

International Encyclopedia of Rehabilitation

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Center for International Rehabilitation Research Information and Exchange (CIRRIE)
515 Kimball Tower
University at Buffalo, The State University of New York
Buffalo, NY 14214
E-mail: ub-cirrie@buffalo.edu
Web: <http://cirrie.buffalo.edu>

This publication of the Center for International Rehabilitation Research Information and Exchange is supported by funds received from the National Institute on Disability and Rehabilitation Research of the U.S. Department of Education under grant number H133A050008. The opinions contained in this publication are those of the authors and do not necessarily reflect those of CIRRIE or the Department of Education.

Borderline Personality Disorder

John S. Ogrodniczuk, Ph.D.
Department of Psychiatry
University of British Columbia
420-5950 University Boulevard
Vancouver, BC, Canada V6T 1Z3
Email: ogrodnic@interchange.ubc.ca

Carlos A. Sierra Hernandez, B.A.

Introduction

Borderline Personality Disorder (BPD) is a serious and prevalent psychiatric condition characterised by affective instability, marked impulsivity, and significant deficits in the capacity to work and maintain meaningful relationships. Patients with BPD struggle with a profound fear of abandonment, identity disturbances, and paranoid ideations. They are at risk for suicide, repetitive self-destructive behaviours, and comorbid mood, anxiety, and substance use disorders. Stern (1938) coined the term “borderline personality” to describe low-functioning, difficult-to-treat psychiatric patients whose symptoms lay between neurosis and psychosis. Thus, ‘borderline’ constituted a “broad category of patients whose psychology did not portray the chaos, disorganization, or defect in reality testing associated with psychotic patients, but also lacked the integration, stability of relationships, and regulation of affect associated with neurotic patients” (Kernberg and Michels 2009). Borderline personality disorder remains one of the most severe mental health problems in all of psychiatry.

Our understanding of borderline personality disorder began to take shape with the seminal work of Otto Kernberg (1967), who offered a perspective of ‘borderline’ as a syndrome and not as a default categorization of individuals that did not meet the neurotic or psychotic diagnosis. Following this breakthrough, Grinker and colleagues published the first empirical study of the Borderline Syndrome (Grinker et al. 1968). Subsequently, Gunderson and Singer (1975) provided the first clinical conceptualization of the disorder and attempted to define diagnostic criteria for BPD. By 1980, the construct of BPD was considered developed and validated to the extent that the disorder was included in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM III; American Psychiatric Association 1980). Since then, the disorder has captured the attention of scores of researchers and clinicians and has become the most studied personality disorder.

Clinical Presentation and Diagnosis

BPD is a complex clinical syndrome that has three core features: emotional instability, impulsive behaviours, and interpersonal turmoil. These basic features, as well as cognitive symptoms, are captured by the DSM-IV-TR diagnostic criteria for BPD (American Psychiatric Association 2000). The DSM-IV-TR considers 9 diagnostic criteria in total, but only 5 are required to make a diagnosis of BPD. Below, we briefly describe each of the 9 criteria.

Avoidance of Abandonment

People with BPD have a strong fear of abandonment, and are thus very sensitive to any cue (real or perceived) that they are being rejected or abandoned. This can include strong reactions to seemingly minor rejections by others (e.g., becoming enraged when someone cancels plans). People with BPD will often engage in behaviours designed to reduce concerns that they are being abandoned (e.g., frequently calling someone they are in a relationship with to "make sure" that there are no signs of impending abandonment). Unfortunately, this type of behaviour may actually create the feared outcome, leading to failed relationships and even greater fears of being abandoned.

Unstable and Intense Interpersonal Relationships

Individuals with BPD attach rapidly and profoundly to others, even early on in relationships. Their perception of intimacy is greater than that of the other persons, and in many cases, it is inappropriate. Moreover, their perception of others often alternates between over-idealization and devaluation, which is also known as splitting. Splitting refers to difficulty holding opposing thoughts, feelings, or beliefs about one self or others. In other words, positive and negative attributes of a person are not joined together into a cohesive set of beliefs. For example, a person with BPD may view her boyfriend as "good" one minute, but shift to seeing him as all "bad" or even evil the next. Because of splitting, it is difficult for individuals with BPD to recognize that "good" people sometimes do things imperfectly or make mistakes.

Identity Disturbances

Unexpected and sudden changes in goals, interests, preferences, and values are portrayed by persons afflicted with BPD. These unanticipated changes can range from relatively minor things, such as changes in appearance, to aspects central to the life of the individual, such as career paths and goals. These sudden changes usually accompany interpersonal turmoil. Realistic or unrealistic perception of abandonment, feelings of loneliness, emptiness, and hopelessness are usually the specific triggers of these changes. Identity disturbances in individuals with BPD usually reflect efforts to preserve a sense of self-worth in the presence of interpersonal turmoil.

