

A BPD BRIEF -----

An Introduction to Borderline Personality Disorder

Diagnosis, Origins, Course, and Treatment

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Borderline Personality Disorder Diagnosis -----

DSM-IV DIAGNOSTIC CRITERIA for BORDERLINE PERSONALITY DISORDER

A pervasive pattern of instability of interpersonal relationships, self-image, affects, and control over impulses beginning by early adulthood and present in a variety of contexts, as indicated by at least five of the following criteria:

- (1) frantic efforts to avoid real or imagined abandonment
Note: do not include suicidal or self-mutilating behavior covered in criterion (5).
- (2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
- (3) identity disturbance: persistent and markedly unstable self-image or sense of self
- (4) impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuses, driving, reckless driving, binge eating)
Note: do not include suicidal or self-mutilating behavior covered in criterion (5).
- (5) recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
- (6) affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and rarely more than a few days)
- (7) chronic feelings of emptiness
- (8) inappropriate, intense anger or lack of control of anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
- (9) transient, stress-related paranoid ideation or severe dissociative symptoms.

Overview of Borderline Personality Disorder Diagnosis ---

As a result of clinical observations since the 1930's and scientific studies done in the 1970's, psychiatrists concluded that patients characterized by intense emotions, self-destructive acts, and stormy interpersonal relationships constituted a type of *personality disorder*. The term "Borderline" was used because these patients were originally thought to exist as atypical ("borderline") variants of other diagnoses and because these patients tested the borders of whatever limits were set upon them. This diagnosis became "official" in 1980.

A "personality disorder," of which there are 11, means that a person has a set of enduring traits that lead to recurrent subjective distress or very impaired functioning. These traits represent enduring patterns of thinking, behavior, relationships, and coping. BPD is the most common, most complex, and one of the most severely impaired types of personality disorders.

Patients with BPD constitute about 15% of outpatients and inpatients. The traits that comprise BPD involve marked instability of self-image, mood, impulse, and relationships. Such individuals are easily upset, are unable to develop stable relationships, and have extremely impaired abilities to handle adult responsibilities. Often patients present with complaints of depression, eating disorders, or substance abuse. About three fourths who come for treatment are female.

The reason this diagnosis escaped identification for as long as it did is that the traits that characterize BPD are so fluctuating. At times, the person may seem quite healthy, or, at worst, as a depressed and lonely person who is very responsive to others. Some will seem capable of being quite insightful. When the same person feels threatened by the loss of whoever (or whatever) he believes is holding on to him, the threat of separation (i.e., abandonment) is often associated with intense anger. The anger can be expressed as devaluation of that person, as rages, or the anger can take the form of self-destructive threats or acts. Such threats or acts are designed to prevent the separation by evoking a protective response. When the person with BPD feels the absence of anyone, an unbearable sense of loneliness sets in. Then, a third set of symptoms occurs: dissociation, ideas of reference, or desperate, panicky, impulsive actions, often under the influence of alcohol or other drugs.

An important way to understand the borderline patient's traits is by viewing them as expressions of three underlying deficits:

- 1) Affect / Impulse Dyscontrol**
- 2) Intolerance of Aloneness**
- 3) Dichotomous Thinking.**

The first of these deficits is expressed in criteria 4, 5, 6, and 8.

The second deficit is expressed in criteria 1, 2, and 7.

The deficit in thinking is evident in criteria 2, 3, and 9.

What's Known about the Origins of BPD -----

Attempts to explain the disorder as the result of a single person, event, or a specific phase of life have always proven to be inadequate. Studies of BPD indicate that this disorder has **multiple causes**. The studies further reveal that these causes must interact rather than act alone in order to produce the disorder. Theories that focus solely on either biological factors or early childhood traumas fail to explain the whole story. It isn't simple and it isn't easy to develop BPD.

