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Borderline Personality Disorder: Ontogeny of a Diagnosis

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Abstract

Objective—The purpose of this article is to describe the development of the borderline personality disorder diagnosis, highlighting both the obstacles encountered and the associated achievements.

Method—On the basis of a review of the literature, the author provides a chronological account of the borderline construct in psychiatry, summarizing progress in decade-long intervals.

Results—Borderline personality disorder has moved from being a psychoanalytic colloquialism for untreatable neurotics to becoming a valid diagnosis with significant heritability and with specific and effective psychotherapeutic treatments. Nonetheless, patients with this disorder pose a major public health problem while they themselves remain highly stigmatized and largely neglected.

Conclusions—Despite remarkable changes in our knowledge about borderline personality disorder, increased awareness involving much more education and research is still needed. Psychiatric institutions, professional organizations, public policies, and reimbursement agencies need to prioritize this need.

On April 1, 2008, the U.S. House of Representatives unanimously passed House Resolution 1005 supporting the month of May as borderline personality disorder awareness month. The resolution stated that "despite its prevalence, enormous public health costs, and the devastating toll it takes on individuals, families, and communities, [borderline personality disorder] only recently has begun to command the attention it requires." House Resolution 1005, which was the outcome of public advocacy efforts, drew attention to the disproportion between the high public health significance of borderline personality disorder and the low levels of public awareness, funded research, and treatment resources associated with the disorder. A recurrent theme in this review is the persistence of borderline personality disorder as a suspect category largely neglected by psychiatric institutions, comprising a group of patients few clinicians want to treat.

The review highlights the major clinical, scientific, and public health issues, as well as some of the remarkable personalities, that have shaped the development of this diagnosis. It is necessarily selective. It is organized chronologically, beginning with the period before the diagnosis was used clinically and then dividing the subsequent period somewhat arbitrarily into decade-long intervals. This approach allows the review of the trials and tribulations of borderline personality disorder to proceed within the framework of the changes that were concurrently transforming psychiatry.

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Before 1970—From Untreatable Patients to Personality Organization: "A Psychoanalytic Colloquialism"

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

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

The construct took its next major step forward in 1967, when Kernberg (9), a psychoanalyst concerned with the boundaries of analyzability, defined borderline as a middle level of personality organization bounded on one side by sicker patients who had psychotic personality organization and on the other by those who were healthier and had neurotic personality organization. As such, *borderline personality organization* was a broad form of psychopathology defined by primitive defenses (splitting, projective identification), identity diffusion, and lapses in reality testing (9). Kernberg then went on to suggest that these patients could be successfully treated with psychoanalytic psychotherapy (10).

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

Even as this therapeutic optimism was swelling, Klein (12) voiced a cynical counterpoint: "Analysts' progressive disillusionment with their ability to make permanent change in nonpsychotic patients has been masked by terminological revision. The diagnosis of *borderline disorder* preserves intact the belief that classical psychoanalysis is the uniformly effective treatment of choice for neurosis, since failures occur only with the borderline patients" (p. 366).

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

1970–1980—From Personality Organization to Syndrome: "An Adjective in Search of a Noun"

In the decade after "borderline" achieved the status of a colloquialism, the advent of descriptive psychiatry and psychopharmacology brought significant changes to psychiatry. The initial effort to describe borderline patients was made by Grinker, an early and powerful advocate of empiricism, and his colleagues in a seminal book entitled *The Borderline Syndrome* (15). This development set the stage for the publication of a review of this syndrome's place within the context of a broader literature in a paper entitled "Defining

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Borderline Patients" (16) and for the borderline syndrome to become reliably assessable with discriminating criteria (17). Soon afterward, it entered DSM-III (18) as "borderline personality disorder."

Borderline personality disorder was official, but what was it? Even before its inclusion in DSM, it had become clear that the disorder was not related to schizophrenia, and the inclusion in DSM-III of another new category, schizotypal personality disorder, finalized this cleavage (19, 20). Even without that, the distinctive phenomenology of borderline personality disorder made a spectrum relationship with schizophrenia unlikely. Borderline patients were interpersonally needy, very emotional, and with the exception of occasional lapses in reality testing, they were definitely not psychotic (Table 1). What was also apparent was that they were "difficult" patients and had considerable suicidal risk. Klein (21) described them as "fickle, egocentric, irresponsible, love-intoxicated." Houck (22) found that they were "intractable, unruly" patients who used hospitals to escape from responsibilities. Thus, these patients attracted pejorative descriptions that discouraged charitable understanding.

Given the high levels of comorbid depression in "borderline" patients, some clinicians felt that they had an atypical form of depression (8, 29-31). Akiskal (32) famously wrote that "borderline was an adjective in search of a noun"—and at that time, in many people's minds, that noun was clearly "depression." Others, echoing Klein's earlier cynicism (12) about the origins of this disorder, felt that borderline personality disorder had been included in DSM-III simply as a conciliatory gesture intended to placate the psychoanalytic plurality, many of whom were opposed to DSM-III's operationalization of psychiatric diagnoses.

During the 1970s, the literature on treatment for borderline personality disorder was almost exclusively about psychoanalytic psychotherapy. Numerous conferences on psychoanalytic therapy for borderline personality disorder were held, drawing large audiences. The featured speakers all achieved local, regional, or national recognition for what was considered at that time to be their heroic tolerance and remarkable skills (10, 11, 33-38). The subsequent flood of books on the disorder (Figure 1) provided compelling accounts of the many serious problems encountered during these therapies, among which were the signal problems of "countertransference hatred" (39) and "negative therapeutic reactions" (10, 40). Kernberg (40) wrote that negative therapeutic reactions were common and that they derived from the borderline patient's "1) unconscious sense of guilt (as in masochistic character structures); 2) the need to destroy what is received from the therapist because of unconscious envy …; and 3) the need to destroy the therapist as a good object because of the patient's unconscious identification with a primitive and sadistic object" (p. 288). In retrospect, it is notable how the failures of psychoanalytic therapies were explained solely by the borderline patient's pernicious motivations.

