The Effects of Childhood Abuse on the Etiology of Borderline Personality Disorder

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Abstract

The purpose of this literature review is to examine how childhood abuse affects the development of borderline personality disorder (BPD). Treatment interventions are reviewed. This literature review explores Alfred Adler’s interpretation of personality disorders and BPD by examining etiology, purpose and presentation of symptoms and treatment options. This literature review also discusses early diagnosis of BPD and the negative effects of stigmatization.
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The Effects of Childhood Abuse on the Etiology of Borderline Personality Disorder

Metro Psychology Support Services Inc. (MPSS) is a consumer-led mental health recovery program, referred to as Adult Rehabilitative Mental Health Services (ARMHS). MPSS is located in St. Paul, MN and provides services to five counties. ARMHS provides intensive rehabilitative services to clients 18 years of age or older who suffer from mental illness. The mission of ARMHS is to help clients recover from their mental illness to attain their personal goals to move forward in life. ARMHS practitioners teach and practice independent living skills, social skills and mental health symptom management.

ARMHS requires an extensive intake process to ensure quality client care. During the intake process, the ARMHS practitioner completes a functional assessment with the client to collect information about impairments in each area of life. When assessing interpersonal relationship functioning, many clients report a history of past traumatic experiences. Sadly, these traumatic events experienced by clients are most commonly in the form of some manifestation of child abuse by a caregiver.

A large proportion of MPSS clients have a borderline personality disorder BPD diagnosis and disclose traumatic childhood abuse experiences. This makes it vital for ARMHS practitioners to understand BPD as a diagnosis. It is also important that ARMHS practitioners understand that childhood abuse is a contributing factor to BPD symptomology. This Master’s Project provides assistance to help ARMHS practitioners increase empathy levels with clients concerning their traumatic childhood abuse histories and to help clients become more independent with higher levels of functioning.

This paper begins with a broad overview of personality disorders. The history and diagnosis criteria are discussed along with the clinical symptoms of BPD. The development of BPD
with and without childhood abuse, biosocial factors, psychodynamic theory and genetics and 
neurochemistry are highlighted. Adler’s interpretation of BPD’s etiology, development, course 
and treatments is covered. Therapy interventions, medications and alternative therapy methods 
used to treat BPD are emphasized. This paper also includes a discussion about early prevention 
of BPD and how advocacy can be used to eliminate stigmatization.

**Personality Disorders**

*According to the Diagnostic and Statistical Manual of Mental Disorders- Fifth Edition (DSM-5)*, a personality disorder (PD) is defined as,

An enduring pattern of inner experience and behavior that deviates markedly from 
the expectations of the inner individual’s culture, is pervasive and inflexible, has an onset 
in adolescence or early adulthood, is stable over time, and leads to distress or impairment 

The DSM-5 (2013) recently updated to a dimensional model used for diagnosis with two 
primary criteria: (a) impairment in personality functioning and (b) pathological traits. The DSM-5 
currently includes ten PDs separated into three separate Clusters. The Clusters are categorized 
based on described similarities (American Psychiatric Association, 2013). Cluster A PDs include 
schizoid, schizotypal and paranoid personality disorders (American Psychiatric Association, 
2013). The DSM-5 (2013) describes individuals with these diagnoses as often appearing “odd or 
eccentric.” Cluster B PD’s include antisocial, histrionic and borderline (American Psychiatric 
Association, 2013). Individuals with diagnoses from Cluster B often appears to be emotional, 
erratic or dramatic. Cluster C PDs include dependent, avoidant and obsessive compulsive disor-
ders. The DSM-5 (2013) describes individuals given these diagnoses as appearing fearful or anx-
ious. Each PD has specific diagnostic features, etiology and course, culture and gender diagnostic concerns and possible differential diagnosis and comorbidity.