What follows will be a summary of the known risk factors for the development of BPD. The risk factors include those present at birth and experiences occurring in childhood, as well as long-lasting environmental influences.

The relatively few studies of twins have shown a substantial level of heritability for BPD. On the other hand, many studies show that disorders of emotional regulation (such as depression) or impulsivity (such as substance abuse) are unnaturally common in relatives of BPD patients. Many borderline patients are very high on the **heritable temperament** called *neuroticism* that predisposes them to being easily upset and to becoming angry, depressed, and anxious. Efforts are now underway to isolate specific genes that may account for this temperament.

Temperament refers to the characteristics of a person's personality that are manifest in childhood and that are thought to be heavily genetic. Some theorists feel that patients with BPD may have excessive aggression due to their inborn temperament. Such children may in turn elicit anger and frustration from their parents who struggle to manage their aggression. Diminished activation of the serotonergic system of the brain has been demonstrated in borderline patients. This may be a neurophysiological reflection of a temperament that explains the useful role that serotonin reuptake inhibitors can have in treatment.

The fact that infant girls are more *affiliative* and boys more *instrumental* is believed to explain why there is a disproportionate frequency of females (i.e., about 75%) who present for treatment with BPD. This suggests that the disorder may be primarily a disorder of relationships (i.e., *affiliation*). In addition, males with the disorder may end up in the penal system as their behaviors are more often directed towards others. Antisocial personality disorder occurs disproportionately in males - about 75% - and is thought to be primarily a disorder of *action*.

Studies of BPD patients have identified an increased incidence of **neurological dysfunction**, such as Attention Deficit Disorder or learning disabilities, and brain wave irregularities similar to those observed after people have had head trauma, meningitis, encephalitis, or epilepsy.

Normal neurological function is needed for such complex tasks as impulse control, regulation of emotions, and perception of social cues. Many types of insults can impair these functions and leave the individual handicapped with impaired impulse control or impaired emotional regulation and experiencing powerful impulses or intense emotions that come on suddenly. These inner experiences then shape the view of other people and reactions to them. The individual's biology may make him prone to feeling rage. He may then look to the outside world to find some explanation of this rage. A person with impaired perception of social cues may inaccurately interpret other people's behavior as critical or cold, thus causing feelings of rejection or other inappropriate responses in social situations.

A variety of investigators have suggested that the particular anatomical section of the brain whose dysfunction is associated with BPD involves the neocortex, areas of the brain which manage information from the limbic system and, thereby, are implicated for regulation of affects and impulses. These sections of the brain are also implicated in the regulatory problems associated with other serious personality disorders. In any event, such **neurological problems may have either genetic or environmental sources.**

Studies have indicated that borderline personality disorder does not originate from a specific, discrete phase of development, such as the separation-individuation phase. About 30% of people with BPD have an unusually high frequency of early **parental loss** and **prolonged separations**, experiences believed to help prime the borderline patient's later fears of being abandoned.

Adoption is probably more common among people with BPD than it is in the general population. Adopted children often fantasize that the "real" biological parents could have and would have protected them from frustrations/hurts. The belief that if only such idealized and nurturing caregivers can be found then life's problems will be solved is central to what BPD patients pursue in their *saving* relationships - whether they had in reality been adopted or not!

Recent studies have suggested that pre-borderline children fail to learn accurate ways to identify feelings or to **accurately attribute motives** in themselves or others. Such children fail to develop basic mental capacities that constitute a stable sense of self and make themselves or others understandable or predictable.

About 70% of people with BPD have been discovered to have a history of **physical or sexual abuse**. Childhood traumas may contribute to traits such as alienation, the desperate search for protective relationships, and the eruptions of intense feeling that characterize BPD and actually predispose to many different forms of psychiatric disorders. Since BPD can develop without such experiences, these traumas are not sufficient by themselves to explain BPD. Indeed, young adults with emerging BPD are at high risk for getting into abusive relationships and are vulnerable to developing **Post Traumatic Stress Syndrome (PTSD)** from modest stressors.