Thus, by 1980, when borderline personality disorder officially entered the DSM classification system, its validity rested primarily and still quite precariously on its clinical utility, and specifically on the ability of the diagnosis to predict a set of clinical dilemmas that were more or less specific to these patients (Figure 2).

1980–1990—From Syndrome to Personality Disorder: "Wisdom Is Never Calling a Patient Borderline"

During the 1980s, biological psychiatry came to the fore and the recession of psychoanalysis began. After DSM-III defined many disorders with specific and measurable criteria, their validity was now being tested using standards set forth by Robins and Guze (41). This meant that the validity of borderline personality disorder, like other diagnostic syndromes, was

measured via examinations for discriminating descriptors, familiality, longitudinal course, treatment response, and biological markers. The systematic examination of these areas was carried out in numerous clinical research projects on borderline personality disorder. Until 1980, fewer than 15 research reports on borderline personality disorder had been published; in the decade from 1980 to 1990, more than 275 appeared. With only one exception, these projects were conducted without federal funding.

This research showed that the borderline personality disorder syndrome was an internally consistent, coherent syndrome (42, 43) with a course that differed from those of schizophrenia and major depression (44-46). It also showed that the syndrome was familial and that the prevalence of schizophrenia and depression was not increased in the families of borderline patients (44, 47, 48). The decade's research also indicated that borderline personality disorder had modest and inconsistent responses to multiple classes of medications (49-51). One conclusion from this considerable body of clinical research was that borderline personality disorder was not simply a variation of—and was probably not closely related to—depression (23, 52) (Table 1).

The research drew attention to a previously unrecognized diagnostic interface—that with posttraumatic stress disorder (PTSD). Here, the differential diagnostic issues were based less on descriptive overlaps than on etiologic considerations. Studies of childhood physical and sexual abuse showed that there were reports of abuse in the histories of 70% of borderline personality disorder patients (53). This observation occurred at the same time that feminist concerns were raised about DSM-III diagnoses, including borderline personality disorder, that pathologized women or that implicitly blamed victims. Feminist clinicians suggested that descriptions of borderline psychopathology were fueled by men's anger (54) and that men's use of this diagnosis for female patients reflected their negative gender biases (55). Herman wrote that the borderline syndrome was a "disguised presentation hiding underlying PTSD" (53).

The high frequency of early dropouts from psychoanalytic therapy was now well documented (56-58), as was the infrequency of success with this therapy (58-60). The harm of neutrality, passivity, poor maintenance of boundaries, and countertransference enactment had become clearer, and out of the crucible of popular debates between Kernberg and other analysts (such as Adler [35] and Kohut [61, 62]) and relational psychologists (such as Jordan et al. [63]), the essential role of empathy and support became more widely appreciated.

Thus, the emerging trauma data and the feminist concerns about the borderline label were joined by the evergrowing chronicle of the problems borderline patients allegedly created within psychoanalytic therapies to consolidate a highly pejorative meaning for the borderline diagnosis. From this confluence, Vaillant wrote that "the beginning of wisdom is never calling a patient borderline" (64).

By this time, sufficient clinical wisdom had accumulated that while we may not have become clear about what we should do, we had learned a lot about what *not* to do. For example, hospitals knew that borderline patients were not simply feigning symptoms to get admitted; rather, the symptoms were real, but they remitted as a result of the hospital's "holding" and supportive functions. Indeed, borderline patients' changing phenomenology could be made coherent by appreciating whether they felt "held" (depressed, cooperative), rejected (angry, self-destructive), or alone (impulsive, brief psychotic experiences) (65). It was also becoming clearer that nonpsychoanalytic modalities, including group and family therapy and medications, could often be helpful. Thus, the hopes for curative changes that had previously propelled psychoanalytic therapies were quietly being replaced by more pragmatic multimodel approaches that had more modest rehabilitative goals (65-71).

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1990–2000—From Unwanted Personality Disorder to Disorder-Specific Treatability: "Would the Patient Be Borderline If She Remitted From a Medication?"

In the 1990s, DSM-IV was published (with only modest changes in the definition of borderline personality disorder) and the biological paradigm had come to dominate psychiatry. During one DSM-IV meeting a new question about borderline personality disorder's diagnostic integrity was raised: "Would the patient be borderline if she remitted from a medication?" (72). This was not an easy question to answer. Indeed, borderline personality disorder's validity was—and still remains—suspect because it has neither a specific pharmacotherapy nor a unifying neurobiological organization from which biological psychiatry can find purchase.

Against this backdrop Siever and Davis (73) proposed two psychobiological dispositions, *affective dysregulation* (with hyperresponsivity of the noradrenergic system) and *behavioral dyscontrol* (with reduced serotonergic modulation), which provided a much-needed conceptual and scientific structure for understanding the origins of borderline personality disorder as well as a way to explain borderline personality disorder's comorbidities and its spectrum relationships with other disorders. On this base, good arguments could be built for viewing borderline personality disorder primarily as an impulse spectrum disorder (74) or an emotional (affective) dysregulation disorder (75, 76).

By this time, the cogent considerations about the etiological overlap between borderline personality disorder and PTSD had informed the borderline construct and had usefully shaped its boundaries (24). Among the clarifying findings were that borderline personality disorder has about 30% comorbidity with PTSD (77), that borderline personality disorder often develops without a history of significant trauma (78), that childhood abuse and trauma predispose to many other psychiatric disorders (79, 80), and that while exploratory/ expressive therapies are even more contraindicated for PTSD than for borderline personality disorder, treating borderline patients as victims of abuse usually made them worse (81). A subsequent group of studies has now confirmed that while childhood trauma, especially sexual abuse, is related to borderline personality disorder, a history of such trauma is unnecessary and usually does not account for much of the etiological variance (82-84).

