

Free research paper on borderline personality disorder

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Abstract:

Borderline personality disorder (BPD) is a personality disorder that may have devastating consequences for the sufferer, their family, friends, work colleagues, and acquaintances. The diagnosis is often feared and greatly misunderstood. This review seeks to understand the nature of the disease and the problems it may cause. This analysis of the literature provides an overview of the diagnostics, epidemiology, course, and treatment of the disease. It discusses the implications of the disease to the patient's family and their ability to have gainful employment. This paper seeks to aid in the understanding of the disease and treatment modalities available.

Borderline Personality Disorder (BPD) is one of 10 personality disorders described in the Diagnostic and Statistical Manual of Mental Disorders. Estimates indicate that BPD affects approximately 3% of the general population, 10% of psychiatric outpatients, and 20% of psychiatric inpatients (American Psychiatric Association, 2000). BPD is characterized by unstable affect, distorted cognition, impulsivity, and volatile interpersonal relationships. The DSM-IV-TR lists nine criteria for diagnosing BPD, five of which must be present for a BPD diagnosis. The criteria are presented in table 1.

Lieb et al. (2004) organize these criteria into four sectors of psychopathology: affective disturbance (criteria 6, 7, 8), disturbed cognition (criteria 3, 9), impulsivity (criteria 4, 5), and intense unstable relationships (criteria 1, 2). Organizing the criteria according to sectors of pathology is diagnostically useful as patients who endorse symptoms in all four areas simultaneously can be successfully discriminated from those with other

forms of personality disorder (Lieb et al., 2004).

Although the DSM states that an individual who meets five out of the nine criteria qualifies for a diagnosis of BPD, the diagnosis and assessment of BPD can be difficult and problematic. BPD has frequent comorbidity with other mental disorders, especially Axis I disorders: namely, Major Depression, Panic Disorder, Bipolar Disorder, eating disorders, Posttraumatic Stress Disorder, and substance abuse disorders. In addition, the diagnosis also has comorbidity with other personality disorders, most commonly Antisocial Personality Disorder and Avoidant Personality Disorder (Sherry & Whilde, 2007). Another aspect of the diagnosis that some experts find problematic is the enormous amount of heterogeneity of the BPD diagnosis with regard to symptoms and traits (Fischer-Kern et al., 2010).

Patients can endorse borderline symptomatology in a variety of patterns and combinations yet all receive the same diagnosis of BPD. In fact, there are 163 different possible combinations of borderline personality criteria in individuals who do not reach the clinical threshold for BPD (Sherry & Whilde, 2007). The frequent comorbidity with other disorders and the heterogeneity of BPD raises the question of whether the diagnosis is a distinct construct. However, many experts do not think this issue is particular to the BPD diagnosis, but instead pertains more largely to the DSM medical model of diagnosis. Sherry and Whilde (2007) write, “ Many have criticized the DSM medical model of diagnosis by indicating that mental disorders are not true prototypes and that the nature of human behavior necessitates a system whereby variations and intensities can be accounted for” (p. 406).

There are also cultural and diversity issues surrounding the BPD diagnosis. Some experts are troubled by the overrepresentation of certain populations in prevalence rates and think there might be important cultural dynamics involved in the conceptualization and application of the diagnosis (Sherry & Whilde, 2007). Research on the relationship between ethnicity and BPD has identified a higher rate of the disorder in American Hispanic than in Caucasian and African American clinical groups (Sherry & Whilde, 2007). However, more salient is that women account for a substantial majority (75%) of BPD diagnoses (American Psychiatric Association, 2000). Studies have sought to determine if the high prevalence rate of women among BPD patients results from interviewers' biases. These studies compare the diagnostic outcomes of unstructured and semi-structured interviews with the idea that a semi-structured interview is more free of biases than an unstructured interview. The studies found that female prevalence rates actually increase with interviews that are more structured; thus, the high prevalence of females does not appear to be a result of interviewers' biases (Sherry & Whilde, 2007). Some experts attempt to account for the high prevalence rate of women among BPD patients by conceptualizing BPD as chronic PTSD. They believe the symptoms of BPD are actually signs of traumatic stress in relation to prolonged and repeated experiences of victimization—experiences that women are more likely to experience than men (Sherry & Whilde, 2007).

