If I had to suggest a definitive book that clinicians in practice need to be more immediately helpful to patients who have borderline personality disorder (BPD), it Paris's *A Concise Guide to Borderline Personality Disorder*. An alternative to a technically focused manualized therapy, this book offers an integrated synthesis of the current state of knowledge about BPD written by an expert in the field who understands what the typical clinician who won't practice a specialized approach needs in order to be informed about this complex disorder.

—**Lois W. Choi-Kain, MD, MEd,** Director, Gunderson Personality Disorders Institute, Belmont, MA; Associate Professor of Psychiatry, Harvard Medical School, Boston, MA, United States; Distinguished Fellow, American Psychiatric Association

Dr. Paris is a consummate clinical educator who has influenced generations of mental health clinicians. This book distills a lifetime of clinical wisdom and blends it with Paris's deep knowledge and masterful critical appraisal of the research literature. This practical guide has something for everyone. It is essential reading for trainees and practicing clinicians in all mental health disciplines.

—**Andrew Chanen, MBBS (Hons), BMedSci (Hons), MPM, PhD, FRANZCP,** Professor, Orygen, Parkville, VIC and The University of Melbourne, Melbourne, VIC, Australia

Practical, research-informed, and clinically focused, Joel Paris has given us an essential guide to BPD diagnosis and treatment. This book is like having an on-hand professional consultant, full of wise, evenly balanced advice and case examples on how to personalize treatment.

—**Brin F. S. Grenyer, PhD,** Professor of Psychology, University of Wollongong, Wollongong, NSW, Australia; Director of the Project Air Strategy for Personality Disorders

This is a deeply instructive text on the treatment of borderline personality disorder. It is not only richly informative but also written in a very straightforward and readily understood manner.

—**Thomas A. Widiger, PhD,** Professor of Psychology, University of Kentucky, Lexington, KY, United States; Editor, *Oxford Handbook of Personality Disorders*

This is a well-organized account of borderline personality disorder that provides a broad and concise overview that should appeal to the targeted readership. The overall approach is balanced and grounded in relevant evidence.

—**John Livesley, MD, PhD, FRSC,** Professor Emeritus, Department of Psychiatry, University of British Columbia, Vancouver, BC, Canada

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INTRODUCTION

Practical Approaches to the Complex Challenges of Borderline Personality Disorder

Borderline personality disorder (BPD) is a diagnosis that describes patients who are often seen in clinical practice but who are generally considered difficult to treat. The clinical picture of BPD is complex and derives from multiple domains: emotion dysregulation, widespread impulsivity, and highly problematic intimate relationships. Most of these patients seriously consider suicide, and many attempt it. Some (fortunately, a minority) will take their own lives. Thus, BPD is a major challenge for psychotherapists and other mental health clinicians.

However, we now know much more about this disorder: what risk factors are associated with it, how it changes over the life span, and how it is best managed in therapy. This book offers clinicians a practical and evidence-based approach to making a diagnosis in patients who are often misunderstood and misdiagnosed. We also know how to effectively treat most cases of BPD.

BPD has been the subject of many books and thousands of journal articles. This includes a longer book of my own, revised a few years ago in a second edition (Paris, 2020c). However, the present volume will not be a shorter version of that book. Even after 5 years, further research has shed additional light on some crucial clinical issues. Moreover, my own views about BPD have

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A Concise Guide to Borderline Personality Disorder, by J. Paris

continued to evolve and change. Unlike the longer book, in this volume I will not attempt to summarize and evaluate large bodies of published research. My intent is to provide a practical message for busy therapists who want to understand the big picture. Moreover, it is not necessary to be an expert to understand BPD. For readers who want to dive more deeply into empirical data, throughout the chapters I will refer to key articles and books that summarize a large scientific literature.

With this rationale in mind, I have written this book in a user-friendly style to make it concise and to the point. I will inform readers about what I can conclude after a half-century of work as a clinician and researcher. Most of what I have to say will be based on empirical evidence. Some issues about BPD are still contested and debated, but most of what I will present here can be considered a consensus of evidence-based opinion. Where important problems have not yet benefited from research, I draw on my clinical experience.

This book will also offer a perspective on BPD that is different from the ideas of other experts. As my views have evolved, I am now convinced that understanding this disorder requires the application of a biopsychosocial model. There is a crucial biological background to BPD that reflects the heritable component in this disorder. There are equally crucial psychological components that derive from adverse life experiences (Porter et al., 2020). Finally, there is a social component related to cultural norms and values.

