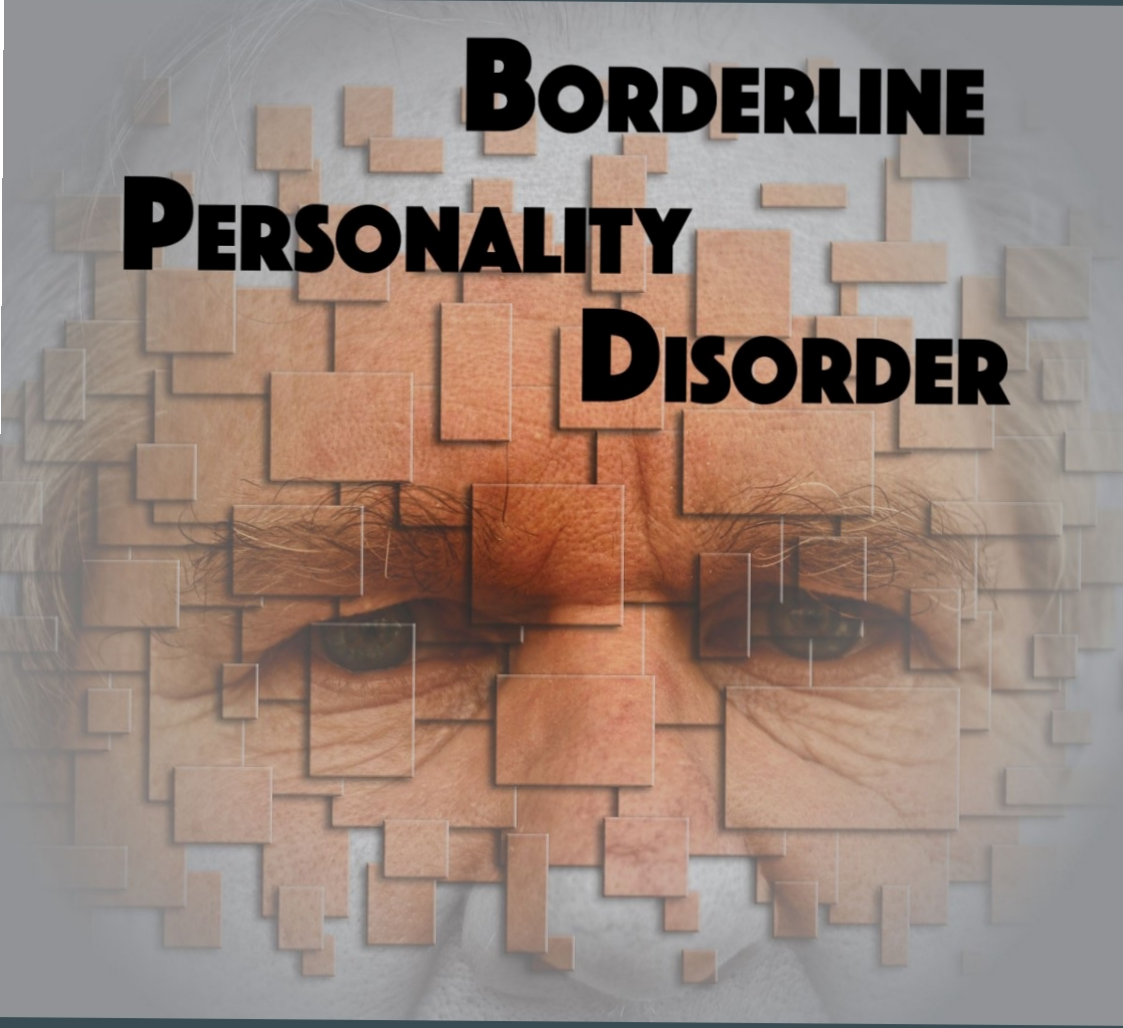
Interpersonal Group Psychotherapy for Borderline Personality Disorder

Diagnosis of Borderline Personality Disorder



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e-Book 2016 International Psychotherapy Institute

From *Interpersonal Group Psychotherapy for Borderline Personality Disorder* by Elsa Marziali and Heather Munroe-Blum

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Diagnosis of Borderline Personality Disorder

Borderline personality disorder eludes meaningful definition. Diagnostic questions abound. Is it a personality disorder? Does it comprise a group of syndromes? Is it a level of severity of psychopathology? Over the past fifty years clinicians and clinical investigators have addressed these questions. However, there remains little consensus on which sets of criteria are specific to describing patients with BPD and whether the classification is useful in clarifying prevention and treatment strategies.

Psychodynamic Approach to Borderline Personality Disorder Diagnosis

Historically psychoanalysts have made the major contributions to refining definitions of the disorder. A category of psychopathology referred to as the "borderline group" was first introduced by Stern (1938) to describe patients who fit neither psychotic nor neurotic forms of psychopathology. Stern noted that these patients were clinically challenging and "extremely difficult to handle effectively by any psychotherapeutic method." Although this definition still applies, subsequent psychoanalysts have attempted to describe more clearly metapsychological features of the disorder as well as its developmental precursors. What has evolved is a definition of the borderline disorder described as a level of psychopathology comprising perse

syndromes that are etiologically linked to early developmental conflicts or deficits in ego function (Knight, 1953) and in object relations (Adler, 1985; Gunderson, 1984; Kernberg, 1975). Viewed in this way BPD or borderline organization (Kernberg, 1975) is classified as a severe personality disorder and includes a heterogeneous group of patients (narcissistic, histrionic, dependent, and antisocial) characterized by

