
Recent developments in borderline personality disorder

Anthony P. Winston

Patients with borderline personality disorder (BPD; known in ICD–10 (World Health Organization, 1992) as emotionally unstable personality disorder) pose some of the most difficult management problems facing the clinical psychiatrist. They frequently present in crisis, but are often difficult to engage in any form of treatment. Their behaviour causes considerable anxiety but their ambivalence about treatment often leaves professionals feeling frustrated and resentful. These feelings can all too easily be transformed into therapeutic nihilism. As well as being a significant problem in its own right, comorbid

personality disturbance complicates the management of other psychiatric disorders and has a negative effect on their prognosis (Reich & Vasile, 1993).

Borderline personality disorder has an estimated prevalence of up to 2% in the community (Widiger & Weissman, 1991) and 15 % among psychiatric inpatients (Kroll *et al*, 1982). Yet, despite an extensive psychoanalytic literature and growing attention in the USA, BPD has until recently received relatively little attention in the British psychiatric literature. However, this situation is beginning to change as a result of recent developments in both research and treatment. Developmental research is shedding increasing light on the aetiology of BPD, new models of treatment have been developed and long-term research on outcome is helping to dispel some of the pessimism that has long surrounded the disorder. This paper will review some of these developments.

Box 1. DSM–IV (American Psychiatric Association, 1994) diagnostic criteria for borderline personality disorder

At least five of:

- Intense and unstable personal relationships**
- Frantic efforts to avoid real or imagined abandonment**
- Identity disturbance or problems with sense of self**
- Impulsivity that is potentially self-damaging**
- Recurrent suicidal or parasuicidal behaviour**
- Affective instability**
- Chronic feelings of emptiness**
- Inappropriate intense or uncontrollable anger**
- Transient stress-related paranoid ideation or severe dissociative symptoms**

New perspectives on aetiology

Research over the past decade or so has emphasised the importance of childhood experiences in the aetiology of BPD. Ideas derived from psychoanalysis have received some empirical support and the central aetiological role of childhood trauma has become apparent. Attachment, identity and the ability to make sense of feelings are increasingly seen as interlinked and all are adversely affected by abuse or neglect in childhood.

Anthony P. Winston is a lecturer in psychiatry at the University of Leicester (University Department of Psychiatry, Brandon Unit, Leicester General Hospital, Leicester LE5 4PW; tel: 0116 225 6286; fax: 0116 225 6235; e-mail: awinston@lgh.u-net.com) and Honorary Senior Registrar in Psychiatry and Psychotherapy, Leicestershire and Rutland Healthcare NHS Trust. His clinical interests are in personality disorder and eating disorders and he has research interests in developmental psychopathology, attachment and the outcome of psychotherapy.

Trauma, affect regulation and self-harm

Childhood abuse and neglect are extremely common among borderline patients: up to 87% have suffered childhood trauma of some sort, 40–71% have been sexually abused and 25–71% have been physically abused (Perry & Herman, 1993). The effect of abuse seems to depend on the stage of psychological development at which it takes place; in general, the earlier it takes place, the more damaging it is likely to be (van der Kolk *et al*, 1994). This is probably due to the young child's cognitive immaturity and consequent inability to make sense of traumatic experiences. Sexual abuse, as well as being damaging in its own right, may also reflect the generally dysfunctional nature of families who are unable to protect their children adequately.

There is considerable evidence that borderline patients have difficulty modulating emotion, and this appears to be linked with early trauma (van der Kolk *et al*, 1994). Trauma, in the form of sexual abuse, is also strongly correlated with self-mutilation in borderline patients (Herman *et al*, 1989). Self-mutilation such as cutting is often experienced as painless at the time, suggesting that it takes place in a dissociated state. Indeed, the combination of severe trauma and dissociative phenomena in BPD has led some researchers to link it with post-traumatic stress disorder.

Attachment and reflective self-function

Research based on attachment theory is beginning to elucidate the links between childhood trauma and the capacity to think about oneself and others. Borderline patients are typically preoccupied with their disturbed early relationships yet unable to give a coherent account of them (Patrick *et al*, 1994; Fonagy *et al*, 1996). Severe childhood trauma in these

patients appears to result in a specific inability to think about their own thoughts and feelings, as well as those of others.

