Borderline Personality Disorder: New Findings and Current Controversies
Ohio State University Psychiatry Grand Rounds
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Baylor College of Medicine
Immediate Past President, American College of Psychiatrists
President-Elect, American Psychiatric Association
Precursors of BPD Concept

- Latent schizophrenia (E Bleuler, 1924)
- The borderline group of neuroses (A Stern, 1938)
- Ambulatory schizophrenia (G Zillborg, 1941)
- “As if” personality (H Deutsch, 1942)
- Pseudoneurotic schizophrenia (P Hoch, P Polatin, 1949)
- Borderline states (R Knight, 1953)
- Psychotic character (J Frosch, 1964)
- The borderline syndrome (R Grinker, B Werble, R Drye, 1968)
The Borderline Syndrome

- Failures of self-identity
- Anaclitic relationships
- Depression based on loneliness
- The predominance of expressed anger

- Grinker et al., 1968
Concepts of Borderline Disorders

- Borderline Personality Disorder (Kernberg)
- Schizophrenia (Kety) (Schizotypal PD - Rado, Meehl)
- Affective Disorders (D. Klein)
- Atypical Affective Disorders (D. Klein)
- Borderline Syndrome (Grinker)

Neuroses
Borderline Personality Disorder (BPD)
APA DSM-IV Criteria
(At least 5 must be present)

1. Fear of abandonment
2. Difficult interpersonal relationships
3. Uncertainty about self-image or identity
4. Impulsive behavior
5. Self-injurious behavior
6. Emotional changeability or hyperactivity
7. Feelings of emptiness
8. Difficulty controlling intense anger
9. Transient suspiciousness or “disconnectedness”
Heterogeneity of BPD

- DSM-IV - defined BPD is an extremely heterogeneous construct (Est. 256 varieties)
- Mix of unstable, stress-induced symptoms and stable personality characteristics (i.e., dimensional traits)
BPD Causes and Risk Factors

- BPD evolves in the presence of biological vulnerability, psychological adversity, and social stressors.
- No single factor accounts for the disorder. BPD cannot be understood without considering a broad range of risks.
- One cannot assume that patients with a typical clinical picture will have a specific pattern of risk.
- One cannot assume that patients with a specific pattern of risk will develop BPD.

- Paris, 2008
# Prevalence of PDs in a Community Sample (N=2053)

<table>
<thead>
<tr>
<th>Personality Disorder</th>
<th>Present Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paranoid</td>
<td>2.4</td>
</tr>
<tr>
<td>Schizoid</td>
<td>1.7</td>
</tr>
<tr>
<td>Schizotypal</td>
<td>0.6</td>
</tr>
<tr>
<td>Antisocial</td>
<td>0.7</td>
</tr>
<tr>
<td>Borderline</td>
<td>0.7</td>
</tr>
<tr>
<td>Histrionic</td>
<td>2.0</td>
</tr>
<tr>
<td>Narcissistic</td>
<td>0.8</td>
</tr>
<tr>
<td>Avoidant</td>
<td>5.0</td>
</tr>
<tr>
<td>Dependent</td>
<td>1.5</td>
</tr>
<tr>
<td>Obsessive-Compulsive</td>
<td>2.0</td>
</tr>
<tr>
<td>Passive-Aggressive</td>
<td>1.7</td>
</tr>
<tr>
<td>Self-Defeating</td>
<td>0.8</td>
</tr>
</tbody>
</table>