1. Identity diffusion
2. Primitive defenses (projective identification, splitting)
3. Intact reality testing.

To apply effectively this diagnostic system, considerable training in psychoanalytic theory and technique is needed. A high level of inference is required for assessing the meanings of patient dialogue in the context of the three dimensions described. Although trained clinicians are able to make the diagnosis of borderline personality organization reliably (Kernberg, Selzer, Koenigsberg, Carr, & Appelbaum, 1989) and the diagnostic theoretical model is closely linked to the recommended treatment (long-term, intensive psychoanalytic psychotherapy), the validity of the diagnostic procedure and the resulting label are difficult to establish. In this respect, a psychodynamic formulation shares with all other diagnostic systems the problem of establishing the specificity and validity of the BPD diagnosis.

Categorical Approach to Borderline Personality Disorder Diagnosis

The DSM categorical approach (APA, 1980, 1987; Spitzer & Williams, 1980) to the diagnosis of BPD is concerned with the application of a specific set of criteria that are considered to represent the disorder best. The original DSM-III (APA, 1980) criteria for BPD included the following:

1. Identity disturbance
2. Unstable, intense relationships
3. Impulsivity that is potentially self-damaging
4. Inappropriate, intense anger
5. Physically self-damaging acts
6. Affective instability
7. Chronic feelings of emptiness and boredom
8. Problems tolerating being alone.

A patient qualifies for the diagnosis on the basis of any five of the eight criteria. Revisions to the criteria for the proposed DSM-IV are in progress and include the following changes:

1. The "intolerance of being alone" criterion is changed to "frantic efforts to avoid real or imagined abandonment "

2. The retention of "chronic feelings of emptiness" but the deletion of "boredom"

3. Addition to the "identity disturbance" criterion of "persistent self-image distortions" (e.g., feeling that one embodies evil or does not exist)

4. Deletion of the "alternation between idealization and devaluation" from the unstable relationships item

5. Inclusion of "marked reactivity of mood" in the affective instability item

6. "Physically self-damaging acts" is expanded to "recurrent self-destructive threats, gestures, or behavior"

7. Addition of a new criterion concerned with cognitive or perceptual aberrations, "transient, stress-related dissociative or paranoid ideation" (Gunderson & Sabo, 1993).

Much of the research on the reliability and validity of the borderline diagnosis has been based on the DSM categorical method. Studies have focused on examining comorbidity of BPD with Axis I and other Axis II disorders. Between 40% and 60% of patients diagnosed with BPD have concomitant Axis I affective disorders (Akiskal, 1981; Frances, Clarkin, Gilmore, Hurt, & Brown, 1984; Gunderson & Elliott, 1985; Perry, 1985; Soloff, George, Nathan, & Schultz, 1987). However, when BPD and affective disorders co-exist, subjects with BPD tend to be more manipulative, suicidal, impulsive,

and suffer from more substance abuse problems than depressed patients (Zanarini, Gunderson, & Frankenberg, 1989). Similarly, Westen and colleagues (1990) found that borderline depressives showed lower capacity than non-borderline depressives on the following four dimensions of object relations and social cognition:

1. Complexity of representations of other

2. Affect tone

3. . 3. Capacity for emotional investment

4. Understanding of social causality.

In contrast, studies on the possible overlap between BPD and schizophrenia show no diagnostic comorbidity-—that is, the disorder is distinct from DSM-III Axis I psychotic disorders (Barasch, Frances, Hurt, Clarkin, & Cohen, 1985; Jonas & Pope, 1992; Pope, Jonas, Hudson, Cohen, & Gunderson, 1983). However, disturbed and quasi-psychotic thought is common among BPD patients (Links, Steiner, Offord, & Eppel, 1988; Silk, Lehr, Ogata, & Westen, 1990; Zanarini, Gunderson, & Frankenburg, 1990).

There is substantial overlap between the borderline diagnosis and other Axis II personality disorders (Fryer, Frances, Sullivan, Hurt, & Clarkin, 1988; Nurnberg et al., 1991; Oldham et al., 1992; Zanariai, Gunderson, Frankenburg,

& Chauncey, 1990); however, the prevalence of comorbidity for BPD does not differ from other Axis II disorders (Fryer, Frances, Sullivan, Hurt, & Clarkin, 1988). Many features of the BPD disorder are non-discriminating from other Axis II disorders (Zanarini, Gunderson, Frankenburg, & Chauncey, 1990). Nurnberg et al. (1991) found that multiple personality disorders apply when BPD is present, but no specific pattern of overlap is evident. Similarly, Oldham (Oldham et al., 1992) found that substantial overlap occurred among the personality disorders and that the borderline group co-occurred more frequently with histrionic and dependent personality disorders. The histrionic disorder also co-occurred with narcissistic and antisoc.al diagnoses; thus, no consistent pairing of any two Axis II disorders was evident.