It is common for individuals to be diagnosed with more than one PD in different clusters (American Psychiatric Association, 2013). For example, an individual with a BPD diagnosis may also meet the criteria for antisocial personality disorder (ASP). The 2001-2002 National Epidemiologic Survey on Alcohol and Related Conditions estimates 15% of the U.S. population have one or more PDs (Grant & Dawson, 2006). According to the DSM-5 (2013), prevalence rates of comorbidity are 1.5% in Cluster A, 6.0% in Cluster B and 9.1% in Cluster C PD’s. In addition to high comorbidity, individuals diagnosed with PDs are also marked by specific personality traits. Awareness of comorbidity and personality traits in BPD and other PDs may be helpful for treatment.

Previous research shows that an individual’s locus of control and self-esteem are important variables in PDs (Watson, 1998). For example, Kimberly A. Morrison’s (1997) research shows that neuroticism is influenced by the presence of lower levels of conscientious, agreeableness and subjective well-being in individuals diagnosed with PDs. A research study conducted by Watson, (1998) shows that at that time, seven of the eleven PD’s are predicted by self-esteem and locus of control levels. Results also show that most of the PDs are negatively related to internal locus of control and positively related to chance and others personal control. Watson’s study applies to individuals diagnosed with BPD.

**BPD**

**History of BPD**

The diagnosis of BPD origins dates back to the 1930’s when psychoanalyst, Adolf Stern, applied “borderline” to his patients who did not fit into the current classification system for disorders under neurosis or psychosis. In these “borderline” patients, Stern identified traits of nega-
tive reactions in therapy, hypersensitivity and difficulties in reality testing. (Craighead, Miklowitz & Craighead, 2013).

In 1940, psychoanalyst, Robert Knight used ego psychology to describe borderline disorder (Friedel, 2004). Ego psychology focuses on mental processes including realistic perceptions about life, developing effective and appropriate reactions to life events and the integration of feelings and thoughts. According to Knight (1953), his borderline patients had severe impairments in their ego functioning and primary processing and were on the border of neurosis and psychosis. From Knight’s observation, he referred to these patients as having “borderline states.” He noticed that patients with borderline disorder had “special needs.” If these needs were unmet by staff, tension with staff members would emerge.

The diagnosis of borderline was not applied until the late 1960’s (American Psychiatric Association, 2013). Psychoanalyst, Otto Kernberg (1967), introduced the concept of borderline personality organization (BPO). Kernberg proposed that there were three levels of character pathology or BPO: mild, moderate and severe. According to Kernberg, individuals on the mild level had neurotic personality organization while the moderate and severe level individuals had BPO. Levels were determined by identity diffusion, primitive defenses (projective identification and splitting) and lapses in reality testing. In Kernberg’s belief, BPO could be effectively treated by psychoanalytic psychotherapy.

In 1968, Grinker, Werble and Drye (1968) added interest to the borderline diagnosis by publishing the first empirical study on the borderline diagnosis. These authors proposed the existence of a borderline spectrum composed of four separate clusters of patients who fell on a continuum from psychosis to neurosis. Patients on the lower end of the spectrum were considered to
suffer from neurosis while patients at the highest end were considered to be on the psychotic border.

A key element in the history of BPD was Gunderson and Singer’s (1975) initial attempt to formulate diagnostic criteria in their book titled The Borderline Syndrome. This book lead to James Peter Frosch’s (1964) publication of a review of the syndrome titled “Defining Borderline Patients.” This publication made the diagnostic criteria accessible and paved the way for BPD to enter the DSM-3 (Gunderson, 2009).

Prior to BPD’s addition to the DSM-III, alternative names for the disorder were considered (Craighead, Miklowitz & Craighead, 2013). One alternative name “unstable personality disorder” was proposed by Spitzer, Endicott and Gibbon (1979). However, a pole from the majority of clinicians decided that the term “borderline personality” should be retained (Craighead, Miklowitz & Craighead, 2013). Some individuals believe that the decision to use the term “borderline” in the DSM-III was an error in judgment for different reasons. Because the term “borderline” originated from psychoanalytic tradition, this may have caused BPD to be less expecting from clinicians who have other theoretical orientations and alternate perspectives. Another reason that BPD may not be as accepted by some clinicians is because the term “border” is undefined.