Torgersen, Kringlen, Cramer; 2001
# PD Prevalence Studies

<table>
<thead>
<tr>
<th>Authors</th>
<th>Location</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zimmerman &amp; Coryell, 1989</td>
<td>Iowa</td>
<td>797</td>
</tr>
<tr>
<td>Black et al., 1992</td>
<td>Iowa</td>
<td>247</td>
</tr>
<tr>
<td>Maier et al., 1992</td>
<td>Mainz</td>
<td>452</td>
</tr>
<tr>
<td>Moldin et al., 1994</td>
<td>New York</td>
<td>303</td>
</tr>
<tr>
<td>Klein et al., 1995</td>
<td>New York State</td>
<td>229</td>
</tr>
<tr>
<td>Lenzenweger et al., 1997</td>
<td>New York State</td>
<td>258</td>
</tr>
<tr>
<td>Torgersen et al., 2001</td>
<td>Oslo</td>
<td>2053</td>
</tr>
<tr>
<td>Samuels et al., 2002</td>
<td>Baltimore</td>
<td>742</td>
</tr>
<tr>
<td>Grant et al., 2004</td>
<td>USA</td>
<td>43,093</td>
</tr>
<tr>
<td>Crawford et al., 2005</td>
<td>New York</td>
<td>597</td>
</tr>
<tr>
<td>Coid et al., 2006</td>
<td>UK</td>
<td>626</td>
</tr>
<tr>
<td>Lenzenweger et al., 2007</td>
<td>USA</td>
<td>214</td>
</tr>
</tbody>
</table>

Torgersen, 2009
## PD Prevalence Studies (n=49,611)

<table>
<thead>
<tr>
<th>PD</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paranoid</td>
<td>1.7</td>
</tr>
<tr>
<td>Schizoid</td>
<td>0.9</td>
</tr>
<tr>
<td>Schizotypal</td>
<td>0.9</td>
</tr>
<tr>
<td>Antisocial</td>
<td>1.1</td>
</tr>
<tr>
<td>Borderline</td>
<td>1.6</td>
</tr>
<tr>
<td>Histrionic</td>
<td>1.5</td>
</tr>
<tr>
<td>Narcissistic</td>
<td>0.5</td>
</tr>
<tr>
<td>Avoidant</td>
<td>1.7</td>
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<tr>
<td>Obsessive-Compulsive</td>
<td>2.1</td>
</tr>
<tr>
<td>Passive-Aggressive</td>
<td>1.7</td>
</tr>
<tr>
<td>Self-Defeating</td>
<td>0.4</td>
</tr>
<tr>
<td>Sadistic</td>
<td>0.1</td>
</tr>
<tr>
<td>Any PD</td>
<td>10.3</td>
</tr>
</tbody>
</table>

Torgersen, 2009
Comorbidity

- 84.5% of BPD patients met criteria for Axis I disorder, mean = 3.2
- Most common =
  - Mood disorders
  - Anxiety disorders
  - Substance use disorders

- Lenzenweger et al., Biol Psychiatry, 2007
Question
Do the personality disorders, defined by DSM-IV-TR, have construct validity?

Answer
It depends...
- Studies differ
- Methodologies differ
- Populations differ
- Conclusions differ
Classification of PDs

- Current [categorical] diagnoses do not “carve nature at its joints.”
- They are not natural kinds based on fundamental differences in the biological organization of personality
- Rather, they are artifactual, contrived constructs used as heuristics to organize clinical information

Livesley, *JPD*, 2005
“...borderline personality disorder is neither borderline nor a personality disorder.”

- Dominated by discrete symptoms rather than traits
- Better classified as a condition of recurrent unstable mood and behavior

P Tyrer, Personality and Mental Health 3:86-95, 2009
Borderline Personality Disorder (BPD)
APA DSM-IV Criteria
(At least 5 must be present)

1. Fear of abandonment
2. Difficult interpersonal relationships
3. Uncertainty about self-image or identity
4. Impulsive behavior
5. Self-injurious behavior
6. Emotional changeability or hyperactivity
7. Feelings of emptiness
8. Difficulty controlling intense anger
9. Transient suspiciousness or “disconnectedness”
Latent Structure Analysis of DSM-IV BPD Criteria

- BPD is a unidimensional construct
- Patients with BPD represent a distinct cohesive class of subjects, yet one with dimensionally distributed temperamental characteristics

Fossati et al., *Comprehensive Psychiatry* 40:72-79, 1999
Construct Validity of BPD

- The 9 DSM-IV criteria of BPD reflect a statistically coherent construct, as measured by confirmatory factor analysis and temporal stability

- Sanislow et al., *Am J Psychiatry*, 2002
- Morey et al., *J Personal Disord*, 2004
Evidence for a Single Latent Class of Borderline Pathology

- Confirmatory factor analysis and latent class analysis of 101 subjects with BPD
- “the DSM-III (and presumably the DSM-IV) describes a single, surprisingly homogeneous construct. Despite the wide range of cognitive, affective, and behavioral symptoms encompassed by the construct, we found no evidence for distinct subtypes of BPD based on either item covariance or latent classes of individuals.”

