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BORDERLINE PERSONALITY DISORDER

AN EVIDENCE-BASED GUIDE FOR GENERALIST MENTAL HEALTH PROFESSIONALS

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An evidence-based guide for generalist mental health professionals

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Preface

Over the past two decades considerable progress has been made in developing specialist psychosocial treatments for borderline personality disorder (BPD) and yet the majority of people with BPD receive treatment within generalist mental health services rather than specialist treatment centres. It turns out that this is no bad thing. Many of the lessons learned from the development of specialist treatments for BPD now inform general psychiatric care and we can confidently say that treatment of people with BPD by generalist clinicians is no longer necessarily suboptimal and may in fact, in some contexts, be equal to specialist treatments as long as certain principles are followed and interventions are skillfully implemented. This is why this book came about.

There is increasing evidence that well-organized and skillful generalist psychiatric treatments for BPD, at least when used as comparators to specialist interventions in research trials, are strikingly effective. We discuss the evidence for this statement in Chapter 2. One of four published and manualized generalist psychiatric treatments used in research—structured clinical management (SCM)—forms the core of this book. SCM was used as a control treatment in a randomized controlled trial investigating the effectiveness of mentalization-based treatment. Patients who received SCM fared well on all measures. SCM follows organizational and clinical principles considered by experts to be important in the treatment of people with BPD. Rather than requiring complex specialist techniques, SCM employs interventions already in use by generalist mental health clinicians. The book is a development of the SCM manual used in the randomized controlled trial and we have extended the information for clinicians, added further suggestions of interventions, and reviewed some of the other literature on generalist psychiatric treatments.

This is not a book by specialists telling generalists what to do. We firmly believe that generalists are highly skilled clinicians and are able to deliver treatment that is not necessarily within the capability of the specialist. We wrestled with the terms "general" versus "generalist" clinicians for the book, eventually choosing generalist despite it being a rather ungainly word in the hope that we would avoid being considered patronizing or insulting. Generalist emphasizes the breadth of the clinician's skill and implies, accurately in our view, an ability to implement a range of techniques according to specific principles and to integrate them into a coherent treatment endeavour. This book speaks to those

skills. It outlines the principles to be followed when treating people with BPD in mental health services and details a range of effective techniques that can be used by generalist clinicians in everyday practice without extensive additional training.

Although the book is organized around the research manual for SCM, it is more than that. It is a comprehensive, best-practice clinical guideline for the treatment of BPD in generalist mental health services. The structure of the book is straightforward. First, we provide considerable information about BPD; second, we discuss the evidence base for and the characteristics of the manualized generalist psychiatric treatments that have been tested in research trials. This is followed by chapters about the general and specific clinical components of SCM, with an emphasis on practical implementation. Finally, we outline our approach to involving families and summarize our top ten tips for effective interventions in the hope that clinicians will go beyond SCM, both safely and effectively, as they grow increasingly confident about treating people with BPD.

We first encountered people with BPD when working as trainees in generalist mental health services and were immediately aware of our lack of understanding of their problems and the limited knowledge we had to draw on to help them. Despite these experiences, or perhaps because of them, we both embarked on a career working with people with BPD, gradually sharing our experience and knowledge, mostly gleaned from our clients/patients, with other mental health clinicians.

That observation raises the issues of who *we*, the authors, are, coming as we do from opposite sides of the globe. We both have considerable psychiatric experience working in public health services. One of us (AB) is a psychiatrist with dynamic leanings whilst the other (RK) is a psychiatrist with behavioral orientation. We hope that as a team we have enough in common to provide a unified view, enough difference to add breadth and plurality to our exposition, and adequate open-mindedness not to be too reverential to our favored approaches. On the whole our collaboration has run smoothly and it has become apparent that our differences are narrower than might be assumed from our distinctive perspectives. Certainly we think that combining our knowledge and experience has strengthened the book.

