A Review of Borderline Personality Disorder: From Symptomology to Treatment

Dr. Jennifer Sumerlin, PsyD

College of Saint Elizabeth
ABSTRACT

Borderline Personality Disorder, also referred to as BPD, has been a commonly diagnosed disorder, especially amongst women, in the mental health field. Treatment modalities such as medication management, in addition to individual, group, and family counseling interventions are being utilized to better understand this disorder and help those that are diagnosed achieve a level of functioning that meets their goals. However, while the aforementioned treatment modalities have proven successful, there remains some resistance on part of men who appear to go undiagnosed with BPD, with medical professionals instead opting to diagnose men, who inhabit similar symptoms, with Antisocial Personality Disorder; which effects treatment options. Many with this diagnosis are often said to exhibit difficulty regulating emotion and maintaining relationships. This paper seeks to explore the effects of BPD in the brain and its relationship to trauma and gender, more specifically in interpersonal and familial relationships.
Overview of Borderline Personality Disorder

Borderline Personality disorder (BPD) is a mental disorder that is commonly associated with high incidences of self-harm, alcoholism, comorbid disorders (e.g., substance abuse, depression, bipolar disorder, and eating disorders), suicidal ideation, experienced trauma (e.g., domestic violence, abuse), and unstable relationships (Crowell, Beauchaine and Linehan, 2009). People with borderline personality disorder are oftentimes described as being impulsive, emotionally unstable, and reckless in behavior; their relationships are described as turbulent, unhealthy in attachment and behavior, and short-term in part due to the aforementioned characteristics (Bhatia, Davila, Eubanks-Carter, & Burckell, 2013).

Borderline Personality Disorder is not as commonly researched as antisocial personality disorder or depression, however Borderline Personality Disorder is said to affect not only the individual but the immediate family and friends as well. “Data suggest that BPD affects from 1.2% to almost 6% of the general population, approximately 10% of those who seek outpatient services, and as many as 20% of those who undergo inpatient treatment” (Crowell, Beauchaine and Linehan, 2009, Pg 495). The article went on to state that up to 10% of those who meet the criteria for Borderline Personality Disorder eventually commit suicide, making this one of the main reasons why more research ought to be done with regards to prevalence and treatment options.

This paper will serve as a review of current research being done to inform not only those effected by the disorder but also the support systems and mental health professionals involved. It is important that all involved become well informed of BPD and its effects on the individual themselves others: emotionally, mentally, socially, intimately, professionally, and financially.
The symptoms of BPD not only effect the “the individual’s” emotional and mental state, but it can also have a negative impact on how they relate to others. This can oftentimes result in isolation on the part of the individual.

**Symptomatology**

According to Barlow & Durand (2015), the diagnostic criteria for Borderline Personality disorder are as follows:

“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 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).
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” (pgs. 427-428).

BPD is commonly associated with childhood trauma such as physical abuse, sexual abuse, and neglect (Dijke, Ford, Son, Frank, & Hart, 2013). When diagnosing someone with BPD, it is common, first and foremost, for more women and adolescents than men to receive this diagnosis (Crowell, Beauchaine, & Linehan, 2009). Borderline personality disorder appears to be the “go to” diagnosis for women as opposed to men, with one of the main reasons being because BPD is associated with impulsivity and aggression. When a male comes in recalling symptoms that could easily be reminiscent of Borderline Personality Disorder, it is almost like an automatic response to look to Antisocial Personality Disorder as opposed to BPD as a valid diagnosis.

Borderline Personality Disorder is viewed as an intense emotional disorder where highs and lows are present, which are not considered to be totally far-fetched when considering the emotional makeup of the stereotypical female. Intense emotions are not always translated the same for both genders; men may, stereotypically, present as being more aggressive than women, which in turn presents a gender bias on the parts of clinical professionals when formally diagnosing individuals with Borderline Personality Disorder.

