An Elaboration on Borderline Personality Disorder

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ABSTRACT: Borderline personality disorder (BPD) is a serious mental illness that centers on the inability to manage emotions effectively. The disorder occurs in the context of relationships: sometimes all relationships are affected, sometimes only one. It usually begins during adolescence or early adulthood. While some persons with BPD are high functioning in certain settings, their private lives may be in turmoil. Most people who have BPD suffer from problems regulating their emotions and thoughts, impulsive and sometimes reckless behavior, and unstable relationships. Other disorders, such as depression, anxiety disorders, eating disorders, substance abuse and other personality disorders can often exist along with BPD. The diagnosis of BPD is frequently missed and a misdiagnosis of BPD has been shown to delay and/or prevent recovery. Bipolar disorder is one example of a misdiagnosis as it also includes mood instability. There are important differences between these conditions but both involve unstable moods. For the person with bipolar disorder, the mood changes exist for weeks or even months. The mood changes in BPD are much shorter and can even occur within the day. Officially recognized in 1980 by the psychiatric community, BPD is more than two decades behind in research, treatment options, and family psycho-education compared to other major psychiatric disorders. BPD has historically met with widespread misunderstanding and blatant stigma. However, evidenced-based treatments have emerged over the past two decades bringing hope to those diagnosed with the disorder and their loved ones.

KEYWORDS: Borderline personality disorder (BPD), Stress, emotions

1. INTRODUCTION

Perhaps no other label in mental health stirs up more negative or conflicted associations than Borderline Personality Disorder. Because of its pejorative connotations, I know many mental health clinicians who are very hesitant to diagnose patients with BPD, or, if they do, they are hesitant to explicitly share this diagnosis. I was recently supervising a doctoral student whose patient revealed that they had been previously diagnosed with BPD. While it

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was not clear if the patient had a solid understanding of what it meant, it was clear that the student clinician experienced some anxiety in dialoguing with the patient about the diagnosis and ended up not doing so. Their avoidance behavior was easy to understand. The patient clearly had many vulnerabilities and it can be hard to know how to talk about the condition without sounding like there is something deeply wrong, broken, and/or unfixable or that the patient is a problem worthy of much blame. As such, talking about BPD can feel like a daunting task at times.

When you hear the term personality disorder, it makes sense that your first reaction is pretty strong and pretty negative. As such, it really is important for you to know what it means. First, you should be aware that such a diagnosis does not mean that I or any clinician can peer deep inside of you and see that there is something fundamentally wrong or broken with your core personhood. And it is not like cancer, where you have bunch of symptoms on the surface that are caused by something else (in cancer’s case, cells going haywire). Instead, a personality disorder is defined by a set of symptoms. To the extent that you have the symptoms, you have a “personality disorder.” If the symptoms go away, you no longer have the condition [1].

A personality disorder is present, by definition, when individuals have long standing problems with their identity, which involves how they think of themselves, their self-esteem, their impulse control and such, and/or their relationships. So, the first question basically is, have you had long standing problems in these areas? And, based on what you told me, from all the conflict you had with your family and later in your romantic relationships, and all the confused and negative feelings you reported about yourself, you have indeed had those symptoms. So the term ‘personality disorder’ is a descriptive label for those long standing patterns of behaving, thinking and feeling. You should also know that, although these patterns often are persistent, research also shows that they definitely can change, and sometimes change dramatically. So it is not the case that once you have it, you always have for life.

The term ‘borderline’ refers to a specific kind of pattern of personality problems. There are three major personality subsystems that are involved in BPD. First, there is the experiential or emotional system. Individuals with BPD have, relative to the norm, very reactive emotional systems. That is, their sensitivity to responding emotionally to events, especially negative ones, is very high. What others might perceive to be relatively minor events can result a powerful wave of emotion in individuals with BPD. Thus, negative feeling states like fear, rage, shame, sadness, guilt, and jealousy are easily accessible and often difficult to regulate.

The second system that is involved is the relationship system. This is the system that organizes and guides ones’ intuitive sense of self in relationship to others. The key dimension in the relationship system is the dimension of relational value, which is the extent to which an individual feels known and valued by important others. Individuals with BPD usually have at least a significant part of themselves that senses or deeply fears that they have low relational
value. That feeling is often a function of troubled early attachments formed with their caregivers, dysfunctional roles and relationships in their families, and/or experiences of physical or sexual abuse. Whatever the etiology, the experience of individuals with BPD is that they are judged by others as being lesser or unworthy or unlovable and that they are in danger of being neglected or abandoned or criticized or controlled. This strong sense of relational vulnerability, coupled with their emotional reactivity, makes for very volatile relationships that can be marked by, say, passionate desire quickly followed by reactive hostility quickly followed by guilt, shame and deep fears of abandonment.