The primary differential diagnostic issue had now become bipolar disorder. There was a substantial overlap in the underlying constructs of the two disorders as identified by Siever and Davis's (73) psychobiological dispositions and in their phenomenology, that is, impulsive/behavioral dyscontrol and affective/emotional instability. Moreover, the bipolar construct was expanding to include spectrum variants—most significantly, bipolar II disorder, for which mania was not required (85). While the response of borderline personality disorder to mood stabilizers was unimpressive (73), the disorder's persisting lack of any distinctive neurobiological base made it an obvious candidate for inclusion in bipolar disorder's growing spectrum.

Even as these propositions and questions about borderline personality disorder's biological integrity were gaining attention, the borderline construct was independently receiving creative and groundbreaking advances with respect to the psychosocial aspects of its development and treatment. From England, Peter Fonagy, a Hungarianborn psychologist and psychoanalyst armed with both his skills as a developmental researcher and his contagious energy, enthusiasm, and creativity, introduced studies of early child development and the vicissitudes of caretaking that he postulated set the stage for later development of borderline personality disorder. Beginning with studies of attachment (86, 87) and building on earlier

work by Winnicott (88) and Bowlby (89), Fonagy postulated that caretakers' failure to accurately mirror a child's mental states was responsible for establishing handicaps in knowing one's self and in empathizing with others—an inability to *mentalize* that made the child vulnerable to borderline personality disorder.

In this context, the first major stimulus to therapeutics since the psychoanalytic therapy initiative of the 1970s arrived from an unexpected source: dialectical behavior therapy was introduced by Linehan (90), a self-described "radical behaviorist." Dialectical behavior therapy was a carefully manualized 1-year outpatient therapy combining well-integrated group and individual therapy components. While targeting the borderline patient's pattern of self-harm and suicidality, its benefits also extended to less utilization of medication and hospitalization (91). Among the innovative departures from prior therapies were dialectical behavior therapy's insistence on split treatment and on identification of treatment goals; its emphasis on validation, skill-building, and here-and-now interventions; its provision of around-the-clock availability; and its definition of the role of the therapist as coach. As important as its empirical support was, and as innovative and learnable as dialectical behavior therapy itself was, one could not have anticipated its impact without appreciating Linehan's personal role. She was bold, charismatic, and plainspoken. She openly challenged the claims of a psychoanalytic tradition and all other non-empirically based therapies. She inspired a new generation of zealously dedicated—and empirically buttressed—much more effective psychotherapists. Moreover, she introduced a borderline personality disorder-specific therapy that, because it was psychosocial, unwittingly offered an unexpected alternative to the reliance on medication response for satisfying the Robins and Guze (41) validation standard of discriminating treatment response.

Eight years later, a second treatment specifically designed for borderline personality disorder was also shown to be effective. "Mentalization-based treatment" was derived from Fonagy's developmental research and established its efficacy in an English partial hospitalization program (92). It was designed to correct the borderline patient's underlying handicaps in mentalizing by adopting a noninterpretive, "not-knowing," inquisitive stance intended to facilitate the accurate recognition and acceptance of one's own and others' mental states (including the therapist's).

2000–2009—Borderline Personality Disorder: "A Good-Prognosis Brain Disease"?

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

Beginning with the stimulus given by several parent advocacy groups (most notably, the National Education Alliance for Borderline Personality Disorder, and most conspicuously, the indomitable and ubiquitous Valerie Porr) and by the establishment of the Borderline Personality Disorder Research Foundation by a bereaved Swiss family, this decade has seen the adoption of borderline personality disorder by major mental health organizations, such as the National Alliance of Mental Illness, the National Institute of Mental Health (NIMH), and, as noted at the beginning of this article, even the U.S. Congress. In this context, borderline personality disorder seems to have achieved a new legitimacy, at least as a subject for scientific study and for public awareness. Why has this occurred and what does it mean?

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Two major findings have greatly affected the borderline construct, one showing that the disorder is significantly heritable and the other that it has an unexpectedly good prognosis. The confluence of these findings is all the more significant because together they seem to defy the expectation that heritable disorders should be among the least changeable. Torgersen and colleagues' (93) finding of a 68% heritability abruptly invalidated the many theories about borderline personality disorder's etiology that had focused exclusively on environmental causes. It established borderline personality disorder's credentials as a "brain disease."

Signaling the potential yield of the still very limited NIMH-funded research, this decade bore the fruits of two NIMH-funded longitudinal studies, the McLean Study of Adult Development (94) and the Collaborative Longitudinal Study of Personality Disorders (53). These studies showed that borderline personality disorder has an unexpectedly good course (Figure 3). After completing her seminal long-term follow-up reports (95, 96), Zanarini even began to call borderline personality disorder "the good-prognosis diagnosis." This fact offered enormous encouragement to patients with the disorder even as it raised questions about how those of us in the mental health fields could have been so mistaken. When this finding is combined with the evidence of heritability, it is clear that the DSM criteria are epiphenomena.

In 2001, despite the relative absence of an empirical basis, APA prepared guidelines for the treatment of borderline personality disorder (97). This was done because, as noted earlier, we now knew a lot about what *not* to do. The guidelines retained a primary role for psychotherapy, but they emphasized the need to enroll patients as collaborators, the need for a primary (i.e., administratively responsible) clinician, and the value of psychoeducation, family involvement, and the use of an algorithm for medications (98).

Even as the APA guidelines retained a primary role for individual psychotherapy, the role of psychoanalytic psychotherapy and the literature about it had seriously declined (see Figure 1). In this decade only four new books on psychoanalytic therapy for borderline personality disorder were published, and three of them were treatment manuals. Most notably these included the manualization of a revised version of Kernberg's original psychoanalytic therapy, transference-based psychotherapy (99). In combination with the earlier pioneering development of mentalization-based therapy, the empirical validation of transference-based psychotherapy's effectiveness (100) revitalized the relevance of psychoanalytic contributions to the treatment of borderline personality disorder.