When it comes to diagnosing Borderline Personality Disorder, all of the articles used to research this topic have pointed out some general points: (1) people with Borderline Personality Disorder have a distorted self-perception and real-life situations/interactions that work hand in hand in resulting in impairing insight and judgment; (2) These distorted views also affect their ability to see and/or accept gray areas, making situations, from their perspective, a “black or white” issue; (3) Due to their limited visibility and judgment, this leads to tumultuous
relationships and those closest to the individual may err on the side of caution whilst taking part in everyday interaction.

Symptoms for BPD do not solely derive from one specific domain of an individual’s life. Borderline Personality Disorder can develop from a number of areas and as a result can be treated using diverse measures.

**Etiology**

Research has brought attention to the number of ways in which Borderline Personality Disorder is likely to develop. One theory is based solely on the biological development of BPD. Through the use of twin studies, research has shown how borderline personality disorder can, in fact, be a heritable disorder and is also strongly associated with other mental disorders among family members.

Another theory, not too far from the biological realm of development, involves the brain, its chemical makeup, and its relation to the prevalence of Borderline Personality Disorder.

“Studies of neurotransmitter dysfunction, particularly within the serotonergic system, suggest a link between reduced serotonergic activity and impulsivity in BPD” (Kuo and Linehan, Pg. 532). With reduced serotonin levels, which is a hormone associated with happy feelings, it can be connected with an increase in impulsivity as a way of filling that void.

Research has shown that Borderline Personality Disorder can possibly develop by way of brain abnormalities, more specifically changes in certain areas in the brain responsible for emotion regulation, impulsivity, and aggression. Also, certain chemicals in the brain that aid in regulating mood, such as serotonin, may not function as properly. Research has shown how the biological model works together with environmental factors to play a part in BPD development.
“According to Linehan, BPD is primarily a disorder of emotion dysregulation and emerges from transactions between individuals with biological vulnerabilities and specific environmental influences. The dysfunction proposed by Linehan is one of broad dysregulation across all aspects of emotional responding. As a consequence, individuals with BPD have (a) heightened emotional sensitivity, (b) inability to regulate intense emotional responses, and (c) slow return to emotional baseline.” (Crowell, Beauchaine and Linehan, 2009, Pg. 496)

Environmental factors can also contribute to the development of Borderline Personality Disorder in such a way that outside stimuli can have an adverse effect on an individual’s self-perception, insight, and mood. Outside stimuli such as childhood trauma and neglect are said to be associated with the presence of BPD in later years. An article by Powers, Gleason and Oltmanns (2013) discussed research involving the correlation between childhood trauma and various personality disorders. The results concluded significant findings that show that the experience of childhood trauma strongly correlates with the development of personality disorders; among the listing of disorders showed a noticeably higher diagnosis of Borderline Personality Disorder when associated with childhood trauma as opposed to the other personality disorders listed.
“Figure 1. Magnitude of relationship between childhood trauma and personality disorder criterion counts. Note: * p < .003, indicating statistical significance after Bonferroni correction for multiple testing within the indicated sample; analyses in the full sample represent the effect of childhood trauma on criterion counts above and beyond the variance accounted for by participant age, education level, and sex.” (p. 472)

Prognosis

According to the DSM-V, Borderline Personality Disorder “is about five times more common among first-degree biological relatives of those with the disorder than in the general population. There is also an increased familial risk for substance use disorders, antisocial personality disorder, and depressive or bipolar disorders” (Diagnostic and statistical manual of mental disorders: DSM-5, 2013, p. 665).

While personality is said to develop through a combination of both biological and environmental factors, as well as childhood experiences, other mitigating factors, with respect to
personality development, can increase the likelihood of Borderline Personality Disorder developing. These mitigating factors are as follows:

1. **Hereditary Predisposition** – An individual may be at higher risk for BPD if a close family member (e.g., mother, father, sister, brother) has the same or a similar disorder, more specifically a disorder involving mood or anxiety.

2. **Childhood Abuse** – Recalled incidences of childhood sexual and/or physical abuse are common themes in individuals formally diagnosed with BPD.

3. **Neglect** – Individuals diagnosed with BPD describe experiences of neglect as severe deprivation as well as childhood neglect and abandonment.

