Phoebe Huang Borderline Personality Disorder

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Borderline Personality Disorder is a psychopathology defined in the Diagnostic and Statistical Manual of Mental Disorders as a “pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts” (American Psychological Association, 2000). This mental illness, which is regarded as a disorder of black and white extremes, has been extremely difficult to diagnose and treat in the past, but has been garnering much more attention in the medical and scientific realms over the last decade thanks to growing research and improved technology. It is now thought that people with Borderline Personality Disorder suffer from impaired brain functioning that results in behavioral abnormalities (O’Neill & Frodl, 2012), which may include excessive or poorly managed emotional responses, harmful impulsivity, impaired reasoning skills, and chaotic relationships (A.D.A.M. Medical Encyclopedia, 2010).

The DSM IV criteria guidelines for Borderline Personality Disorder are as follows: 1) Desperate attempts to escape abandonment (both real and imaginary), 2) Unstable and intense relationships characterized by alternating extremes of idealization and devaluation, 3) Identity disturbances, or a markedly and persistently unstable sense of self, 4) Potentially damaging impulsivity in at least two areas (e.g., spending, sex, substance abuse, reckless driving, binge eating), 5) Recurrent suicidal and self-mutilating behavior, 6) Instability and excessive reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days), 7) Chronic feelings of emptiness and loneliness, 8) Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper and recurrent physical fights), and 9) Severe dissociative symptoms (American Psychological Association, 2000).

The first criteria, experiencing intense fear of abandonment, described by the manual perhaps drives all other behaviors and symptoms associated with this psychopathology (Coifman, 2012). Sufferers of this mental illness cling to others and become very attached, otherwise feeling worthless and lonely. To them, abandonment contributes to the self-image as bad or evil (A.D.A.M. Medical Encyclopedia, 2010), and the BPD sufferer will thus even resort to desperate manipulation to gain the care and concern of others. As the second criteria notes, people with BPD exhibit dramatic shifts of emotion regarding their relationships with others. They will often waver between feeling immense attachment and then aversion to certain individuals in an endless cycle (Coifman, 2012). Of course, due to their behaviors, BPD sufferers’ intense fear of abandonment is frequently a self-fulfilling prophecy, as others exposed to such behavior tend to distance themselves, causing the individual with BPD to feel insignificant or unloved. That person may try to lure others back into their life through self-harm, as noted in criteria five, or a suicide attempt, even if it is a “mock suicide,” in order to be rescued and cared for. In this way, people with BPD enter a cycle of rejecting others and trying to get them back into their lives.

Due to this lack of meaningful relationships, BPD sufferers can feel like they do not exist or that their lives are empty. Moreover, their own behaviors contribute to a highly chaotic lifestyle. Not only are they impulsive in dangerous ways but they also typically engage in self-mutilation as mentioned earlier. These self-inflicted injuries include cutting and burning the self. While about 70% of all BPD sufferers make suicide attempts, 8-10% actually do commit suicide (American Psychological Association, 2000). The reasons for self-mutilation are thought to be the experience of self-inflicted pain reaffirming the individual’s ability to feel or as a method of punishment because the individual’s sense of being evil and unworthy (Coifman, 2012). Since they become easily angered with others after experiencing real or perceived abandonment, people with BPD often feel ashamed and guilty after the episode, which further heightens this sense of being evil. Overall, it is believed that many of the behaviors associated with BPD are defense mechanisms used by sufferers to cope with their illness because of the overwhelming emotions they feel.

Not only does this mental illness impair the daily functioning of individuals, but also the symptoms of BPD can result in very severe consequences. Self-inflicted injuries and failed suicide attempts, which are extremely common, can lead to permanent damage and physical handicaps. In addition, due to both their chaotic lifestyles and inability to have stable relationships, sufferers of BPD tend to experience recurrent job losses, interrupted education, and broken marriages (A.D.A.M. Medical Encyclopedia, 2010).

