# Borderline Personality Disorder, New Treatment, and Minority Diagnosis

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Borderline Personality Disorder is characterized by mood instability, impulsivity, and impaired social relationships and is part of the "dramatic, emotional, and erratic" Cluster B of personality disorders. (Comer, 2014) It was first recognized by the American Psychiatric Association in 1980 when it became part of the standard diagnostic classification system. The ontogeny of the disorder was first looked into as patients increasingly did not fit into the diagnostic criteria of other disorders or providers deemed it to be an atypical variant of another disorder. Many times, providers believed their patients may have had schizophrenia, as "they had lapses in their reality testing; like depression, they were often desperately unhappy; and like antisocial personality, they seemed impulsive and willfully noncompliant". (Gunderson et al., 2013) As more research was conducted on "spectrum disorders" throughout the 1960's-1970's, Borderline Personality Disorder was officially added to the DSM-III in 1980.

In the DSM-5, the current BPD diagnostic criteria emphasize a significant pattern of instability with self-image, interpersonal relationships, impulsivity, and affects beginning by at least early adulthood, and present in a variety of settings. To be diagnosed with Borderline Personality Disorder, at least 5 of the following criteria must be met:

(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

(American Psychiatric Association, 2013).

Though the information above is the standard which clinicians and other health care providers adhere to when attempting to diagnose BPD, there exists a proposed redefinition to the aforementioned criteria that was created by the DSM-5 Task Force. (Gunderson et al., 2013) In this proposed redefinition, BPD would be considered a trait disorder that is a variant of a normal personality instead of pertaining to the Cluster B of personality disorders. However, due to the lack of research surrounding this theory, the experts in the psychiatric field deemed that it would be too drastic a change to implement immediately. (Gunderson et al., 2013) Still, there are many proponents for a more dimensional approach to diagnosing BPD.

Prevalence of Borderline Personality Disorder in the general population is estimated to be between 1.5%-2.5%, with 75% of those diagnosed identifying as female. (Comer, 2014) In most

epidemiological studies' community samples however, both genders demonstrated similar rates of BPD prevalence. Further challenges occur with stereotypes pertaining to gender when diagnosing BPD, namely, characteristic traits such as anger and impulsivity are more likely to be considered pathological in women than in men. Additionally, female providers are more likely to diagnose females with BPD. (Gunderson et al., 2013) Presently, challenges with diagnosing BPD no longer lie in its validity as a disorder, but more so with understanding its etiology. Though there are no epidemiological studies which have recorded a specific age of onset for BPD, emergence of symptoms such as impulsivity and self-destructive behaviors are noted to begin most often during adolescence, especially affecting those within lower social classes. In particular, having "low socioeconomic status, family disruption, life stress, maternal inconsistency in the presence of over-involvement, aversive or hostile parental behaviors, and low parental affection" are key psychodynamic and cultural indicators that show how environment and parental factors may contribute to the development of BPD. (Gunderson et al., 2013) In early neurobiological research, results demonstrated "hyperreactivity in limbic structures, primarily the Amygdala, while later studies began to describe distinct dysfunction in prefrontal and frontolimbic activity" as the biggest marker of emotional dysregulation. (Gunderson et al., 2013)

Though much progress has been made regarding the neurobiological research of BPD, further studies are needed to assess overlap between this disorder and other disorders, such as Major Depressive Disorder or PTSD. Comorbidity is often present with BPD patients, with up to 75% of those diagnosed with borderline having co-occurrence with MDD. Another issue in question is determining the differential diagnosis between BPD and Major Depressive Disorder, Bipolar, and complex PTSD. Oftentimes, providers diagnose MDD because the prevailing

symptoms appear to be depression, but later find that BPD's depression does not respond to antidepressants alone. (Gunderson et al., 2013) With the prevalence of spectrum disorders, BPD patients also tend to be mislabeled as bipolar due to their apparent emotional and behavioral dysregulation. There have also been challenges dispelling early research which suggested that the trauma experienced by borderline patients was associated with PTSD. It is now known that many BPD patients do not experience these traumas, and supporting this fact are the various treatments available to BPD patients, such as DBT and schema therapy, that focus on gaining control of and understanding emotions rather than concentrating treatment on the trauma that cannot be changed. (Gunderson et al., 2013)