Impulsivity

Impulsivity is a tendency to act quickly without thinking about the consequences of one's actions. Impulsive behaviour usually occurs in reaction to some event that has caused the person to have some kind of emotional response. Unprotected promiscuous sex, substance abuse, reckless driving, and binge eating are some examples of the impulsive behaviours seen in people with BPD. The impulsivity of individuals with BPD may be the consequence of their perception that they are not valued by others. As such, impulsive self-damaging behaviours are used to shield themselves from possible abandonment by a significant other. Alternatively, impulsivity in people with BPD may be caused by an inability to control motor responses (Nigg et al. 2005). These behaviours can increase the risk of suicide, and thus are of great concern.

Recurrent Suicidal Behaviour, Gestures, or Threats, or Self-Mutilating Behaviours

Emotional instability, behavioural impulsivity, and fears of abandonment put individuals with BPD at a high risk for self-harming behaviours. It is believed that suicidal behaviours, gestures,

or threats are meant to retain the attention and affection of significant others. Although these threats are usually regarded as manipulative tactics on the part of the individual with BPD, they are very difficult to ignore. Therefore, such behaviour is reinforced by the success of bringing the other person closer and eliminating the sense of abandonment. On the other hand, if the threat is ignored, an actual attempt at ending their lives might be carried out with a great probability of being successful.

Self-mutilating behaviour involves the direct and deliberate destruction or alteration of the body. This is also referred to as self harm or self injury. Examples of self harming behaviours include cutting, burning, needle sticking, and severe scratching. Self-mutilating behaviours are seen as coping mechanisms used to regulate negative emotions such as pain, loneliness, and extreme anger (Klonsky and Olino 2008). These behaviours are generally not conducted with the intent to commit suicide.

Affective Instability

A key feature of BPD is affective instability (also called emotional lability or affective dysregulation). People with BPD experience a lot of dramatic shifts in their emotional states. They may feel okay one moment but then feel angry, sad, lonely, afraid, jealous, or shameful moments later. These emotional shifts are intense and frequent. Changes in mood can last for hours and in rare cases for days. People with BPD experience changes in their affect more readily when confronted with interpersonal stress. This being said, it is rare that others can persuade these individuals out of their mood states. Instead, people with BPD may react with intense anger to the efforts of those attempting to provide some emotional relief.

Chronic Feelings of Emptiness

Persistent feelings of emptiness are often expressed by individuals with BPD. They are usually unable to express their aspirations and desires. To an outside observer, a person affected with BPD may appear as shallow and unmotivated. The feeling of emptiness and the inability to express what they desire in life brings upon feelings of anxiety and self-defeating behaviours. Individuals with BPD often believe that their feelings of emptiness will push significant others away, thus, increasing their fear of abandonment. This can elicit behaviours that are meant to attract others, while in reality these behaviours usually trigger interpersonal conflict.

Inappropriate, Intense, Uncontrollable Anger

Intense, inappropriate anger is one of the more troubling symptoms of BPD. Anger in BPD is deemed inappropriate because its level is usually more intense than is warranted by the situation or event that triggered it. For example, a person with BPD may react to an event that may seem small or unimportant to someone else (e.g., a misunderstanding) with very strong feelings and manifestations of anger (e.g., yelling or becoming physically violent). The stability of social relationships is constantly threatened due to the explosive nature of the anger.

Paranoid and Dissociative Symptoms

Paranoid thoughts and dissociative symptoms are common in BPD. They are typically transient and appear at times of extreme stress. Perceived abandonment from a significant other frequently serves as the cause of these symptoms. Paranoid thoughts of someone with BPD may involve

unrealistic ideas about others trying to harm him/her, or that everyone around is purposefully abandoning him/her as part of a conspiracy plan. Dissociative symptoms reflect depersonalization experiences whereby the person feels as an observer in his or her own life, and able to observe his or her life from outside their own body. Generally, by taking away the trigger of the stress it is possible to end the paranoid or dissociative experiences. Consequently, the paranoid and dissociative episodes characteristic of BPD patients differ significantly from those experienced by patients with psychotic disorders whose symptoms are more stable.

