

Borderline Personality Disorder

The concept of ‘personality’ presents many problems when diagnosing psychiatric disorders. Researchers often disagree about the boundaries between personality disorders and even the distinction between healthy and unhealthy personalities. On the whole, observing someone’s personality is highly subjective. The concept of personality implies certain common features in what a person thinks, feels, and does over a period of time in changing situations. But the influence of these traits is difficult to distinguish from the influence of mental disorders, passionate emotional states, common responses to stress, and imposed or adopted social roles.

A host of theories surround the origin of Borderline Personality Disorder, yet none are supported with substantial empirical evidence. The symptoms of the disorder can be briefly summarized as instability in mood, thinking, behavior, personal relations, and self-image. Although people diagnosed with this disorder cannot bear to be alone and constantly demand attention, they are often difficult to work and live with. Chronically angry, quick to take offense, and easily depressed are just some of the traits that they exhibit. They also may make unreasonable demands on friends and family, engage in provocative behavior, throw tantrums, and make suicide threats. The individual suffering from BPD feels incomplete, lacking a solid core, who is at once entirely dependent on and attached to others, and then suddenly quite able to abruptly break away.

Epidemiology Borderline personality disorder occurs in 2 to 3% of the general population and is the most common personality disorder in clinical settings. It appears to occur about three times more often in women than in men. BPD is also approximately five times more likely among first-degree relatives than in the general population.

The Role of Child Abuse Some researchers believe BPD patients are suffering from Posttraumatic Stress since many of their symptoms resemble those found in physically and sexually abused children and adults who have been diagnosed with Posttraumatic Stress Disorder, a condition that results from an overwhelming assault on the mind and emotions. About 25% of patients with BPD are also given a diagnosis of PTSD. Research suggests that BPD patients have often been subjected to physical and sexual abuse.

Because of child abuse, some borderline patients may be so vulnerable that they overreact to events that would be insignificant to most people. Although borderline personality results from traumatic stress, not all studies have found an unusually high rate of child abuse. The present consensus is that child abuse may be important in some cases but is not a necessary cause of the borderline condition.

Why BPD Occurs 3 Times More Often in Woman Than in Men?

1. There may be more women who suffer from BPD as a result of an endocrinological and/or chemical predisposition towards the disorder, making women more biologically vulnerable.
2. There are more women who suffer from BPD as a result of sociocultural expectations of women, notably, perceived roles, attitudes, or behaviors.
3. Similar symptoms may generate a diagnosis of narcissistic personality disorder in men. Interestingly, the DSM-IV narcissistic criteria of grandiosity, self-importance, lack of empathy, and arrogance seem to fit sociocultural expectations of men. Men are less likely to be viewed as vulnerable to emotional lability or impulsivity and more likely to be viewed as cold, calculating, and interpersonally exploitive.

Causes Many researchers in the field today believe that for severe mental illness, such as BPD, there first must be an inherited biological vulnerability—or a genetic susceptibility. Family pedigree studies have suggested that people with BPD may be non-specifically predisposed to poor regulation of impulses and moods. Other preliminary studies suggest the dysregulation may be related to a low threshold of excitability of the limbic system, and deficiencies in the central serotonin function may be linked to impulsive and hostile features associated to the disorder. Most of the time, BPD, like schizophrenia and major depression, are caused by a combination of genetic risk and environmental circumstances. Some studies have found high rates of brain injury or developmental brain damage in these patients,

Symptoms of BPD

- instability in mood, thinking, behavior, self-image
- easily depressed
- cannot bear to be alone/constant demand of attention
- quick to take offense
- makes unreasonable demands
- engages in provocative behavior
- chronically angry
- claim they are “bored”, “life is empty”, or they “do not know who they are”
- suicide threats
- self-destructive, impulsive behavior

especially in the frontal lobes and limbic region, where injury often results in impulsiveness, irritability, and emotional instability. But most research is retrospective, beginning in adulthood, thus limiting any definitive results. Overall, available research supports the disorder's multifactorial origins. It appears to be the result of a variety of nonspecific predisposing neurobiological, early developmental, and socializing factors.

Self-Destructiveness and Suicide: The Role of Impulsivity in the BPD Sufferer

The self-destructiveness of the borderline patient can emerge in several ways, from self-mutilation to highly lethal behaviors.

