Family dynamics in the development of borderline personality disorder

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Nature versus nurture is a huge debate that will likely continue for centuries to come. Nature advocates state, " just as a sunflower grows in an orderly way – unless flattened by an unfriendly environment – so does the human grow in an orderly way" (Santrock, 2010, p. 22). This sentence alone completely negates the nature-nurture debate. Stating that orderly growth can be flattened by an unfriendly environment further implicates that nurture has more of an impact on development than nature does. An individual's biological inheritance will always be his or her biological inheritance. It is the way that it is nurtured that largely influences who he or she becomes. It is my intention to provide the reader with information regarding adolescents with either symptoms or a diagnosis of Borderline Personality Disorder, apply the theoretical orientation of Erik Erikson to facilitate my beliefs regarding this subject, and present an intervention strategy that I believe would assist in this escalating problem. My hypothesis is that if the family and the adolescent with Borderline Personality Disorder learn how to establish a functional lifestyle, the adolescent will be less likely to develop the severe, life-shattering symptoms of this disorder.

Literature Review

Borderline Personality Disorder is an Axis II diagnosis according to the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision, DSM-IV-TR, (American Psychiatric Association, 2000). The general diagnostic criteria for a personality disorder involve an " enduring pattern of inner experience or behavior that deviates markedly from the expectations of the individual's culture" (American Psychiatric Association, 2000, p. 286). The aforementioned pattern can be present in four areas and is deemed diagnosable if two or more are present. These four areas include distortions in cognition, affectivity, interpersonal functioning, and impulse control. These distortions coincide well with the diagnostic criterion of Borderline Personality Disorder.

The American Psychiatric Association (2000) identifies Borderline Personality Disorder (BPD) as involving patterns of unstable interpersonal relationships. Instability of one's self image and affects are also evident. Marked impulsivity is present and usually begins by early adulthood. These characteristics are present in various forms of the nine criterion listed. If five or more of the criterion are present, a diagnosis of BPD is justified. The American Psychiatric Association identifies the nine criterions as follows:

Frantic efforts to avoid real or imagined abandonment.

A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.

Identity disturbance: markedly and persistently unstable self- image or sense of self.

Impulsivity in at least two areas that are potentially self- damaging (e. g., spending, sex, substance abuse, reckless driving, and binge eating).

Recurrent suicidal behavior, gestures, threats, or self-mutilating behavior.

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).

Chronic feelings of emptiness.

Inappropriate, intense anger or difficulty controlling anger (e. g., frequent displays of temper, constant anger, and recurrent physical fights).

Transient, stress-related paranoid ideation or severe dissociative symptoms (p. 292-293).

There is little information regarding the prevalence of BPD in adolescence because the subject matter has not been sufficiently researched. It is safe to assume, however, that the percentages of adults and children with Borderline Personality Disorder would be relatively close in comparison. Research on the presence of BPD in adolescence has been increasing. Muscari (2005) states that many mental health professionals believe that personality disorders cannot be reliably diagnosed in adolescents due to the development of personality still being in progress (para. 1). Regardless, personality disorders are diagnosable in adolescents when " maladaptive traits have been present for at least 1 year, are persistent and all-encompassing, and are not likely to be limited to a developmental stage or an episode of an Axis I disorder" (Muscari, 2005, para. 1). Muscari (2005)

also states that borderline pathology that is present in children is not necessarily an antecedent to BPD in adulthood; however, evidence shows remarkably similar risk factors. The risk factors involved are " family environments characterized by trauma, neglect, and/or separation; exposure to sexual and physical abuse; and serious parental psychopathology (para 2).

