Chapter 15

Cluster B Personality Disorders: Borderline

Our consideration of Cluster B personality disorders begins with the borderline patient, because borderline personality disorder serves as a reference point for the entire cluster. Narcissistic, antisocial, and histrionic personality disorders are often defined by how they differ from borderline personality disorder. Moreover, when *borderline* is used in the broad sense of a spectrum (Meissner 1988) or a personality organization (Kernberg 1967), all the personality disorders in Cluster B, along with those in Cluster A as well, may be subsumed under the general category of borderline conditions. Unfortunately, the increasing popularity of the borderline diagnosis in the last two decades has made it something of a psychiatric "wastebasket"—both overused and misused. Patients who are diagnostically confusing may receive the label *borderline* by default. A brief historical survey of the term *borderline* in American psychiatry may shed light on the place of borderline personality disorder (BPD) in the current nomenclature.

Evolution of the Term

In the late 1930s and throughout the 1940s, clinicians began to describe certain patients who were not sick enough to be labeled schizophrenic but who were far too disturbed for classical psychoanalytic

treatment. In an effort to capture the "in between" state typical of these patients, Hoch and Polatin (1949) referred to this group as having pseudoneurotic schizophrenia characterized by a symptomatic pattern of "panneurosis," "pananxiety," and "pansexuality." Robert Knight (1954) further characterized this ill-defined group by focusing on several impairments in ego functioning, including the inability to plan realistically, the incapacity to defend against primitive impulses, and the predominance of primary process thinking over secondary process thinking.

These early contributors were observing a "messy" syndrome that did not fit well into preexisting diagnostic rubrics. Grinker et al. (1968) brought some diagnostic rigor to the syndrome in the early 1960s with their statistical analysis of approximately 60 such patients who were hospitalized in Chicago. A cluster analysis of data on these patients suggested that there were four subgroups of borderline patients (see Table 15–1). These patients appeared to occupy a continuum from the "psychotic border" (Type I) all the way to the "neurotic border" (Type IV). In between the two extremes could be found a group with predominantly negative affects and difficulty maintaining stable interpersonal relationships (Type II), and another group (Type III) characterized by a generalized lack of identity, resulting in a need to borrow identity from others.

Table 15–1. Grinker's four subtypes of borderline patients

Type I: The Psychotic Border:
- A. Inappropriate, nonadaptive behavior
- B. Problems with reality testing and sense of identity
- C. Negative behavior and openly expressed anger

Type II: Core Borderline Syndrome:
- A. Pervasive negative affect
- B. Vacillating involvement with others
- C. Anger acted out
- D. Inconsistent self-identity

Type III: As-If Group:
- A. Tendency to copy identity of others
- B. Affectless
- C. Behavior more adaptive
- D. Relationships lacking in genuineness and spontaneity

Type IV: Neurotic Border:
- A. Anaclitic depression
- B. Anxiety
- C. Neurotic and narcissistic features

Source. Based on Grinker et al. 1968.

Grinker and his associates (1968) also attempted to identify common denominators in the borderline syndrome that were present regardless of the subtype. They came up with the following four key features: 1) anger as the main or only affect, 2) defects in interpersonal relationships, 3) absence of consistent self-identity, and 4) pervasive depression. One of the most significant contributions of this empirical study was the finding that the borderline syndrome was clearly distinct from schizophrenia. Grinker et al. found that these patients do not deteriorate into frank schizophrenia over time. Rather, they are stably unstable (Schmideberg 1959) throughout the course of their illness. This discovery helped refute the belief some skeptics held that borderline patients were actually schizophrenic.

