



# Borderline Personality Disorder

What  
you need  
to know  
about this  
medical  
illness

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## ■ **Borderline Personality Disorder: What You Need to Know**

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Borderline personality disorder (BPD) is an often misunderstood condition that has many challenging aspects. Behaviors of the disorder are characterized by intense and stormy relationships, low self esteem, self-sabotaging acts, mood fluctuations and impulsivity. The hallmark of BPD is emotional dysregulation (severe difficulty regulating emotions).

These symptoms can make for difficulties in personal, social and employment relationships. BPD is estimated to affect about 1-2 percent of Americans. More females are diagnosed with BPD than males by a ratio of about 3-to-1, though some clinicians suspect that males are underdiagnosed.

New research and treatment ideas have improved the outlook for people living with BPD.

## ■ **What's in a name?**

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Historically, the term “borderline” has been controversial. BPD used to be considered on the “borderline” between psychosis and neurosis. The name stuck, even though it doesn't describe the condition very well and, in fact, may be more harmful than helpful. The term “borderline” also has a history of misuse and prejudice—BPD is a clinical diagnosis, not a judgment.

Current ideas about the condition focus on ongoing patterns of difficulty with self-regulation (the ability to soothe oneself in times of stress) and trouble with emotions, thinking, behaviors, relationships and self-image.

## ■ **Is BPD a serious mental illness? Isn't it a personality disorder?**

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BPD is a serious mental illness that can cause a lot of suffering, carries a risk of suicide and needs an accurate diagnosis along with targeted treatment. BPD is a relative newcomer to the psychiatric world—it was officially recognized by the American Psychiatric Association (APA) for the first time in 1980. Related areas of research, medication, treatment options and family support programs should follow suit.

BPD is currently classified by the APA as a “personality disorder.” “Personality” is defined as a cluster of traits, unique to each person, which determines how one relates to oneself, other people and the world. A “personality disorder” is a regular pattern of relating to oneself and others that is troubled.

In imaging studies, people with BPD have been shown to have changes in brain structure and chemistry, providing proof that there is a biological component to the disorder. Some experts believe that the condition is not a personality disorder but should instead be classified akin to other serious conditions like bipolar disorder. However, BPD is currently classified as a personality disorder. As with all mental illnesses, there is still a lot to be learned about the condition, and there is an ongoing need for more research.

## ■ **Is it true that a person with BPD will do self-harming and impulsive things? Why?**

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It can be difficult to imagine being in the shoes of a person with BPD, but intentionally injuring oneself and impulsive and mood-dependent actions are actual characteristics of the disorder. Cutting and other self-injurious behavior are scary and often difficult to understand. This way of dealing with overwhelming feelings may have biological roots. Research suggests a release of endorphins—chemicals naturally found in the brain—after cutting. Substituting alternate coping strategies for self-injury is a key part of treatment. Fear of abandonment and a tendency to overvalue or devalue others are also characteristics of the disorder. Patterns of impulsive behavior and problems with anger—combined with self-harming behaviors and ways of thinking—can lead to stormy relationships. Fortunately, many people with BPD are able to recognize these patterns in themselves, develop strategies to cope with them and improve the quality of their lives over time.

## ■ **Is suicide a risk?**

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Suicide is a very real concern for persons with the condition. Overall, the total percentage of people with BPD who commit suicide is about 8-10 percent. This puts persons diagnosed with BPD among the highest risk for suicide attempts.

Many factors make this risk more or less likely, however. For example, the risk increases for people with BPD who also have alcohol or drug problems but who don't get needed treatment. Treatments like Dialectical Behavior Therapy (DBT) can reduce the risk (more on DBT is discussed later in this booklet). Sadly, some people likely kill themselves by accident as part of an effort to self-injure.

## ■ What is the course of the condition?

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The course of BPD depends on many factors. Research has shown that outcomes can be quite good for people with BPD, particularly if they are engaged in treatment. Often, the teens and early twenties are the hardest years, with frequent hospitalizations, suicide attempts and self-injury (like cutting) crises being common. Research has shown that many people's conditions improve over time. Pursuing treatment and learning about the condition and ways to manage it often pay off. In this way, BPD is a high-risk condition but may have a good outlook.

