

2. About borderline personality disorder

What is BPD?

The best way I have heard borderline personality disorder described is having been born without an emotional skin, no barrier to ward off real or perceived emotional assaults. What might have been a trivial slight to others was for me an emotional catastrophe, and what would be a headache in emotional terms for someone else was a brain tumor for me. This reaction was spontaneous and not something I chose. In the same way, the rage that is often one of the hallmarks of borderline personality disorder, and that seems way out of proportion to what is going on, is not just a “temper tantrum” or a “demand for attention.” For me, it was a reaction to being overwhelmed by present pain that reminded me of the past. (Williams, 1998)

Borderline personality disorder (BPD) is a serious, long-lasting and complex mental health problem. Though it has received less attention than other serious mental health problems, such as bipolar disorder or schizophrenia, the number of people diagnosed with BPD is similar or higher than these disorders. People living with BPD have difficulty regulating or handling their emotions or controlling their impulses. They are highly sensitive to what is going on around them and can react with intense emotions to small changes in their environment. People with BPD have been

described as living with constant emotional pain and the symptoms of BPD are a result of their efforts to cope with this pain. This difficulty with handling emotion is the core of BPD.

Some common symptoms displayed by a person with BPD include:

- intense but short-lived bouts of anger, depression or anxiety
- emptiness associated with loneliness and neediness
- paranoid thoughts and dissociative states in which the mind or psyche “shuts off” painful thoughts or feelings
- self-image that can change depending on whom the person is with; this can make it difficult for the affected person to pursue his or her own long-term goals
- impulsive and harmful behaviours such as substance abuse, overeating, gambling or high-risk sexual behaviours
- non-suicidal self-injury such as cutting, burning with a cigarette or overdose that can bring relief from intense emotional pain (onset usually in early adolescence); up to 75 per cent of people with BPD self-injure one or more times
- suicide (about 10 per cent of people with BPD take their own lives)
- intense fear of being alone or of being abandoned, agitation with even brief separation from family, friends or therapist (because of difficulty to feel emotionally connected to someone who is not there)
- impulsive and emotionally volatile behaviours that may lead to the very abandonment and alienation that the person fears
- volatile and stormy interpersonal relationships with attitudes to others that can shift from idealization to anger and dislike (a result of black and white thinking that perceives people as all good or all bad).

The types and severity of BPD symptoms experienced may differ from person to person because people have different predispositions and life histories, and symptoms can fluctuate over time.

The term borderline personality disorder was coined in 1938 by Adolph Stern, a psychoanalyst who viewed the symptoms of BPD as being on the borderline between psychosis and neurosis. However, some experts now feel the term does not accurately describe BPD symptoms and should be changed. Some also feel that the existing name can reinforce the stigma already attached to BPD.

The road to specialized treatment and recovery is often hard because the symptoms of BPD can make the affected person emotionally demanding and difficult to engage and retain in treatment. As a result, the disorder is often stigmatized and helping services may be reluctant to accept clients with a BPD diagnosis.

However, with appropriate treatment, people with BPD can make significant life changes, though not all symptoms of BPD will disappear. Remission is more common as people reach the middle years of life. Hope and recovery are important to both the person and family members. These issues are discussed in more detail on p. 39. “The overarching message of ‘recovery’ is that hope and meaningful life are possible. Hope is recognized as one of the most important determinants of recovery” (O’Grady & Skinner, 2007).

What feelings are associated with BPD?

I feel empty and lonely, sometimes like I don't exist at all, and saying my name feels like a lie because I know there's nothing inside. I play roles, try to be who I'm "supposed" to be, and I'm good at being anyone but me. I fill in the space with what's appropriate—my goals, careers, values, it's all based on the situation. I want to feel something, anything other than nothing. I go from okay to suicidal in an instant and don't even know why. But one constant is a sense of worthlessness that spills over into a desperate need for self-destruction.

— a client

Borderline personality disorder can have degrees of severity and intensity, but at its most severe and intense the emotional vulnerability of a person with BPD has been described as akin to a burn victim without skin. The tiniest change in a person's environment, such as a car horn, a perceived look, a light touch from another person, can set a person with BPD on fire emotionally. Some of the extreme feelings associated with BPD have been identified and include intense grief, terror, panic, abandonment, betrayal, agony, fury or humiliation.

Family members have feelings around BPD as well. They have described living with a person affected by BPD as constantly "walking on egg shells," never knowing what will trigger an outpouring of emotion or anger (DBTSE, 2006).

Family members may often feel manipulated by their loved one, but any perceived manipulation is not deliberate. The person living with BPD is trying to manage and deal with intense emotions that greatly affect his or her behaviour.

How common is BPD?

Studies in personality disorders are at an early stage of development. Community surveys of adults have indicated that the prevalence of BPD is close to one adult in 100, similar to that of schizophrenia (Paris, 2005). The most recent (and largest) community survey in the United States found a prevalence of BPD of six per cent. At this time, we don't have accurate rates for Canada (Grant et al., 2008).