Otto Kernberg conceptualizes BPD in terms of personality organization. His psychoanalytic formulation of BPD integrates American ego psychology and British object relations. Kernberg's theory asserts that BPD has its origins in

developmental challenges occurring between six and 36 months (Sherry & Whilde, 2007). Prior to this period, infants rely heavily on “splitting” as a defense against intolerable affect. Splitting refers to the infant’s organization of his affect and experiences with others in terms of good and bad objects. For example, if the infant has a mental representation of his mother as a “good object,” he will only attribute positive interactions to her. If he has a negative interaction with his mother, he will “split off” this experience from his representation of her and instead assign his resulting negative affect to another object. Kernberg argues that personality development depends on the progressive differentiation between self and object representations and the increasing integration of their bad and good aspects (Fischer-Kern et al., 2010). Through integration, the infant will begin to develop a realistic self-concept and see others as complex and whole.

Kernberg argues that individuals with BPD are not able to completely master this developmental task. Symptoms of BPD represent the limited integration of disparate (all good and all bad) representations of self and others, resulting in the predominance of developmentally early defenses (Fischer-Kern et al., 2010). Kernberg theorizes that BPD patients are unable to form a distinct sense of self nor whole, complex objects because they were overrun with an excess of aggression and threatening negative representations during this developmental period. Therefore, these individuals are forced to continue to rely on splitting as a defense against the intolerable feelings (Sherry & Whilde, 2007). Such an excessive use of splitting constitutes a developmental arrest that interferes with the BPD patient’s ability to develop a stable self-concept that can manage impulses and respond to external

challenges. Kernberg also noted that BPD patients tend to regress in close relationships and fuse their self and object representations, which can lead to transient psychotic episodes for some people in certain circumstances (Sherry & Whilde, 2007).

In terms of familial patterns, BPD is five times more common among first-degree biological relatives of those with the disorder than in the general population (American Psychiatric Association, 2000). Does that indicate a genetic component to the disorder? Data for the role of genetic factors is sparse. In one twin study, based on DSM IV criteria, concordance rates were seen for BPD of 35% and 8% in monozygotic and dizygotic twins pairs respectively. These results suggest a strong genetic effect in the development of the disorder (Lieb et al., 2004).

Gunderson (2008) argues that integration of the genetic perspective on BPD has been delayed in the literature because of an almost exclusive emphasis on psychosocial sources as an explanation for the disorder. Gunderson (2008) writes, “ The salient component of interpersonal dynamic of the disorder led people to conceptualize the disorder almost exclusively in psychosocial terms and to ignore the potential of the disorder having genetic roots” (p. 7). Gunderson points out that normal personality traits have significant heritability, as do other forms of mental illness. More support for a genetic component to the disorder is that the siblings of a BPD patient can be well adjusted and many children survive trauma without developing the disorder. The question then becomes what is inherited? Gunderson (2008) writes, “ More likely, what is inherited is some combination of the predisposing temperament (‘ phenotypes’) believed to underlie borderline

psychopathology” (p. 7). Should BPD have a genetic basis, the medical “disease” model applies to BPD as much as it applies to schizophrenia, major depression, bipolar disorder, obsessive-compulsive disorder, or other “brain disorders” (Gunderson, 2008).

