

Borderline Personality Disorder

Struggling
Understanding
Succeeding

Colleen E. Warner, PsyD

PSI HEALTHCARE

Copyright © 2004

PESI HEALTHCARE, LLC
PO Box 1000
200 Spring Street
Eau Claire, Wisconsin 54702

Printed in the United States of America

ISBN: 0-9749711-0-3

PESI HealthCare strives to obtain knowledgeable authors and faculty for its publications and seminars. The clinical recommendations contained herein are the result of extensive author research and review. Obviously, any recommendations for patient care must be held up against individual circumstances at hand. To the best of our knowledge any recommendations included by the author or faculty reflect currently accepted practice. However, these recommendations cannot be considered universal and complete. The authors and publisher repudiate any responsibility for unfavorable effects that result from information, recommendations, undetected omissions or errors. Professionals using this publication should research other original sources of authority as well.

Continuing Education Self Study Credit Available: PESI HealthCare provides self study credit for this publication. Please see the information contained in the back of this book for details.

**For information on other PESI HealthCare products
and seminars, please call 800-843-7763**



www.pesihealthcare.com

Acknowledgments

I wish to express my deepest gratitude to the colleagues, friends, and family who have supported me in this and many other endeavors. Thank you to Michael Olson and PESI Healthcare for having the faith in me to pursue this work. Thanks to Dr. Christopher Babbitt and the Staff of Northwest Counseling in New Richmond, Wisconsin for their flexibility and support. Special appreciation to the Cumberland Memorial Library Staff for their assistance in obtaining reference materials.

Not a word would have been written without the encouragement and support of dear friends and colleagues Cindy O'Keefe and Karen Kaufman. Thank you to Lydia Vitort of Systemic Solutions LLC for keeping me realistic and on task. Most of all for being a good friend in the process. During the writing process I was supplied with encouragement and great coffee from the Women's Entrepreneurs Group and Railway Espresso of Spooner, Wisconsin. Finally, thank you to my life partner, Michael, who makes me feel like I can do anything, (but I don't have to!) and to our children who make me laugh and remind me what is most important.

About the Author

Dr. Colleen Warner is a licensed psychologist in the state of Wisconsin and a member of the National Registry of Health Services Providers in Psychology. She holds a Bachelors of Music Education in Music Therapy from the University of Kansas and completed her Doctorate of Psychology at the Minnesota School of Professional Psychology (*Argosy University*).

Dr. Warner provides training nationally for PESI Healthcare on the topic of Borderline Personality Disorder. Her years of experience, passion, and empathy combined with her “down to earth” presentation style and sense of humor have been appreciated by professionals across the country. She draws on her experience as a supervisor in rural mental health clinics where her caseload often consisted of the most difficult to treat clients, including those with Borderline Personality Disorder. Dr. Warner provides supervision and consultation to other practitioners struggling with the challenges of treating Borderlines and thus, has developed an understanding of the health care provider’s frustration elicited by these difficult cases.

Currently in private practice, Dr. Warner continues to have an interest in clients with Borderline Personality Disorder and other Co-Morbid conditions. Dr. Warner also conducts training in the areas of Suicide Prevention, Crisis Management, Dealing with Difficult Patient Behavior, and Mental Health Topics for School and Medical Professionals.

Dr. Warner is available for consultation and as a presenter on a variety of topics at: drcolleen@charter.net.

Table of Contents

<i>Preface</i>	<i>xi</i>
Chapter 1: The Struggle: Living with Borderline Personality Disorder	1
The Provider's Struggle	1
The Client's Struggle	3
The Community's Struggle	4
Chapter 2: The Struggle to Define Borderline Personality Disorder	5
Historical Foundations of BPD	5
DSM-IV Diagnostic Criteria	7
Onset & Pervasiveness	8
Symptoms	9
Assessment Tools	12
Prevalence of BPD	14
Prognostic Indicators	16
Comorbidity and Differential Diagnosis	16
Case Examples	22
Chapter Summary	26
Chapter 3: Understanding the Etiology of the Disorder	29
Dialectic Behavioral Theory Regarding the Etiology of BPD	30
Chapter Summary	36

Chapter 4: The Biological Struggle: Neurobiological Findings in Borderline Personality Disorder	37
Neuropsychological Test Findings	37
Brain Imaging and Chemical Findings	38
Factors Affecting Neurobiological Development	39
Genetics/Temperament	39
Attachment	40
Trauma	41
Clinical Implications of Neurobiological Findings	42
Chapter Summary	43
Chapter 5: The Struggle to Stay Alive: Dealing with Suicidal & Parasuicidal Behaviors	45
Parasuicidal Behavior in BPD	45
Functions of Parasuicidal Behavior	47
Parasuicidal Behavior as a Means of Regulating Emotions	48
Parasuicidal Behavior as a Means of Communication	51
Parasuicidal Behavior as a Means of Relieving Dissociation	52
Parasuicidal Behavior as a Means of Stopping Racing or Obsessive Thoughts	53
Parasuicidal Behavior as a Means of Gaining Control	53
Assessment of Parasuicidal Behavior	54
Suicide Risk Factors	54
Assessment of Risk Factors	55
Assessing Lethality	61
No Harm Contracts	62
Chronic Versus Acute Risk	63
Documentation of Risk Assessment	65
Chapter Summary	67
Chapter 6: Succeeding: Effective Treatment for Borderline Personality Disorder	69
Recovery Rates & Prognostic Indicators	69
Psychopharmacological Approaches	71
Other Biological Treatments	73

Psychotherapeutic Approaches	73
Commonalities Between Approaches	73
Summary of DBT Efficacy Research	74
Chapter Summary	75
Chapter 7: One Success Story: An Understanding of DBT	77
History of DBT	78
Principle vs. Protocol Driven Treatments	80
DBT Assumptions about Patients & Therapy	81
Components of the DBT Program	81
The Skills Training Modules	83
Mindfulness Skills	84
Emotion Regulation Skills	84
Interpersonal Effectiveness Skills	86
Distress Tolerance Skills	86
Diary Cards	88
“Consultant to the Patient” Strategy	89
Dealing with Phone Calls & Emergencies	89
Common Problem Callers	90
Chapter Summary	94
Chapter 8: Understanding the Clinician’s Struggles	97
Recognizing Countertransference	97
Rescue Fantasies	98
The Total Responsibility vs. Complete Uselessness Dialectic	99
About Splitting	99
Changing Unhelpful Thoughts	100
Preventing Burnout	101
Chapter Summary	102
Chapter 9: Redefining Success	105
Redefining Success for the Client	105
Redefining Success for the Clinician	106