In the most current debate, the absence of a clear definition for borderline may have lead the ICD-10 to use the descriptive term, “emotionally unstable disorder” instead of BPD (Craighead, Miklowitz & Craighead, 2013). Changes to BPD and other personality disorders were proposed for the DSM-5. The Personality and Personality Disorders Work Group desired to remove several personality disorders and re-conceptualize personality pathology. While BPD never was eliminated in the DSM-5, it was proposed that diagnosis should be determined by cat-
eigorizing patients by narrative prototypes. Because this proposal was such a “radical shift” from the DSM-IV, it was quickly rejected (Gunderson, 2010). In fact, none of the proposals by the Personality Disorders Work Group were honored and are only mentioned in section III of the DSM-5. Subsequently, BPD in DSM-5 and DSM-IV are identical (Craighead, Miklowitz & Craighead, 2013; Gunderson, 2010).

**Clinical Symptoms of Borderline Personality Disorder**

The BPD diagnosis is considered to be one of the most complex personality disorders and is the most common personality disorder in clinics in the United States (Craighead, Miklowitz & Craighead, 2013; Loranger et al., 1994; Torgersen, Krüglen & Cramer, 2001; Widiger & Frances, 1989). The DSM-5 (2013) categorizes BPD under Cluster B Personality Disorders along with antisocial personality disorder (ASP), histrionic personality disorder (HPD) and narcissistic personality disorder (NPD). Cluster B personality disorders are thought to be characterized by egocentric, emotional and dramatic features (Seligman, 2014). The DSM-5 estimates that the population prevalence could be as high as 5.9% with diagnostic features including:

- pervasive pattern of instability of interpersonal relationships, self-image, and affects,
- and marked impulsivity that begins by early adulthood and is present in a variety of contexts (American Psychiatric Association p., 2013, p. 663).

The DSM-5 (2013) also informs that not all symptoms are required to be present for a BPD diagnosis.

Aside from the DSM-5 criteria for BPD, Zanarini and Frankenburg (1997) presented the perspective of BPD patients through self-report of their emotional pain level being “the worst pain anyone has felt since the history of the world began (p. 511).” BPD is also characterized by
patterns of intense and unstable interpersonal relationships, unstable emotional regulation and self-image and impulsive behaviors (American Psychiatric Association, 2013).

It is believed that the core of BPD is affective dysregulation (Linehan, 1993; Siever, Torgersen, Gunderson, Livesley, & Kendler, 2002; Tragesser, Solhan, Schwartz-Mette, & Trull, 2007). Individuals diagnosed with BPD are extra sensitive to their environment and have highly reactive emotions (Manning, 2011). In one of the most notable books about BPD, “Loving Someone with Borderline Personality Disorder,” author, Shari Y. Manning, explains that reactive emotions are “fast emotions” that are unpredictable and often over-intensified (Manning, 2011, p. 14). To assist in describing the intensity an individual diagnosed with BPD feels, Manning wrote,

> Emotion dysregulation can feel like drinking a cup of boiling coffee that everyone else insists is luke-warm. Where you feel a twinge of irritation, an emotionally dysregulated person feels instant rage. Where you feel a flush of attraction to someone, the person with BPD may feel irresistible desire. (2011, p. 14)

Individuals diagnosed with BPD have a continuous history of unstable and intense personal relationships (American Psychiatric Association, 2013). Romantic and non-romantic relationships can begin with high levels of idolization or admiration at first and later shift to devaluation. Clifton, Pilkonis, and McCarty (2007) conducted research assessing social network functioning and found that individuals with BPD had a higher number of partners and a higher number of self-break ups in their social networks than other individuals without a personality disorder diagnosis. Another self-report study by Russell, Moskowitz, Zuroff, Sookman, and Paris (2007) discovered that BPD individuals had higher submissiveness, lower dominance and more quarrelsome interpersonal behaviors when compared to a control group. Instability and intensity
in BPD individual’s relationships may be influenced by fears of real or perceived abandonment (American Psychiatric Association, 2013).

