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Primary Article for Discussion
Why borderline personality disorder is neither borderline nor a personality disorder

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ABSTRACT

Objectives *Borderline personality disorder is the most well-studied personality disorder in psychiatry. Despite its great influence in the study of these conditions, it has not been properly recognized that borderline personality disorder is atypical.*

Design *A critical analysis of the differences between borderline and other personality disorders is made.*

Method *A comparison is made between borderline personality disorder and other personality disorders with respect to diagnostic criteria, relationship to normal personality variation and treatment options.*

Results *Analysis of the operational criteria for borderline and schizotypal personality disorders shows that these are the only personality disorders that are dominated by discrete symptoms rather than traits. Cluster analysis of a data set of personality traits obtained between 1976 and 1978 (before borderline personality disorder became fashionable in the UK) could find no profile that supports the existence of a borderline personality disorder grouping, and the study of published papers on treatment in personality disorder shows a 3 : 1 ratio for borderline personality disorder compared with all other personality disorders combined, approaching 9 : 1 when unspecified (probably mainly borderline) conditions are taken into account.*

Conclusions *Borderline personality disorder is incorrectly classified as a personality disorder and does an injustice to those who suffer from it. It is better classified as a condition of recurrent unstable mood and behaviour, or fluxithymia, which is better placed with the mood disorders than in odd isolation as a personality disorder.*

Introduction

The very name 'borderline personality disorder' implies an unsatisfactory diagnosis. As Millon (1989) puts it, 'unless the word is used to signify a class that borders on something then it has no clinical or descriptive meaning at all' (p. 332). The reason why the term has stuck is because the borderland in which it is placed is a useful buffer zone between conditions that appear to be separate and yet need to be separated by a zone constituting another disorder. This borderland has included the zones between psychotic and neurotic conditions, including Hoch and Polatin's (1949) term 'pseudo-neurotic schizophrenia' (p. 195), the zone between depression and other affective disorders and impulsive behavioural syndromes, and the zone between mood and identity disorders. Otto

Kernberg (1975) was among the first to attach the word 'personality' to borderline when he described borderline personality disorder organization as a fundamental concept in understanding the thinking of those with the condition. Even though the subsequent work of Gunderson and Singer (1975) identified most of the features of borderline personality disorder as clinical symptoms rather than personality traits, the pressure to include borderline personality disorder in a separate Axis II of the Diagnostic and Statistical Manual of Mental Disorders-III (DSM-III) was so great that borderline became an official personality disorder. It is also fair to add that there was a significant political influence here that needs to be more widely known. There was considerable resistance to the introduction of the DSM-III in the USA from psychotherapists and psychoanalysts, and a separate axis of personality disorder, a diagnostic group that general psychiatry had neglected, was offered as a bargaining counter to obtain consensus and allow the introduction of the DSM-III. Since that time, the concept of borderline personality disorder has become so accepted that the fundamental inconsistencies that lay behind its introduction have never been properly addressed. This paper attempts to do so.

Method

The status of borderline personality disorder was examined from three viewpoints, with each comparing the borderline diagnosis with other personality disorders. These viewpoints are the following:

(1) A comparison of the diagnostic criteria of borderline personality disorder with other disorders.
(2) The place of borderline personality disorder in a dimensional spectrum of personality abnormality.
(3) The treatment of borderline personality disorder compared with other personality disorders.

Results

Comparison of diagnostic criteria

Although there is considerable argument over the accuracy of the definition of personality disorder, it nonetheless remains in both classifications as a long-standing morbid tendency. In the words of the DSM-IV, 'a personality disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment'. It would therefore be expected that the diagnostic criteria for each of these disorders would satisfy at least part of the requirements of persistence, pervasiveness and inflexibility similar to those for personality traits, which describe 'behaviour and beliefs about our enduring dispositions' (Matthews & Deary, 1998). When I look at the individual criteria for the diagnosis of personality disorders, I find some striking differences. Almost all the personality disorders are described in terms of traits with only two exceptions, schizotypal and borderline personality disorders (Table 1). Schizotypal personality disorder contains a predominance of clear symptoms that show overlap with some aspects of schizophrenia (e.g. ideas of reference, magical thinking, odd perceptions), and only three of them (a tendency towards suspiciousness or paranoid ideation, generally odd and eccentric behaviour, and lack of close friends (also shared by schizoid personality disorder)) can be described in any way as trait-based. In this context it is interesting to note that schizotypal personality disorder is placed among the schizophrenic group of disorders in the 10th revision of the International Classification of Diseases (ICD-10) (World Health Organisation, 1992), and in this context it sits much more appropriately. The other outlier is borderline personality disorder in which only two features, a pattern of unstable and intense personal relationships and persistent impulsivity (also shared with antisocial personality disorder), are in any way trait-based.

