OVERVIEW OF BORDERLINE PERSONALITY DISORDER

John G. Gunderson, M.D.

Before 1970

From Untreatable Patients to Personality Organization: "A Psychoanalytic Colloquialism"

CONTRIBUTIONS FROM EARLY PSYCHOANALYTIC WRITINGS

- lapses in reality testing
- "stable instability"
- transitional object relatedness
- the unstable disturbed sense of self
- abandonment fears
- reliance on splitting, other primitive defenses

1970 – 1980

From Personality Organization to Syndrome: "An Adjective in Search of a Noun":

Descriptive Psychiatry and Psychopharmacology

Vol. 132 No. 1 January 1975

THE AMERICAN JOURNAL OF PSYCHIATRY

In this issue

John G. Gunderson and Margaret T. Singer on Defining Borderline Patients

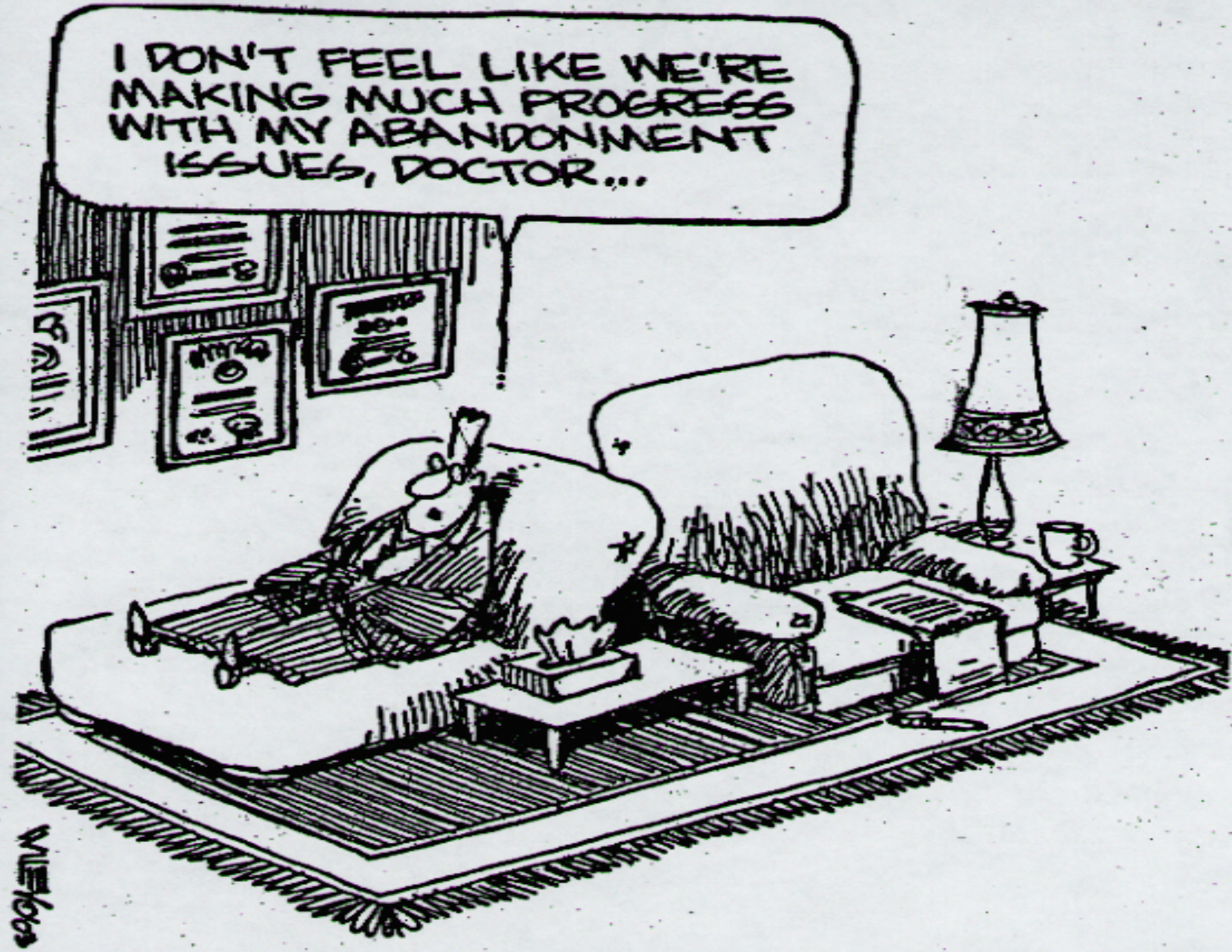
OFFICIAL JOURNAL OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Treatment Dilemmas Predicted by the Borderline Syndrome

- **Dramatic fluctuations in phenomenology and psychological capacities will challenge diagnostic certainty.**
- **Urgent appeals for an exclusive helping relationship will generate strong countertransference responses, often involving rescue efforts that prove to be inadequate.**
- **Treaters and others will have intense and distinct reactions, seeing the patient as a deprived waif or as an angry bully.**
- **Separation experiences (or decreased structure) will prompt behavioral (self harm) and cognitive (psychotic-like) regressions.**
- **Neither psychoanalysis nor drugs will help significantly and will often be harmful.**