High instability in personal relationships has been associated with the BPD individual having a constant fear of abandonment triggered by the perception of rejection, future separation or changes in environment (American Psychiatric Association, 2013). When an individual with BPD anticipates and interprets that they have been abandoned, they experience drastic alterations in their affect, self-image and cognitions. Fears of abandonment often lead BPD individuals to behave in ways to keep people in their lives close through self-injurious behaviors or suicide attempts (Craighead, Miklowitz & Craighead, 2013).

Many researchers have shown that externalizing behaviors or defensive mechanisms are a component in personality disorders (Perry, Presniak & Olson, 2013). According to the DSM-IV (1994), defense mechanisms are defined as automatic psychological responses used by individuals in response to external stress or conflict and anxiety. Types and motives for the use of defense mechanisms have been found to be different in each personality disorder, including BPD. When an individual with BPD’s ego is threatened, defense mechanisms will be used for self-protection (Perry, Presniak & Olson, 2013).

Research shows that BPD has the strongest relationship between pathology in personality and the use of defense mechanisms compared to Schizotypal Personality Disorder (SPD), Antisocial Personality Disorder (ASP) and Narcissistic Personality Disorder (NPD) (Perry, Presniak & Olson, 2013). Kernberg’s (1984) theory proposed that BPD centers around seven defense mechanisms including omnipotence, idealization, devaluation, denial, projective identification or primitive projection and splitting (between others and the self). Kernberg also theorized that BPD individuals have the absence of repression or episodes of cycling from having excessive or
smaller amounts of repression. Later research suggested additional defense mechanisms associated with BPD including dissociation, passive-aggression, rationalization, help-rejecting complaining, undoing, absence of reaction formation and general acting out (Perry, Presniak & Olson, 2013). These defense mechanisms associated with BPD can often result in aggressive behaviors (Newhill et al., 2009).

BPD has been found to be associated with aggression during conflicts with a partner or other intimate relationships (Newhill et al., 2009; Sansone & Sansone, 2012). Additional research shows that individuals with BPD have a high risk for being a victim or predator, engaging in assaultive behaviors and child maltreatment, experiencing abuse with intimate partners, committing property damage, and perpetrating mental or emotional violence (McGowan, King, Frankenburg, Fitzmaurice, & Zanarini, 2012; Ostrov, Hart, Kamper, & Godleski, 2011; Perekhlechikova, Ansell, & Axelrod, 2012; Sansone & Sansone, 2012). Research shows BPD personality traits such as proneness of impulsivity, anger and irritability co-vary with ASP, but BPD aggression is linked to difficulty in regulating emotions (Scott, Stepp & Pilkonis, 2014; Newhill et al., 2009). Emotion dysregulation during interpersonal conflict is considered to be one contributing factor to physical or psychological aggressive behaviors used as an effort to gain control when an individual with BPD feels a threat of abandonment (Scott, Stepp & Pilkonis, 2014).

Reactive emotions may also cause impulsivity and self-harming behaviors in individuals with BPD (American Psychiatric Association, 2013). BPD individuals often experience two or more self-damaging impulsive behaviors in their life including gambling, binge eating, substance use, unsafe sex, excessive spending, or reckless driving. Impulsive behaviors can also include parasuicidal behaviors e.g. suicidal attempts and self-injurious behaviors. These harmful behaviors are often expressed in the effort to solve a perceived crisis. Sometimes a crisis can be caused
by painful emotions from a perceived loss in life. In effort to avoid the feelings of pain, the BPD individual will use impulsive behaviors as a form of numbing. There are high suicide completion rates in the BPD population. Lifetime suicide rates are 3%-10% and past suicidal behaviors are found in 60%-70% in individuals diagnosed with BPD (Links, Kolla, Guimond & McMain, 2013). Of these BPD individuals, 10% will eventually complete suicide (Oldham, 2006).