The majority of research on BPD looks at life events, especially early trauma. In general, BPD patients have experienced a high number of traumatic events in their childhoods. Some theorists even conceptualize the condition as a chronic form of PTSD (Sherry & Whilde, 2007). A history of sexual abuse is also frequently common among BPD patients. Being a victim of childhood sexual abuse and incest greatly increases one’s chances of developing BPD and is considered an indicator of poor prognosis; this is particularly true when the abuse experiences occur at a young age, are repeated, and involve intrafamilial sexual abuse (Sherry & Whilde, 2007). However, it appears that the existence of sexual abuse alone is not the best predictor of BPD. Instead, the level of severity of the trauma and its combination with other types of abuse better predicts the development of BPD (Sherry & Whilde, 2007). In addition to abuse, BPD patients have histories of loss and abandonment. Individuals with BPD have a significantly higher percentage of parental loss through divorce or death than people with other disorders. Additionally, they have a higher incidence of prolonged separations in the first five years of life, are more likely to come from divorced families, have a higher incidence of father loss, and have more often experienced a developmentally important loss (Sherry & Whilde, 2007). In addition, BPD patients may have experienced poor caretaking from their attachment figures during these traumatic events. Thus, instead of having positive caretaking to help

mitigate trauma, BPD patients likely received poor caretaking that exacerbated the original trauma.

Experts' opinions on the stability of the BPD diagnosis have changed in recent years. In the past there was a hypothesis that because the condition included psychotic-like or depressive symptoms it would evolve over time into Axis I disorders such as schizophrenia or major affective illness (Gunderson & Zanarini, 1987). In their 1987 article, Gunderson and Zanarini countered that hypothesis by citing numerous follow up studies that demonstrated that such shifts were rare and that borderline patients generally retained their borderline diagnoses. In fact, Gunderson and Zanarini argued that the stability of the BPD diagnosis was an indicator of BPD's strong categorical validity. While BPD may not evolve into schizophrenia or major affective illness, it may not be necessarily true that BPD patients stay borderline. In his 2008 article, Gunderson discusses two major studies (The McLean Study of Adult Development and the Collaborative Longitudinal Personality Disorder Study) that demonstrate that BPD is less stable than was previously believed. According to the two studies, 50% of BPD patients remit by two years and, once remitted, rarely relapsed. The most common reason that patients remit is situational change—leaving a high stress environment and/or attaining a highly supportive environment. In new environments that offer higher support and lower stress, symptoms such as anger, impulsivity, dissociative experience, and emptiness can disappear quickly. These findings support the longstanding clinical observation that BPD patients are very sensitive to situational stress and that BPD patients who are suicidal and out of control can quickly

become calm and cooperative in hospitals (Gunderson, 2008).

Even if an individual qualifies for a BPD diagnosis over the course of his lifetime, studies show that the severity of the illness decreases over time (Gunderson & Zanarini, 1987). Many individuals with the diagnosis experience improved functioning as they age. Longer term follow up studies have shown that BPD patients who receive intensive treatment, many move into stable employment, endorse less symptoms, and have a decreased need for psychiatric care (Gunderson & Zanarini, 1987). In addition to increased functionality in the realm of employment, BPD patients may experience more stability in their interpersonal relationships as they age. Roughly 20%-40 % of patients with BPD eventually marry and establish their own families. Thus, a BPD patient is likely to experience more extended periods of instability during the young adult years but gain more stability in employment and relationships in their later years (Gunderson & Zanarini, 1987).

Approximately 45% of BPD patients are unemployed (Sansone & Sansone, 2012). The difficulty in finding and maintain employment or completing education goals has been linked to the impulsivity that is the hallmark of a BPD diagnosis (Sio, Chanen, Killackey, Gleeson, 2011). Amongst the impulsive behaviors that make continued employment difficult are: substance abuse, reckless driving, and promiscuous behavior. Certain other aspects of the disease such as 'frantic efforts to avoid abandonment', 'unstable and intense interpersonal relationship', 'identity disturbance' might not be as damaging to the employment prospects of an individual (Sio, Chanen, Killackey, Gleeson, 2011).