BPD's Pejorative Attributions

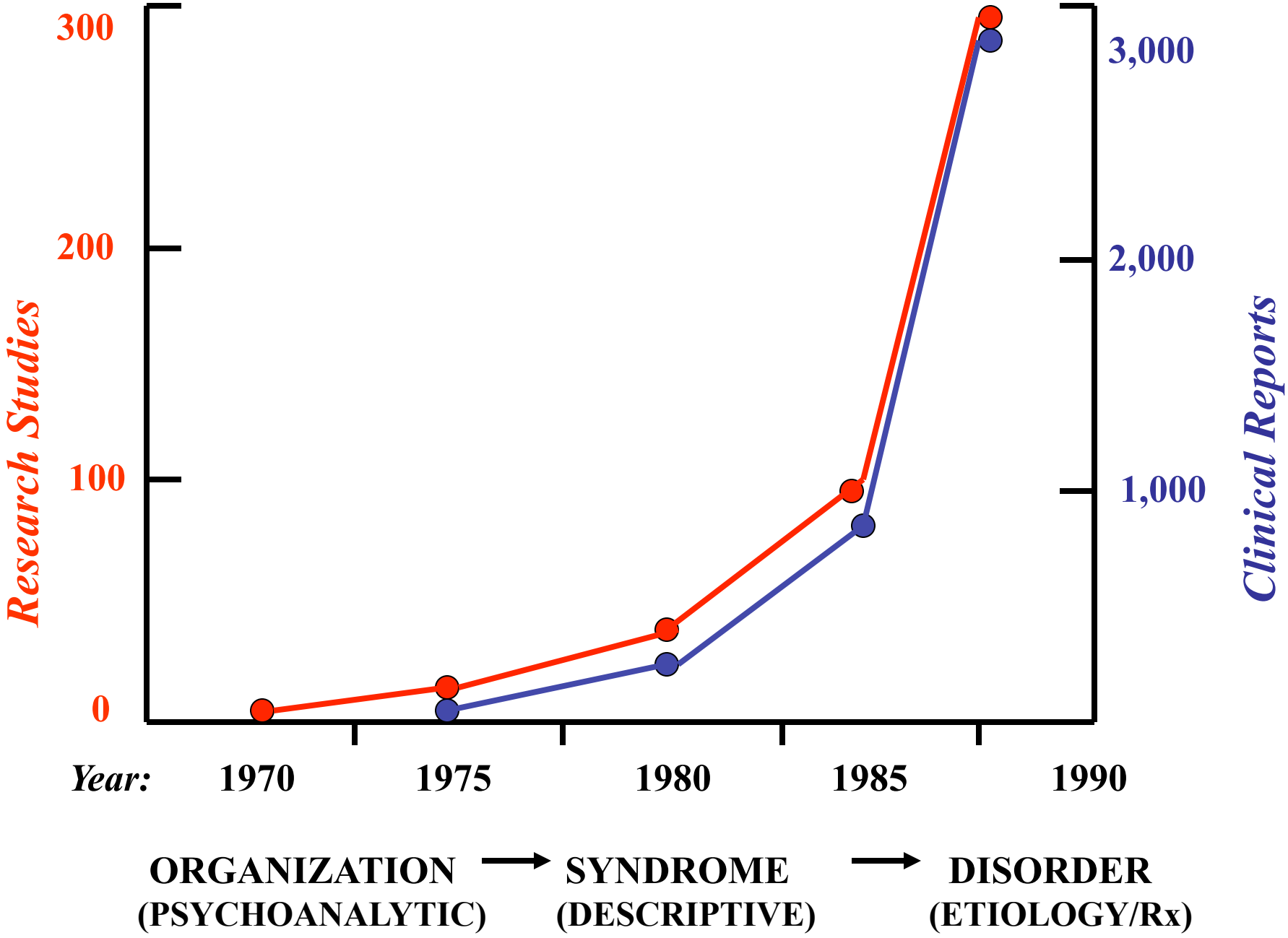
- "frequent flyers"
- "help-rejecting complainers"
- intractable, treatment resistant
- irresponsible, fickle, egocentric
- "emotional hypochondriacs" (attention-seeking)
- iatrogenic


I DON'T FEEL LIKE WE'RE MAKING MUCH PROGRESS WITH MY ABANDONMENT ISSUES, DOCTOR...

