What is Borderline Personality Disorder?

Patients with borderline personality disorder (BPD) have problems with almost every aspect of their lives. They have problems with constantly changing moods, their relationships with others, unclear identities and impulsive behaviours. Outbursts of rage and crises are commonplace. Despite the fact that many BPD patients are intelligent and creative, they seldom succeed in developing their talents. Often their education is incomplete and they remain unemployed. If they work, it is often at a level far below their capabilities. They are at a great risk of self-harm by means of self-mutilation and/or substance abuse. The suicide risk is high and approximately 10% die as a result of a suicide attempt (Paris, 1993).

The DSM-IV diagnostic criteria for BPD are used as the standard definition for the diagnosis and indication of BPD and not the psychoanalytical definition of the borderline personality organization (Kernberg, 1976, 1996; Kernberg et al., 1989). The borderline personality organization includes a number of personality disorders and axis-I disorders and is therefore far too extensive for the specific treatment for BPD that will be described here. According to the DSM-IV, patients must satisfy at least five of the nine criteria, as listed in Table 1.1, to obtain a diagnosis of BPD. The essential general feature of the DSM-IV definition of BPD is instability and its influence on the areas of interpersonal relationships, self-image, feelings and impulsiveness.
Table 1.1 DSM-IV diagnostic criteria for borderline personality disorder.

A pervasive pattern of instability of interpersonal relationships, self-image and affects, as well as marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by at least five (or more) of the following criteria:

1. Frantic efforts to avoid real or imagined abandonment. Note: Not including suicidal or self-mutilating behaviour as 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, promiscuous sex, binge eating, substance abuse and reckless driving). Note: Not including suicidal or self-mutilating behaviour as covered in criterion 5.
5. Recurrent suicidal behaviour, gestures, threats or self-mutilating behaviour such as cutting, interfering with the healing of scars or picking at oneself.
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, worthlessness.
8. Inappropriate anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger and recurrent physical fights).
9. Transient, stress-related paranoid suicidal ideation or severe dissociative symptoms.


Prevalence and Comorbidity

BPD is one of the most common mental disorders within the (outpatient) clinical population. Prevalence in the general population is estimated at 1.1% to 2.5% and varies in clinical populations depending on the setting, from 10% of the outpatients up to 20–50% of psychiatric committed patients. However, in many cases the diagnosis of BPD is still made late in assessment or not given at all. This might be due to the high comorbidity and other problems associated with BPD, which complicate the diagnostic process.
The comorbidity in this group of patients is high and diverse. On axis-I, there is often depression, eating disorders, social phobia, PTSD or relationship problems. In fact one can expect any or all of these disorders in stronger or weaker forms along with BPD.

All of the personality disorders can be co-morbid to BPD. A common combination is that of BPD along with narcissistic, antisocial, histrionic, paranoid, dependent and avoidant personality disorders (Layden et al., 1993).

Reviews and studies by Dreessen and Arntz (1998), Mulder (2002) and Weertman et al. (2005) have shown that anxiety and mood disorders are treatable when the patient has a comorbidity with a personality disorder. However, in the case of BPD, one must be careful to only treat the axis-I disorder. BPD is a serious disorder that results in permanent disturbance of the patient’s life with numerous crises and suicide attempts, which makes the usual treatment of axis-I disorders burdensome. Axis-I complaints and symptoms often change in nature and scope, making the diagnostic process even more difficult. This often results in the treating of BPD taking priority. Disorders that should take priority over BPD in treatment are described in ‘(Contra-) Indications’ (see Chapter 2).

**Development of BPD**

The majority of patients with BPD have experienced sexual, physical and/or emotional abuse in their childhood, in particular between the ages of 6 and 12 (Herman, Perry and van der Kolk, 1989; Ogata et al., 1990; Weaver and Clum, 1993). It is more problematic to identify emotional abuse in BPD patients than to identify sexual or physical abuse. Emotional abuse often remains hidden or not acknowledged by the BPD patient out of a sense of loyalty towards the parents or due to a lack of knowledge of what a normal, healthy childhood involves.

These traumatic experiences in combination with temperament, insecure attachment, developmental stage of the child, as well as the social situation in which things took place, result in the development of dysfunctional interpretations of the patient’s self and others (Arntz, 2004; Zanarini, 2000). Patients with BPD have a disorganized attachment style. This is the result of the unsolvable situation they experienced as a child, in which their parent was both a menace or threat, as well as a potential safe haven (van
Ijzendoorn, Schuengel and Bakermans-Kranenburg, 1999). Translated into cognitive terms, a combination of dysfunctional schemas and coping strategies results in BPD (e.g. Arntz, 2004).

Patients with BPD have a very serious and complex set of problems. Because the patient’s behaviour is so unpredictable, it exhausts the sympathy and endurance of family and friends. Life is not only difficult for the patients, but also for those around them. At times, life is so difficult that the patient gives up (suicide) or her support system gives up and breaks off contact with the patient. Treating BPD patients is also fatiguing for the mental health care giver.

Schema therapy offers BPD patients and therapists a treatment model in which the patient is helped to break through the dysfunctional patterns she has created and to achieve a healthier life.