## ■ How can families deal with the behavior they find so unpredictable and difficult?

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BPD can be challenging to live with for persons who have it, and also for their families and loved ones. Strong emotions and impulses can affect loved ones. Enduring relationships are important to help people with BPD, but the disorder often strains those relationships. Those in relationships with people with BPD need strategies and support, too. Fortunately, there are good resources and programs available to support people in this area. The National Education Alliance on Borderline Personality Disorder (NEA-BPD) has the “Family Connections Program”<sup>©</sup> designed to meet this need. The NAMI Family-to-Family program, offered through many NAMI affiliates in communities across the country, also offers knowledge and support. Also, there are many books that offer excellent resources to help families think about how best to support their loved one—and themselves—when living or working with someone who has BPD.

## ■ With BPD, is having been a victim of abuse usually part of the “cause” or “history?”

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Not necessarily. There are, however, events that may play a role in the development of the condition. The most severe event may be various forms of abuse: emotional, physical and sexual. Loss and neglect may also be contributing factors. However, some people with no history of abuse at all also develop BPD. The current theory is that some people may have a higher biological or genetic vulnerability to this condition, and adverse childhood conditions can increase the risk of eventually developing the disorder. The experiences of people living with BPD who have no history of experiencing abuse also indicate that there can be a very strong biological component to the condition. It is important to remember that due to biological differences, some children need much more support, emotional coaching and interpersonal validation than

others. The current emphasis of many treatments is to focus on the present-day realities and strategies to cope while respecting the role of the past in the person's life.

## ■ Is there a blood test to help with the diagnosis?

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No. At this time, there are no blood tests or imaging studies (like CAT scans) that help diagnose BPD. Brain imaging is helping researchers and clinicians to understand the condition, and more brain research is needed. The condition is a clinical diagnosis; there are certain patterns of behaviors and experiences that lead to the diagnosis.

## ■ What are the clinical criteria used to make a diagnosis of BPD?

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The following are the current diagnostic criteria as published by the American Psychiatric Association in the *Diagnostic and Statistical Manual (DSM) IV*:

A pervasive pattern of instability of interpersonal relationships, self-image and affects and marked impulsivity beginning in early adulthood and presenting 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;
- 3) identity disturbance;
- 4) impulsivity in at least two areas that are self-damaging;
- 5) recurrent suicidal behavior, suicidal gestures, threats or self-mutilating behavior;
- 6) affective [mood] instability;
- 7) chronic feelings of emptiness;
- 8) inappropriate, intense anger; and
- 9) transient stress-related paranoid ideation or severe dissociative symptoms.

*-Ed. Note: for the criteria 9, people with BPD only have paranoid thinking under severe stress and do not have this kind of symptom on a regular basis. Dissociative symptoms are when your consciousness splits off (e.g. a trauma survivor driving down a one-way street without realizing it).*

These criteria are being reviewed for the next version of the APA's DSM, currently projected to be published in 2012.



## **Do all people with BPD act the same?**

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No. While the symptom picture is often similar, each person has unique strengths and a specific relationship to his family and friends. Some may have other mental and medical conditions that complicate the condition. For instance, people with BPD often experience one or more of the following: depression, bipolar illness, eating disorders, anxiety, posttraumatic stress disorder and substance abuse. One person with BPD may be able to work productively, while another struggles as an employee. A complete assessment is necessary to put a good treatment plan in motion that addresses the person's strengths and weaknesses.

## **Why can't my sister see she has BPD? She meets all the criteria!**

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Many references to the disorder in the media and in books suggest that people with the disorder are bad or manipulative and that they are very hurtful to others. Many people with BPD can't see their own role in the storms of their lives. Difficulty tolerating strong feelings and a deep sense of shame can make people look to explain their problems as being caused by other people. The blaming that can result can be very stressful and bring on feelings of loneliness. Some people, often aided by good treatment, learn to accept their role in their troubles over time.