- Clifton and Pilkonis, Comprehensive Psychiatry 48:70-78, 2007
Robins and Guze (1970)

1. Delineation of symptoms
2. Course of illness
3. Familial clustering
4. Predictable treatment response
5. Biological markers
BPD and Axis I

“...the evidence for the Robins and Guze criteria strongly argue for the consideration of BPD as a serious mental illness.”

New et al., *Biological Psychiatry*, 2008
Revising the DSM-5 BPD Proposal

“In its present form the BPD diagnosis has been validated.”

Gunderson, *JPD*, 2010
Revising the DSM-5 BPD Proposal
- Gunderson, *JPD*, 2010

List of Supporters
Bateman, Anthony, MD
Beck, Aaron T., MD
Black, Donald W., MD
Bohus, Martin, MD
Choi-Kain, Lois W., MD
Clarkin, John F., PhD
First, Michael B., MD
Fonagy, Peter, PhD
Gabbard, Glen O., MD
Goodman, Marianne, MD
Hoffman, Perry, PhD
Koenigsberg, Harold W., MD
Lenzenweger, Marc F., PhD
Linehan, Marsha M, PhD
McGlashan, Thomas H., MD
New, Antonia S., MD
Paris, Joel, MD
Pilkonis, Paul A., PhD
Ronningstam, Elsa F., PhD
Schulz, S. Charles, MD
Silk, Kenneth R., MD
Soloff, Paul H., MD
Stanley, Barbara H., MD
Trull, Timothy J., PhD
Zanarini, Mary C., EdD
Neurobiology of BPD
BPD as a Personality Disorder Emerging from the Interaction of Underlying Genetically-Based Traits

Impulsive aggression and affective instability = heritable endophenotypes that would contribute significantly to development of BPD

Siever et al., 2002
Amygdala-Prefrontal Disconnection in BPD

**Normal:** prefrontal cortex $\rightarrow$ inhibitory control over amygdala

**BPD:** Absence of normally tight coupling

$=$ disconnect between orbital frontal cortex and amygdala

$\rightarrow$ failure to downregulate amygdala in response to aversive stimuli

- New et al., 2007
Normal

**Cortex** (thought center)

**Amygdala** (emotion center)
Borderline

Cortex (thought center)

Amygdala (emotion center)
Stimulus Response to Facial Viewing

Neurobiological Model of BPD

Summary

Dysfunctional in BPD

Personality dimensions

- Herpertz, 2011 ISSPD Congress
Heritability of BPD

- Twin study (Torgersen et al. 2000)
- Novelty seeking (Cloninger, 2005)
- Impulsivity (New and Siever, 2002)
- Dopamine transporter polymorphism (Joyce et al., 2006; Tadic et al., 2009)
- Serotonin transporter gene (Ni et al., 2006, 2009)
- MAO-A gene (Ni et al., 2007)
- BDNF polymorphism (Wagner et al., 2010)
BPD Features: Genetic vs. Cultural?

- Genetic effects – 45% variance
- Unique environmental effects – 55% variance
- Gene-environment interaction:
  - Those with “sensitive” genotype will be at greater risk to develop BPD if an undesirable environment is present

- Distel et al., *PLoS ONE*, 2009
The Genetic Epidemiology of Personality Disorders: Results from the Norwegian Institute of Public Health Twin Registry

Kenneth S. Kendler, MD
Virginia Institute of Psychiatric and Behavioral Genetics
Virginia Commonwealth University
American College of Psychiatry
Feb 23, 2011
Highlights

1. As measured by structured interview, PDs are modestly heritable.
2. Correcting for measurement error, however, they are at least moderately heritable.
3. No evidence for shared environmental effects for PDs.
4. Examining individual clusters, so interesting results:
   - E.g. schizotypal PD archetypal cluster A disorder
   - ASPD and BPD – a “special” relationship.

