Borderline personality disorder | overview

Borderline personality disorder is a mental illness that develops during adolescence or early adulthood. BPD is marked by patterns of emotional instabilities, impulsive behaviors, and distorted self-imaging, and/or unstable relationships. Approximately 5. 9 percent of people will develop BPD. According to the American Psychiatric Association, there are three major causes of borderline personality disorder: Genetics, environmental, and serotonin abnormalities. A scientific study on twins and BPD suggested that there is a good likelihood that the disorder is inherited. Personality traits, such as aggression and impulsivity, seen in BPD and other disorders may also be inherited. Also growing up in an unstable, abusive, or neglectful environment may cause or be a factor in the development of BPD. Lastly abnormalities in serotonin, a hormone that regulates mood, production may make you susceptible to developing BPD.

BPD was officially recognized as a diagnosis in 1980. Since that time, the borderline category has been used so widely that 10-20 percent of psychiatric patients are given this diagnosis although it is only estimated to occur in 6 percent of the general population. (Gross et al., 2002; hyman 2002). About two-thirds of those with BPD are females. A heterogeneous group of individuals received this diagnosis, but they share a number of characteristics, including unstable personal relationships, threats of self-destructive behavior, a chronic range of cognitive distortions, impulsivity, and/or fears of abandonment.

Consequently, intense clinging dependency and manipulation characterizes the interpersonal relationships of those with BPD, making interaction very difficult. These people seem to wish for dependent and exclusive

relationships with other people. This desire for dependency is clear to people who observe from the outside, but ardently denied by the individual with the disorder. As part of this ardent denial, such individuals devalue or discredit the strengths and personal significance of others. Often this could take the form of extreme anger when the other person, in the relationship with someone who has BPD, sets limits in the relationship or when they are about to be separated. The BPD individual uses manipulative behaviors to control relationships, such as: complaining about physical symptoms and making or carrying out self-destructive threats.

According to the Mayo Clinic Staff, “ Borderline Personality Disorder is a mental health disorder that generates significant emotional instability. This can lead to a variety of other stressful mental and behavioral problems.” With BPD, it is possible to have, a fundamentally flawed, distorted self-image and feelings or worthlessness. Anger, impulsiveness, and mood swings could push others away, even if the person wishes to have long and loving relationships. If a person is diagnosed with BPD there is no reason to feel hopeless, they can get better with treatment and can live a fulfilling life. BPD could possibly affect how they feel about themselves and others and also how they relate to others and behavior.

Self-destructive behaviors have been called ” the behavior specialty” of those with BPD. Overdosing with drugs and self-mutilation are common, and so are suicidal threats. One study found that over a 27-year period, 10. 3 percent of BPD patients have committed suicide and 7. 9 percent died in other ways (Paris and Zweig-Frank 2001). Recently, bulimia has become a common self-destructive tactic. Such behaviors are designed to call forth a “

saving” response from another meaningful person. Individuals who are diagnosed with BPD are often a burden to the police and hospitals. Some self-destructive acts are suicidal threats, accidental overdose, self-mutilation, drug abuse, and/or promiscuity. Also some of the signs of BPD are; impulsive/risky behavior, reckless driving, unsafe sex, gambling habits, and illegal dug use. They can also have chronic feeling of emptiness.

Self-destruction is one of the characteristics of individuals with BPD that generates the most discomfort in those who try to help them. A therapist’s hope of saving an endangered life is sometimes encouraged, only to have the patient with BPD dash the efforts with malicious acts of self-destruction. Therapists periodically experience exceptional feelings of responsibility for BPD patients. Their individual efforts of being supportive when the patient threatens suicide can lead to a great responsibility for the patient’s life and a great involvement outside of therapy sessions. Unless the controlling nature of the patient’s response is interrupted in the therapy sessions, the situation may become unworkable for the therapist. It is important to make the patient understand that the therapist cannot be manipulated by threats of suicide , and also that the patient must work to understand these self-destructive urges without acting upon them. If this effort is not achieved, than the threats of self-destruction can and will reoccur and the danger to the patient will be increased if the therapist fails to respond at the appropriate time.