Epidemiology

Prevalence

In the general population, the prevalence of BPD varies from 0.4% to 1.8%, with a pooled rate of 1.1% (Korzekwa et al. 2008). The lifetime prevalence of BPD among primary care patients has been estimated at 6.4% (Gross et al. 2002). In clinical samples, BPD is usually the most common personality disorder. In outpatient samples, the rates of BPD have varied from 8% to 27%. More recently, reported rates of 9.3% to 18% have been reported, with a pooled rate of 11.9% (Korzekwa et al. 2008). Studies of psychiatric inpatient populations have reported rates of BPD at about 40% (Marinangeli et al. 2000).

Sex Distribution

Women are more often diagnosed with BPD compared to men, accounting for about 75% of the cases of BPD (Nehls 1998). A variety of explanations have been proposed to account for this disparity. For example, it has been suggested that the prevalence difference is due to differences in the presentation of symptoms among men and women. Johnson and colleagues (2003) found that women diagnosed with BPD tend to exhibit the more dramatic aspects of BPD symptoms such as intense and unstable emotionality and self-harm behaviours, while men present more subtle antisocial and impulsive behaviours. The prevalence difference may also reflect biases held by mental health providers when diagnosing BPD. Skodol and Bender (2003) argue that the general belief that BPD is more prevalent in women than in men creates a bias toward identifying the disorder in women while exploring other disorders for men. Recent studies from Norway, the United States, and Great Britain have challenged the notion of a sex disparity, finding little or no difference in the prevalence of BPD among men and women (Coid et al. 2006; Lenzenweger et al. 2007; Torgersen et al. 2001).

Comorbidity

BPD is highly comorbid with other personality disorders, as well as with a number of Axis I disorders, most notably depression, anxiety, eating disorders, posttraumatic stress disorder, and substance abuse (Zanarini et al. 1999). Zanarini and colleagues (Zanarini et al. 1999) found that BPD could be depicted by a pattern of what she called complex comorbidity, characterized by multiple comorbid diagnoses that included both internalizing and externalizing disorders. Consistent with this finding, Grilo and colleagues (Grilo et al. 1997) found that 86% of those meeting criteria for major depression and substance abuse were comorbid for BPD. This is particularly problematic in relation to the finding that treatment outcome studies of Axis I disorders that included comorbid BPD patients have found that BPD has detrimental effects on the treatment of the Axis I disorders (Clarkin 2006).

Aetiology

As with many other psychiatric disorders, BPD is widely regarded as the product of complex interactions among multiple factors, including genetic, neurochemical, neuroanatomical, and psychological factors. It is important to emphasize that there is considerable diversity in the literature with regard to etiological understandings of BPD, and that many conclusions remain speculative.

Genetic Factors

Evidence suggests that BPD runs in families. Through the study of biological relatives of people with BPD, it has been proposed that BPD is 4 to 20 times more prevalent among relatives of those with BPD compared to relatives of individuals not diagnosed with BPD (Links et al. 1988; White et al. 2003). Torgersen and colleagues (2000) provided support for the genetic vulnerability of BPD by studying monozygotic and dizygotic twins. In their study, the concordance rate of BPD among monozygotic twins was 35% compared to a 7% concordance rate among dizygotic twins. The high concordance rate of BPD found in monozygotic twins is strongly suggestive of genetics playing a role in the aetiology of BPD.

Neurochemical Factors

There is some support for neurochemical vulnerability in people with BPD. Specifically, two neurotransmitters have caught the attention of researchers: serotonin and norepinephrine. Serotonin has been found to be associated with aggression and impulsivity, whereby as levels of serotonin decrease, aggression and impulsive behaviours increase. Thus, it has been suggested that the characteristic aggressive and impulsive behaviours of BPD are the result of decreased or low levels of serotonin in the brain (Rinne et al. 2000). In much the same way, norepinephrine has been found to be related to aggressive behaviours in BPD. Coccaro et al (2003) found that males with lower levels of norepinephrine were more likely to be diagnosed with BPD and more likely to have a lifetime history of aggression.

Neuroanatomical Factors

Researchers have also found anatomical and physiological brain differences between those with and without BPD. Hyperactivity of the amygdala, a brain structure in charge of autonomic responses associated with fear, arousal, and emotional responses, has been found in people with BPD (Wingenfeld et al. 2010). Additionally, decreased functioning of the prefrontal and preorbital cortex in patients with BPD has been related to a decreased capacity of affect control (Kernberg and Michels 2009). These findings might explain the sensitivity to environmental stressors and the deep impact that these stressors have in the interpersonal relationships and the affect of individuals with BPD.