People with BPD report feeling neglected during their childhood. Sometimes the sources for this sense of **neglect** are not obvious and might be due to a sense of not being sufficiently understood, but patients usually report feeling alienated or disconnected from their families. Studies indicate a **block in communication**. Often the patients feel that the communication problems are due to the parents, and the parents often remember difficulty in understanding the patient's needs. Parents and spouses often feel severely misjudged and unfairly criticized when the person with BPD directs **blame** at them. It is common to respond by defending oneself with indignant **anger**.

However reasonable such anger may be, it never serves a useful purpose. To the borderline son/daughter, the parent's anger will only be seen as an indication of their not being listened to, or understood, or of their being bad and unwanted. These reactions, in turn, will escalate the BPD patient's sense of mistreatment, unwillingness to talk about differences, perhaps even further self-destructive actions. For many psychiatric illnesses, it has been shown that familial criticism/hostility is associated with higher rates of relapse and rehospitalization. Angry responses are never helpful. What is useful is **listening** without either accepting or denying the blame.

The Course of BPD -----

BPD usually becomes apparent in early adulthood, but there is some variability. Studies of the course of BPD have indicated that the first five years of treatment are usually the most crises-ridden. A series of intense, unstable relationships that end angrily with subsequent self-destructive behaviors are characteristic. Though such crises are likely to persist for years, there is often a decline in both the number of hospitalizations and days in hospital over this period. Whereas about 60% of discharged BPD patients are readmitted in the first six months, this rate declines to about 50% in the six months - one-year interval, and to about 35% in the 18 months - two-year period. In general, health care utilization gradually diminishes and increasingly involves briefer interventions.

Although suicide risks often endure for many years, the chances diminish with each crisis the BPD patient survives. About 8 - 9% of people with BPD die of suicide, an increase of 400 - 800 times the rate of people of that age and gender in the general population. Changes in the frequency and seriousness of self-destructive behavior are one of the earliest indications of improvement. It may mean either that borderline patients have achieved some stability in their external lives, or that they have given up hope for the sustained caretaking that fueled earlier hopes and disillusionments.

About half of such patients eventually achieve relative stability in their lives through close relationships, or by finding a niche at work, or through involvement with social support networks such as AA or church. Such stabilization does not mean that they are well, but it suggests positive change from both a public health and interpersonal point of view. Better outcomes are associated with more intelligence, more attractiveness, and less substance abuse.

Suicidality and Self-Destructive Behavior-----

The most dangerous and fear-inducing feature of BPD is the self-destructive behavior and potential for suicide. This is a common feature of BPD, occurring in approximately 75% of patients having the diagnosis and in an even higher percent for those who have been hospitalized. These acts result in many physical scars and handicaps, and suicide occurs in about one in 10 BPD patients. Each time the BPD person survives a suicidal crisis, the chance of future suicide is diminished.

Self-destructive behavior takes many forms in patients with BPD. Patients with BPD often will intentionally behave in self-injurious ways without suicidal intent. Most often, this involves

cutting, but can involve burning or banging oneself. These behaviors can at best be expected to diminish gradually in frequency and severity over a period of several years.

Some self-destructiveness is unintentional and indirect and may be expressed as eating disorders such as Anorexia Nervosa or Bulimia Nervosa.

Motives behind self-destructive/suicidal behaviors may clearly be known only by the specific individual. However, reasons reported include efforts to affect painful feelings and/or to affect others. Self-destructive acts are a means to escape from feelings of anger, badness, or depression. Cutting may bring neurochemical responses and atonement for a sense of sinfulness. People with BPD sometimes make a suicide attempt at a point when they feel the danger of losing someone important to them. Often, such attempts are made under the influence of alcohol or other drugs. There is often a vaguely conceived plan to be rescued, which represents an attempt to relieve the feelings, intolerable feelings of being alone by establishing some connection with others.