- Kendler, ACP Annual Meeting 2011
Highlights

5. A multivariate model for DSM-IV PDs does not support the cluster A, B, C typology. Results more complex. Three factors:

- a broad vulnerability to PD pathology and/or negative emotionality
- a vulnerability to high impulsivity and low agreeableness and introversion
- a vulnerability to introversion.

- Kendler, ACP Annual Meeting 2011
Key Phenotypic Features of BPD with Identified Neural Correlates

Affective Instability

Relationship Disturbances

Impulsive-Aggression

Anomalous Pain Processing

- Koenigsberg, ACP Annual Meeting 2011
Dysregulation of Endogenous Opioids in BPD

- BPD ≠ Controls
  - Baseline $\mu$-opioid receptors (reflection of $\downarrow$ baseline endogenous neurotransmitter tone)
  - Endogenous opioid response to negative emotions
- Implicated in regulation of emotion, response to stress

Prossin et al., *AJP*, 2010
A Neuropeptide Model of BPD

- Oxytocin involved in affiliation and trust (Deficient in BPD?)
- Vasopressin correlated with aggression (Elevated levels in BPD?)

- Stanley and Siever, *AJP*, 2010
**Oxytocin and Trust in BPD**

_Bartz et al. SCAN in press_

**Assurance Game:** a variation of the Prisoner’s Dilemma: the PC program made the partner always cooperate.

**Partner strategy expectations**

- **BPD:** N = 14
- **CON:** N = 13
- 40 IU intranasal OXT

**Strategic response to partner**

= strategy they would have chosen if they knew the partner would cooperate.

They expected the partner not to cooperate and they were more likely to defect.

- Herpertz, 2011 ISSPD Congress
The Rupture and Repair of Cooperation in BPD

- BPD patients
  → profound incapacity to maintain cooperation
  → impaired ability to repair broken cooperation
- Altered activity of anterior insular cortex in BPD
- Norms used in perception of social gestures are pathologically perturbed or missing altogether in BPD

- King-Casas et al., *Science*, 2008
Attachment in BPD Patients

- Review of 13 studies
- All 13 showed strong association between BPD and insecure attachment
- 3 main types:
  - Unresolved
  - Preoccupied
  - Fearful

Agrawal et al., Harvard Review of Psychiatry, 2004
Sequential Theoretical Model of BPD Pathogenesis

Insecure Attachment

Endophenotypes
  • Impulsive aggression
  • Affect instability

Unstable Interpersonal Relationships
  • Excessive intensity
  • Overvalued Expectations
  • Unfounded Anxieties
  • Cognitive-Perceptual Symptoms

Oldham, AJP, 2009
Longitudinal course
Collaborative Longitudinal Personality Disorders Study (CLPS)

- 5 Collaborative Sites
  Brown (Shea), Columbia (Skodol), Harvard (Gunderson), Yale (McGlashan), Texas A&M (Morey)
- 668 Patients Recruited Originally (+65)
  STPD (N= 86), BPD (N=175), AVPD (N= 158), OCPD (N= 154), MDD and no PD (N= 95)
- Followed Longitudinally for >14 Years
  To determine the stability of symptoms, diagnoses, dimensions, and functioning and to determine the predictors of clinical course
Remission (12 month) From Personality Disorder Over 4 Years
Diagnostic Remission (cumulative): Lifetest survival estimates

Remission definition:

- BPD ≥ 12 mo

Gunderson et al., *Arch Gen Psych*, 2011
Mean Number of BPD Criteria

Gunderson et al., Arch Gen Psych, 2011
Functional Remission (GAF > 70 for 12 months): Lifetext survival estimates