Gunderson and Singer (1975) reviewed the descriptive literature and delineated six features as the basis for a rational diagnosis of borderline patients: 1) an intense affect of a predominantly depressed or angry nature, 2) impulsivity, 3) a superficial adaptation to social situations (which helped differentiate these patients from schizophrenics), 4) transient psychotic episodes, 5) a proneness to loose thinking in projective testing or other unstructured situations, and 6) a vacillating pattern of relationships that shifts from extreme dependency to transient superficiality. Gunderson (1984) continued his study of the borderline diagnosis with the intent of identifying criteria that would clearly distinguish the borderline personality from other psychiatric diagnoses. By 1990, Gunderson and his colleagues (Zanarini et al. 1990b) were able to identify clear discriminating features based on research that focused on descriptive characteristics (see Table 15–2).

Table 15–2. Discriminating characteristics of borderine personality disorder

Quasi-psychotic thought	Demandingness/entitlement
Self-mutilation	Treatment regressions
Manipulative suicide efforts	Countertransference difficulties
Abandonment/engulfment/ annihilation concerns	

Source. Based on Zanarini et al. 1990b, pp. 165–166.

Many of these criteria are interrelated. Borderline patients are consumed with establishing exclusive one-to-one relationships with no risk whatsoever of abandonment. They may demand such relationships with an air of entitlement that overwhelms and alienates others. Moreover, when they do become close with another person, a set of twin anxieties are activated. On the one hand, they begin to worry that they will be engulfed by the other person and lose their own identity in this primitive merger fantasy. On the other hand, they experience anxiety verging on panic related to the conviction that they are about to be rejected or abandoned at any moment. To prevent being alone, borderline patients may resort to wrist-cutting or suicidal gestures, hoping to elicit rescue by the person to whom they are attached. Cognitive distortions, such as quasi-psychotic thought (defined as transient, circumscribed, and/or atypical strains on reality testing), also may occur in the context of interpersonal relationships. Near-delusional perceptions of abandonment by loved ones are common, and psychotic transference regressions may appear when patients become attached to their therapists. Clinicians who witness this kaleidoscopic display of shifting ego states are prone to a variety of intense countertransference reactions, including rescue fantasies, guilt feelings, transgressions of professional boundaries, rage and hatred, anxiety and terror, and profound feelings of helplessness (Gabbard 1993; Gabbard and Wilkinson 1994).

While Gunderson and Grinker et al. focused primarily on descriptive diagnostic criteria, Otto Kernberg (1967, 1975) sought to characterize borderline patients from a psychoanalytic perspective. Using a combined ego psychological–object relations approach, he coined the term *borderline personality organization* to encompass a group of patients who showed characteristic patterns of ego weakness, primitive defensive operations, and problematic object relations. He observed a variety of symptoms in these patients, including free-floating anxiety, obsessive-compulsive symptoms, multiple phobias, dissociative reactions, hypochondriacal preoccupations, conversion symptoms, paranoid trends, polymorphous-perverse sexuality, and substance abuse. Kernberg cautioned, however, that descriptive symptoms were not sufficient for a definitive diagnosis. He believed instead that the diagnosis rested on a sophisticated structural analysis that revealed four key features (Table 15–3).

1. *Nonspecific manifestations of ego weakness.* One aspect of ego functioning is the capacity to delay the discharge of impulses and to modulate affects such as anxiety. Borderline patients, in Kernberg's view, are unable to marshal ego forces to perform those functions because of inherent nonspecific weaknesses. Similarly, they have a difficult time sublimating powerful drives and using their conscience to guide behavior.
2. *Shift toward primary-process thinking.* Like Robert Knight, Kernberg noted that these patients tend to regress into psychotic-like thinking in the absence of structure or under the pressure of strong affects. However, these shifts primarily occur in the context of generally intact reality testing.
3. *Specific defensive operations.* Foremost among these defenses was splitting, which Kernberg viewed as an active process of separating contradictory introjects and affects from one another (see Chapter 2). Splitting operations in the person with BPD manifest themselves clinically as follows: a) an alternating expression of contradictory behaviors and attitudes, which the patient regards with a lack of concern and bland denial; b) a compartmentalization of all persons in the patient's environment into "all good" and "all bad" camps, with frequent oscillations between camps for a given individual; and c) coexisting contradictory views and images of oneself (self-representations) that alternate in their dominance from day to day and from hour to hour.