This finding is consistent with the observation that maltreated children have difficulty in expressing both negative and positive feelings. As well as contributing to problems in interpersonal relationships, the inability to think about feelings may combine with defective affect regulation to produce the impulsivity which is so characteristic of borderline patients.

Identity and the self

The lack of a sense of self is a core feature of the psychopathology of BPD, and psychoanalysts have traditionally linked this phenomenon to pathological splitting of the ego and object. Splitting is often very marked in borderline patients, who may engender powerful yet conflicting feelings in different members of the psychiatric team. Such splitting has traditionally been thought of as a 'primitive' defence mechanism that indicates arrested psychological development. However, it may be an appropriate response to abuse from someone who is also a parent or carer. Recent research confirms the link between splitting and sexual abuse and suggests that it may, in fact, be a relatively sophisticated psychological mechanism for dealing with traumatic experience (Calverley *et al*, 1994).

The concept of self is central to the work of Heinz Kohut and the branch of psychoanalysis known as self-psychology (Kohut, 1984). Kohut's ideas have been incorporated into the treatment approach developed by Stevenson & Meares (1992). Ryle (1997), from the somewhat different perspective of cognitive-analytic therapy, has developed an aetiological model of BPD based on the concept of multiple self-states. These are partially dissociated states between which the patient switches abruptly. Each self-state is linked to specific moods, behaviours and symptoms and is associated with corresponding interpersonal roles. Both these therapies are described later in this paper.

Box 2. Possible effects of childhood trauma in borderline personality disorder

Self-mutilation
Defective affect regulation
Lack of reflective capacity
Dissociation
Impulsivity
Disturbed interpersonal relationships

New developments in treatment

Several new forms of treatment for BPD have been developed over the past few years and evidence is also emerging for the effectiveness of some of the more established approaches.

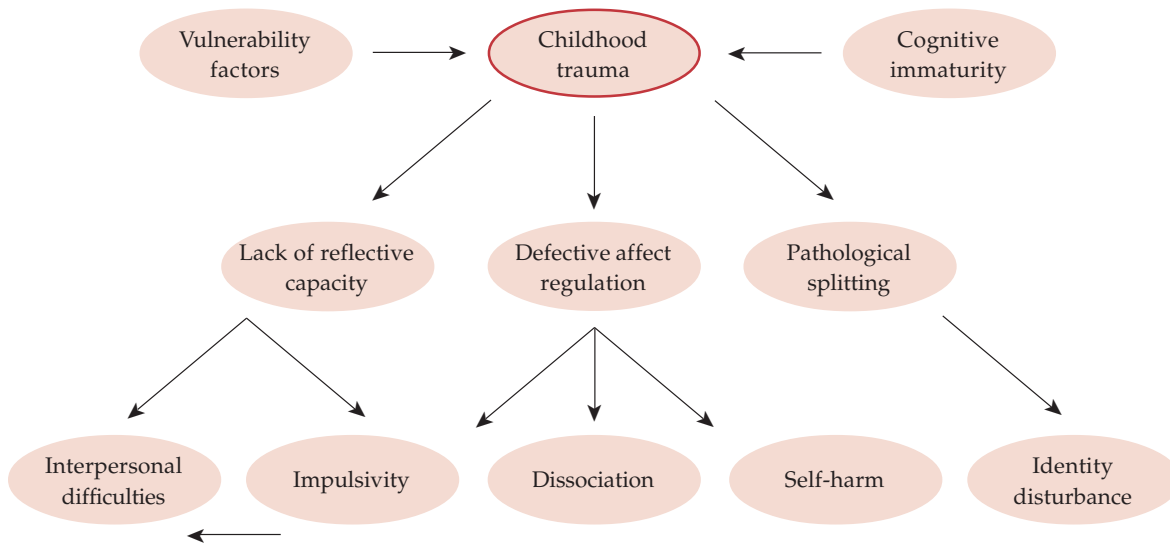


Fig. 1 An aetiological model of borderline personality disorder

Dialectical behaviour therapy

Dialectical behaviour therapy (DBT; Linehan, 1993) is based on the principle that BPD is essentially the result of deficits in interpersonal and self-regulatory skills and that these skills can be taught in therapy. Defective affect regulation is seen as particularly important. Treatment consists of weekly individual and group therapy sessions based on a skills-training model, together with out-of-hours telephone contact with the therapist.

