

**Borderline Personality Disorder:  
Birth Pains of This Still-new Diagnosis**

**John G. Gunderson, MD**

**(SLIDE 1)**

**(SLIDE 2)** On April 1, 2008, the U.S. House of Representatives unanimously passed House Resolution 1005 supporting the month of May as borderline personality disorder awareness month. The resolution stated that “despite its prevalence, enormous public health costs, and the devastating toll it takes on individuals, families, and communities, [borderline personality disorder] only recently has begun to command the attention it requires.”

This Resolution, which was the outcome of public advocacy efforts, and pointed was not an outcome related to psychiatry’s advocacy, drew attention to the disproportion between the high public health significance of borderline personality disorder and its low levels of public awareness, funded research, treatment resources and adequately trained treaters.

In this review I will describe how borderline personality disorder persists as a suspect category still largely neglected by psychiatric institutions, comprising a very sizable fraction of psychiatry’s patients -- but still they remain patients that few clinicians want to treat. I will highlight the major clinical, scientific, and public health issues, as well as some of the remarkable personalities, that have shaped the development of this diagnosis. My review is organized chronologically, beginning with the period before the diagnosis was used clinically and

then dividing the subsequent period somewhat arbitrarily into decade-long intervals. This approach allows the review of the trials and tribulations of the borderline personality disorder diagnosis to proceed within the framework of the changes that were concurrently transforming psychiatry. I will also add personal and professional vignettes that accompanied and illustrate this development.

**(SLIDE 3) Before 1970 – From Untreatable Patients to Personality**

**Organization: “A Psychoanalytic Colloquialism”**

**Psychoanalysis**

The identification of patients as “borderline” first arose in the 1930s, in an era when the psychoanalytic paradigm dominated psychiatry and our classification system was primitive. At that time classification was tied to analyzability: patients with neuroses were considered analyzable -- and therefore treatable -- and those with psychoses were considered not analyzable -- and therefore untreatable.

The psychiatrists most responsible for introducing the label “borderline” were Stern (1) and Knight (2). By identifying the tendency of certain patients to regress into “borderline schizophrenia” mental states in unstructured situations, these authors gave initial clinical meaning to the borderline construct. The primary category to which these patients were “borderline” was schizophrenia (3–7). Still, until the 1970s the term “borderline” remained, as Mike Stone has noted, a rarely and inconsistently used “colloquialism within the psychoanalytic fraternity” (8).

**(SLIDE 4)** *Vignette 1: It was at this stage that I, as a beginning resident, holding Dr. Zhivago as my ego-ideal, first heard the term used. When I began my training in the summer of 1968, I encountered a young female patient -- strawberry blonde, cheerleader attractive, alcoholic, promiscuous, she clung to a tattered teddy bear. After I learned about the terrible things she did to herself with pieces of broken glass I needed to look away from her in community meetings. But, before that, she took a liking to my fellow resident, Jeffrey, who took up her cause with the experienced nursing staff and alienated them and took up her cause with*

*our supervisor and alienated him, and took up his own cause, wanting sympathy, from his fellow trainees, including me, and alienated us.*

*Worse even, Jeffrey's heroic efforts and all the commotion had no visible benefit for the blonde - she still did terrible things to herself with glass.*

*And, not coincidentally, Jeffrey himself paid a very high price for the strawberry blondes' appreciative attentions. This initiation introduced me to the heartaches that followed in the path of a type of patient who -- at that time -- were still poorly defined.*

## **Kernberg**

Even as Jeffrey and I were learning from the strawberry blonde, the borderline construct was taking its next major step forward. **(SLIDE 5)** In 1967, Otto Kernberg (9), a psychoanalyst concerned with the boundaries of analyzability, defined borderline as a middle level of personality organization **(SLIDE 6)** bounded on one side by sicker patients who had psychotic personality organization and on the other by those who were healthier and had neurotic personality organization. As such, *borderline personality organization* was a broad form of psychopathology defined by primitive defenses (splitting, projective identification), identity

diffusion, and lapses in reality testing (9). Kernberg then went on to suggest that these patients could be successfully treated with psychoanalytic psychotherapy (10).