Below is a table/chart that summarizes what is incorporated in the diagnosis of BPD based on biological and social factors, based on an article published by Crowell, Beauchaine and Linehan (2009):

---

**Biological Vulnerabilities**
- Genetic influences (5-HTT, polygenic polymorphism, TP16-1 gene, 5-HTreceptor genes, DAT-1 gene)
- Abnormalities of brain systems (5-HT, DA, HPA axis)
- Frontal-subcortical dysregulation, low RSA

---

**High-Risk Transactions**
- Instability of child emotions
- Inadequate coaching of emotion
- Negative reinforcement of excessive emotional expression
- Ineffective parenting due to presence of fit and/or insufficient family resources (e.g., time, money, usual supports)

---

**Increased Risk for Psychopathology**
- Information processing distorted
- Cannot organize to achieve non-mood-dependent goals
- Cannot control mood-dependent behavior
- Shuts down, freezes

---

**Repetitive maladaptive behaviors serve an emotion regulation/avoidance function and become reinforcing.**
Borderline Personality Disorder is said to be most commonly diagnosed amongst young adults and adult women, with the research articles and the DSM-V reporting an average of 75% of the adult population who are formally diagnosed with Borderline Personality Disorder are women (NAMI, 2015).

With respect to culture and ethnicity, Borderline Personality Disorder is identifiable in various settings worldwide, especially amongst adolescents and young adults experiencing identity problems. Especially when combined with substance use/abuse, the behaviors associated with the aforementioned combination can result in a misleading diagnosis of Borderline Personality Disorder. In addition to behavioral differences leading to a misdiagnosis, another issue could lie in a dual diagnosis. Oftentimes Borderline Personality Disorder is diagnosed as a part of a dual diagnosis, co-occurring, most commonly, with depressive or bipolar disorders. Usually due to the fact that symptoms that meet the criteria for Borderline Personality Disorder may also imitate an episode of depressive or bipolar disorders.

**Psychosocial**

When discussing the psychosocial implications and treatment options for individuals diagnosed Borderline Personality Disorder, the possibilities appear to be varied and diverse. In an article by Powers, Gleason and Oltmanns (2009), stressors, both internal and external, can have a negative impact by way of increasing already present symptoms in individuals with Borderline Personality Disorder. Furthermore, as individuals with BPD transition into later adulthood, findings on advancement of symptoms, especially as stressors change to coincide with the individual’s stage of development, are becoming acknowledged less and less. The article concluded suggesting that certain symptoms, such as impulsivity and aggression, will
continue to negatively impact an individual with Borderline Personality Disorder as that individual progresses through late adulthood.

Additional psychosocial treatments have served as advancements within the mental health field, so as to aid in managing and possibly decreasing symptoms. In a research article by Goodman, Anderson and Diener (2014), two psychiatric inpatients, both formally diagnosed with BPD, took part in a study, where each participated in a formal treatment plan geared towards minimizing symptoms related to their BPD. Both patients took part in sessions utilizing a combination of the following therapeutic approaches: dialectical behavioral therapy, transference-focused therapy, interpersonal therapy, cognitive behavioral therapy, and psychodynamic therapy. In the article the CBT approach was significantly more prevalent in patient 1’s therapy as opposed to patient 2, which resulted in a negative correlation between the CBT approach and patient’s distress levels. Utilizing multiple approaches to treat one client is a rising concept and this article goes on to provide deeper insight into this integrative model:

According to this approach, techniques of many treatment approaches are used from time to time as determined by the patient’s ongoing psychological needs. These different techniques ultimately serve a psychodynamic conceptualization of treatment and accomplish the twin therapeutic goals of symptom reduction and personality integration. (p. 31)

A more detailed description of possible therapeutic approaches to treat Borderline Personality Disorder are as follows:

1. **Dialectical Behavior Therapy (DBT):** DBT was designed specifically to treat Borderline Personality Disorder. An approach commonly done by way of individual, group and phone counseling, DBT uses a skills-based approach combined with
physical and meditation-like exercises to teach you how to regulate your emotions, tolerate distress and improve relationships.

