SECOND EDITION

Borderline Personality Disorder

A CLINICAL GUIDE

John G. Gunderson, M.D.

WITH

Paul S. Links, M.D., F.R.C.P.C.

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Dr. Gunderson has been integrally involved in the diagnosis and treatment of borderline personality disorder since 1969. His studies helped to define the diagnosis of borderline personality disorder and establish an empirical standard for evaluating treatment of this disorder.

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INTRODUCTION

THIS BOOK IS A SEQUEL to *Borderline Personality Disorder: A Clinical Guide,* published in 2001, which was a sequel to *Borderline Personality Disorder,* published in 1984. These books have summarized what was known—or believed—about treating borderline personality disorder (BPD) at the time of their publication. This revision of the 2001 book updates the rapidly expanding treatment literature. Clinical perspectives, concepts, and modalities continue to become more sophisticated, detailed, and empirically buttressed. A great deal is currently known about what to do and, just as important, what not to do to treat BPD effectively. After only a 7-year interval, a significant revision was needed to accommodate the mushrooming of information, expertise, and specialization.

This book is meant to cover comprehensively all the recognized therapies for BPD. It details long-term multimodal treatment, with an appreciation that no one modality is by itself sufficient. I attempt to emphasize advances from empirical research and to synthesize them with what is feasible and with what derives from clinical experience. Above all, this book is meant to be useful and practical, primarily for clinicians, but also potentially for trainees, patients' families, and health care administrators. Although no treatment is excluded from consideration because of its cost, all treatments are considered with issues of cost-effectiveness and feasibility in mind.

The first chapter covers the issue of the diagnosis itself: what the diagnosis means and the biases that affect its use. Special attention is given to the borderline patients' behavioral specialty (i.e., their self-destructiveness) and to the use of this diagnosis in adolescents. Perhaps the most important message for clinicians is that we do these patients (and their families) a favor by identifying the diagnosis and educating them about it. Patients and families deserve to know what is known, and, as often as not, the success of treatments rests on their being included as responsible allies.

Chapter 2 describes BPD's most common differential diagnostic issues. These have shifted from schizophrenia to depression to posttraumatic stress disorder to the current controversy about the interface with bipolar disorder. The last issue is now given more attention.

Three theories guide most clinicians—biological, cognitive-behavioral, and psychodynamic. My psychodynamic background inevitably anchors much of this book, but the theory most central to this book's goals is a theory about therapies found in Chapter 3. Chapter 3 offers an empirically and clinically anchored theory on the sequencing of goals (i.e., targets for intervention), on processes of change, and on the modalities that are best suited for a patient's changing needs. The chapter underscores the feasibility and value of establishing initial short-term goals. In this chapter, I also describe the basic role of psychoeducation for patients and families—both as a way to establish an alliance with longer-term goals and as a therapeutic intervention in its own right. Psychoeducation superimposes a logic on treatment planning, and it anticipates the sequence of the chapters that compose the rest of the book.

After Chapter 3, the book proceeds to chapters concerning the implementation of overall treatment plans (Chapters 4 and 5). These chapters emphasize the need for someone to develop the plan, establish an appropriate level of care, and include rehabilitative services that address the borderline patients' typically severe impairments in social functioning. Chapters 6 through 12 describe the specific modalities in a sequence consistent with the severity of the borderline patient's mental state and with the length of time needed to meet the primary goals of each modality.

Chapter 4 outlines the primary clinician's responsibilities. In an era when managed care hovers in the background of treatment authorization, and in which care of borderline patients moves across multiple settings, it is easy to ignore the central requirement of having some one clinician be identified to all, including the patient, as being in charge—the *primary* clinician. This chapter introduces the thesis that rather than being problematic, *split treatments* that emerge from the current multimodal, multitreater environment are treatment enhancing. This book repeatedly points out how a treatment having two or more components not only adds breadth to the treatment goals but also offers a structure that safeguards treatment against the borderline patients' enactment of their intrapsychic splits.

Chapter 5 concerns four levels of care. Here empirical evidence is introduced about the potential value of the two most intensive levels: hospital care (level IV) and residential or partial hospital (level III). The four levels are not seen here as competitive but as having different goals, durations (this was intended 7 years ago), structures, and staffing. Of most interest may be the endorsement given to a newer level of care, intensive outpatient programs. Intensive outpatient programs represent a level of care that, although not widely available, may be more effective and certainly more cost-beneficial than relying on hospital or partial hospital services.

Reflecting the fact that medications have quietly become the single most widely and uniformly used treatment for BPD, two chapters (6 and 7) are devoted to psychopharmacology. Chapter 6 offers an extensive account of the seemingly irrational in vivo complexities surrounding prescribing medications and evaluating their effectiveness. In contrast, Chapter 7 offers a rational algorithm to guide selection of medications that should usefully inform prescribing physicians.

