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Review Article

Borderline Personality Disorder: A Brief Contemporary Review

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Abstract

Borderline Personality Disorder (BPD) is a severe mental illness that is correlated with low quality of life, and inadequate psychosocial functioning, at a significantly high cost for society. Historically, BPD has been diagnosed as an unstable and pervasive pattern 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) diagnostic criteria. It is also important to note that many with this disorder are highly intuitive and perceptive. Historically, BPD has been stereotyped as a deteriorating condition. However, contemporary data affords the patient the hope, that combined with their willingness and dedicated application of evidence-based treatments, genuine healing can be theirs. Patients are encouraged to be self-accountable, to make amends to those they have hurt, shift from a learned helplessness and victim mentality, to a more confident, positive, proactive approach to their lives. Families and loved ones are encouraged to seek their own support system, and to engage in the practice of skill building, effective communication, and self-agency. This paper will discuss what is relevant and pertinent to the current diagnosis and treatment of BPD in accordance to the DSM-5. Included, will be current perspectives in diagnosis, assessment and treatment, including an integrative discussion of traditional psychological research and neuroscience.

Keywords: *Borderline Personality Disorder; Neuroscience; Gender; Treatment; Dialectical Behavioral Therapy*

Introduction

According to the American Psychiatric Association (APA), mental illnesses are health conditions involving changes in emotion, thinking or behavior (or a combination of these). Mental illnesses are associated with distress and/or problems functioning in social, work or family activities. In a given year nearly one in five (19 percent) U.S. adults experience some form of mental illness, one in 24 (4.1 percent) has a serious mental illness, one in 12 (8.5 percent) has a diagnosable substance use disorder. Having a mental illness is not a final diagnosis of something irreversible: it is treatable, and most people with mental illness continue to function in their daily lives (APA 2018). Regarding the mental illness discussed in this paper, Borderline Personality Disorder (BPD), is predominantly about core deficits in interpersonal functioning and identity formation (APA, 2018).

Recent advancements in neuroscience, psychology, psychiatry, and psychotherapy, have opened the doors to a more informed, and useful, account of the inner brain workings, and the effect on behavior. Of course, the application of this psychiatric knowledge is a reflection of social reality. According to Horwitz [1], this task involves organizing the symptoms of mental illness into culturally appropriate idioms, social influences on the development of mental disorders, the political economy of mental illness, and the contextual reasons for how people come to define themselves and others as having a mental illness and to seek various forms of treatment once these definitions are made, among many others ([1], p. 18).

Central to the discussion of BPD, are the Big Five personality traits. The Big Five are general measurements of personality, and under the acronym of OCEAN, include the following traits: openness, conscientiousness, extraversion, agreeableness, and neuroticism. There are

numerous studies conducted by researchers, examining the Big Five relative to the following key subjects: personality disorders, heritability, gender differences, academic achievement, learning styles, cultural differences, brain structures, and work success [2].

Borderline Personality Disorder

The Clinical Problem

It is estimated that approximately 6% of primary care patients, and 15 - 20% of people in psychiatric hospitals and outpatient clinics have BPD. Approximately 75% of those diagnosed with BPD, are female, with a lower estimated percentage in community- based samples [3]. Incomplete suicide attempts and deliberate attempts at self-injury, are the typical reasons why patients with BPD engage with mental health treatment. The average hospital stays, following these unfortunate episodes, are 6.3 days per year, and an emergency room visit in two-year intervals. For those with major depressive disorder, the rates are six to twelve times higher [3].

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. 2. A pattern of unstable and intense interpersonal relationship 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). 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 [4].

Treatment

Cultural Considerations

Racism, discrimination, and specific cultural norms and values are important considerations. Regardless of which specific culture the patient identifies with, the therapist needs to provide an open, trusting, candid and informative process. It is well known that culture has an emotional impact in the way in which people describe their symptoms. For example, culture will affect if and how a person chooses to describe emotional or physical symptoms (will the symptoms be expressed in a "culturally appropriate" way?). This is to prevent the culture from being reflected badly by the person's depiction of their symptoms. The patient's culture may impact them in not offering the support and resources, to address the significant emotional underpinnings of stated emotional turmoil, and corresponding symptomology.

