Justification for Separating Schizotypal and Borderline Personality Disorders*

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Abstract

Siever and Gunderson (1979) have questioned the decision to separate Schizotypal Personality Disorder from Borderline Personality Disorder in DSM-III. The justification for this separation rests not on genetic evidence, but rather on the relative independence of the behavioral characteristics of two dimensions that up to now have both been referred to with the appellation "borderline." We believe that this separation provides the tools with which investigators may usefully study the interaction of genetic and environmental factors as they relate to personality and the major psychiatric disorders. The benefits of this separation are already apparent in that research investigators are now using two terms to describe different phenomena, when previously they were using the single term borderline. Proposed diagnostic criteria for Schizotypal Personality Disorder and Borderline Personality Disorder are appended.

Just as physicians are cautioned, above all, do no harm to your patient, so too, any contributor to the diagnostic morass of the literature on borderlines should do his best to clarify rather than obfuscate. It is therefore a serious charge that Siever and Gunderson (1979) make regarding our foray into the heartland of the borderline literature when they state that the separation of Schizotypal Personality Disorder from Borderline Personality Disorder in DSM-III has "complicated scientific problems and could have serious ethical problems as well" (p. 83). We therefore appreciate having been given the opportunity to respond to their article. Appendices 1 and 2 present the text and criteria as they appear in the 1/15/78 draft of DSM-III.

The article by Siever and Gunderson can be conveniently divided into two parts. The first reviews the very complicated literature dealing with data relevant to "the possibility that borderline conditions have significant genetic determinants" (p. 59). We do not question their conclusion that the available data indicate that only some patients characterized as borderline appear to share genetic determinants with Chronic Schizophrenia. The second part of their article discusses the diagnostic implications of these findings and critically assesses what is purported to be our approach to this complicated problem.

The authors state, "Spitzer, Endicott, and Gibbon (1979) have argued that borderline patients who share genetic determinants with chronic schizophrenics should be made a distinct diagnostic category 'Schizotypal Personality Disorder'" (p. 82). Not true! This statement misrepresents our position in several ways. First of all, it implies that we have asserted that there is a strong genetic linkage between the group of patients with Schizotypal features and those with Chronic Schizophrenia. This is not the case. In our article (Spitzer, Endicott, and Gibbon 1979), we stated that "the apparent genetic relationship of schizotypal personality to chronic schizophrenia is still controversial" (p. 24). Secondly, in both the article

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and the DSM-III Personality Disorders section, we explicitly avoided any implication that the so-called “Personality Disorders” represent mutually exclusive and distinct diagnostic categories. For that reason we have argued that both Schizotypal and Borderline Personality Disorders are best conceptualized as independent dimensions of personality that can coexist within the same individual rather than as mutually exclusive diagnostic entities.

So that the reader can understand our position, it is necessary to review briefly our own work in this area (Spitzer, Endicott, and Gibbon 1979) and the options that we believe are available. The reader can then determine whether the approach that we have taken will aid or impede future work in this area.

We started with the unfortunate fact that despite a large literature on various borderline conditions, no consensus had yet emerged as to the defining diagnostic criteria. It appeared to us from reviewing the literature that there were two major ways in which the term borderline was currently being used. The first referred to a constellation of relatively enduring personality features of instability and vulnerability. Examples of this use of the concept are reflected in the writings of Gunderson and Singer (1975) on the Borderline Patient, and Kernberg (1967) on Borderline Personality Organization. The second major usage was to describe patients with certain psychopathological characteristics reminiscent of residual schizophrenia and believed by some to be genetically related to a spectrum of disorders that includes Chronic Schizophrenia. This was exemplified by Kety, Rosenthal, and Wender’s use of the term “Borderline Schizophrenia” in their series of adoption studies (Kety et al. 1971; Rosenthal et al. 1971).