**(SLIDE 7)** Beyond the substance of Kernberg's contributions, their significant impact must be appreciated in part as the product of his authoritative Old-World style and his tireless campaigning on their behalf. He, and to a lesser extent Masterson (11), who highlighted abandonment issues and poor early parenting, fueled the enthusiastic pursuit of ambitious long-term intensive psychoanalytic psychotherapies for these patients.

### **Opposition**

Already then opposition was strong: Don Klein (12) voiced a cynical counterpoint: "Analysts' progressive disillusionment with their ability to make permanent change in nonpsychotic patients has been masked by terminological revision. The diagnosis of *borderline disorder* preserves intact the belief that classical psychoanalysis is the uniformly

effective treatment of choice for neurosis, since failures occur only with [what they now term] “borderline patients” (p. 366).

### **Psychoanalytic Contributions**

**(SLIDE 8)** Despite such doubts about this diagnosis’s parentage, important contributions to the borderline construct from these early psychoanalytic observations have endured, among them recognition of their “stable instability” (13); their desperate need to attach to others as transitional objects (14); their unstable, often distorted, sense of self and others; their reliance on splitting; and their abandonment fears.

### **(SLIDE 9) 1970–1980 - From Personality Organization to**

### **Syndrome: “An Adjective in Search of a Noun”: Descriptive**

### **Psychiatry and Psychopharmacology**

In the decade after “borderline” achieved the status of a colloquialism, the advent of descriptive psychiatry and psychopharmacology brought significant changes to psychiatry.

## Grinker

The initial effort to describe borderline patients was made by Grinker, **(SLIDE 10)** an early and powerful advocate of empiricism, in a seminal book entitled *The Borderline Syndrome* (15).

After I had moved from residency to the Center for Studies of Schizophrenia at NIMH. While there, I met both Kernberg & Grinker. Their work and their support set the stage for my writing a review of this syndrome's place within the context of a broader literature. My paper entitled "Defining Borderline Patients" (16) **(SLIDE 11)** made me an overnight expert -- though my clinical experience remained limited. Still, buttressed by this start, when I moved to McLean Hospital in 1973, I developed a method for assessing the borderline syndrome reliably from which its discriminating criteria were established (17) **(SLIDE 12)**. Soon afterward, it entered DSM-III (18) as "borderline personality disorder".

## **Schizophrenia**

**(SLIDE 13)** Borderline personality disorder was official, but what was it? Even before its inclusion in DSM, it had become clear that the disorder was not related to schizophrenia, and the inclusion in DSM-III of another new category, schizotypal personality disorder, finalized this cleavage (19, 20). Even without that, the distinctive phenomenology of borderline personality disorder made a spectrum relationship with schizophrenia unlikely. Borderline patients were interpersonally needy, very emotional, and with the exception of occasional lapses in reality testing, they were definitely not psychotic (Table 1).

## **Negative Descriptors**

**(SLIDE 14)** What was also apparent was that they were “difficult” patients and had considerable suicidal risk. The literature described them as “fickle, egocentric, irresponsible, love-intoxicated, “intractable, and unruly”. These were the patients who were “frequent flyers in ER’s”, and who used hospitals to escape from responsibilities. Thus, these patients attracted pejorative descriptions that discouraged charitable understanding.

## Depression

Given the high levels of comorbid depression in “borderline” patients, some clinicians felt that they had an atypical form of depression (8, 23–25). Akiskal (26) famously wrote that “borderline was an adjective in search of a noun” -- and at that time, in many people’s minds, that noun was clearly “depression.” Others, echoing Klein’s earlier attack (12) that the “borderline disorder” was a psychoanalytic pretext to excuse their failures, felt that the diagnosis had been included in DSM-III simply as a conciliatory gesture intended to placate the psychoanalytic plurality, many of whom were opposed to DSM-III’s operationalization of psychiatric diagnoses.