Appendix A: 50 Things You Can Try Instead of Hurting Yourself	109
Appendix B: Risk Assessment Worksheet	111
<i>Resources</i>	115
<i>References</i>	117

Preface

While clients with Borderline Personality Disorder (BPD) are thought to be some of the most difficult to work with, clinicians with the least experience and training often wind up with a disproportionate number of borderlines on their caseloads. More experienced clinicians set limits on the number of Borderlines on their caseload, while naïve and eager new professionals take them on. In addition, these demanding clients often fill inpatient units, group homes, and case management programs where staff providing the bulk of direct services may have minimal experience or training in dealing with the complexities of BPD.

Like so many novices I eagerly took on Borderline clients with minimal understanding of their complexities. I entered the mental health field thinking that if I just cared enough I could somehow be more effective with clients than my predecessors. The problem was simply that other clinicians were not motivated or dedicated enough or were “too judgmental.” How ironic it is now to see that it was I that was being judgmental! It’s hard to admit I was ever this naïve and arrogant, but I doubt I am the first (or last) clinician to have such grandiose and self-important fantasies.

My ideals of “caring enough” were most quickly shot down in working with my first client with Borderline Personality Disorder. No amount of caring could ameliorate her self-abusive patterns and if anything, at times, my empathy seemed to make it worse. What I needed was not “empathy,” it was skills. What she needed was not “caring,” it was skills.

At the time, the field didn’t offer much help. Training in dealing with Borderlines was minimal and many people considered Borderline clients “untreatable.” This thinking was particularly unhelpful in inpatient and community mental health settings where chronic struggles with self injury and repeat hospitalizations forced the community to “try something” to help these clients. The “psychobabble” of the

analytic theories was confusing to me at best and even when I could understand it, I was left wondering “Okay, but what do I *do*?”

As a result, the skills I did develop were mostly a result of trial and error experience and good advice from experienced clinicians with good instincts. Unfortunately, even the skills I learned in terms of “setting boundaries” and “avoiding manipulation” seemed to backfire at times. I felt like I was “experimenting” on each client. I was usually left feeling incompetent. I needed a better way of understanding these people and I needed to know what skill to use when.

Answers began to come in graduate school when we were required to read Marsha Linehan’s pivotal book *Cognitive Behavioral Therapy for Borderline Personality Disorder*. Finally, a theory that made sense to me and wasn’t so judgmental. I was eager to put it into practice. Unfortunately, in the rural community mental health center where I worked, the resources to do a full DBT program didn’t exist. Furthermore, I was one of very few providers who had even heard of DBT. Nonetheless I began applying the principles to the best of my ability and found that even if they didn’t always seem to work, at least I found myself less frustrated!

A new struggle came when I was promoted to supervisor. Now not only was I supposed to help the client, but it was my role to help the clinician as well. How could I share what I had learned, especially with seasoned clinicians who had years of experience on me, and had developed an attitude of “I don’t do Borderlines!”

I had to start at the beginning. I had to change attitudes. I had to take Linehan’s useful but dense and intensive work and break it down into simple and brief steps that could be presented in a few minutes at staffing. I needed to do it in an understandable and down to earth language that clinicians could understand and remember. Most importantly I needed to be patient. Like the work with Borderline clients, change would happen but it would be slow and tedious.

This book is both a result of and part of that change. It is intended to be a resource to both clinicians with experience and new comers to the field. It is a humble attempt to share experiences, knowledge, and most importantly, attitudes that I have found useful in treating clients with this disorder. More than anything it is an attempt to give providers a way of understanding Borderlines that will make the work less frustrating and with any luck, more effective.

Finally, it is a tribute to those clients who have been willing to work with me. For as difficult as this disorder may be for clinicians it is even more difficult to live with it twenty-four hours a day. The clients I have known with BPD are amongst the strongest, bravest, most resourceful and creative people I've known, and it has been honor to share with them their struggles and successes.

AUTHOR'S NOTE

The clients described in this book are composites based on the author's experience. Every effort has been made to conceal the actual identities of clients. Any similarities between these descriptions and actual individuals is purely coincidental and likely a result of the commonalities of experiences these clients share.

1

The Struggle: Living with Borderline Personality Disorder

THE PROVIDER'S STRUGGLE

"I left graduate school naïve and full of empathy . . . I knew I'd met my first Borderline when I had the urge to strap her to a nuclear rocket and ship her straight to the moon."

"I enjoyed your conference immensely, but will still refer borderlines out. I have practiced 25 years and find them to be extremely difficult and dangerous."

The above comments by providers of human services illustrate the frustration, fear, and avoidance elicited by clients with Borderline Personality Disorder (BPD). As I travel conducting trainings I ask providers to begin by describing their immediate reactions to the term BPD. Consistently, responses include such descriptions as "difficult," "gamey," "manipulative," "demanding," "self-injurious," "suicidal," "untreatable," "dramatic," "emotional," and "unpredictable." One survey of mental health providers indicated that 84% of these providers reported that dealing with Borderlines was more difficult than any other patient group (Cleary, Siegfried, & Walter, 2002). Providers not only express attitudes that they will be unable to be helpful to such individuals, but also fears that they will be sued or harassed by these clients.

2 *Living with Borderline Personality Disorder*

Such descriptions, even if true (and I would argue that most are not true), provide little hope or guidance as to what to do in dealing with these individuals. Thus, providers face these clients not only lacking effective strategies, but also impaired by negative attitudes that do nothing to create trust or positive regard between the client and provider. Such attitudes only lead to behaviors which further perpetuate the Borderline's feelings of alienation and lack of trust. Further, they leave the provider feeling inadequate, frustrated and helpless. The result is a culture which reinforces a view of working with these clients as an unending and miserable struggle.

