

BORDERLINE PERSONALITY DISORDER (BPD)

What is BPD?

Borderline Personality Disorder (BPD) is a most misunderstood, serious mental illness characterized by pervasive instability in moods, interpersonal relationships, self-image, and behavior. It is a disorder of emotion dysregulation. This instability often disrupts family and work, long-term planning, and the individual's sense of self-identity. While less well known than schizophrenia or bipolar disorder (manic-depressive illness), BPD is as common, affecting between .07 to 2% of the general population.

The disorder, characterized by intense emotions, self-destructive acts, and stormy interpersonal relationships, was officially recognized in 1980 and given the name Borderline Personality Disorder. It was thought to occur on the border between psychotic and neurotic behavior. This is no longer considered a relevant analysis and the term itself, with its stigmatizing negative associations, has made diagnosing BPD problematic. The complex symptoms of the disorder often make patients difficult to treat and therefore may evoke feelings of anger and frustration in professionals trying to help, with the result that many professionals are often unwilling to make the diagnosis or treat persons with these symptoms. These problems have been aggravated by the lack of appropriate insurance coverage for the extended psychosocial treatments that BPD usually requires. Nevertheless, there has been much progress and success in the past 25 years in the understanding of and specialized treatment for BPD. It is, in fact, a diagnosis that has a lot of hope for recovery.

What are the symptoms of BPD?

Borderline Personality Disorder Diagnosis: DMS-IV-TR Diagnostic Criteria

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood ** and present in a variety of contexts, as indicated by five (or more) of the following:

- 1) Frantic efforts to avoid real or imagined abandonment.

Note: Do not include suicidal or self-mutilating behavior*** covered in Criterion 5.

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

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

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

Note: Do not include suicidal or self-mutilating behavior*** covered in Criterion 5.

- 5) Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior***.

- 6) 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).

- 7) Chronic feelings of emptiness.
- 8) Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
- 9) Transient, stress-related paranoid ideation or severe dissociative symptoms.

*Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association

** Data collected informally from many families indicate this pattern of symptoms may appear as early as the pre-teens

***The preferred term is self-harm or self-injury

What are the causes of BPD?

At this point in time, clinical theorists believe that biogenetic and environmental components are both necessary for the disorder to develop. These factors are varied and complex. Many different environments may further contribute to the development of the disorder. Families providing reasonably nurturing and caring environments may nevertheless see their relative develop the illness. In other situations, childhood abuse has exacerbated the condition. The best explanation appears to be that there is a confluence of environmental factors and a neurobiological propensity that leads to a sensitive, emotionally labile child.

How is BPD treated?

A discussion of hospitalization and treatment techniques, including specialized treatment for BPD, follows:

A. **Hospitalization:** Hospitalization in the care of those with BPD is usually restricted to the management of crises (including, but not limited to, situations where the individual's safety is at risk). It is not uncommon for medication changes to take place in the context of a hospital stay, where professionals can monitor the impact of new medications in a controlled environment. Hospitalizations are usually short in duration.

B. **Medications** play an important role in the comprehensive treatment of BPD. For more on this topic, refer to the section on this website "Medications Used and Studied in the Treatment of BPD".

C. **Psychotherapy:** Psychotherapy is the cornerstone of most treatments for Borderline Personality Disorder. Although development of a secure attachment to the therapist is generally essential for the psychotherapy to have useful effects, this does not occur easily with the BPD diagnosed individual, given the intense needs and fears about relationships. The standard recommendation for individual psychotherapy involves one to two visits a week with an experienced clinician. The symptoms of the disorder can be as difficult for professionals to experience as those experienced by family members. Some therapists are apprehensive about working with individuals with this diagnosis.

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There are currently three major psychotherapeutic approaches to treatment of BPD:

1. Psychodynamic
2. Cognitive-behavioral
3. Supportive

D. Group Modalities: DBT and CBT interventions are often like classes with much focus and direction offered by the group leader(s) and with homework/practice exercises assigned between sessions based on the material presented during the session. DBT, for example has a manual that is followed each week where both the lectures and the practice exercises are put together for easy access. Some patients with BPD may be resistant to interpersonal or psychodynamic groups which require the expression of strong feelings or the need for personal disclosures. However, such forums may be useful for these very reasons. Moreover, such groups offer an opportunity for borderline patients to learn from persons with similar life experiences, which, in conjunction with the other modalities discussed here, can significantly enhance the treatment course. Many individuals with BPD find it more acceptable to join self-help groups, such as AA. Self-help groups that provide a network of supportive peers can be useful as an adjunct to treatment, but should not be relied on as the sole source of support.

E. Family Therapy: Parents, spouses and children bear a significant burden. Often, family members are grateful to be educated about the borderline diagnosis, the likely prognosis, reasonable expectations from treatment, and how they can contribute. These interventions often improve communication, decrease alienation, and relieve family burdens. Some mental disorders, as in the treatment of schizophrenia, require close family involvement in the treatment process to be optimally effective. There are now preliminary research data that suggest that family involvement is also very important in the effective treatment of borderline disorder.

Several organizations offer education programs and/or support to families challenged with mental health issues. The National Alliance on Mental Illness (NAMI), The National Education Alliance for Borderline Personality Disorder (NEA-BPD), The Depression and Bipolar Support Association (DBSA) and the Mental Health Association (MHA) offer programs across the nation.

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