Dialectical behaviour therapy has been shown, in a single study, to be superior to 'treatment as usual' in reducing self-harm and time spent in hospital, but not subjective experiences such as depression and hopelessness (Linehan *et al*, 1991). There were also significant improvements in social and global

functioning and anger (Linehan *et al*, 1994). However, by one year after the end of treatment, rates of self-harm were no different in the DBT and treatment-as-usual groups, although both had improved (Linehan *et al*, 1993).

Despite this essentially negative finding, DBT has attracted considerable interest; however, Linehan's study is open to a number of methodological criticisms. Only 39 patients were studied, all of them female, and of these only 20 were fully assessed. The level of self-harm required for entry into the study (two episodes in the last five years and one in the last eight weeks) may have led to the inclusion of patients who were less severely disturbed than those commonly seen in clinical practice. Furthermore, DBT involves a high level of input from professionals and it is not yet clear whether it is the skills training itself or simply the high level of support which leads to the reduction in self-harm.

Box 3. New therapies for borderline personality disorder

Cognitive analytic therapy
 Brief psychoanalytic psychotherapy
 Interpersonal psychotherapy
 Dialectical behaviour therapy
 Schema-focused cognitive therapy

Psychoanalytic psychotherapy

Psychoanalytic psychotherapy has long been used in the treatment of borderline patients but has never been subjected to formal evaluation. The available data suggest that only a minority of borderline patients benefit from psychoanalytic psychotherapy in its traditional form (Waldinger & Gunderson, 1984). However, a modified approach, which

emphasises current rather than past experiences and in which the therapist takes a more active role, may be more suitable for the treatment of BPD.

Stevenson & Mearns (1992) have described encouraging results using a specialised form of brief psychotherapy which is designed specifically to meet the needs of borderline patients. This model draws on both self-psychology and Hobson's 'conversational model' (Hobson, 1985). Patients are seen twice-weekly for a year and therapy can be delivered by trainee therapists following a treatment manual. In their study, this form of therapy produced significant improvements in violent behaviour, use of medication, self-harm and hospital admissions. Improvements were also observed in impulsivity, affective instability and suicidal behaviour and by the end of treatment, 30% of patients no longer met DSM-III-R (American Psychiatric Association, 1987) criteria for BPD.

Therapeutic communities

Recent work has provided evidence for the effectiveness of therapeutic community treatment. Dolan *et al* (1997) compared 70 patients treated at the Henderson Hospital with those referred but refused funding by their health authorities. Eighty per cent of their patients had a diagnosis of BPD and many also met the diagnostic criteria for other personality disorders. Forty-three per cent of the treated patients showed a clinically significant change in core borderline psychopathology at one year after discharge, compared with 18% of those who had been refused funding.

Another approach to evaluating the effectiveness of therapeutic community treatment is to calculate service consumption and costs to public services before and after treatment. Recent studies have found substantial reductions in service consumption and costs following treatment in three National Health Service therapeutic communities: the Cassel and Henderson Hospitals in London and Francis Dixon Lodge in Leicester (Chiesa *et al*, 1996; Dolan *et al*, 1996; Davies *et al*, 1999).

Interpersonal therapies

Interpersonal difficulties are one of the most common presenting features of BPD. Not only do they cause considerable suffering to the patient but they are also likely to manifest themselves in complex and ambivalent relationships with professionals.

Benjamin (1996) has developed a technique for analysing patterns of interpersonal behaviour known as the Structural Analysis of Social Behavior

(SASB). This instrument allows dysfunctional interpersonal patterns to be identified and coded and has led to the development of a therapeutic approach that is aimed at modifying interpersonal behaviour. In therapy, maladaptive interpersonal patterns are identified and their origins explored. An eclectic mix of techniques is used including role play, free association, dream analysis and educational assignments. When the patient is ready to do so, the therapist helps him or her to 'block' maladaptive patterns and learn new ways of functioning.

The brief interpersonal therapy (IPT) developed by Klerman and his colleagues (Klerman *et al*, 1984) has also been adapted for use with borderline patients. Originally designed to treat depression, IPT is a structured and time-limited therapy which focuses on the relationship between symptoms and interpersonal difficulties. A small pilot study has been carried out using an 18-session programme for borderline patients (Angus & Gillies, 1994), but the results have yet to be published.

Cognitive-analytic therapy

Cognitive-analytic therapy (CAT) for borderline patients employs a collaborative approach between patient and therapist in order to identify self-states (Ryle *et al*, 1997). Inadequate parenting is thought to result in an inability to integrate these self-states, leading to rapid shifts between them. These shifts between self-states and their associated interpersonal roles are seen as a cause of the instability that borderline patients display.