The presence of Borderline Personality Disorder in adolescents needs to be addressed as quickly as possible. The largest barrier that I foresee is insurance coverage. Insurance coverage for mental health diagnoses is very limited. On top of that, most adolescents being treated for a mental illness only have coverage for Axis I diagnoses (Miller, Muehlenkamp, Jacobson, 2008, para. 1). Borderline Personality Disorder is an Axis II diagnosis. Ruocco (2005) identifies Axis I diagnoses as clinical syndromes and Axis II diagnoses as personality disorders. The distinction involves phenomenology, cause, and course. Clinical syndromes are " characterized by transient symptoms with biological causes and an unstable course; personality disorders . . . characterized by long-standing personality traits, whose roots were primarily psychological, and a stable and unremitting course (para. 1). There has been a large amount of advocacy to move Borderline Personality Disorder to an Axis I diagnosis. Miller et al., (2008) indicates that " by ignoring Axis II criteria, many adolescents may not receive specific treatment for their dysfunctional behaviors, or worse, receive inappropriate treatments" (para. 1). Mental health professionals that provide services to individuals with BPD have to be extremely knowledgeable about the pathology associated with it. As I mentioned earlier, those with BPD struggle with extreme idealization and

devaluation of individuals in close relationships. Because of the idealization and devaluation, those with BPD are often labeled as being manipulative and playing games. Kreger (2005c) identifies three common games that borderlines may engage in with non-borderlines. The first game is known as “ Splitting”. Quite often individuals with BPD think in terms of black and white and have difficulty seeing the gray areas. Borderlines use this as a defense mechanism; however, it is draining to those that are victims to the splitting. The second game is “ Tag: You’re It”. In order to ease the borderlines pain, anxiety, feelings of shame or guilt, the borderline engages in a game of projection. This game is far more complex than splitting because it involves splitting, denial, shame, and projection. The game is when a borderline experiences feelings of shame regarding his or her “ own unpleasant traits, behaviors, or feelings by attributing them (often in an accusing way) to someone else” (para. 6). Though this game of tag is unconscious to the borderline, it is also draining to those that are victims to it. Kreger identifies the third game as “ Everything Is Your Fault”. Borderlines will use continuous blaming and criticizing as another defense mechanism. This is an ineffective survival tool for borderlines. The intense criticism is also draining to those that are victims to it (para. 10). Due to the intense criticism, borderlines’ loved ones often become exasperated and feel hopeless. Due to the continuous presence of these games in a borderline’s life, it is crucial that the mental health professionals working with them know how to interact with them in a way that does not positively reinforce the use of these games.

It’s important that the mental health professionals are aware of Marsha Linehan’s Biosocial Developmental Model of Borderline Personality Disorder. Crowell, Beauchaine, and Linehan (2009) state that researchers are beginning to change their focus to developmental precursors to psychological disorders. Many researchers have recognized that “ complex transactions between biological vulnerabilities and psychosocial risk factors shape emotional and behavioral development beginning at conception” (p. 495). Crowell et al., (2009) states that Marsha Linehan, the founder of the biosocial developmental model of borderline personality disorder, describes BPD as “ primarily a disorder of emotion dysregulation and emerges from transactions between individuals with biological vulnerabilities and specific environmental influences” (p. 496). Linehan was able to identify three common characteristics in individuals with the aforementioned biological vulnerabilities in transaction with specific environmental influences. These three characteristics are: “(a) heightened emotional sensitivity, (b) inability to regulate intense emotional responses, and (c) slow return to emotional baseline” (Crowell et al., 2009, 496). Individuals that have a biological predisposition to be emotionally dysregulated and live in an environment that is invalidating can potentially develop Borderline Personality Disorder. Linehan’s biosocial theory supports my hypothesis.

Linehan is the founder of Dialectical Behavior Therapy (DBT). Dialectical Behavior Therapy (DBT) has shown extreme success in relation to rehabilitation of those with BPD. This therapy addresses four areas of concern that need to decrease: “ interpersonal chaos, labile emotions or mood, impulsivity and confusions about self or cognitive dysregulation”

