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Borderline Personality Disorder

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Borderline Personality Disorder (BPD) is one of the most controversial diagnoses in psychology today. Since it was first introduced in the Diagnostic and Statistical Manual of Mental Disorders (DSM), psychologists and psychiatrists have been trying to give the somewhat vague concepts behind BPD a concrete form. Kernberg's explanation (Otto F. Kernberg, Psychologist) of what he calls *Borderline Personality Organization* is the most general, while Professor John G. Gunderson, though a psychoanalyst, is considered by many to have taken the most scientific approach to defining BPD. The Diagnostic Interview for Borderlines and the DIB-Revised were developed from research done by Gunderson, Kolb, and Zanarini. Finally, there is the 'official' DSM-IV definition.

Some researchers, like Judith Herman, believe that BPD is a name given to a particular manifestation of Post-Traumatic Stress Disorder. In *Trauma and Recovery*, she theorizes that when PTSD takes a form that emphasizes heavily its elements of identity and relationship disturbance, it gets called BPD; when the somatic (body) elements are emphasized, it gets called hysteria; when the dissociative deformation of consciousness elements are the focus, it gets called DID/MPD (Dissociative Identity Disorder/Multiple Personality Disorder). Others believe that the term 'borderline personality' has been so misunderstood and misused that trying to refine it is pointless and suggest instead simply scrapping the term.

What causes Borderline Personality Disorder?

Marsha Linehan, PhD, ABPP, theorizes that borderlines are born with an innate biological tendency to react more intensely to lower levels of stress than others and to take longer to recover. They peak 'higher' emotionally on less provocation and take longer coming down. In addition, they were raised in environments in which their beliefs about themselves and their environment were continually devalued and invalidated.

These factors combine to create adults who are uncertain of the truth of their own feelings and who are confronted by three basic dialectics they have failed to master; thus rushing frantically from pole to pole of:

- vulnerability vs. invalidation
- active passivity (tendency to be passive when confronted with a problem and actively seek a rescuer) vs. apparent competence (appearing to be capable when in reality internally things are falling apart)
- unremitting crises vs. inhibited grief

Dialectical Behaviour Therapy (DBT) tries to teach clients to balance these by giving them training in skills of mindfulness, interpersonal effectiveness, distress tolerance, and emotional regulation.

Kernberg's Borderline Personality Organization

Diagnoses of BPO are based on three categories of criteria. The first, and most important, category, comprises two signs:

- The absence of psychosis (eg., the ability to perceive reality accurately)
- Impaired ego integration - a diffuse and internally contradictory concept of self. Kernberg is quoted as saying, "*Borderlines can describe themselves for five hours without your getting a realistic picture of what they're like.*"

The second category is termed 'non-specific signs' and includes such things as low anxiety tolerance, poor impulse control, and an undeveloped or poor ability to enjoy work or hobbies in a meaningful way.

Kernberg believes that borderlines are distinguished from neurotics by the presence of 'primitive defences.' Chief among these is splitting, in which a person or things is seen as all good or all bad. Note that something which is all good one day can be all bad the next, which is related to another symptom: borderlines have problems with object constancy in people -- they read each action of people in their lives as if there were no prior context; they don't have a sense of continuity and consistency about people and things in their lives. They have a hard time experiencing an absent loved one as a loving presence in their minds. They also have difficulty seeing all of the actions taken by a person over a period of time as part of an integrated whole, and tend instead to analyze individual actions in an attempt to divine their individual meanings. People are defined by how they last interacted with the borderline.

Other primitive defences cited include:

- Magical thinking (beliefs that thoughts can cause events)
- Omnipotence
- Projection of unpleasant characteristics in the self onto others
- Projective identification, a process where the borderline tries to elicit in others the feelings he/she is having.

Kernberg also includes as signs of BPD chaotic, extreme relationships with others; an inability to retain the soothing memory of a loved one; transient psychotic episodes; denial; and emotional amnesia. About the last, Linehan says, *“Borderline individuals are so completely in each mood, they have great difficulty conceptualizing, remembering what it’s like to be in another mood.”*

Gunderson’s conception of BPD

Gunderson is respected by researchers in many diverse areas of psychology and psychiatry. His focus tends to be on the differential diagnosis of Borderline Personality Disorder, and Janice M. Cauwels, PhD, gives Gunderson’s criteria in order of their importance:

- Intense unstable relationships in which the borderline always ends up getting hurt. (Gunderson admits that this symptom is somewhat general but considers it so central to BPD that he says he would hesitate to diagnose a patient as BPD without its presence.)
- Repetitive self-destructive behaviour, often designed to prompt rescue.
- Chronic fear of abandonment and panic when forced to be alone.
- Distorted thoughts/perceptions, particularly in terms of relationships and interactions with others.
- Hypersensitivity, meaning an unusual sensitivity to nonverbal communication. (Gunderson notes that this can be confused with distortion if practitioners are not careful. Somewhat similar to Herman’s statement that, while survivors of intense long-term trauma may have unrealistic notions of the power realities of the situation they were in, their notions are likely to be closer to reality than the therapist might think).
- Impulsive behaviours that often embarrass the borderline later.
- Poor social adaptation. (In a way, borderlines tend not to know or understand the rules regarding performance in job and academic settings.)

The Diagnostic Interview for Borderlines, Revised

Gunderson and his colleague, Jonathan E. Kolb, MD, tried to make the diagnosis of BPD by constructing a clinical interview to assess borderline characteristics in patients. The DIB was revised in 1989 to sharpen its ability to differentiate between BPD and other personality disorders. It considers symptoms that fall under four main headings:

1. Affect

- Chronic major depression
- Helplessness
- Hopelessness
- Worthlessness
- Guilt
- Anger (including frequent expressions of anger)
- Anxiety
- Loneliness
- Boredom
- Emptiness

2. Cognition

- Odd thinking
- Unusual perceptions
- Nondelusional paranoia
- Quasipsychosis

3. Impulse action patterns

- Substance abuse dependence
- Sexual deviance, manipulative suicide gestures
- Other impulsive behaviours

4. Interpersonal relationships

- Intolerance of aloneness
- Abandonment, engulfment, annihilation fears
- Counterdependency
- Stormy relationships
- Manipulativeness
- Dependency
- Devaluation
- Masochism sadism
- Demandingness
- Entitlement

The DIB-R is the most influential and best-known 'test' for diagnosing BPD. Use of it has led researchers to identify four behaviour patterns they consider peculiar to BPD: abandonment, engulfment, annihilation fears; demandingness and entitlement; treatment regressions; ability to arouse inappropriately close or hostile treatment relationships.

DSM-IV Criteria

The DSM-IV gives the following nine criteria; a diagnosis requires that the subject present with at least five of these. In *I Hate You – Don't Leave Me!* Jerold Kriesman and Hal Straus refer to BPD as '*emotional hemophilia; (a borderline) lacks the clotting mechanism needed to moderate his spurts of feeling. Stimulate a passion, and the borderline emotionally bleeds to death.*'

Traits involving emotions:

Quite frequently people with BPD have a very hard time controlling their emotions. They may feel ruled by them. Linehan said, "*People with BPD are like people with third degree burns over 90% of their bodies. Lacking emotional skin, they feel agony at the slightest touch or movement.*"

1. Shifts in mood lasting only a few hours.
2. Anger that is inappropriate, intense, or uncontrollable.

Traits involving behaviour:

3. Self-destructive acts, such as self-mutilation or suicidal threats and gestures that happen more than once.
4. Two potentially self-damaging impulsive behaviours. These could include alcohol and other drug abuse, compulsive spending, gambling, eating disorders, shoplifting, reckless driving, compulsive sexual behaviour.

Traits involving identity

5. Marked, persistent identity disturbance shown by uncertainty in at least two areas. These areas can include self-image, sexual orientation, career choice or other long-term goals, friendships, values. People with BPD may not feel like they know who they are, or what they think, or what their opinions are, or what religion they should be. Instead, they may try to be what they think other people want them to be. Someone with BPD said, "*I have a hard time figuring out my personality. I tend to be whomever I'm with.*"
6. Chronic feelings of emptiness or boredom. Someone with BPD said, "*I remember describing the feeling of having a deep hole in my stomach. An emptiness that I didn't know how to fill. My therapist told me that was from almost a 'lack of a life'. The more things you get into your life, the more relationships you get involved in; all of that fills that hole. As a borderline, I had no life. There were times when I couldn't stay in the same room with other people. It almost felt like what I think a panic attack would feel like.*"