The Present—Awareness: "Borderline Personality Disorder Is to Psychiatry What Psychiatry Is to Medicine"

House Resolution 1005 states that "it is essential to increase awareness of borderline personality disorder among people suffering from this disorder, their families, mental health professionals, and the general public by promoting education, research, funding, early detection, and effective treatments." Borderline personality disorder remains terribly and unfairly stigmatized. Most mental health professionals want to avoid—or actively dislike—borderline patients (B.M. Pfohl et al., May 1999 data from unpublished survey). Borderline personality disorder remains far behind other major psychiatric disorders in awareness and research. The difference between its reported prevalences in clinical settings (15%–25%) (28) and in the community (1.4%–5.9%) (101, 102) indicates that a large number of people with the disorder are undiagnosed and untreated. Research on the disorder receives a total of only about $6 million annually in NIMH funds, less than 2% of the amount allocated to research on schizophrenia (which has a prevalence of 0.4%) (103) and less than 6% of that for bipolar disorder (which has a prevalence of 1.6%) (104). Despite the significant impact

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of borderline personality disorder on the course and treatment of anxiety disorders (105) and mood disorders (106), psychiatric research on these other disorders often fails even to document its co-occurrence.

Research on borderline personality disorder suffers from a lack of young investigators. Most of those who put this diagnosis on the map are approaching retirement, and few of them have the research credentials or funding to nurture a next generation. A growing number of empirically validated treatments for borderline personality disorder exist, but they remain largely unavailable or, when available, are often not reimbursed. More remarkable is that borderline personality disorder still lacks a standing presence in psychiatric training curricula. Appropriate teaching—both academic and clinical—for residents is nonexistent in all but a few institutions. Figure 4 identifies some of the future directions for borderline personality disorder in light of these facts.

The escalating number of books written for nonprofessionals (see Figure 1) bears witness to the devastating toll the disorder takes on others. Still unknown are the public health costs of this disorder, but given borderline patients' heavy utilization of psychiatric services; medical complications; involvement in divorce, libel, and childrearing lawsuits; and violence and sexual indiscretions, the costs can be expected to be tremendous. Also unknown, despite significant advances (107-109), is borderline personality disorder's core psychopathology and its related neurobiology. While spectrum relationships with bipolar disorder and antisocial personality disorder (110) seem most significant, borderline personality disorder's defining clinical features remain interpersonal (111).

With the development of DSM-V under way, borderline personality disorder's internal coherence and integrity stand on firm ground (112-115), but questions can be expected about whether the label "borderline" should be retained, about whether the diagnosis belongs on axis I instead of axis II, and about whether the diagnosis should be given to adolescents. I believe the term "borderline" has earned honorific status by virtue of its familiarity. As highlighted in this review, it accurately signifies borderline personality disorder's unclear boundaries while reminding us of an unwanted truth, namely, that psychiatric disorders, like other medical conditions, are heterogeneous and have flexible boundaries. It should not be scapegoated because of this. With respect to the question of whether it should be on axis I or axis II, it belongs on axis I to signify its severity, its morbidity, and its unstable course. But it belongs there too to prioritize its usage and to underscore the need for its treatment to be reimbursed. Use of the borderline diagnosis clearly should be extended to adolescents; its clinical usage in this group is already extensive, its internal coherence and stability are established, and it predicts adult dysfunction as well as adult borderline personality disorder (116).

In modern psychiatry, borderline personality disorder has become the major container for sustaining the relevance of the mind, an arena that has been endangered by our growing biological knowledge. For example, when a borderline patient cuts him- or herself, the behavior can be understood as providing relief by redirecting intolerable and inchoate psychic pain into physical pain with both a welcome focus of attention and a welcome release of neurohormones. This behavior can just as aptly be considered a breakdown in the ability to mentalize, that is, to keep in mind both the feelings about oneself and another. Such conceptualizations still need to recognize that the intensity or intolerance of the affect has a heritable base—as does, probably, the violent and impulsive cutting behavior itself—and that the patient has a special sensitivity to rejection. But so much is lost if in addition to these explanatory conceptions the cutting is not also seen as an act of self-punishment related to an overly harsh self-judgment reflecting a long-standing perception of "badness." It is the latter translation of the event that reintroduces the mind. When that sense of badness

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is further understood as having been derived in part from a family context with much criticism and little nurturance, we begin to give color and distinction to the environmental experiences that account for much of the etiological variance behind the patient's cuttings. We also begin to recognize a unique personal narrative that allows the person's life experience to be meaningful and unique and for the person to feel understandable and acceptable—and not as bad as he or she thought.

At this time, borderline personality disorder is the only major psychiatric disorder for which psychosocial interventions remain the primary treatment. Residents who go into psychiatry with an interest in personal involvements, in seeing themselves in their patient's experiences and their selves as therapeutic tools, now can find few other places in psychiatry to actualize these aspirations. Residents and other mental health professionals who make a serious investment in treating patients with borderline personality disorder can expect to become proud of their professional skills and of their personal growth in tolerance and empathy and to experience a highly personal, deeply appreciated, life-changing role for their patients.