(Linehan, 1993, p. 107). Linehan (1993) identifies DBT as a skills training group that offers training in core mindfulness skills, emotion regulation skills, interpersonal effectiveness skills, and distress tolerance skills (p. 107). Core mindfulness skills are central to DBT that are “ psychological and behavioral versions of meditation practices from Eastern spiritual training” (Linehan, 1993, p. 63). Linehan states that we all have three primary states of mind: “ reasonable mind”, “ emotion mind”, and “ wise mind”. When an individual is in “ reasonable mind”, she is “ approaching knowledge intellectually, is thinking rationally and logically, attends to empirical facts, is planful in her behavior, focuses her attention, and is ‘ cool’ in her approach to problems” (p. 63). When one is in “ emotion mind”, they display behaviors consistent with the name of the state of mind. Linehan states that one is in “ emotion mind” when her thoughts and behaviors are controlled by her current emotional state. Cognitions are labeled as “ hot” and logical thinking is extremely difficult. Facts are magnified or twisted according to the emotional state the individual is in (p. 63). Linehan indicates that when “ emotion mind” and “ reasonable mind” are integrated, “ wise mind” is formed. This state of mind adds “ intuitive knowing to emotional experiencing and logical analysis” (p. 63). The goal is to be in “ wise mind” as often as possible; however, it is impossible to be in this state of mind at all times.

Emotion Regulation is the module that teaches individuals to identify emotions as they experience them and being able to apply the mindfulness skills of observing and describing emotions (Linehan, 1993, p. 83). In this module, the clients will learn the functions of their emotions in order to decrease negative vulnerability and increase positive emotions. It’s also

desired that they will learn how to decrease their emotional suffering. The first step to regulating one's emotions is to learn to identify and label the emotions currently being experienced. Emotions in themselves are difficult behavioral responses. In order to identify them properly, one must gain the ability to observe his or her own responses and be able to accurately describe the situation where the emotion occurred (p. 83). Linehan indicates that learning to identify emotional responses are made easier if one can observe and describe

(1)the event prompting the emotion; (2) the interpretations of the event that prompt the

emotion; (3) the phenomenological experience, including the physical sensation, of the

emotion; (4) the behaviors expressing the emotion; and (5) the aftereffects of the emotion on

other types of functioning (p. 84).

The next module in DBT is interpersonal effectiveness skills. Linehan (1993) states that the three goals of interpersonal effectiveness are " objective effectiveness, relationship effectiveness, and self-respect effectiveness" (p. 73). When one is communicating with others, it's important to determine whether maintaining her objective, relationship, or self-respect is her goal. Linehan uses acronyms to teach the skills. When one's goal is to maintain her objective, she can use the following acronym, " DEAR MAN: Describe, Express, Assert, Reinforce, Mindfully, Appear confident, and Negotiate" (p.

79). These basic guidelines will help the individual communicate effectively while maintaining her objective. If one's goal is to maintain the relationship, she can use the following acronym, " GIVE: Gentle, Interested, Validate, Easy Manner" (p. 81). The individual should use the skills addressed in DEAR MAN, but also express these actions in the ways that the acronym GIVE suggests. When one's goal is to maintain her self-respect, she can use the following acronym, " FAST: Fair, (no) Apologies, Stuck to values, Truthful" (p. 83). Using all of these skills can help the borderline communicate effectively with others while maintaining her objective, the relationship, and self-respect.

Linehan (1993) identifies the final module as Distress Tolerance. This module teaches the clients how to tolerate painful situations that they can do nothing about. The skills in this module are ways of " surviving and doing well in terrible situations without resorting to behaviors that will make the situation worse" (p. 97). The specific skills taught involve distracting oneself, self-soothing, improving the moment, and focusing on pros and cons. Linehan has come up with another acronym to help individuals remember methods of distraction. She calls this "' Wise Mind ACCEPTS': activities, contributing, comparisons, emotions, pushing away, thoughts, and sensations" (p. 98). Getting involved in activities and contributing to others are ways tolerate negative emotions. Making comparisons can help one realize that her situation isn't as bad as she perceived it to be. Generating opposite emotions with less negative emotions builds tolerance. " Pushing away" means leaving a situation that causes emotional distress. Distracting oneself with thoughts opposite of the one being experienced proves to be beneficial, as well as causing intense sensations. The next skill discussed in

Distress Tolerance is self-soothing. One can learn how to self-sooth by focusing mindfully on each of the five senses can enhance one's tolerance to a situation. The third skill is " Improving the Moment". This skill is also presented in an acronym. " IMPROVE: Imagery, Meaning, Prayer, Relaxation, One thing in the moment, Vacation, Encouragement" (p. 99). All of these techniques will also help borderlines improve their tolerance level. Linehan identifies the fourth skill as " thinking of pros and cons". She states that thinking of the pros and cons of the situation help the borderline gain some perspective (p. 99).