## **What types of treatment are there?**

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A good plan for an individual will likely involve first trying to find a therapist who is trained in one of the evidence-based treatments for BPD. Some of these are described below. There are also now treatments for families and friends that can help them be more supportive of the person with BPD. It can be very difficult sometimes to find therapists trained in specific evidence-based treatments. In these cases a therapist may apply parts of treatments or a menu of interventions: talk



therapy, skills training, group work, peer support, family education, work and school support, medications and issue-specific support groups, such as Alcoholics Anonymous or even NAMI Connection recovery support groups. A good plan has to be designed to meet the needs of a person based on their particular concerns. There is no "one-size-fits-all" remedy for persons living with BPD. More details about various treatments are given here:

### **Skills Training/Dialectical Behavioral Therapy**

Dialectical behavioral therapy (DBT) is a relatively recent treatment, developed by Marsha Linehan, Ph.D. To date, DBT is the best-studied intervention for BPD. DBT targets first and foremost the reduction of life-threatening and other out-of-control behaviors (such as severe drug addiction, eating disorders, interpersonal chaos, inability to regulate extreme emotions) that make a "life-worth-living" seem impossible. It then targets the reduction of emotional dysregulation and distress (quiet desperation) that is so common in BPD. Finally, it targets problems that interfere with the quality of life. DBT teaches a variety of self-regulation skills including: mindfulness, emotion regulation, interpersonal effectiveness and distress tolerance. Central components of DBT are the teaching and development of skills that the individual can use independently to manage strong feelings and impulsive urges. The treatment uses group and individual sessions, homework as well as telephone coaching, and the hard work often shows results. For example, DBT reduces the risk of suicide, anger, number of days in the hospital and, in general, increases positive concepts of self and helps many people function better in relationships.

DBT offers clear options for self-care, alternatives to self-destructive acts and new ways to understand one's behavior. Unfortunately, it can be difficult to find help; there is a shortage of professionals who are trained in this modality. Although insurance usually pays for DBT, it is wise to check to be sure. Asking your local service center to have practitioners trained in DBT is an important strategy for advocates.





There are also several other therapies that have shown to be effective (although even less available, to date, than DBT). While DBT has the best research base of any psychotherapy treatment for BPD, other psychotherapy strategies have a smaller research base to show that they may also help people with BPD. The examples of alternative psychotherapies are:

- Focusing on differentiating one’s feelings from those of others (mentalization);
- Focusing on the therapeutic relationship dynamic (transference focuses therapy); and
- Intensive one-to-one therapy called schema-focused therapy.

## **Psychotherapy**

A therapeutic relationship with a knowledgeable, compassionate professional can offer great help to people with BPD (see Eileen White’s experience). There are many branches of psychotherapy that may be useful for BPD. Typically, they have several features in common: the centrality of a clinical alliance, a focus on relationships (including the relationship with the therapist), the development of alternatives to self-destructive behaviors and a safe place for a person to take their concerns and learn new behaviors. For many people, a good relationship with a therapist can make all the difference.

Cognitive Behavioral Therapy (CBT) is focused on evaluating and changing a person’s thinking, which often drives a person’s experience. This may be a useful way to address depression and anxiety as well since both conditions often co-occur with BPD.

## **Peer Support**

Learning from someone who has “been there” can be a very useful tool. When a person with BPD manages to get control of his or her symptoms and develops alternative behaviors and strategies, he or she can become models for hope and learning. Peer support can be helpful in reducing shame and isolation that can occur with the condition. Such support is not a substitute for professional care, but it can be a crucial element in helping people manage and recover. See NAMI Peer-to-Peer and NAMI Connection in the resources section. Also, some people use online forums developed for and by people with BPD to enhance treatment.

## **Family Education**

Without help, living with a person affected by BPD can be exhausting and difficult. As people with BPD are very sensitive to their relationships and environment, improving family support can assist all concerned. There are strategies that family members can use to help themselves and, in turn, support the person who has BPD. See the resources section of this booklet for information on the NAMI Family-to-Family program as well as a list of other resources.

## Medications

While medicines can be a very important part of helping people with BPD, there is no single medication to treat the condition. Medications can address symptoms that occur with BPD and can help the effectiveness of therapy. Studies have shown that medication coupled with therapy often leads to improvement for people with BPD.

The selection of medication depends on the person's needs and, if considered, should be part of the overall treatment plan as decided by the mental health professional and the individual. For instance, antidepressants can help with symptoms of depression and anxiety. Antipsychotic medications can alleviate breaks from reality, organize thinking and reduce paranoia. Impulse-control medicines may help with this important area of concern for people with BPD.