In therapy, the patient is helped to make links between early experience and current behaviour. The collaborative nature of the therapeutic relationship also gives the patient experience of a new and more healthy way of relating and thus contributes to the process of change. Although promising, CAT has yet to be evaluated adequately in clinical practice.

Schema-focused cognitive therapy

Another novel but untested approach is schema-focused cognitive therapy (Young, 1994). This therapy concentrates on identifying and modifying the 'early maladaptive schemas' thought to underlie BPD. Schemas are:

"broad pervasive themes regarding oneself and one's relationship with others, developed during

childhood and elaborated throughout one's lifetime, and dysfunctional to a significant degree" (Young, 1994).

Early maladaptive schemas have their origins in adverse childhood experiences and are particularly resistant to change. They cover themes familiar to psychoanalytic psychotherapists and are organised into five principal domains: disconnection and rejection; impaired autonomy and performance; impaired limits; other-directedness; and over-vigilance and inhibition.

Therapy consists initially of identifying and activating core schemas (for example, with the use of imagery), which therapist and patient then discuss. Schemas are then modified using cognitive reconstruction, behavioural and experiential techniques and discussion of issues arising in the therapist-patient relationship.

Long-term outcome

Several studies have now established that the long-term prognosis in BPD is significantly better than is often assumed and that the majority of patients improve over time (for review see Stone, 1993). For example, Links *et al* (1998) found that 53% of patients followed-up for seven years no longer met diagnostic criteria for BPD. In one of the largest studies, long-term follow-up of a cohort of patients treated at the New York Psychiatric Institute found that two-thirds were clinically well (Stone *et al*, 1987).

Future developments

Our understanding of the aetiology of BPD has grown considerably over the past decade and it is increasingly being seen as a disorder of psychological development. However, major questions remain. Are some individuals more vulnerable to the development of the disorder than others? Are there potentially protective factors? Perhaps most crucially of all, can early intervention with at-risk families help to prevent the development of BPD?

At the clinical level, there is an urgent need for more research into the outcome of different forms of treatment. Studies of treatments such as DBT and

brief psychoanalytic psychotherapy need to be replicated, and the effectiveness of therapies such as CAT and IPT needs to be evaluated. The relative merits of different therapies have yet to be assessed and it is unclear how best to match patients to therapies. Many of the new therapies for BPD share a theoretically coherent, manual-based structure and it may be that the coherence and consistency this provides is particularly important for borderline patients. We do not yet know whether these structured, short-term therapies will prove sufficient on their own or will in future be used as a prelude to more exploratory therapy for suitable patients. Moreover, it is probable that most borderline patients will continue to be managed by general psychiatrists and the place of such specialised therapies within generic mental health services will need to be determined.

The apparent success of these brief therapies is somewhat at odds with the view held by many clinicians that borderline patients benefit from a relatively prolonged relationship with a therapist or therapeutic team. This view is consistent with the evidence for disordered attachment in BPD, which suggests that a stable therapeutic attachment may be helpful in allowing patients to develop psychologically in a more functional way. Long-term follow-up studies will be needed to clarify whether the effects of brief therapies persist beyond the end of the treatment period.

Despite many unanswered questions, recent developments give grounds for optimism. It is now difficult to sustain the view that all borderline patients are untreatable. Psychoanalysis, cognitive therapy and empirical research are converging, and a coherent aetiological model of the disorder is beginning to emerge. The outlook for this challenging group of patients may be starting to improve.

References

- American Psychiatric Association (1987) *Diagnostic and Statistical Manual of Mental Disorders* (3rd edn, revised) (DSM-III-R). Washington, DC: APA.
- (1994) *Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV)*. Washington, DC: American Psychiatric Association.
- Angus, L. & Gillies, L. A. (1994) Counselling the borderline client: an interpersonal approach. *Canadian Journal of Counselling*, **28**, 69–83.
- Benjamin, L. S. (1996) *Interpersonal Diagnosis and Treatment of Personality Disorders*. New York: Guilford Press.
- Calverley, R. M., Fischer, K. W. & Ayoub, C. (1994) Complex splitting of self-representations in sexually abused adolescent girls. *Development and Psychopathology*, **6**, 195–213.
- Chiesa, M., Iacoponi, E. & Moris, M. (1996) Changes in health service utilization by patients with severe

