

Borderline Personality Disorder

What is Borderline Personality Disorder?

Borderline Personality Disorder (BPD) is a most misunderstood, serious mental illness characterized by pervasive instability in moods, interpersonal relationships, self-image, and behavior. It is a disorder of emotion dysregulation. This instability often disrupts family and work, long-term planning, and the individual's sense of self-identity. While less well known than schizophrenia or bipolar disorder (manic-depressive illness), BPD is as common, affecting between .07 to 2% of the general population.

The disorder, characterized by intense emotions, self-destructive acts, and stormy interpersonal relationships, was officially recognized in 1980 and given the name Borderline Personality Disorder. It was thought to occur on the border between psychotic and neurotic behavior. This is no longer considered a relevant analysis and the term itself, with its stigmatizing negative associations, has made diagnosing BPD problematic. The complex symptoms of the disorder often make patients difficult to treat and therefore may evoke feelings of anger and frustration in professionals trying to help, with the result that many professionals are often unwilling to make the diagnosis or treat persons with these symptoms. These problems have been aggravated by the lack of appropriate insurance coverage for the extended psychosocial treatments that BPD usually requires. Nevertheless, there has been much progress and success in the past 25 years in the understanding of and specialized treatment for BPD. It is, in fact, a diagnosis that has a lot of hope for recovery.

What are the Symptoms of Borderline Personality Disorder?

Borderline Personality Disorder Diagnosis: DMS-IV-TR Diagnostic Criteria

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, as indicated by five (or more) of the following:

- 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: markedly and persistently unstable self-image or sense of self.
- 4) Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, 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 only rarely more than a few days).
- 7) Chronic feelings of emptiness.
- 8) Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
- 9) Transient, stress-related paranoid ideation or severe dissociative symptoms.

*Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association

** Data collected informally from many families indicate this pattern of symptoms may appear as early as the pre-teens

***The preferred term is self-harm or self-injury

Important Considerations about Borderline Personality Disorder

1. The five of nine criteria needed to diagnose the disorder may be present in a large number of different combinations. This results in the fact that the disorder often presents quite differently from one person to another, thus making accurate diagnosis somewhat confusing to a clinician not skilled in the area.
2. BPD rarely stands alone. There is high co-occurrence with other disorders.
3. BPD affects between .07 to 2% of the population. The highest estimation, 2%, approximates the number of persons diagnosed with schizophrenia and bipolar disorder.
4. Estimates are 10% of outpatients and 20% of inpatients who present for treatment have BPD

5. 75% are women. This number may, in part, reflect that women more often seek treatment, that anger is seen as more acceptable in men, and that men with similar symptoms often enter the penal system receiving a diagnosis of antisocial personality disorder.
6. 75% of patients self-injure.
7. Approximately 10% of individuals with BPD complete suicide attempts.
8. A chronic disorder that is resistant to change, we now know that BPD has a good prognosis when treated properly. Such treatment usually consists of medications, psychotherapy and educational and support groups.
9. In many patients with BPD, medications have been shown to be very helpful in reducing the severity of symptoms and enabling effective psychotherapy to occur. Medications are also often essential in the proper treatment of disorders that commonly co-occur with BPD.
10. There are a growing number of psychotherapeutic approaches specifically developed for people with BPD. Some of these have been in use, tested in research trials, and appear to be very effective; the newer ones are very promising.
11. These and other treatments have been shown to be effective in the treatment of BPD, and MANY PATIENTS DO GET BETTER!

Theories of Origins and Pathology of Borderline Personality Disorder

At this point in time, clinical theorists believe that biogenetic and environmental components are both necessary for the disorder to develop. These factors are varied and complex. Many different environments may further contribute to the development of the disorder. Families providing reasonably nurturing and caring environments may nevertheless see their relative develop the illness. In other situations, childhood abuse has exacerbated the condition. The best explanation appears to be that there is a confluence of environmental factors and a neurobiological propensity that leads to a sensitive, emotionally labile child.

Co-occurring Disorders

Borderline Personality Disorder rarely stands alone. BPD occurs with, and complicates, other disorders.

Co-morbidity with other disorders:

Major Depressive Disorder	-- 60%
Dysthymia (chronic, moderate to mild depression)	-- 70%

Eating Disorders	-- 25%
Substance Abuse	-- 35%
Bipolar Disorder	-- 15%
Antisocial Personality Disorder	-- 25%
Narcissistic Personality Disorder	-- 25%

Treatment

In the past few decades, treatment for Borderline Personality Disorder has changed radically, and, in turn, the prognosis for improvement and/or recovery has significantly improved. Unfortunately, specialized treatment for BPD is not yet widely available.