Challenges to both the psychoanalytic and the Axis II categorical approach to diagnosis of BPD have come from biological psychiatry. Klein (1973, 1977) has argued that borderlines should be included as a subcategory of patients with affective disorders. He has noted specific parallels between Grinker and associates' (1968) subgroups of borderlines and some categories of affective disorders. For example, he compares Grinker's hostile depressive subgroup to his hysteroid dysphoric group who responded favorably to monamine oxidase (MAO) inhibitors. Similarly, Grinker's emotionally unstable borderlines responded to lithium, and Grinker's more neurotic, phobic, anxious subgroup of borderlines responded well to imipramine. Like

Klein, Akiskal (Akiskal et al., 1985, & Akiskal, 1992) has advocated the elimination of the BPD diagnosis because he views the affective components of the disorder as overriding all other diagnostic criteria; borderlines should be included in the affective disorder group of patients and therefore treated with pharmacological interventions.

In summary, the studies of comorbidity between BPD with Axis I disorders or other Axis II disorders show that

1. There is a relationship between BPD and affective disorders but the exact nature of the relationship is unknown

2. The consistency of overlap between BPD and other personality disorders is unknown.

The revisions to the DSM (DSM-III-R) have partially dealt with the problem of comorbidity among the Axis II disorders by proposing "clusters" of personality disorders; borderlines are included in a cluster of dramatic, emotionally unstable personality disorders (histrionic, narcissistic, and antisocial). Although this attempt at resolving the issue of comorbidity within the Axis II disorders acknowledges the sharing of criteria within the subgroups, diagnostic clarity essential for designing effective treatments has not been advanced.

Studies of the reliability, validity, specificity, and sensitivity of DSM

criteria for diagnosing borderline personality disorder have used a series of semi-structured interview methods and self-report instruments. The one most frequently used, the Diagnostic Interview for Borderlines (DIB) (Gunderson, Kolb, & Austin, 1981) and its revised version the DIB-R (Zanarini, Gunderson, Frankenburg, & Chauncey, 1989) are specific to the borderline diagnosis. Other instruments have included diagnostic criteria for all 11 Axis II disorders. Examples include two self-report measures, the Millon Clinical Multiaxial Inventory (MCMI) (Millon, 1987) and the Personality Disorder Questionnaire (PDQ) (Hyler et al., 1989), and two coded interview schedules, the Personality Disorder Examination (PDE) (Loranger, Susman, Oldham, & Russakoff, 1985), and the Structured Clinical Interview for DSM-III-R (SCID-II) (Spitzer, Williams, & Gibbon, 1987). Each of these diagnostic systems has demonstrated good reliability but has added little to enhancing the discriminant validity of the BPD diagnosis.

Dimensional Approach to Borderline Personality Disorder Diagnosis

Investigators who have been concerned with enhancing the validity of the BPD diagnosis suggest that a precisely defined boundary for the disorder may not be found (Livesley & Jackson, 1992; Widiger & Frances, 1985). Frances (1982) suggests that "a dimensional approach will eventually become a standard method for personality diagnosis because personality disorders do not have the internal homogeneity and clear boundaries most

suited for classification in a categorical system" (p. 526). With a dimensional approach certain personality factors other than behaviors and symptoms are included in the diagnostic description. For example, dimensions such as affective response, type of cognitive functioning, pattern of interpersonal behavior, self-concept (Millon, 1987), complexity of representations of self and others, regulation of affect, capacity for emotional investment, and social cognition (Westen, 1991) would provide important focal points for exploration. However, attempts to distinguish the unique and independent contributions of these dimensions within a system of diagnostic categories would be relinquished in favor of an approach that would integrate the relative contributions of all of the dimensions in explaining the pathological syndrome.

Several dimensional approaches have been proposed. Livesley and Schroeder (1991) used factor analysis of self-report measures of features that span the DSM-III-R Cluster B diagnoses (antisocial, borderline, histrionic, and narcissistic). For the BPD group, factor loadings for 14 theoretically derived criteria for identifying BPD were analyzed. The first factor was chosen to represent core features of borderline pathology. In addition to replicating several of the DSM criteria (diffuse self-concept, unstable moods, and unstable interpersonal relationships), the factor included two additional features not found in the DSM system (separation protestation and brief stress-related psychosis) that were both related to significant problems in

attachment relationships

Livesley and Jackson (1992) have debated whether personality disorders are best classified using categorical or dimensional models. Dimensional models assume a continuity between normal and abnormal personalities. The authors address three issues that need to be considered for determining factors that could enhance diagnostic reliability and validity:

1. Theoretical issues focus on defining for each disorder the disorder's unique features and their interrelatedness.

2. Measurement issues are concerned with determining how many criteria are relevant and whether these should be summed to the minimum required (e.g., five of eight DSM-III, Axis II criteria for BPD) or summed to yield a total score.

3. Issues that have to do with assigning meaning to the diagnostic system must be considered. For example, using the DSM system, how is one to interpret the significance of endorsing five rather than eight of the criteria for BPD or the differences about which five criteria are endorsed? Similarly, when a reliable diagnostic measure such as the DIB uses a cutoff score to assign the diagnosis, how is this to be interpreted (e.g., score range 7 to 10 for the DIB or 8 to 10 for the DIB-R)?

Perry (1990) argues that information from several domains is important to validate the diagnosis of personality disorders. These include

DSM descriptive criteria, the psychological mechanisms that determine pathogenesis and maintenance of the disorder, the course of the disorder, and the response to treatment. Although this approach would be all-inclusive, there are problems in generating reliable and valid methods for appraising the significance of patient information in each of these domains. For example, the measurement of "psychological mechanisms" would involve a complex measurement enterprise with significant problems in terms of levels of inference and generalizability.