As of 2000, it is believed that Borderline Personality Disorder affects 2% of the general population and is present among 30-60% of all patients diagnosed with a personality disorder (American Psychological Association). For unknown reasons as of now, the disorder mainly affects or is at least diagnosed in developed or western nations (Sanu, 2009). It is speculated that the reason behind this lies in the culture of these nations, as western countries tend to emphasize independence and thus look down on the clingy symptoms of people with BPD. For example, since children in India remain dependent on their family members, elders, and spouses for an extended period of time, these behaviors may be viewed as culturally acceptable rather than as a psychopathology that needs to be cured (Sanu 2009). Moreover, this mental illness is much more commonly diagnosed in females than in males, at a ratio of 3 to 1, or 75% (American Psychological Association, 2000).

These discrepancies, however, may in fact be biased and misrepresentative due to the tricky nature of diagnosing Borderline Personality Disorder. Many individuals may not seek treatment while others may be misdiagnosed with other similar mental illnesses due to the many overlapping criteria and comorbidities of BPD. Comorbidities include mood disorders, substance-related disorders, eating disorders, post-traumatic stress disorder, and attention deficit or hyperactivity disorder (A.D.A.M. Medical Encyclopedia, 2010). Even when treatment is sought, it is especially difficult to diagnose BPD in the beginning of treatment because the symptoms described earlier are not as easily identifiable with acquaintances of BPD patients (Rizvi et al., 2011). Since the patient does not initially have a close bond or high level of attachment to his or her clinician, the patient will be less likely to exhibit the same clinginess as he or she would towards a family member or good friend, since people with BPD are more afraid of losing close relationships. Diagnosis is also complicated by the fact that BPD patients tend to drop out of therapy at higher rates than other mental illnesses (Rizvi et al., 2011).

Furthermore, it is debated whether women are actually more prone to developing BPD due to genetic and biological factors or if this stereotype is merely due to bias in diagnosing this disorder or even social influences like the media. On the one hand, this generalization may be true due to the socialization of women to be more dependent than men (Becker, n.d.). Traditional gender roles place girls in more subordinate positions in society and thus may cause them to engage in clingy, attached behaviors. Additionally, since females are typically more sensitive to rejection and generally more emotional people, they may be more likely to develop BPD. However, it is also believed that this discrepancy may be in fact due to diagnostic bias, as social influences and stereotypes may cause clinicians to identify BPD more in women. Men are also more likely to end up in jail rather than a treatment center for exhibiting the dangerous behaviors associated with BPD and thus are not accounted for in the statistics (Becker & Lamb, 1994).

The onset of Borderline Personality Disorder is a controversial subject due to the nature of the disorder’s symptoms (National Collaborating Centre for Mental Health, 2009). The aforementioned symptoms of the mental illness can begin to emerge in childhood or adolescence, but in order for the individual to be diagnosed with BPD, these symptoms and behaviors must be persistent, usually lasting for 1-2 years. It is important to distinguish between a child exhibiting BPD symptoms, such as intense anger, impulsivity, or an unstable sense of self, and a child that is either going through a developmental stage or who is reacting to a disruptive and stressful situation such as divorce or loss. Many researchers and practitioners also believe that personality traits do not stabilize until adulthood and thus only adults can truly be diagnosed and treated for Borderline Personality Disorder. They assert the fact that children and young adolescents are still developing and changing on a daily basis, which can dramatically affect their behaviors. Moreover, they believe that it is better for adolescents to avoid the stigma attached to mental illness. Others, however, argue that if Borderline Personality Disorder is not treated as early as possible, this allows symptoms to worsen, delaying much needed treatment.