Traits involving relationships

7. Unstable, chaotic intense relationships characterized by splitting (see below).
8. Frantic efforts to avoid real or imagined abandonment
 - Splitting: the self and others are viewed as 'all good' or 'all bad'. Someone with BPD said, "*One day I would think my doctor was the best and I loved her, but if she challenged me in any way, I hated her. There was no middle ground as in 'like'. In my world, people were either the best or the worst. I couldn't understand the concept of middle ground.*"
 - Alternating clinging and distancing behaviours (*I Hate You, Don't Leave Me*). Sometimes you want to be close to someone. But when you get close, it feels TOO close and you feel like you have to get some space. This happens often.
 - Great difficulty trusting people and themselves. Early trust may have been shattered by people who were close to you.
 - Sensitivity to criticism or rejection.
 - Feeling of 'needing' someone else to survive.
 - Heavy need for affection and reassurance.
 - Some people with BPD may have an unusually high degree of interpersonal sensitivity, insight, and empathy.
9. Transient, stress-related paranoid ideation or service dissociative symptoms
This means feeling 'out of it', or not being able to remember what you said or did. This mostly happens in times of severe stress.

Miscellaneous attributes of people with BPD:

- People with BPD are often bright, witty, funny, life of the party.
- They may have problems with object constancy. When a person leaves (even temporarily), they may have a problem recreating or remembering feelings of love that were present between themselves and the other person. Often, BPD patients want to keep something belonging to the loved one around during separations.
- They frequently have difficulty tolerating aloneness, even for short periods of time.
- Their lives may be a chaotic landscape of job losses, interrupted educational pursuits, broken engagements, hospitalizations.
- Many have a background of childhood physical, sexual, or emotional abuse or physical/emotional neglect.

Treatment

Treatments for BPD have improved in recent years. Group and individual psychotherapy are at least partially effective for many patients. Within the past 15 years, the new psychosocial treatment, Linehan's Dialectical Behaviour Therapy (DBT) was developed specifically to treat BPD, and this technique has looked promising in treatment studies.

Pharmacological treatments are often prescribed based on specific target symptoms shown by the individual patient. Antidepressant drugs and mood stabilizers may be helpful for depressed and/or unstable mood. Antipsychotic drugs may also be used when there are distortions in thinking.

Recent research findings

Although the cause of BPD is unknown, both environmental and genetic factors are thought to play a role predisposing patients to BPD symptoms and traits. Studies show that many, but not all individuals with BPD report a history of abuse, neglect, or separation as young children. Forty to 71 percent of BPD patients report having been sexually abused, usually by a non-caregiver. Researchers believe that BPD results from a combination of individual vulnerability to environmental stress, neglect, or abuse as young children, and a series of events that trigger the onset of the disorder as young adults. Adults with BPD are also considerably more likely to be the victim of violence, including rape and other crimes. This may result from both harmful environments as well as impulsivity and poor judgement in choosing partners and lifestyles.

Neuroscience research is revealing brain mechanisms underlying the impulsivity, mood instability, aggression, anger, and negative emotion seen in BPD. Studies suggest that people predisposed to impulsive aggression have impaired regulation of the neural circuits that modulate emotion. The *amygdala*, a small almond-shaped structure deep inside the brain, is an important component of the circuit that regulates negative emotion. In response to signals from other brain centers indicating a perceived threat, it marshals fear and arousal. This might be more pronounced while under the influence of drugs like alcohol, or stress. Areas in the front of the brain (pre-frontal area) act to dampen the activity of this circuit. Recent brain imaging studies show that individual differences in the ability to activate regions of the prefrontal cerebral cortex thought to be involved in inhibitory activity predict the ability to suppress negative emotion.

Serotonin, *norepinephrine*, and *acetylcholine* are among the chemical messengers in these circuits that play a role in the regulation of emotions, including sadness, anger, anxiety, and irritability. Drugs that enhance Serotonin's function may improve emotional symptoms in BPD. Likewise, mood-stabilizing drugs that are known to enhance the activity of *GABA (Gamma-Amino Butyric Acid)*, the brain's major inhibitory neurotransmitter, may help people who experience BPD-like mood swings. Such brain-based vulnerabilities can be managed with help from behavioural interventions and medications, much like people manage susceptibility to diabetes or high blood pressure.

Future progress

Studies that translate basic findings about the neural basis of temperament, mood regulation, and cognition into clinically relevant insights -- which bear directly on BPD -- represent a growing area of NIMH-supported research. Research is also underway to test the effectiveness of combining medications with behavioural treatments like DBT, and gauging the effect of childhood abuse and other stress in BPD on brain hormones. Data from the first prospective, longitudinal study of BPD, which began in the early 1990's, is expected to reveal how treatment affects the course of the illness. It will also pinpoint specific environmental factors and personality traits that predict a more favourable outcome. The institute is also collaborating with a private foundation to help attract new researchers to develop a better understanding and better treatment for BPD.

“Mental illness ... learn more, learn to help.”