Our goal was to derive diagnostic criteria for these two major uses of the concept and to study the relationship between them in order to determine whether a single diagnostic category would be sufficient or whether two or more were warranted in DSM-III. Two item sets were developed through a series of studies that will be briefly summarized. The item set that was later designated Schizotypal was derived by reviewing the case records of cases diagnosed by Wender, Kety, and Rosenthal as being within the Schizophrenia spectrum as defined by them. Eight items were finally selected that were able to correctly identify such cases without misidentifying cases judged to be outside of the spectrum. The item set that later was used to define Borderline Personality Disorder was developed initially by reviewing the literature and consulting with a number of investigators working in this area, including Drs. John Gunderson, Michael Sheehy, Michael Stone, Donald Rinsley, and Otto Kernberg. This process resulted in nine items that were then applied to patients at the New York State Psychiatric Institute who had been given a diagnosis of Borderline Personality Organization by either Dr. Kernberg, then the Director of the General Clinical Service, or one of the senior psychiatrists on his service. This item set was able to correctly identify such patients without misidentifying a control group with other diagnoses.

Three major questions were still unresolved: (1) How well would the item sets identify patients diagnosed as Borderline by a large sample of psychiatrists as distinguished from patients diagnosed as having a non-Borderline diagnosis? (2) Do the two item sets describe relatively independent dimensions that characterize patients diagnosed as having a Borderline disorder? (3) If there are two relatively independent dimensions, to what extent are they mutually exclusive?

To answer these questions, a questionnaire was developed that used the two sets of items as well as five additional items thought to be related to the Borderline concept. The 22 items were intermingled and all were in a true-false format. The questionnaire was completed by 808 out of 4,000 psychiatrists who were randomly selected from the membership of the American Psychiatric Association. Each psychiatrist was asked to describe two adolescent or adult patients whom he knew well. The first was to be one judged to warrant a diagnosis of either Borderline Personality, Borderline Personality Organization, or Borderline Schizophrenia. The second patient was to be a control in that the patient should be moderately to severely ill but not have a diagnosis of a psychosis or any of the Borderline categories.

Two factor analyses were performed. The first involved the 808 Borderline patients only; the second involved the combined sample of 1,616 Borderline and Control patients. In each case, two factors were rotated to test the hypothesis that the two item sets described two separate and relatively independent dimensions. With only a single exception, all of the Schizotypal items loaded on factor II, and the Borderline items loaded on factor I. When the factor analysis for the total sample was rotated for five
factors, the first two factors continued largely to describe the Borderline and Schizotypal dimensions.

The internal consistency coefficient, a measure that reflects the degree to which an item set measures a unitary dimension, was determined for each item set. Although the internal consistencies for the two item sets were only .54 (Schizotypal) and .58 (Borderline), the internal consistency of the combined sets was only .57 in spite of the large increase in the number of items. The lack of an increase for the combined item set is further support for the appropriateness of two measures rather than a single measure of the Borderline concept.

The sensitivity and specificity of the two item sets were tested applying various cutoff scores to determine the best discrimination between patients with a clinical diagnosis of one of the Borderline categories as applied by the clinicians, and patients with a non-Borderline diagnosis. Using the cutoff score of at least four items out of eight for the Schizotypal set, and at least five items out of eight for the Borderline set, high sensitivity and specificity were achieved. (The ninth item from the original set, “Work history or school achievement unstable or below expected on the basis of intelligence, training or opportunities,” was dropped because on a discriminant function analysis it had a stronger relationship to the clinical diagnosis of Borderline Schizophrenia than to Borderline Personality.)

The relationship between the two item sets was determined by several procedures. Although more than half of the patients diagnosed as some type of Borderline by the clinicians met the criteria for both item sets, the correlation between the two item sets was actually .06, indicating that within a group of Borderline patients the two item sets are independent and not mutually exclusive. We also discovered an interesting fact: When the Control patients were added, so that the proportion of Borderline to Control patients is equal, the correlation rises to .52. This indicates that although the two item sets are independent when limited to patients with a diagnosis of Borderline, there is a substantial correlation in a more heterogeneous group. This mathematical necessity may explain the perception of some investigators that the Borderline phenomena are unitary.