1980 – 1990

From Syndrome to Personality Disorder: "Wisdom Is Never Calling a Patient Borderline":

Testing Validity


300
200
100
0
Research Studies
3,000
2,000
1,000
Clinical Reports
Year:
1970
1975
1980
1985
1990
ORGANIZATION
(PSYCHOANALYTIC)
SYNDROME
(DESCRIPTIVE)
DISORDER
(ETIOLOGY/Rx)

BPD's Discrimination From Other Disorders

	Schizophr	MDD	PTSD	Bip D
Descriptive	-	+/-	-	+/-
Course	-	-	-	-
Familiality	-	+/-	-	-
Treatment Response	+/-	-	-	-

From Gunderson & Phillips 1991; Gunderson & Sabo 1993; Koeningsburg et al. 2002; White et al 2003; Paris et al. 2007; Gunderson & Links 2008

BPD & Drug/Alcohol Abuse

- ~ 50% of BPD patients have either alcohol or substance use disorders (CLPS, MSAD).
- ~ 50% of SUD patients have BPD (Trull 2000)
- ~ 45% of opium addict patients have BPD (Drake ’05)
- Family history studies show strong aggregation with *impulse spectrum* disorders (notably alcohol/drug abuse) (White ’08)

PIONEERING RESEARCHERS

N. Blum
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J. Gunderson
O. Kernberg
J. Kroll
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A. Loranger
T. McGlashan
J. Oldham
C. Perry
E. Plakun
C. Schulz
L. Siever
K. Silk
P. Soloff
M. Stone
S. Torgersen
D. Westen
M. Zanarini

1990 - 2000

From Unwanted Personality Disorder to Disorder-Specific Treatability:

Biological Psychiatry

DBT's Innovations

- Identification of goals
- Emphasis on skill building
- Therapist availability
- Therapist as coach

MBT's Innovations

- An empirical developmental base
- A "not knowing" non-interpretive stance
- Applicable within institutions

Neurobiological Advances

- **MRI & PET studies demonstrate a hyperresponsive amygdala (“*bottom up*”) and impaired inhibition from the prefrontal cortex (“*top down*”)**
- **neurohormones such as oxytocin and opioids mediate BPD’s exaggerated fears of abandonment and rejection**

2000 - 2010

Borderline Personality Disorder: "A Good-Prognosis Brain Disease"?: Etiology

HERITABILITY

Schizophrenia	**85%**
Bipolar	**80%**
ADHD	**75%**
BPD	**52-68%**
MDD	**45%**
Panic Disorder	**40%**
PTSD	**30%**

Lyons & Plomin/Smoller

Prototypes of the Phenotypes for BPD

- **Emotional ("hyperbolic" temperament) Dysregulation**
  - **Fearful/angry, chronically depressed, dysphoric**
  - **Readiness to shift from anxiety to depression**
  - **Neurotics on Neuroticism**
- **Behavioral Dyscontrol**
  - **Acts without concern for consequences (often self-injurious)**
  - **Externalizes**
- **Interpersonal Hypersensitivity**
  - **Intolerant of aloneness**
  - **Insecure attachments characterized by longings for closeness and fears of rejection or abandonmen**
- **Cognitive**
  - **distorted self-image, misattributions**
  - **unstable identity**

McLean Family Study: Results and Interpretation

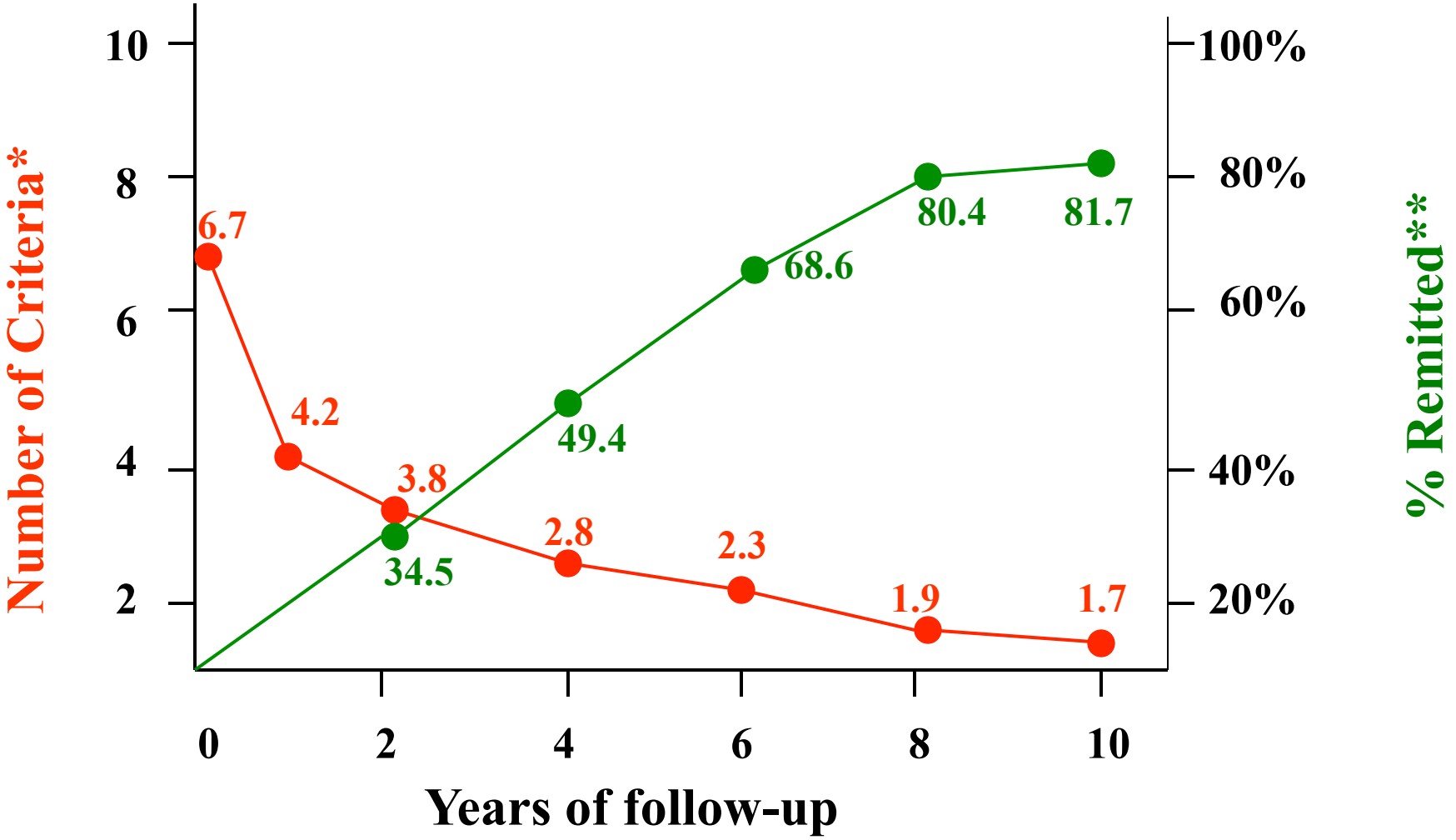
- **Common pathway is better fitting model than independent pathways***
  - **Pattern of traits within individuals and families is best explained by an underlying liability of BPD**
    - **Heritability of 59% for liability**
- **Supports BPD as a unitary entity rather than simply a sum of components**