The strong emotional sensitivities and deep sense of low relational value sets the stage for disturbance in the third broad domain of personality, one’s identity. The powerful needs and feelings pull an individual’s identity, which is the conscious beliefs and values one has about themselves and the world around them, all over the map. When relationships are going well, an individual might feel ok, that they are worthwhile, that life will be good. However, when conflicts emerge, the powerful emotional and relational sensitivities drive the individual to see the world through a very different lens. One moment, they might believe that their partner is controlling and vindictive and is trying to hurt them. Later, they see themselves as being hypersensitive or maybe “crazy” and feel guilty that they reacted in such extreme ways. The constant back and forth, of being pulled by one’s strong feelings and needs, can lead to a fragmented, chaotic sense of self, and much self-criticism. Over time, one can come to believe one is helpless or worthless or be left with a deep feeling of emptiness. All of this internal chaos can set the stage for self-injury. Cutting or other nonsuicidal forms of injury can serve as ways of focusing, grounding, and/or distracting one’s self from the internal chaos. It can also be a symbol of rage or pain, directed at self or others. Suicidal behaviors can either be a way to solve the problem of the deep “psyche ache” or can be efforts at communicating distress or enlisting others’ aid to ward off profound abandonment fears.

From the perspective of others, individuals with BPD are often experienced as dramatic, erratic, attention seeking, and manipulative. Of course, such a perspective or negative evaluation is precisely what the individual with BPD fears and their first person perspective is that they are not trying to be manipulative or attention seeking. These differences in perspective are why relationships so often are tense and ridden with conflict.

Ultimately, BPD is a descriptive label for a complicated set of issues involving heightened emotional reactivity, a strong sense of vulnerability in relationships, a fragmented, confused identity that often has many highly conflicted self-states, and a pattern of chaotic, conflicted social relations. And although these symptoms are serious, to the extent that we can figure out a way to help you grow out of them, you will no longer meet criteria for this descriptive label [2].
2. CHARACTERISTICS OF BORDERLINE PERSONALITY DISORDER

Individuals with Borderline Personality Disorder make frantic efforts to avoid real or imagined abandonment. The perception of impending separation or rejection, or the loss of external structure, can lead to profound changes in self-image, affect, cognition, and behavior. These individuals are very sensitive to environmental circumstances. They experience intense abandonment fears and inappropriate anger even when faced with a realistic time-limited separation or when there are unavoidable changes in plans (e.g., sudden despair in reaction to a clinician’s announcing the end of the hour; panic or fury when someone important to them is just a few minutes late or must cancel an appointment). They may believe that this “abandonment” implies they are “bad.” These abandonment fears are related to an intolerance of being alone and a need to have other people with them. Their frantic efforts to avoid abandonment may include impulsive actions such as self-mutilating or suicidal behaviors.

Individuals with Borderline Personality Disorder have a pattern of unstable and intense relationships. They may idealize potential caregivers or lovers at the first or second meeting, demand to spend a lot of time together, and share the most intimate details early in a relationship. However, they may switch quickly from idealizing other people to devaluing them, feeling that the other person does not care enough, does not give enough, is not “there” enough. These individuals can empathize with and nurture other people, but only with the expectation that the other person will “be there” in return to meet their own needs on demand. These individuals are prone to sudden and dramatic shifts in their view of others, who may alternately be seen as beneficent supports or as cruelly punitive. Such shifts often reflect disillusionment with a caregiver whose nurturing qualities had been idealized or whose rejection or abandonment is expected.

There may be an identity disturbance characterized by markedly and persistently unstable self-image or sense of self. There are sudden and dramatic shifts in self-image, characterized by shifting goals, values, and vocational aspirations. There may be sudden changes in opinions and plans about career, sexual identity, values, and types of friends. These individuals may suddenly change from the role of a needy supplicant for help to a righteous avenger of past mistreatment. Although they usually have a self-image that is based on being bad or evil, individuals with this disorder may at times have feelings that they do not exist at all. Such experiences usually occur in situations in which the individual feels a lack of a meaningful relationship, nurturing, and support. These individuals may show worse performance in unstructured work or school situations.

Individuals with Borderline Personality Disorder display impulsivity in at least two areas that are potentially self-damaging. They may gamble, spend money irresponsibly, binge eat, abuse substances, engage in unsafe sex, or drive recklessly.
Individuals with Borderline Personality Disorder may also sometimes display recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior. Completed suicide occurs in 8%-10% of such individuals, and self-mutilative acts (e.g., cutting or burning) and suicide threats and attempts are very common. Recurrent suicidality is often the reason that these individuals present for help. These self-destructive acts are usually precipitated by threats of separation or rejection or by expectations that they assume increased responsibility. Self-mutilation may occur during dissociative experiences and often brings relief by reaffirming the ability to feel or by expiating the individual’s sense of being evil.