Legal And Ethical Issues

Risk assessment and safety should be addressed at the onset of treatment. The highest risk for BPD is self-harm, which is different from suicide. There is an estimated 9% of completed suicide in clinical samples of those with BPD. Extremely notable, is that in 90% of clinical samples, suicide threats or gestures are estimated to happen [5]. Conducting a suicide and self-harm assessment, contracting with the client to refrain from all self-harm and providing a referral to a psychiatrist specializing in personality disorders, are prioritized clinical duties.

Biological Model

There are noticeable differences in the brains of those with BPD, both structurally and functionally. Neuroscientific research [6], has proven that there are neuroanatomical structural, and chemical differences with people who have BPD. There is less volume in the following seven brain regions: 1) the insula, 2) middle and superior temporal cortex (Mid-Sup T), 3) the fusiform gyrus (FG), 4) the anterior

cingulate cortex (ACC), 5) the hippocampus, 6) the para-hippocampus, and 7) the amygdala. I would utilize this diagnostic case conceptualization as a tool for describing the client's needs, difficulties, symptoms, and treatment planning.

The treatment plan, in collaboration the patient and their caregivers, will directly follow from the case conceptualization. Based on the diagnostic impressions and self-reported data, I would provide clinical treatment by offering and encouraging the use of a set of tools, that is evidenced-based. Such clinical tools will help the patient to understand their symptoms, current functioning, develop an understanding of needs and circumstances, choose personal goals, and determine on the most effective interventions for accomplishing treatment plan goals. Examples of tools can be distress tolerance practice (discipling oneself *not* to react emotionally, but to respond appropriately when calmed down), deep breathing, regular meditation, using a wise frame of mind, in place of impulsive reactivity, and a host of great tools available online.

Psychopharmacology

Since the FDA does not have any specific medication for the treatment of BPD, APA recommends a polypharmacy approach. Some examples of recommended medications are: selective serotonin reuptake inhibitors (SSRIs), mood stabilizers, and antipsychotic drugs. Although a polypharmacy approach most likely will yield drug-drug adverse effects and interactions, it may help improve the cluster of troublesome symptoms of BPD, such as: "impulsivity, mood dysregulation, depression, aggression, anxiety, and cognitive-perceptual symptoms" [4].

Dialectical Behavior Therapy

Dialectical behavior therapy (DBT) is the primary and most researched, evidenced based talk-therapy treatment for BPD applying the cognitive-behavioral approach. This therapy places emphasis on the psychosocial aspects of treatment. The theoretical underpinnings to this approach are that some people have a pattern of reacting toward some emotional situations, in a more intense and out-of-the-ordinary manner. These specific situations tend to include romantic, family and friend relationships. DBT theory insinuates that the arousal level in the aforementioned situations can quickly escalate versus the average person's reactivity and return to baseline. Furthermore, people with Borderline PD reach a more elevated level of emotional stimulation and take a substantial amount of time to return to baseline arousal levels [6].

Combined with possible medication management, DBT may help the patient cope with insecure attachment issues, alter, or reduce impulse, anger and fear-based symptomology. Research indicates that the use of DBT has shown a significant decrease in fear, impulse, anger, self-harm, and anxiety compared to those only being treated with medication alone.

The therapist will invite the patient and family to be active participants in the treatment. Utilizing a therapeutic alliance, the patient will be guided and supported in creating and maintaining a life worth living.

DBT approaches aim to identify and change dysfunctional thoughts, that contribute to the person's pain and suffering. One main way this is done is by guiding the person in interpreting the situation differently. Restructuring thoughts is an indispensable skill in this training modality [5]. It is important that the patient feels safe in discussing fears, anxieties, and that experiences normalized. Strengthening the therapeutic relationship will be an ongoing process.