Gunderson et al. Arch Gen Psych 2011

Other Support

- Twin studies using similar sectors support a common pathway model (Distel et al. 2010, Kendler et al., 2010)
- Factor analytic studies support a single factor solution (Fossati et al., 1999; Clifton & Pilkonis, 2007)

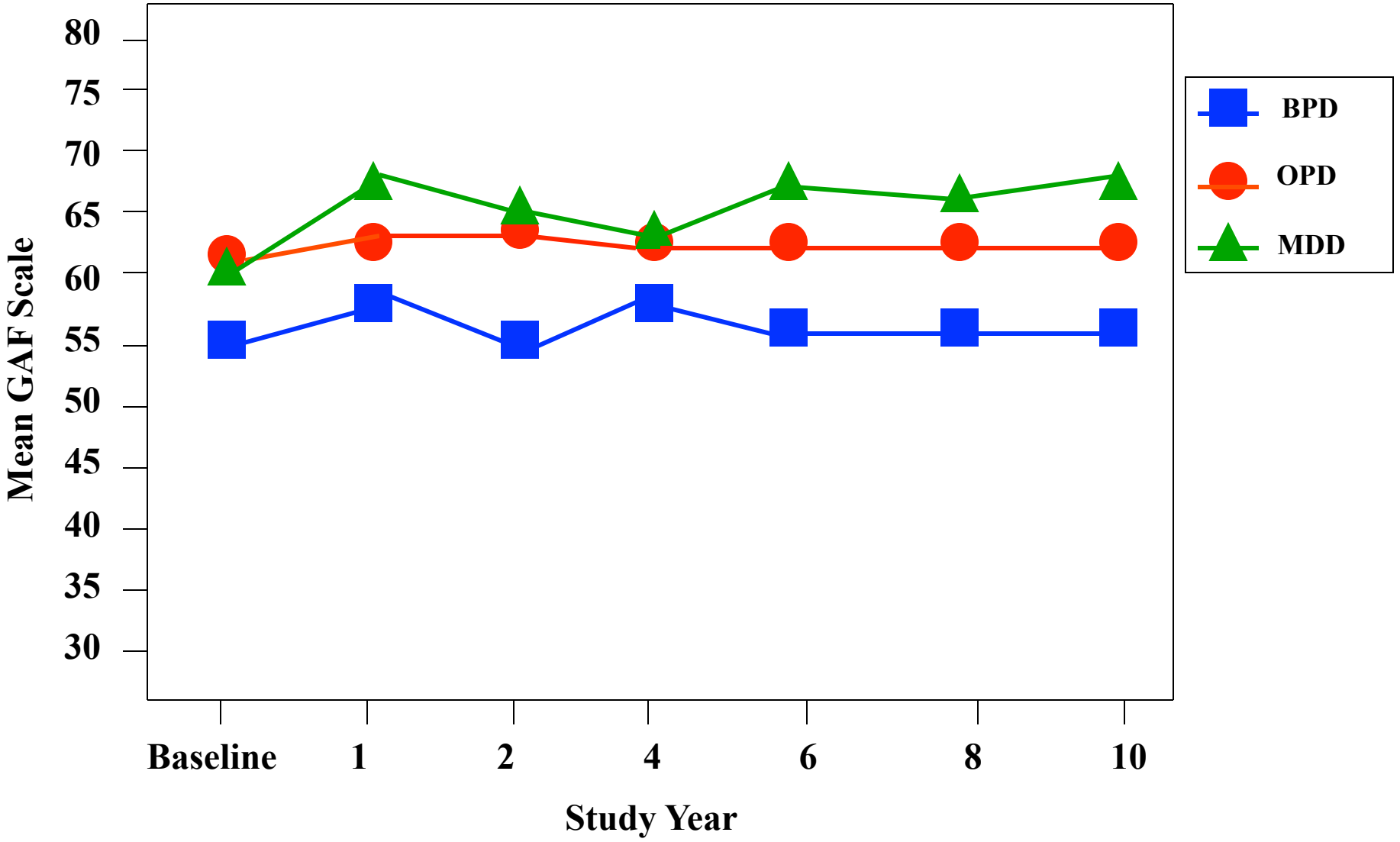
BPD's Longitudinal Course



*From the Collaborative Longitudinal Study of Personality Disorders (unpublished)