Individuals with Borderline Personality Disorder may display affective instability that is due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days). The basic dysphoric mood of those with Borderline Personality Disorder is often disrupted by periods of anger, panic, or despair and is rarely relieved by periods of well-being or satisfaction. These episodes may reflect the individual’s extreme reactivity to interpersonal stresses [3].

Individuals with Borderline Personality Disorder may be troubled by chronic feelings of emptiness. Easily bored, they may constantly seek something to do. Individuals with Borderline Personality Disorder frequently express inappropriate, intense anger or have difficulty controlling their anger. They may display extreme sarcasm, enduring bitterness, or verbal outbursts. The anger is often elicited when a caregiver or lover is seen as neglectful, withholding, uncaring, or abandoning. Such expressions of anger are often followed by shame and guilt and contribute to the feeling they have of being evil.

During periods of extreme stress, transient paranoid ideation or dissociative symptoms (e.g., depersonalization) may occur, but these are generally of insufficient severity or duration to warrant an additional diagnosis. These episodes occur most frequently in response to a real or imagined abandonment. Symptoms tend to be transient, lasting minutes or hours. The real or perceived return of the caregiver’s nurturance may result in a remission of symptoms.

3. SIGNS AND SYMPTOMS AND DIAGNOSIS

People with BPD may experience extreme mood swings and can display uncertainty about who they are. As a result, their interests and values can change rapidly [4].

Other symptoms include;
- Frantic efforts to avoid real or imagined abandonment
- A pattern of intense and unstable relationships with family, friends, and loved ones, often swinging from extreme closeness and love (idealization) to extreme dislike or anger (devaluation)
- Distorted and unstable self-image or sense of self

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• Impulsive and often dangerous behaviors, such as spending sprees, unsafe sex, substance abuse, reckless driving, and binge eating
• Recurring suicidal behaviors or threats or self-harming behavior, such as cutting
• Intense and highly changeable moods, with each episode lasting from a few hours to a few days
• Chronic feelings of emptiness
• Inappropriate, intense anger or problems controlling anger
• Having stress-related paranoid thoughts
• Having severe dissociative symptoms, such as feeling cut off from oneself, observing oneself from outside the body, or losing touch with reality

Seemingly ordinary events may trigger symptoms. For example, people with BPD may feel angry and distressed over minor separations—such as vacations, business trips, or sudden changes of plans—from people to whom they feel close. Studies show that people with this disorder may see anger in an emotionally neutral face and have a stronger reaction to words with negative meanings than people who do not have the disorder.

Some of these signs and symptoms may be experienced by people with other mental health problems—and even by people without mental illness—and do not necessarily mean that they have BPD. It is important that a qualified and licensed mental health professional conduct a thorough assessment to determine whether or not a diagnosis of BPD or other mental disorder is warranted, and to help guide treatment options when appropriate.

Unfortunately, BPD is often underdiagnosed or misdiagnosed. A licensed mental health professional experienced in diagnosing and treating mental disorders—such as a psychiatrist, psychologist, or clinical social worker—can diagnose BPD based on a thorough interview and a comprehensive medical exam, which can help rule out other possible causes of symptoms [5].

The licensed mental health professional may ask about symptoms and personal and family medical histories, including any history of mental illnesses. This information can help the mental health professional decide on the best treatment. In some cases, co-occurring mental illnesses may have symptoms that overlap with BPD, making it difficult to distinguish BPD from other mental illnesses. For example, a person may describe feelings of depression but may not bring other symptoms to the mental health professional's attention.

Research funded by NIMH is underway to look for ways to improve diagnosis of and treatments for BPD, and to understand the various components of BPD and other personality disorders such as impulsivity, relationship problems, and emotional instability [6].

4. RISK FACTORS
The causes of BPD are not yet clear, but research suggests that genetic, brain, environmental and social factors are likely to be involved [7].

- **Genetics.** BPD is about five times more likely to occur if a person has a close family member (first-degree biological relatives) with the disorder.

- **Environmental and Social Factors.** Many people with BPD report experiencing traumatic life events, such as abuse or abandonment during childhood. Others may have been exposed to unstable relationships and hostile conflicts. However, some people with BPD do not have a history of trauma. And, many people with a history of traumatic life events do not have BPD.

- **Brain Factors.** Studies show that people with BPD have structural and functional changes in the brain, especially in the areas that control impulses and emotional regulation. However, some people with similar changes in the brain do not have BPD. More research is needed to understand the relationship between brain structure and function and BPD.

Research on BPD is focused on examining biological and environmental risk factors, with special attention on whether early symptoms may emerge at a younger age than previously thought. Scientists are also studying ways to identify the disorder earlier in adolescents [8].