Individuals diagnosed with BPD may also be diagnosed with other non-PD disorders (American Psychological Association, 2013). BPD has been found to have high comorbidity with major depressive disorder (MDD), substance use disorders, ASP, post-traumatic stress disorder (PTSD), panic disorder, and eating disorders (Linehan et al., 2006). The clinical symptoms for BPD often overlap with PTSD symptoms of feelings of emptiness, interpersonal dysfunction and affect instability, especially irritability and anger (Zlotnick, Johnson, Yen et al., 2003). Shea, Zlotnick and Weisberg (1999) found that 68% of PTSD patients also met diagnostic criteria for BPD. Zlotnick, Johnson, Yen et al. (2003) conducted a comparison study examining levels of impairment, history of trauma and clinical criteria between women diagnosed with BPD compared to women diagnosed with BPD and PTSD. Results showed that BPD and PTSD comorbidity increased levels of lifestyle impairments and hospitalizations. Of the women with BPD and PTSD, 89% disclosed emotional, physical, sexual or verbal abuse before age thirteen (Zlotnick, Johnson, Yen et al., 2003). Gunderson and Sabo (1999) provided an explanation for this finding that traumatic pasts in early childhood makes individuals diagnosed with BPD attain trauma-related personality traits that make them vulnerable to developing PTSD later in life. Childhood abuse is one type of trauma.
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Etiology of BPD

Childhood Abuse and BPD

Childhood trauma is a large factor in the development of BPD. Trauma of the psyche has been connected to many mental health disorders, including BPD (Yen et al., 2002; Zanarini, Yonge, & Frankenburg, 2002). Past and current research shows that childhood abuse contributes to the development of personality disorders, including BPD (Battle et al., 2004). Childhood abuse is defined as physical, emotional or sexual abuse prior to age 18 (Bornovalova et al., 2013). Cross-sectional studies showed that 30% to 90% of BPD patients self-reported experiences of physical, emotional or sexual abuse before age 18 (Ball & Links, 2009; Bornovalova et al., 2006; Carlson et al., 2009; Golier et al., 2003; Laporte & Guttman, 1996; Zanarini, 2000). This research has been collected through studies in outpatient and psychiatric inpatient settings (Bradley, Jenei, & Westen, 2005; Golier et al., 2003), community adolescents (Rogosch & Cicchetti, 2005) and urban drug users (Bornovalova et al., 2006).

Some of the most common research on childhood abuse and BPD focuses on emotional invalidation. Emotional invalidation is defined as the child’s thoughts and emotions being minimized, put down, ignored, trivialized or met with erratic or unpredictable responses from the caregiver (Linehan, 1993). In the biosocial theory of the development of BPD, the invalidating environment is considered to be one of the most crucial contributing factors. If a child experiences invalidation in their family environment, they will not learn the skills of emotion regulation causing impairments in their sense of self and ability to control their external behaviors. Linehan concluded that childhood sexual abuse (CSA) is a type of experience that contributes to the perception of an invalidating environment. Besides the actual experience of invalidation in the form of CSA, invalidating responses from individuals the CSA is disclosed to may contribute to the development of BPD (Zanarini et al., 1997). However, Hong, Ilardi and Lishner’s (2011) re-
search showed that the family environment, instead of CSA, is a better predictor of the etiology of BPD symptomology. In a more recent study, Rochefort (2014) analyzed associations between perceived emotional invalidation and BPD features on a university student population. Students’ perceived attachment security with a caregiver were also assessed. Results showed perceived invalidation from caregivers was positively associated with BPD features of the students. The concept of attachment originated with John Bowlby (1973) and Mary Ainsworth (1978) where four different attachment styles were identified including secure, insecure-ambivalent, insecure-avoidant and insecure-disorganized. According to Bowlby, individuals with caregivers who do not provide sensitivity and support when needed are more likely to develop one of the insecure attachment styles that characterize BPD. Individuals with BPD lack the relational bond with their caregiver that would allow them to cope with stressful events and maintain their self-esteem and emotional stability.

