always gives the patient the illusion that the tangle of relationships which the borderline subject has always inhabited (perhaps starting with a traumatic childhood) has been unravelled. Years ago, Akiskal argued – a bit cynically – that “borderline” was an adjective in search of a name. A few decades later, we can rather say that to be a borderline means to experience a condition of “being obliged to be”, tormented by a *mood in constant search for an affect*, in the vain attempt to get rid of a bad mood that comes from far away.

Conflict of interest

None.

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