Theoretical Orientation

" Don't laugh at a youth for his affectations; he is only trying on one face after another to find his own." This quote by Logan Pearsall Smith briefly summarizes the general outcome desired in Erik Erikson's Eight Stages of Psychosocial Development. Corey (2007) explains Erikson's model as holistic, addressing humans inclusively as biological, social, and psychological beings. Erikson's developmental theory describes human development over the entire life span in terms of various stages. He suggests that each stage is marked by a particular crisis that needs to be resolved (p. 86).

Erikson's stages begin in infancy and go through the remainder of life. He developed eight separate stages that signify a certain level of achievement. For healthy development to occur, it is necessary to establish a clear sense of our unique selves in the context of our connection with others at each stage of life (Corey, 2007, p. 86). Larsen (2008) states that each stage represents a conflict, also known as a developmental crisis which needs to

be resolved. Erikson also sustained the belief that fixations, meaning if the crisis was not successfully and adaptively resolved, then personality development could become arrested and the person would continue to be preoccupied by that crisis in development (p. 334).

Each stage is specified by a specific age range; however, when the crisis in each stage is not successfully resolved, it makes it difficult to enter the next stage at the same age that is expected. Corey (2007) identifies the four stages before the adolescent stage: trust versus mistrust, autonomy versus shame and doubt, initiative versus guilt, and industry versus inferiority. In the first stage, trust versus mistrust, the developmental crisis is to develop a sense of trust with the child’s caregiver between the ages of birth and one. The developmental crisis in the second stage is to gain autonomy, or emotional competence, between the ages of one and three. The developmental crisis in the third stage, initiative versus guilt, is to gain initiative in social interactions between the ages of three and six. The fourth stage, industry versus inferiority, identifies the developmental crisis as gaining a sense of industry between the ages of six and 12 (p. 86-88) Corey also identifies the fifth stage which is known as identity versus identity confusion and is specific to adolescents between ages 12 and 20. The developmental crisis that should be mastered is gaining an identity (p. 89). If Erikson believes humans are inclusively biological, social, and psychological beings, then his theoretical orientation supports my hypothesis that if the family and the adolescent with Borderline Personality Disorder learn how to establish a functional lifestyle, the adolescent will be less likely to develop the severe, life-shattering symptoms of this disorder.

Identity

Females are more prone to a borderline diagnosis than males. Kreger (2005a) states that in the general population, 75% of the individuals diagnosed with borderline personality disorder are female (Statistics about BPD section, para. 1). The important question here is why BPD is more prevalent in females than males. There are multiple theories to this phenomenon. One indicates that women are more likely to seek professional help than men. Another is that " women experience more inconsistent and invalidating messages in this society" (Kreger, " Myths and Realities about BPD, 2005b). Santrock (2010) states that " gender development is influenced by biological, social, and cognitive factors" (p. 168). The biological factors are related to pubertal changes; social factors are primarily derived from social experiences; and cognitive factors result from the intermingling of the child and the social environment (p. 168-173). The social cognitive theory of gender supports my hypothesis. This theory accentuates that " children's and adolescent's gender development is influenced by their observation and imitation of others' gender behavior, as well as by the rewards and punishments they experience for gender-appropriate and gender-inappropriate behavior" (Santrock, 2010, p. 173). Adolescents experience many, many mixed messages that are constantly thrown at them as they develop. These mixed messages have the potential to do a large amount of damage. One skill that is important to develop during adolescence is emotion regulation and behavior regulation. Santrock identifies low self-control as being an antecedent of behavioral problems. Low self-regulation has been linked with " greater aggression, teasing of others, overreaction to frustration, low cooperation, and inability to delay gratification" (p. 180).

These behaviors are consistent with common borderline behaviors. Teaching emotion regulation skills is a crucial component in a specific therapy that will be used in my intervention strategy. Though my intervention will not be specifically targeted for adolescent females, it appears as if a majority of the clients being served will be female. Regardless of the gender being served, emotion regulation is crucial in the success of my intervention.