**Development of Borderline Personality Disorder without Childhood Abuse**

Childhood abuse is a large contributing factor to the development of BPD but there are other different theoretical perspectives on the etiology of BPD (Craighead, Miklowitz & Craighead, 2013). Each theory has its own perspective and supporting research but narrows down to the combination of biological and environmental factors. Though research offers more understanding on BPD’s etiology, the exact cause for onset is currently still unknown (Craighead, Miklowitz & Craighead, 2013; Paris, 1994). Joel Paris (1994) hypothesized that a multidimensional theory approach of BPD etiology should be considered taking in account psychological, social and biological factors. According to Paris, BPD is a “complex” disorder influenced by social conditions, biological vulnerability and triggered by psychological experiences.
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Biosocial Factors

Marsha Linehan's (1993) biosocial theory states that biological and temperamental vulnerabilities in a child caused the formation or increase of emotion dysregulation. Emotion dysregulation was thought by Linehan to be caused by intense emotional reactivity to specific events, high levels of sensitivity to negative emotions and difficulties returning to a more balanced emotional state after an episode of intense emotional reactivity. According to Linehan, if the child fails to learn skills to successfully regulate their emotions, the child will likely feel invalidated in their family environment. In an invalidating environment, the child receives responses to their communications that are not reality based, are inconsistent or are inappropriate for the situation (Fruzetti, Shenk & Hoffman, 2005). It is hypothesized that invalidating responses can impair the child from accepting and trusting their emotions and emotional responses (emotion dysregulation) and can result in the development of BPD (Craighead, Miklowitz & Craighead, 2013). In a recent study of 250 patients with BPD, the Biosocial Theory was tested to determine if the interaction between invalidating parenting and childhood emotional vulnerability caused emotion dysregulation (Gill & Warburton, 2014). Results showed that invalidating parenting and emotional vulnerability significantly predicted emotion dysregulation, but no interaction effects could be concluded during the study.

Psychodynamic Theory

Kernberg (1975) presented early research on the psychodynamic approach with the hypothesis that high levels of aggression in children interferes with the natural development process. Kernberg believed that this disruption in natural development caused a child’s sense of self and perception of others to be fragmented and leads to the formation of “primitive” defense mechanisms. Kernberg referred to this process as “borderline personality organization.” From
childhood to adulthood, Kernberg believed that determining what is real and what is imaginary is difficult. It is possible that the inability to distinguish reality from imagination may be traced back to parenting practices.

Winnicot (1953) also supported the psychodynamic approach. Winnicot hypothesized that a child who lacks “good enough mothering” from a caretaker can be predisposed to the etiology of BPD. “Good enough mothering” includes validation of the child’s innovation and autonomy and empathetic responses to the child’s strengths. If these components are in place, the child will feel soothed, validated and emotionally comforted by their caretaker and hold these long-lasting images in their mind. In the absence of these necessary components from a caretaker, the child’s needs are not met and their feelings of anger prevent a healthy sense of self from developing. Buie and Adler’s (1982) research showed that the absence of positive long-lasting images is a factor in emotion regulation difficulties and may contribute to the development of BPD.

**Genetics and Neurochemistry**

Studies show that genetics may be a factor in the etiology of BPD (Craighead, Miklowitz & Craighead, 2013). Links, Steiner and Huxley (1988) found that BPD prevalence rates increased by 3.4% when direct family members also had the disorder. In a twins study, Torgersen and colleagues (2001) reported a BPD concordance rate of 7% in dizygotic twins compared to 35% in monozygotic twins.

Alternate research suggests that BPD traits may be more inheritable than the actual diagnosis (Zanarini et al., 2004). Past research supports the heritability in underlying personality traits of impulsiveness, affective lability, cognitive dysregulation, neuroticism and anxiety.
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(Goodman, New, & Siever, 2004; Jang, Livesley, Vernon, & Jackson, 1996; Livesley, Jang, Jackson, & Vernon, 1993).

