random-effects model for meta-analysis, as this includes consideration of heterogeneity in the effect-size estimate. The authors also note that 'even though a random-effects model helps to consider heterogeneity, it does not remove it – heterogeneity still needs to be considered in interpreting the results'. We used a random-effects model and examined heterogeneity.

We would like to reiterate that for those who wish to examine for themselves other points of the type raised by Peters, a detailed database of the studies we included is available online (http://www.cbtinschizophrenia.com/).

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Borderline personality disorder and mood

Parker examined whether borderline personality disorder (BPD) is a bipolar or unipolar mood condition and concluded by suggesting that it is probably neither.[1] I would like to offer a supplementary interpretation of the literature; that is BPD is in large part a mood disorder but is not necessarily a bipolar or unipolar mood variant.

Borderline personality disorder is highly comorbid with bipolar disorder[2] and depression,[3] and those who develop bipolar disorder have early temperamental markers of emotional dysregulation.[4] Support that BPD is a mood disorder is also aligned with the fact that affective instability is a core feature of the syndrome. While under- investigated, there is emerging evidence that affect or mood instability, as opposed to mood episodes, might be the core feature of bipolar disorders.[5] The majority of patients with established bipolar disorder, even after symptomatic control continue to experience daily or weekly mood swings.[6] Further, the prevalence of mood instability and cyclothymic temperament is increased in unaffected bipolar probands[7] and it predicts functioning in those with bipolar disorder.[5] Mood instability is highly prevalent in unipolar depression[8] and independently links to suicidality and health-service use. Furthermore in BPD, affective instability is the least stable of the 'trait-like' features of the syndrome over 2 years.[9] Thus, all three disorders share mood instability as a clinical component and this all points to BPD, at least in part, being a disorder of mood.

However BPD does not exactly fit into the bipolar or depressive affect rubric, given that the affective shifts do not last long enough for either diagnosis. Detailed studies of the nature of affective instability in mood disorders and BPD using the same measurement methods are limited. However, as Parker states, there are differences. Those with bipolar disorder have greater levels of euthymia–elation and affect intensity. In BPD there are more shifts between anxiety, depression and euthymia–anger.[10] Negative emotionality is a critical feature of BPD but it is changeable, as is obvious to clinicians who have been charged with the care of people with BPD on in-patient wards.

Affect can be studied on the basis of intensity, frequency of shift, rapidity of rise-times and return to baseline, reactivity to psychosocial cues or whether endogenously driven, and the extent to which there is overdramatic expression.[11] To this could be added valence. Using this framework, BPD could be conceptualised as a disorder of mood in which affect changes are intense, frequent, rapid to occur, slow to dissipate and in which the valence of the mood state is typically negative incorporating depression, anxiety and anger. This pattern of difficulties although related to mood, do not appear to overlap to a significant extent with how depression or bipolar disorder might be described using the same affective framework. Though it is clear that terms such as 'intensity', 'frequency' and 'rapidity of rise' need to be better specified, experience-sampling methods analysing affective patterns in the three disorders might further illuminate this area and indeed the debate.

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Gordon Parker makes a powerful case against the hypothesis that borderline personality disorder is really a form of bipolar or unipolar disorder.[1] In so doing he is tilting at a windmill in whose

construction I had absolutely no part. In my article[2] and in other critiques[3,4] I do not claim any connection between bipolar, unipolar and borderline: I only state that borderline personality disorder has far greater affinity to mood than to personality. Its core is not a disorder of depression or mania, but one of emotional dysregulation associated with many other mood states;[5] nothing about it is driven by personality. The very name 'borderline personality disorder' betrays an abrogation of diagnosis. It overlaps with post-traumatic stress disorder, other personality disorders, anxiety, depression, and dissociative and adjustment disorders, yet does not belong to any of them. By having layer upon layer of diagnostic requirements that allow it to become grossly heterogeneous, it has confused everybody and satisfied none. Personality disorders are trait based and these traits are persistent over time and linked to normal personality variation. There is good evidence that borderline-personality characteristics are closely linked to affective instability, not normal personality variation,[6] and its natural history is one of remission rather than persistence.[7] The task of nosology is now to separate the essential core of emotional dysregulation from personality disorders, where its infiltration has been most damaging,[8] and from the many disorders that give the term 'comorbidity' such a bad press. A start has been made in the reclassification of personality disorder in ICD-11, where borderline personality disorder and the other current categories of personality disorder have all been removed,[9,10] but much more needs to be done.