2. **Cognitive Behavioral Therapy (CBT):** With CBT, you work with a mental health counselor (therapist) to become aware of inaccurate, negative or ineffective thinking; view challenging situations more clearly and objectively; and search for and put into practice alternative solution strategies.

3. **Mentalization-Based Therapy (MBT):** MBT is a type of talk therapy that helps you identify and separate your own thoughts and feelings from those of people around you. MBT emphasizes thinking before reacting.

4. **Schema-Focused Therapy (SFT):** SFT combines therapy approaches to help you evaluate repetitive life patterns and life themes (schemas) so that you can identify positive patterns and change negative ones.

5. **Transference-Focused Psychotherapy (TFP).** Also called psychodynamic psychotherapy, TFP aims to help you understand your emotions and interpersonal difficulties through the developing relationship between you and your therapist. You then apply these insights to ongoing situations (Vezeeta Services, 2015).

Other ways for the individual to manage symptoms, so as to take more of a proactive role in their mental health is to take part in the following strategies:

- Learn about the disorder so that you understand its causes and treatments
- Stick to your treatment plan
- Attend all therapy sessions
- Take medications as directed and report to your doctor the benefits and side effects you experience
➢ Practice healthy ways to ease painful emotions and prevent impulsive behaviors, such as self-inflicted injuries
➢ Don't blame yourself for having the disorder but recognize your responsibility to get it treated
➢ Learn what may trigger angry outbursts or impulsive behavior
➢ Don't feel embarrassed by the condition
➢ Get treatment for related problems, such as substance abuse
➢ Reach out to others with the disorder to share insights and experiences
➢ Keep up a healthy lifestyle, such as eating a healthy diet, being physically active and engaging in social activities (Vezeeta Services, 2015).

**Psychopharmacological Treatment**

Medication such as anti-psychotics, anticonvulsants, antidepressants, and anti-anxiety medications are not meant to serve as a “cure-all” in eliminating any and all symptoms related to Borderline Personality Disorder (FortisHealthcare, 2015). Medication is prescribed to manage co-occurring symptoms such as impulsivity, depression, and anxiety. Some of the more common medications to treat BPD symptoms include:

**Anti-psychotic**: Seroquel, Risperdal, Zympexa, Clozaril, and Abilify

**Anticonvulsants**: Lamiclal, Topamax, Depakote, Trileptal, Zonegan, Neurontin, and Gabitril

**Antidepressant**: SSRIs such as: Prozac, Paxil, and Effexor XR

**Anti-anxiety**: Ativan, Klonopin, Xanax, Valium

Medication used to manage symptoms related to Borderline Personality Treatment are meant to be prescribed by the individual’s physician, preferably in adequate doses with
consistent supervision and follow-up visits so as to “check-in” to see about the effectiveness of the prescribed medication.

Conclusion

In conclusion, Borderline Personality Disorder involves factors from every domain of an individual’s life when considering diagnosis. While diagnosis most commonly occurs during late adolescence and early adulthood, research has implied that symptoms, oftentimes wane by late adulthood. BPD is a disorder that effects men and women alike, however research is lacking that supports the prevalence and treatment of Borderline Personality Disorder in men. As additional research is being conducted to better educate and inform patients and professionals of the extent of this disorder, there is an apparent need to research that focuses specifically on how the symptoms related to BPD may translate in men and if those symptoms do, in fact, translate differently in men than women.

Borderline Personality Disorder effects everyone involved, not just the diagnosed individual. It is refreshing to see articles that make mention of and look to assist support systems of those with BPD, mainly because individuals with Borderline Personality Disorder appear to want socialization, but are unable to do so in a healthy and positive manner. So to have a support system present in treatment, in some way, shape, or form can serve as the foundation to positive and healthy relationship-building for both “identified patient” and support system as well as aiding in decreasing depressive symptoms while increasing awareness and cohesion. There’s no one right way to treat Borderline Personality Disorder, yet research has shown that the best method can come from a combination of treatment approaches.
References