The familial etiology, whether genetic or related to abuse, has previously

been discussed, but as personality disorders are primarily disorders of socialization it is also necessary to look at the consequences on family life that the disease has. Carers have felt neglected in the past and it is important to include them in therapy in order to provide the patient with the most efficacious outcomes and to relieve the burden that they have in dealing with the ill person (Porr, emergenceplus.org.uk). Carers are often exasperated by the patients' behavior as much as the lack of information they receive about the disease (Dunne & Rogers, 2012). The instability of the sufferer leads to lack of employment and ultimately dependence on the carer that can create a substantial financial burden. Furthermore, the disease may subsume the carer too, making it difficult for them to lead their own lives (Dunne & Rogers, 2012). The carer also forms a key component of the diagnosis, since personality disordered individuals are often unreliable, the carer's reports to the practitioner often provide valuable information that aids the treatment process. Carers have a profoundly difficult time coming to grips with the patient, the patient's feelings, and the invariable mood fluctuations. A commonly reported theme is the feeling or desire to simply "walk away" from the patient, "After her breakdown I walked away I just had, I couldn't, I was too shocked and too damaged" (Dunne & Rogers, 2012). Family members, often overwhelmed by the disease, are often looking for advice regarding dealing with the problems they face, particularly when the caring becomes a full time position:

"I don't think they realise we've gotta put up with situations for a whole week, say, before they get seen again." The full-time aspect of the caring role meant it limited their time available for work or leisure; "My leisure time

is spent at home looking after [service user]." (Dunne & Rogers, 2012)

Treatment modalities for borderline personality disorder are usually multipronged. It is the naïve practitioner that thinks simply using pharmacotherapy can relieve the burden of the disease, while purely approaching the illness with psychotherapy will leave the patient and his carers struggling.

Pharmacotherapy has proven useful in treating BPD patients. Antipsychotics, Antidepressants, MAO inhibitors, Benzodiazepines, Anticonvulsants, and Selective Serotonin Reuptake Inhibitors all have their place in the management of BPD (Kaplan & Sadock, 2007, p. 801). As with all human disease, some patients respond better to different drugs and the symptomology of the disease might also call for different classes of medications.

Psychotherapy is a long-term endeavor. Some features of the psychotherapeutic side of therapy include: establishing a strong relationship between the therapist and patient, assigning clear roles to both parties, therapy should be active and the therapist should be giving instructions, the patient and the practitioner should work together to establish priorities, the therapist should be empathic and at the same time urge the patient to control their behavior, the therapist should be flexible, limits must be set, and group and individual sessions should both be used (Kaplan & Sadock, 2007, p. 801).

Psychotherapy is difficult for both parties, patients often regress and the tendency to revert to splitting defense will mean the patient often hates and loathes their therapist depending on the time and context. Behavior therapy has

proven useful as has social skills training. Video playback is used to show patients how their behaviors affect people around them (Kaplan & Sadock, 2007, p. 801). BPD patients often do well in in-patient settings where organizing group sessions is easier. Furthermore, the trained staff constantly available is more readily able to cope with the patient and the in-patient setting removes the possibility of abuse by family members that may be the etiological basis of the disease. Dialectical behavior therapy has also proven useful for patients that suffer from para-suicidal behavior (Kaplan & Sadock, 2007, p. 801).

Finally, family therapy is also very helpful for the treatment of BPD. Not only does it help the patient, but it also makes an effort to relieve the overwhelming burden placed on the family (Marcinko & Bilic, 2010). The American Psychiatric Association has limited published information on the utility of family therapy in management of the disease and the reports differ in their recommendations. Family therapy should not be the only modality used in patient management, and the psycho-educational model is promoted. Clearly though, when the family derangement is severe the therapy model can prove very useful and in Marcinko & Bilic's (2010) small study of 30 patients, the results indicated that patients treated with family therapy had significant improvement in depression, suicidality, and self-destructive behavior.

In conclusion, Borderline Personality Disorder is a complex disease with a very complex etiological basis. Differing theories attempt to explain the origins of the disease and very few, if any, provide a satisfactory complete explanation. The course of the disease, by definition, is erratic and the

patients often have a difficult time coping with social lives including, family, friends, and employment. Treatment options are numerous too, and should be tailored to the symptomology of the patient. BPD is a manageable diagnosis and patients may go on to live fruitful functional lives. However, improper treatment can easily result in the suicide of the patient and families, friends, and acquaintances exasperated and frustrated.

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