Psychological Factors

Consistently, individuals diagnosed with BPD report trauma and adversity as characteristic of their early lives. These individuals tend to differ from those without mental health concerns and from people diagnosed with other personality or mood disorders on reports of physical abuse, sexual abuse, and neglect during childhood (Ogata et al. 1990; Perry and Herman 1993; Weaver and Clum 1993; Zanarini et al. 2000). Similarly, people with BPD report more maternal and

paternal abandonment, more parental conflict, and higher rates of being raised by relatives or in foster homes (Bandelow et al. 2005).

The emotional and interpersonal instability characteristic of BPD may be the result of a failure to create secure attachments early in life. Bowlby (1973) suggested that there is continuity between the quality of our early relationships with caregivers and our adult interpersonal relationships. Therefore, the early unstable and ambivalent relationships consistently found in people with BPD are more likely to lead to insecure relationships in adulthood (Levy 2005).

Integrating parallel streams of thought from the fields of psychoanalysis, developmental psychology, and cognitive neuroscience, comprehensive theories of BPD have been developed by leading authorities in the field including Kernberg (1984), Fonagy (1991), and Linehan (1993). Although differing in certain aspects, these theories all attend to the issue of mentalisation. The concept of mentalisation describes the way humans make sense of their social world by imagining the mental states (e.g., beliefs, motives, emotions, desires, and needs) that underpin their own and others' behaviours in interpersonal interactions. Fonagy (1991) has elaborated a theory of how the capacity to mentalise develops in early childhood and, alternatively, how deviations from this normal developmental path result in severe forms of adult psychopathology, most notably BPD.

An Integrative Perspective

Oldham (2009) recently provided an eloquent and succinct summary of contemporary research on BPD, which integrates recent advances in our understanding of BPD. As Oldham explains, contributions of clinical and basic science research have helped us recognize that the "stress-vulnerability" model of disease is a useful guide for considering a biopsychosocial concept of BPD. Researchers have identified core heritable endophenotypes (a special kind of biomarker) of affective dysregulation and impulsive aggression (Siever et al. 2002). Additional findings that brain abnormalities can be identified by brain imaging techniques, and that inherent hyperactivity of the amygdala has been detected lend further support to the idea that borderline pathology is at least partially "hard-wired" (Donegan et al. 2003). The heritable "priming" for emotional overactivity, coupled with an impairment in the usual cortical capacity to downregulate or inhibit this limbic-driven emotionality or impulsivity (New et al. 2007), can interfere with the normal attachment process during development (which can be magnified when there is inadequate parental support). Such a disposition can arrest or distort integration of aspects of self and others, resulting in early onset and persistence of profound interpersonal difficulties that characterise those with BPD.

Natural Course and Prognosis

A common misconception is that BPD is a chronic, unrelenting mental health disorder - a sentence to a life of misery. Fortunately, evidence suggests otherwise. Most people with BPD improve with time (Paris 2007). About 75% will regain adaptive functioning by the age of 40 years, and 90% will recover by the age of 50 (Paris and Zweig-Frank 2001). A long-term study of the phenomenology of BPD (Zanarini et al. 2007) found that half of the 24 BPD symptoms assessed showed patterns of sharp decline over time and were reported at 10-year follow-up by less than 15% of the patients who reported them at baseline. The other 12 symptoms showed patterns of less dramatic decline over the 10-year period. Symptoms reflecting core areas of

impulsivity (e.g., self-mutilation and suicide efforts) and active attempts to manage interpersonal difficulties (e.g., problems with being demanding/entitlement and serious treatment regressions) seemed to resolve the most quickly. In contrast, affective symptoms reflecting areas of chronic dysphoria (e.g., anger and loneliness/emptiness) and interpersonal symptoms reflecting abandonment and dependency issues (e.g., intolerance of aloneness and counterdependency problems) seemed to be the most stable. Unfortunately, about 10% of people with BPD eventually succeed in committing suicide (Paris 2003). However, this outcome is difficult to predict, and 90% of those with BPD improve despite having threatened to end their lives on multiple occasions. We do not fully understand the mechanisms of recovery in BPD, but impulsivity generally decreases with age, and people learn over time how to avoid the situations that give them the most trouble (e.g., intense love affairs), finding stable niches that provide the structure they need. The development of effective treatments for BPD has also helped improve the prognosis of those affected with this disorder.

Treatment

Psychological Approaches

The mainstay of treatment for BPD is psychotherapy. Currently, four comprehensive forms of psychotherapy have been found to be effective in treating those with BPD (Hadjipavlou and Ogrodniczuk 2010). Two of these treatments (mentalisation based therapy, transference focused therapy) are viewed as psychodynamic in nature and two (dialectical behavioural therapy, schema focused therapy) are viewed as more cognitive behavioural in nature.