Table 15–3. Kernberg's criteria for borderline personality organization

I.	Nonspecific manifestations of ego weakness
	A. Lack of anxiety tolerance
	B. Lack of impulse control
	C. Lack of developed subliminatory channels
II.	Shift toward primary-process thinking
III.	Specific defensive operations characteristic of borderline personality organization
	A. Splitting
	B. Primitive idealization
	C. Early forms of projection, especially projective identification
	D. Denial
	E. Omnipotence and devaluation
IV.	Pathological internalized object relations

Source. Based on Kernberg 1975.

> A 41-year-old Catholic priest was admitted to a psychiatric hospital upon discovery that he had engaged in extensive sexual behavior with children of both sexes. Shortly after admission, his routine laboratory studies revealed a positive test for syphilis. When confronted with the lab result, the priest responded, "I don't know how that's possible. I'm a celibate priest." The resident treating the priest simply pointed out that the patient had been admitted to the hospital because of his extensive sexual activity with minors. The priest blandly responded to this confrontation by saying, "What do you expect? I'm only human."

This clinical vignette illustrates how contradictory self-representations coexist in the borderline patient—a "celibate priest" coexisted with a promiscuous, bisexual pedophile. Moreover, the priest's matter-of-fact response was typical of the bland denial that many borderline patients display when confronted with the splitting maneuvers they employ. Other defenses, such as primitive idealization, omnipotence, and devaluation, similarly reflect splitting tendencies (i.e., others are seen in wholly positive or wholly negative terms). Projective identification, in which self-representations or object-representations are split off and projected onto others in an effort to control them, is another prominent defense in borderline personality organization, according to Kernberg.

4. *Pathological internalized object relations.* As a result of splitting, the person with borderline personality organization does not view other people as having a mixture of positive and negative qualities. Instead, others are divided into polar extremes and are regarded, in the words of one patient, as "either gods or devils." These individuals cannot integrate libidinal and aggressive aspects of others, which inhibits their ability to truly appreciate the internal experiences of other people. Their perceptions of others may alternate daily between idealization and devaluation, which can be highly disturbing for anyone in a relationship with such a person. Similarly, their inability to integrate positive and negative representations of the self results in profound identity diffusion, as illustrated by the previous example of the priest.

Kernberg's concept of borderline personality organization is distinct from the actual phenomenological characteristics that identify a specific personality disorder. In other words, his term encompasses many different personality disorders. In his view, patients with narcissistic, antisocial, schizoid, paranoid, infantile, and cyclothymic personality disorders, for example, are all characterized by an underlying borderline personality organization.

Because of the burgeoning literature on borderline conditions during the decades of the 1960s and 1970s, BPD was added to DSM-III (American Psychiatric Association 1980). (There is no precise equivalent category in DSM-II [American Psychiatric Association 1968]. Prior to the publication of DSM-III, borderline patients were usually diagnosed with the DSM-II category of schizophrenia, latent type.) In developing diagnostic criteria for BPD, an effort was made both to include the descriptive features identified by Gunderson and to reflect the structural analysis of Kernberg.

One of the major controversies revolving around the DSM-III and DSM-III-R (American Psychiatric Association 1987) criteria for BPD concerned the failure to include the empirically and clinically observed brief psychotic episodes. This situation has been rectified in DSM-IV (American Psychiatric Association 1994) by adding criterion 9—transient, stress-related paranoid ideation or severe dissociative symptoms (see Table 15–4). Empirical research has demonstrated that virtually all borderline patients experience some form of disturbed cognition, while at least 40% experienced quasi-psychotic thought (Zanarini et al. 1990a). Furthermore, as previously noted, quasi-psychotic thought has been shown to be one of the most discriminating features of BPD, and its inclusion in DSM-IV was designed to increase the clinician's capacity to distinguish the diagnosis from other Axis II disorders. Finally, the emphasis on persistent self-image distortions in criterion 3 and on dissociative symptoms in criterion 9 provides a recognition of the link between childhood trauma and BPD.