Many providers choose to deal with these struggles by avoiding working with Borderlines altogether. One participant indicated "*I was advised by the malpractice folks to refer all borderlines to my worst enemies.*" While providers in private practice may have the luxury of choosing not to work with Borderlines, most human services providers, especially those in community mental health, emergency services or inpatient settings, cannot avoid contact with Borderlines. Further, clients with BPD can look deceptively well during first contacts and thus, it is often not apparent to the provider that he or she is dealing with a Borderline until problems develop.

While professionals certainly should know their own limits and set boundaries about what clients they feel competent and capable of treating, it is ultimately unhelpful to "give up" or avoid working with these individuals. Imagine if all brain surgeons gave up conducting surgery because it was difficult, has a high mortality rate, and high risk of law suit! Instead some individuals choose this profession and learn to manage the stress and risk of such difficult work. Likewise, there is a need for brave and innovative professionals who are willing to take on the challenges and risks inherent in treating these difficult clients. These individuals need to be equipped with both effective strategies and new attitudes toward these clients in order to be more successful and also to make the work more pleasurable and less stressful.

Research supports the need and desire of mental health providers for assistance in becoming more effective with these individuals. In one study, mental health staff completed a survey with regard to their knowledge and attitudes toward clients with BPD (Cleary, Siegfried, & Walter, 2002). 85% of the providers reported having contact with Borderline clients once a month or more frequently. 32% reported daily contact with Borderlines. 80% of providers reported feeling that dealing with clients who have BPD is

“moderately” to “very” difficult. 84% of these providers felt that dealing with Borderlines was more difficult than any other patient group. 95% indicated a willingness to gain further education and training in the management of these clients.

Borderline Personality Disorder: Struggling, Understanding, Succeeding is intended to provide such training in language easily understandable to clinicians of all backgrounds. The title is intended to describe not only the process the individual with BPD goes through in recovering, but also the process providers must go through to live with and treat BPD as well. The struggling client with BPD must learn to understand her behavior in order to change it. Likewise, the struggling clinician must learn to understand the Borderline client before they will be able to provide successful interventions.

THE CLIENT'S STRUGGLE

*“Everyone expects me to have goals for the future.
I'm just struggling to survive each day.”*

—Client with BPD

Such is the struggle of persons with Borderline Personality Disorder (BPD). Plagued by chronic urges to harm themselves, overwhelming emotions, impulsivity, and/or conflictual relationships, every day, and sometimes, every moment, is a struggle to get through. The tasks of every day life which most people seem to handle with minimal discomfort leave the Borderline client feeling confused, overwhelmed, and inadequate.

Each Borderline's struggle and experience is unique, yet there tend to be common themes to the Borderline experience. Life has almost always been hard for these individuals. Their backgrounds are often filled with chaos, instability, trauma, and/or abuse. Even those with a relatively stable family of origin have erratic relationships with their loved ones. Impulsive behaviors such as alcohol and drug use, spending, and emotional outbursts create further chaos in their lives. Many are chronically angry and depressed and vacillate between blowing up at others and turning in on themselves.

Compounding these difficulties are the natural, but unhelpful reactions and attitudes of those around them. Loved ones, providers, and the community tend to view these individuals' erratic behavior as “manipulative,” “attention seeking,” and “selfish” implying that

4 *Living with Borderline Personality Disorder*

they want to live this way and could easily change things if they would just “try harder.” The prevailing attitude seems to be that these individuals “get off” on making life miserable for everyone. Such attitudes only leave the client feeling more confused, inadequate, isolated and ashamed. Further, even if such attitudes are true, they provide little information as to how to help these individuals.

THE COMMUNITY'S STRUGGLE

Such reactions by those who come into contact with Borderlines are not without justification. Persons with BPD create difficulties for those who try to live with them and help them. These individuals are perpetually in crisis yet do things that exacerbate their crisis. When others try to assist they either reject help or become completely dependent. They tend to idealize or devalue others resulting in a view of others as “all good” or “all bad.” This results in a “no win” situations for those who care for individuals with BPD. As a result many who start out eager to help become frustrated, angry and exhausted.

Further, these clients tend to seek assistance from multiple sources leading to an enormous amount of energy and resources being devoted to their care. Families, churches, social service departments, police departments, medical providers and others all struggle in their contacts with Borderlines. They tend to be high utilizers of mental health and medical services, and are often involved in the legal or social service systems because of their impulsive and sometimes aggressive behavior. Their difficulties in interpersonal relationships can create havoc in religious communities.

Thus, it is critical that not only mental health therapists but also other human service professionals be educated regarding the dynamics of BPD and effective ways of understanding and intervening with these individuals.

2

Struggling to Define Borderline Personality Disorder

Borderline Personality Disorder is a controversial, complex topic. Just defining it is like trying to catch a fish with your bare hands, blindfolded and in the rain.

*Stop Walking on Eggshells: Taking Back Your
Life When Someone You Care About Has
Borderline Personality Disorder*
—Randi Kreger

Not only is it difficult to live with BPD, it is difficult to define and explain the disorder as well. Adding to this difficulty, the term “Borderline” itself provides no useful information as to the characteristics of this disorder. Why is it called “Borderline” and what does that mean?

HISTORICAL FOUNDATIONS OF BPD

The term “Borderline” first appeared in the psychoanalytic literature in the early 1900s. However, literary examples of individuals who would likely meet criteria for the diagnosis date back to at least the 16th century (Lawson, 2002). Further, BPD has been reported to be present in many cultures around the world (APA, 2001).

Originally, analysts used this term for clients who appeared appropriate for psychoanalysis but later proved to have difficulty with the process. Early psychoanalytic theoretical descriptions of

6 *Defining Borderline Personality Disorder*

the “Borderline” fell into two categories. One group saw these clients as having a mild form of schizophrenia or as “borderline” schizophrenics. The other group saw them as a distinct group who were neither neurotic nor psychotic but operated psychologically on a level between psychosis and neurosis. Thus, they described these clients as being in the “border” between psychosis and neurosis.

Early writings describing these clients were common as they did not seem to fit the usual psychodynamic theories and did not respond to treatment as expected. In 1967, Otto Kernberg wrote a seminal paper entitled “Borderline Personality Organization” which integrated these earlier writings and provided a comprehensive framework for understanding the disorder. This framework was based on sophisticated psychoanalytic theory that is difficult to understand for those who are not analytically trained. Nonetheless, this work integrated the earlier discussions and provides an interesting historical reference for the understanding of the disorder.