Each person responds differently to medication, so it is essential that this element of care is discussed in detail on an ongoing basis with a qualified practitioner. All medicines have risks and benefits. Since people with BPD can benefit from taking medications, the task is then to find the most effective combination of medications with the fewest side effects. Medicines can help alleviate some of the symptoms so that learning in psychotherapy can occur more easily.

## ■ How do I select a health care provider?

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Finding a good fit with a health care provider is an important piece of the puzzle. As there is a shortage of caregivers for the condition, it can be difficult to find one in some parts of the country. Some questions to consider when talking with a potential health care provider are:

- Do you have experience working with people who have BPD?
- Do you have training in DBT or other psychotherapy that may help me?
- Do you have support from your clinic in terms of helping me?
- Do you work with a nurse-practitioner or psychiatrist in a coordinated way in case I need medication?
- What happens when you are on vacation?
- What strategies have worked for people you have helped?
- Do you see our work as a partnership?

## Why didn't anyone tell me that I had BPD?

Sometimes people with BPD can get as many as five other diagnoses before being given a diagnosis of BPD. There are likely many reasons for this. Sometimes doctors focus on an additional illness, like depression or bipolar illness, and “overlook” BPD. Other mental health professionals feel that the diagnosis of BPD may bring the person discrimination—reflecting the history of how people with BPD have been treated at times in the past—so they don't name it. Also, personality disorder diagnoses are often not made in short-term settings, like hospitals. Still, most individuals with BPD report that they are helped by learning that their experiences have a name, a biological component and specific treatment options. Knowledge is power. Once told the diagnosis, whether to patients or family members, people often say, “if only we had known.”



## **I can't get a therapist to see me. What can I do?**

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This can be a major concern. Finding someone who has the training, inclination and professional network to treat people with BPD can often be challenging. Network and ask others in your community for referrals to qualified clinicians. Work with the advocacy groups in your area to press the local center for more resources. Find out if your insurance program is required to provide you with qualified treatment.

## **I want to advocate to make things better for people with BPD and their families. What can I do?**

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Advocacy can take many forms. Insurance problems, research needs, a shortage of therapists and prejudice and discrimination are all important problems for persons living with BPD. Organizations like NEA-BPD and NAMI have active advocacy agendas and can help point you in the right direction to get started. In addition to participating in organized advocacy groups, speaking openly about the role of BPD in your life can help improve awareness and attitudes, one person at a time.

*Written by Ken Duckworth, M.D.*

*With thanks to Marsha Linehan, Ph.D., for her editorial assistance.*

### **Eileen's Testimonial:**

*Borderline Personality Disorder has altered my life. While everyone else seemed to have lives that flowed with ease, my life was a book of unrelated chapters of chaos.*

*Relationships were impossible—ranging from jaunts with strangers who quickly became my “soul mates” to men that I despised and blamed for my internal turmoil. This led to multiple marriages and relationships.*

*A lack of sense of self was the hallmark symptom of my disorder and one that had the greatest impact on my traumatic years of nonrecovery. I remember the first time I saw my psychologist and he asked me to describe myself. I honestly could not give him an answer besides “slim, blond and 5’6.” I had no adjectives to describe my core self because there was no core self—it was a foreign concept to me.*

*I always adapted the interests and values of the person I was involved with. If my husband was a Yankees fan, then so was I. If he liked Greek food, then it quickly became my favorite. I actually felt like an empty hole that could never be filled up. When a relationship ended, it was completely catastrophic to me. Working on developing a sense of self has been the hardest part of recovery for me.*

*My greatest fear—one that often became a self-fulfilling prophecy—was fear of abandonment. I always knew that people in my life were there temporarily and that often led to my hero-to-zero treatment of them becoming the norm. They never knew when they would change from being my other half and the best thing that ever happened to me to the reason I had problems to begin with. It's not easy to live with someone who changes like the wind, and I regret all of the innocent people that were at the receiving end of my unpredictable wrath. But the sad truth is that as much as I know that I've hurt people with my ever-changing, all-or-nothing moods and decisions, they were never close to feeling the pain I had inside. To know that you are alone, or feel the loneliness that only those with BPD experience, is a living hell.*