The class was asked to consider this controversy and weigh in on what should be done about diagnosing children and adolescents with Borderline Personality Disorder due to the nature of the illness and its symptoms that seem to overlap with natural behaviors occurring during the transition from childhood to adulthood. Should there be an age cut-off for diagnosing BPD? What are the consequences to either side (not diagnosing the problem versus potentially misdiagnosing too early)? The responses received from the class were initially divided into almost even groups supporting each side of the debate. One interesting comment was in support of the idea that adolescents should not be diagnosed with BPD because the diagnosis could be a self-fulfilling prophecy in itself, causing the individual to develop worse behaviors because they feel as if this is inevitable. Many of them suggested that diagnosing too early might lead to labeling of children, which is problematic especially because there is the potential for the child to grow out of the personality traits associated with the disorder if he or she is simply going through a transitional phase. They did, however, acknowledge that avoiding a diagnosis might mean that the child or adolescent will possibly develop more problems in the future because he or she will not have learned how to effectively cope with the symptoms of BPD and the negative behaviors can worsen overtime without appropriate care and medication. Throughout the discussion, the majority seemed to favor the idea that the most important issue at hand is not diagnosing patients with the specific and potentially stigmatizing label of “Borderline Personality Disorder,” but instead to focus of treating the symptoms of the individuals and helping them better cope with their emotions. They generally agreed that the true diagnosis did not have to come right away but that help should be sought to reduce the intensity of the symptoms experienced. One student favored diagnosis on a case-by-case basis. Also, one student remarked that perhaps the best course of action would be to additionally note that the patient may have a predisposition for BPD and to watch for signs of worsening symptoms before diagnosing.

The causes behind Borderline Personality Disorder are not definite as of yet, but genetic, family, and social factors are considered to play important roles in the development of this mental illness (American Psychological Association, 2000). These contributing factors can be described in terms of “nature versus nurture”. On the nurture side, BPD is thought to be the product of a history of unstable relationships, physical, sexual or emotional abuse, family violence, and neglect via parental loss or separation, typically in early childhood (Hernandez et al., 2012). For example, in a 2012 study of 358 patients with BPD, 91% reported childhood abuse and 92% reported childhood neglect (Hernandez et al.). Moreover, this same study found that there is a correlation between the severity of the reported incident and the severity of symptoms in the individual. Previously, it was believed that these were the main factors contributing to the onset of this disorder. However, with the development of enhanced neuroimaging technology allowing for brain scan studies, researchers now support a nature side of BPD. This imaging technology allows them to identify structural, functional, and neurometabolic abnormalities in BPD patients (Hazlett et al., 2012). Researchers have increasingly found evidence that the disorder is linked to overactive amygdalae, which is a part of the brain that controls memory and emotional reactions. In BPD sufferers, the pathway connecting this to the visual cortex, which is what processes images to the brain, is disrupted. The overactive amygdalae then causes people with BPD to react intensely to emotion-related stimulus, so that a neutral face may seem hostile or intimidating. However, despite increasingly attempts to determine the genetic causes of BPD, information concerning early life experiences and trauma still outweigh this research (O’Neill & Frodl, 2012).

Borderline Personality Disorder is the only serious mental disorder for which psychotherapy is the primary recommended form of treatment (Bateman, 2011). The psychotherapy must continue long-term and remain intensive throughout, because the disorder’s symptoms interfere with the daily functioning of individuals and may chronically recur without proper care and attention. In general, although it is hard to change the personality traits of any given individual, treatment has been designed to reduce the frequency and intensity of symptoms. In the 1980s, Marsha Linehan developed a cognitive-behavioral approach of psychotherapy known as Dialectic Behavioral Therapy (DBT). With this approach, therapists essentially target the negative behaviors of the individuals by helping them monitor their thoughts and actions. By doing so, they generate a plan to cope with symptoms (Rizvi et al., 2011). For example, since self-inflicted injury is a common behavior of BPD sufferers, therapists may try to work with them so that instead of reaching for a razor blade, they will put lotion on their arms instead. The assumption that DBT rests on is that these negative behaviors are simply coping mechanisms used by individuals in response to biological impairments (for example, a person who is more sensitive will react to situations with excessive emotion) or environmental factors (for example, an individual who has been denied attention and understanding may develop clinginess). The way in which BPD sufferers are taught to regulate their emotions is by first identifying the unwanted emotions or mood swings when they occur, determining the urges (known as action tendencies) associated with these feelings, coming up with actions that counteract these urges, and then “rewiring” the brain to engage in these opposite actions (Rizvi et al., 2011). As of now, there are no psychiatric drugs or medications that can be taken that target BPD itself. However, since there are many comorbidities and overlapping symptoms, people with this disorder typically take medication to control their mood swings, anxiety, depression, anger and impulsivity (National Collaborating Centre for Mental Health, 2009).