Additional data that would be useful for developing an effective diagnostic system include outcome predictors that have been derived from follow-up studies. For example, follow-up studies (McGlashan, 1986; Paris, Brown, & Nowlis, 1987; Plakun, Burkhardt, & Muller, 1986; Stone, 1993) of borderline patients have isolated the following positive predictors:

1. Higher IQ
2. Distractibility
3. Shorter length of hospitalization prior to index treatment
4. Talent and attractiveness
5. Absence of parental porce.

Negative predictors include:

1. Substance abuse

2. Affective instability

3. Antisocial traits

4. Dysphoria

5. Narcissistic entitlement and traits

6. Chronic feelings of emptiness and boredom.

Integration of Categorical and Dimensional Diagnostic Systems

The DIB interview schedule (Gunderson, Kolb, & Austin, 1981; Zanarini, Gunderson, Frankenberg, & Chauncey, 1989) for diagnosing BPD can be viewed as including both a dimensional and categorical approach. Four dimensions present in both the original DIB and the revised DIB (DIB-R) identify specific areas for exploration:

1. Affective

2. Cognitive

3. Impulse

4. Interpersonal.

Each is weighted differently to reflect the special relevance of that

dimension for identifying the disorder. Scores of 7 to 10 (DIB) or 8 to 10 (DIB-R) are used to assign the patient to the BPD category. For the DIB-R Zanarini (1989) changed the scoring algorithm to reflect the findings of previous diagnostic studies that supported higher weights for the interpersonal and impulse dimensions. Thus, both the dimensions and the scoring system of the DIB and DIB-R provide opportunities for assigning the diagnosis reliably and for examining clinically relevant dimensions that are important for designing treatment interventions and assessing treatment effects.

Oldham and colleagues (1992) have suggested that the DSM system could be used to study the specific nature of the overlap between BPD and other Axis II personality disorders. Because several diagnostic categories share similar criteria, it would be possible to isolate combinations of criteria that apply consistently when BPD patients qualify for a second Axis II diagnosis. For example, what are the overlapping criteria when both BPD and narcissistic personality disorder diagnoses are assigned? When these dual diagnoses apply, how can the overlapping criteria be used to design effective models of treatment?

Similarly, studies of comorbidity would be useful for understanding the distinction between BPD patients who have affective symptoms (e.g., depression) but do not qualify for an Axis I affective disorder diagnosis and patients who qualify for both the BPD diagnosis and Axis I major depressive

disorder. After DSM categorization, a dimensional approach could be used to generate finer distinctions between these two groups of patients (Zimmerman, Pfohl, Coryell, Stangl, & Corenthal, 1988). For example, it would be possible to isolate dimensions that distinguish depressive disorders that occur in the context of significant pathology of object relations from those that occur in sub jects who have a capacity for initiating and maintaining intimate relationships. Evidence for this approach has been provided by studies that have shown that borderline depressives display exaggerated feelings of loneliness and desperation in relation to important people in their lives and that they also differ qualitatively from non-borderline depressives in their expression of labile, diffuse negative affect (Westen, Lohr, Silk, Gold, & Kerber, 1990; Wixom, 1988).

The success of any system for diagnosing BPD largely depends on the dimensions chosen for study and the degree of inference required in assessing their independent and combined contributions to describing the disorder (Widiger, Mieler, & Tilly, 1992). The DIB and DIB-R instruments have good face validity, clinical sensitivity, and require low levels of inference for scoring the contribution of each dimension. In contrast, Kernberg's diagnostic dimensions for assessing borderline personality organization (identity diffusion, use of primitive defenses, intact reality testing) require complex levels of inference in that patient dialogue needs to be assessed within the context of psychoanalytic perspectives about early development

and personality formation.

Alternate diagnostic systems could evolve from the use of measures that assess object relations and social cognition. Westen and colleagues (1990) have developed a measure for assessing phenomena that focus on two areas of functioning that are particularly relevant for identifying problems shared by severe personality disorders patients, the regulation of emotions and the cognitive attribution of cause in interpersonal contexts. However, the use of the measure in clinical settings is not currently feasible because the reliable application of the scales requires considerable training and the availability of extensive data (either transcribed responses to a Thematic Apperception Test, or transcribed interviews). However, this measure and other similar ones developed to assess core personality features (Bell, Billington, & Becker, 1986; Burke, Summers, Selinger, & Polonus, 1986; West, Sheldon, & Reiffer, 1987) could be tested so as to extract multiple dimensions related to the diagnosis of BPD and could be important for designing parsimonious and effective treatment models for BPD. The fit between salient dimensions of pathological forms of the BPD disorder, specific models of treatment, and predicted outcomes could be greatly enhanced. (See table 2.1.)

Table 2.1
Approaches to the Diagnosis of
Borderline Personality Disorder

Categorical Psychodynamic
Identity diffusion

Primitive defensive operations
Capacity for reality testing

Categorical DSM-III-R Axis II
Marked, persistent identity disturbance
Unstable intense relationships
Impulsivity
Inappropriate, intense anger
Recurrent suicidal threats/gestures
Affective instability
Chronic emptiness/boredom
Frantic efforts to avoid abandonment

Dimensional Multiple Factors
Affective response
Cognitive functioning
Pattern of interpersonal behavior
Complexity of representations of self and others
Psychological mechanisms that determine pathogenesis
Substance abuse
Response to treatment
Course of the disorder

Models for Isolating Subtypes of Borderline Personality Disorder: An Overview

Despite the diagnostic problems outlined, models for sub-classifications of BPD have been proposed. Grinker (1966) outlined a typology of borderlines based on "functions of the ego." Four subgroups of borderlines were identified:

1. Lowest functioning group: borderline psychosis

2. Core borderline group

3. Adaptive, affectless "as if" group

4. Depressive group that bordered on neuroses

Gunderson (1984) has described levels of borderline functioning according to subjective experiences of the primary object; these span a continuum in which at the highest level the object is perceived as supportive, at the next level the object is perceived as frustrating, and at the lowest level of functioning the object is perceived as absent. Clarkin and colleagues (1991) used an agglomerative cluster analysis to generate subsets of DSM-III criteria used in the clinical diagnosis of a large cohort of borderline patients. Three clusters were identified:

1. Identity cluster

2. Affect cluster

3. Impulse cluster

In a subsequent publication Hurt (Hurt, Clarkin, Marziali, & Munroe-Blum, 1992) demonstrated how the three clusters form the basis for the development of specified treatment strategies for BPD.

The Random Control Trial Analyses of Borderline Personality Disorder Subtypes

Several methods for determining subtypes of BPD were developed in the Random Control Trial (RCT) that tested the effects of Interpersonal Group

Psychotherapy (IGP) for borderline patients. The ultimate aim is to examine whether subgroups, once identified, differ in terms of response to treatment. The DIB was used as the primary screening instrument. A subset of qualifying patients were also interviewed with three other interview schedules: the DIB-R; the PDE (Lorange:, Susman, Oldham, & Russakoff, 1985), which screens for all Axis II disorders; and the Schedule for Affective Disorders and Schizophrenia (SADS) (Endicott & Spitzer, 1978), which screens for Axis I disorders. In addition patients completed several measures of symptoms and problematic behaviors.

In terms of reliability of the BPD diagnosis, 77% of the patients referred with a clinical diagnosis of the disorder qualified on the DIB (scores of 7 or more); agreement between the original and revised version of the DIB (DIB-R) was only 71%, but there was adequate agreement between each version of the DIB and the PDE (77% for the DIB and 100% for the DIB-R). Approximately 55% of the DIB-diagnosed subjects also qualified for major depressive disorder.

In addition, the findings showed that the DIB and DIB-R scores when correlated separately with the symptom scores functioned as indices of severity. For example, subjects with the lowest DIB qualifying score of 7 were the least severe symptomatically. Conversely, DIB subjects with scores of 8 or more were more severely symptomatic and were more likely to be alcohol

and drug dependent. From these analyses it was clear that BPD severity subgroups could be identified on the basis of their DIB scores.

A second strategy for isolating BPD subgroups was tested. A qualitative analysis of multiple assessment measures used in the treatment comparison trial was conducted. The aim was to examine whether subgroups that included a number of dimensions in addition to severity would evolve. Diagnostic criteria, DIB scores, individual item scores and total scale scores from the assessment measures were examined for 7 patients who participated in one of the groups treated in the treatment comparison trial. The aim was to locate diagnostic and clinical dimensions that appeared to distinguish subgroups and exclude dimensions that showed little to no variation across subjects. Ten data sets were examined in the analysis: three diagnostic systems (DIB [Gunderson, Kolb, & Austin, 1981]; SADS [Endicott & Spitzer, 1978]; PDE [Loranger et al., 1985]), six measures of symptoms and behaviors (HSCL 90 [Derogatis, Lipman, & Covi, 1973]; Beck Depression Inventory [Beck, Ward, Mendelsohn, Mock, & Erbaugh, 1961]; Objective Behaviors Index Scale [Munroe-Blum & Marziali, 1986]; Social Adjustment Scale [Weissman & Bothwell, 1976]; Inventory of Interpersonal Problems [Horowitz, Rosenburg, Baer, Ureno, & Villasenor, 1988]; Stress Events Scale [Marziali & Pilkonis, 1986]), information on family history, and previous therapeutic experiences.

Contrary to expectation, half of the data sets did not show sufficient contrast between patients to warrant subgroupings within the borderline disorder. These included the DSM III Axis-II-R criteria (PDE); the Inventory of Interpersonal Problems (Horowitz et al., 1988); the People in Your Life Scale (measure of social support, Marziali, 1987); a Stress Events Scale (Marziali & Pilkonis, 1986); and the Target Complaints measure (Battle et al., 1966).

From the analysis of the remaining 5 dimensions, three subgroups emerged: a Dependent group (3 patients), a Substance Abuse group (1 patients), and an Impulsive Angry group (2 patients). The DIB scores separated the three groups; the patients in the Dependent subgroup' obtained scores in the 7-8 range (mean 7.3); the Substance Abuse group' had scores of 8 and 10 (mean 9); and the Impulsive Angry group' scored 9 and 10 (mean 9). If the DIB represents an index of overall severity, then the latter two groups could be classified in the more severe category.

The Beck Depression Inventory (Beck, Rush, Shaw, & Emery, 1979) distinguished the three groups, but the levels of severity did not parallel the DIB score levels. The Substance Abuse group had the lowest mean score on the BDI (mean 23); the Dependent group scored at the next highest level (mean 25), and the Impulsive Angry group scored in the severe range (mean 33.5).