Chapter 8 encourages clinicians to involve families far more than has been customary. I describe how clinicians can use consumer-friendly psychoeducational interventions. Note that many interventions, albeit brief and not called therapies, may be very valuable. Furthermore, use of traditional dynamic family therapies is reserved for only selected cases and then only in a late stage of treatment. For most families, the primary treatments are parental coaching and assisted problem solving. Preliminary data that show the value of such coaching and problem solving are offered.

Chapter 9 underscores the role that interpersonal groups should play in the first year or so of most borderline patients' treatment. This type of treatment is readily exportable and nicely complements the functions served by individual therapies or psychopharmacology by addressing the interpersonal impairment that is central to most borderline patients' disorder. The available empirical evidence underscores the need for more use of and more research on interpersonal groups.

In Chapter 10, I argue that initiating individual psychotherapy should be done selectively, taking into account the motivation, the aptitude, and the social supports required of both patients and therapists. Otherwise skilled cognitive-behavioral or dynamically oriented therapists still need special training and experience, and perhaps special personality traits, to do such therapies well. Chapter 10 also outlines some of the general overlapping characteristics of all effective psychotherapies.

Although cognitive-behavioral principles have always been needed for adequate treatment of BPD, Chapter 11 recognizes that specific types of cognitive-behavioral treatments have now become the cornerstone for much modern theory and practice. Indeed, dialectical behavior therapy (DBT) has rapidly become the most BPD-specific and empirically substantiated treatment for BPD. Unquestionably, DBT was the major advance in therapeutics of the 1990s. Chapter 11 tries both to acquaint the uninitiated with DBT and to place it in some perspective. Other notable developments cited in Chapter 11 include the recent addition of a promising second empirically validated cognitive-behavioral treatment, schema-focused psychotherapy, and evidence for the potential for short-term cognitive-behavioral therapies to be effective for discrete goals.

Chapter 12 is devoted to psychodynamic (i.e., psychoanalytic) psychotherapy, the modality that for several decades was considered the treatment of choice for BPD. Chapter 12 highlights the long-needed emergence of empirical support for Kernberg's transference-focused form of therapy. It also delineates the phases of psychotherapeutic progress and change over a period of 4 or more years. Both the corrective power of the relationship and the growth made possible by learning (i.e., insights) are described. The case is made that progress should be ongoing, and its absence should be cause for review and consultation. This optimistic message is set against the need for a protracted multiyear process.

Chapter 13 begins by noting that the borderline diagnosis has achieved a place in the consciousness of the mental health world, but it is only beginning to establish a place in the public consciousness. The development and influence of the Borderline Personality Disorder Research Foundation, the explicit recognition of a need for more research on BPD by the National Institute of Mental Health, the rise of family advocacy groups, and the adoption of BPD as a brain disease by the National Alliance on Mental Illness dramatically signal that this expansion is under way. Chapter 13 also introduces how the rise in neurobiological research is likely to greatly transform our understanding of borderline patients.

The remarkable advancements in treatment for BPD described and celebrated in this book can be expected to continue. The current diversity of theory and research creates a healthy, vibrant vehicle for continued growth.

Borderline patients require an array of clinical services, any of which can be harmful or helpful. But to treat this disorder effectively requires clinicians with specialized knowledge and training. When such conditions are present, beneficial changes occur that greatly reduce patients' dysphoric mental states and enhance social functioning. Effective treatment results in a concurrent reduction in the burden on borderline patients' significant others, an improved morale by treaters, and a decrease in the otherwise enormous public health costs.

Chapter 1

THE BORDERLINE DIAGNOSIS

THE BORDERLINE PERSONALITY DISORDER (BPD) diagnosis entered the American Psychiatric Association's DSM-III in 1980 (American Psychiatric Association 1980) and 12 years later, in 1992, was adapted for the World Health Organization's ICD-10 (World Health Organization 1992). The growth in the recognition and use of this diagnosis during the period from 1975 to 1990 has been remarkable. It is easily the most widely and commonly used diagnosis for personality disorders in modern clinical practice (Loranger 1990; Loranger et a1. 1997). Individuals with BPD constitute about 2%–3% of the general population (Swartz et al. 1990; Zimmerman and Coryell 1989), about 25% of all inpatients, and about 15% of all outpatients (Koenigsberg et al. 1985; Widiger and Weissman 1991).

Origins of the Diagnosis

The origins of the borderline diagnosis, illustrated in Figure 1–1, are usually traced to the clinical observations of Adolph Stern (1938), a psychoanalyst in office practice, who recognized that a subgroup of his patients disregarded the usual boundaries of psychotherapy and did not fit into the existing classification system, a system concerned primarily with dividing psychoses from neuroses. A scholarly review of the work preceding Stern's can be found in Mack (1975). The patient group became somewhat more widely recognized in the early 1950s as a result of several influential papers by Robert Knight (1953, 1954). He expanded the descriptor *borderline* from relating to only the border with neurosis to being equally relevant to the border with psychosis. Like Stern, he began by decrying the "wastebasket" diagnostic status for such patients. However, he added that failure to identify the unique needs of these patients was responsible for the troubling disagreements between staff members on inpatient units; he further stated that this failure led clinicians to ignore providing the structure such