Ironically, BPD patients have a strong need for a relationship that leads them to have chronic and long-lasting fears that the people who they are dependent on will abandon them. These fears are connected to the extreme

panic they feel when they are alone. As a defense mechanism against this fear, BPD people are compulsively social. Despite their need for social interactions, some of their behaviors drive people away. These include their intense indignation and demands, their suspiciousness, and their impulsiveness. BPD patients deal with their stress by being sexually promiscuous, engaging in violent behavior, and binge eating and purging.

BPD patients display instability with sudden shifts to uneasiness and depression, Which may last only a few hours, nut never more than a few days. BPD individuals display disturbance in their concepts of identity. They are doubtful about their self-image, gender identity, values, loyalties, and goals. They may have long-lasting feelings of emptiness or boredom and may be unable to tolerate being apart from people.

The work “ borderline” suggests a marginal level of functioning, something that borders on becoming something else. Initially, the term was used to an account on a marginal or milder form of schizophrenia. Researchers have argued that BPD patients represent the limit between personality disorders and mood disorders. Most of the time, these patients are likely to have a family history of mood disorders. Sometimes patients who are diagnosed as BPD and those who are diagnosed with schizophrenia seem to resemble. To my knowledge and understanding, the schizophrenic and BPD classifications are significantly different. The schizophrenic category emphasizes cognitive symptoms such as suspicious thoughts and illusions that they may posses magical powers. The BPD category stresses effective or emotional symptoms such as feelings of emotional instability, emptiness, boredom, and unsuitable and exceptional hostility. Some relative of those diagnosed with BPD are

more likely to agree that the disorder seems to “ breed true”. Schizophrenic patients are social set apart, where BPD patients cannot accept being isolated.

There are some psychoanalytical writers who agree with whether BPD in childhood is a valid diagnosis. The meaning of diagnostic terms has fundamentally changed in recent classifications. It used to be applied to children and adults with conditions thought to be intermediate between psychosis and neurosis. The psychoanalytical literature contains many descriptions of “ borderline” children with ego shortages and abnormal psychological defenses which would now be labeled as schizoid or schizophrenic.

In DSM III, “ borderline” was split into two categories; schizophrenic, connected to schizophrenia, and borderline disorder, which is the instability in behavior, relationships, identity, emotional experiences, impulsivity, suicidal behavior, oversensitivity to possible rejection, and vulnerability to psychotic episodes. Petti and Vela (1990) emphasize this distinction in their literature review of these conditions in childhood.

The usefulness of the BPD diagnosis in children remains doubtful, although seriously disturbed children often fulfill its criteria. Greenman at al (1986) applied Guderson’s Diagnostic Interview for Borderlines (DIB) retrospectively to the case notes of psychiatric hospitalized children age 6-12 years of age. Almost a third met the diagnostic criteria. Many BPD characteristics were found in other children as well. There are high rates of commonality in those diagnosed with having BPD, conduct disorder, overanxious disorder, ADHD,

and other personality disorders. The BPD children had been more delinquent, more aggressive, assaultive, hostile, irritable, and demanding. There most discriminating feature were episodes of psychotic thinking.

Biologically oriented clinicians make use of various types of medication in treatment of BPD individuals including antidepressants, antianxiety medications, mood regulation medications. In general, medication alone is mildly effective with patients improving from severely to moderately impaired. Improvement from the use of medication may come in the form of a reduction in unstable moods and impulsive behavior. Combinations of several therapeutic approaches may prove to be effective. (Gunderdson, 2011; Word Group on Borderline Personality, 2001). Mediation along with psychotherapy and family support could be useful in dealing with a BPD person’s multiple problems.