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Commentary
The case for borderline personality disorder

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Peter Tyrer's discussion of the appropriateness of the term 'borderline' is also a discussion of how to conceptualize a complex biopsychosocial phenomenon. The term itself has accrued meaning, as words do over time, as the pathology has been, and continues to be, studied and better understood. The current meaning of the term 'Borderline Personality Disorder' has more to do with all that have been written about on it over the decades than with the original idea of bordering between psychosis and neurosis (Deutsch, 1942; Hoch & Polatin, 1949; Knight, 1953), or the later idea of being on the 'borderline' of an affective disorder (Akiskal et al., 1985; Liebowitz & Klein, 1981; Stone, 1980). Therefore, it would seem unwise to change the name simply because the name itself does not communicate the essence of the disorder. As Paris, Silk, Gunderson, Links, and Zanarini (2009) point out, this is certainly not the only diagnostic label that does not do so. One reason that the term should be kept is that it has become the signifier of the extensive literature that has accrued on it. Another reason is that a search to find a diagnostic label that does convey the essence of the condition may be doomed because this is a complex a condition that does not lend itself to be summarized in a simple term such as fluxithymia or even interpersonal emotional dysregulation disorder (New, Triebwasser, & Charney, 2008). The discussion of a new name that would try to capture the essence of the condition therefore becomes a proxy for the debate as to what constitutes the core pathology of borderline personality disorder (BPD). This discussion most recently has been played out in the discussion of an endophenotype for the disorder (Lenzenweger, Clarkin, Yeomans, Kernberg, & Levy, 2008)

Before going into more specifics of our position, we would like to point out that we agree with Paris et al., who reject the argument (not included in Tyrer's comments) that the name should be changed because of the stigma it carries with it. The stigma has more to do with the combination of some of the interpersonal manifestations of the disease—episodes of angry, aggressive and impulsive behaviour—in combination with clinicians who traditionally have not been equipped with the specialized treatments that are now available to treat this condition (Silk, 2008). This need for specialized treatments that have been designed specifically for BPD is, as Paris et al. point out, an additional reason not to change the name. Lumping BPD in with affective illnesses could turn the tide back to a situation in which general therapists (still

all too often the treaters of borderline patients) too often take on these cases that require therapists trained in one of the special modalities designed for this population.

In brief, the term should be maintained with all the meaning it has accrued from the extensive literature on it. To change the term would be to misplace the discussion when the more substantial issues are (1) whether the phenomenon it refers to constitutes a personality disorder and (2) whether the current diagnostic system captures the pathology of this personality disorder or if we might consider an alternative diagnostic system. We will move on to discuss these more interesting questions.

Comparing BPD and affective illness

In our discussion, we will try to avoid repeating the arguments presented by Paris et al. (2009) with which we generally agree, but we will attempt to expand on some further issues. Nonetheless, a few additional comments are in order with regard to the relation of BPD to affective disorders. We know that the depressive experiences of BPD patients are quite different from those with primary affective disturbance at the level of phenomenology, family history, course and treatment response. The content of depressions in BPD patients appears more harsh, unintegrated and characterological as opposed to episodic (Levy, Edell, & McGlashan, 2007; Rogers, Widiger, & Krupp, 1995; Southwick, Yehuda, & Giller, 1995; Westen et al., 1992; Wixom, Ludolph, & Westen, 1993). Additionally, depression in BPD is more likely to co-occur with externalizing disorders and behaviours (e.g., substance use, antisocial traits and behaviours) in addition to the more typical internalizing disorders (e.g., anxiety) (James & Taylor, 2008; Levy et al., 2007; Zanarini et al., 1998). Furthermore, compared with depressed patients, BPD patients displayed more variability over time in both their negative and positive affects, and demonstrated significantly more instability on successive scores for hostility and fear as well as sadness (Trull et al., 2008).

The phenomenology of both impulsivity and affective lability is also different than that found in patients with bipolar disorder (Henry et al., 2001; Koenigsberg et al., 2001, 2002). Borderline patients show higher levels of and more chronic and hostile-aggressive impulsivity, and have more rapidly shifting affective lability that vacillates between dysphoria and anger rather than the euphoria that characterizes bipolar disorder.