There is also considerable controversy over whether the term *borderline* should be applied to a specific personality disorder or should be used broadly, as Kernberg used it, to describe a dimension of personality (Gunderson and Zanarini 1987). Grinker and his associates (1968) clearly believed that there were several subcategories of the borderline syndrome, constituting a spectrum. Meissner (1984, 1988) categorized borderline conditions differently than Grinker et al., but he, too, believed that limiting the usage of the term *borderline* to a specific personality disorder was misleading. He noted that there were clear descriptive groupings within the spectrum, specifically, a hysterical

continuum and a schizoid continuum. Adler (1981) and Rinsley (1985) also regarded borderline conditions as comprising a continuum on which the core borderline patient described by DSM-IV represents the lower end and the patient with narcissistic personality disorder represents the upper end. In a retrospective study of 180 inpatients who had been diagnosed with BPD by DSM-III criteria, Fyer et al. (1988) found that 91% had another diagnosis as well, while 42% had two or more additional diagnoses. They speculated that the diagnosis of borderline personality is often applied to a heterogeneous group of patients whose symptoms overlap extensively with those of other diagnoses. To avoid conceptual confusion (and because related personality disorders, such as paranoid, schizoid, narcissistic, antisocial, and histrionic, are discussed at length in other chapters of this volume), the discussion in this chapter will be confined to those patients with the borderline features described by DSM-IV.

Table 15–4. DSM-IV criteria for borderline personality disorder

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. frantic efforts to avoid real or imagined abandonment (Note: Do not include suicidal or self-mutilating behavior covered in criterion 5)
2. a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
3. identity disturbance: markedly and persistently unstable self-image or sense of self
4. impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating) (Note: Do not include suicidal or self-mutilating behavior covered in criterion 5)
5. recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
6. affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
7. chronic feelings of emptiness
8. inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
9. transient, stress-related paranoid ideation or severe dissociative symptoms

Source. DSM-IV (American Psychiatric Association 1994), p. 654. Used with permission.

Demographic Features and Course of Illness

At least three-fourths of the patients who are diagnosed with BPD are female (Gunderson et al. 1991). This finding may be due largely to cultural biases stemming from sex-role stereotypes, because male patients who have the features of BPD are often diagnosed as having narcissistic or antisocial personality disorders. BPD is by far the most commonly used Axis II diagnosis, with a prevalence somewhere between 15% and 25% in clinical populations (Gunderson and Zanarini 1987). Its prevalence in the general population probably ranges between 1.8% and 4% (Baron et al. 1985; Gunderson and Zanarini 1987; Loranger et al. 1982; Swartz et al. 1990). The legitimacy of the diagnostic category of BPD has been substantiated by long-term follow-up studies demonstrating that, over time, borderline patients continue to manifest consistent clinical symptomatology; in the vast majority of cases, these patients do not shift into other major psychiatric disorders (Gunderson and Zanarini 1987).

Since all the major long-term follow-up studies (McGlashan 1986; Plakun et al. 1985; Stone et al. 1987; Werble 1970) have focused on subjects who have had rather extensive treatment experiences, the untreated course of BPD remains something of a mystery. In fact, the key follow-up studies have been undertaken with patients who have had long-term (1–2 years), psychoanalytically oriented hospital treatment. These studies suggest that BPD usually becomes apparent in late adolescence or young adulthood and that it runs a rocky course during its first decade of treatment, leading many clinicians to become discouraged with the patient's lack of progress. However, after approximately 5 or 6 years of treatment, borderline patients often begin to show substantial improvement that peaks in the second decade after their first hospitalization.