We hope that the book is reader- and clinician-friendly; parts are set out so that they can be easily copied to support treatment and we give a liberal sprinkling of consumer comments to illustrate many of our points. We are only too aware of the many faults of omission in the book. We have not tackled in detail the issues of ethnicity, class, social context, and gender in relation to BPD. Apropos of the latter, like many contemporary authors we have been stymied

by the problem of pronouns, but, in the end, decided to mix and match, sometimes using the possibly less grammatically obtrusive, but patriarchal, "he" and at other times "she." For the most part we have avoided the grammatically clumsy "they" with a singular verb and the clumsy "s/he". We had a similar struggle with a decision on whether to use the terms "client," "service user," "consumer" or "patient". "Client" is considered to imply equality and collaboration whilst "patient" is often taken to indicate a hierarchical interaction. So, believing that neither portrayal is necessarily accurate, we have used both "client" and "patient." We have also used "consumer" when we report comments given to us by people with BPD, or their families, where they had experience of the services and treatments. We have avoided "service user," which lacked finesse.

It is our hope that this book will be a modest contribution to improving generalist psychiatric treatments for people with BPD. Above all we hope that the information and clinical suggestions contained in the book will help generalist clinicians approach people with BPD not only with increasing confidence about being able to offer effective treatment, but also with a level of commitment and seriousness that many clients have arguably been deprived of in the past both in their personal lives and in their contact with services.

Anthony W. Bateman
Roy Krawitz
London, UK, and Auckland/Waikato,
New Zealand, July 2012

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Chapter 1

Borderline personality disorder

Summary

- Community lifetime prevalence of BPD is 1% (Grant et al., 2008; Schwartz, 1991), with equal rates of males and females in the Grant et al. study (2008).
- 70% of those diagnosed are female (Schwartz, 1991).
- It is likely that males are underrepresented and underdiagnosed in mental health settings and more likely to be found (but not diagnosed) in substance-use centers and in the justice system.
- 40–70% of those diagnosed have a history of past sexual abuse.
- 46% of people with BPD have a history of being victims of adult violence (Zanarini et al., 1999).
- Prevalence of people with BPD is estimated at community clinics to be about 11% and 20% in inpatient units (Swartz, Blazer, George, & Winfield, 1990).
- 75% of people with BPD have a history of having self-harmed on at least one occasion (Dubo, Zanarini, Lewis, & Williams, 1997).
- Most experts in the field accept BPD as a valid recognizable condition.
- For a DSM-IV-TR diagnosis of BPD, five or more of the criteria listed in DSM-IV-TR are required.
- It is important that diagnosis is only one part of understanding the unique individuality of the person.
- It is important that the diagnosis is integrated with other ways of understanding the person.
- Severe dissociation and persistent self-harm are often discriminating features in making a diagnosis.
- Co-occurring Axis 1 and II conditions are the norm.
- Suicide rates in older studies were 10% and are lower now with better treatments.

- There is considerable overlap between BPD and depression, dysthymia, bipolar affective disorder, and psychotic phenomena.
- Biological and psychological factors may be causal, with each client having a unique pathway to developing the disorder.
- The function of self-harm is almost always to decrease distress, and can be categorized by decreasing distress directly or by decreasing distress indirectly by effects on people in the environment.
- Naturalistic studies show that people with BPD improve over time, with high rates of remission lasting longer than 4 years (86%) and with low rates of relapse (33% over 8 years) at 10-year follow-up.
- Psychotherapy is the recommended treatment, with medication as an adjunct.
- There are now nearly 20 randomized controlled trials demonstrating the effectiveness of psychological treatments.
- There is a modest research base providing evidence of the effectiveness of high-quality generalist treatments.