Unfortunately, many of the best-known models of BPD consider only one of these domains (i.e., biological, psychological, social). I will challenge a currently popular model associated with what is being called *complex post-traumatic stress disorder*. This book will show that although childhood trauma is associated with BPD, and worsens its prognosis, it is not the primary cause of the disorder.

The focus of this book will be the development of a model that guides an eclectic and integrated approach to treatment. Thus, BPD need not be seen as mainly rooted in abnormal brain circuitry, or as entirely due to traumatic experiences. Instead, its development is best understood in terms of gene–environment interactions. I will apply a similar model to understanding what makes treatment of BPD successful. Over the past few decades, various methods of psychotherapy designed specifically for BPD have been promoted, but each of these approaches tends to describe only one part of the interventions that work for patients. In this book, I propose an eclectic model that integrates ideas drawn from many sources. I also show how well-planned therapies of several kinds can help patients with BPD. You do not have to take courses or follow a manual to manage these cases.

Finally, I will show that many (if not most) patients with BPD do not necessarily need years of therapy but can be helped by briefer interventions that can rapidly set them on a road to recovery—often within months rather than years. Moreover, time-limited therapy allows more patients to enter the mental health system and receive treatment that is more specific to the complexity of BPD.

UNDERSTANDING AND MISUNDERSTANDING BPD

BPD describes a common form of psychopathology that can be diagnosed in nearly 10% of all outpatients with personality disorders (Zimmerman et al., 2005), yet this disorder remains one of the most misunderstood conditions in psychiatry and clinical psychology.

First, consider that the name "borderline" is rather misleading. Although once thought to fall between psychosis and neurosis, the condition lies not on one border but on many. BPD is a very complex diagnosis, presenting with a toxic mix of unstable mood, impulsivity, and unstable relationships.

Many have thought the name of BPD should be changed, that it might more accurately be labeled "emotion regulation disorder," or "emotionally unstable personality disorder." The reason is that dysregulated emotions are a primary feature of BPD. However, they do not tell the whole story. Patients with BPD also experience widespread impulsivity (in particular, chronic suicidality and self-harm) as well as other impulsive features, such as substance use, and eating disorders. The clinical picture is also marked by highly unstable interpersonal relationships that many see as a hallmark of the condition. One cannot diagnose BPD if emotion dysregulation is the only clinical feature.

These intersections between pathological domains lead to another diagnostic problem. BPD has a wide range of symptoms that overlap with other mental disorders. These comorbidities lead to a good deal of misdiagnoses that promote mistreatment. For example, most BPD patients have chronic depression, anxiety, or both, leading them to be treated, sometimes for years, with antidepressants, but these pharmacological agents have little benefit in this population. Moreover, standard cognitive behavior therapy methods have limited efficacy in BPD. This is why most specialists see these patients after other attempts at treatment have failed.

A second difficulty is that many models of the etiology of and treatment for BPD have a weak grounding in evidence. Thus, BPD is often misunderstood as mainly the result of childhood adversities, in particular highly traumatic

events. In this model, BPD tends to overlap with diagnoses of posttraumatic stress disorder or complex posttraumatic stress disorder. It is true that many BPD patients (at least one-third) have histories of early trauma, but the majority describe a more subtle risk factor: neglect of their emotions and having those emotions misunderstood, invalidated, or dismissed (Linehan, 1993).

Even if traumatic events are not the primary or the only cause of BPD, they make the course of the disorder more problematic. The majority of patients with BPD do not have a history of childhood trauma (unless you define "trauma" so broadly that it describes any kind of dysfunctional family or problematic relationship). Moreover, only a minority of children who are seriously traumatized grow up to develop BPD. Instead, as hypothesized decades ago by Linehan (1993), most patients struggle with two "hits"—that is, two interacting risk factors—that create a vicious cycle. The first consists of heritable traits that make emotions stronger and more problematic (Amad et al., 2014). The second consists of experiences of having emotions invalidated by family members and caretakers.

The evidence shows that emotional neglect, not trauma, is the most universal psychological risk factor for BPD (Porter et al., 2020). Moreover, life adversity is the "second hit" that amplifies emotions and makes them dysregulated. BPD is unlikely to develop in the absence of heritable traits that lead to high levels of emotionality.