Siever and Gunderson have not questioned these findings. In fact, they seem satisfied that the Schizotypal item set adequately describes some of the subjects who are genetically related to Chronic Schizophrenia and that the Borderline item set adequately describes the patients characterized by Gunderson and Singer as Borderline Personality Disorder. What is at issue is our having elevated the Schizotypal features to the level of a separate diagnostic class. Siever and Gunderson (p. 82) argue that the justification for doing this should rest on (1) the ability to show that “people with schizotypal characteristics can be discriminated from patients with borderline personality disorder” and (2) demonstration that “such people have a clearly defined genetic relationship to chronic schizophrenia.”

The first argument assumes that the characteristic Personality Disorders that have traditionally been included in the psychiatric classification represent mutually exclusive categories and that it is therefore reasonable to require a similar demonstration for a newly proposed category. As indicated in the introduction to the DSM-III Personality Disorders section, “By tradition, in diagnosing Personality Disorders, the clinician is directed to find a single specific Personality Disorder that adequately describes the individual’s disturbed personality functioning. Frequently this can be done only with difficulty since many individuals exhibit features that are not limited to a single personality subtype. In this manual, diagnoses of more than one Personality Disorder may be made if the individual meets the criteria for more than one.”

We believe it is quite likely that the kind of overlap between what we have termed Borderline Personality Disorder and Schizotypal Personality Disorder exists for many of the Personality Disorders. For example, it is well known that Narcissistic, Histrionic, and Dependent Personality features overlap considerably. Furthermore, Kernberg has argued that certain personality types—in particular, Narcissistic, Infantile, and Antisocial—frequently meet his criteria for Borderline Personality Organization.

Siever and Gunderson apparently believe that Gunderson’s criteria for Borderline Personality Disorder (Gunderson and Kolb 1978; Gunderson and Singer 1975) are more restrictive than those of Kernberg’s Borderline Personality Organization. They also believe that since Gunderson’s criteria require evidence of a tendency to brief losses of reality testing and psychotic-like experiences, there would not be much overlap with other personality diagnoses. Although they may be correct in both regards, we do not
believe that Gunderson has presented data in which both Kernberg’s psychostructural criteria and those of Gunderson have been used on the same group of patients. Neither do we believe he has conducted studies examining how often patients diagnosed according to Gunderson’s criteria as Borderline Personality do not also meet the criteria for another specific Personality Disorder, such as Hysterical Personality, Narcissistic Personality, and Masochistic Personality.

Siever and Gunderson’s (p. 82) clearly defined second assumption, that it is necessary to demonstrate a “genetic relationship to chronic schizophrenia” before establishing a separate category for Schizotypal Personality Disorder, is certainly not held by us. We believe, as do the authors, that the evidence for the genetic relationship between Schizotypal features and Chronic Schizophrenia is suggestive rather than proven. We have also acknowledged (Spitzer, Endicott, and Gibbon 1979) the suggestion of Stone (1978) that some of the patients with our Borderline Personality Disorder diagnosis may be related genetically to Affective Disorder. What is at issue is whether the separation of the two sets of diagnostic criteria into two separate categories will help or hinder the clarification of these issues and possibly of treatment issues as well.

Given the data, let us examine the options that are available. The first option would be to continue the current state of affairs in which the term Borderline is used to refer to patients characterized either by both sets of behaviors or predominantly by one or the other. Surely this can only prolong the confusion that has plagued the interpretation of research findings. The alternative option would be to use the term Latent or Borderline Schizophrenia within the Schizophrenia section of DSM-III for patients with the features that we have labeled Schizotypal. We agree with the authors that the genetic evidence is not sufficiently strong to justify such a categorization. For this reason, the category of Latent or Borderline Schizophrenia is not included in DSM-III and the term Schizotypal Personality Disorder is used in a purely descriptive sense signifying that patients with this diagnosis have clinical features that resemble some of the features of patients with prodromal or residual Schizophrenia.

The reader will be interested in the history of how we finally arrived at the two terms Schizotypal and Borderline Personality Disorders. After some persuasion, the Wender, Kety, and Rosenthal group acknowledged the potential advantages of their giving up the term Borderline and adopting the term Schizotypal. Initially we suggested that the term Unstable Personality Disorder be used for the other dimension and argued that the term Unstable was appropriate because of the lack of stability in affect, interpersonal relations, identity, and social functioning. However, the Borderline Personality mavens were persuasive in arguing that (1) the term Unstable was not suitable because it suggested that the Personality Disorder was unstable when in fact it was the opposite and (2) if DSM-III insisted on using Unstable Personality Disorder, they predicted that clinicians would merely continue to use the Borderline term and ignore DSM-III because of the vast literature on Borderline Personality that referred predominantly to individuals with the clinical features covered by our term Unstable.