These dangerous behaviors are often “communicative gestures,” conveying great distress, but lacking the intent to severely harm the self. However, BPD is one of the most lethal psychiatric disorders: completed suicide is a final outcome in 3% to 9.5% of patients with BPD, only slightly less than patients with depression, alcoholism or schizophrenia. Studies have shown that demographic, psychosocial and psychiatric risk factors for suicidal behavior among borderline populations include being older and having a higher level of education, and frequent childhood loss. Those at risk often also suffer from depressed moods, substance abuse disorders, bingeing and purging, driving recklessly, and self-mutilation.

The BPD patient's physical self-damaging actions, such as cutting, burning, and punching, are common and are usually precipitated by threats of separation from others, by rejection, or by demands of parenting or intimacy. The acts may also occur during dissociated states, when self-mutilation may help the person feel real while also expiating feelings of badness. Self-mutilation does not necessarily predict suicidal behavior, but it is a “severity” marker for the disorder. Those who self-mutilate are more likely to report genuine suicidal behaviors.

Many researchers prefer to measure the degree to which patients display BPD traits and where they fall on the continuum of psychiatric disorders since the diagnosis of BPD is not highly reliable. One of these traits is substance abuse, a common symptom of BPD. Probably more than half have a serious alcohol or drug problem at some time in their lives, and the rate of substance abuse is also high among parents, siblings, and children.

Impulsive Aggression: The Hallmark of BPD

Impulsivity fuels many of the self-destructive actions of BPD patients. Many doctors think that BPD is a disorder that should be placed on the spectrum of impulse control disorders. Impulse control disorders include conditions like Antisocial Personality Disorder, Intermittent Explosive Disorder, and Pathological Gambling. Researchers have found that the impulsive nature of patients with these disorders, including BPD, is a serotonergically mediated personality dimension which predisposes the patient to aggressive and suicidal behaviors under duress. Serotonin is involved in the inhibition of affect and behavior at the cortical function in the brain. Impulsive aggression is also associated with low activation of parts of the prefrontal cortex involved in the processing of emotional information and inhibition of activity. While the serotonin dysfunction and the prefrontal dysfunction in impulsive aggressive patients might be linked, their relationship has not been studied directly yet.

Unfortunately, impulsivity plays a key role in self-mutilation, unstable relationships, violence, and in completed suicides. Studies have revealed that having both a current depressive episode and BPD dramatically increases the chance of suicidal behavior than does having a depressive episode alone. What this means is that depression alone usually does not result in self-destructive behavior unless there is the element of impulsivity and aggression, which are traits of BPD. However, depressed patients need not be diagnosed with BPD to exhibit impulsivity and aggression. These traits increase the risk of suicide in psychiatric illness. It just so happens that the seat of these personality traits is found in BPD.

Depression and BPD

Unstable and extreme moods are the connection between borderline personality and affective disorders. As many as 60% of these patients have had episodes of major depression, and the rate of depression in their families is high. They often complain that they are bored, their life is empty, or they do not know who they are. However, in many ways they differ greatly than those who are chronically depressed. Their moods are much more susceptible to change in response to

external events, and their depression is qualitatively different, with less guilt, appetite loss, and lethargy, but more loneliness, emptiness, and boredom. They do not generally respond well to antidepressant drugs.

Treatment Despite an estimated 20% of psychiatric patients having BPD, there are no strong guidelines for treatment. Controlled research on the treatment of personality disorder is difficult: personality is often very difficult to change, and patients may regard attempts to change it as brainwashing or punishments.

Medications

There is little controlled research on the pharmacological treatment of BPD. However, preliminary results from several studies suggest that a certain class of antidepressants, selective serotonin reuptake inhibitors (SSRI), may reduce the depressive and impulsive symptoms of BPD. In another study a psychosocial treatment called Dialectic Behavior Therapy (DBT), combines intensive individual psychotherapy and group work to develop emotional and interpersonal skills. The new skills emphasize change and acceptance of the patient as they are, and acceptance of the moment as it is.

Currently research on the combined use of DBT and SSRI is underway, and may provide a new approach to conducting systematic medication trials in BPD and possibly lead to the development of a synergistic state-of-the-art treatment for BPD.

The therapeutic effect of SSRIs is due to their antidepressant effect, and more importantly, their enhancement of serotonin activity. The serotonin system impacts aggression and impulsive and self-destructive behavior. Improved serotonin function can diminish rage and mood changes, producing a state of mild indifference to self-criticism and self-doubt. SSRI's alone may be insufficient for some borderline patients, but because of their safety they are usually the first class of drugs to be tried.