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References

1. Stern A. Psychoanalytic investigation and therapy in the borderline group of neuroses. Psychoanal Q. 1938; 7:467–489.
2. Knight R. Borderline states. Bull Menninger Clin. 1953; 17:1–12. [PubMed: 13009379]
3. Rorschach, H. Psychodiagnostics. 5th ed.. Bern; Switzerland, Huber: 1942.
4. Hoch P, Polatin P. Pseudoneurotic forms of schizophrenia. Psychiatr Q. 1949; 23:248–276. [PubMed: 18137714]
5. Rado, S., editor. Psychoanalysis of Behavior. Vol. 2. Grune & Stratton; New York: 1962.
6. Frosch J. The psychotic character: clinical psychiatric considerations. Psychiatr Q. 1964; 38:1–16. [PubMed: 14148392]
7. Kety, SS.; Rosenthal, DH.; Wender, P.; Schulsinger, F. The types and prevalence of mental illness in the biological and adoptive families of adopted schizophrenics. In: Rosenthal, D.; Kety, S., editors. The Transmission of Schizophrenia. Pergamon Press; New York: 1968. p. 345-362.
8. Stone, MH. The Borderline Syndromes. McGraw-Hill; New York: 1980.
9. Kernberg O. Borderline personality organization. J Am Psychoanal Assoc. 1967; 15:641–685. [PubMed: 4861171]
10. Kernberg O. The treatment of patients with borderline personality organization. Int J Psychoanal. 1968; 49:600–619. [PubMed: 5715051]
11. Masterson, J. Treatment of the Borderline Adolescent: A Developmental Approach. John Wiley & Sons; New York: 1972.
12. Klein, D. Psychopharmacological treatment and delineation of borderline disorders. In: Hartocollis, P., editor. Borderline Personality Disorders: The Concept, the Syndrome, the Patient. International Universities Press; New York: 1977. p. 365-384.
13. Schmideberg, M. The borderline patient. In: Arieti, S., editor. American Handbook of Psychiatry. Vol. 1. Basic Books; New York: 1959. p. 398-416.
14. Modell A. Primitive object relations and the predisposition to schizophrenia. Int J Psychoanal. 1963; 44:282–292.
15. Grinker, R.; Werble, B.; Drye, R. The Borderline Syndrome: A Behavioral Study of Ego Functions. Basic Books; New York: 1968.
16. Gunderson JG, Singer MT. Defining borderline patients: an overview. Am J Psychiatry. 1975; 132:1–10. [PubMed: 802958]

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17. Gunderson JG, Kolb JE. Discriminating features of borderline patients. Am J Psychiatry. 1978; 135:792–796. [PubMed: 665789]
18. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 3rd ed.. American Psychiatric Association; Washington, DC: 1980.
19. Spitzer RL, Endicott J, Gibbon M. Crossing the border into borderline personality and borderline schizophrenia: the development of criteria. Arch Gen Psychiatry. 1979; 36:17–24. [PubMed: 760694]
20. Siever LJ, Gunderson JG. Genetic determinants of borderline conditions. Schizophr Bull. 1979; 5:59–86. [PubMed: 375383]
21. Klein, D. Drug therapy as a means of syndrome identification and nosological revision. In: Cole, J.; Freeman, A.; Friedhoff, A., editors. Psychopathy and Psychopharmacology. Johns Hopkins University Press; Baltimore: 1972.
22. Houck JH. The intractable female patient. Am J Psychiatry. 1972; 129:27–31. [PubMed: 5034179]
23. Gunderson JG, Phillips KA. A current view of the interface between borderline personality disorder and depression. Am J Psychiatry. 1991; 148:967–975. [PubMed: 1823531]
24. Gunderson JG, Sabo AN. The phenomenological and conceptual interface between borderline personality disorder and PTSD. Am J Psychiatry. 1993; 150:19–27. [PubMed: 8417576]
25. Koenigsberg HW, Harvey PD, Mitropoulou V, Schmeidler J, New AS, Goodman M, Silverman JM, Serby M, Schopick F, Siever LJ. Characterizing affective instability in borderline personality disorder. Am J Psychiatry. 2002; 159:784–788. [PubMed: 11986132]
26. Paris J, Gunderson JG, Weinberg I. The interface between borderline personality disorder and bipolar spectrum disorders. Compr Psychiatry. 2007; 48:145–154. [PubMed: 17292705]
27. White CN, Gunderson JG, Zanarini MC, Hudson JI. Family studies of borderline personality disorder: a review. Harv Rev Psychiatry. 2003; 11:8–19. [PubMed: 12866737]
28. Gunderson, JG.; Links, P. Borderline Personality Disorder: A Clinical Guide. 2nd ed.. American Psychiatric Press, Inc; Washington, DC: 2008.
29. Klein, D. Psychopharmacology and the borderline patients. In: Mack, I., editor. Borderline States in Psychiatry. Grune & Stratton; New York: 1975. p. 75-92.
30. Stone M. Contemporary shift of the borderline concept from a sub-schizophrenic disorder to a subaffective disorder. Psychiatr Clin North Am. 1979; 2:577–594.
31. Akiskal HS. Subaffective disorders: dysthymic, cyclothymic, and bipolar II disorders in the “borderline” realm. Psychiatr Clin North Am. 1981; 4:25–46. [PubMed: 7232236]
32. Akiskal HS, Chen SE, Davis GC, Puzantian VR, Kashgarian M, Bolinger JM. Borderline: an adjective in search of a noun. J Clin Psychiatry. 1985; 46:41–48. [PubMed: 3968045]
33. Chessick, RD. Intensive Psychotherapy of the Borderline Patient. Jason Aronson; New York: 1977.
34. Giovacchini PL. The psychoanalytic paradox: the self as a transitional object. Psychoanal Rev. 1984; 71:81–104. [PubMed: 6433382]
35. Adler, G. Borderline Psychopathology and Its Treatment. Jason Aronson; New York: 1986.
36. Searles, HF. My Work With Borderline Patients. Jason Aronson; Northvale, NJ: 1986.
37. Grotstein, JS. Transitional phenomena and the dilemma of the me/not me interface. In: Horton, PC.; Gewirtz, H.; Kreutter, KJ., editors. The Solace Paradigm: An Eclectic Search for Psychological Immunity. Conn, International Universities Press; Madison: 1988. p. 59-74.
38. Akhtar, S. Broken Structures: Severe Personality Disorders and Their Treatment. Jason Aronson; Northvale, NJ: 1992.
39. Maltsberger JT, Buie DH. Countertransference hate in the treatment of suicidal patients. Arch Gen Psychiatry. 1974; 30:625–633. [PubMed: 4824197]
40. Kernberg, OF. Structural change and its impediments. In: Hartocollis, P., editor. Borderline Personality Disorders. International Universities Press; New York: 1977. p. 275-306.
41. Robins E, Guze SB. Establishment of diagnostic validity in psychiatric illness: its application to schizophrenia. Am J Psychiatry. 1970; 126:983–987. [PubMed: 5409569]
42. Hurt SW, Hyler SE, Frances A, Clarkin JF, Brent R. Assessing borderline personality disorder with self-report, clinical interview, or semistructured interview. Am J Psychiatry. 1989; 141:1228–1231. [PubMed: 6486257]