In spite of its prevalence, BPD did not gain official diagnostic status until 1980 when, like the other personality disorders, it was officially adopted as a diagnostic entity in the DSM-III nomenclature. At that time there was little debate regarding the disorder’s presence or features but great debate as to what it should be called. The following excerpt from Theodore Millon’s June 1978 memo to the DSM-III committee summarizes the concerns with this label (Millon, 1981).

I would like to register my strong agreement with the point raised . . . to the effect that the label, borderline is perhaps the most poorly chosen of all the terms selected for the DSM-III. I know a small segment of the profession feels that this is the most apt descriptive term for this population, but frankly, I find the word, borderline, to mean, at best, a level of severity and not a descriptive type . . . Unless the word is used to signify a class the borders on something, then it has no clinical or descriptive meaning at all . . .

I would like the Personality Committee to reassess the term borderline . . . other alternative labels that might be considered are the following: ambivalent personality disorder, erratic personality disorder, impulsive personality disorder, quixotic personality disorder, etc. Any one of these would be far preferable than the meaningless borderline label.

As Millon indicates, unless one is using the term to describe a level of functioning in relationship to some other level of functioning, the term “borderline” itself is meaningless. However, because early use of the term had become associated with a class of clients in the professional community, the term stuck. It remains to be seen whether or not the term will be eventually changed to something more descriptive and consistent with current theoretical understandings.

Unfortunately, imprecision in nomenclature only adds to the struggle of these clients because their diagnostic label adds nothing to the understanding of their concerns. Thus, using this term with clients and their loved ones is seldom useful unless it is accompanied by a concrete description of the kinds of struggles such clients experience.

This became increasingly apparent to me as I began traveling to speak on BPD. Friends without mental health training often ask me what I speak about. If I respond “Depression” or “Antisocial Personality Disorder,” the response is often “That’s interesting, you know I knew someone who . . .” If I respond “Borderline Personality Disorder,” I am met with looks of confusion and the topic is abruptly changed.

Friends with mental health training however, respond with knowing looks and groans or sighs. Ones’ first experience with a Borderline’s angry outburst or self injury is something few clinicians forget. But while mental health providers tend to have an intuitive understanding of the disorder, they often cannot articulate a concrete and accurate description of its characteristics. Unfortunately this can lead to misdiagnosis and inaccurate judgments about clients. So how do we concretely define BPD?

DSM-IV DIAGNOSTIC CRITERIA

To understand BPD more clearly, one must first turn to the diagnostic criteria as described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). The reader is referred to the DSM-IV for the specific criteria which will be summarized here.

ONSET & PERVASIVENESS

One of the most important features of BPD is the pervasiveness of the symptoms in the client's life. Many individuals may at one time or another experience one or more of the nine diagnostic criteria but for those with BPD these symptoms are chronic and pervasive. Often misdiagnosis may occur when an individual, at some crisis point in their life, exhibits several of the symptoms but historical information reveals that this is an isolated episode rather than part of a "pervasive pattern." Thus, it is critical to obtain adequate historical information in order to make an accurate diagnosis.

For this reason, the diagnostic criteria includes a statement regarding the onset and prevalence of such symptoms.

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. (emphasis added)

Note that the instability of relationships, self-image, and affects must be a "pervasive pattern." In other words this isn't a one time conflictual romantic relationship or a temporary disruption in self-concept or mood. These clients have *chronic* or episodic difficulties in *many* relationships. Unlike brief disruptions in self-image brought about by life changes or traumatic events, these clients continuously have difficulty defining who they are and/or have a pervasive negative self-concept. They have difficulty regulating their emotions not only under stress but in the face of seemingly minor events as well. These difficulties do not just occur in isolated situations such as school or home but "in a variety of contexts."

Also important is the onset of the symptoms. By definition, one does not suddenly develop BPD at age 40! This pervasive pattern must be present "by early adulthood" which means somewhere in the late teens or early 20s. Thus, such symptoms are present by the time the individual has developed a characteristic way of being in the world or "personality." Further, by definition, these symptoms are not just part of a "stage" in the client's development but are a well established pattern of interacting with the world.

Sometimes these criteria are erroneously interpreted to mean that adolescents can not be diagnosed as having a personality disorder. While caution should be used in labeling a teenager as borderline because of the stigma attached to the label, there are cases

where such a label may be appropriate. However, here again, the pervasiveness of the pattern is the key consideration. In addition one must consider whether or not the symptoms are part of a developmental process or if they have become an established manner of interacting with the world.

For example, many would argue that most girls in Jr. High experience affective instability, impulsivity, identity disturbance, and unstable relationships! With the onset of puberty comes moodiness and questions of “Who am I?” Adolescents may change clothes, styles, interests, and friends at the drop of the hat. A friend or boyfriend may be “wonderful” one day and “terrible” the next. However, these explorations of self usually resolve into a general sense of themselves, their likes and dislikes, and their companions.

For the Borderline individual such inconsistencies are not just temporary explorations but chronic difficulties. If such difficulties persist without resolution, and are accompanied by the other symptoms, then a diagnosis of BPD may be appropriate for the adolescent. Thus, I tend to use the diagnosis only in later adolescents and only when there is a preponderance of evidence in the absence of alternative diagnosis.

SYMPTOMS

The individual diagnostic criteria are generally self-explanatory, however, it can be beneficial to understand ways in which such symptoms typically manifest themselves in BPD. It should be noted that each set of symptoms may be present with other disorders and it is only when several (5 of 9 criteria) are met in a pervasive pattern that the diagnosis is warranted.

Criterion 1 and 2 are related to relationship issues and include “frantic efforts to avoid real or imagined abandonment” and “a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.” Linehan (1993) refers to these two symptoms as “interpersonal dysregulation.”

Clients with BPD have difficulty maintaining long term relationships. They are very sensitive to perceived rejection and will attempt to “be good” to avoid the loss of the relationship. Families, churches, social service departments, police departments, medical providers and others struggle in their contacts with Borderlines.