- personality disorders before and after inpatient psychosocial treatment. *British Journal of Psychotherapy*, **12**, 501–512.
- Davies, S., Campling, P. & Ryan, K. (1999) Therapeutic community provision at regional and district levels. *Psychiatric Bulletin*, **23**, 79–83.
- Dolan, B., Warren, F., Menzies, D., *et al* (1996) Cost-offset following specialist treatment of severe personality disorders. *Psychiatric Bulletin*, **20**, 413–417.
- , — & — (1997) Change in borderline symptoms one year after therapeutic community treatment for severe personality disorder. *British Journal of Psychiatry*, **171**, 274–279.
- Fonagy, P., Leigh, T., Steele, M., *et al* (1996) The relation of attachment status, psychiatric classification, and response to psychotherapy. *Journal of Consulting and Clinical Psychology*, **64**, 22–31.
- Herman, J. L., Perry, C. & Kolk, B. (1989) Childhood trauma in borderline personality disorder. *American Journal of Psychiatry*, **146**, 490–495.
- Hobson, R. (1985) *Forms of Feeling: The Heart of Psychotherapy*. London: Tavistock.
- Klerman, G. L., Weissman, M. M., Rounsaville, B. J., *et al* (1984) *Interpersonal Therapy of Depression*. New York: Basic Books.
- Kohut, H. (1984) *How Does Analysis Cure?* Chicago, IL: University of Chicago Press.
- Kroll, J., Carey, K., Sines, L., *et al* (1982) Are there borderlines in Britain? *Archives of General Psychiatry*, **39**, 60–64.
- Linehan, M. M. (1993) *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. New York: Guilford Press.
- , Armstrong, H. E., Suarez, A., *et al* (1991) Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry*, **48**, 1060–1064.
- , Heard, H. & Armstrong, H. E. (1993) Naturalistic follow-up of a behavioral treatment for chronically parasuicidal borderline patients. *Archives of General Psychiatry*, **50**, 971–974.
- , Tutek, D., Heard, H., *et al* (1994) Interpersonal outcome of cognitive behavioral treatment of chronically suicidal borderline patients. *American Journal of Psychiatry*, **151**, 1771–1776.
- Links, P. S., Heslegrave, R. & van Reekum, R. (1998) Prospective follow-up study of borderline personality disorder: prognosis, prediction of outcome, and Axis II comorbidity. *Canadian Journal of Psychiatry*, **43**, 265–270.
- Patrick, M., Hobson, R. P., Castle, P., *et al* (1994) Personality disorder and the mental representation of early social experience. *Developmental Psychopathology*, **94**, 375–388.
- Perry, J. C. & Herman, J. L. (1993) Trauma and defence in the etiology of borderline personality disorder. In *Borderline Personality Disorder: Etiology and Treatment* (ed. J. Paris). Washington, DC: American Psychiatric Press.
- Reich, J. H. & Vasile, R. G. (1993) Effect of personality disorders on the treatment outcome of axis I conditions: an update. *Journal of Nervous and Mental Disease*, **181**, 475–484.
- Ryle, A. (1997) The structure and development of borderline personality disorder: a proposed model. *British Journal of Psychiatry*, **170**, 82–87.
- , Leighton, T. & Pollock, P. (1997) *Cognitive Analytic Therapy of Borderline Personality Disorder*. Chichester: John Wiley.
- Stevenson, J. & Meares, R. (1992). An outcome study of psychotherapy for patients with borderline personality disorder. *American Journal of Psychiatry*, **149**, 358–362.
- Stone, M. H. (1993) Long-term outcome in personality disorders. *British Journal of Psychiatry*, **162**, 299–313.
- , Hurt, S. W. & Stone, D. K. (1987) The PI-500: Long term follow-up of borderline in-patients meeting DSMIII criteria. I: Global outcome. *Journal of Personality Disorders*, **1**, 291–298.
- van der Kolk, B. A., Hostetler, A., Herron, N., *et al* (1994) Trauma and the development of borderline personality disorder. *Psychiatric Clinics of North America*, **17**, 715–730.
- Waldinger, R. J. & Gunderson, J. G. (1984) Completed psychotherapies with borderline patients. *American Journal of Psychotherapy*, **38**, 190–202.
- Widiger, T. A. & Weissman, M. M. (1991) Epidemiology of borderline personality disorder. *Hospital and Community Psychiatry*, **42**, 1015–1021.
- World Health Organization (1992) *The ICD-10 Classification of Mental and Behavioural Disorders. Clinical Descriptions and Diagnostic Guidelines*. Geneva: World Health Organization.
- Young, J. E. (1994) *Cognitive Therapy for Personality Disorders: A Schema-focussed Approach* (2nd edn). Sarasota, FL: Professional Resource Press.