**From the McLean Study of Adult Development (Zanarini et al. AJP 2003; 160:274-283)

Mean GAF Scores

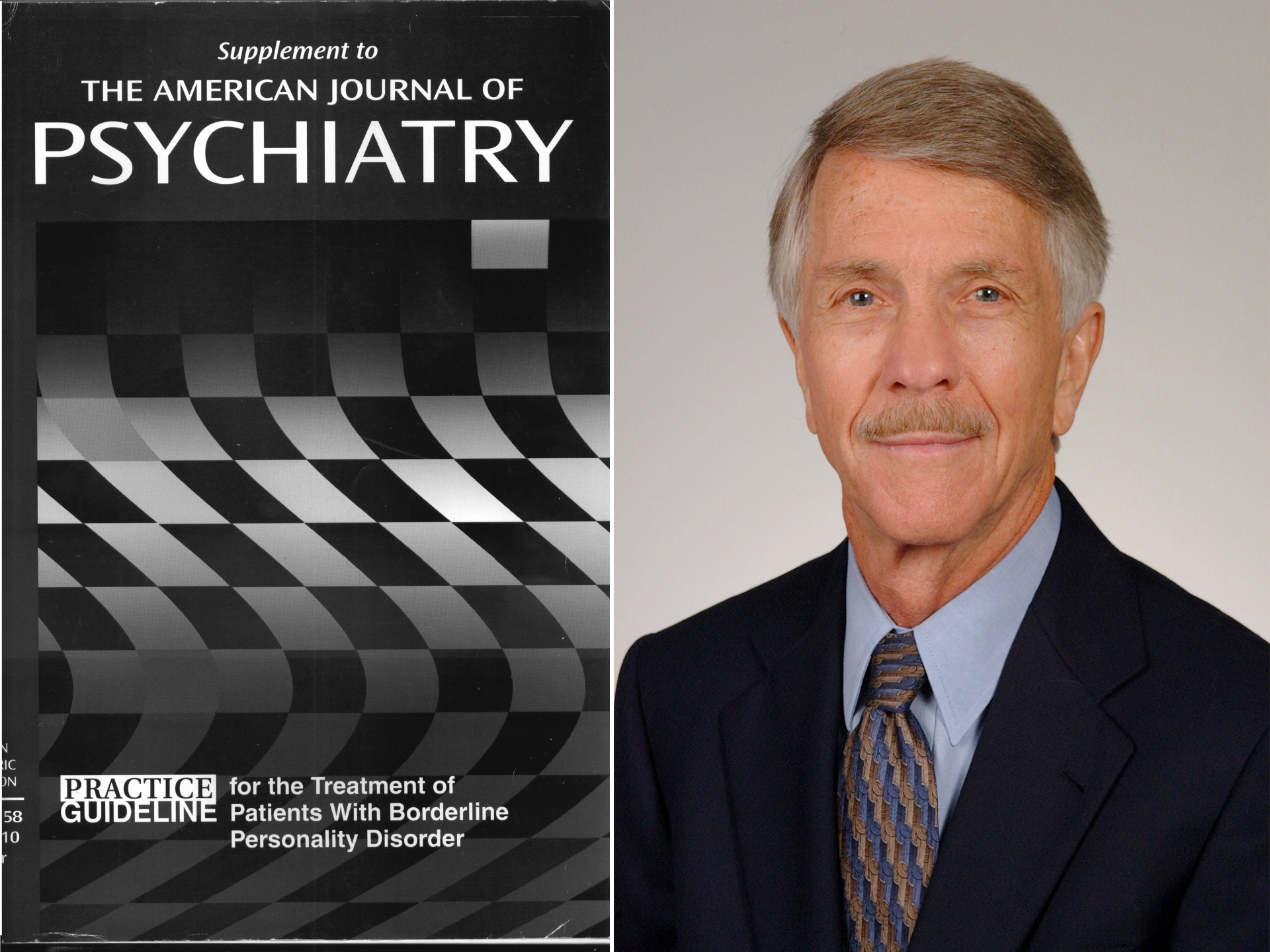


INTERACTIONS OF AXIS I WITH BPD