Although early reports found BPD and mood disorders run in families (Akiskal, 1981; Stone, 1977), these studies did not use standardized criteria or reliable instruments. Subsequent studies have found relatively low rates of BPD and mood disorders in first degree relatives—rates that are not much higher than what is found in the general population and about the same as in relatives of schizophrenic patients. White, Gunderson, Zanarini, and Hudson (2003) found familial aggregation of impulse spectrum disorders (substance use disorder, antisocial personality disorder) and BPD. Thus, the familial link between BPD and mood disorders is ambiguous and generally not supported (Kelsoe, 2003).

There is also the question of the reactivity of mood in relation to events. Are BPD patients more reactive only because of neurobiological sensitivity (Koenigsberg, 2009) or could the hyperreactivity be also as a result of flaws in their information processing? Studies have found that BPD patients both interpret facial expressions more quickly than normal controls, and that they tend to perceive negative affect in neutral faces (Donegan, et al., 2003; Fertuck, 2009). If the mood dysregulation involves difficulties with information processing, then that would bring a level of complexity to the disorder that would not fit with categorization as an affective illness.

The question of traits

With regard to the question of whether BPD constitutes a personality disorder, Tyrer (2009) argues

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that the condition is not characterized by a stable set of traits but rather by the central feature of 'recurrent unstable mood and behaviour'. There are two comments with regard to this: (1) why can instability, as an ongoing feature of a personality (that is therefore a 'stable feature'), not be seen as a trait? Is it not possible to note instability as a cardinal feature of a person's affective life and behaviour? (2) Tyrer's view does not allow for considering consistent identity disturbance as a trait.

Furthermore, it is possible to move from the symptoms of BPD to the traits that are involved in the condition. Clarkin, Hull, Cantor, and Sanderson (1993) found that the Diagnostic and Statistical Manual of Mental Disorders-III-Revised (DSM-III-R) BPD construct manifested traits as assessed by the five-factor model. The predominant trait profile in a sample of 62 hospitalized patients diagnosed with BPD on the Structured Clinical Interview for DSM-IV, Axis II Disorders (SCID II) was a very high neuroticism score, and low agreeableness and conscientiousness scores. Further analysis correlated each NEO-Personality Inventory scale and subscale with three factors that were found to underlie the eight (DSM-III-R) BPD criteria: the identity/interpersonal factor (disturbed relationships), the affect factor (emotional dysregulation) and the impulsivity factor (Clarkin, Hull, & Hurt, 1993).

The multidimensional argument

The presence of these three factors supports the view that BPD is a multidimensional disorder, as argued by Paris et al. (2009). Our understanding of the disorder would be diminished by reducing the defining characteristic to one of these factors. There would be implications for research. The current research scene is very active with researchers involved in neurobiological and neurocognitive studies; genetic studies; treatment studies looking at outcome, mechanisms, mediators and moderators of change; developmental studies that have a bearing on possible aetiologies of BPD; and longitudinal descriptive studies. A decision to rename BPD and to classify it as an affective disorder could constrict the options of researchers whose interests in the phenomenon addressed the broader psychosocial aspects of the disorder that might come to be considered marginal to its affective core.

The diagnostic criteria problem

Are the DSM-IV criteria consistent with a personality disorder? Is the problem with the condition (BPD) or with the current system of diagnosing it, which is a system that might not be at the level of our current understanding of it?

The DSM definition of personality disorder, as Tyrer points out, emphasizes 'an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment'. As the multidimensional argument implies, a personality disorder is a syndrome that brings together biological/tempermental, developmental/interpersonal and symbolic functioning/information processing aspects of the human experience (the sources of the 'inner experience'). Thus, this concept of 'inner experience' is central to the discussion. It may be that the core element of BPD is the *lack* of a stable inner experience or core sense of self (this fits with an object relations model that sees identity disturbance as the central feature of BPD from which the other more specific symptoms devolve (Clarkin, Yeomans, & Kernberg, 2006)). So, why would this *unstable* inner experience not constitute an 'inner experience' as required by the DSM-IV definition of personality disorder?