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Table 1: Ratio of symptoms and symptomatic behaviour to traits in the current DSM-IV personality disorders

Named personality disorders	Diagnostic criteria that are primarily symptoms	Ratio of traits to symptoms
Borderline	Efforts to avoid abandonment Persistently unstable self-image Recurrent suicidal behaviour Affective instability Chronic feelings of emptiness Inappropriate intense anger Stress-related paranoid ideation or dissociation	2:7
Paranoid	None	7:0
Schizoid	None	7:0
Schizotypal	Ideas of reference Odd beliefs or magical thinking Unusual perceptual experiences Odd thinking and speech Inappropriate or constricted affect Excessive social anxiety	3:6
Antisocial	None (with one shared with borderline—impulsivity)	7:0
Histrionic	Rapidly shifting and shallow expression of emotions	7:1
Narcissistic	None	9:0
Avoidant	None	7:0
Dependent	None	8:0
Obsessive–compulsive	None	8:0

Note: For this separation, symptoms or symptomatic behaviour is defined.
DSM-IV, Diagnostic and Statistical Manual of Mental Disorders-IV.

Indeed it could also be considered that these two are not really traits because their unpredictability and variability make it difficult for them to be described as persistent.

It is therefore reasonable to conclude that the diagnostic criteria for borderline personality disorder are out of keeping with those of other personality disorders and that the only similar disorder with essentially similar symptomatic characteristics, schizotypal personality disorder, also has a dubious status as a personality disorder.

The place of borderline personality disorder in a dimensional personality spectrum

It is becoming increasingly apparent that most psychiatric disorders can be placed on a dimensional spectrum between the extremes of complete absence of symptoms, and their intense and pervading presence. This indicates that the dividing line between disorder and non-disorder is essentially arbitrary and that even apparently normal individuals show some evidence of the illness characteristic in mild degrees.

The recognition of the advantages of a dimensional approach is even admitted more strongly in the field of personality, and there seems little doubt that a dimensional structure will be introduced in the DSM-V and ICD-11 when they are eventually published. On the basis that the central features of all abnormal personalities should be identified equally well in those of normal personality (but of lesser degree) means that the individual factors of normal personality variation should accord with those of personality disorder. Although there is still considerable argument over the best way of describing normal personality variation, the original links made by Galen (190) to Hippocrates' four humours (Table 2) have not only stood the characteristic test of time but has also received great

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Table 2: Synonyms for the Big Four higher order traits that make up the fundamental structure of personality

Source	Sociopathic group	Neurotic or negative affectivity group	Withdrawn or eccentric group	Inhibited or obsessional group	Other factors
Galen (190)	Choleric	Melancholic	Phlegmatic	Sanguine	
Eysenck and Eysenck (1964)	Extroversion	Neuroticism	Psychoticism		
Tyrer and Alexander (1979)	Sociopathic	Passive-dependent	Schizoid	Anankastic	
McCrae and Costa (1987)	Disagreeable	Neurotic	Introverted	Conscientiousness	Openness
Goldberg (1990)	Surgency	Emotional stability	(Low) agreeableness	Conscientiousness	Intellect
Cloninger, Svrakic, and Pryzbeck (1993)	Novelty-seeking	Harm avoidance	(Low) reward dependence	Persistence	Self-directedness cooperativeness self-transcendence
Current cluster model (DSM-IV) (American Psychiatric Association, 1994)	Cluster B	Cluster C	Cluster A		
Mulder and Joyce (1997)	Antisocial	Asthenic	Asocial	Anankastic	
Livesley et al. (1998)	Dissocial	Emotional dysregulation	Inhibitedness	Compulsivity	
Proposed cluster model (Tyrer et al., 2007)	Cluster B (dissocial)	Cluster C (dysthymic)	Cluster A (detached)	Cluster D (dutiful)	

DSM-IV, Diagnostic and Statistical Manual of Mental Disorders-IV.

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support from recent studies. Although different authorities describe between three and seven personality factors, the evidence for a common core of four is now getting overwhelming.