On the Objective Behaviors Index scale (Munroe-Blum & Marziali 1986) all of the patients reported problems with intimate relationships All had been involved in a number of intimate relationships that had ended badly. Verbal and/or physical abuse occurred in all intimate relationships, but the frequency and intensity varied across groups Some of the patients in both the Substance Abuse group and the Impulsive Angry group were verbally and physically abusive with both their mates and their children. However they were frequently the recipients of abuse. Because of problems with their children, these1 patients had contacts with school counseling services, child mental health agencies, and child welfare services. In contrast, the Dependent group was more apt to be the recipients of either verbal or physical abuse. For both the Impulsive Angry and the Substance Abuse groups control of anger was a major problem. These patients tended to develop rage reactions to what appeared to be daily routine events The Dependent group reported the experience of anger but inhibition in its expression; several of these patients resorted to bouts of overeating or overdrinking in response to helplessness and frustration. Two of the patients in this group used various self-harming behaviors in response to anxiety and frustration.

In terms of family history, both the Dependent and Substance Abuse groups had experienced early childhood traumas, but for the majority, their parents had remained together despite severe marital difficulties Although a number of the patients eventually witnessed their parents' separations, these

tended to occur just prior to the onset of puberty or later.

All of the patients in the three groups suffered some form of early childhood trauma, but higher severity and longer duration applied to the Impulsive Angry group: physical and/or sexual abuse, periods of separation from the parents; and erratic and unpredictable affectionate caring juxtaposed with either a harsh or lax disciplinary regime. Many of the patients were well aware of the strategies they used as children to deal with their frustrations and helplessness. One patient dealt with the trauma of being abandoned by her father by clinging to her mother and complaining of physical ailments so as to gain her attention. Another patient was able to predict when another foster home placement might occur on the basis of her observations of the escalating violence between her parents. Many of the patients left home by mid-adolescence because of severe quarrels and unresolvable disagreements with their parents.

The patients varied in terms of their views of psychiatric treatments prior to the index treatment. The Dependent group tended to describe favorable prior experiences in psychotherapy; they spoke positively about their past therapists and felt that they had been helped despite the fact that their problems had not been entirely resolved. The patients in the Substance Abuse group had more varied responses to their prior experiences with therapy. One had had successful experiences with Alcoholics Anonymous and

had managed to remain alcohol free. The other patient abused both alcohol and drugs and had not been as successful in curtailing these habits despite repeated periods of treatments with various mental health services. The patients in the Impulsive Angry group felt extremely angry with their previous experiences in therapy. They were critical of their therapists and of the health care system in general. They felt rejected and "turfed out" every time they showed up in emergency psychiatric services. Both had had a series of brief hospitalizations in conjunction with suicidal threats or attempts. One of these patients had made good connections with therapists during stays in hospital but felt rejected by them when at discharge a referral to an outpatient service had been made. It was clear that the mental health care system had failed to meet the therapeutic needs of this subgroup of patients.

The qualitative analysis of a comprehensive set of assessment data on a cohort of 7 patients provides some support for defining subgroups of the disorder. Thus, the question is no longer which treatment is more effective for BPD but, rather, which treatment is more effective with which subtype of the disorder. In the analyses of the IGP treatment, one of the groups treated in the trial was examined to explore how patients in each of the subgroups participated in the process of the group. (See table 2.2.) In chapter 8 patients from each of the subgroups are selected to highlight their unique responses to IGP. The aim is to illustrate the continuity between specific diagnostic features of the borderline disorder, specific treatment strategies, and patient

responses both within and across the treatment sessions.

Table 2.2
Dimensions of Borderline Personality Disorder Subtypes

DIMENSIONS	SUBTYPES		
	Dependent	Substance Abuse	Impulsive Angry
DIB Mean Score	7.3	9	9
BDI Mean Score	25	23	33.5
OBI Dimensions	Recipient of verbal/physical abuse, self-harming behaviors and suicidal gestures/attempts	Recipient or perpetrator of verbal /physical abuse, alcohol/ drug abuse	Verbal/physical abuse toward significant others, frequent loss of control over anger
Family History	Intact family of origin during early childhood, parent marital conflicts, verbal/physical abuse of children	Intact family of origin during early childhood, later separation/porce of parents, verbal/physical abuse of children	Family breakdown during early childhood, frequent periods of separation from parents, verbal/physical abuse of children
Treatment Compliance	Positive about previous therapy experiences, high compliance to index therapy	Ambivalent about previous therapy experiences, moderate compliance to index therapy	Very negative about previous therapy experiences, high compliance to index therapy

Summary of Diagnostic Perspectives of Borderline Personality Disorder

It may be that a clear-cut method for isolating a single “pure type" of BPD cannot be found and that such a goal may be irrelevant in terms of

clinical management and the study of the course of the illness. Although a system for describing subtypes of BPD may be useful, it may be more important to describe diagnostic features that are not only common to all subtypes but have special relevance for designing effective models of treatment. For example, all criteria systems developed to diagnose the borderline disorder include at least one interpersonal dimension among the following:

1. Identity diffusion (Kernberg, 1975)

2. Intense, unstable interpersonal relationships and an unstable sense of self (Gunderson, 1984)

3. Identity disturbance and unstable, intense relationships (DSM-III & III-R, Axis II, APA, 1980,1987).

Furthermore, many of the remaining features used by each system to confirm the presence of the borderline disorder could be described as symptomatic and behavioral responses to core problems in the interpersonal domain:

1. Primitive defensive operations (Kernberg, 1975)

2. Manipulative suicide attempts, negative affects, and impulsivity (Gunderson, 1984)

3. Inappropriate intense anger, physically self-damaging acts,

affective instability, impulsivity, chronic emptiness/boredom, and intolerance of being alone (DSM-III & III-R).