Gunderson et al., Arch Gen Psych, 2011
Treatment Studies
APA Practice Guidelines Work Group on Borderline Personality Disorder

John Oldham, M.D. (Chair)
Glen Gabbard, M.D.
Marcia Goin, M.D., Ph.D.
John Gunderson, M.D.
Paul Soloff, M.D.
David Spiegel, M.D.
Michael Stone, M.D.
Katherine Phillips, M.D.
APA Treatment Recommendations for Patients with Borderline Personality Disorder

Evidence-based Treatment Strategies for BPD

Psychotherapy (core treatment)
Pharmacotherapy (adjunctive, symptom-targeted)
Types of Psychotherapy for BPD (published RCTs)

1. Mentalization-Based Therapy (MBT)
2. Dialectical Behavior Therapy (DBT)
3. Schema-Based Therapy (SBT)
4. Transference-Focused Therapy (TFT)
5. Generalized Psychiatric Management (GPM)
6. Cognitive Behavioral Therapy (CBT)
7. Systems Training for Emotional Predictability and Problem Solving (STEPPS)
Overview of Psychotherapy for BPD

- Four manualized psychosocial treatments
  1. MBT
  2. DBT
  3. SFT
  4. TFP
- All are effective to ↓ selected aspects of borderline psychopathology, especially self-mutilation and suicide attempts
- Symptoms relating to temperament are relatively slow to resolve

- Zanarini, 2009
Behavioral PSA

DBT  SFT  MBT  TFP

- Gunderson
Pharmacotherapy for BPD
Cochrane review of RCTs

- Drug treatment may help core symptoms and associated psychopathology
- Especially mood stabilizers and SGAs
- Not effective for overall severity of BPD
- Should be targeted at specific symptoms

- Lieb et al., Br J Psychiatry, 2010
Four Essentials of Effective BPD Treatment

1. Establishment of a strong therapeutic alliance
2. Availability of skilled therapists
3. Funds / insurance coverage
4. Time

NOTE: THERE IS NO QUICK FIX
Greatest Stressors for Professionals

1. Patient anger
2. Suicide attempts
3. Threats of suicide

Hellman et al., 1988
Why Israel Can’t Win

The siege of Gaza may punish Hamas, but it won’t make Israel safe. Why it is in peril like never before.

BY TIM McGIRK

PLUS: How Obama can forge a Middle East peace

BY MARTIN INDYK
What about DSM-5?
Should the Name be Changed?

“Borderline personality disorder by any other name would still be as real, as disabling, and as necessary to treat, as other serious mental illnesses.”

- Thomas Insell, MD
  Director, National Institute of Mental Health
  Director’s Post, April 19, 2010
DSM-5
Proposed Self-Report System for All Patients (not just PDs)
Patient-Rated Cross-Cutting Measures

1. Level One
   a. 22-Item Questionnaire
   b. Emotional Distress – Depression – Short Form 1*
   c. Emotional Distress – Anger – Short Form 1*
   d. Emotional Distress – Anxiety – Short Form 1*
   e. Patient-Rated 36-Item Scale of Personality

* From Patient-Reported Outcomes Measurement System (PROMIS), a network of NIH-funded primary research sites
Note: The following questions inquire about how you have been feeling over the past two weeks.

<table>
<thead>
<tr>
<th>During the <strong>past 2 weeks</strong>, how much have you been bothered by the following problems:</th>
<th>None</th>
<th>Slight</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. Not knowing who you really are or what you want out of life?</td>
<td>Not at all</td>
<td>Rare, less than a day or two</td>
<td>Several days</td>
<td>More than half the days</td>
<td>Nearly every day</td>
</tr>
<tr>
<td>19. Not feeling close to other people or enjoying your relationship with them?</td>
<td>Not at all</td>
<td>Rare, less than a day or two</td>
<td>Several days</td>
<td>More than half the days</td>
<td>Nearly every day</td>
</tr>
</tbody>
</table>
# Patient-Rated Level 1 Scale of Personality

This is a list of things different people might say about themselves. We are interested in how you would describe yourself. Please tell us what is typical of you during most of your adult life.