Tyrer seems to argue that this view would not fit the 'requirements of persistence, pervasiveness and inflexibility' of personality traits. However, most BPD individuals, and their therapists and others in their life, might argue that, over time, the instability of inner experience is quite persistent, pervasive and inflexible. It could be that the interaction of an unstable inner experience and a choleric temperament underlies the emotional

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lability. A coherent self, the glue that brings together the otherwise disparate aspects, is consistently missing. One of the interesting current debates involves the relation of emotional dysregulation to identity disturbance. One point of view is that the former leads to the latter (Linehan, 1993); a contrasting view sees the latter as underlying the former (Caligor, Diamond, Yeomans, & Kernberg, in press). As in most debates, there is probably some truth on both sides, and the field will advance most from seeing the interaction between emotional dysregulation and lack of a coherent identity. Such syntheses are in process. For example, Caligor et al. propose that transference-focused psychotherapy fosters the interaction of reflective functioning and identity integration in promoting each other and increasing affect modulation (Caligor et al., in press).

Tyrer's conclusion that the DSM-IV diagnostic criteria for BPD are 'out of keeping' with what a personality disorder is begs the question of reviewing our way of diagnosing psychiatric disorders in general and BPD in specific. Along with disputing this notion in the arguments above, we can also look to ways to improve our diagnostic manual's definition of personality disorders and its system of how to classify them. Our field is considering ways of re-conceptualizing personality disorders beyond the descriptive criteria level. Blatt and Luyten (in press) state that we can now consider 'more encompassing models of psychopathology' by using an approach that 'is more theory-driven and dimensionally oriented, emphasizing life history and personality dynamics, conceptualizing psychopathology as evolving out of the manifold interactions between biological endowment and responses to both the external environment and intrapsychic reality'. They argue that this approach is becoming more relevant because 'Theoretical, empirical, and methodological developments in both psychosocial research and the neurosciences …are now increasingly leading researchers to believe that a more etiologically based diagnostic system of psychiatric disorders is possible (e.g., Blatt, 2004, 2008; Blatt & Levy, 1998; Clark, 2005; Luyten & Blatt, 2007; McHugh, 2005; Parker, 2005; Watson, 2005) which has led to renewed interest in combining a descriptive/categorical and etiological/dimensional approach (Westen, Shedler, & Bradley, 2006)'. They add that 'one of the most important tasks psychiatry faces at the present moment is to come to terms with the complexity of mental disorders'. Indeed, rather than reduce our appreciation of the complexity of BPD, perhaps we should see it in its complexity as a paradigm for our understanding of the complex nature of many psychiatric phenomena.

The entire field of personality pathology is concerned with the current atheoretical and polythetic diagnostic system of the personality disorders that results in questionable construct validity, rampant comorbidity and likely subtypes within the diagnostic categories with no theoretical conceptualization behind the groupings. The next step to research advancement is not to discard the accumulated knowledge about the disorders, including BPD, but to advance to methodical research on the descriptive phenotypes of BPD leading to examination of endophenotypes (Lenzenweger et al., 2008). On the clinical front, Tyrer wonders why there is so much focus on BPD, and it relates to the prevalence of individuals with the disorder (see Lenzenweger, Lane, Loranger, & Kessler, 2007), and the tremendous attention and health-care costs related to patients with this diagnosis. Borderline patients, he notes, are different from other personality disorder patients in that they seek treatment. This is an oversimplification. With their anxious ambivalent attachments to others, including health and mental health-care providers, they seek and disrupt multiple treatments, leaving them insufficiently treated and ready to repeat the ineffective and costly cycle again. Accumulated clinical wisdom and a handful of empirically supported treatments are beginning to arrive at principles for addressing this pathology.

In sum, the data to date strongly suggests that BPD is not a mood disorder *per se*, at least as conceptualized by DSM. Folding BPD into such a

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scheme would most likely lead to other confusions, not only in terms of which treatments to employ but also in terms of overall conceptual issues. We believe such a change would be a disservice to the study of BPD and, in light of a number of efficacious treatments available, the treatment of those suffering from the disorder. Further, we suggest that conceptually, it is useful to think of BPD as a personality disorder where emotional lability and chronic interpersonal difficulties are rooted in persistent ways of perceiving, interpreting and interacting with others as a function of the content and structure of their representational world. Such impairments and distortions in social cognition or representations of self and others lead to chronic emotional dysregulation and interpersonal problems.

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