History

The term "borderline personality disorder" (BPD) was initially suggested in the 1930s by clinicians to identify a group of clients who did not fit into the usual categorizations of "neurotic," including what we now refer to as anxiety and depressive disorders, or "psychotic," including what we now refer to as bipolar disorder and schizophrenia. Clinicians found that there was a group of clients who, descriptively, in most ways fitted the "neurotic" category except that they did not respond to the usual treatments at the time. The term "borderline" referred to the belief at the time that this group of people were on the "border" between "neurotic" and "psychotic." Whilst some people with BPD do have occasional psychotic or psychotic-like experiences, this definition of BPD, being on the "border," no longer applies, but the term has become ingrained. This might change as a result of controversial modifications to the classification of personality disorders being proposed by both the work group for the new *Diagnostic and Statistical Manual 5* (Skodol et al., 2011) and the personality disorder development group of the *International Classification of Diseases* 11th revision (Tyrer et al., 2011). In both classifications BPD will not be a discreet category of personality disorder, much to the disquiet of many experts (Bateman, 2011; Gunderson, 2010).

There was discussion in the 1970s of BPD as a variant of schizophrenia, in the 1980s as a variant of depression, in the 1990s as a variant of post-traumatic disorder, and since then as a variant of bipolar affective disorder. We have always seen and continue to see BPD rather as a dimensional disorder and variant of normal personality. This latter view is likely to be reflected in the DSM-V diagnostic system.

For the majority of the 20th century, treatment outcomes for people diagnosed with BPD were generally poor. Clinicians and research scientists turned their energies and interests in other directions. In the late 20th century, clinicians began successfully modifying and adapting their treatments, resulting in improved outcomes for people diagnosed with BPD. Professional and scientific interest in the condition soared and continues to grow.

The first scientific evidence of effective treatment was published in 1991, representing a major turning point in the treatment of people with BPD. Since 1991, there have been numerous further reports of effective treatment, with publications growing at an increased rate. People with BPD are now recognized as having a disabling condition that is often extremely severe and warranting compassionate and effective treatment.

Epidemiology

The most recent and very large (35,000 people) epidemiological study in the USA showed a lifetime prevalence rate of 5.9% (Grant et al., 2008). Earlier studies showed a prevalence of 1–1.8% (Swartz, Balzer, George, & Winfield, 1990; Widiger & Weissman, 1991).

As yet an unanswered question is whether the number of people meeting criteria for BPD would be less in cultures where strong family and extended family connections remain. The movement of people to cities, increased family mobility, loss of the small village culture, and lessened family and extended family connections are all sociocultural factors that might plausibly increase the likelihood of people developing BPD. Nuclear families might not have the same protection as the small village and extended family culture. Anecdotal evidence suggests the prevalence in westernized countries may also be directly correlated with the ratio of the earnings gap between the poorest and richest people, with Norway having the lowest prevalence and the USA the greatest prevalence.

Seventy-five percent of those diagnosed are female (Swartz, Blazer, et al., 1990); but there was no difference in rates in Grant et al.'s 2008 community epidemiological study. It is likely that males are underrepresented and underdiagnosed in mental health settings and more likely to be found (but not diagnosed)

in substance-use centers and in the justice system. Black et al. (2007) found 29.5% of recently imprisoned people met the criteria for BPD. Forty to seventy percent of those diagnosed have a history of past sexual abuse (Herman, Perry, & van der Kolk, 1989; Ogata, Silk, & Goodrich, 1990; Widiger & Frances, 1989). Zanarini et al. (1999) report 46% of people with BPD in their study as having a history of being victims of adult violence (physical and/or sexual assault). People meeting the criteria are well represented in mental health facilities, with estimates of 11% at community clinics and 20% in inpatient units (Swartz, Balzer, et al., 1990). Seventy-five percent of people with BPD have a history of having self-harmed on at least one occasion (Dubo et al., 1997).

Diagnosis

Most experts in the field accept BPD as a valid recognizable condition and this is acknowledged in BPD being a DSM-IV-TR diagnosis. For a DSM-IV-TR diagnosis of BPD, one needs to have five or more of the criteria listed in DSM-IV-TR and the criteria need to be pervasive (wide range of personal/social situations) and enduring (long-standing, with onset usually in adolescence or early adulthood and stable over time), and lead to significant distress or impairment in functioning. If a person meets three or four of the nine BPD criteria, and if these features are enduring and causing significant life problems, they could be said to have BPD traits.