## Psa Psychotherapy: literature and conferences

During the 1970s, the literature on treatment for borderline personality disorder was almost exclusively about psychoanalytic psychotherapy (**SLIDE 15**). Numerous conferences on psychoanalytic therapy for borderline personality disorder were held, drawing large audiences. The featured speakers all achieved local, regional, or national

recognition for what was considered at that time to be their heroic tolerance and remarkable skills (10, 11, 27–32).

**(SLIDE 16)** The subsequent flood of books on the disorder provided compelling accounts of the many serious problems encountered during these therapies, among which were the signal problems of “countertransference hatred” (33) and “negative therapeutic reactions” (10, 34).

**(SLIDE 17)** Kernberg (34) wrote that negative therapeutic reactions were common and that they derived from the borderline patient’s “1) unconscious sense of guilt (as in masochistic character structures); 2) the need to destroy what is received from the therapist because of unconscious envy of him ...; and 3) the need to destroy the therapist as a good object because of the patient’s unconscious identification with a primitive and sadistic object” (p. 288). In retrospect, it is notable how the failures of psychoanalytic therapies were explained solely by the borderline patient’s pernicious motivations.

[Perhaps the movie character who best captures the scary hostile and destructive prototype of a borderline is Glen Close in “Fatal Attraction.”].

**(SLIDE 18)** Thus, by 1980, when borderline personality disorder officially entered the DSM classification system, its validity rested primarily and still quite precariously on its clinical utility, and

specifically on the ability of the diagnosis to predict a set of clinical dilemmas that were more or less specific to these patients (Figure 2).

**(SLIDE 19) 1980–1990 - From Syndrome to Personality Disorder:**

**“Wisdom Is Never Calling a Patient Borderline”: Tests of validity**

During the 1980s, biological psychiatry came to the fore and the recession of psychoanalysis began. **(SLIDE 20)** The adoption of borderline/personality disorder as a topic within academic psychiatry is shown in the sudden increase in psychiatric books.

**(SLIDE 21) Robbins/Guze** - After DSM-III defined many disorders with specific and measurable criteria, their validity was now being tested using standards set forth by Robbins and Guze (35). This meant that the validity of borderline personality disorder, like other diagnostic syndromes, was measured via examinations for discriminating descriptors, familiarity, longitudinal course, treatment response, and biological markers.

**(SLIDE 22) Research** - The systematic examination of these areas was carried out in numerous clinical research projects on BPD. **(SLIDE 23)** Until 1980, fewer than 15 research reports on BPD had been published; in the decade from 1980 to 1990, more than 275 appeared. With only

one exception, these projects were conducted without federal funding by investigators -- many of whom are identified in this slide.

**(SLIDE 24) Not Depression** - This research showed that the borderline personality disorder syndrome was an internally consistent, coherent syndrome (36, 37) with a course that differed from those of schizophrenia and major depression (38–40). It also showed that the syndrome was familial and that the prevalence of schizophrenia and depression was not increased in the families of borderline patients (38, 41, 42). The decade's research also indicated that borderline personality disorder had modest and inconsistent responses to multiple classes of medications (43–45). One conclusion from this considerable body of clinical research was that borderline personality disorder was not simply a variation of -- and was probably not closely related to -- depression (46, 47) (Table 1).

**(SLIDE 25) PTSD** - The new body of research drew attention to a previously unrecognized diagnostic interface -- that with posttraumatic stress disorder (PTSD). Here, the differential diagnostic issues were based less on descriptive overlaps than on etiologic considerations.

Studies of childhood physical and sexual abuse showed that there were reports of abuse in the histories of 70% of borderline personality disorder patients (48). This observation occurred at the same time that feminist concerns were raised about DSM-III diagnoses, including borderline personality disorder, that pathologized women or that implicitly blamed victims. Feminist clinicians suggested that descriptions of borderline psychopathology were fueled by men's anger (49) and that men's use of this diagnosis for female patients reflected their negative gender biases (50). Herman wrote that the borderline syndrome was a "disguised presentation hiding underlying PTSD" (48).