An abstract by Michael H. Stone published in World Psychiatry, February 2006, explained a hierarchy in therapy management for the patient with the BPD diagnosis. "Therapists must pay attention first to suicidal and self-mutilative behaviors. Next, one deals with any threats to interrupt therapy prematurely. Third in order of seriousness: non-suicidal symptoms such as (mild to moderate) depression, substance abuse, panic and other anxiety manifestations, or dissociation. Psychopharmacological treatment will often be used adjunctively to help control any target symptoms, which usually fall into such categories as cognitive-perceptual, affect dysregulation, or impulsive/behavioral dyscontrol. Therapists must then be alert to any signs of withholding, dishonesty, or antisocial tendencies, since these have an adverse effect on prognosis. When all these disruptive influences are (to the extent possible) dealt with, therapists will next take up milder symptoms such as social anxiety or lability of mood" as well as the enduring personality issues such as extreme attitudes and inappropriate anger.

One of the preliminary questions confronting families/friends is how and when to place confidence in those responsible for treating the patient. Generally speaking, the more clinical experience the treatment provider has had working with borderline patients, the better. Most often, a good "fit" with the primary therapist is the "key" to successful therapy intervention.

A discussion of hospitalization and treatment techniques, including specialized treatment for BPD, follows:

- A. Hospitalization: Hospitalization in the care of those with BPD is usually restricted to the management of crises (including, but not limited to, situations where the individual's safety is at risk). It is not uncommon for medication changes to take place in the context of a hospital stay, where professionals can monitor the impact of new medications in a controlled environment. Hospitalizations are usually short in duration.

- B. Medications play an important role in the comprehensive treatment of BPD. For more on this topic, refer to the section on this website "Medications Used and Studied in the Treatment of BPD".
- C. Psychotherapy: Psychotherapy is the cornerstone of most treatments for Borderline Personality Disorder. Although development of a secure attachment to the therapist is generally essential for the psychotherapy to have useful effects, this does not occur easily with the BPD diagnosed individual, given the intense needs and fears about relationships. The standard recommendation for individual psychotherapy involves one to two visits a week with an experienced clinician. The symptoms of the disorder can be as difficult for professionals to experience as those experienced by family members. Some therapists are apprehensive about working with individuals with this diagnosis.

There are currently three major psychotherapeutic approaches to treatment of BPD:

1. Psychodynamic
 2. Cognitive-behavioral
 3. Supportive
- D. Group Modalities: DBT and CBT interventions are often like classes with much focus and direction offered by the group leader(s) and with homework/practice exercises assigned between sessions based on the material presented during the session. DBT, for example has a manual that is followed each week where both the lectures and the practice exercises are put together for easy access. Some patients with BPD may be resistant to interpersonal or psychodynamic groups which require the expression of strong feelings or the need for personal disclosures. However, such forums may be useful for these very reasons. Moreover, such groups offer an opportunity for borderline patients to learn from persons with similar life experiences, which, in conjunction with the other modalities discussed here, can significantly enhance the treatment course. Many individuals with BPD find it more acceptable to join self-help groups, such as AA. Self-help groups that provide a network of supportive peers can be useful as an adjunct to treatment, but should not be relied on as the sole source of support.
 - E. Family Therapy: Parents, spouses and children bear a significant burden. Often, family members are grateful to be educated about the borderline diagnosis, the likely prognosis, reasonable expectations from treatment, and how they can contribute. These interventions often improve communication, decrease alienation, and relieve family burdens. Some mental disorders, as in the treatment of schizophrenia, require close family involvement in the treatment process to be optimally effective. There are now preliminary research data that suggest that family involvement is also very important in the effective treatment of borderline disorder.

Several organizations offer education programs and/or support to families challenged with mental health issues. The National Alliance on Mental Illness (NAMI), The National Education Alliance for Borderline Personality Disorder (NEA-BPD), The Depression and Bipolar Support Association (DBSA) and the Mental Health Association(MHA) offer programs across the nation.

Family training and support programs such as NAMI's Family to Family and NEA-BPD's Family Connections (www.neabpd.org) are in great demand. Nonetheless, too often many psychiatrists and other mental health clinicians continue to deny meaningful input from family members of a client with BPD. This situation is especially frustrating for family members, who often provide the sole financial support for everyday living and treatment expenses, and much of the moral support, but who receive little or no response from the treating professionals. Families are especially distressed when the treatment plan is not effective, and their loved one isolates them from their therapists. Given the importance of the family in establishing functional relationships in the lives of people with borderline disorder, families should actively seek "family friendly" treatments and/or treatment providers and investigate family classes and support groups in their communities.