A positive diagnosis of BPD is ideally made without it being a diagnosis of exclusion (when all other diagnoses have been tried and eliminated, or there is a failure to respond to medications). Avoiding making a diagnosis to avoid clinician and client negativity is now inappropriate given the positive, natural course of the disorder and the availability of effective treatment. On the other hand, the diagnosis of BPD may only become apparent after a longitudinal pattern, not readily recognizable at initial cross-sectional presentation, becomes more clearly illuminated during treatment.

People with substance-use conditions often have unstable lives due to the direct physiological destabilizing effects of the substance and sometimes due to associated behaviors such as engaging in criminal activity to fund the purchase of substances. As such, we need to be a little cautious making a BPD diagnosis in the presence of a substance-use disorder. However, about 50% of people with a BPD diagnoses have a lifetime history of alcohol or other drug problems (Swartz, Balzer, et al., 1990). Making both diagnoses can be very helpful.

BPD is a diagnosis most often applied only to adults. As adolescence is a period when many BPD features occur as part of normal adolescent development,

many clinicians tend to prefer not to make the diagnosis in teenage years. The terms "emerging" and "subsyndromal" BPD are sometimes used to describe young people who are having problems related to BPD features but who are too young to be sure that they will have the condition as they enter adulthood. Many experts working with adolescents are confident of being able to diagnose BPD where the behaviors are florid, and they emphasize the value of making an early diagnosis so as to be able to initiate effective treatments before the person and mental health system get locked into mutually reinforcing ineffective behaviors. Chanen et al.'s (2008) randomized controlled trial demonstrated that it is possible to identify and effectively treat adolescents with full or subsyndromal BPD, thereby also going some way to alleviate fears of iatrogenic dangers of diagnosis in adolescence (Chanen, Jovev, & Jackson, 2007).

To diagnose or not to diagnose?

More important than diagnosis, we encourage understanding of the condition called BPD so that we can put in place effective treatments for the condition. The disadvantages of any mental health diagnosis can potentially include a failure to recognize the uniqueness and humanity of the person with the condition. Disadvantages specific to BPD potentially could be clinician and client negativity where the diagnosis triggers pessimism. Neither of these needs to occur. Diagnosis can serve as a guide to effective compassionate treatment, with clinicians and clients sourcing information about the condition, developing a common language, and researching into the condition and into effective treatments. Increasingly people with BPD are being told about the diagnosis, enabling clinician and client to join together as a true collaborative team, each with their individual responsibilities.

Consumer comment

As a registered nurse trained in the early 1980s I had absorbed the profession's negative perception of people with BPD at the time, which meant that when I was finally diagnosed with BPD that I was mortified to be seen to be one of those "terrible" people. Being given a correct diagnosis, however, resulted for the first time in my receiving appropriate support and treatment. Being given an accurate diagnosis was the major turning point in my life, eventually allowing me to leave BPD behind and live the fulfilling life I do now. (Jackson, personal communication)

Alternative names used to describe BPD

There have been explorations of alternative names for BPD. "Complex post-traumatic stress disorder" (Herman, 1992) acknowledges in the name the role of past trauma, but is not inclusive of those for whom trauma is not a feature. "Emotion regulation disorder" and "emotional intensity disorder" highlight the central feature of heightened emotional sensitivity and reactivity. We like the term "emotion regulation disorder," if not as a diagnostic name, then as a way of understanding the condition and as a way of thinking to aid treatment and recovery, although it fails to highlight the interpersonal sensitivity that many feel is at the core of the disorder. Perhaps "emotional and interpersonal regulation disorder" might be better, albeit rather a mouthful! To some extent the new classification systems are trying to focus more on these core areas of personality disorder.

The International Classification of Diseases (ICD) proposal is to classify personality disorders according to whether one is present or absent. Personality disorder is based on an assessment of a person's capacity to function interpersonally. If present, one of five levels of severity is given to the individual. Only then does the clinician determine the main aspects of the personality disturbance using five major domains, namely asocial, dissocial, anxious dependent, emotionally unstable, and obsessional/anankastic. People with BPD are likely, therefore, to be classified as personality disorder, severe, with anxious/dependent and emotionally unstable characteristics.