It should also be noted that the concept of Schizotypal Personality Disorder is merely a subdivision of what has for years been referred to as Schizoid Personality Disorder. In DSM-III, the Schizoid Personality Disorder is divided into Schizotypal, for individuals with odd cognitive and perceptual features, and another category (probably to be called Schizoid without modification), for individuals with a defect in the capacity to form social relationships, a history of extreme social isolation, and bland or constricted affect but without any of the Schizotypal cognitive or perceptual features. Most clinicians seem to believe that such a distinction within the group formerly called Schizoid makes good clinical sense and has obvious advantages for research.

Siever and Gunderson also argue that Schizotypal Personality Disorder is not a true personality type because it is largely symptom oriented in the cognitive sphere. This raises the interesting question of what is a Personality Disorder. In the DSM-III introduction to this section of the classification, Personality Disorders are defined as “deeply ingrained, inflexible, maladaptive patterns of relating to, perceiving, and thinking about the environment and oneself that are of sufficient severity to cause either significant impairment in adaptive functioning or subjective distress.” It is not at all clear why the idiosyncratic styles of thinking, perceiving, and relating to the world of individuals with many Schizotypal features does not constitute a Personality Disorder.

The authors imply that their concept of Borderline Personality is
a unitary personality type. As already noted, Kernberg (1967) specifically refers to Borderline Personality Organization as applying to several different personality styles or disorders. In addition, we have data indicating that a large proportion of patients who meet our criteria for Borderline Personality (which Siever and Gunderson evidently feel are similar to Gunderson's) have at least one clinical feature that is incompatible with one of Gunderson's criteria. Fifty-six percent of the 606 patients judged clinically to have a Borderline diagnosis and who met the Borderline Personality Disorder item set criteria were judged by the clinician to have "Social isolation, e.g., no close friends or confidants, social contacts limited to essential everyday tasks." This contrasts with Gunderson and Kolb's (1978, p. 795) statement that the "intense attachments of borderline patients are characterized by instability." It also contrasts with one of the characteristics found by Gunderson and Kolb (1978, p. 795) to best discriminate borderlines from other diagnostic entities: "Borderline patients were definitely not socially isolated ('loners') and were, in fact, intolerant of being alone, i.e., compulsively social."

As is evident from Siever and Gunderson's initial statement, they view "an enduring tendency to brief losses of reality testing and psychotic-like experiences" (p. 60) as a requirement for the diagnosis of Borderline Personality. Yet we do not believe that in Gunderson's studies (Gunderson and Kolb 1978; Gunderson and Singer 1975) on the characteristics of Borderline Personality patients diagnosed according to his criteria, he has demonstrated that such losses of reality testing or other psychotic-like experiences are always present. Rather, he has demonstrated that such experiences are more common in Borderline than in non-Borderline groups. This, of course, is not the same as demonstrating their presence in all Borderline Personality patients. The issue is of some importance since we do not believe that as the term Borderline Personality is currently used by most clinicians, it is an absolute requirement that there be episodes of impaired reality testing or psychotic-like experiences. If Siever and Gunderson are using the term "tendency" to mean either the past occurrence or likely future occurrence of such episodes, this should be clarified.

Related to the issue of whether or not our Schizotypal Personality Disorder is best conceptualized as a personality disorder, Siever and Gunderson state that neither Kety et al. (1971) nor Spitzer, Endicott, and Gibbon (1979) have studied other characteristics of individuals with Schizotypal features, such as "interpersonal relations, impulsivity, and social adaptation" (p. 79). We agree that these features may not have been attended to by the interviewers who assessed the subjects in the studies of Kety et al. In fact, in our article (Spitzer, Endicott, and Gibbon 1979), we raised the possibility that "the interviewers were not asking for or noting such behaviors [Borderline Personality features] because they were focusing on mild schizophrenic-like symptoms" (p. 24). However, we included three items in the questionnaire that related directly to "interpersonal relations, impulsivity, and social adaptation." What we found is that these items had an essentially zero loading on the Schizotypal factor and all loaded on the Borderline factor.