*My anger in those untreated years was full-blown rage. I could go from happy to all-out rage in a matter of seconds—I could even taste adrenaline in my mouth in those periods of total chaos. I also have been known to physically trash a room in a blind rage.*

*My impulse-driven behavior has been the cause of great anguish. I would get drunk as early as 14 years old and experimented with drugs. I would often drive a car recklessly. I compulsively shop and spend money, a symptom I struggle with to this day. I had to declare bankruptcy at 25, after a binge following the breakup of a relationship.*

*The many years I lost to BPD were years marked by sadness, depression, chaos, loneliness and hopelessness. I thought of suicide often, and I worked at countless jobs and was even fired from a few—my erratic behavior baffled many employers. I was always chasing a rainbow that I could never catch. I moved from state to state, and tried to move out of the country several times. I was sure my location was the root of my problems.*

*In my past, I took anything that was said to me to heart and let it completely ruin my day, week or month. I now know that some comments that initiated a major meltdown*

with me were words that the person who said them probably didn't give two thoughts about. For the first few years in therapy (and yes, I said years), I would take everything my doctor said to heart. I was sure he hated me and wished I would just go away or die. I ran people out of my life on a regular basis, but he decided that I wasn't a bad person, but that I was ill and that it was his job to help me. I can not say how extremely important therapy with a reputable therapist is to someone with BPD, and even though things have calmed down as I've gotten older, I feel it's only because of the skills I've developed as a result of therapy and medication. I also believe that making a commitment with a therapist as to rules of behavior on both ends is crucial. I had to know that my doctor would be there for me, and I had to keep up my end of the bargain by showing up for scheduled appointments, stopping any self-mutilation or suicide attempts and believing in myself and the possibility of a future.

I now have a wonderful life. I still deal with symptoms of my BPD and other related illnesses. The education and support I have received through NAMI has been essential to my "rebirth." Now, my mission is to tell others who are living through this nightmare that they are worthy of recovery and that it is possible. I was extremely lucky in that I found a psychologist who knew what he was up against but still knew that I could have a future and a happy life. That miracle can happen to others, but not until the medical community decides to finally treat BPD as the serious illness that it is, and not a character flaw.

I'm not free from BPD, especially when I experience stress. However, I now recognize my triggers and have the skills to manage the symptoms. It's time to take this disease and its misconceptions and stereotypes out of the dark ages and into the light of recovery and hope.

Sincerely,

Eileen White

## What is NAMI?

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The National Alliance on Mental Illness (NAMI) is the nation's largest grassroots mental health organization dedicated to improving the lives of individuals and families affected by mental illness. NAMI has over 1,100 affiliates in communities across the country who engage in advocacy, research, support and education. Members of NAMI are families, friends and people living with mental illnesses such as major depression, schizophrenia, bipolar disorder, obsessive-compulsive disorder (OCD), panic disorder, post-traumatic stress disorder (PTSD) and borderline personality disorder.

### To learn more about your local affiliate:

**Call** your state's NAMI office

**Write to:** NAMI • 3803 N. Fairfax Drive  
Arlington, VA 22206

**Contact the NAMI Information HelpLine** at  
1 (800) 950-NAMI (6264) or

**Visit NAMI's Web site** at [www.nami.org](http://www.nami.org)

Many NAMI affiliates offer programs designed to assist individuals and families affected by mental illness:

**NAMI Peer-to-Peer** is a free nine-week education course on the topic of recovery for any person with a serious mental illness. Led by mentors who themselves have achieved recovery from mental illness, the course provides participants comprehensive information and teaches strategies for personal and interpersonal awareness, coping skills and self-care.

**NAMI Family-to-Family** is a free 12-week course for family caregivers of adults with mental illness. Taught by trained NAMI family members who have relatives with mental illness, the course provides caregivers with communication and problem-solving techniques, coping mechanisms and the self-care skills needed to deal with their loved ones and the impact on the family.