These are all easily demarcated, and only their names vary, and in terms of current personality disorder classification, the nearest link is to the cluster model from the DSM classification. It is commonly separated into three clusters, the odd, eccentric group (Cluster A); the flamboyant, dramatic or erratic group (Cluster B); and the anxious or fearful group (Cluster C); but the inclusion of the obsessive–compulsive (anankastic) disorder in this group is idiosyncratic (Tyrer, 2005), and there is a strong case from empirical data that the obsessive–compulsive personality disorder should be classified separately as Cluster D (Tyrer et al., 2007). Although the most prominent of the standard measures of personality has five clear factors (McCrae & Costa, 1987), its description as the Big Five, the category described as *openness*, does not have an obvious link to any form of personality pathology, and when it is taken away we return to the more universal Big Four. All the other classifications fit well to this apart from the three-factor model of Eysenck and Eysenck (1964), and this too can be integrated without much difficulty (Zuckerman, Kuhlman, Joireman, Teta, & Kraft, 1993) into Mulder and Joyce's (1997) four 'As' and Livesley's Dimensional Assessment of Personality Pathology (Livesley, Jang, & Vernon, 1998).

The examination of these factors suggests that the cluster grouping of personality disorder in the DSM classification, an aggregation that is generally frowned upon by many personality disorder researchers as having no satisfactory theoretical basis, fits in extremely well with the four factors of normal personality variations if the existing Cluster C personality grouping, not an entirely satisfactory one (Tyrer, 2005), is split so as to create a separate Cluster D for obsessive–compulsive (anankastic) personality disorder.

This natural grouping of both normal and pathological personality variation into four factors is illustrated by an early study that was carried out before the introduction of the DSM-III (Tyrer & Alexander, 1979). In this study, 130 patients were chosen by a group of research clinicians so that 65 had a clinical personality disorder (often in conjunction with another psychiatric disorder) and the other 65 had a clinical diagnosis but without personality disorder. Factor analysis of the 24 characteristics based on personality traits in the personality assessment schedule (PAS) revealed the Big Four factors summarized in Table 2, and these were found in both personality- and non-personality-disordered groups. However, in addition, I also wanted to see how patients grouped together and used hierarchical cluster analysis in this approach. Using this method, seven distinct clusters emerged from the 130 patients, and these were also similar in profile for the personality-disordered and non-personality-disordered patients, thus satisfying the dimensional criterion.

This is illustrated in Figure 1 where seven clusters are identified. At the time, these were labelled explosive, paranoid-aggressive, histrionic, asthenic, anankastic, schizoid and normal personality variations. Following the adjustments of Strauss, Bartko, and Carpenter (1973) regarding analysis of these data using a measure of distance between points that was not simply geometric but instead related to the correlation between observations led to a hierarchical cluster analysis revealing only five clusters, sociopathic, passive-dependent, anankastic, schizoid and normal, the same as the Big Four factors. In both distance and correlation analyses, one cluster was comprised largely of the non-personality-disordered group (normal), which accounted for 55 of the 65 non-personality-disordered patients in the furthest neighbour distance-based analysis, while all but two of the 65 personality-disordered cases were grouped into the other personality disorder clusters in the same analysis. Subsequent analysis of 256 further cases yielded the same four major groupings, but an additional subclassification was possible within those groups (Tyrer & Alexander, 1988). These data are shown in detail because there is one notable absentee—borderline personality disorder. Although it