Initially, treatment for borderline patients was focused on the disorder's behavioral and emotional deficits. Clinicians sought to "restructure personality and eliminate BPD symptoms" with intensive treatment that was mostly patient-led and unstructured, and consequently ineffective. (Gunderson et al., 2013) Beginning in the 1990's, structured, goal/symptom-oriented treatments that often involved a team of therapists were introduced to borderline patients. (Gunderson et al., 2013) The most recognized and frequently used of the treatments that were introduced for BPD was DBT, or Dialectical Behavior Therapy. According to *Table 6. Evidence-Based Treatments for BPD*, DBT is a "behavioral therapy that teaches distress tolerance, emotional regulation, interpersonal effectiveness, and mindfulness" encouraging the patient to take control of themselves through awareness of their specific symptoms. (Gunderson et al., 2013) When a patient is able to recognize the difficulties they experience with their disorder, they may be more inclined to learn how to navigate their maladaptive behaviors. Borderline patients are better able to recognize their potential triggers when engaged in mindfulness, and subsequently, they are able to identify and utilize coping mechanisms that help them regulate

their emotions. DBT can incorporate group therapy and individual sessions with the patient in order to maximize efficacy. Combining family treatment with DBT or other therapies has also proven to be positive in supporting the borderline patient due to family dynamics being integral to the patient's success or failure, families inherently being exposed to stress due to the borderline patient's problems, and finally, families may have existing dysfunction that impacts their relationship to each other and the patient. (Gunderson et al., 2013) When this type of treatment is integrated, there is a considerably wider support network and families are better able to communicate effectively with the borderline patient, assist with navigating their emotions, and provide validation for their perceived injustices or difficulties; all which may lend to the development of empathy and a more positive connection between the patient and their family.

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In recent years, clinicians with borderline patients have begun to implement Schema therapy into their treatment plans. Schema therapy was developed as a treatment for personality disorders and is a multifaceted approach to psychotherapy. It integrates concepts from Cognitive Behavioral Therapy (CBT), attachment theory, gestalt therapy and psychodynamic perspectives (Tan et al., 2018). Schema therapy relies on two conceptual models that determine the patients' issues and help to understand the process of change. The first is known as EMS, or Early Maladaptive Schemas, which help identify persistently self-defeating behaviors and dysfunctional thought patterns or cognitions; all of which typically develop during childhood but continue to increase in prevalence throughout the person's life. (Tan et al., 2018). EMS typically develop as a result of unmet needs, encountering hostility, or experiencing unwarranted criticism during these periods of critical childhood development. The second is the schema mode model which describes the state a patient is currently in rather than the traits they display in regard to

Borderline Personality Disorder. The model then analyzes the patient's interaction with their schema and particular coping mechanisms. Schema therapy also uses experiential treatments such as imagery reframing, which is "a method that subsequently assists in re-creating and altering parts of that situation in order to change one's experience and meaning of that past situation", essentially giving the patient the tools to take control of their emotions and modes. (Tan et al., 2018) Schema therapy has demonstrated that it is a promising alternative to more common forms of treatment, such as DBT, CBT, or other psychodynamic therapies.

There is a wealth of information that details ST, its systems, and treatment modality. BPD patient self-reported experiences of DBT, art therapies, and other support groups are noted in a few reports, and there exists one study that analyzed patient perspectives in a post-treatment setting; however, that study did not have patients that would have met the criteria for BPD. (Tan et al., 2018) *Schema therapy for borderline personality disorder: A qualitative study of patients' perceptions* is a study that aimed to reveal BPD patient experiences with ST and gather feedback for improving the therapy in group and individual sessions, explore group dynamics and processes, and consider patients' opinions about ST structure. (Tan et al., 2018) A total of 36 participants (8 male and 28 female) from eight sites across three countries were selected for the study; all of which were past the halfway mark of ST treatment. Regarding patients' comorbidities, 92% displayed affective disorders while 67% demonstrated anxiety disorders while more than half of them also met criteria for another personality disorder. (Tan et al., 2018)

Gathering feedback from the patients themselves demonstrates a particular importance. Firstly, it would allow for clinicians to gather much-needed data about the efficacy of treatment through the use of direct interviews. Secondly, and perhaps as an unintended effect, as clinicians gather direct feedback and suggestions for improvements from BPD patients that have undergone

ST therapy, it may allow for trust and rapport-building in the clinician/patient setting. When asked questions such as “how was your experience with schema therapy” or “to what extent did you feel that your needs were met”, (Tan et al., 2018) the BPD patients not only provided critical feedback to further understand their perspective of ST treatment, but also improvements that may be implemented for future ST treatment of others, which is essential to the advancement of any program.

Of the data reflecting the extent to which ST helped provide insight about themselves, 86% of BPD patients in this study responded positively, with many indicating that they were better able to recognize their EMS, as well as 72% of patients learning skills to help them cope adaptively to triggers. (Tan et al., 2018) Experiences within the group ST setting were also highly positive, with 89% of the 36 participants stating that they felt comfortable, connected, and safe within their group. (Tan et al., 2018) On the opposite end, only 42% reported feeling less harsh to themselves with another 39% describing the level of difficulty of ST as too high, using descriptors such as: “overwhelming”, “scary”, “painful”, and “draining” when asked to recall past traumas or triggers. (Tan et al., 2018) Additionally, 61% reported dissatisfaction with the length of therapy, with many citing the reason as being they “felt they had not made sufficient progress” in their 1.5-2 years of treatment. (Tan et al., 2018) Despite many patients describing difficulties in their respective treatments, the biggest takeaway was overall satisfaction of ST therapy in comparison to past therapies. 64% of patients preferred ST to their past therapies, 61% found it to be more effective than alternatives, and of 20 patients that willingly submitted feedback about their 1:1 therapist sessions, 75% used terminology such as “supportive” and “attuned” to describe their therapeutic relationship with providers. (Tan et al., 2018) As the first

analysis of its kind, this study was able to provide comprehensive detail regarding positive and negative perceptions and feedback about ST therapy as experienced by individuals with BPD.