**NAMI In Our Own Voice** is a public education presentation. It enriches the audiences' understanding of how the over 58 million Americans contending with mental illness cope while also reclaiming rich and meaningful lives. Presented by two trained speakers who themselves live with mental illness, the presentation includes a brief video and personal testimonials, lasts 60-90 minutes and is offered to a variety of audiences free of charge.



**NAMI Connection** is a recovery support group for adults with mental illness regardless of their diagnosis. Every group is offered free of charge and meets weekly for 90 minutes. NAMI Connection offers a casual and relaxed approach to sharing the challenges and successes of coping with mental illness. The groups are led by trained individuals who are in recovery—people who understand the challenges others with mental illness face.

**NAMI Basics** is a free educational program for parents and other primary caregivers of children and adolescents with mental illness. The course is presented in six different classes, provides learning and practical insights for families and is taught by trained parents and caregivers who have lived similar experiences with their own children.

## ■ Information Resources:

**www.nami.org** NAMI's Web site is visited by over half a million unique visitors each month and features the latest information on mental illness, medication and treatment, news and resources promoting support, education and advocacy. Special Web sections include resources for Veterans, college students, multicultural groups and others. Additional features include online discussion groups and options for registration through **myNAMI**, which enables users to receive personalized information and e-mail updates on a variety of topics of their choosing.

**1 (800) 950-NAMI**, the NAMI Information HelpLine receives over 4,000 requests each month from individuals needing support, referral and information. Over 60 fact sheets on a variety of topics are available along with referrals to NAMI's network of local affiliates in communities across the country.

**Peer-to-Peer:** [www.nami.org/peertopeer](http://www.nami.org/peertopeer)

**Family-to-Family:** [www.nami.org/familytofamily](http://www.nami.org/familytofamily)

**In Our Own Voice:** [www.nami.org/IOOV](http://www.nami.org/IOOV)

**Connection:** [www.nami.org/connection](http://www.nami.org/connection)

**Basics:** [www.nami.org/basics](http://www.nami.org/basics)

**Behavioral Tech, LLC a site founded by Dr. Marsha Linehan:**  
<http://behavioraltech.org>

**National Institute of Mental Health (NIMH):**  
[www.nimh.nih.gov](http://www.nimh.nih.gov)

**National Education Alliance for Borderline Personality Disorder:** [www.neabpd.org](http://www.neabpd.org)

**Borderline Personality Disorder Resource Center (run by New York Presbyterian, the University Hospital of Columbia and Cornell):** [www.bpdresourcecenter.org](http://www.bpdresourcecenter.org)

**BDP Central, a site founded by author Randi Kreger:**  
[www.bpdcentral.org](http://www.bpdcentral.org)

## Books

The following books are a good place to start learning about BPD. They are available in many libraries or can be ordered from booksellers, including a link to Amazon.com at [www.nami.org/store](http://www.nami.org/store). New books are also listed in the *Advocate*, the NAMI news magazine available to NAMI members, and frequently listed in the *Advocate* e-Newsletter, NAMI's electronic newsletter available by subscription through registration on NAMI's Web site, [www.nami.org](http://www.nami.org).

*Stop Walking on Eggshells: Taking Your Life Back When Someone You Care About Has Borderline Personality Disorder* (1998) by Paul T. Mason and Randi Kreger

*Borderline Personality Disorder Demystified* (2004) by Robert Friedel

*Cognitive-behavioral Treatment of Borderline Personality Disorder* (1993) by Marsha Linehan

*Skills Training Manual for Treating Borderline Personality Disorder* (1993) by Marsha Linehan

*Dialectical Behavior Therapy with Suicidal Adolescents* (2006) by Alec L. Miller, Jill H. Rathus, Marsha M. Linehan and Charles R. Swenson

*Understanding and Treating Borderline Personality Disorder: A Guide for Professionals and Families* (2005) John Gunderson and Perry Hoffman, editors

*Get Me Out of Here; My Recovery from Borderline Personality Disorder* (2004) by Rachel Reiland

*Borderline Personality Disorder (The Facts)* (2008) by Roy Krawitz and Wendy Jackson

*The Borderline Personality Disorder Survival Guide* (2007) by Alex Chapman and Kim Gratz

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NAMI Information Helpline:  
1 (800) 950-NAMI (6264)

[www.nami.org](http://www.nami.org)