It is unclear whether BPD is more common among women than men and some reports state that about 70 to 80 per cent diagnosed are women. Other research suggests that although there are more women in a treatment setting, there is no significant difference between the incidence of BPD in women and men (Grant et al., 2008).

How is BPD diagnosed?

In Ontario, a physician, a psychiatrist or a registered psychologist can make a formal diagnosis of BPD or any other mental health disorder. The first step toward diagnosis is often with a family physician or the emergency department of a hospital. If there is enough reason to be concerned about someone's mental health, the family physician can make a referral for further assessment.

Whoever makes the diagnosis will use the *DSM-IV-TR* to ensure that the person fits the criteria for a diagnosis for BPD.

What other disorders co-occur with BPD?

It is very common for someone with borderline personality disorder to have other mental health problems that can complicate the diagnosis of BPD. Some disorders that commonly co-occur with BPD include major or moderate to mild depression, substance use disorders, eating disorders, problem gambling, posttraumatic stress disorder (PTSD), social phobia and bipolar (manic-depressive) disorder. Sometimes it can be difficult to diagnose BPD because the symptoms of the co-occurring disorder mimic or hide the symptoms of BPD. As well, relapse in one disorder may trigger a relapse in the other disorder.

When does BPD begin?

Like the onset of other serious mental health problems such as schizophrenia, the symptoms of BPD appear in late adolescence or early adulthood. In some cases, parents may have no warning that something is wrong; their child who had appeared to be functioning well suddenly falls apart with the onset of behaviours such as emotional outbursts and suicidal gestures.

What causes BPD?

As with other mental health disorders, our current understanding of BPD is that a person's genetic inheritance, biology and environmental experiences all contribute to the development of BPD. That is, a person is born with certain personality or temperamental characteristics because of the way their brain is "wired," and these characteristics are further shaped by their environmental experiences as they grow up and possibly by their cultural experiences.

Researchers have found differences in certain areas of the brain that might explain impulsive behaviour, emotional instability and the way people perceive events. As well, twin and family history studies have shown a genetic influence, with higher rates of BPD and/or other related mental health disorders among close family members. Environmental factors that may contribute to the development of BPD in vulnerable individuals include separation, neglect, abuse or other traumatic childhood events. However, families that provide a nurturing and caring environment may still have children who develop BPD, while children who experience appalling childhoods do not develop BPD.

Though histories of physical and sexual abuse are reported to be high among those with BPD, many other experiences can play a role for a child who is already emotionally vulnerable.

Stigma and BPD

*In the world outside I met ignorance, stigma and judgment.
I felt isolated, stressed, full of guilt, shame and fear.*

— a client

Many societies look down on people with mental health and/or substance use disorders. They and their families face negative attitudes, behaviours and comments. This is known as stigma.

Stigma can:

- shame, isolate and punish the person who needs help
- reduce the chances that a person will get appropriate help
- reduce social support
- lead to lower self-confidence
- make the person feel that he or she will never be accepted in society.

Family members also experience the effects of stigma. Their social support network may shrink and they may face negative attitudes if they reveal their situation. We know that the risk factors of separation, neglect or abuse in childhood have been associated with the development of BPD in some people. Because of this, family members may be blamed and may feel or be seen by others as “part of the problem.”

Newcomers to Canada may experience greater stigma because of their culture and what is considered acceptable within that culture. Sometimes even asking for help can be difficult for someone whose culture does not encourage counselling or outside help. They may have difficulty finding the service they need because the counselling is not available or when it is, it is not in their language.

Some therapists are reluctant to treat people with BPD because they are seen as being resistant to treatment and because of their emotionally demanding behaviour. Their tumultuous relationships, mood swings and suicidal gestures can provoke anger and frustration in the therapist. Some programs have formal or informal policies that refuse treatment to people with BPD. Advocacy groups have also identified lack of funding for research on BPD, and exclusion of BPD from research studies.

Sadly, people living with BPD often experience more stigma than people living with other mental health disorders. More information about understanding stigma, experiencing stigma, surviving stigma and combating stigma can be found in *A Family Guide to Concurrent Disorders* listed under Publications on p. 44 at the end of this booklet.

Stigma and BPD with a concurrent disorder

It is common for someone with borderline personality disorder to also have a substance use or other addiction problem, and the stigma experienced by someone with one disorder is magnified for those living with two or even more disorders. Negative and blaming attitudes toward those with substance use and mental health problems (concurrent disorders) are often internalized, and a person with concurrent disorders may experience social isolation, poverty, depression, reluctance to seek treatment and loss of hope for recovery, as well as prejudice and discrimination when seeking health care, housing, employment or other services. Again, *A Family Guide to Concurrent Disorders*, listed on p. 44, is an excellent source for information on stigma.