Specific genes in the body may be a contributing factor in the development of BPD traits. Research is beginning to show a link between the serotonin transporter gene (5-HTT) with impulsivity, emotional lability and suicide (Bondy, Erfurth, doJonge, Kruger, & Meyer, 2000; Frankle et al., 2005; Hoefgen et al., 2005). These findings suggest 5-HTT may increase the prevalence of BPD. Studies on the dopamine transporter gene (DAT1) and other similar genes associated with dopamine reception production have also provided evidence of the existence of a link to the development of BPD (Cloninger, 2000). Dopamine is part of the reward pathways made up in the brain that control BPD traits of impulsivity and novelty seeking. Cloninger hypothesizes that alterations in dopaminergic functioning in the brain may cause these traits in individuals diagnosed with BPD. Future research will reveal more insight on this topic.

Adlerian and Individual Psychology Interpretation

Adler’s View and the Individual Psychology Perspective on BPD

Alfred Adler (1956) never discussed personality disorders or BPD directly, but did propose a theory on personality structure. Adler believed there were two dimensions of personality structure: social interest or usefulness and level of activity. Of these two dimensions, Adler believed an individual could be described in one of four personality typologies: ruling (high activity level and low social interest), avoiding (low activity level and low social interest), getting (low activity level and high social interest) and ideal (high activity level and high social interest) (Sperry & Carlson, 1996). Adler’s (1956) personality pathologies are one component of an individual’s Lifestyle.
Lifestyle and BPD

Adler believed that the lifestyle of an individual with BPD developed in the early years of childhood (Mosak & Maniaci, 1999). In non-Adlerian terms, the Lifestyle is equivalent to personality and patterns of behavior (Croake, 1989). Personal beliefs based on subjective experience creates an individual with BPD’s private logic (irrational beliefs) of what kind of world it is, who they are, who they are to others and what other people are like (Mosak & Maniaci, 1999).

Lifestyle is developed by the overall components and characteristics of the family of the individual with BPD. Family constellation, family atmosphere and birth order are known concepts in Adlerian psychology. Family constellation is the formation and psychological position of each family member (Griffith, & Powers, 2007). The family atmosphere has also been referred to as the “emotional tone” or climate in the family (Dewey, 1971; Shulman & Mosak, 1988). Even though children may be raised in the same household, each child will experience the family atmosphere through their own perception and be shaped by it (Mosak & Maniaci, 1999).

The family atmosphere is a great influence on the child’s position in the family. Adler (1956) acknowledged ordinal positions but believed that family dynamics were most influenced by psychological positions of the children including eldest, second, middle, youngest and only. Adler believed that each psychological position has unique strengths and challenges that influence the individual’s Lifestyle and goals. The BPD individual’s Lifestyle and goals are also influenced by the type of parenting they experienced.

Adler (1956) believed in the power of parenting. Individuals with BPD likely had caregivers who were at times neglectful and abusive, but also pampered their child. In Adlerian terms, pampering is completing a task that a child is capable of doing themselves without any assistance from adults. A neglected child will feel discouraged and not learn the skills needed to
be a successful adult. A child who has been neglected or pampered will become self-centered with their worldview. Because of inconsistent parenting practices, the adult individual with BPD will fear being neglected and believe that people will not be there for them when they are in need. These experiences cause the child to have a pessimistic outlook on life in general. The child feels inadequately cared for and feels that love comes with conditions (Croake, 1989).

When a situation occurs that the child feels they are unequipped to handle because of their underdeveloped sense of self, they can experience a shock in life (Adler, 1956).

Adler used the term, “shock” or “crisis situation” in place of trauma or stress. Adler believed that a crisis situation occurs when an individual experiences a specific situation in their life where they are forced to operate differently than their own lifestyle. Even so, the existence of tension in the individual with BPD is what causes the neurotic symptoms to surface (Dreikurs, 1953). For the individual with BPD, these neurotic symptoms always serve a purpose.