10 *Defining Borderline Personality Disorder*

Frequently, these clients will excessively ask a provider or loved one “Are you mad?” They fear that if they have angered an important person he or she will leave them emotionally or physically. A therapeutic response in this situation would be to honestly describe one’s feelings but include reassurance that being angry doesn’t mean you don’t care or will leave. The Borderline needs reassurance that in spite of your emotional state you will continue the relationship with them.

A common example of Criterion 2 is the Borderline who comes into the new therapist’s office and complains continuously about a prior provider or another individual. This is usually followed by generous praise and statements about how much more understanding and trustworthy you are. At that point the other individual is “all bad” and you are “all good.” While this feeds our countertransference and desire to be appreciated, rest assured that eventually you will do something that will knock you off your pedestal. A therapeutic response to this situation is to try to make observations about both the good and bad in others and in ourselves. I often thank the client with BPD for their compliments and then proceed to warn them of my human frailties. I advise them that at some point I will disappoint and/or anger them.

Criteria 3 and 7 have to do with issues of identity and fulfillment. Linehan (1993) refers to these criteria as “dysregulation of the self.” However, the client with BPD does not walk into your office and announce “I have a markedly unstable self-image!” Instead there will be comments like, “I don’t know who I am.” “When I’m in a room I just watch everyone else and try to figure out how to act.” Further, they will have difficulties completing activities such as goal setting, self collages, lists of things they like, lists of traits about themselves, or autobiographies as these activities require a sense of themselves and their identity. Feelings of emptiness are often described by these clients in the following manner. “I feel like there’s a black hole inside of me that will never be filled.” “I’m just numb.” “I know people love me but I just can’t feel it.”

Criteria 4 and 5 have to do with impulsive behaviors that are in some way self destructive including self injurious behavior. Linehan (1993) refers to these symptoms as “behavioral dysregulation.” This can include things such as chemical use, driving too fast, or promiscuity, but can also include self destructive behavior such as quitting jobs or school impulsively or abruptly discontinuing medication or therapy. Two such types of behavior must be present to meet criteria 4.

Criterion 5 is specific to suicidal or intentionally self-injurious behavior. It is important to note that BPD is the only psychiatric disorder in which self injury is part of the diagnostic criteria. Not all Borderlines self injure but a high percentage (about 80%) engage in this behavior at some point. Likewise, not everyone who self injures is Borderline. Nonetheless, self-injurious behavior is often thought of as the hallmark of BPD. Interventions for self-injurious behavior will be discussed in detail in Chapter 5.

Criteria 6 and 8 have to do with mood related symptoms. Linehan (1993) calls these symptoms “emotional dysregulation” and states that this problem underlies all the other symptoms which occur in BPD. Borderlines tend to be described as “moody” individuals who “can be fine one minute and fly into a rage the next.” Many Borderlines have particular difficulty with the expression of anger. Either they are chronically angry and irritable and/or they have episodic angry outbursts. Often significant others describe them as being “like Dr. Jekyll and Mr. Hyde.” It is important to note that such mood symptoms tend to be of relatively short duration and are often in reaction to interpersonal issues.

Linehan (1993) refers to criteria 9 as “cognitive dysregulation” which includes the transient cognitive symptoms of dissociation and paranoia. These symptoms tend to be present more in times of acute stressors rather than the chronic presence in the psychotic disorders. Frequently the dissociation with take the form of “checking out” during a session as indicated by the client staring at the floor or into space with a blank look. Clients will also describe dissociating either prior to or during episodes of self injury. “I felt like I was disappearing and it (cutting) brought me back.” Or “I don’t feel anything when I’m doing it (burning). It just makes me numb.”

The paranoia identified here can take the form of bizarre delusions (e.g. “The FBI is monitoring me through my t.v.”) however, these are much less common in persons with BPD. More common is a heightened sensitivity to and over personalization of interpersonal stimuli (e.g. “I saw them talking in the corner and I know they’re talking about what a loser I am.”). Borderlines will also sometimes report auditory hallucinations which most often take the form of self critical statements or command hallucinations telling the client to harm themselves.

Again, while individuals *without* BPD may at times exhibit any or all of these traits, the individual with BPD exhibits a *chronic and pervasive pattern* of 5 or more of these traits and this pattern was present by *early adulthood*. Understanding these traits can be help-

12 *Defining Borderline Personality Disorder*

ful to providers who need to communicate information to the physician or psychologist making the diagnosis. Further, because many of these traits can be present or similar in other disorders it is important to understand the full diagnostic picture to avoid misdiagnosis. Finally, it can be helpful for the individual dealing with the Borderline to understand that these traits are part of their illness, not conscious attempts to manipulate or cause problems.

ASSESSMENT

Obviously, the initial assessment of these individuals must first focus on suicide risk and issues of safety to determine an appropriate level of care. These issues will be further addressed in Chapter 5. After this risk assessment, a standard diagnostic interview including a thorough psychosocial history is warranted. Because the disorder is defined by a pervasive pattern of interacting with the world, a thorough history is necessary to establish the presence of the diagnostic criteria over time and beginning by early adulthood. For this reason, assessment should not only consist of one or more clinical interviews with the client, but obtaining records of prior treatments and consulting with collateral sources of information (family, friends, etc.) as well.

There are some diagnostic tools which may be useful in confirming the diagnosis but frankly these are seldom necessary if a good diagnostic interview has been completed and records obtained. The exception to this may be for research purposes when the diagnosis must be standardized and corroborated or in settings where a self administered assessment tool may expedite the interview in an attempt to deal with time limitations. Table 1 summarizes some of the more common assessment tools specific to BPD as well as findings on some of the most commonly used psychometric assessment tools.

Table 1: Summary of Assessment Tools for Diagnosing BPD

Assessment Tool	Source	Type	Comments
Borderline Personality Disorder Severity Index	Leichsenring, (1999).	53 item, True/False Self Report	Based on Kernberg's Psychodynamic formulation of BPD and compatible with DSM-IV diagnostic criteria. Provides a cut-off score for diagnosis. Good reliability, sensitivity, and specificity.