The new DSM proposal is more complex. Personality disorder is defined according to an assessment of interpersonal function and self along with the presence of pathological personality traits. Once the level of interpersonal function has been defined, the clinician decides if one of six defined types is present. Currently these are antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal so the term "borderline" will remain but become a subcategory in a dimensional classification system.

Diagnostic criteria

The current criteria in the DSM-IV-TR for BPD are well known. Patients with BPD show 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. Five out of nine criteria have to be present for a formal diagnosis. The nine criteria are:

1. frantic efforts to avoid real or imagined abandonment
2. pattern of unstable and intense interpersonal relationships
3. identity disturbance

4. impulsivity
5. recurrent suicidal behavior, gestures or threats, or self mutilating behavior
6. affective instability
7. chronic feelings of emptiness
8. inappropriate intense anger or difficulty controlling anger
9. transient, stress-related paranoid ideation or severe dissociative symptoms.

DSM-IV-TR diagnostic criteria for borderline personality disorder

The DSM-IV-TR diagnostic criteria for borderline personality disorder are detailed in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000) and are reprinted here with permission.

> 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. Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5
> (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). Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5
> (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.

We have adapted the formal diagnostic criteria into a series of initial common-language screening questions we ask our clients:

1. Are you scared of rejection and abandonment, and being left all alone?
2. Are your relationships with your friends and family unstable?
3. Do you see things as either all good or all bad, 100% right or 100% wrong, or in absolute terms, e.g. everybody is…; all men are…?
4. Do you have trouble knowing who you are and what is important to you?
5. Do you impulsively do things which might damage yourself in some way?

6. Do you self-harm (intentional harm to body, including overdoses) or behave in a suicidal manner?
7. Do you have mood swings that could change quickly?
8. Do you feel empty and feel you need others to fill you up and make you whole?
9. Do you get excessively angry in a manner that is to your own detriment?
10. Do you numb out (dissociate) or sometimes feel overly suspicious or paranoid when stressed?

Elaboration of DSM-IV-TR criteria with view to understanding

Criterion 1: Frantic efforts to avoid real or imagined abandonment

Does your client cling to others or become desperate when someone seems to reject them? If for whatever reason (biological predisposition, psychological trauma) our clients as children did not have regular experiences of being securely attached to important people who would be able to assist them deal with their intense distress, it is likely that they will bring this experience into their adult world, believing that important people may not be there for them when they need them. They might fear being left alone and helpless to face what they believe is a tough harsh world. This fear of abandonment will understandably result in "frantic efforts to avoid real or imagined abandonment."

"Frantic efforts to avoid real or imagined abandonment" may take forms from being as helpless as possible to expressing drastic thoughts of what will happen if left feeling abandoned. These behaviors might encourage some people to engage, which may prevent abandonment, especially in the short term. However, these behaviors may actually drive people away or be destructive to the very relationship that the individual is trying to protect. Sometimes the person with BPD may themselves end the relationship as a way of getting in first, thereby avoiding the imagined inevitable abandonment.

Consumer comment

I often caused myself a lot of distress by ending friendships or relationships if someone seemed angry or unhappy with me because I believed they were going to walk out of my life, even if they were only a little angry with me. It was really important to me that I took control and walked away first. I lost a lot of relationships like this (Krawitz & Jackson, 2008).

Criterion 2: A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation

Does your client put others on an elevated platform, seeing them as perfect—or possibly perfect—saviors and everything that they had wished for and later find themselves full of contempt for the person and hating them? Young children often relate to important people in an all-or-nothing manner, seeing them one moment as perfect before, after a real or imagined slight, raging against them and hating them. Without the right circumstances, children might not develop and mature into adults that see people as having both desirable and less desirable attributes. This idealizing and devaluation will be very hard on your client and the people with whom they are in relationships. Identity disturbance (Criterion 3), impulsivity (Criterion 4), affective instability (Criterion 6), and difficulty controlling anger (Criterion 8) will contribute to unstable and perhaps turbulent relationships.