We’d like you to take your time and read each statement carefully, selecting the response that best describes you.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Very False or Often False</th>
<th>Sometimes or Somewhat False</th>
<th>Sometimes or Somewhat True</th>
<th>Very True or Often True</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I prefer not to get too close to people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. I usually do things on impulse without thinking about what might happen as a result</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Even though I know better, I can’t stop making rash decisions</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. I really don’t care if I make other people suffer</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. I keep to myself</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Other people seem to think my behavior is weird</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. People have told me that I think about things in a really strange way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. I almost never enjoy life</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the last 30 days and answer these questions thinking about how much difficulty you had doing the following activities. For each question, please circle only one response.

<table>
<thead>
<tr>
<th></th>
<th>How do you rate your overall health in the past 30 days?</th>
</tr>
</thead>
<tbody>
<tr>
<td>H1</td>
<td>Very good</td>
</tr>
</tbody>
</table>

In the last 30 days, how much difficulty did you have in:

### Understanding and communicating

<table>
<thead>
<tr>
<th>D1.1</th>
<th>Concentrating on doing something for 10 minutes?</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Extreme / Cannot Do</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1.2</td>
<td>Remembering to do important things?</td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td>Extreme / Cannot Do</td>
</tr>
<tr>
<td>D1.3</td>
<td>Analyzing and finding solutions to problems in day-to-day life?</td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td>Extreme / Cannot Do</td>
</tr>
</tbody>
</table>

### Getting around

### Self care

### Getting along with people

### Life activities

### Participation in society
DSM-5
Proposed PD Diagnostic System
Levels of Personality Functioning

Self

• **Identity**: Experience of oneself as unique, with boundaries between self and others; coherent sense of time and personal history; stability and accuracy of self-appraisal and self-esteem; capacity for a range of emotional experience and its regulation

• **Self-direction**: Pursuit of coherent and meaningful short-term and life goals; utilization of constructive and prosocial internal standards of behavior; ability to productively self-reflect

Interpersonal

• **Empathy**: Comprehension and appreciation of others’ experiences and motivations; tolerance of differing perspectives; understanding of social causality

• **Intimacy**: Depth and duration of connection with others; desire and capacity for closeness; mutuality of regard reflected in interpersonal behavior

In applying these dimensions, self and interpersonal difficulties should not be better understood as a norm within an individual’s dominant culture.
Self and Interpersonal Functioning Continuum

Please indicate the level that most closely characterizes the patient’s functioning in the self and interpersonal realms:

___ No Impairment
___ Mild Impairment
___ Moderate Impairment
___ Serious Impairment
___ Extreme Impairment
Proposed Personality Types for DSM-5

1. Schizotypal
2. Borderline
3. Antisocial
4. Avoidant
5. Obsessive-Compulsive
6. Personality Disorder, Trait-Specified
Borderline Personality Disorder Type
(overall prototype description)

Individuals who resemble this personality disorder type have an impoverished and/or unstable self-structure and difficulty maintaining enduring and fulfilling intimate relationships. Self-concept is easily disrupted under stress, and often associated with the experience of a lack of identity or chronic feelings of emptiness. Self-appraisal is filled with loathing, excessive criticism, and despondency. There is sensitivity to perceived interpersonal slights, loss or disappointments, linked with reactive, rapidly changing, intense, and unpredictable emotions. Anxiety and depression are common. Anger is a typical reaction to feeling misunderstood, mistreated, or victimized, which may lead to acts of aggression toward self and others. Intense distress and characteristic impulsivity may also prompt other risky behaviors, including substance misuse, reckless driving, binge eating, or dangerous sexual encounters.