Suicidality and Self-harm Behavior

The most dangerous and fear-inducing features of BPD are the self-harm behaviors and potential for suicide. An estimated 10% kill themselves. Deliberate self-harm (cutting, burning, hitting, head banging, hair pulling) are common features of BPD, occurring in approximately 75% of cases. Individuals who self-harm report that causing themselves physical pain generates a sense of release and relief which temporarily alleviates excruciating emotional feelings. Self-injurious acts can bring relief by stimulating production of endorphins, which are naturally occurring opiates produced by the brain in response to pain. Some individuals with BPD also exhibit self-destructive acts such as promiscuity, bingeing, purging, and blackouts from substance abuse.

It is important for the client, family, and clinician to be able to draw a distinction between the intent behind suicide attempts and self-injurious behaviors (SIB). Patients and researchers frequently describe self-injurious behavior as a means of reducing intense feelings of emotional pain. The release of the endogenous opiates provides a reward to the behavior. Some data suggest that self-injurious behavior in BPD patients doubles the risk of suicide attempts. This dichotomy of intent between these two behaviors requires careful evaluation and relevant therapy to meet the needs of the patient.

In addition to substance abuse, major depression can contribute to the risk of suicide. Approximately 50% of people with BPD are experiencing an episode of major depression when they seek treatment. About 70% have a major depressive episode in their lifetimes. It is imperative that treatment providers evaluate the client's mood carefully, and treat the depression appropriately, which may include the use of medication.

An expanded discussion of this topic can be found in "A BPD Brief ", by John G. Gunderson, M.D.

Medications Studied and Used in the Treatment of Borderline Personality Disorder

There are two reasons why medications are used in the treatment of BPD. First, they have proven to be very helpful in stabilizing the emotional reactions, reducing impulsivity, and enhancing thinking and reasoning abilities in people with the disorder. Second, medications are also effective in treating the other emotional disorders that are frequently associated with borderline disorder like depression and anxiety.

The group of medications that have been studied most for the treatment of borderline disorder are neuroleptics and atypical antipsychotic agents. At their usual doses, these medications are very effective in improving the disordered thinking, emotional responses, and behavior of people with other mental disorders, such as bipolar disorder and schizophrenia. However, at smaller doses they are helpful in decreasing the over-reactive emotional responses and impulsivity, and in improving the abilities to think and reason for people with BPD. Low doses of these medications often reduce depressed moods, anger, and anxiety, and decrease the severity and frequency of impulsive actions. In addition, clients with borderline disorder report a considerable improvement in their ability to think rationally. There's also a reduction, or elimination of, paranoid thinking, if this is a problem.

Medications Studied and Used in the Treatment of Borderline Disorder is adapted from the book, "Borderline Personality Disorder Demystified " by Dr. Robert O. Friedel, Marlowe & Co., 2004.

Side Effects of Medications Used to Treat Borderline Personality Disorder

All medications have side effects. Different medications produce different side effects, and people differ in the amount and severity of side effects they experience. Side effects can often be treated by changing the dose of the medication or switching to a different medication. Antidepressants may cause dry mouth, constipation, bladder problems, sexual problems, blurred vision, dizziness, drowsiness, skin rash, or weight gain or loss. One class of antidepressants, the monoamine oxidase inhibitors (MAOIs) have strict food restrictions with the consequence of life threatening elevation of blood pressure. The SSRIs and newer antidepressants tend to have fewer and different side effects such as nausea, nervousness, insomnia, diarrhea, rash, agitation, sexual problems, or weight gain or loss. Mood stabilizers could cause side effects of nausea, drowsiness, dizziness and possibly tremors. Some require periodic blood tests to monitor liver function and blood cell count.

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dyskinesia. This is an abnormal, involuntary movement disorder that typically occurs in those receiving average to large doses of neuroleptics. The risk appears to be less with low doses of neuroleptics or the atypical antipsychotic agents. Atypical antipsychotics and/or traditional neuroleptics could have the ability to produce weight gain, drowsiness, insomnia, breast engorgement and discomfort, lactation, and restlessness. Some of the side-effects are temporary and others are persistent. Before starting on a traditional neuroleptic or atypical antipsychotic, review the side-effect profile with the treating psychiatrist.

Much of the material in these BPD web pages is taken with permission from:

Borderline Personality Disorder Demystified by Robert O. Friedel, M.D., Marlowe & Co., 2004

National Education Alliance for Borderline Personality Disorder's Teachers Manual for Family Connections, 2006

A BPD Brief, An Introduction to Borderline Personality Disorder by John G. Gunderson, M.D., 2006