This overemphasis on childhood trauma has led to serious mistakes in planning treatment, with some therapists focusing mainly on early memories. However, that approach fails to understand the complex etiology of BPD, and it fails to help patients cope with a problematic temperament. Most important, it fails to take into account current life problems that can be triggered by a perception that one's emotions are invalidated by other people.

An even more important missing link is the genetics of traits that are heritable risk factors for the disorder. Twin studies (Bornovalova et al., 2009; Skaug et al., 2022) have shown that these factors account for about half the variance in BPD as an outcome. Of course, genes alone do not explain why patients develop BPD, but the disorder is most likely to arise from gene–environment interactions. That means that people who have specific genetic predispositions respond differently and more intensely to adverse life events than those who do not. One cannot understand trauma without taking into consideration the traits that influence the way a person processes life events.

An emphasis on the past has fed the perception that BPD is intractable to treatment. That point of view is, to put matters plainly, wrong. We now know that most patients get better with time and that most specialized treatments are effective. Unfortunately, clinicians tend to be impressed by

the minority who keep coming back when the disorder fails to remit. We now have much better and more specific forms of therapy to offer patients with BPD. Successful therapy can damp down emotion dysregulation, bring impulsivity under control, and teach patients the skills they need to manage intimate relationships.

There are now several forms of psychotherapy with demonstrable efficacy and effectiveness for BPD. Unfortunately, as is the case in general for talk therapy, clinicians tend to become attached to one particular method that claims to be superior to its competitors. My view makes use of concepts derived from dialectical behavior therapy (Linehan, 1993) that are combined with ideas from other methods, including good psychiatric management (Sonley & Choi-Kain, 2021), integrated modular treatment (Livesley, 2017), and mentalization-based treatment (Bateman & Fonagy, 2004). Concentration on a single model can prevent clinicians from making their own synthesis of the best ideas from all sources. In this book, I will show that several methods have good research support and that no single approach is necessarily better than any other.

Before applying any of these methods, one has to recognize the disorder. Unfortunately, many clinicians have biases that lead to a failure to make an early diagnosis of BPD. Because of its association with mood swings, BPD can be confused with bipolar disorder. Because most of these patients are chronically depressed, it may be treated (usually unsuccessfully) with antidepressants. Because BPD has multiple comorbidities, it can also be confused with posttraumatic stress disorder or attention-deficit/hyperactivity disorder.

Once recognized, the road to recovery from BPD is open. Successful therapy can damp down emotion dysregulation, bring impulsivity under control, and teach patients the skills they need to handle intimate relationships. BPD is a disorder with many faces, and clinicians need to assess personality and not just symptoms.

BPD also has a variable course and outcome. It usually begins in adolescence, a time when hormones and developmental challenges trigger symptoms even in relatively typical people. But the disorder typically (but gradually) remits during young adulthood and only rarely meets diagnostic criteria by early middle age. Thus, the vast majority of patients get better with time.

Still another problem derives from the belief that BPD patients need to be treated (at great expense) over many years to get better. Although the recovery process varies in length, once things get on the right trajectory improvement gains momentum. The larger problem concerns accessibility to effective and evidence-based psychotherapy, which many, or most, patients cannot afford.

My recommendations for management will be based on a model in which the best ideas for all current forms of therapy can be used; framed within an application of a stepped care model of treatment, in which most patients are treated briefly; and in which only a subset require longer therapy. I will describe our clinical team's specialized program and explain how it often leads to symptomatic remission and how others have applied similar methods, all supported by empirical data. Moreover, although BPD is common in practice, treatment tends to be too expensive or not readily available. For that reason, brief therapy allows easier access to treatment for more patients.

A final point of misunderstanding concerns whether BPD can or should be diagnosed as early as adolescence. I will review data showing that the early teenage years are usually the stage at which the disorder first appears. That said, there can be a significant delay between the onset of symptoms and contact with the mental health system.

BPD is a common clinical problem that therapists find challenging, largely because of its association with suicidal ideas and behaviors. This book was written for clinicians who see these patients and who are looking for practical management tools. I will not advocate the adoption of still another specific therapy with a three-letter acronym—we have enough of those already. Instead, my approach will be integrative and eclectic, combining ideas from multiple sources. BPD patients have unusual ways of feeling, thinking, and behaving, yet a good deal of what works in therapy is close to common sense.