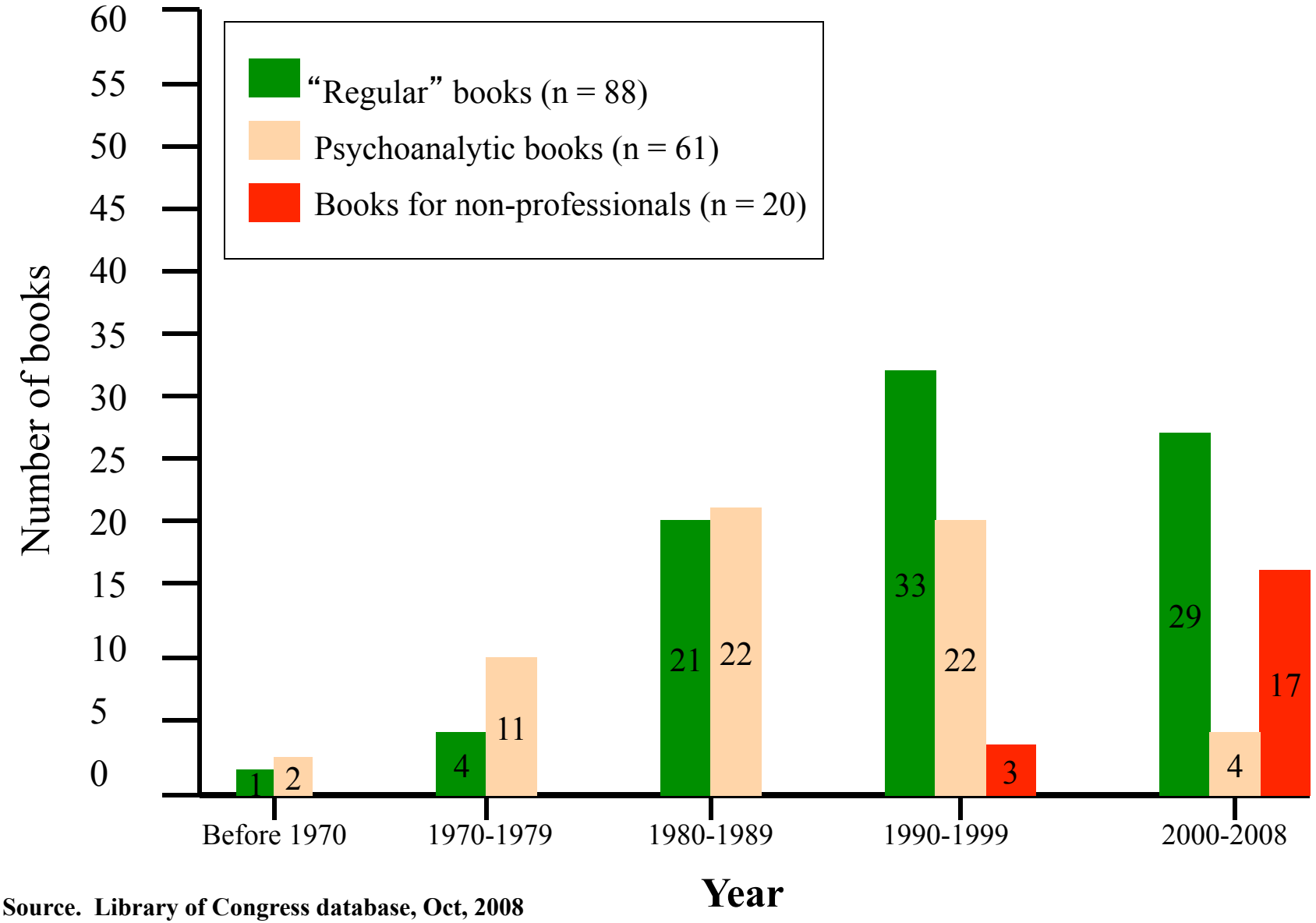
Effect	Co-Occurring Axis I Disorder			
	SUD	MDD	Bipolar	ED
↓ BPD Course	YES	?	NO	NO
↓ Axis I Course	YES	YES	YES	YES
↑ Med Use	?	YES	YES	?