Comparing Two Treatment Approaches

In the study conducted by Fassbinder., *et al.* [7], researchers compared two treatment approaches for BPD; DBT and Schema therapy (ST), in a controlled outpatient program. Both of these treatment approaches have proven to help reduce BPD symptoms and the costs incurred. Prior to this research study, comparison data on these two approaches, has not been done. Another inspiration for this study, was scant 'real world studies' that reproduce positive findings in mental healthcare facilities. Hence, the researchers titled the study: "the PROgrams for Borderline Personality Disorder (PRO*BPD)".

In this randomized trial, researchers recruited one hundred and sixty BPD patients, who were randomly assigned to either DBT or ST treatment groups. Each group received treatment in a comparable framework, with one group therapy and one individual therapy session, per week. This occurred for a maximum of eighteen months. The purpose of ST is two-fold: to assist patients in meeting their needs,

and to teach and guide them in changing their maladaptive schemas. In order to accomplish this, the following tasks are pursued for every emotional state: 1) teaching self-soothing behaviors to nurture the vulnerable child, 2) meeting frustrated needs, and coaching the angry inner child to identify and handle anger, 3) challenge the punitive parent and encourage the detached inner protector. The opportunity presented for the patients is to lessen, or even positively alter, ways in which they avoid, and manage, their emotions and relationships [7].

Contemporary Research

In recent history, there has been some cutting-edge research findings on BPD, with significant treatment implications. In the Hybrid model utilized by researchers [8,9], they discuss the use of a model of borderline pathology containing two categories of borderline PD elements: 1) more stable temperamental characteristics (the Big Five), and 2) more short-lived acute symptoms. They explain the need to utilize this model, instead of the classic categorical model of BPD, which is comprised of characteristic impairments in personality functioning and a set of pathological personality traits in the Alternative DSM-5 Model for Personality Disorders [4].

Their research results show that the underpinnings of borderline PD should differentiate the stable and dynamic elements (elements that are temporary, such as environmental triggers, etc.) [8,9]. They advocate for this, because one cannot foretell change in borderline proneness (core BPD traits). Research that pools core traits, and the varying dimensions, into one category, will misjudge the indicators of any predictive factor or intervention. They recommend that research into the fundamentals of genetics and early rearing environment, as it relates to borderline PD, should focus on the stable borderline proneness paradigm. Their rationale is because it is free of "noise" created by the variability in situations, and error in measurement (typical in the research process) [8,9].

There are times when clinicians are hesitant to move forward with a diagnosis of BPD, when the symptoms described, appear to vary, sometimes significantly. Severe symptom change is usually thought to be exclusively portraying episodic conditions, like substance abuse, mania or psychosis. The transient nature of these symptoms is only revealing half of the picture, since they are the part of the transient category of BPD. However, acute symptoms are a plausible feature of borderline pathology. The durable and chronic nature of symptoms, therefore, may not be a satisfactory criterion for differential diagnosis between borderline PD and, for example, mood disorders such as major depression [8,9].

It is important to note that the mental illness of BPD wears many faces, depending on the person diagnosed with this serious disorder. According to Conway., *et al.* (2018, pp. 590-601): "the possibility that borderline PD has both stable (i.e. consistently present across time and situation, as modern diagnostic systems stipulate) and dynamic (i.e. episodic and situational) elements", was tested.

Their noteworthy study expands upon the extensive literature connecting borderline PD to the Big Five basic personality traits. The data showed that the Big Five personality traits could elucidate a significant amount of between-person variance in borderline PD qualities. This occurs by elucidating the "true" correlations. These correlations often get somewhat concealed by measurement error, and mood-state distortion, among the unchanging components of these trait-like constructs. They found that of the Big Five, Neuroticism (r .74), Agreeableness (r .48), and Conscientiousness (r .38) had exceptionally vigorous associations with borderline proneness. Furthermore, the connections among these stable components were closely connected with the genetic correlations [8,9].

Does Gender Mediate In BPD?