*Vignette 2: These feminist concerns became personal to me. When McLean decided to establish a Womens Treatment Center staffed by Stone Center leaders, they wanted to distance themselves from my "tough love" ideas about treatment of borderline patients. I found myself defending the value of interpretations and limits, admonishing clinicians not to be "held hostage by the threat of suicide," and by advocating the use of emergency rooms rather than late night calls. While I could justifiably defend these hard-won truths about "tough*

*love” I was less successful in defending myself from charges of gender-bias. In retrospect, I now see that I was failing to recognize the validity of my feminist critics. Even then, again in retrospect, the changes in my therapeutic stance that I was ostensibly resisting were nonetheless occurring. I had by now become a more relaxed and more confident psychotherapist, more flexible and available. Rather than taking pride in my ability to say “no”, I now felt regrets. Questions about love were not experienced as appeals for reassurance, but as legitimate and profound.*

**(SLIDE 26)** The high frequency of early dropouts from psychoanalytic therapy was now well documented (51–53), as was the infrequency of success with this therapy (53–55). The harm of neutrality, passivity, poor maintenance of boundaries, and countertransference enactment had become clearer, and out of the crucible of popular debates between Kernberg and other analysts (such as Adler [29] and Kohut [56, 57]) and relational psychologists (such as Jordan et al. [58]), the essential role of empathy and support became more widely appreciated.

**(SLIDE 27) Pejorative Meanings** - Thus, the emerging trauma data and the feminist concerns about the borderline label were joined by the ever-growing chronicle of the problems borderline patients were alleged to create within psychoanalytic therapies to consolidate a highly pejorative meaning for the borderline diagnosis. From this confluence, Vaillant wrote that “the beginning of wisdom is never calling a patient borderline” (59).

**(SLIDE 28) Clinical Wisdom** - By this time, sufficient clinical wisdom had accumulated that while we may not have become clear about what we should do, we had learned a lot about what *not* to do. For example, hospitals knew that borderline patients were not simply feigning symptoms to get admitted; rather, the symptoms were real, but they remitted as a result of the hospital’s “holding” and supportive functions. For me, by this time I had learned that borderline patients’ changing phenomenology could be made coherent by appreciating whether they felt “held” (depressed, cooperative), rejected (angry, self-destructive), or alone (impulsive, brief psychotic experiences) (60). It was also now clear that nonpsychoanalytic

modalities, including group and family therapy and medications, could often be helpful. Thus, the hopes for curative changes that had previously propelled psychoanalytic therapies were quietly being replaced by more pragmatic multimodel approaches that had more modest rehabilitative goals (60–66).

**(SLIDE 29) 1990–2000 - From Unwanted Personality Disorder to Disorder-Specific Treatability: “Would the Patient Be Borderline If She Remitted From a Medication?”: Biological Psychiatry**

**DSM IV**

In the 1990s, DSM-IV was published (with only modest changes in the definition of borderline personality disorder) and the biological paradigm had come to dominate psychiatry. During one DSM-IV meeting the brilliant and enigmatic Bob Cloninger raised a new question about borderline personality disorder’s diagnostic integrity: “Would the patient be borderline if she remitted from a medication?” (67). This was

not an easy question to answer. Indeed borderline personality disorder's validity was -- and still remains -- suspect because it fails to fulfill Robbins & Guze's fifth validating standard. It has neither a specific pharmacotherapy nor a unifying neurobiological organization from which biological psychiatry can find purchase.