Table 1: Summary of Assessment Tools for Diagnosing BPD (Continued)

Assessment Tool	Source	Type	Comments
Borderline Personality Inventory	Arntz, van de Hoorn, Corneli, Verheul, van den Bosch, Wies, de Bie (2003)	Semistructured interview.	Good reliability and internal consistency. Good discriminant validity. Good sensitivity to improvement making it appropriate for outcome research.
Diagnostic Interview of Borderline Personality Disorder (DIB-R)	Zanarini, Gunderson, Frankenburg & Chancey, (1989)	1-hour semi-structured interview based on DSM-II-R Criteria	Strong Reliability, Sensitivity & Specificity for the Diagnosis.
Personality Assessment Inventory (PAI)	Morey, (1991)	344 item inventory	Good reliability and validity data. 22 scales including four borderline feature subscales: Affective Instability, Identity Problems, Negative Relationships, and Self-Harm.
Millon Clinical Multi-Axial Inventory III (MCMI)	NCS	Self-report questionnaire comprised of True/False Statements	Based on Millon's taxonomy for personality disorders. Inadequate convergent or discriminate validity.
Minnesota Multiphasic Psychological Inventory (MMPI-2)	NCS	567 True/False Statements	No clear pattern of results that distinguishes BPD from other disorders. High F scores and overall elevations are common.

Table 1: Summary of Assessment Tools for Diagnosing BPD (Continued)

Assessment Tool	Source	Type	Comments
Rorschach (Exner Scoring Method)	Gartner, Hurt, & Gartner (1989)	Projective test based on responses to 10 inkblots.	No specific profile. However, clients with BPD tend to display the following: Lower D scores, High Egocentricity Index, Minimal thought disorder without evidence of severe thought disorder, High affective ratios, Poor form quality, Poor emotion regulation as evidenced by high Sum of Shading & Color Responses.
Structured Clinical Interview for the DSM-III-R Personality Disorders (SCID-II)	Spitzer, Williams, & Gibbon, (1987)	Structured Interview based on DSM-III-R Criteria for Axis I & Axis II Disorders.	Strong Validity & Interrater reliability.

PREVALENCE OF BPD

The prevalence of BPD in the general population is estimated at anywhere from .2 to 15 percent (Swartz, et al., 1990). Approximately 10 percent of psychiatric outpatients have a BPD while 15 to 20% of psychiatric inpatients have BPD (Swartz, et. al., 1990; Dean, 1991). While such numbers may not seem terrifically impressive, they become very concerning when one considers the utilization pattern and subsequent cost of treatment for these individuals. It is estimated that 75 to 80% of inpatient dollars are spent on 30 to 35% of the patients. In other words, a small number of individuals use the greater portion of treatment resources. Studies of utilization of mental health services indicate that 9 to 40% of high utilizers are diagnosed with BPD (Dean, 1991). Thus, while this may not be one of the most common disorders, persons with BPD utilize a significant portion of treatment resources. This adds to the frustration and hopelessness of providers and makes improvement of treatment methods even more critical.

BPD is 2 to 4 times more common in women and it is for this reason that the feminine pronoun is used throughout this book to refer to clients with BPD. In part this may be due to a gender bias in diagnosis in which women are more likely to be diagnosed as Borderline and put in the mental health system while men may be more likely to be diagnosed as having Antisocial or Narcissistic personality disorder and put in the corrections system. However, the differing rates of occurrence may also result from real gender difference and cultural factors.

Several possible explanations for such differences exist. As will be discussed in Chapter 3, history of abuse seems to be one factor placing an individual at risk for developing BPD. Since women are statistically more likely to be abused this may place them at greater risk for development of the disorder. In addition, at least one theory of etiology proposes that a significant risk factor is difficulty in emotion regulation. Because women tend to be both biologically and culturally more oriented to relational and emotional stimuli, they may be more vulnerable to problems in this area. Further, the hormonal factors associated with child bearing may contribute to emotion regulation difficulties. To put it bluntly, anyone who has experienced or lived with someone with PMS knows that hormones strongly affect mood and mood regulation! Any combination of these factors may make women more vulnerable to the development of this disorder.

At least one study found that the occurrence of BPD was greater in “non-whites” than whites (Swartz, et al., 1990). However, due to methodological concerns, this finding should be confirmed in further research. Specifically, the tool used to assess for the presence of BPD tended to look only at the presence of symptoms and not at the prevalence and pervasiveness criteria.

Nonetheless, these findings raise a number of cultural concerns which should be considered. First, there may be racism in the application of the diagnosis with some tendency to be more likely to attribute this label to people of color. Second, people of color may be prone to cultural factors such as increased rates of poverty, malnutrition, and trauma which may increase the etiological risk factors for development of the disorder. Finally, cultural bias in assessment of behavior may be a factor. Specifically, what is considered “affective instability” and/or “inappropriate anger” may differ significantly depending on the cultural context of the individual. Thus, it is critical in making the diagnosis to consider whether or not the individual’s behavior is consistent with their cultural context. Again,

further research with regard to cultural factors in this disorder is needed.

The highest rates for presence of the disorder are at ages 19 to 34 (Swartz, et.al. 1990). This makes sense as given the pervasiveness criteria one would expect few confirmed cases prior to early adulthood. Further, the rate of psychiatric disorders in general is highest in this age groups with many disorders showing substantial improvement in middle adulthood. Likewise, Borderline symptoms, especially the impulsive behavior, do improve over time. Recovery rates are further discussed in Chapter 6.

PROGNOSTIC INDICATORS

Several prognostic indicators have been explored in long-term follow-up studies of BPD (Dean, 2001; Paris, Brown & Nowlis, 1987; Plakun, 1991; Ryle & Golyunkina, 2000).

Obviously, those with the most severe symptoms have a poorer prognosis. Longer hospitalizations is also associated with poorer outcomes but this is correlational research not causal research so it is impossible to determine to what extent those with shorter hospitalizations were less severely impaired to begin with. However, as will be discussed in Chapter 5 shorter hospitalizations tend to be preferred for Borderlines as long hospitalizations tend to lead to regression, dependence on the system, and difficulty transferring skills to an outpatient setting.

Other factors include the presence of dysphoria, substance abuse, unemployment, and strong antisocial traits. All of which tend to be poor prognostic signs as well. History of family mental illness and a younger age when first seen for treatment may also predict a poorer outcome.