Moral Development

Interpersonal effectiveness is another target area in my intervention. The goal is to become more interpersonally effective in relationships; however, this may be more difficult for some than others. Those with a BPD diagnosis typically have difficulty in maintaining stable relationships. This deficit can be related to dysfunction in moral development. Moral development involves two dimensions: interpersonal and intrapersonal. The intrapersonal dimension is specific to one’s individual values and sense of self whereas the interpersonal dimensions is specific to what is expected of someone in their interactions with others (Santrock, 2010, p. 236). Santrock identifies Lawrence Kohlberg as developing a theory on adolescents and their perceptions of right and wrong. Kohlberg’s theory involves three levels with two stages in each level. The first level, preconventional reasoning, involves stages one and two. Stage one is identified as punishment and obedience orientation (p. 238). Moral thought processes in this stage are frequently congruent with punishment. Obedience is expected because parents request it. Stage two is identified as individualism, instrumental purpose, and exchange (p. 238). This stage involves pursuit of individual interests and reciprocating that freedom to others. One example would be the golden rule

which involves an equal exchange. Kohlberg’s second level, conventional reasoning, involves stages three and four. Stage three is labeled mutual interpersonal expectations, relationships, and interpersonal conformity (p. 238). This stage is characterized by basing moral judgments on demonstrating trust towards others, caring for others, and remaining loyal towards others. Stage four is labeled social systems morality (p. 238). This stage is basing moral judgments on the comprehension of social order, law, justice and duty. Kohlberg’s third level is known as postconventional reasoning which involves stages five and six. Stage five is known as social contract or utility and individual rights. This stage involves reasoning one’s values, principles, and rights as exceeding the law. Stage six is known as universal and ethical principles. This stage involves developing a moral standard with a basis on universal human rights. Personal risk is involved in this stage and requires an individual to determine if he or she will follow the law or his or her conscience in regards to human rights (p. 239).

Stage two, preconventional reasoning, of Kohlberg’s theory is likely where borderline individuals adapt distorted thought patterns. The concept of pursuing one’s own interests is understandable to the borderline; however, allowing others to pursue their own interests becomes difficult. I attribute this to emotional dysregulation. Allowing others to pursue their own interests is not always difficult for the borderline. It only becomes difficult when the borderline is experiencing intense emotions and feels abandoned by the other person’s desire to pursue other interests. Stage three is also a difficult stage for borderline individuals to master. Borderlines do value the other individual’s trust, caring, and loyalty; however, their value of these

characteristics is often taken to the extreme. If the other individual shows any sign of providing care towards others, the borderline can fluctuate between extreme idealizations and devaluations. Those with BPD will go to extreme measures in order to avoid being abandoned by someone important to them. Borderline individuals also struggle with interpersonal relationships. The thought of " impending separation from an important other person has a destabilizing effect on the mood, sense of self, thought patterns, and behavior", even if this separation is imagined (Gunderson & Hoffman, 2005, p. 5). The alternating of idealization and devaluation of others is known as splitting. Melanie Klein identifies this phenomenon in her Object Relations Theory (Wasdell, 1980). Gunderson and Hoffman (2005) say that people with BPD often find themselves drawn towards others that are caring and loving. They often put the other person's virtues and capacities on a pedestal. It is when that other person disappoints or hurts them in some way that " there can be a rapid shift to devaluating the other person, who now does not give or care nearly enough" (p. 5). These drastic changes of mood are often caused by the borderline thinking that he or she is being abandoned or rejected. When stages two and three of Kohlberg's theory are dominated by such intense emotions, typical moral development is less likely to occur. Emotion regulation and interpersonal effectiveness are target areas in a specific therapy I will use in my intervention.

Intervention Strategy

My hypothesis stated that if the family and the adolescent with Borderline Personality Disorder learn how to establish a functional lifestyle, the adolescent will be less likely to develop the severe, life-shattering symptoms

of this disorder. The individuals that qualify for receiving my services are adolescents diagnosed with Borderline Personality Disorder and their immediate family members. The American Psychiatric Association (2000) states that in order for an adolescent to be diagnosed with BPD, he or she must display five or more of the diagnostic criterion for a duration of at least one year (p. 286).