**(SLIDE 30) Siever** - Against this backdrop Siever (68) proposed two psychobiological dispositions, *affective dysregulation* (with hyperresponsivity of the noradrenergic system) and *behavioral dyscontrol* (with reduced serotonergic modulation), which provided a much-needed conceptual and scientific structure for understanding the origins of borderline personality disorder as well as a way to explain borderline personality disorder's comorbidities and its spectrum relationships with other disorders. On this base, good arguments could be built for viewing borderline personality disorder primarily as an impulse spectrum disorder (69) or an emotional (affective) dysregulation disorder (70, 71).

**(SLIDE 31) PTSD** - By this time, the cogent considerations about the etiological overlap between borderline personality disorder and PTSD

had informed the borderline construct and had usefully shaped its boundaries (72). **(SLIDE 32)** Among the clarifying findings were that borderline personality disorder has about 30% comorbidity with PTSD (73), that borderline personality disorder often develops without a history of significant trauma (74), that childhood abuse and trauma predispose to many other psychiatric disorders (75, 76), and that while exploratory/expressive therapies are even more contraindicated for PTSD than for borderline personality disorder, treating borderline patients as victims of abuse usually made them worse (77). A subsequent group of studies has now confirmed that while childhood trauma, especially sexual abuse, is related to borderline personality disorder, a history of such trauma is unnecessary and usually does not account for much of the etiological variance (78–80).

**Bipolar Disorder** - The primary differential diagnostic issue had now become bipolar disorder. There was a substantial overlap in the underlying constructs of the two disorders as identified by Siever and Davis's (68) psychobiological dispositions and in their phenomenology, that is, impulsive/behavioral dyscontrol and affective/emotional instability. Moreover, during this decade the bipolar construct was expanding to include spectrum variants -- most significantly, bipolar II disorder, for which mania was not required (81). While the response of borderline personality disorder to mood stabilizers was unimpressive (68), the disorder's persisting lack of any distinctive neurobiological

base made it an obvious candidate for inclusion in bipolar disorder's growing spectrum.

### **Psychosocial Advances - Fonagy**

Even as these propositions and questions about borderline personality disorder's biological integrity were gaining attention, the borderline construct was independently receiving creative and groundbreaking advances with respect to the psychosocial aspects of its development and treatment.

**(SLIDE 33)** From England, Peter Fonagy, a Hungarian-born psychologist and psychoanalyst armed with both his skills as a developmental researcher and his contagious energy, enthusiasm, and creativity, introduced studies of early child development and the vicissitudes of caretaking that he postulated set the stage for later development of borderline personality disorder. Beginning with studies of attachment (82, 83) and building on earlier work by Winnicott (84) and Bowlby (85), Fonagy postulated that caretakers' failure to accurately mirror a child's mental states was responsible for establishing handicaps in knowing one's self (akin to DBT's concept of mindfulness)

and in empathizing with others - an inability to *mentalize* that made the child vulnerable to borderline personality disorder.

**(SLIDE 34) DBT** - In this context, in 1993 the first major stimulus to therapeutics since the psychoanalytic therapy initiative of the 1970s arrived from an unexpected source: Dialectical behavior therapy was introduced by Linehan (86), a self-described “radical behaviorist.”

Dialectical behavior therapy was a carefully manualized 1-year outpatient therapy combining well-integrated group and individual therapy components. While targeting the borderline patient’s pattern of self-harm and suicidality, its benefits also extended to less utilization of medication and hospitalization (87).

**(SLIDE 35)** Among the innovative departures from prior therapies were dialectical behavior therapy’s insistence on split treatment and on identification of treatment goals; its emphasis on validation, skill-building, and here-and-now interventions; its provision of around-the-clock availability; and its definition of the role of the therapist as coach. As important as its empirical support was, and as innovative and learnable as dialectical behavior therapy itself was, one could not have anticipated its impact without appreciating Linehan’s personal role. She was bold, charismatic,

and plainspoken. She openly challenged the claims of a psychoanalytic tradition and all other non-empirically based therapies. She inspired a new generation of zealously dedicated -- and empirically buttressed -- much more effective psychotherapists.