Approximately 50% of people with BPD have an episode of **major depression** when they seek treatment and about 70% have such episodes in their lifetime. When major depression complicates BPD, suicide attempts may reflect a sense of hopelessness or despair that makes death seem welcome.

Episodes of major depression refer to a state of mind and physical state somewhat like the symptoms of a chronic physical illness. In the management of suicidality, physicians take care to evaluate the patient's mood carefully and treat a depression with medications. The pain of depression in borderline patients joined by their underlying handicap in tolerating intense emotion makes them particularly apt to act impulsively on their feelings.

About 40% of the self-mutilation done by borderline patients occurs during **dissociative experiences** and is actually accompanied by a sense of relief. Some evidence indicates that self-mutilation brings relief by stimulating the synthesis of endorphins. Endorphins are naturally occurring opiates produced by the brain in response to pain.

Serotonin, a **neurotransmitter**, is another chemical occurring in the brain that has been implicated in mediating self-mutilation. The serotonin re-uptake inhibitors (SRI's), a class of antidepressants, have been found to be particularly helpful in diminishing the felt urge to injure oneself.

People with BPD can have a profound and intense **sense of badness** or sinfulness that can lead to a disturbing state in which the patient has depersonalization, a feeling of being numb, unreal, detached from his body. Here, self-mutilation may be experienced as physically painful, but the pain breaks into this terrifying state and is, therefore, another form of reassuring relief and atonement.

Families can feel tormented by the threat of such acts and will often respond in the same ways that traditionally vex treaters - either by wanting to protect the patient, or by growing impatient and angry at the attention-demanding aspects of the behavior. It is useful for families to realize that the problems causing the self-destructiveness are chronic and the solution offered by hospitalization is only temporary. Understandably, families often feel terrified by the risk of suicide, fearful of the impact on family and social life, and angered when the acts seem unwarranted and willful. But, it is always important to show concerned attention to self-destructive behavior for ignoring it will almost always lead to its dangerous escalation.

Families should not burden themselves by attempting to assume too much responsibility for their BPD member's safety. Whenever a patient gives a clear-cut sign that she has an urge to hurt herself or has done so already, a professional should be contacted. The borderline person may plead to keep her communications or behavior a secret. However, **safety** must come first. The patient, treaters, and family cannot work together effectively and comfortably until they establish that the danger of self-destructive acts cannot be kept a secret; that it overreaches a family's capacity to take care of their son/daughter/spouse; and that communication with professional help is required.

By the time a patient resorts to self-destructive behaviors, it is safe to assume that there is a backlog of problems in her life that have not yet been addressed. The first step in diminishing the likelihood of recurring self-destructive threats or acts is to invite the patient to talk about underlying feelings, anger and otherwise. This invitation requires that you then *listen carefully* to what is answered, without interrupting to disagree or criticize.

What's Known About Treatment -----

Until 1970, the literature about the treatment of patients with borderline personality disorder was primarily about the difficulties patients presented, and it was widely doubted whether anyone with any personality disorder could be successfully treated. About that time, a few widely-read publications reported that borderline patients were psychologically understandable and could be cured by long-term, intensive, psychoanalytically informed treatments.

After the syndrome was entered into the diagnostic system in 1980, research began to test empirically the responsiveness of such patients to treatment. These studies have demonstrated that long-term, intensive, psychoanalytic therapy can occasionally, but not frequently, result in a curative change for these patients. These studies also showed that many borderline patients improve significantly without such therapies.

One of the most important questions confronting families is how and when to place confidence in those responsible for treating their borderline relative. Generally speaking, the more clinical experience and the more willingness to answer questions, the better. In the event that several professionals are involved in the care of a borderline patient, it will be important to know that they are compatible in their approaches. In the event that a borderline patient is receiving some exceptional form of treatment, the patient's family should be made aware of this and understand its reasons. The professionals should be able to offer those reasons.