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Declaration of Interest

The author is Chair of the ICD-11 Working Group for the Revision of Classification of Personality Disorders.

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Authors' reply: Two letters in response to my brief editorial seeking to argue why borderline personality disorder (BPD) is not a mood disorder. One (by Dr Stephen Marwaha) gently offers a 'supplementary interpretation' that seemingly positions BPD in an ineffable zone. The other (by Professor Peter Tyrer) is also gracious, but accuses me of 'tilting at a windmill'. What is it about BPD that promotes intense professional interchanges and risks splitting?

Let me proceed less impulsively. Peter states that he did not claim any connection between 'bipolar, unipolar and borderline', but I did not ascribe any such claim to him. Further, he suggests that, in my arguing against BPD as a mood disorder, I was 'tilting against a windmill' in whose construction he had 'absolutely no part'. Here I risk being more coyote-like than Don Quixote-like in recording that Peter did lead me up the path to the windmill. As then Editor of the *British Journal of Psychiatry*, he invited me (personal communication, 16 July 2013) to write an editorial on the 'status and relationship of those disorders', and there observed that he 'wrote a paper in 2009 saying that BPD was a mood disorder so I have already nailed my placard on the diagnostic wall'.

It would be fairer to Peter, however, to report his actual referenced 2009 paper.[1] Its abstract stated that BPD 'is better placed with the mood disorders than in odd isolation as a personality disorder'. In the body of the paper, he judged that BPD does not fit within the general descriptors of a personality disorder and, later, in considering whether it were to be 'accepted as a mood disorder', he suggested that it might warrant a 'term such as fluxithymia, or "rapidly changing" mood disorder'. In relation to other points made in his letter, I agree with all but one of his interpretations. Peter states that BPD characteristics are linked closely to affective instability, not normal personality variation. But is not an affective stability/instability dimension a personality dimension? Even if such instability in those with BPD remits with time (as the data show), this does not of necessity eject BPD from a personality home base. If attenuation with age were to discount a personality base, where would we place sociopathy nosologically when it also commonly 'burns out'?

Marwaha effectively argues that 'BPD is in large part a mood disorder but is not necessarily a bipolar or unipolar mood variant.' While there is one public figure who has described his mood disorder as a 'tripolar one', and there are usually three options in life, our current classificatory systems in psychiatry allow only for unipolar and bipolar disorders. If BPD is a mood disorder, it has to be positioned as one or other: there is no mood condition beyond their borders.

Marwaha proceeds to argue that 'affect' nuances allow BPD to be positioned as a mood disorder. Let us consider paranoid personality disorder (PPD) as an analogy for his points. Do not individuals with a PPD temperament experience changes in affect that are 'intense, frequent, rapid to occur, slow to dissipate' and with 'valence' components weighting anger and emotional dysregulation? If so, as I would argue, would we not, logically, similarly risk positioning PPD (and several other personality disorders) akin to BPD if we accept Marwaha's arguments? I doubt whether we would feel comfortable with such a suggestion. In essence, if we concentrate on features shared across conditions (especially emotional dysregulation) we will predictably find convergence and risk diagnostic confusion. My editorial adopted the opposite approach: focusing on points of distinction between BPD and mood disorders, and which seek to advance diagnostic differentiation, especially in a clinical context.

1 Tyrer P. Why borderline personality disorder is neither borderline nor a personality disorder. *Personal Ment Health* 2009; **3**: 86–95.

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