Consumer comment

I was an expert at putting people on a pedestal. I would meet somebody and they were the answer to my dreams. Then they would turn out to be only human after all and my image of the person was dashed—they were the most dreadful person in the world and how could I have been such a bad judge of character? (Krawitz, 2008).

Criterion 3: Identity disturbance: markedly and persistently unstable self-image or sense of self

Does your client ask questions of themselves like, "Who am I, what do I want from life, and what do I want to do with my life?" Does your client search continuously for answers to these questions only to find that when they think they are getting to know what they want from life that they lose interest? This may be an outcome of unharnessed emotional intensity or it might be an understandable searching for what makes sense to them in a world that has, to date, not made that much sense. If their previous experience of emotions has been very painful, they might have coped by shutting out/avoiding as much of their feelings and emotions as they could. This may have worked for our clients to some degree in decreasing distress in the short term. Deprived of the important information that emotions give people, this may have had the effect of leaving people with BPD feeling empty and uncertain about what they want from life.

Consumer comment

For most of my life I had no idea who I was. I would suck up the identities of those around me. I would meet someone and as mentioned above would think they were the perfect example of the human species. I would hang out with them, and do the things they did. At various points I was an active left-of-centre political party member, right-of-centre political party member, had short hair, long hair, liked country music, then rock, loved being a nurse, hated being a nurse, and on it went (Krawitz & Jackson, 2008).

Criterion 4: Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). Note: do not include suicidal or self-mutilating behavior covered in Criterion 5

Impulsive behaviors may arise for our clients when they are so distressed that they will do virtually anything to feel even a little bit better even if this only lasts a short while and even if it has serious long-term consequences. It is much like, and includes, being addicted to substances like alcohol or heroin that briefly help people feel better in the short term but have serious negative consequences. If our lives are full of pain and we have yet to learn effective ways of dealing with our distress, then impulsive behaviors are understandable, and very likely. Impulsive behaviors may include gambling, binge eating, driving recklessly, sex that is regretted, excessive spending, assault, alcohol use, and other substance use.

Consumer comment

For many years, spending was something that gave me instant gratification. If I was feeling distressed, I would go shopping—frequently buying things I never used and often not being able to pay essential bills. I would have some sense in the back of my mind that I might regret this later, but the need to instantly feel better was all-encompassing (Krawitz & Jackson, 2008).

Criterion 5: Recurrent suicidal behavior, gestures or threats, or self-mutilating behavior

Self-harm refers to harm inflicted upon the body, usually as a means of relieving emotional distress, and can take many forms, including overdosing, cutting, hitting, scratching, burning, pulling hair, and deliberately getting beaten up. Self-harm and suicidal behaviors serve the function of decreasing emotional

distress either directly or indirectly by encouraging people in the environment to respond in a manner that decreases the person's short-term distress. Not infrequently, the idea of suicide and/or suicide planning can result in the person feeling less distressed, having an awareness of suicide as a back-up (albeit highly dysfunctional) solution to their distress. The dangers of this process are obvious and serious.

Criterion 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)

Do your client's emotions shift rapidly and unpredictably in response to internal or external cues or sometimes for reasons that the person has yet to identify? This may seem like an intense roller-coaster ride, with the person feeling out of control of their emotions and actions, and that instead their emotions are controlling them. Because emotions are so intense and labile, it is more challenging to use skilful ways of coping when distressed. It is more likely therefore that your client's behavior will be determined by their mood; that is, mood-dependent actions and responses dominate rather than skilful behaviors and reflection, whatever their mood.

Consumer comment

I experienced extremely intense and floridly raging emotions. When these emotions were distressing, all my actions were driven towards avoiding feeling as I tried consciously (and now recognize also unconsciously) to completely suppress my experience. When I "succeeded," I felt nothing; a kind of emotional neutrality or numbness. This unfortunately seemed to be only temporarily effective at not feeling, with the feelings often returning with even greater intensity with the next trigger. The result of this was that very little of my actions was wise. Instead it was mood dependant, creating even further problems and distress over time (Jackson, personal communication).