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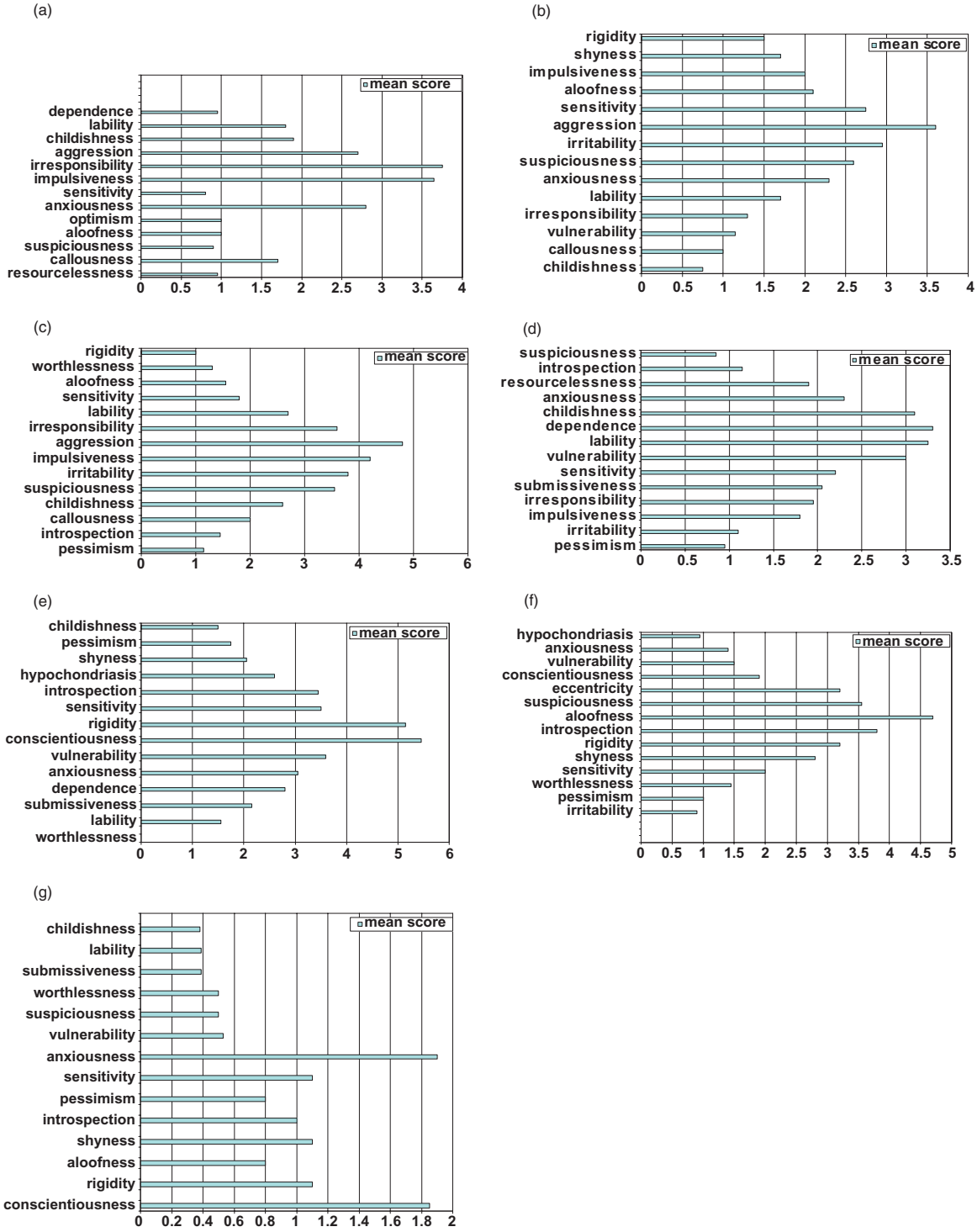

Figure 1: The seven clusters originally identified with data from the personality assessment schedule (PAS) in 1979. The PAS records 24 personality variables, and only the high-scoring ones are shown in the illustrated clusters. No evidence of a borderline grouping is identifiable from this data set. (a) Cluster 1: explosive; (b) Cluster 2: paranoid-aggressive; (c) Cluster 3: histrionic; (d) Cluster 4: asthenic; (e) Cluster 5: anankastic; (f) Cluster 6: schizoid; (g) Cluster 7: normal personality variation (9%)

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could be argued the 24 personality characteristics of the PAS do not include 'borderline traits', close examination of these suggest that these are present if borderline was indeed a trait-based condition, as the traits of worthlessness, lability, impulsiveness and pessimism should easily aggregate together if borderline personality disorder was indeed a trait-based personality abnormality. Indeed, these four characteristics constitute the PAS base for the derived diagnosis of borderline personality disorder in several personal studies.

In examining why borderline personality disorder does not seem to be present on the dimensional spectrum of personality, it is important to ask whether the borderline constellation of symptoms does indeed constitute a natural personality 'factor' in the population. Examination of Figure 1 suggests it does not, and close study of Table 2 yields the same conclusion. The only factor that appears superficially to match with the borderline group is the melancholic group of Galen, or the neurotic or negative affectivity group (Watson & Clark, 1984) of personalities, where emotional instability or dysregulation is prominent (Goldberg, 1990; Livesley et al., 1998). However, it is right to ask whether efforts to avoid abandonment, an unstable self-image, impulsivity, recurrent suicidal behaviour, rapid changes in mood, chronic feelings of emptiness and inappropriate intense anger link in to the neurotic spectrum. I contend they do not, for the predominant feature of borderline personality disorder is the great fluctuation in symptoms, quite removed from the persistent anxiety, gloom, avoidance and worry of the person with typical Cluster C pathology. Mood is of great importance in borderline personality disorder, but it is not an ingrained persistent feeling nagging away continuously in the background; it is more of a sudden visitation of alarm that is much more in keeping with acute mood disorders.