Treatment for Borderline Personality Disorder can be successful for many. For example, 33.3% of those admitted to short-term treatment facilities no longer met the criteria for BPD just two years later, and 88% achieved remissions after ten years (Rizvi et al., 2011). However, the tendency for patients to regress is not uncommon. This is exacerbated by the problems with getting the necessary amount of money and funding for programs to help people with BPD (Bateman, 2011). Group therapy is most commonly used because this has been found to be the most cost-effective, but due to the lack of intimacy between therapist and patient in this setting, there is an especially high rate of dropouts. There are many other treatment complications that arise simply due to the nature of this mental illness. Borderline Personality Disorder may be considered the “heart sink” disorder (Bateman, 2011) because patients engage in avoidant or counterproductive behaviors to treatment, including abusing drugs, attempting suicide, and coming late to or even missing therapy sessions. They may emotionally shut down during sessions, not wanting to discuss their life, behaviors, and problems as required, which is problematic because the therapist will not fully know what symptoms the patient is experiencing so destructive actions will continue to occur (Rizvi et al., 2011). As a result, therapists often find treating BPD to be a stressful and disheartening task, mostly because it is hard to establish a therapeutic alliance with the patient.

This was the premise of the second discussion question. The class was asked to consider that the biggest barrier to treating patients with BPD is frustration from the therapists and practitioners who may sometimes feel that the situation is hopeless and incurable due to patients’ instability and counterproductive behaviors. Is there anything that can be done to alleviate the situation for the therapists themselves? How can it be ensured that the therapists themselves will not be negatively affected by this immense frustration during sessions? The general consensus of the class was that a support system would be helpful to the therapists. For example, more experienced practitioners could help advise and guide novice, especially as they are just beginning to treat BPD patients. Moreover, they pointed out the fact that therapists know what they are getting into before they start treating patients. Although they will almost inevitably be affected by the therapy sessions, they will most likely be mentally prepared for the challenge. Moreover, the fact that they are helping people suffering with a serious mental illness probably gives them gratification in the face of adversity. Professor Litchman further contributed the fact that therapists must go through therapy sessions themselves before practicing themselves, which aids them in dealing with stressful situations. It is definitely important to recognize that therapists are humans themselves just like the patients they are helping, and they obviously will not always know the right answer but they are trying their best to make the right decisions. Rizvi, Steffel, and Carson-Wong (2012) further discuss the importance of working in teams of three or more BPD therapists to prevent burnout and create a support system for each team member.

Already, Borderline Personality Disorder has made significant strides from being considered an enigmatic mental illness to a somewhat (and increasingly) understandable disorder that has the potential to be treated when given the proper medical attention and care. Although the environmental stressors contributing to the development of this mental disorder as early as childhood or in young adolescents are generally well understood today, much more needs to be learned about regarding the neurological impairments associated with BPD. Given adequate funding and attention, it is possible that there may even be medication developed that specifically targets the overactive amygdalae and disrupted pathway from the visual cortex to the amygdalae that contributes to excessive emotional reactivity in these patients. It is important to continue research on the neuroscience behind BPD in order to discover ways that these problematic behaviors may be reduced in both frequency and intensity. Moreover, another factor that is necessary to consider is spreading awareness of BPD to the general public so that they can make informed decisions regarding friends and family members exhibiting these symptoms. By recognizing behaviors that resemble BPD early on, people with BPD can be treated not only medically but also through other people making more efforts to maintain positive relationships with these individuals. With continued efforts to research and treat this potentially chaotic mental illness, the future of Borderline Personality Disorder will look increasingly brighter.

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