DBT was a borderline personality disorder-specific therapy that, because it was psychosocial, unwittingly offered an unexpected alternative to the reliance on medication response for satisfying the Robbins and Guze (35) validation standard of discriminating treatment response.

**(SLIDE 36) MBT** - Six years later, a second treatment specifically designed for borderline personality disorder was also shown to be effective, i.e., “Mentalization-based treatment”. Derived from Fonagy’s developmental research, Anthony Bateman established its efficacy in an English partial hospitalization program (88). MBT was designed to correct the borderline patient’s underlying handicaps in mentalizing by adopting a noninterpretive, “not-knowing,” inquisitive stance intended to facilitate the accurate recognition and acceptance of one’s own and others’ mental states (including the therapist’s). MBT also began to

fulfill one of the most appealing promises of psychoanalysis, i.e., linking problematic parent-child interactions into a prescription for adult-patient corrections. This is consistent with the futuristic ideal of customizing parenting and customizing family environments.

**(SLIDE 37) 2000–2009 - Borderline Personality Disorder: “A Good-Prognosis Brain Disease”?: Etiology**

The current decade has been associated with a search for the underlying etiological bases for psychiatric disorders. This reflects both a growing impatience with the extensive comorbidities in the DSM-III and DSM-IV classification systems and an excitement about the newly available neurobiological and genetic technologies.

**Advocacy**

Beginning with the stimulus given by several parent advocacy groups (most notably, the National Education Alliance for Borderline Personality Disorder, **(SLIDE 38)** led by wonderfully competent and upbeat Perry Hoffman, and most conspicuously **(SLIDE 39)**, TARA led

by the indomitable and ubiquitous Valerie Porr) and by the establishment of the BPDRF by a bereaved Swiss family, this decade has seen the adoption of borderline personality disorder by major mental health organizations, such as the NAMI, the NIMH, and, as noted at the start of my talk, even by the U.S. Congress. In this context, borderline personality disorder seems to have achieved a new legitimacy, at least as a subject for scientific study and for public awareness. I could now comfortably talk about it as an illness. Why has this occurred and what does it mean?

### **Two Findings**

Two major findings have greatly affected the borderline construct, one showing that the disorder is significantly heritable and the other that it has an unexpectedly good prognosis. The confluence of these findings is all the more significant because together they seem to defy the expectation that heritable disorders should be among the least changeable.

**(SLIDE 40)** Svenn Torgersen's (89) finding of a 68% heritability abruptly invalidated the many theories about borderline personality

disorder's etiology that had focused exclusively on environmental causes. With NAMI & NIMH's acceptance, it established borderline personality disorder's credentials as a "brain disease."

**(SLIDE 41)** This decade bore the fruits of two NIMH-funded longitudinal studies, the McLean Study of Adult Development (90) and the Collaborative Longitudinal Study of Personality Disorders (48).

These studies showed that borderline personality disorder has an unexpectedly good course. After identifying this course in her seminal long term study, my colleague, Mary Zanarini even began to call BPD "the good prognosis diagnosis". This fact offered enormous encouragement to patients with the disorder even as it raised questions about how those of us in the mental health fields could have been so mistaken. When this finding is combined with the evidence of heritability, it is clear that the DSM criteria are epiphenomena.

### **Guidelines**

**(SLIDE 42)** In 2001, despite the relative absence of an empirical basis, but guided by the silken glove of John Oldham, the APA prepared guidelines for the treatment of borderline personality disorder (93). This

was done because, as noted earlier, we now knew a lot about what *not* to do. The guidelines retained a primary role for psychotherapy, but they emphasized the need to enroll patients as collaborators, the need for a primary (i.e., administratively responsible) clinician, and the value of psychoeducation, family involvement, and the use of an algorithm for medications developed by Paul Soloff (94).