In the sample of 251 borderline patients studied by Stone and his colleagues (1987), approximately two-thirds were "recovered" or doing reasonably well after a decade or so, although many of these patients continued to receive outpatient treatment. In the Austen Riggs study (Plakun et al. 1985), borderline patients achieved a mean Global Assessment Scale score of 67, which placed them in the "good" range of functioning after a mean follow-up period of 15 years (comparable to Stone's study). In the Montreal study at the Jewish General Hospital (Paris et al. 1987), borderline patients were also reinterviewed at a

mean of 15 years after hospitalization, and the investigators found that 75% of the patients no longer met the criteria for BPD as defined by Gunderson's Diagnostic Interview for Borderlines. In McGlashan's (1986) follow-up study of 81 patients originally hospitalized at Chestnut Lodge, most of the patients were able to live independently and to adjust satisfactorily to work. However, the sample revealed a bimodal distribution when it came to functioning in intimate relationships: while one group managed to maintain meaningful intimate relationships over time, the other group adjusted to life by avoiding close interpersonal contact.

All of these studies suggest that clinicians have reason for optimism in the treatment of borderline patients. The patients studied all had better outcomes than did schizophrenic patients who were used in comparison groups, and they were very similar to patients with affective disorders on most measures. This optimism is tempered, however, by the finding that between 3% and 10% of the borderline patients committed suicide.

Relationship With Affective Disorders

When the term *borderline* first appeared in the psychiatric literature in the 1950s and 1960s, it clearly denoted a clinical entity that was "on the border" of psychosis or, more specifically, schizophrenia. As time has passed and long-term follow-up data have accumulated on the course of BPD, this disorder has been more closely linked to affective disorders than to schizophrenia (McGlashan 1983; Rinsley 1981b; Stone 1980; Stone et al. 1987). Whereas the course of schizotypal personality disorder is similar to that of schizophrenia, the course of BPD is distinctly different from that of schizophrenia but quite similar to that of affective disorder (McGlashan 1983).

The interface between Axis I major depression and BPD has been the source of ongoing controversy in clinical psychiatry. In one long-term follow-up study (Stone et al. 1987), there was a 69% overlap between major affective disorder and BPD. Another study found an 80% lifetime prevalence of major depression in patients with both dysthymia and BPD (Zanarini et al. 1989a). However, newer research has suggested that the comorbidity between major affective disorder and BPD is nonspecific in light of findings that other personality disorders have equal or higher frequencies of concurrence with major depression (Barasch et al. 1985; Fyer et al. 1988; Gunderson and Phillips 1991; Pfohl et al. 1984; Shea et al. 1987).

Similar shifts have occurred in the thinking about family history data and pharmacologic response. Whereas earlier studies had suggested a higher prevalence of affective disorder in the relatives of borderline patients, newer data have indicated that these linkages do not hold if borderline probands who also have major affective disorder on Axis I are removed from consideration (Gunderson and Phillips 1991). The unpredictable and uneven response of borderline patients to antidepressant medications also suggests that depression in borderline patients may be a different entity than Axis I major depression in nonborderline patients. Reviewing all the available evidence about the interface between BPD and major depression, Gunderson and Phillips (1991) concluded that the two disorders often coexist in one person but are otherwise unrelated.

A common problem confronting the clinician is differentiating the characterological depression typical of borderline personality from the major affective disorder that may coexist with BPD. A knowledge of the specific characteristics of each type of depression can assist clinicians in making this determination (Table 15–5). Borderline patients may use the term *depression* to describe chronic feelings of boredom, emptiness, and loneliness, but diagnostically may lack the vegetative signs of Axis I major depression (Gunderson and Zanarini 1987). Moreover, conscious feelings of rage are often intermingled with the characterological depression of the borderline patient, in contrast to the patient with a more autonomous and endogenous type of depression (Gunderson and Phillips 1991). Clinicians must keep in mind, however, that while these distinctions are helpful, both forms of depression may coexist in the same patient and may require pharmacologic intervention.