5. **CONCLUSION: TREATMENTS AND THERAPIES**

BPD has historically been viewed as difficult to treat. However, with newer and proper treatment, many people with BPD experience fewer or less severe symptoms and an improved quality of life. Many factors affect the length of time it takes for symptoms to improve once treatment begins, so it is important for people with BPD and their loved ones to be patient and to receive appropriate support during treatment. People with BPD can recover.

If you think you have BPD, it is important to seek treatment.

NIMH-funded studies indicate that BPD patients who never recovered may be more likely to develop other chronic medical conditions and are less likely to make healthy lifestyle choices. BPD is also associated with a high rate of self-harm and suicidal behavior.

If you are thinking about harming yourself or attempting suicide, tell someone who can help right away. Call your licensed mental health professional if you are already working with one. If you are not already working with a licensed mental health professional, call your personal physician or go to the nearest hospital emergency room.

If a loved one is considering suicide, do not leave him or her alone. Try to get your loved one to seek immediate help from his or her doctor or the nearest hospital emergency room, or call 911. Remove any access he or she may have to firearms or other potential tools for suicide, including medications, sharp edges such as knives, ropes, or belts.
If you or a loved one are in crisis: Call the toll-free National Suicide Prevention Lifeline at 1-800-273-TALK (8255), available 24 hours a day, 7 days a week. The service is available to anyone. All calls are confidential.

The treatments described below are just some of the options that may be available to a person with BPD. However, the research on treatments is still in very early stages. More research is needed to determine the effectiveness of these treatments, who may benefit the most, and how best to deliver treatments.

Psychotherapy

Psychotherapy (or “talk therapy”) is the main treatment for people with BPD. Current research suggests psychotherapy can relieve some symptoms, but further studies are needed to better understand how well psychotherapy works.

Psychotherapy can be provided one-on-one between the therapist and the patient or in a group setting. Therapist-led group sessions may help teach people with BPD how to interact with others and how to express themselves effectively. It is important that people in therapy get along with and trust their therapist. The very nature of BPD can make it difficult for people with this disorder to maintain a comfortable and trusting bond with their therapist.

Types of psychotherapy used to treat BPD include:

- Cognitive Behavioral Therapy (CBT): CBT can help people with BPD identify and change core beliefs and/or behaviors that underlie inaccurate perceptions of themselves and others and problems interacting with others. CBT may help reduce a range of mood and anxiety symptoms and reduce the number of suicidal or self-harming behaviors.

- Dialectical Behavior Therapy (DBT): This type of therapy utilizes the concept of mindfulness, or being aware of and attentive to the current situation and moods. DBT also teaches skills to control intense emotions, reduce self-destructive behaviors, and improve relationships. DBT differs from CBT in that it integrates traditional CBT elements with mindfulness, acceptance, and techniques to improve a person’s ability to tolerate stress and control his or her emotions. DBT recognizes the dialectical tension between the need for acceptance and the need for change.

- Schema-Focused Therapy: This type of therapy combines elements of CBT with other forms of psychotherapy that focus on reframing schemas, or the ways people view themselves. This approach is based on the idea that BPD stems from a dysfunctional self-image—possibly brought on by negative childhood experiences—that affects how people react to their environment, interact with others, and cope with problems or stress.

- Systems Training for Emotional Predictability and Problem Solving (STEPPS) is a type of group therapy that aims to educate family members, significant others, and health care professionals about BPD and gives them guidance on how to interact consistently with the person with the disorder using the STEPPS approach and terminology. STEPPS is designed to
supplement other treatments the patient may be receiving, such as medication or individual psychotherapy.

Families of people with BPD may also benefit from therapy. The challenges of dealing with a loved one with BPD on a daily basis can be very stressful, and family members may unknowingly act in ways that worsen their relative's symptoms. Some therapies include family members in treatment sessions. These types of programs help families develop skills to better understand and support a relative with BPD. Other therapies focus on the needs of family members and help them understand the obstacles and strategies for caring for a loved one with BPD. Although more research is needed to determine the effectiveness of family therapy in BPD, studies on other mental disorders suggest that including family members can help in a person's treatment.

Other types of psychotherapy may be helpful for some people with BPD. Therapists often adapt psychotherapy to better meet a person's needs. Therapists may also switch from one type of psychotherapy to another, mix techniques from different therapies, or use a combination of psychotherapies. For more information, please see the NIMH webpage on Psychotherapies.

Medications should not be used as the primary treatment for BPD as the benefits are unclear. However, in some cases, a mental health professional may recommend medications to treat specific symptoms, such as mood swings, depression, or other disorders that may occur with BPD. Treatment with medications may require care from more than one medical professional.

Because of the high risk of suicide among people with BPD, health care providers should exercise caution when prescribing medications that may be lethal in the event of an overdose.

Certain medications can cause different side effects in different people. Talk to your doctor about what to expect from a particular medication.

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