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43. Clarkin JF, Hull JW, Hurt SW. Factor structure of borderline personality disorder criteria. J Pers Disord. 1993; 7:137–143.
44. Pope HG Jr, Jonas JM, Hudson JI, Cohen BM, Gunderson JG. The validity of DSM-III borderline personality disorder: a phenomenologic, family history, treatment response, and long-term follow-up study. Arch Gen Psychiatry. 1983; 40:23–30. [PubMed: 6849616]
45. McGlashan TH. The Chestnut Lodge follow-up study, III: long-term outcome of borderline personalities. Arch Gen Psychiatry. 1986; 43:20–30. [PubMed: 3942471]
46. Paris J, Brown R, Nowlis D. Long-term follow-up of borderline patients in a general hospital. Compr Psychiatry. 1987; 28:530–535. [PubMed: 3691077]
47. Loranger AW, Oldham JM, Tulis EH. Familial transmission of DSM-III borderline personality disorder. Arch Gen Psychiatry. 1982; 39:795–799. [PubMed: 7165479]
48. Links PS, Steiner M, Huxley G. The occurrence of borderline personality disorder in the families of borderline patients. J Pers Disord. 1988; 2:14–20.
49. Cowdry RW, Gardner DL. Pharmacotherapy of borderline personality disorder: alprazolam, carbamazepine, trifluoperazine, and tranylcypromine. Arch Gen Psychiatry. 1988; 45:111–119. [PubMed: 3276280]
50. Soloff PH, George A, Nathan RS, Schulz PM, Ulrich RF, Perel JM. Progress in pharmacotherapy of borderline disorders: a double-blind study of amitriptyline, haloperidol, and placebo. Arch Gen Psychiatry. 1986; 43:691–697. [PubMed: 3521532]
51. Links PS, Steiner M, Boiago I, Irwin D. Lithium therapy for borderline patients: preliminary findings. J Pers Disord. 1990; 4:173–181.
52. Gunderson JG, Elliott GR. The interface between borderline personality disorder and affective disorder. Am J Psychiatry. 1985; 142:277–288. [PubMed: 2857532]
53. Herman, J. Trauma and Recovery. Basic Books; New York: 1992.
54. Stiver, IP. The meaning of care: reframing treatment models. In: Jordon, JV.; Kaplan, AG.; Miller, JB.; Stiver, IP.; Surrey, JL., editors. Women's Growth in Connection: Writings from the Stone Center. Guilford Press; New York: 1991. p. 250-267.
55. Henry KA, Cohen CI. The role of labeling processes in diagnosing borderline personality disorder. Am J Psychiatry. 1983; 140:1527–1529. [PubMed: 6625010]
56. Skodol AE, Shea MT, McGlashan TH, Gunderson JG, Morey LC, Sanislow CA, Bender DS, Grilo CM, Zanarini MC, Yen S, Pagano ME, Stout RI. The Collaborative Longitudinal Personality Disorders Study (CLPS): overview and implications. J Pers Disord. 2005; 19:487–504. [PubMed: 16274278]
57. Gunderson JG, Frank AF, Ronningstam EF, Wachter S, Lynch VJ, Wolf PJ. Early discontinuance of borderline patients from psychotherapy. J Nerv Ment Dis. 1989; 177:38–42. [PubMed: 2909661]
58. Waldinger RJ, Gunderson JG. Completed psychotherapies with borderline patients. Am J Psychotherapy. 1984; 38:190–202.
59. Waldinger, RJ.; Gunderson, JG. Effective Psychotherapy With Borderline Patients. Macmillan; New York: 1987.
60. Wallerstein, R. Forty-Two Lives in Treatment. Guilford; New York: 1986.
61. Kohut, H. The Analysis of the Self. International Universities Press; New York: 1971.
62. Kohut, H. The Restoration of the Self. International Universities Press; New York: 1977.
63. Jordan, JV.; Kaplan, AG.; Miller, JB.; Surrey, JL.; Stiver, IP. Women's Growth in Connection: Writings From the Stone Center. Guilford; New York: 1991.
64. Vaillant GE. The beginning of wisdom is never calling a patient borderline. J Psychother Pract Res. 1992; 1:117–134.
65. Gunderson, JG. Borderline Personality Disorder. American Psychiatric Press; Washington, DC: 1984.
66. Soloff P. Pharmacotherapy of borderline disorders. Compr Psychiatry. 1981; 22:535–543. [PubMed: 6118234]
67. Kroll, J. The Challenge of the Borderline Patient: Competency in Diagnosis and Treatment. WW Norton; New York: 1988.