It is argued that the assessment of the interpersonal problem core of BPD provides the salient diagnostic elements essential for its effective management and treatment. There is considerable support for this perspective (Gunderson, 1984; Kernberg, 1975; Westen, 1990). In particular, Widiger and Frances (1985) state “an interpersonal nosology is particularly relevant to personality disorders. Each personality disorder has a characteristic and dysfunctional style that is often central to the disorder. There is also some empirical support for the hypothesis that a personality disorder is essentially a disorder of interpersonal relatedness" (p. 621).

Borderline patients report that their major disappointments and accompanying symptoms arise from conflicted, unstable relationships with important others. For example, the salient feature, consistent across the three subgroups of BPD described, was a history of repeated conflicts in managing important relationships. A patient in the Dependent group differed from a patient in the Impulsive Angry group in terms of external manifestations of the disorder, with the former resorting more to depression and isolation and the latter showing frequent angry or violent outbursts. Yet, what was most painful for both patients was their despair about securing and maintaining mutually gratifying relationships with significant people in their current life

situations. There was much evidence to show that their patterned ways of interacting with significant others was replicated in all new relationships, including those with therapists. The style of interacting manifested by the Dependent subgroup had been more successful in sustaining previous therapeutic contacts, whereas that of the Impulsive Angry subgroup had resulted in many failed contacts with the helping professions.

It is postulated that each borderline patient's style of managing interpersonal conflicts is manifested in the initial diagnostic session and that the assessing therapist's responses vary according to overall philosophy of treatment approach with borderline patients. The therapist's understanding of interpersonal conflicts as they are transacted within the assessment session provides important indicators for the fit between salient diagnostic criteria and treatment approach. Various approaches to assessing BPD, concluding with the process and strategies recommended from the perspective of IGP, follow.

Clinical Formulation of Borderline Personality Disorder

Psychoanalytic Assessment Process

Kernberg (1975; Kernberg, Selzer, Koenigsburg, Carr, & Appelbaum, 1989) and Silver and Rosenbluth (1992) discuss both the aims and process of

assessment sessions with BPD. Their primary goal is to determine the borderline patient's capacity for engaging in intensive psychoanalytic psychotherapy. In approaching the assessment process Silver recommends that the therapist should have an open-minded and eclectic attitude; that is, he believes that a variety of social, biological, and psychodynamic theoretical models are applicable to understating and treating the borderline patient. In contrast, Kernberg's approach to conceptualizing the borderline patient is concerned with assessing the presence of criteria for borderline personality organization that draw on an object relations perspective to explain the origins of borderline pathology.

Both Silver and Kernberg view the assessment process as requiring two to four sessions. In addition to taking an extensive early and current life history, they observe the patient's reactions to the therapist within the session, noting in particular transference demands that parallel patterns of interactions with significant others. Suicidal risk is assessed and discussed openly with the patient. Whereas Silver is prepared to hospitalize a patient who is suicidal, Kernberg recommends referral to a hospital and is clear about keeping separate the aims of psychotherapy and the management of suicidal risk. Silver assesses criteria for major depressive disorder and recommends pharmacological intervention when warranted as an adjunct to psychotherapy. A similar approach has been taken by Clarkin and colleagues (1992) who are investigating the reliability and validity of Kernberg's model

of psychoanalytical psychotherapy.

Silver emphasizes the importance of assessing the patient's capacity for developing a therapeutic alliance with the therapist. An important diagnostic indicator is whether the patient has had at least one meaningful, not self-destructive relationship for a minimum of 1 year between adolescence and the current assessment (Silver, 1992). Silver also adds that the patient must demonstrate a capacity for empathy in order to make therapeutic progress.

An additional important diagnostic parameter is the assessment of the therapist's subjective reactions to the patient during the diagnostic interview. When extreme anxiety or negative feelings are evoked and the therapist has difficulty restoring balance in his or her communication with the patient, then the therapist should be alerted to the possibility of borderline interpersonal phenomena being played out in the diagnostic session. It may be that this is one of the most valid and reliable criteria for testing hypotheses about the possible presence of BPD.

For both Kernberg and Silver the assessment process inducts into therapy those patients who fit the criteria for borderline personality organization and who are able to contain acting-out impulses sufficiently to agree to the conditions presented in the form of a therapeutic contract. Responsibilities of both patient and therapist are discussed, and Silver is

especially explicit about explaining to the patient the clinical realities, including what can be realistically achieved.

In summary, a psychoanalytically oriented assessment process is well suited to the structure and procedures of intensive psychoanalytic psychotherapy. Both the patient and the therapist experience within the diagnostic sessions their respective role functions as well as affective and attitudinal reactions. Thus, the assessment process represents an initial trial of the therapeutic process; a test of what can be expected once commitment to therapy has been mutually agreed on.

The Interpersonal Group Therapy Approach

Patients were referred to the treatment comparison trial following a clinical DSM-III-R-based diagnosis of BPD. The initial screening took place in psychiatric outpatient clinics as part of standard procedures. Following referral to the study, additional screening procedures were used. In particular, standardized diagnostic interviews were used with referred patients. Although these procedures were essential to ensure the internal and external validity of the RCT, it is recommended that a diagnostic schedule such as the DIB or DIB-R be used routinely to confirm a clinical diagnosis of BPD, especially when a model of treatment designed to respond to specific features of the disorder is being used.