When psychopharmacologic agents are necessary to address the Axis I component of the depression in borderline patients, monoamine oxidase inhibitors such as tranylcypromine have been shown to be therapeutically effective (Cowdry and Gardner 1988). Whether tricyclic antidepressants are as useful is more controversial (Gunderson and Zanarini 1987; Soloff et al. 1986). In general, psychopharmacologic treatment approaches to borderline personality should be geared to target symptoms, such as the use of antidepressant medication for symptoms of depression. For behavioral dyscontrol, carbamazepine has been effective, while trifluoperazine has been helpful for psychotic or paranoid distortions of thinking (Cowdry and Gardner 1988). Be-

cause borderline patients frequently complain of anxiety, clinicians may be tempted to prescribe antianxiety agents such as benzodiazepines. However, these agents, particularly alprazolam, may cause disinhibition, resulting in increased problems with impulse control (Cowdry and Garner 1988; Gardner and Cowdry 1985). Since drug abuse is common in borderline patients, the potential for dependency on benzodiazepines is another reason to avoid their usage.

Evidence from three uncontrolled open trials indicates that fluoxetine may also be helpful in some borderline patients (Cornelius et al. 1990; Norden 1989; Markovitz et al. 1991). All three studies showed improvement primarily in the areas of impulsivity and self-injury, and the presence or absence of major depression did not appear to affect outcome in any of the trials. These preliminary findings, coupled with the unpredictable response of most borderline patients to traditional antidepressant medications, lend further credence to the notion that depression in borderline patients is qualitatively different from typical major depressive disorder. Gunderson and Phillips (1991) have postulated that impulse dysregulation rather than affective problems may be primary in BPD.

Table 15–5. Differential diagnosis of major depressive disorder and characterological depression typical of borderline personality disorder

Borderline Characterological Depression	Shared Characteristics	Major Depressive Disorder
1. Loneliness	1. Depressed mood: early onset, sustained	1. Guilt feelings, remorse
2. Emptiness	2. Worthlessness hopelessness	2. Withdrawal/agitation
3. Repeated suicidal gestures	3. Object hunger (without gestures)	3. Suicidality
4. Conscious rage	4. Dependency in relationships	4. Stable relationships
5. Demanding, hostile dependent relationships	5. Fragile self-esteem	5. Concern with defeat, failures
6. Concern with interpersonal loss, separation		6. Caregiving welcomed (with history of independence)
7. Illusory self-sufficiency (with history of dependency)		7. More severe vegetative symptoms

Source. Based on Gunderson and Phillips 1991.

While pharmacotherapy is an important adjunct in the treatment of BPD, medications must be prescribed judiciously. These patients commonly accumulate large numbers of prescriptions from a variety of doctors, all of whom share feelings of frustration in their attempts to satisfy the unending demands for attention. Borderline patients may repeatedly test their treating clinicians to see if they "really care." Limiting prescription medication is only one way for the psychiatrist to use firm limits with the borderline patient. When a psychopharmacologic agent is used to treat a target symptom, clinicians must be careful to emphasize that the agent is not a panacea and that the main thrust of treatment must be a slow and painful examination of relationship patterns, both in the transference and in the patient's life outside the therapeutic relationship.

In one survey of dynamic psychotherapists who were highly experienced in the treatment of borderline patients (Waldinger and Frank 1989), 90% of the respondents acknowledged that they prescribed medication for the borderline patients they were seeing in therapy. They were more likely to prescribe when they were feeling pessimistic about a particular patient's ability to work psychotherapeutically. These therapists also reported that nearly half the patients misused prescribed medication. This abuse was intimately connected with transference themes, and the investigators suggested that therapists should actively explore the patient's fantasies about the medication to prevent misuse.

Psychodynamic Understanding

Kernberg

Kernberg (1975) linked the etiology and pathogenesis of BPD to the developmental scheme of Margaret Mahler (Mahler et al. 1975). Readers may wish to review this scheme, outlined in Chapter 2, before continuing with this discussion. Specifically, Kernberg viewed borderline