The role of **hospitalization** in the care of borderline patients is usually restricted to the management of crises, providing an asylum where the patient has an opportunity to gain distance and perspective on the crisis, and where the professionals involved can assess the patient's psychological and diagnostic problems and resources.

TREATMENT OPTIONS

Psychotherapy is the cornerstone of most treatments for borderline patients. Although a secure attachment to the therapist is probably essential for the psychotherapy to have useful effects, this does not occur easily. Psychotherapists are sometimes apprehensive about working with borderline patients because they are likely to be troubled by the same strong reactions that will be familiar to family members or others who get involved with the borderline experience: namely, the wish to be a very protective caretaker, or angry feelings of being misused. Even very able, motivated therapists are often left abruptly by borderline patients. Therapists, and the patients' relatives, can experience such termination of therapy as a failure, but one should bear in mind that often these brief therapies served a very valuable role in helping the patient through an otherwise uncontrolled crisis.

The type of **individual psychotherapy** that has commanded by far the most attention in the literature over the years involves two and often three visits a week with a senior, psychoanalytically-trained clinician for a period of three to six years. The expressed purpose is to help the borderline patient identify problems, to learn to tolerate feelings and impulses without losing control, and to gain perspective on and distance from the sources of those problems. Such treatments are potentially curative, but should be undertaken with caution because, unless provided by very experienced clinicians, they often lead to impasses that are harmful.

Dialectical Behavior Therapy (DBT) combines individual and group therapy modalities and is directed at modifying the borderline patient's expression of anger, control of impulses, and, most especially, control of self-destructiveness. This therapy's proactive, problem-solving approach readily engages more borderline patients than a traditional psychodynamic approach. It has been shown to diminish self-destructiveness, as has been well established in a controlled outcome study.

In general, **cognitive-behavioral interventions** are especially useful for borderline patients in the earlier phases of their treatment because these interventions are not anxiety provoking and are directed at controlling, not evoking, impulses and affects. Because such therapies are more emotionally neutral, structured, and managerial, they have an important place within the overall social-rehabilitative strategies needed by most borderline patients.

Group Therapies

Group Treatments can be divided into those that are professionally led with selected membership and self-help groups comprised of people who gather because they share common problems. Both types are of use to borderline patients, but, despite their usefulness, borderline patients will be often resistant to getting involved. Since groups with a specific focus do not encourage or require the expression of strong feelings or the sharing of personal details, they are likely to be more useful.

Many borderline patients will find it more acceptable to join **self-help groups** such as AA, or other groups that are directed to problems like eating, or that have purely supportive functions, such as the survivors of incest. Such self-help groups that provide a network of supportive peers can be very useful. Though not defined as self-help groups, membership in any organization, such as a church, will often serve these same functions.

Family Support and Programs

Family members typically appreciate support from and contact with mental professionals. Family members welcome a psycho-educational approach where they can learn about the diagnosis, the usual course, expectations from treatments, and an opportunity to acquire skills for their own well-being. Reports from participants in family psychoeducation or support groups indicate that such involvement helps decrease levels of depression, decrease alienation, reduce family burden, and improve communication.

Medication

Most classes of **medications** have some useful role in treating patients with BPD. But no medication is uniformly effective.

The benefits from medications are limited to “taking the edge off” the borderline patient’s anxiety, agitation, impulsivity, depression, panic, or ragefulness. Different classes of medications have somewhat differential effectiveness and the selection of medications will, to some extent, reflect the types of symptomatic and behavioral problems most evident and predominant in any given patient.

Serotonin reuptake inhibitors are the most widely used class of medications and have established the best empirical support via controlled trials. This class of medication is still undergoing investigation as new varieties are developed and the long-term effects are understood. At this time, SRI’s are the usual first choice of medication because of their broad range of benefits and relatively low risk of side effects. A major problem in the pharmacotherapy of borderline patients involves compliance.