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68. Dawson, D.; MacMillan, HL. Relationship Management and the Borderline Patient. Brunner/ Mazel; New York: 1993.
69. Silk KR, Eisner W, Allport C, Demars C, Miller C, Justice RW, Lewis M. Focused time-limited inpatient treatment of borderline personality disorder. J Pers Disord. 1994; 8:268–278.
70. Paris, J. American Psychiatric Press; Washington, DC: 1994. Borderline Personality Disorder: A Multidimensional Approach.
71. Links PS, Mitton JE, Steiner M. Stability of borderline personality disorder. Can J Psychiatry. 1993; 38:255–259. [PubMed: 8518977]
72. Cloninger CR, Svrakic DM, Przybeck TR. A psychobiological model of temperament and character. Arch Gen Psychiatry. 1993; 50:975–990. [PubMed: 8250684]
73. Siever LJ, Davis KL. A psychobiological perspective on the personality disorders. Am J Psychiatry. 1991; 148:1647–1658. [PubMed: 1957926]
74. Links PS, Heslegrave R, van Reekum R. Impulsivity: core aspect of borderline personality disorder. J Pers Disord. 1999; 12:1–9. [PubMed: 10228922]
75. Livesley WJ, Jackson DN, Schroeder ML. Factorial structure of traits delineating personality disorders in clinical and general population samples. J Abnorm Psychol. 1992; 101:432–440. [PubMed: 1500600]
76. Linehan, MM. Dialectical Behavioral Therapy of Borderline Personality Disorder. Guilford; New York: 1993.
77. Swartz M, Blazer D, George L, Winfield I. Estimating the prevalence of borderline personality disorder in the community. J Pers Disord. 1990; 4:257–272.
78. Stone, MH. The fate of borderline patients. Guilford; New York: 1990.
79. Paris J, Zweig-Frank H, Guzder J. Psychological risk factors for borderline personality disorder in female patients. Compr Psychiatry. 1994; 35:301–305. [PubMed: 7956187]
80. Zanarini MC, Frankenburg FR. Emotional hypochondriasis, hyperbole, and the borderline patient. J Psychother Pract Res. 1994; 3:25–36.
81. Gunderson JG, Chu JA. Treatment implications of past trauma in borderline personality disorder. Harv Rev Psychiatry. 1994; 1:75–81. [PubMed: 9384833]
82. Fossati A, Madeddu F, Maffei C. Borderline personality disorder and childhood sexual abuse: a meta-analytic study. J Pers Disord. 1999; 13:268–280. [PubMed: 10498039]
83. Bierer LM, Yehuda R, Schmeidler J, Mitropoulou V, New AS, Silverman JM, Siever LJ. Abuse and neglect in childhood: relationship to personality disorder diagnoses. CNS Spectr. 2003; 8:737–754. [PubMed: 14712172]
84. Bandelow B, Krause J, Wedekind D, Broocks A, Hajak G, Ruther E. Early traumatic life events, parental attitudes, family history, and birth risk factors in patients with borderline personality disorder and healthy controls. Psychiatry Res. 2005; 134:169–179. [PubMed: 15840418]
85. Akiskal HS, Pinto O. The evolving bipolar spectrum: prototypes I, II, III, and IV. Psychiatr Clin North Am. 1999; 22:517–534. [PubMed: 10550853]
86. Fonagy P. Playing with reality: the development of psychic reality and its malfunction in borderline personalities. Int J Psychoanal. 1995; 76:39–44. [PubMed: 7775035]
87. Fonagy P, Target M, Gergely G. Attachment and borderline personality disorder: a theory and some evidence. Psychiatr Clin North Am. 1999; 23:103–122. [PubMed: 10729934]
88. Winnicott, DW. The Maturational Process and the Facilitating Environment. Hogarth Press; London: 1965.
89. Bowlby, J. Separation: Anxiety and Anger. Vol. 1. Basic Books; New York: 1969. Attachment and Loss.
90. Linehan, MM. Skills Training Manual for Treating Borderline Personality Disorder. Guilford; New York: 1993.
91. Linehan MM, Armstrong HE, Suarez A, Allmon D, Heard HL. Cognitive-behavioral treatment of chronically parasuicidal borderline patients. Arch Gen Psychiatry. 1991; 48:1060–1064. [PubMed: 1845222]

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92. Bateman A, Fonagy P. Effectiveness of partial hospitalization in the treatment of borderline personality disorder: a randomized controlled trial. Am J Psychiatry. 1999; 156:1563–1569. [PubMed: 10518167]
93. Torgersen S, Lygren S, Øien PA, Skre I, Onstad S, Edvardsen J, Tambs K, Kringlen E. A twin study of personality disorders. Compr Psychiatry. 2000; 41:416–425. [PubMed: 11086146]
94. Zanarini MC, Frankenburg FR, Hennen J, Reich DB, Silk KR. Psychosocial functioning of borderline patients and axis II comparison subjects followed prospectively for six years. J Pers Disord. 2005; 19:19–29. [PubMed: 15899718]
95. Zanarini MC, Frankenburg FR, Hennen J, Silk KR. The longitudinal course of borderline psychopathology: 6-year prospective follow-up of the phenomenology of borderline personality disorder. Am J Psychiatry. 2003; 160:274–283. [PubMed: 12562573]
96. Zanarini MC, Frankenburg FR, Reich DB, Silk KR, Hudson JI, McSweeney LB. The subsyndromal phenomenology of borderline personality disorder: a 10-year follow-up study. Am J Psychiatry. 2007; 164:929–935. [PubMed: 17541053]
97. American Psychiatric Association. Practice Guideline for the Treatment of Patients With Borderline Personality Disorder. Am J Psychiatry. Oct.2001 158(suppl)
98. Soloff PH. Algorithm for pharmacological treatment of personality dimensions: symptom-specific treatments for cognitive-perceptual, affective, and impulsive-behavioral dysregulation. Bull Menninger Clin. 1998; 62:195–214. [PubMed: 9604516]
99. Clarkin, JF.; Yeomans, FE.; Kernberg, OF. Psychotherapy for Borderline Personality: Focusing on Object Relations. American Psychiatric Publishing, Inc; Washington, DC: 2007.
100. Clarkin JF, Levy KN, Lenzenweger MF, Kernberg OF. Evaluating three treatments for borderline personality disorder: a multiwave study. Am J Psychiatry. 2007; 164:922–928. [PubMed: 17541052]
101. Lenzenweger MF, Lane MC, Loranger AW, Kessler RC. DSM-IV personality disorders in the National Comorbidity Survey replication. Biol Psychiatry. 2007; 62:553–564. [PubMed: 17217923]
102. Grant BF, Chou SP, Goldstein RB, Huang B, Stinson FS, Saha TD, Smith SM, Dawson DA, Pulay AJ, Pickering RP, Ruan WJ. Prevalence, correlates, disability, and comorbidity of DSM-IV borderline personality disorder: results from the Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions. J Clin Psychiatry. 2008; 69:533–545. [PubMed: 18426259]
103. Saha S, Chant D, Welham J, McGrath J. A systematic review of the prevalence of schizophrenia. PLoS Med. 2005; 2:413–433.
104. Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry. 2005; 62:593–602. [PubMed: 15939837]
105. Massion AO, Dyck IR, Shea MT, Phillips KA, Warshaw MG, Keller MB. Personality disorders and time to remission in generalized anxiety disorder, social phobia, and panic disorder. Arch Gen Psychiatry. 2002; 59:434–440. [PubMed: 11982447]
106. Fan AH, Hassell J. Bipolar disorder and comorbid personality psychopathology: a review of the literature. J Clin Psychiatry. 2008; 69:1794–1803. [PubMed: 19026249]
107. King-Casas B, Sharp C, Lomax-Bream L, Lohrenz T, Fonagy P, Montague PR. The rupture and repair of cooperation in borderline personality disorder. Science. 2008; 321:806–810. [PubMed: 18687957]
108. New AS, Goodman M, Triebwasser J, Siever LJ. Recent advances in the biological study of personality disorders. Psychiatr Clin N Am. 2008; 31:441–461.
109. Silbersweig D, Clarkin JF, Goldstein M, Kernberg OF, Tuescher O, Levy KN, Brendel G, Pan H, Beutel M, Pavony MT, Epstein J, Lenzenweger MF, Thomas KM, Posner MI, Stern E. Failure of frontolimbic inhibitory function in the context of negative emotion in borderline personality disorder. Am J Psychiatry. 2007; 164:1832–1841. [PubMed: 18056238]
110. Torgersen S, Czajkowski N, Jacobson K, Reichborn-Kjennerud T, Roysamb E, Neale MC, Kendler KS. Dimensional representation of DSM-IV cluster B personality disorders in a population-based sample of Norwegian twins: a multivariate study. Psychol Med. 2008; 11:1617–1625. [PubMed: 18275631]