The authors raise the specter of "serious ethical problems" in labeling patients with the diagnosis of Schizotypal Personality Disorder in the absence of "significant functional disorder." We do not know what level of severity of impairment they would consider sufficient to justify a diagnosis of a mental disorder. Just as there are mild disorders in other medical fields, so too, in psychiatry not all mental disorders are disabling. We do acknowledge the distinction between personality traits and a personality disorder. However, we believe that any person who has at least four of the Schizotypal items which are "characteristic of the individual's long-term functioning and are not limited to episodes of illness" will have significant impairment in adaptive functioning which would justify the application of a psychiatric label. Do the authors propose that the diagnosis of Borderline Personality requires gross incapacity or severe functional impairment?

References


Kety, S.S.; Rosenthal, D.; Wender, P.H.; and Schulsinger, F. Mental illness in the biological and adoptive


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*State Trends in Resident Patients—State and County Mental Hospital Inpatient Services. *Statistical Note No. 150, June 1978.
Appendix 1

DSM-III Draft of Schizotypal Personality Disorder
(1/15/78)

The essential features are various oddities of thinking, perception, communication and behavior, but never severe enough to meet the criteria for Schizophrenia. No single feature is invariably present. The disturbance in thinking may be expressed as magical thinking, ideas of reference, or paranoid ideation. Perceptual disturbances may include recurrent illusions, depersonalization, or derealization (not associated with panic attacks). Often there are marked peculiarities in communication; concepts may be expressed unclearly or oddly, words being used deviantly, but never to the point of derailment (loosening of associations) or incoherence. Frequently, but not invariably, the behavioral manifestations include social isolation and constricted or inappropriate affect that interferes with rapport in face-to-face interaction.

Associated Features

Frequently, there are varying admixtures of anxiety, depression, and other dysphoric moods. Often there are features of Borderline Personality Disorder, and in some cases both diagnoses may be warranted. Because of peculiarities in thinking, such individuals are prone to eccentric convictions, such as bigotry and various fringe religious beliefs.

Impairment

Often there is some interference with social or occupational functioning.

Complications

There may be brief periods of bizarre behavior or oddities of thinking which approach delusional proportions. Short-lived psychotic episodes may occur and should be noted as additional diagnoses, such as episodic Schizoaffective Disorder, Schizophreniform Disorder, Brief Reactive Psychosis, Atypical Psychosis, and Paranoid State. Adjustment Disorders frequently occur as superimposed conditions. If the psychosis is of sufficient duration and has the other features that justify a diagnosis of Schizophrenia, this Personality Disorder diagnosis is not made.

Prevalence and Sex Ratio

No information available.

Familial Pattern

There is some evidence that Chronic Schizophrenia is more common among family members with the disorder than among the general population.

Differential Diagnosis

Schizotypal Personality Disorder is distinguished from Introverted Personality Disorder and Avoidant Personality Disorder by the presence of the oddities of behavior, thinking, perception, and communication that are only present in Schizotypal Personality Disorder. Frequently individuals with Schizotypal Personality Disorder also meet the criteria for Borderline Personality Disorder. In such instances, both diagnoses should be given.

Diagnostic Criteria

The following are characteristic of
the individual’s long-term functioning and are not limited to episodes of illness.

A. At least four of the following are required:

1. Magical thinking, e.g., superstitiousness, clairvoyance, telepathy, “sixth sense,” “others can feel my feelings.”

2. Ideas of reference, self-referential thinking.

3. Social isolation, e.g., no close friends or confidants, social contacts limited to essential everyday tasks.

4. Recurrent illusions, sensing the presence of a force or person not actually present (e.g., “I felt as if my dead mother were in the room with me”), depersonalization, or derealization not associated with panic attacks.

5. Odd communication (not derailment [loose associations] or incoherence), e.g., speech that is tangential, digressive, vague, over-elaborate, circumstantial, metaphorical.