Interpersonal Group Psychotherapy was designed to integrate a definition of the borderline disorder that focuses on pervasive problems in interpersonal relationships with an empirically based method for defining the disorder. Diagnostically, the aim was to include patients who met DSM-III Axis II (APA, 1980) criteria for BPD. Patients qualify for IGP if they meet criteria for BPD on the basis of a reliably administered semi-structured diagnostic interview schedule such as the DIB (Gunderson, Kolb, & Austin, 1981), the DIB-R (Zanarini, Gunderson, Frankenburg, & Chauncey, 1989), the PDE (Loranger et al., 1985), or the SCID-II (Spitzer et al., 1987). All of these instruments include DSM-III, Axis II-R criteria for BPD. The original and revised versions of the DIB also include psychodynamic criteria and a section on nonpsychotic odd thought processes that the others exclude.

The BPD patients treated with IGP in the treatment comparison trial were selected for inclusion if they met the cutoff score (7 or more) on the original DIB, so that the outcome results could be generalized to patients selected on this instrument. When patients are identified reliably with instruments such as the DIB, it is possible subsequently to compare the results of a treatment trial with those obtained by other investigators using the same instrument for patient selection. Also, variability of treatment response can be understood only when patient factors are controlled and examined in relation to the effects of specific treatment strategies. In other words, the effects of a treatment program can only be understood and

generalized when the patient population is carefully described and when the treatment methods are well articulated and reliably applied. For BPD there is sufficient heterogeneity within the disorder that still eludes precise definition; thus, it is imperative that reliable methods for identifying the disorder be used so that the interaction between specific diagnostic and treatment variables car be examined. The recommended diagnostic schedules are easy to administer, and only a small amount of training is needed to achieve acceptable levels of reliability. From our experience with the various diagnostic instruments, it appears that the original version of the DIB- and DSM-based diagnostic systems such as the PDE and SCID includes a wider band of BPD patients who show greater variance in symptomatic severity and types of overlap with Axis I and Axis II disorders, whereas the revised version of the DIB, the DIB-R, seems to include a narrower band of BPD patients who may be somewhat closer to the criteria planned for DSM-IV. In addition, the suggested instruments do not exclude patients with co-occurring major depressive disorder and point to the need to screen for this Axis I disorder. When major depressive disorder is suspected, an interview schedule that screens for Axis I disorders needs to be used. The SCID (Spitzer, 1987) can serve this purpose, whereas the PDE screens personality disorders only and the two versions of the DIB are specific to BPD. With its focus on core personality features of the disorder (pervasive instability of interpersonal relationships), the IGP model of treatment was viewed as addressing the

needs of both the dual-diagnosed patients (BPD and major affective disorder) and those with BPD only. However, in order to explore factors that might explain variations in response to treatment, it was important to identify, from the onset, the dual-diagnosed BPD patients.

Table 2.3
Characteristics of Measures of Borderline Personality Disorder

Characteristic	DIB	DIB-R	PDE	SCID	PDQ	MCMI
Interview	X	X	X	X		
Self-report					X	X
All DSM-III-R Axis II diagnoses	no	no	yes	yes	yes	yes
BPD diagnosis only	yes	yes	no	no	no	no
Number of items	165	136	126	120	155	175
Scoring system	X	X	X	X	X	X
Completion time	60 min.	60 min.	90 min.	90 min.	20 min.	20 min.

Note: For a complete list of instruments for measuring BPD, see Reich (1992).

Summary of Features Relevant to Interpersonal Group Therapy

If a continuum exists between diagnostic precision, treatment specificity, and predicted treatment effects, the linkages between diagnostic criteria selected to represent BPD best, the application of IGP, and the expected outcomes need to be made specific. Because IGP was designed to

respond to the interpersonal features of the borderline disorder, the interpersonal diagnostic dimensions have saliency over others. Similarly, symptoms and problematic behaviors were not viewed as independent diagnostic criteria but as responses to interpersonal conflicts; thus, treatment effects would be demonstrated by a reduction in these response behaviors. A summary of the diagnostic features of BPD that were particularly relevant in the design of an interpersonal group psychotherapy treatment for BPD included the following:

1. Pervasive problems in distinguishing self-motivations from those of significant others

2. Impulsive behaviors that are potentially harmful to self and/or others and that are responses to intense disappointments in important relationships

3. Difficulty in managing emotions, especially anger that erupts in disproportionate response to threats of rejection or abandonment by significant others

4. Multiple unsatisfactory experiences in all areas of functioning that reinforce low self-esteem and malevolent representations of others.

In summary, the review of diagnostic systems for describing patients with BPD shows that diagnostic precision is best achieved when a reliable diagnostic schedule or measure is used. However, the issue of diagnostic

validity remains problematic. Within the BPD category there is considerable variation in the style of presentation of each patient. As was demonstrated in the qualitative, dimensional approach described, each of the three subgroups (Dependent, Substance Abuse, and Impulsive Angry) varied considerably in the manifestation of forms and levels of severity of BPD psychopathology. Yet, consistent across all three groups was the core problem of managing intimate relationships effectively. Thus, regardless of the external manifestations of the anxiety, frustration, and despair associated with conflicted, painful interpersonal issues, all BPD patients are engaged in a lifelong search for more caring, gratifying, and secure relationships with significant others. This primary patient focus converged with the central rationale for designing the IGP treatment.