### **Manuals: TFP**

**(SLIDE 43)** Even as the APA guidelines retained a primary role for individual psychotherapy, the role of psychoanalytic psychotherapy and the literature about it had seriously declined. Since 1990, only four new books on psychoanalytic therapy for borderline personality disorder were published. Three of them were treatment manuals! Most notably these included the manualization of a revised version of Kernberg's original psychoanalytic therapy, transference-focused psychotherapy (95). In combination with the pioneering development of mentalization-based therapy noted earlier, the empirical validation of transference-focused psychotherapy's effectiveness (96) revitalized the relevance of

psychoanalytic contributions to the treatment of borderline personality disorder.

**(SLIDE 44) The Present—Awareness: “Borderline Personality Disorder Is to Psychiatry What Psychiatry Is to Medicine”**

(I first thought of this heading as signifying BPD and psychiatry were unwanted stepchildren to their parent organizations. I now think that is a poor analogy. I think BPD reflects what is central to psychiatry, just as psychiatry reflects what has been central to the good practice of medicine. BPD focus psychiatry’s attention to its psychosocial and humanistic perspectives just as psychiatry focus medicine’s attention to the essential translation of offering involved caring doctors to those who are ill.

**(SLIDE 45)** House Resolution 1005 states that “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.”

**Implications**

**(SLIDE 46)** What are the implications? Borderline personality disorder remains terribly and unfairly stigmatized . Most mental health professionals want to avoid—or actively dislike—borderline patients. Borderline personality disorder remains far behind other major psychiatric disorders in awareness and research. The difference between its reported prevalences in clinical settings (15%–25%) (97) and in the community (1.4%–5.9%) (98, 99) indicates that a large number of people with the disorder are undiagnosed and untreated.

**(SLIDE 47)** Research on the disorder receives a total of only about \$6 million annually in NIMH funds, less than 2% of the amount allocated to research on schizophrenia (which has a prevalence of 0.4%) (100) and less than 6% of that for bipolar disorder (which has a prevalence of 1.6%) (101). **(SLIDE 48)** Despite the significant impact of borderline personality disorder on the course and treatment of anxiety disorders (102) and mood disorders (103), psychiatric research on these other disorders often fails even to document its co-occurrence.

Research on borderline personality disorder suffers from a lack of young investigators. Most of those who put this diagnosis on the map are

approaching retirement, and few of them have the research credentials or funding to nurture a next generation. A growing number of empirically validated treatments for borderline personality disorder exist, but they remain EBT's largely unavailable or, when available, are often not reimbursed.

**Training (Slide 49)** - More remarkable is that borderline personality disorder still lacks a standing presence in psychiatric training curricula. Starting with the premise that all borderline patients are entitled to be treated by professionals who have been trained to do this, it is scandalous that appropriate teaching - both academic and clinical - for residents is nonexistent in all but a few institutions. (Let me expand a bit about training. To assure that professionals who treat them have had adequate training, minimal training goals should be standardized. These slides offer a proposal for what that didactic **(SLIDE 50)** and clinical **(SLIDE 51)** training might involve. That such standards do not already exist I think is due to the negative attitudes about borderline patients within our professional organizations **(SLIDE 52)** The escalating number of books written for nonprofessionals bears witness to the devastating toll the disorder takes

on others. Still unknown are the public health costs of this disorder, but given borderline patients' heavy utilization of psychiatric services; medical complications; involvement in divorce, libel, and childrearing lawsuits; and their violence and sexual indiscretions, the costs can be expected to be tremendous. Also unknown, despite significant advances (104–106), is borderline personality disorder's core psychopathology and its related neurobiology. While spectrum relationships with bipolar disorder and antisocial personality disorder (107) seem most significant, borderline personality disorder's defining clinical features remain interpersonal (108).