COMORBIDITY AND DIFFERENTIAL DIAGNOSIS

Part of the difficulty in diagnosing BPD is that the presence of other disorders is so common. Further complicating the picture is the fact that patients with other disorders may possess Borderline traits but not meet full diagnostic criteria and vice versa. 60% of Borderlines meet full criteria for other disorders with the most common comorbid disorders being Anxiety Disorders and Major Depression. (Grilo, et al., 2003; Swartz, et al., 1990; Zanarini, et al. 1998).

Resources

RECOMMENDED READING:

- Alderman, Tracy (1997). *The Scarred Soul: Understanding and Ending Self-Inflicted Violence*. New Harbinger Publications, Oakland, CA.
- Cohen, R. H. (1997). *The Angry Heart: Overcoming Borderline and Addictive Disorders*. New Harbinger Publications, Oakland, CA.
- Dimeff, L. & Linehan, M. M. (2001) Dialectical behavior therapy in a nutshell. *The California Psychologist*, 34, 10–13. (available at www.behavioraltech.org)
- Kreger, R. (2002). *The Stop Walking On Eggshells Workbook*. Oakland, CA. New Harbinger Publications.
- Kreisman, J. J. & Straus, H. (1989) *I Hate You—Don't Leave Me: Understanding the Borderline Personality Disorder*. Avon Books, New York.
- Lawson, C. A. (2002). *Understanding the Borderline Mother: Helping Her Children Transcend the Intense, Unpredictable, and Volatile Relationship*. Northvale, NJ. Jason Aronson Inc.
- Mason, P. T. & Kreger, R. (1998). *Stop Walking On Eggshells: Taking Your Life Back When Someone You Care About Has Borderline Personality Disorder*. Oakland, CA. New Harbinger Publications.
- Thorton, M. F. (1998). *Eclipses: Behind the Borderline Personality Disorder*. Monte Sano Publishing, Madison, AL.

VIDEOS:

Linehan, M. M. (2000) *DBT Skills Training Video: Opposite Action*. Seattle, WA. The Behavioral Technology Transfer Group.

Linehan, M. M. (1995). *Treating Borderline Personality Disorder: The Dialectical Approach*. New York. The Guilford Press.

Linehan, M. M. (1995). *Understanding Borderline Personality Disorder: The Dialectical Approach*. New York. The Guilford Press.

INTERNET SITES:

www.pesihealthcare.com

www.behavioraltech.com

www.BPDCentral.com

www.onelist.com/subscribe.cgi/WelcometoOz

www.mhsanctuary.com/borderline

www.ruinyourlife.com (regarding self-mutilation)

TO CONTACT THE AUTHOR:

drcolleen@charter.net

References

- Ajamieh, A. & Anseau, M. (2000). Biological markers in schizotypal and borderline personality disorders. *Encephale*, 26(6), 42–54.
- American Psychiatric Association (1998). Integrating DBT into Community Mental Health: The Mental Health Center of Greater Manchester, New Hampshire. *Psychiatric Services*, 49, 1338–1340.
- American Psychiatric Association. (2001). Part A: Treatment Recommendations for Patients with Borderline Personality Disorder. *American Journal of Psychiatry*, 158(10), 5–25.
- Antai-Otong, D. (2001). *Psychiatric Emergencies: How to accurately assess and manage the patient in crisis*. Eau Claire, WI: PESI Healthcare.
- Arntz, A., van den Hoorn, M., Cornelia, J., Verheul, R., van den Bosch, W. M., de Bie, A. J. (2003). Reliability and validity of the borderline personality disorder severity index. *Journal of Personality Disorders*, 17(1), 45–59.
- Bateman, A. & Fonagy, P. (2003). Health service utilization costs for borderline personality disorder patients treated with psychoanalytically oriented partial hospitalization versus general psychiatric care. *American Journal of Psychiatry*, 160(1), 169–171.
- Coccaro, E. F. & Kavoussi, R. J. (1991). Biological and pharmacological aspects of borderline personality disorder. *Hospital and Community Psychiatry*, 42(10), 1029–1033.
- Cleary, M. Siegfried, N. & Walter, G. (2002) Experience, knowledge and attitudes of mental health staff regarding clients with a borderline personality disorder. *International Journal of Mental Health Nursing*, 11(3), 186–191.

- Dean, M. A. (2001). *Borderline Personality Disorder: The Latest Assessment and Treatment Strategies*. Kansas City: Compact Clinicals.
- Dimeff, L., Koerner, K. & Linehan, M. M. (2001). *Summary of Research on DBT*. The Behavioral Technology Transfer Group. Seattle, WA 98105.
- Favazza, A. R. & Coterio, K. (1989). Female habitual self-mutilators. *Acta Psychiatrica Scandinavica*, 79, 783–289.
- Fine, M. E. & Sansone, R. A. (1990). Dilemmas in the management of suicidal behavior individuals with Borderline Personality Disorder. *American Journal of Psychotherapy*, 44(2), 160–172.
- Gartner, J., Hurt, S. W., Gartner, A. (1989) Psychological test signs of borderline personality disorder: A review of the empirical literature. *Journal of Personality Assessment*, 54(3), 423–441.
- Goin, M. K. (1998). Borderline personality disorder: Splitting countertransference, 15(11).
- Goldstein, W. N. (1998) The Borderline Patient: An Overview. *Psychiatric Times*, January, 1998.
- Galloway, V. A. & Brodsky, S. L. (2003) Caring less, doing more: The role of therapeutic detachment with volatile and unmotivated clients. *America Journal of Psychotherapy*, 57(1), 32–38.
- Grilo, C. M., Sanislow, C. A., Skodal, A. E., Gunderson, J. G. & Stout, R. L. (2003). Do eating disorders co-occur with personality disorders? Comparison groups matter. *International Journal of Eating Disorders*, 33(2), 155–164.
- Guzder, J., Paris, J., Zelkowitz, P., & Feldman, R. (1999). Psychological Risk Factors for Borderline Pathology in School Age Children. *Journal of the American Academy of Child & Adolescent Psychiatry*, 38(2), 206–212.
- Jeungling, F. D., Schmahl, C., Heblinger, B., Ebert, D., Bremner, J. ., Gostomzyk, J., Bohus, M., Lieb, K. Positron emission tomography in female patients with borderline personality disorder. *Journal of Psychiatric Research*, 37(2), 109–115.
- Judd, P. H. & Ruff, R. M. (1993). Neuropsychological Dysfunction in Borderline Personality Disorder. *Journal of Personality Disorders*, 7(4), 275–284.