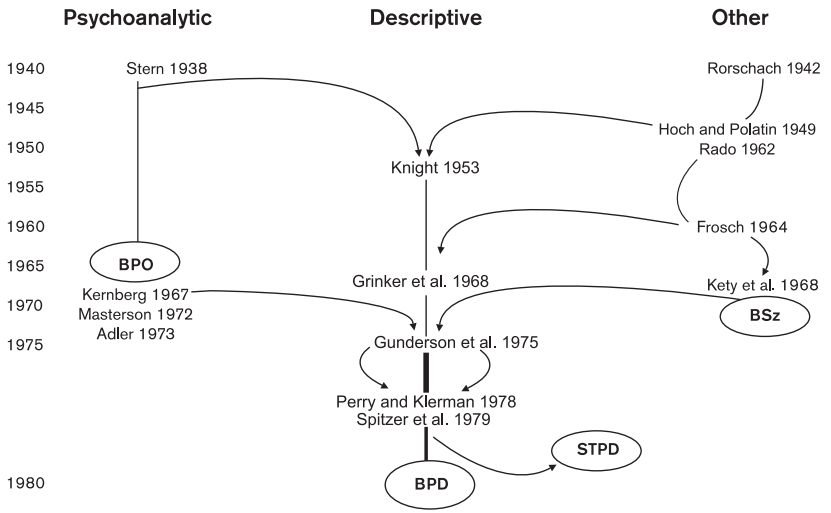

FIGURE 1–1. Development of the borderline construct, I.

BPD=borderline personality disorder; BPO=borderline personality organization; BSz=borderline schizophrenia; STPD=schizotypal personality disorder.

patients needed to avoid regressing. After Knight, the term *borderline* to denote troublesome patients who were neither psychotic nor neurotic retained some currency but primarily within the community of psychoanalysts who worked in hospital settings (Sidebar 1–1).

Sidebar 1–1: Where Were the Borderline Patients Before the Diagnosis?

A review of medical records from Danish and British psychiatric institutions before the diagnosis was used showed that borderline patients existed (Gunderson et al. 1983; Kroll et al. 1982). Although Freud himself used the term *borderline* only to differentiate delinquent acting-out adolescents from those with neuroses (Aichhorn 1925/1945, Introduction), years later Wolberg (1973) rediagnosed one of Freud's most famous patients, the "Wolf Man," as being borderline. Certainly, before the diagnosis, clinicians (Aichhorn 1925/1945; Alexander 1930; W. Reich 1949) described impulse-driven disorders presaging what was to become the BPD diagnosis. Therefore, there is every reason to believe that borderline patients were present in clinical settings long before the diagnosis.

Still, it is possible that what was formerly rare is now far more common. Grinker et al. (1968) suggested that bor-

derline psychopathology is a by-product of social changes during the twentieth century. The earlier burdens of manual labor and the earlier restrictions of travel, communication, and leisure time may have offered the structure, survival activities, and monitors that silently kept such psychopathology in check. Millon (1987) developed a thesis (subsequently elaborated by Paris (1992)) about sociocultural causes for BPD that, if taken to its extreme, is consistent with the possibility that BPD would have been far less common in other eras. At present, this thesis can be tested only by epidemiological work showing whether the incidence and prevalence of BPD vary between cultures and their levels of modernity.

Use of the term *borderline* for atypical, clinically troubling cases staggered along in the periphery of psychiatric thinking without notable progress until developments in the late 1960s. At this point, the confluence of three independent investigations forced the questions about a borderline consciousness.

The first of these investigations came from Otto Kernberg (1967). Even as a relatively young man, Kernberg authoritatively added to the psychoanalytic perspective of the borderline construct. He defined *borderline personality organization* as one of three forms of personality organization, to be differentiated from sicker patients, who had *psychotic personality organization,* and healthier patients, who had *neurotic personality organization* (Figure 1–2). Borderline personality organization was characterized by failed or weak identity formation, primitive defenses (namely, splitting and projective identification), and reality testing that transiently lapsed under stress. Kernberg's scheme was a conceptual advance within the psychoanalytic community by virtue of integrating object relations with ego psychology and the instincts and by virtue of giving a rationale and organization to a basic classification system. However, the effect of his scheme within the larger mental health community derived more from the optimistic therapeutic mandates that he gained from his way of understanding these patients than from the concept itself (see Kernberg 1968, 1975).

The second seminal contribution was provided by Roy Grinker et al. (1968), a senior and respected statesman within American psychiatry. Armored with a brief personal analysis by Freud himself, Grinker had become chairman of psychiatry at The University of Chicago and editor of the *Archives of General Psychiatry.* As one of the early champions of the need for empirical research, and having already made major contributions to studies of depression and posttraumatic stress disorder (PTSD), Grinker undertook the first empirical study of borderline patients. With