The treatment of borderline personality disorder

Most treatments for personality disorder are given for the borderline condition. Although the average clinician will recognize this when he or she reflects on his or her practice, it is often not fully appreciated. The 'big three' of borderline, antisocial and schizotypal personality disorders accounts for almost all published papers on personality disorder, and only that for borderline personality disorder is growing rapidly (Blashfield & Intoccia, 2000). When it comes to publications about treatment, the predominance of borderline personality disorder becomes even more prominent, and this was explored formally by examining all the papers listed in the PubMed database under 'treatment' and 'personality disorders' in the seven major journals concerned with clinical research in personality disorders: *Acta Psychiatrica Scandinavica*, *American Journal of Psychiatry*, *Archives of General Psychiatry*, *British Journal of Psychiatry*, *Journal of Clinical Psychiatry*, *Journal of Personality Disorders* and *Psychological Medicine* up to the end of April 2008. The results of this review are shown in Table 3, which confirms that almost three quarters of all papers directly concerned with treatment refer to borderline personality disorder. When the additional 15% of papers that describe treatment for personality disorder in non-specific terms, many of which refer to the borderline group predominantly, are taken into account, this figure approaches 90%.

This predominance is not unexpected when one realizes that most people with personality disorders are resisting treatment and do not want to have their personalities touched by any form of therapy; it is only some within the borderline and, to a somewhat lesser extent, the Cluster C personality group, who desire treatment (Tyrer et al., 2003). Those with the borderline condition often desire it intensely and is illustrated by the language of those who suffer (e.g. Reiland, 2004). Those with other personality disorders, particularly the antisocial group, have to be wooed into treatment as it is only at this point that they can engage properly with any form of complex therapy (Howells & Day, 2003). Because of the egosyntonic nature of most personality traits—we accept ourselves as we are and do not regard any of our characteristics

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Table 3: Distribution of published papers on personality disorders in seven major psychiatric journals from 1960 to 2008

Journal	Number of papers on personality disorder and treatment	Papers on borderline personality disorder			Papers on Cluster B personality disorder			Papers on all personality disorders			Other papers on named personality disorders
		RCT	Open	Rev	RCT	Open	Rev	RCT	Open	Rev	
Acta Psychiatrica Scandinavica	146	0	0	0	2	0	0	0	2	0	One paper on Cluster C group
American Journal of Psychiatry	509	8	11	5	1	0	0	2	0	1	One paper each on Cluster C, narcissistic and obsessive–compulsive personality disorders
Archives of General Psychiatry	231	9	1	0	1	0	0	0	0	0	
British Journal of Psychiatry	311	3	1	4	0	2	1	1	0	1	
Journal of Clinical Psychiatry	172	8	15	2	2	0	0	0	0	0	Two studies (1 RCT) in Cluster C group, 1 RCT in kleptomania
Journal of Personality Disorders	131	4	4	6	0	0	1	2	3	5	
Psychological Medicine	86	0	1	0	1	0	0	0	0	0	
Total papers	1586	32	33	17	7	2	2	5	5	7	
Percent of all papers on treatment of personality disorders			74.5			10			15.5		

RCT, randomized controlled trial; Open, open or uncontrolled study; Rev, review.

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as alien—the desire of the borderline patient to effect a complete makeover of his or her personality structure is an atypical, if understandable, response.

Discussion

The findings of this review show that borderline personality disorder is a statistical outlier hovering several standard deviations away from the core conditions in this group. Its symptom rather than trait profile, its failure to coalesce as a coherent persistent personality group and its treatment-demanding propensities make it very different from almost all other personality disorders. While its prominence in clinical presentation improves the profile of personality disorder in scientific and clinical terms, this is not sufficient for it to remain in a group of disorders where it fundamentally does not belong.

The association of borderline personality disorder with affective symptoms has been noted many times previously, but very few have gone so far as to conclude that the condition should be classified elsewhere. Coid (1993) has perhaps put the most persuasive case for such a change. In his study of female forensic patients, admittedly not the most typical of populations with the borderline syndrome, he identified four factors, anxiety, anger, depression and tension, in their symptomatic profile, and, importantly, found these were not related to the features of other individual personality disorders identified in the sample. Coid concluded that the persistence of this disorder could explain all the symptoms of the borderline condition; 'the affective syndrome proposed in this study would predispose its sufferers both to major depressive episodes over the lifetime as well as to the essential BPD features of impulse dysregulation, unstable affect, personal relationship difficulties and possibly disturbed self-image.' If such a condition was to be accepted as a mood disorder, then a term such as fluxithymia, or 'rapidly changing mood disorder', would constitute its essential characteristics. Akiskal et al. (1985) suggested many years ago that 'borderline' did not belong to personality disorder. I suggest that it does not belong anywhere; it should be abolished as it is a passport to heterogeneity. Unless it is redefined and reformulated, it will remain a condition that undoubtedly exists but will do so in so many forms that it defies predictions about treatment and prognosis, and will remain a constant puzzle for both practitioners and patients.

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