6. Inadequate rapport in face-to-face interaction due to constricted or inappropriate affect, e.g., aloof, distant, cold.

7. Suspiciousness or paranoid ideation.

8. Undue social anxiety or hypersensitivity to real or imagined criticism.

B. Does not meet the criteria for Schizophrenia.

Special Report: Schizophrenia

Single copies of Special Report Schizophrenia 1976 by Samuel J. Keith et al. are available free of charge from the Center for Studies of Schizophrenia. Multiple copies will also be supplied to requesters who wish to use the report for teaching purposes. The 58-page booklet summarizes recent research in schizophrenia, with special emphasis on work carried out by investigators who have received grant support from the National Institute of Mental Health. The major research areas covered in the report are Diagnosis, Genetics, Biology, Psychophysiology, Psychological Functioning, Family Studies, Studies of Populations at High Risk, Childhood Psychoses, Borderline Conditions, and Treatment. Requests for the report should be addressed to the Center for Studies of Schizophrenia, National Institute of Mental Health, 5600 Fishers Lane, Rm. 10C-26, Rockville, MD 20857.
Appendix 2

DSM–III Draft of Borderline Personality Disorder (1/15/78)

The essential feature is instability in a variety of areas, including interpersonal relationships, behavior, mood, and self-image. No single feature is invariably present. Interpersonal relationships are often intense and unstable with marked shifts of attitude over time. Frequently there is impulsive and unpredictable behavior that is potentially physically self-damaging. Mood is often unstable with marked shifts from normal mood to some dysphoric mood or with inappropriate intense anger or lack of control of anger. A profound identity disturbance may be manifested by uncertainty about several issues relating to identity, such as self-image, gender identity, long-term goals, or values. There may be problems in tolerating being alone, and chronic feelings of emptiness or boredom.

Associated Features

Frequently there are many features of Schizotypal and Histrionic Personality Disorders, and in some cases more than one diagnosis may be warranted. Quite often there is social contrariness, and a generally pessimistic outlook. Vacillation between dependency and self-assertion may contribute to the impulsive and quixotic emotionality.

Impairment

Often there is considerable interference with social or occupational functioning.

Complications

There may be brief periods of bizarre behavior or oddities of thinking that approach delusional proportions.

Short-lived psychotic episodes may occur and should be noted as additional diagnoses, such as Schizoaffective Disorder, Schizotypal Disorder, Brief Reactive Psychosis, Atypical Psychosis, and Paranoid State. Adjustment Disorders and Major Depressive Disorder may occur as superimposed conditions.

Predisposing Factors

No information is available.

Prevalence and Sex Ratio

The prevalence is not known, but the disorder may be fairly common. It is more commonly diagnosed in women.

Familial Pattern

No information is available.

Differential Diagnosis

Frequently individuals with this disorder will also meet the criteria for Schizotypal or Histrionic Personality Disorder. In such instances, multiple diagnoses should be given.

Diagnostic Criteria

The following are characteristic of the individual’s long-term functioning and are not limited to episodes of illness. At least five of the following are required:

1. Impulsivity or unpredictability in at least two areas that are potentially self-damaging, e.g., spending, sex, gambling, drug or alcohol use, shoplifting, overeating, physically self-damaging acts.
(2) A pattern of unstable and intense interpersonal relationships, e.g., marked shifts of attitude, idealization, devaluation, manipulation (consistently using others for one's own ends).

(3) Inappropriate intense anger or lack of control of anger, e.g., frequently loses temper, always angry.

(4) Identity disturbance manifested by uncertainty about several issues relating to identity, such as self-image, gender identity, long-term goals or career choice, friendship patterns, values, and loyalties, e.g., "Who am I?"; "I feel as if I am my sister when I am good."

(5) Affective instability: marked shifts from normal mood to depression, irritability, or anxiety, usually lasting hours and only rarely for more than a few days, with a return to normal mood.

(6) Problems tolerating being alone, e.g., frantic efforts to avoid being alone, depressed when alone.

(7) Physically self-damaging acts, e.g., suicidal gestures, self-mutilation, recurrent accidents, or physical fights.

(8) Chronic feelings of emptiness or boredom.

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