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Introduction to the special section on theories of Borderline Personality Disorder

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Special Section Editors

In their target article, Gunderson and colleagues compare four theories of the core features of borderline personality disorder (BPD): excessive aggression (Kernberg, 1967), emotional dysregulation (Linehan, 1993), failed mentalization (Fonagy, Luyten, & Allison, 2015), and interpersonal sensitivity (Gunderson & Lyons-Ruth, 2008). These theories are compared according to their ability to: explain the co-aggregation of four putative components of BPD, account for the overlap between BPD and other disorders, distinguish BPD from other disorders, incorporate findings related to heritability, and have clear and understandable clinical implications. The authors generally conclude that each of these theories has value in general and in specific, often complementary ways. They suggest a greater focus in the literature on testing differences between and synthesizing these theories.

There was some agreement between commenters and the target authors suggestion that these theories could be a conduit through which fundamental hypotheses could be tested (Schoenleber, this issue; Sharp, this issue). For example, Schoenleber focused her commentary on ways in which using the theories reviewed by Gunderson et al. as a theoretical model could help sharpen research hypotheses and tools for understanding emotional dynamics in psychopathology more generally.

However, all four reviewers challenged the standards proposed by Gunderson and colleagues. Sharp argues that these standards assume -- but do not justify -- a Robins and Guze (1970) model of BPD as a discrete diagnostic category. Conceptualizing BPD as a discrete diagnostic category leads to a form of argument that frames the answers to a certain degree, and thus commenters tended to articulate a

broader and more thematic conceptualization than the one embodied in Gunderson et al.'s specific assertions.

For example, Sharp (this issue) opines the importance of correctly capturing the empirical structure of BPD features vis-à-vis all forms of psychopathology. Clarkin (this issue) emphasized the need to reorganize the received units of dysfunction and conceptualize them in dynamic relation to one another. Widiger & McCabe (this issue) underscored the utility of the Five Factor Model (FFM) of personality for this kind of reorganization, and Sharp (this issue) reviewed recent work situating BPD as a general factor underlying different forms of psychopathology. Indeed, a robust literature shows that the dispositional aspects of BPD can be largely accounted for by hierarchical dimensional models of personality dysfunction like those pointed to by Sharp and Widiger.

We noticed the correspondence between the BPD structure Gunderson proposes and DSM-5 Alternative Model of Personality Disorder (AMPD; APA, 2013) features: Mentalization is similar to criterion A level of personality functioning; emotional dysregulation is similar to the criterion B trait facet of emotional lability; anger is like the hostility facet; and interpersonal sensitivity as described by Gunderson et al. appears to involve several facets, including separation insecurity, intimacy avoidance, anxiousness, and suspiciousness. This linkage suggests the possibility of using the AMPD or similar models as a means for providing a common language for the theories Gunderson et al. compare.

More generally, using an evidence-based hierarchical model of personality and psychopathology dimensions to link different explanatory models allows for a potentially productive reframing of their commonalities, virtues, and weaknesses. Such a model places these theories on relatively equal footing and is associated with a suite of validated assessment techniques useful for measuring the common and different elements of each theory (Clarkin, this issue; Sharp, this issue; Widiger & McCabe, this issue). This kind of re-organization can clarify and enhance etiological research (Schoenleber, this issue; Sharp, this issue). When re-conceptualized as patterns of overlapping and distinct patterns across ostensible

disorders, otherwise problematic patterns of comorbidity and heterogeneity can enrich the formulation and be incorporated into treatment plans (Clarkin, this issue; Widiger & McCabe, this issue).

Overall, a synthesis of the reviewers' comments reveals an overall narrative similar to our own (Krueger et al., 2014; Hopwood et al., 2015) but in some contrast to conceptualizing BPD as a discrete mental disorder: DSM-IV defined BPD refers to some combination of a general factor of personality psychopathology (Sharp, this issue) and traits within an evidence based hierarchical trait scheme (Widiger & McCabe, this issue). The interactions of the component features of BPD emphasized by various authors would be clinically useful to understand as variation within the components of an evidence-based scheme that incorporates all manner of traits and dysfunction (Clarkin, this issue). Indeed, recent and imminent work on the temporal dynamics of emotion dysregulation (Schoenleber, this issue) provides a prime example. In sum, we look forward to continued work in this vein and hope this special section helps to frame and encourage such efforts.

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