BPD and Alcohol/Substance Abuse

- Active SUD can: a) cause false positive BPD dx, b) make tx of BPD unfeasible
- Co-occurring SUD slow time-to-remission of BPD more than any other Axis I disorder (Zanarini ’06)
- BPD predicts SUD of all types (Fiske ’08, Walter ’09) opioids make BPD subjects euthymic not high (41% of buprenorphine seekers have BPD) (New & Stanley, ‘10)
- OD & BPD → increase suicide, high risk needle use, non-compliance with HIV care (Drake ’05)


Supplement to
THE AMERICAN JOURNAL OF
PSYCHIATRY
PRACTICE GUIDELINE for the Treatment of Patients With Borderline Personality Disorder

Books on borderline personality disorder, 1968-2008



Source. Library of Congress database, Oct, 2008

The Present

Awareness: "Borderline Personality Disorder Is to Psychiatry What Psychiatry Is to Medicine"

"It is essential to increase awareness of borderline personality disorder among people suffering from this disorder, their families, mental health professionals, and the general public by promoting education, research, funding, early detection, and effective treatments."

House Resolution 1005, April 1, 2008

NIMH RESEARCH FUNDS

Disorder	Amount (millions)	% Population
Schizophrenia	300	0.4%
Bipolar Disorder	100	1.6%
BPD	6	1.4-5.9%

Research

- **There is a shortage of young BPD investigators**
  - **fellowships are needed**

PIONEERING RESEARCHERS

N. Blum (~ 70)
J. Clarkin (~ 75)
R. Cowdry (d)
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O. Kernberg (~ 85)
J. Kroll (~ 75)
P. Links (~ 65)
A. Loranger (d)
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D. Westen (~ 55)
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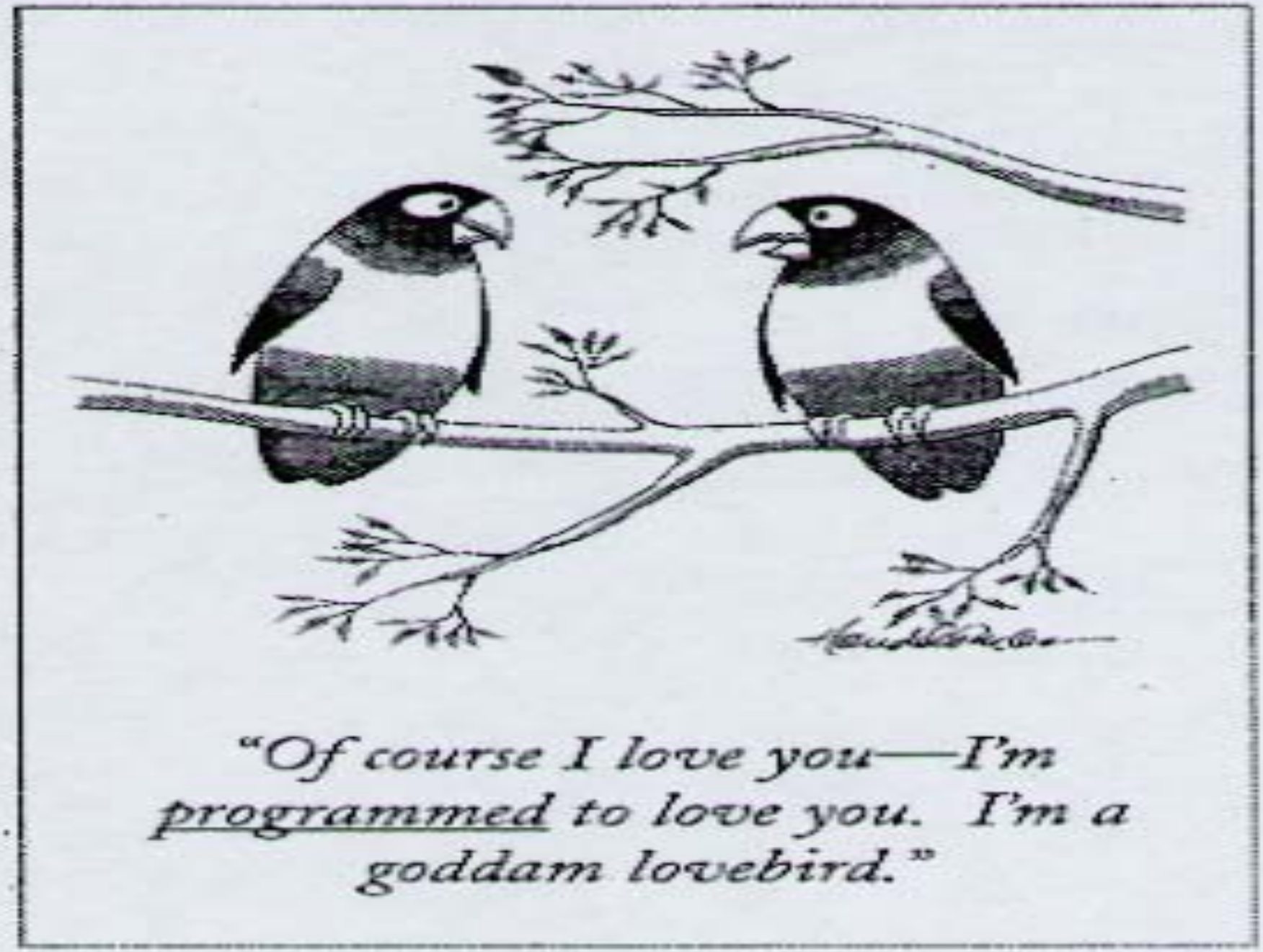
Research

- **There is a shortage of young BPD investigators – fellowships are needed**
- **Cutting edges of research**

- Neuropeptides - ? pharmacotherapies



"Of course I love you—I'm programmed to love you. I'm a goddam lovebird."