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Challenges in diagnosis of Borderline Personality Disorder continue to exist, and in this case, take the form of insufficient awareness of the disorder in sexual minority populations or implicit bias in diagnosis once sexual orientation of a patient is known. In a recent study by Dr. Rodriguez-Seijas and colleagues, bias is explored amongst Lesbian, Gay, and Bisexual minority individuals regarding their diagnosis with Borderline Personality Disorder. (Rodriguez-Seijas et al., 2020)

Lesbian, Gay, and Bisexual individuals in this study (referred to as sexual minority individuals or LGB+) experience higher rates of BPD diagnosis than heterosexual counterparts. Due to the increased instances of comorbidity with other psychological disorders, there is debate about whether "clinicians are more likely to diagnose BPD when sexual minority status is made salient" or if there is simply increased severity and prevalence of this disorder in sexual minority individuals. (Rodriguez-Seijas et al., 2020) It is important then to understand the factors leading to a diagnosis for sexual minority individuals, and the overlap between their psychosocial dysfunction and meeting the BPD diagnosis. There are many issues to take into consideration when working with sexual minority individuals as the vast majority experience traumatic events due to their sexual orientation and may therefore meet many of the qualifying BPD criteria. Maladaptive behaviors also likely result as coping mechanisms in various social and interpersonal life circumstances, which may interfere with "normal" psychological functioning. (Rodriguez-Seijas et al., 2020)

In a study conducted by the Center for American Progress, or CAP, sexual minority individuals' coping methods were assessed in different settings, all in response to avoid discrimination. Behaviors such as avoidance, changes in usual behavior, or making specific decisions to reduce the risk of discrimination in their life are sometimes seen as necessary in order to succeed in work, school, or other professional settings. CAP's data showed that 41% of all LBG people surveyed used vague language to describe their relationships to others (for fear of exposing themselves) and over 36% hid their relationship; these two percentages nearly doubled if they had experienced discrimination within the last year. (Singh & Durso, 2017) Sexual minority individuals are essentially forced to have much higher awareness of their choices, actions, and expression than their heterosexual counterparts due to the increased risk of harassment or impact their status could have on their lives if it were to be made salient to untrusted parties. Avoiding certain social situations, choosing specific places to shop or conduct business, and selecting particular areas to live are some of the biggest stressors for those in the sexual minority, with almost 50% of them having experienced discrimination for each of those categories in the last year. (Singh & Durso, 2017) LGB+ people in general exhibit higher levels of impulsivity, disproportionately high levels of suicidality and self-harm, and make drastic efforts to avoid abandonment; all of which increase the likelihood of meeting BPD criterion. (Rodriguez-Seijas et al., 2020) Finally, when accounting for the healthcare setting, a 2010 survey cited more than half of LGBT people reported being discriminated against by providers, further diminishing trust and willingness to seek care. (Singh & Durso, 2017)

With this information in mind, it should be noted that stressors experienced by sexual minority individuals likely result in avoidance, anxiety, impulsivity, self-harm, suicidality, and identity disturbance; all of which overlap with the major symptoms of BPD. It may therefore

stand to reason that when sexual orientation is made clear to clinicians who are diagnosing a person identifying as a sexual minority, they are not taking full consideration of the traumas, behaviors, or changes in affect that are not usually part of heterosexual peoples' lives, which notably impact LBG+ people. Presently, research concerning diagnosis of BPD among sexual minority individuals that "reflects elevated rates of psychopathology associated with both the BPD diagnosis and sexual minority status or bias independent of psychopathology remains unexplored". (Rodriguez-Seijas et al., 2020) Lastly, and to the detriment of LGB people, due to unfamiliarity with normative behavior and coping mechanisms in the sexual minority community, as well as being uninformed of traumas and experiences within this cohort, clinicians may be inclined to give a biased diagnosis of Borderline Personality Disorder once the patient's sexual orientation is disclosed.

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In conclusion, Borderline Personality Disorder is a complex personality disorder that has undergone many revisions since its addition to the DSM-5 in 1980. Opinions resound in the psychiatric community regarding the diagnosis of BPD and whether considering a dimensional approach would be more effective. With prevalence at a median 1.7% in the general population, as well as it being the most common personality disorder in clinical settings (Gunderson et al., 2013), BPD should certainly be regarded with importance. Further investigation into the efficacy of new treatments such as Schema Therapy, as well as investigating potential clinician bias when diagnosing sexual minority people with BPD should be at the forefront of research in upcoming decades.

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