

PATIENTS AS PARTNERS

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Understanding borderline personality disorder

Empowering patients through knowledge

By Dessy Tzoneva

Dealing with a personality disorder can be very frightening and challenging for both a patient and his/her family and friends. Not awarded the same attention as other mental illnesses, such as depression and bipolar, personality disorders are not very well known in society and are rarely the focus of public discussion. Extremely disruptive in nature, these disorders are long-standing and are often viewed as shameful.

An increasing amount of research in recent years has suggested that more people may be suffering from personality disorders than previously thought. The lack of acknowledgement of and information on these disorders only serves to reinforce the difficulties experienced by patients.

Personality disorders explained

Personality disorders can be described as enduring, inflexible, maladaptive traits that result in personal and social difficulties, as well as in the impairment of general functioning. "Such disorders should be diagnosed with great caution and only after the age of 18," warns Johannesburg psychologist Linde Viviers. "It is also important to note that people often display traits of these disorders, but do not necessarily meet the criteria for full-blown personality disorder diagnoses."

Identifying borderline personality disorder

Borderline personality disorder (BPD) is distinguished from other personality disorders by mood swings over fairly short periods and instability in self-image and interpersonal relationships. Dr Lynda Albertyn, a principal specialist psychiatrist at the Charlotte Maxeke Johannesburg Academic Hospital, believes the diagnosis is often avoided: "I think many so-called bipolar type two patients are actually suffering from BPD."

This disorder affects both psychological and social functioning, and work-related problems often arise. "There is usually high drama in interpersonal relationships and rage attacks are common," says Dr Albertyn. Patients are plagued by feelings of emptiness and are generally impulsive, often present with sexual difficulties and exhibit unusual, intense behaviour and suicidal tendencies. In fact, the rate of completed suicide for BPD patients is higher than that of the general population.¹

"These patients have little sense of self and are frequently in a state of crisis. BPD is, however, the most destructive in interpersonal relationships, as patients are driven by an intense fear of abandonment and rejection," says Viviers. She further explains that sufferers are not able to self-nurture or self-soothe and have very little understanding of the feelings of others, as they find their own so overwhelming.

Believed to affect approximately one to two percent² of the population, this disorder is much more common in women than men.

Exploring the causes

With studies of personality disorders still in the early stages, its causes are only just starting to be explored. Evidence tends to point to a combination of biological, psychological and social factors, as is the case with most mental illnesses. An important discovery, neuroimaging research suggests neurotransmitter impairment and dysfunction in certain brain regions of patients with BPD.³

"This condition tends to stem from childhood attachment difficulties and a history of abuse and neglect," explains Dr Albertyn. Viviers agrees: "Most theories support childhood abandonment or a dysfunctional relationship with a significant other, such as a mother, where little nurturing occurred and/or the patient's emotions were not validated." According to Viviers, a person's sense of self develops through their relationship with their mother. If rejection occurs, lifelong patterns of dysfunctional relationships may develop.

Considering treatment

Dr Albertyn says a combination of medication and psychotherapy is the most beneficial, but emphasises that the medication will only really be helpful if patients are diagnosed with coexistent conditions, such as depression or anxiety. She also comments that patient withdrawal from therapy is a major problem.

Thankfully, most patients with BPD seem to improve over time.⁴⁻⁶ By the age of 35 to 40, 75% of patients regain close to normal functioning and 90% recover by the age of 50.⁴ These improvements are partly based on the fact that with age, impulsivity decreases. Throughout the years, patients also learn how to avoid disruptive situations and maintain a kind of stability in their lives. Psychotherapy helps to reduce symptoms, decrease hospitalisation and improve interpersonal and social functioning. "Treatment mostly focuses on helping patients learn how to process feelings, on improving patients' relationships with themselves and with others, and on challenging mistaken beliefs," says Viviers. She advises that treatment will be the most useful and best able to support a patient through times

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of crises if a BPD patient is able to form a stable, consistent relationship with a therapist – a very challenging feat indeed for such patients. “Therapists treating BPD patients, who may appear very demanding and needy, have to construct clear boundaries and need to be consistent and available,” comments Viviers.

It is increasingly believed that psychotherapy for BPD needs to be long-term and highly structured. Developed specifically for the disorder, dialectical behaviour therapy (DBT) uses individual and group sessions to teach patients the skills to regulate their emotions, tolerate distress and form effective interpersonal relationships. A foundation for these skills, mindfulness is a vital concept in DBT and helps patients master the ability to pay attention to the present moment non-judgementally. This type of behaviour therapy tends to have an additional positive effect on suicidal behaviour, which can also be minimised through the effective management of BPD symptoms and various life stressors that worsen suicidal thoughts.

Other beneficial treatments for this disorder include mentalisation-based therapy (MBT), which aims to strengthen a patient's ability to recognise their and others' mental states, and then see these states as able to have an impact on, but still separate from behaviour. Using the patient-therapist relationship, transference-focused therapy (TFT) allows psychologists a glimpse of how a patient interacts with others and then enables them to use this information to help patients form and maintain healthier relationships.

Addressing the challenges

BPD has historically been seen as a volitional rather than legitimate disorder, especially in the medical field. Throughout the years the understanding of this disorder has evolved, however it does not yet receive the same amount of research and awareness as other psychiatric disorders and many people remain undiagnosed. The traditional view of BPD as a 'bad' illness still exists to some degree today. As a result of the stigma associated with this disorder, patients may experience marginalisation, both socially and even by some medical professionals.

“Patients tend to be disliked by health care professionals, who become frustrated at the difficulties in treating them and at their lack of response to medication,” says Dr Albertyn. This stigma, together with a lack of BPD advocacy in South Africa and internationally, prevents a greater understanding of this illness and fails to nurture the public intelligence needed for society's acceptance of this disorder. A lot still needs to be done in terms of increasing public awareness and providing widespread education on BPD.

TOOLBOX

Diagnosing BPD

The Diagnostic and Statistical Manual of Mental Disorders fourth edition requires the presence of at least five of the below-mentioned symptoms for a diagnosis of BPD.⁷

1. Frantic efforts to avoid real or imagined abandonment
2. A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation 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 behaviour, gestures or threats, or self-mutilating behaviour
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

Common signs of BPD

People suffering from this disorder may be seen as very manipulative and have great difficulty in forming intimate and rewarding connections and relationships. Oscillating between extremes, they can come to idealise a person just as quickly as they can exit that relationship should they perceive any signs of rejection. BPD patients struggle with interpersonal boundaries, becoming too close too soon in relationships and so appearing rather superficial. These patients also tend to engage in self-destructive behaviour, such as self-harming, substance abuse and eating disorders.

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