Research

- **There is a shortage of young BPD investigators – fellowships are needed**
- **Cutting edges of research**

- Neuropeptides - ? pharmacotherapies

- Risk markers in children - ? impulsivity, early interventions

- Integrating tx of BPD & SUD

- Social rehabilitation therapies

Borderline patients should be able to assume that professionals who treat them have been trained to do so.

Training

- There is a shortage of clinicians trained to treat BPD
- Evidence-based-treatments such as DBT, MBT, or TFP require extensive training and an extended duration that make them unavailable and unfeasible
- General Psychiatric Management (GPM) is an EBT that may be more generalizable
- Life experience and revised family environments are strong allies for change

BPD AS A VARIANT

If not of:

- **i) schizophrenia (1970's)**
- **ii) depression (1980's)**
- **iii) PTSD (1990's)**
- **iv) Bipolar disorder (2000's)**

perhaps;

- **v) normal personality**

Journal of Personality Disorders, 24(6), 694–708, 2010

REVISING THE BORDERLINE DIAGNOSIS FOR DSM-V: AN ALTERNATIVE PROPOSAL

John G. Gunderson, MD

The changes in the borderline personality disorder (BPD) diagnosis proposed by the DSM-V personality disorder work group involve radical changes in format (prototype and dimensions) and descriptive characteristics (traits). Changes of this magnitude will create an unwelcome and potentially harmful discontinuity with the definition that has guided BPD research and the development of disorder-specific therapies. This paper offers an alternative proposal that was developed in collaboration with clinical and research leaders. It includes modification of existing criteria, use of a diagnostic algorithm based on phenotypes, and giving BPD a hierarchical relationship vis-à-vis other personality disorders. These changes are incremental, diminish overlap and heterogeneity, sustain clinical and research development, and will improve utilization.

Within a year after borderline personality disorder's (BPD) coming of age was celebrated by the American Journal of Psychiatry (Kernberg & Michaels, 2009; Oldham, 2009) and the American Psychiatric Association's Annual Meeting, the DSM-V Personality Disorder Work Group has proposed major changes in the BPD diagnosis (prototypes, traits, and dimensions; see dsm5.org). A thoughtful consideration of such change is timely insofar as changes have been few despite an ever-expanding body of research (Blashfield & Intoccia, 2000; Gunderson, 2009). The BPD syndrome defined in DSM-III, III-R, and IV is frequently criticized for too much overlap with other personality disorders and it's polythetic algorithm allows too much heterogeneity.

The proposed changes by the DSM-V work group radically alter a definition of BPD that has survived with minimal changes since it entered the DSM system 30 years ago and from which has come a body of knowledge

From McLean Hospital, Harvard Medical School.

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The author was assisted by Igor Weinberg, PhD, and is deeply indebted to the many colleagues who offered encouragement, identified relevant research, and helped shape this proposal (see Appendix).

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IMPLICATIONS FOR DSM V

- BPD's identity should be retained
- BPD should move to Axis I
- BPD should be legitimatized for adolescents
- Criteria → phenotypes

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ORIGINAL PAPER

Borderline Personality Disorder: Considerations for Inclusion in the Massachusetts Parity List of ''Biologically-Based'' Disorders

Mary Ellen Foti • Jeffrey Geller • Laura S. Guy • John G. Gunderson • Brian A. Palmer • Lisa M. Smith

Published online: 1 October 2010

Abstract: Borderline Personality Disorder (BPD) is a common and severe mental illness that is infrequently included under state mental health parity statutes. This review considers BPD parity, using the Massachusetts mental health parity statute as a model. While BPD can co-occur with other disorders, studies of its heritability, diagnostic validity/reliability, and response to specific treatments indicate it is best considered an independent disorder, one that negatively impacts the patient's treatment response to comorbid disorders, particularly mood disorders. Persons with BPD are high utilizers of treatment, especially emergency departments and inpatient hospitalizations—the most expensive forms of psychia tric treatment. While some patients remain chronically symptomatic, the majority improve. The findings from psychopharmacologic and other biologic treatment data, coupled with associated brain functioning findings, indicate BPD is a biologicallybased disorder. Clinical data indicate that accurately diagnosing and treating BPD conserves resources and improves outcomes. Based on this analysis, insuring BPD in the same manner as other serious mental illnesses is well-founded and recommended.

Keywords Borderline personality disorder Mental health parity
Biologically-based mental illness Mental health policy

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