The setting for my intervention is at a private mental health facility that specifically serves adolescents with a BPD diagnosis. There are three stages of treatment that have specific interventions: intensive in-patient hospitalization, transitional hospitalization, and partial hospitalization. The commitment required is one year. Each stage involves four components that have specific goals. The four components include: Dialectical Behavior Therapy, individual psychotherapy for the adolescent, family therapy with the adolescent, and family therapy without the adolescent. Aside from the four main components, day-habilitation groups will be provided to the adolescent for the purposes of community reintegration and social and leisure skill development. Support groups for the adolescents are available at specified times, and support groups for family members are available at specified times as well.

The intensive in-patient hospitalization stage occurs when the adolescent is either court-committed to treatment or the guardians bring their adolescent in for treatment at the facility. The adolescent remains at the facility for a minimum of six months or until a court commitment is lifted. During this stage, the adolescent is required to attend all programming on a daily basis while the family is required to attend programming three days a week. The

DBT skills group meets daily for two hours. The adolescent is required to attend this group daily. The adolescent is also required to see one of our therapists two times each week. Each week, the family is required to attend family therapy with the adolescent, family therapy without the adolescent, and the family support group. The purpose of the DBT skills group is to solely teach the skills of Dialectical Behavior Therapy. Individual therapy is more personal for the adolescent and is when he or she is able to process real life situations and attempt to apply the skills learned in group. Family therapy with the adolescent is an integral component of this treatment program. Santisteban, Muir, Mena, and Mitrani (2003) indicate that one area that is lacking in treatment of Borderline Personality Disorder is “ a treatment model with a strong family therapy component that can specifically address family interactions central to a child’s and adolescent’s life” (p. 252). These family interactions can potentially be consistent maladaptive patterns. Considering the adolescents are at a time in their lives when their immediate family is still largely present, it’s important to address the maladaptive patterns that may be contributing to the borderline pathology. As mentioned above, Marsha Linehan’s biosocial theory discusses the impact invalidating environments can have on individuals with a biological predisposition to be emotionally vulnerable. Santisteban, et al., (2003) states that “ failing to change parental communication that invalidate the adolescent’s point of view will hinder any progress in the adolescent’s emerging ability to effectively express needs” (p. 253). Family therapy is intended to target relationship patterns within the family that aggravate emotion dysregulation. Family interactions that are maladaptive in nature, “ begin to interact with the adolescent’s vulnerability to emotion dysregulation in such a way that

the family becomes the fertile ground in which the borderline behaviors . . . blossom fully" (p. 256). Our family therapist seeks to help the family identify the maladaptive patterns, process the patterns, and learn how to change them. The family therapy sessions without the adolescent present are important because family members often become drained by borderline behaviors being exhibited by their loved ones. To assist the family in not becoming the fertile ground that their adolescent's borderline behaviors can blossom on, family therapy without the adolescent present provides a safe environment to express some of the intense feelings they experience that come with having a loved one with BPD. The family support group provides another safe environment for families to share their experiences with others with similar experiences.

After the first six months, if it is deemed appropriate and the adolescent has successfully completed the first stage, the adolescent will begin the transitional hospitalization stage. The adolescent is required to attend programming three days a week while the family is required to attend programming two days a week. The adolescent will be required to attend the DBT skills group three times a week, family therapy once a week, and individual therapy once a week. The family will be required to attend family therapy with the adolescent once a week and family therapy without the adolescent once a week. This stage lasts for three months and involves transitioning the adolescent back into the home. As the family and adolescent demonstrate knowledge and application of the skills being taught, the adolescent will be able to have overnight passes to their home. Through the duration of the three months, the overnight passes will slowly

increase to two-day passes, three-day passes, etc. The passes are not able to be used during scheduled programming. After successful completion of the second stage, the adolescent will begin the partial hospitalization stage.

The partial hospitalization stage ideally starts in the tenth month. This is when the adolescent is discharged from the facility and becomes an out-patient. The adolescent will move back into the home environment. The adolescent will be required to come to programming at least two days a week while the family will be required to come to programming one day a week. The adolescent's programming will involve individual therapy and family therapy once a week and the DBT skills group once a week. The family will be required to come to family therapy with the adoles