111. Gunderson JG. Disturbed relationships as a phenotype for borderline personality disorder (commentary). Am J Psychiatry. 2007; 164:1637–1640. [PubMed: 17974925]
112. New AS, Triebwasser J, Charney DS. The case for shifting borderline personality disorder to axis I. Biol Psychiatry. 2008; 64:653–659. [PubMed: 18550033]
113. Sanislow CA, Grilo CM, Morey LC, Bender DS, Skodol AE, Gunderson JG, Shea MT, Stout RL, Zanarini MC, McGlashan TH. Confirmatory factor analysis of DSM-IV criteria for borderline personality disorder: findings from the Collaborative Longitudinal Personality Disorders Study. Am J Psychiatry. 2002; 159:284–290. [PubMed: 11823272]
114. Johansen M, Karterud S, Pedersen G, Gude T, Falkum E. An investigation of the prototype validity of the borderline DSM-IV construct. Acta Psychiatr Scand. 2004; 109:289–298. [PubMed: 15008803]
115. Fossati A, Maffei C, Bagnato M, Donati D, Namia C, Novella L. Latent structure analysis of DSM-IV borderline personality disorder criteria. Compr Psychiatry. 1999; 40:72–79. [PubMed: 9924881]
116. Winograd G, Cohen P, Chen H. Adolescent borderline symptoms in the community: prognosis for functioning over 20 years. J Child Psychol Psychiatry. 2008; 49:933–941. [PubMed: 18665882]

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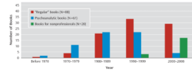

FIGURE 1. Books on Borderline Personality Disorder Published From 1968 to 2008[a]

[a]Data from the Library of Congress database, October 2008.

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- Dramatic fluctuations in phenomenology and psychological capacities will challenge diagnostic certainty.
- Urgent appeals for an exclusive helping relationship will generate strong countertransference responses, often involving rescue efforts that prove to be inadequate.
- Treaters and others will have intense and distinct reactions, seeing the patient as a deprived waif or as an angry bully.
- Separation experiences (or decreased structure) will prompt behavioral (self-harm) and cognitive (psychotic-like) regressions.
- Neither psychoanalysis nor medication will help significantly and will often be harmful.

FIGURE 2. Treatment Dilemmas Predicted by the Borderline Syndrome

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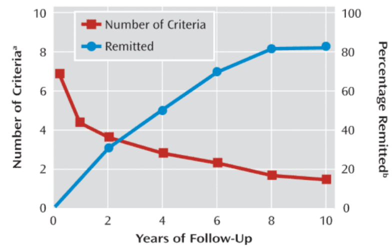

FIGURE 3. Longitudinal Course of Borderline Personality Disorder

[a]Data from the Collaborative Longitudinal Study of Personality Disorders (unpublished).

[b]Data from the McLean Study of Adult Development (see reference 95).

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- Increased public awareness is needed to decrease the stigma of borderline personality disorder, increase recognition of the disorder in schools and medicine, and increase appropriate treatment (and diminish mistreatment).
- Research on the description, course, treatment, and epidemiology of mood disorders and anxiety disorders should document the co-occurrence and effects of borderline personality disorder.
- Psychiatric residency programs should be required to include training on borderline personality disorder psychopathology and therapies.
- Centers of excellence (as in the past for the psychoses) are needed to develop a new generation of borderline personality disorder researchers and clinicians.

FIGURE 4. Future Directions for Borderline Personality Disorder

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TABLE 1

Borderline Personality Disorder's Discrimination From Other Disorders[a]

Characteristic	Schizophrenia	Major Depressive Disorder	PTSD	Bipolar Disorder
Descriptive	−	+/−	−	+/−
Course	−	−	−	+/−
Familiality	−	+/−	−	−
Treatment response	+/−	−	−	−

[a]Data from references 23-28.