**(SLIDE 53) DSM V** - With the development of DSM-V under way, borderline personality disorder's internal coherence and integrity stand on firm ground (109–112), but questions can be expected about whether the label “borderline” should be retained, about whether the diagnosis belongs on axis I instead of axis II, and about whether the diagnosis should be given to adolescents. I believe the term “borderline” has earned honorific status by virtue of its familiarity. As highlighted in this review, it accurately signifies borderline personality disorder's unclear boundaries while reminding us of an unwanted truth, namely, that psychiatric disorders, like other medical conditions, are heterogeneous and have flexible boundaries. It should not be scapegoated because of this. With respect to the question of whether it should be on axis I or axis II, it belongs on axis I to signify its severity, its morbidity, and its

unstable course. But it belongs there too to prioritize its usage and to underscore the need for its treatment to be reimbursed. Use of the borderline diagnosis clearly should be extended to adolescents; its clinical usage in this group is already extensive, its internal coherence and stability are established, and it predicts adult dysfunction as well as adult borderline personality disorder (113).

## **DISCUSSION:**

### **The mind**

In modern psychiatry, borderline personality disorder has become the major container for sustaining the relevance of the mind, an arena that has been endangered by our growing biological knowledge. For example, when a borderline patient cuts him- or herself, the behavior can be understood as providing relief by redirecting intolerable and inchoate psychic pain into physical pain with both a welcome focus of attention and a welcome release of neurohormones. This behavior can just as aptly be considered as a breakdown in the ability to mentalize; that is, to keep in mind both the feelings about oneself and another. Such conceptualizations still need to recognize that the intensity or intolerance of the affect has a heritable base -- as does, probably, the violent and

impulsive cutting behavior itself -- and that the patient has a special sensitivity to rejection. But so much is lost if in addition to these explanatory conceptions the cutting is not also seen as an act of self-punishment related to an overly harsh self-judgment reflecting a long-standing perception of “badness.” It is the latter translation of the event that reintroduces the mind. When that sense of badness is further understood as having been derived in part from a family context with much criticism and little nurturance, we begin to give color and distinction to the environmental experiences that account for much of the etiological variance behind the patient’s cuttings. We also begin to recognize a unique personal narrative that allows the person’s life experience to be meaningful and unique and for the person to feel understandable and acceptable -- and not as bad as he or she thought.

### **Why Do This?**

*Vignette 3: This vignette took place last month just before I was leaving Boston to join my now-retired wife in Florida.*

*To my surprise, Carla, who I have seen 2x a week for 4 months agreed that to stay in town and attend her groups would be better for*

*her than to visit her family while I was away. Equally surprising, she noted that my leaving really was upsetting to her. These two unexpected disclosures prompted me to email the other treaters in her IOP exclaiming, “amazing!” That night Carla called, I was out, and she overdosed. I spent much of my final day and evening arranging for her hospitalization, assuring her of my continued commitment, admonishing her that “overdosing wasn’t necessary” (either to say “no” to her mother or to say “yes” to her treatment), and fielding angry criticisms from her mother about my irresponsibility as a doctor.*

*That night I felt guilty and helpless. I needed a sleeping pill. As I flew to Florida in the morning, I recalled that I had recently confided to a long-term colleague that borderline patients turn out to be much easier to treat than we originally thought. He said, “no, not really, they’re not”. My colleague was right. This isn’t easy. I asked myself, “so why do you do this work?”*

My answer: borderline personality disorder is now the only major psychiatric disorder for which psychosocial interventions remain the primary treatment. I entered psychiatry with an inherent interest in

personal involvements and with the hope of understanding myself and others. I have increasingly been able to see myself in my patients' experiences and have increasingly been able to see myself as a therapeutic agent. Few other places in modern psychiatry provide opportunities to actualize these aspirations. So why do this? Mental health professionals who are willing to make a serious investment in treating patients with borderline personality disorder can expect to become proud of their professional skills and of their personal growth in tolerance and empathy, (I think that, like the Grinch, my heart has grown larger). When I look back on my career, to have experienced highly personal, deeply appreciated, and often-enough a life-changing role for my borderline patients has been the most meaningful work I've done. It is in this arena alone that I feel I've best fulfilled my ego ideal of Dr. Zhivago.

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