Multiple choice questions

- The prevalence of borderline personality disorder among in-patients is estimated to be:
 - 10%
 - 15%
 - 20%
 - 12%
 - 5%.
- Multiple self-states are associated with:
 - schema-focused cognitive therapy
 - self-psychology
 - cognitive-analytic therapy
 - dialectical behaviour therapy
 - interpersonal therapy.
- In borderline personality disorder:
 - a disturbed sense of self is common
 - patients are preoccupied with disturbed early relationships
 - pathological splitting is uncommon
 - the New York Psychiatric Institute follow-up study found that one-third were clinically well
 - therapeutic community treatment produces a reduction in service consumption.
- With respect to childhood trauma:
 - physical abuse is more common than sexual abuse
 - defective affect regulation is related to early trauma
 - trauma has been linked to difficulty thinking about oneself and others
 - sexual abuse is strongly correlated with self-mutilation
 - up to 87% of patients have suffered childhood trauma.

5. In the treatment of borderline personality disorder:
- a dialectical behaviour therapy is clearly superior to treatment as usual
 - b dialectical behaviour therapy reduces depression
 - c cognitive–analytic therapy is more effective than interpersonal therapy
 - d theoretical coherence may be important
 - e interpersonal therapy was originally developed to treat depression.

MCQ answers

| | | | | |
|-----|-----|-----|-----|-----|
| 1 | 2 | 3 | 4 | 5 |
| a F | a F | a T | a F | a F |
| b T | b F | b T | b T | b F |
| c F | c T | c F | c T | c F |
| d F | d F | d F | d T | d T |
| e F | e F | e T | e T | e T |

Commentary

Richard Cawthra

Anthony Winston reviews and describes current perspectives on the aetiology of borderline personality disorder, covering areas such as the role of traumatic factors, attachment theory and self-psychology. The author links these to the psychopathology of the borderline patient who experiences difficulties such as regulation of affect, impulse control and cognitive capacity to both think and reflect. The psychological function of splitting is considered along with other defence mechanisms as having adaptive potential for the borderline patient. Winston describes in a helpful way the links between human development, psychodynamics and psychopathology as he reveals some of the more recent contributions to the field of BPD. At the beginning of his article, he emphasises the problems encountered when attempting to treat or manage patients with BPD. He centres these difficulties on the counter-transference of the clinician, pointing out how such feelings can “all too easily be transformed into therapeutic nihilism”. His article can easily be read as an attempt to counter such a state of mind and he appears to try to generate a more hopeful if not optimistic outlook. In doing so, I fear

that he goes beyond his own account of the research evidence for the effectiveness of treatment. Such enthusiasm or optimism can readily be understood as a reactive polar opposite to nihilism or pessimism. I would like to consider further Winston’s statements germane to this aspect of his article and raise for further discussion some other ideas which extend beyond the narrower confines of aetiology and psychological therapy.

When describing the particular psychological therapies – namely dialectic behaviour therapy (DBT), psychoanalytic psychotherapy, interpersonal therapies, cognitive–analytic therapy (CAT) and schema-focused cognitive therapy – Winston acknowledges that in each case the evidence for their efficiency is still lacking. For example, with CAT, he states that “though promising it has yet to be evaluated adequately in clinical practice”. He describes schema-focused cognitive therapy as “another novel but untested approach”. He also describes a brief approach developed by Klerman within interpersonal therapy, for which “a small pilot study has been carried out but the results have yet to be published”. Psychoanalytic psychotherapy, he