Biological studies show inadequate regulation of serotonin, dopamine, and other neurotransmitters in patients with BPD. Monoamine oxidase (MAO) inhibitors, which prevent the breakdown of norepinephrine and other neurotransmitters, appear to be moderately helpful for patients experiencing rejection-sensitive dysphoria (excessive sensitivity to real or imagined rejection).

Several controlled studies indicate that low doses of antipsychotics may help alleviate sustained symptoms of obsessive thoughts, physical complaints, and to dissociative experiences. In the short term, neuroleptics are effective at reducing the tendency to misinterpret what others say and the projection of rage onto others. The newer atypical antipsychotic drug, clozapine, may help control self-inflicted injury and other abusive behavior in seriously disturbed patients. A study done with patients exhibiting severe self-mutilation and/or violence showed statistically significant reductions in incidents of self-mutilation, seclusion, and injuries to staff and peers after treatment with clozapine.

Unlike other personality disorders such as antisocial, paranoid, obsessive-compulsive, and schizotypal, Borderline Personality Disorder is often called the 'unspecialized' personality because of its vague name, and because it is often too easily applied to patients that appear to be difficult or do not fit the profiles of other personality disorders. On a standard test like the Minnesota Multiphasic Personality Inventory, borderline patients do not show a common profile. Instead, the personality traits seem to be a combination of histrionic personality, narcissistic personality, and antisocial personality.

Borderline Personality Disorder

Histrionic Personality

- self-dramatizing
- self-indulgent
- demanding
- excitable
- vain

Narcissistic Personality

- narcissistic
- intolerant of criticism
- self-important
- lacking in empathy
- envious
- constantly demanding special favors

Antisocial Personality

- callous
- reckless
- impulsive
- irritable
- deceitful
- emotionally shallow

Therapy

Generally, one starts treatment planning for BPD inclusively to combine individual psychotherapy, groups and family therapy, and pharmacotherapy, as determined by the particular symptoms of the specific patient. Usually, psychotherapists attempt to modify personality traits in order to change some aspect of the patient's behavior. Many authorities disagree on how to treat the illness, but it is widely accepted that classical psychoanalysis is not effective because BPD patients cannot tolerate a psychoanalyst's silence and apparent neutrality, and often develop psychotic delusions as a result, which can be dangerous to both patient and psychotherapist. The most common treatment is individual psychotherapy (supportive or interpretive) conducted several times a week, lasting from several months to several years.

Supportive psychotherapy involves a professional who helps the patient deal with immediate problems, but devotes little or no time to interpret the patient's fantasies or past experiences. The therapist makes suggestions, gives advice, or may even directly intervene in the patient's life. Supportive therapy is most helpful for preventing emotional crises, and is needed when the patient's emotional life is out of balance.

Interpretive therapy involves a more profound search for the causes and meanings of the patient's behavior. This process requires the patient to establish a relationship with the therapist as a real person in the effort to replace distorted relationships caused by inadequate and immature ego defenses, such as splitting, devaluation, projection and denial. Some therapists try to provide the comfort and affection that the borderline patient may have lacked

as a child, although this approach can lead to dangerously intense transference reactions. Other therapists choose to confront these patients directly with the nature and motives of their behavior and set rules for them in the effort to prevent self-destructive behavior. Once rules have been established and the risk of self-destructive behavior reduced, the patient is able to talk more about the relationship with the therapist and make use of childhood memories and interpretations. It is then the therapist's duty to identify, address, and modify these defenses.

G l o s s a r y

transference: the redirection of feelings and desires, especially those unconsciously retained from childhood, toward a new object.

splitting: the act of extreme idealization and devaluation of another person and/or the self.

devaluation: the act of lessening the value, importance, or stature of another person and/or the self.

projection: the attribution of one's own ideas, feelings, or attitudes to other people or to objects; the externalization of blame, guilt, or responsibility as a defense against anxiety.

denial: a psychological defense mechanism in which confrontation with a personal problem or with reality is avoided by denying its existence.

NARSAD RESEARCH

The National Alliance for Research on Schizophrenia and Depression

60 Cutter Mill Road, Suite 404

Great Neck, NY 11021

Fax: (516) 487-6930

1-800-829-8289

www.narsad.org

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