Criterion 7: Chronic feelings of emptiness

Does your client describe a painful feeling of emptiness or hollowness inside? Emptiness has a number of different causes. Understandably, if peoples' lives have involved numerous disappointments they may become fearful of trying things and fearful of engaging in life; they may avoid a lot of things to try decrease their distress. Unfortunately this is likely to leave the person with not enough going on in their life that is meaningful. Shutting out/avoiding

emotions will leave people without the ability to know what is meaningful and satisfying, and therefore feeling empty. Attempts to fill this emptiness whilst either avoiding engaging in life or blocking the experience of emotions may be to no avail. This is like trying to fill a bucket with water when the bucket has holes in the base. Emptiness is also likely to result from difficulties establishing and maintaining satisfying intimate attached relationships that would otherwise be fulfilling and give a person a sense of recognition and completeness.

Consumer comment

It was not until I read the diagnostic criteria for BPD that I was able to put words to the big hole inside me. I felt that I was hollow and worthless, and that my existence had no meaning or substance. Later, I needed to be constantly active to fill the black hole in me (Krawitz & Jackson, 2008).

Criterion 8: Inappropriate intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)

Is your client easily cued into rages? Anger may be experienced by all of us in response to our experience of frustrated needs and experience of disappointment and can be a very powerful experience that may be overwhelming. Being angry in itself is not necessarily a problem. DSM uses the language of "inappropriate" here to refer to anger leading to actions (such as assault) that are contrary to the person's best interests or outside socially recognized norms and are so excessive that viable relationships become impossible. People with BPD might be biologically primed to experience emotions intensely, including the emotion of anger. Also, if their worldview is that important people should be perfect then it will be inevitable that rage will occur when this unrealistic expectation is not met.

Criterion 9: Transient, stress-related paranoid ideation or severe dissociative symptoms

If our clients have had past experiences of feeling misunderstood by people, or worse that people have been dangerous (e.g., physical/or sexual assault), it is likely that they will be supersensitive to and highly watchful for danger. This can sometimes result in an over-reaction to incorrectly perceived danger, when none exists. This may result in wariness or even frank paranoid thinking.

Your client may be someone who intentionally or unintentionally dissociates as a way of not feeling. Dissociation may take milder forms of detachment—"feeling

numb" or "switching out," where the person is simultaneously aware of dissociating—or more extreme forms where the person has no awareness of dissociating and has memory absences for event/s and periods of time.

Consumer comment

At times of stress I have had experiences of completely "losing time," becoming aware of being in a different place (even city) to where I last recalled and having no idea of the time or day. Whilst I have been able to "choose" to dissociate, 90% of the time the experience has come upon me without choosing (Jackson, personal communication).

Dissociation and self-harm as discriminating features

Severe dissociation (Zanarini, Ruser, Frankenberg, & Hennen, 2000) and persistent self-harm correlate with a diagnosis of BPD and are probably the two most discriminating features in making a diagnosis. Of course, neither self-harm nor severe dissociation is sufficient for the diagnosis. Many people who do not meet criteria for BPD self-harm or severely dissociate. The literature is less clear about what percentage of people who engage in an episode of self-harm meet diagnostic criteria for BPD, as most studies of suicidal behavior have not reported on Axis II diagnoses (Linehan, 1993a). See sections on co-occurring conditions and understanding self-harm later in this chapter for further information.

Understanding borderline personality disorder

It is important to recognize that the diagnosis of BPD is only one part of understanding the unique personhood of the individual with BPD and that the diagnosis is integrated with other ways of understanding the person. Identification of specific and unique factors that maintain problems will guide personalized, validating, and humanizing treatment planning and suggest solutions specific to our clients.

Consumer comment

When I was diagnosed with BPD, the common language used was that I "was" a borderline personality disorder. I hated this, emphasizing for me the sense that I was entirely damaged. As consumers we speak of ourselves as "someone who meets diagnostic criteria for BPD" or as someone "who has BPD." This sits much better with me, as it indicates that this is just one part of what made up the person that was me (Krawitz & Jackson, 2008).