- Keperman, I., Russ, M. J., & Shearin, E. (1997). Self-injurious behavior and mood regulation in Borderline patients. *Journal of Personality Disorders, 11*(2), 146–157.
- Kernberg, O., Koenigsberg, H., Stone, M., Yeomans, F., Appelbaun, A. & Diamond, D. (2002). *Borderline Patients: Extending the Limits of Treatability*. New York: Basic Books.
- Koenigsberg, H. W. (1984). Indications for hospitalization in the treatment of borderline patients. *Psychiatric Quarterly, 56*(4), 247–258.
- La Rowe, K. D. (2001) *Working with Survivors of Traumatic Stress*. Eau Claire, WI: PESI Healthcare, LLC.
- Leichsenring, F. (1999). Development and First Results of the Borderline Personality Inventory: A Self-Report Instrument for Assessing Borderline Personality Organization. *Journal of Personality Assessment, 73*(1), 45–63.
- Levine, D., Marziali, E., & Hood, J. (1997). Emotional processing in Borderline Personality Disorders. *Journal of Nervous and Mental Disease, 185*, 240–246.
- Linehan, M. M. (1993) *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. New York: The Guilford Press.
- Linehan, M. M. (1993) *Skills Training Manual for Treating Borderline Personality Disorder*. New York: The Guilford Press.
- Miller, L. J. (1989). Inpatient management of borderline personality disorder. *Journal of Personality Disorders, 3*(2), 122–134.
- Millon, T. (1981) *Disorders of Personality: DSM-III, Axis II*. New York: John Wiley & Sons.
- Morey, L. C. (1991). *Personality Assessment Inventory*. Odessa, FL: Psychological Assessment Resources, or San Antonio, TX: The Psychological Corporation.
- Paris, J. (1990). Completed suicide in borderline personality disorder. *Psychiatric Annals, 20*(1), 19–21.
- Paris, J. (2002). Implications of long-term outcome research for the management of patients with borderline personality disorder. *Harvard Review of Psychiatry, 10*(6), 315–323.

- Paris, J., Brown, R., & Nowlis, D. (1987). Long-term Follow-up of Borderline Patients in a General Hospital. *Comprehensive Psychiatry*, 28(6), 530–535.
- Plakun, E. M. (1991). Prediction of Outcome in Borderline Personality Disorder. *Journal of Personality Disorders*, 5(2), 92–101.
- Sar, V., Kundakci, T., et al (2003). The Axis-I dissociative disorder comorbidity of borderline personality disorder among psychiatric outpatients. *Journal of Trauma & Dissociation*, 4(1), 199–136.
- Schmahl, C. G., Vermetten, E., Elzinga, B. M., Bremner, J.D. (2003). Magnetic resonance imaging of hippocampal and amygdala volume in women with childhood abuse and borderline personality disorder. *Psychiatry Research. Neuroimaging*, 122(3), 193–198.
- Schroeder, S. R., Oster-Granite, M. L., & Thompson, T. (2002). *Self Injurious Behavior: Gene, Brain, Behavior Relationships*. Washington, DC. American Psychological Association.
- Siever, L. J. (1997). The biology of borderline Personality Disorder. *The Journal of the California Alliance for the Mentally Ill*.
- Soloff, P. H. (1994). Is there any drug treatment of choice for the borderline patient? *Acta Psychiatrica Scandinavica*, 89(379), 50–55.
- Soloff, P. H. (2000). Psychopharmacology of Borderline Personality Disorder. *Psychiatric Clinics of North America*, 23(1), 169–92.
- Spitzer, R. L., Williams, J. B. W., & Gibbon, M. (1987) *Structured Clinical Interview for DSM-III-R*. New York: New York State Psychiatric Institute.
- Stone, M. H., Hurt, S. W., and Stone, D. K. (1987). The PI 500: Long-Term Follow-up of Borderline Inpatients Meeting DSM-III Criteria I. Global Outcome. *Journal of Personality Disorders*, 1(4), 291–298.
- Swartz, M. Blazer, D., George, L. & Winfield, I. (1990). Estimating the prevalence of borderline personality disorder in the community. *Journal of Personality Disorders*, 4(3), 257–272.

- White, C. N., Gunderson, J. G., Zanarini, M. C., Hudson, J. I. (2003). Family studies of borderline personality disorder: A review. *Harvard Review of Psychiatry*, 11(1), 8–19.
- Zanarini, M. C. (1997). Pathways to the development of borderline personality disorder. *Journal of Personality Disorders*, 11(1), 93–104.
- Zanarini, M. C. (2003). The longitudinal course of borderline psychopathology: 6-year prospective follow-up of the phenomenology of borderline personality disorder. *American Journal of Psychiatry*, 160(2), 274–283.
- Zanarini, M. C. & Frankenburg, F. R. (2003). Omega-3 fatty acid treatment of women with borderline personality disorder. A double-blind, placebo-controlled pilot study. *American Journal of Psychiatry*, 160(1), 167–169.
- Zanarini, M. C., Frankenburg, F. R., Dubo, E. D., Sickel, A. E., Trikona, A. N., Levin, A. & Reynolds, V. (1998). Axis I Comorbidity of Borderline Personality Disorder. *American Journal of Psychiatry*, 155(12), 1733–1739.
- Zanarini, M. C., Gunderson, J. G., Frankenburg, F. R., & Chauncey, D. L. (1989). The revised diagnostic interview for borderlines: Discriminating BPD from other Axis II disorders. *Journal of Personality Disorders*, 3(1), 10–18.
- Zanarini, M. C., Frankenburg, F. R., Reich, D. B., Marion, M. F., Haynes, M. C. & Gunderson, J. G. (1999). Violence in the lives of adult borderline patients. *Journal of Nervous and Mental Disease*, 187(2), 65–71.
- Zelkowitz, P., Paris, J., Guzder, J., & Feldman, R. (2001). Diatheses and stressors in borderline pathology of childhood: the role of neuropsychological risk and trauma. *Journal of American Academy of Child and Adolescent Psychiatry*, 40(1), 100–105.