Research studies have found BPD to be gender-skewed, suggesting that women are the dominant sufferers of this severe mental illness [4,10]. As depicted in their research article, Godbout N, Daspe MÈ, Runtz M, Cyr G and Briere J [11], this common gender difference can be partly attributed to the higher rates of childhood sexual abuse (CSA) among females. CSA is related to larger numbers of women diagnosed with BPD. Furthermore, borderline PD behaviors may suggest gender-stereotypic behaviors, usually associated with females. Examples of these gender-stereotypic behaviors include suicidal "gestures," self-injury, and a more effusive expression of emotions [11].

The researchers quote the findings in a national U.S. representative study (Grant., *et al.* 2008), that generated similar frequency rates in men and women. In light of the obvious gender-gap in diagnosis, and outcomes of BPD, further research is needed to understand the role of gender in BPD etiology, facilitation and structure [11].

I would like to note that the statistics on CSA may be under-reported for a variety of reasons. Shame, repression, denial, fear of retaliation and not being believed, among a host of other reasons, may be why survivors do not report the occurrences. In consideration of the massive Catholic Church sex abuse scandal, an enormous number of males reported sexual victimization as children. In recent history, the "Me Too" movement has drawn forth an increased number of males and females sharing their own stories of CSA, not previously disclosed.

Perhaps in the near future, researchers can collect current data to reflect CSA prevalence in males and females. In regard to the stereotypical suicidal "gestures," self-injury, and more demonstrative expression of emotions, I present the question if males express their underlying pain in more socially acceptable ways. Male aggression, acts of violence, both sexual and non-sexual in nature, are some examples of how males with BPD might express themselves. Their symptomology, display of symptoms and conduit, may be in stark contrast to females, and this may be because of underlying neuroanatomical structural, hormonal and chemical differences among the genders.

Intervention: Family And Carers Training Support (MBT-FACTS)

It is important to include some treatment options and support, for families and caregivers of those with BPD. The MBT-FACTS program [12], is an educational program for families and loved ones of those suffering with BPD. Included in the psychoeducation, is basic information on BPD, skill training, and coping skills, for safe and simple management and response to typical problems encountered. For example, families are taught to identify the typical displays of BPD, which are signals of insufficient mentalizing of a problem. The rationale for their approach, was based on the effects of the impact of family conflict on mentalizing - and to avoid the ineffective mentalizing interactions, that are a part of the dynamics between borderline PD's and others.

Included in the theoretical model of mentalization-based treatment (MBT), is the acquisition of agency, considered a non-negotiable aspect for personal development. The term 'acquisition of agency' refers to viewing people's behavior as a result of their momentary mental state. Other vital ingredients incorporated in the MBT model, are empathy, open-mindedness, and a willingness to continue learning [12].

Conclusion

The significance of BPD is in social relations; unstable, intense, fraught with anxiety and push-pull dynamics. The significance of emotional regulation, skill building, making amends when wrong, seeking to change dysfunctional behavior, and remaining mindful of one's mental state - are vital for core character development and improvement of symptomology. Those stable character traits, the Big Five, point the way for tailored research and further treatment options. Neurotic manifestations, lack of agreeableness, and high self-consciousness, provide an immediate starting ground for targeted treatment.

The role of social skills in our lives, is vital, interconnected, and very much brain-based. There is significant scientific data, and common sense, that as social creatures, we need satisfying social relationships, and that being liked is directly related to personality impressions [13-15].

Living a socially isolated, or troubled life, for most people, has risk factors. We can safely conclude that our brains are wired for satisfying social lives, which may very well protect humans against illness, both medical and psychological. People with BPD are just as capable to learn new, adaptive skills, unlearn dysfunctional behaviors and responses, and learn to re-direct negative thinking, and related symptomology. They are also just as capable to hold themselves accountable, make appropriate amends as necessary, shift from a learned helplessness and victim mentality, to a more confident, positive, proactive approach to their lives. The capacity is there, so long as there

is a genuine willingness to practice self-agency. There is enough data showing the efficacy of treatments, and along with medication management, to make recovery and remission entirely possible for them personally. The answer of course, always lies in their own self-determination and willingness, to learn, heal and grow. This is the free choice we are all afforded.

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