Mentalisation based therapy (MBT) is a complex psychodynamic treatment that is rooted in attachment theory and draws on concepts from cognitive psychology. Bateman and Fonagy (2006) describe MBT as “a focus for therapy rather than a specific therapy in itself,” employing “a reiteration of well-known basic therapy practices such as support, empathy, exploration and challenge” (2006). The focus of MBT is on enhancing mentalisation. As described above, mentalisation is the capacity to understand behaviour, one’s own and that of others, in terms of underlying mental states (for example, thoughts and feelings). MBT seeks to enhance this reflective capacity, which is posited to be disrupted in patients with BPD—particularly in the context of relationships that activate their attachment system—and underlies their disturbed interpersonal relatedness. The integration of one’s experience of one’s own mind with the view presented by the therapist is a key component of MBT.

Transference focused therapy (TFP) is a structured, psychodynamic approach, which emphasizes the integration of affect-laden mental representations of self and others that were originally derived through the internalization of attachment relationships with caregivers (Clarkin et al. 2006). Understanding how these internal representations become activated in the here-and-now relationship with the therapist is a key part of therapy. In this way, negative affect states, particularly aggression, are gradually controlled by understanding them as they unfold in the relationship with the therapist. TFP aims for full recovery, which encompasses reducing suicidality and self-injurious behaviour, improving behavioural control and affect regulation, and enhancing the ability to pursue gratifying relationships and meaningful life goals.

Dialectical behavioural therapy (DBT) conceptualizes the core problem of BPD as a habitual breakdown of patients' cognitive, behavioural and emotional regulation systems when they experience intense emotions (Linehan 1993). It is thought to facilitate change through the learning of emotional regulation skills in the validating treatment environment. DBT is a comprehensive treatment package that involves 4 modes of therapy: individual, in which the therapist oversees treatment integration and manages life-threatening behaviours and crises; group skills training, including mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness; skills generalization through telephone contact outside of normal therapy hours; and a consultation team to support therapists working with difficult clients.

Schema focused therapy (SFT) is an integrative therapy that brings together elements of cognitive therapy, behavioural therapy, object relations, and gestalt therapy. It focuses on patients' maladaptive schemas or pervasive patterns of thinking, feeling, and behaving that are developed during childhood and are associated with problems in one's identity and sense of self, interpersonal functioning, and affect regulation (Kellogg and Young 2006). In this approach, BPD is thought to involve regression into early maladaptive modes of being that are tied to specific schemas and associated intense emotional states. Therapy involves recognition of self-perpetuating processes that maintain maladaptive schemas and render them resistant to change. Identifying and changing maladaptive schemas is the main focus of treatment. Changing schemas involves both cognitive and experiential work. It also includes approaches such as limited adaptive re-parenting (emphasizing acceptance and validation) and empathic confrontation. Maladaptive behaviours outside of therapy are also addressed. Recovery is the goal of treatment, and is achieved when maladaptive schemas no longer dominate patients' lives, allowing them to implement more adaptive coping skills.

There are a number of other promising psychological treatments for BPD. Included among these are systems training for emotional predictability and problem solving (STEPPS) and nidotherapy. STEPPS is an adjunctive treatment program designed to supplement patients' ongoing care, be it psychotherapy or case management (Blum et al. 2008). STEPPS combines elements of CBT and skills training with a "systems" component, which actively involves people with whom the patient interacts regularly and has designated as their system members (family, significant others, and health care professionals). Nidotherapy refers to the systematic manipulation of the physical and social environment to help achieve a better fit for a person with personality disorder such as BPD (Tyrer and Bajaj 2005). There are five essential principles of nidotherapy: collateral collocation, the formulation of realistic environmental targets, the improvement of social function, personal adaptation and control, and wider environmental integration involving arbitrage (i.e., involving others in resolving change).

Pharmacological Approaches

Pharmacological treatments for BPD are limited in their effectiveness. In most cases, the use of drugs to treat BPD only 'manages' the symptoms by decreasing their impairment on the patient. Although some authors have suggested that mood stabilisers and second-generation antipsychotics may be effective for treating specific symptoms of BPD and associated pathology (Lieb et al. 2010), the National Institute for Health and Clinical Excellence (NICE 2009) guideline for BPD does not recommend drug treatment other than for the treatment of comorbid disorders. Specifically, these guidelines state that "drug treatment should not be used

specifically for borderline personality disorder or for the individual symptoms or behaviour associated with the disorder (for example, repeated self-harm, marked emotional instability, risk-taking behaviour, and transient psychotic symptoms).”

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