Relationships are often based on excessive dependency, a fear of rejection and/or abandonment, and urgent need for contact with significant others when upset. Behavior may sometimes be highly submissive or subservient. At the same time, intimate involvement with another person may induce fear of loss of identity as an individual – psychological and emotional engulfment. Thus, interpersonal relationships are commonly unstable and alternate between excessive dependency and flight from involvement. Empathy for others is significantly compromised, or selectively accurate but biased toward negative elements or vulnerabilities. Cognitive functioning may become impaired at times of interpersonal stress, leading to concrete, black-and-white, all-or-nothing thinking, and sometimes to quasi-psychotic reactions, including paranoia and dissociation.
Borderline Personality Disorder Type

**Self Structure**: Individuals who resemble this personality disorder type have an impoverished and/or unstable self-structure and a self-concept that is easily disrupted under stress, and often associated with the experience of a lack of identity or chronic feelings of emptiness. Self-appraisal is filled with loathing, excessive criticism, and despondency.
Interpersonal Relationships: Individuals who resemble this type have difficulty maintaining enduring and fulfilling intimate relationships. Relationships are often based on excessive dependency, a fear of rejection and/or abandonment, and urgent need for contact with significant others when upset. Behavior may sometimes be highly submissive or subservient. At the same time, intimate involvement with another person may induce fear of loss of identity as an individual—psychological and emotional engulfment. Thus, interpersonal relationships are commonly unstable and alternate between excessive dependency and flight from involvement. Empathy for others is significantly compromised, or selectively accurate but biased toward negative elements or vulnerabilities.
Borderline Personality Disorder Type (continued)

**Emotions:** Self-appraisal is filled with loathing, excessive criticism, and despondency. There is sensitivity to perceived interpersonal slights, loss or disappointments, linked with reactive, rapidly changing, intense, and unpredictable emotions. Anxiety and depression are common. Anger is a typical reaction to feeling misunderstood, mistreated, or victimized.
Borderline Personality Disorder Type (continued)

Cognitions: Cognitive functioning may become impaired at times of interpersonal stress, leading to concrete, black and white, all or nothing thinking, and sometimes quasi-psychotic reactions, including paranoia and dissociation.
Borderline Personality Disorder Type (continued)

Behavior: Anger may lead to acts of aggression toward self and others. Intense distress and characteristic impulsivity may also prompt other risky behaviors, including substance misuse, reckless driving, binge eating, and dangerous sexual encounters.
BPD Type Matching Scale

Instructions: Rate the patient’s personality using the 5-point rating scale shown below. Circle the number that best describes the patient’s personality.

5  Very Good Match: patient exemplifies this type
4  Good Match: patient significantly resembles this type
3  Moderate Match: patient has prominent features of this type
2  Slight Match: patient has minor features of this type
1  No Match: description does not apply
If no specific PD type judged to be present, then consider Personality Disorder, Trait-Specified
Personality Trait Domains

1. Emotionality
2. Detachment
3. Antagonism
4. Disinhibition
5. Compulsivity
6. Schizotypy
Personality Trait Facets for Trait Domain of Emotionality

1. Emotionality
   a. Emotional lability
   b. Anxiousness
   c. Submissiveness
   d. Separation insecurity
   e. Pessimism
   f. Low self-esteem
   g. Guilt/shame
   h. Self-harm
   i. Depressivity
   j. Suspiciousness

(etc. for other Trait Domains)
Personality Trait Domain or Facet Rating Scale

0  -  Very little or not at all descriptive
1  -  Mildly descriptive
2  -  Moderately descriptive*
3  -  Extremely descriptive*

*considered clinically significant
Adaptive Personality Traits (Draft)

- Intelligence
- Self-esteem
- Self-efficacy
- Optimism
- Achievement motivation
- Persistence
- Conscientiousness
- Commitment
- Sociability
- Altruism
- Emotional expressiveness
- Empathy
General Diagnostic Criteria for Personality Disorder

The essential features of a personality disorder are impairments in **identity and sense of self** and in the capacity for effective **interpersonal functioning**. To diagnose a personality disorder, the impairments must meet *all* of the following criteria:

A. A rating of mild impairment or greater in **self** and **interpersonal functioning** on the Levels of Personality Functioning

B. Associated with a “good match” or “very good match” to a **personality disorder type** or with a rating of “extremely descriptive” on one or more personality **trait domains**

C. Relatively stable across time and consistent across situations

D. Not better understood as a norm within an individual’s dominant culture

E. Not solely due to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or a general medical condition (e.g., severe head trauma)
Overall Personality Assessment

**Level 1**
patient self-report

Patient completes 1) 22-item (2 PD items) Cross-Cutting Measure & 2) 36-item Personality Trait Scale

If positive on either 1 or 2, continue to Clinician Assessment

**Level 2**
clinician assessment

Level of Impairment in Personality Functioning
(self, interpersonal)

- Positive

PD Types

PD Trait Domains

If either is positive

Meets All Other General PD Criteria

PD Diagnosis Confirmed
Diagnostic Criteria for BPD

A. Significant Impairment in Self and Interpersonal Functioning manifest by:

1. Impairments in **identity** and **self-direction** such as:
   
a. Markedly and persistently unstable self-image and self-esteem  
b. Self-appraisal filled with excessive self-criticism  
c. Lack of cohesive identity and/or chronic feelings of emptiness  
d. Dissociative states of mind and deficits understanding own mental processes  

2. Impairments in the capacity for **empathy** and **intimacy** such as:
   
a. Difficulty in establishing fulfilling interpersonal relationships, often engaging in unstable, intense, and possibly abusive involvements  
b. Anxious preoccupation with real or imagined abandonment; alternating between over involvement and withdrawal and between extremes of idealization and devaluation of close others  
c. Interpersonal hypersensitivity, i.e., prone to inaccurately feel slighted or insulted  
d. Empathy for others compromised or selectively biased toward negative elements or vulnerabilities  
e. Episodic, stress-related paranoid ideation
Diagnostic Criteria for BPD (continued)

B. Pathological Personality Traits manifest by:

1. **Negative Emotionality**, characterized by indicators such as:
   a. Emotional instability due to significant reactivity of mood, particularly in relation to interpersonal situations
   b. Intense episodic dysphoria, e.g., despair, depression, irritability, or anxiety (usually lasting a few hours and only rarely more than a few days)

2. **Disinhibition**, characterized by indicators such as:
   a. Impulsivity in behavior and self-expression, e.g., serious arguments, unsafe sex, substance abuse, reckless driving, binge eating
   b. Recurrent self-harm, such as suicidal behavior, gestures, or threats; or self-mutilation, such as scratching, cutting, or burning

3. **Antagonism**, characterized by indicators such as:
   a. Intense, inappropriately expressed anger, e.g., frequent displays of temper, constant anger, recurrent physical fights
C. The impairments in personality functioning and expressions of pathological personality traits are relatively stable across time and consistent across situations.

D. The impairments in personality functioning and expressions of pathological personality traits are not better understood as a norm within an individual’s dominant culture.

E. The impairments in personality functioning and expressions of pathological personality traits are not solely due to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or a general medical condition (e.g., sever head trauma).
Diagnostic Criteria for BPD (continued)

Criteria Rating:
0 = Absent
1 = Mild
2 = Moderate
3 = Severe
4 = Extreme

Indicate the degree to which the individual meets each component of the criteria:
A1: Identity and sense of self
A2: Capacity for interpersonal functioning
B1: Negative Emotionality
B2: Disinhibition
B3: Antagonism

Total Score
DSM-5 Recap

- Evidence-based medicine involves both rigorous research and extensive clinical experience and wisdom
- Personality is a dimensional construct
- Personality disorders are clinical syndromes
- Published research supports either a categorical system (e.g., DSM-IV) or a dimensional system (e.g., FFM) as a framework
- The DSM-5 Work Group has proposed a hybrid model, but it is still a “work in progress”
- The DSM-5 Field Trials will inform us about the clinical utility of the model
- Your continued suggestions are welcome
Thank you for your interest!