Grouping DSM-IV-TR diagnostic criteria

One way of thinking about the main features of BPD is to group the DSM-IV-TR diagnostic criteria into three groupings:

- *emotion group* (highly reactive mood and emotions, unstable relationships, emptiness, abandonment fears, intense anger)
- *impulsivity group* (e.g., self-harm, substance use)
- *identity group* (emptiness, abandonment fears, unstable self-image/sense of self).

Many people consider adding a sensitivity group (paranoid thinking) as some patients' main symptoms may be related to a self-referent and crippling interpretation of the world and a sensitivity to others' views of them.

Linehan's biological vulnerability theory

Linehan's (1993a) theory is that people with BPD might have a constitutional biological vulnerability that predisposes them to developing BPD. This biological vulnerability comprises:

- high sensitivity (low threshold of emotional response to situations)
- high reactivity (emotional response is large)
- slow return to baseline (emotional distress persists over time).

This biological emotional sensitivity and intensity is neither good nor bad and has advantages and disadvantages that can be worked with.

Emotional sensitivity

There is now some research evidence that people with BPD have high baseline emotion sensitivity, especially to unpleasant emotions (Jacob et al., 2008, 2009; Kuo & Linehan, 2009; Rosenthal, Gratz, Cheavens, Lejuez, & Lynch, 2008). This research is congruent with clinical experience, where a number of people with BPD and clinicians have described the emotional sensitivity of people with BPD as being like that of the physical sensitivity of people with severe extensive burns. One of us (Roy) worked for a few months many years ago in a hospital burns unit. The physical pain of the patients was enormous, as can no doubt be imagined. The burns left people with understandable skin sensitivity, where what would have been for others slight changes, such as movement of the sheets, caused pain of a level that words seemed unable to communicate. Another simile is that the emotional intensity and distress of people with BPD is a bit like the pain of being romantically dumped, which some of us might have experienced, except that the pain does not lessen with the passage of time (with the permission of Ruth E.S. Allen).

Consumer comment

It seemed that behaviors that appeared insignificant to others could lead to emotional reactions from me of stratospheric proportions. It seemed that no action, including severe self-harm, or words could effectively communicate to others the intensity of my experience. Other people didn't seem to "get it," not that I made it easy for them. Caring meaningful attempts at expressions of empathy by others led to derision from me as I did not believe that anyone could possibly understand the intensity of my pain.

Even when the seemingly insignificance or "smallness" of the trigger was apparent to me on an intellectual level, I struggled to express to anyone how I could be upset by such an apparently insignificant comment, action or inaction (Jackson, personal communication).

Mentalizing vulnerability

Fonagy and others have proposed that people with BPD have a vulnerability to losing mentalizing abilities, particularly in interpersonal interactions. (Fonagy & Bateman, 2008a; Fonagy, Gergely, Jurist, Elliot, & Target 2002; Fonagy, Target, & Gergely, 2000). This vulnerability arises from a complex interaction between temperamental and developmental factors. People with BPD are left with a biology of "being frazzled" and easily taken "off-line" (Arnsten, 1998). People with BPD are uniquely sensitive to interpersonal stress and the brain "brakes" in the higher brain centers fail to control the "gas pedal" located in the lower centers. The model takes into account constitutional vulnerability and is rooted in attachment theory and its elaboration by contemporary developmental psychologists (Fonagy, 2003; Fonagy & Bateman, 2007, 2008b; Gergely, 2001). The model suggests that disruption of the attachment relationship early in development in combination with later traumatic experiences in an attachment context interacts with neurobiological development. The combination leads to hyper-responsiveness of the attachment system, which makes mentalizing, the capacity to make sense of ourselves and others in terms of mental states, unstable during emotional arousal. The emergence of earlier modes of psychological function at these times accounts for the symptoms of BPD such as:

- frantic efforts to avoid abandonment
- pattern of unstable and intense interpersonal relationships
- rapidly escalating tempo moving from acquaintance to great intimacy
- emotional dyscontrol.