argues, has never been subject to formal evaluation. I am not sure that this view is strictly correct in light of the work of the Menniger Group in Topeka (Wallerstein, 1986) – it depends on what is understood by ‘formal evaluation’. Regarding DBT, he discusses the work of Linehan and colleagues comparing this approach with a “treatment as usual” approach for self-harming behaviour, and then states that “despite this essential negative finding, DBT has attracted considerable interest”. Winston then proceeds to point out methodological criticisms of Lineham’s studies. In this way, he appears realistically to appraise the different psychotherapeutic approaches to treating BPD, but when he turns to the future he again seems to believe that the evidence suggests that patients with BPD tend to improve, stabilise or mature over longer periods of time. It is not clear from his article what this evidence is, or whether he is referring to a natural phenomenon (Stone, 1993). He admits that there is “urgent need for more research into the outcome of different forms of treatment” and acknowledges that the different therapies have yet to be properly assessed. Yet, in spite of the lack of evidence, he seems to be optimistic in his outlook. Winston does admit that the jury is still out in considering the case for short-term therapies; he poses the possibility of some form of unspecified early intervention with at-risk families in order to help prevent the development of BPD. Given that he has previously stated an estimated prevalence of BPD in the community of 2%, the nature of any proposed interventions would surely need to be on a grand scale, in the context of much wider socio-political initiatives.

Winston addresses the thorny issue of where specialised therapies might fit within the total mental health service; he regards it as probable that most borderline patients will continue to be the responsibility of general psychiatrists. This matter is open to ongoing debate (Cawthra & Gibb, 1998). I concur with Winston that the place of such specialised therapies within generic mental health services needs to be determined. Psychoanalytic understanding of mental mechanisms including denial, displacement, projection and transference has enormously assisted the psychiatrist in appreciating how and why the borderline patient can have such a powerful and disturbing impact on the clinical team, which may become divided in ways that mirror the inner world of the patient (Main, 1989). Here, our understanding of the borderline patient can help with clinical management in a broad sense. The development and promotion of treatment by specialised individual therapies or within therapeutic communities, as described by Winston, needs careful consideration before more resources are committed to them. Kernberg (1984) – often quoted in this field

– warns against the frequently encountered scenario whereby an enthusiastic group establishes a therapeutic community model in a sector of the hospital (service), so forming an ‘ideal society’, which generates gratification, excitement, hope and perhaps a messianic spirit in both staff and patients, to be followed later by bitter disappointment because of the “lack of understanding” and apparent rejection of this ideal society by the hospital (service) within which it has developed. The incipient danger of idealisation as a state of mind affecting not only borderline patients but also psychotherapists and psychiatrists needs to be addressed before we can have a sustainable conviction that by receiving treatment, patients with BPD can be significantly changed. Many clinicians, especially general psychiatrists, remain unconvinced about the existing arguments for therapeutic optimism. Given the endeavours of those working in the field, coupled with the spirit of collaboration between the different schools of thought, there are grounds to be more hopeful that in future we will make progress in helping patients with BPD. Furthermore, we may be more able to determine which individuals within this diagnostic category could have therapeutic strategies better tailored to meet their individual needs (Horwitz *et al*, 1996). One factor that seems to be regarded as crucial by some in determining treatability is that of patient motivation – a most enigmatic quality (Higgitt & Fonagy, 1992).

In commenting on Winston’s paper, it would be somewhat unfair and wrong to suggest that his overall message sounds like that of a Jackanorian Utopian ideal in a post-modernist world. Equally, it would be inaccurate to regard my own comments as simply those of a Jeremiah or doubting Thomas. To do either would be a distortion of the truth and probably a form of splitting, but it might contribute to further reflection on this most difficult but important topic.

References

- Cawthra, R. & Gibb, R. (1998) Severe personality disorder – whose responsibility? *British Journal of Psychiatry*, **173**, 8–10.
- Higgitt, A. & Fonagy, P. (1992) Psychotherapy in borderline and narcissistic personality disorder. *British Journal of Psychiatry*, **161**, 23–43.
- Horwitz, L., Gabbard, G., Allen, J., *et al* (1996) *Borderline Personality Disorder – Tailoring the Psychotherapy to the Patient*. Washington, DC: American Psychiatric Press.
- Kernberg, O. (1984) *Severe Personality Disorders – Psychotherapeutic Strategies*. New Haven, CT: Yale University Press.
- Main, T. (1989) *The Ailment and other Psychoanalytic Essays*. London: Free Association Press.
- Stone, M. H. (1993) Long-term outcome in personality disorders. *British Journal of Psychiatry*, **162**, 299–313.
- Wallerstein, R. S. (1986) *42 Lives in Treatment: A Study of Psychoanalysis and Psychotherapy*. New York: Guilford Press.