**Purpose of Behaviors**

Adler believed that all behaviors serve a purpose (Mosak & Maniacci, 1999). In the case of an individual with BPD, Dreikurs said,

> We cannot disregard the fact that in the neurotic, we have a healthy man who gives the impression of being ill and undeniably exhibits symptoms of illness, with the result that it is not always easy in making a diagnosis to distinguish between a “merely” nervous and a “real” illness. (Dreikurs, 1953, p. 77)

Individuals with BPD will use provoking behaviors to test other’s love and support for them. To attempt to get a response, the individual with BPD will use attention-seeking and dramatic behavior like self-harm or having emotional outbursts. Unfortunately, these behaviors often result in short-term and unstable relationships with others. As a child, the individual with BPD learned
that they can aim to please for attention or be neglected. Because of this, the individual with BPD will either attempt to please others or use manipulation for attention. Overall, the individual with BPD learned that these behaviors provided them a sense of belonging, even if they were maladaptive and often self-harming. Attention seeking behaviors will also be used by the individual with BPD to avoid abandonment (Croake, 1989). According to Gunderson and Zanarini (1987), individuals with BPD also fear being alone because they may self-harm or complete suicide. The decision for an individual with BPD to complete suicide is connected to their low levels of social interest (Adler, 1956).

**BPD and Social Interest**

Adler (1956) believed that individuals with BPD are self-centered and have low levels of social interest. According to Adler, social interest or community feeling means “To see with the eyes of another, to hear with the ears of another, to feel with the heart of another,” (p. 135). The individual with BPD is self-centered instead of other-centered and has lower levels of social interest. Adler said,

> From the sociological point of view, the normal man is an individual who lives in society and whose mode of life is so adapted that whether he wants it or not, society derives a certain advantage from his work. From the psychological point of view, he has enough energy and courage to meet the problems and difficulties as they come along. Both of these qualities are missing in the case of abnormal persons. They are neither socially adjusted nor are they psychologically adjusted to the daily tasks of life (p. 54).

Individuals with BPD are born with the innate potential for social interest, which must be developed out of conscious awareness through participation in social situations. The relationship be-
tween the primary caregiver and the child plants the seed for the child’s opportunity to cultivate social interest. A primary caregiver who exposes the child to social situations outside of the home is allowing the child to learn empathy and community feeling. In contrast, a primary caregiver who limits social opportunities for the child restricts learning and understanding of social interest that can lead to challenges later in life because of their inability to cooperate in society. The inability to cooperate often leads to symptoms and safeguarding behaviors).

**Symptoms and Safeguarding**

What clinicians refer to as externalizing behaviors in an individual with BPD, Adler (1956) referred to as safeguarding behaviors. Safeguarding behaviors protect the individual with BPD’s self-esteem and style of life. Safeguarding behaviors act as a barrier put in place by the individual with BPD to cover up feelings of inferiority and discouragement that originated in childhood. The individual with BPD will use physical altercations, parasuicidal behaviors and emotional outbursts for the purpose of safeguarding (Croake, 1989). According to Adler (1956), the hesitating or (Yes, but…) attitude is a distance seeking form of safeguarding behavior characteristic of the individual with BPD. The (Yes) in the hesitating attitude represents that the individual recognizes what commonsense is and the (but…) signifies the various, creative excuses used in effort to avoid the life tasks (Griffith & Powers, 2007). Avoiding the life tasks also allows the individual with BPD to fall on the useless side of life because of their feelings of inferiority.

**Useless side of Life and Meeting Life Tasks**

According to Adler (1956), every individual strives to meet a personal goal out of feelings of inferiority. This striving can be carried out in a socially useful or socially useless way. If the individual with BPD has a healthy amount of social interest, they feel valued and purposeful
in the social community and are able to meet the tasks of life: occupation, friendship and sex more successfully.

Individuals with BPD were never taught basic interpersonal skills and feel inferior in social situations (Adler, 1956). The individual with BPD’s feelings of inferiority and the loss of courage causes them to find shortcuts to meet life tasks or avoid them altogether. Instead of being useful and contributing to the social community, the individual with BPD turns inward and often seeks their goal of superiority at the costs of others. When the individual with BPD feels a sense of superiority in result of their behaviors, the satisfaction they feel is only felt by them alone.

Sadly, Adler (1956) believed that suicide can also be a resulting behavior and imminent mistaken solution when an individual fails to meet the life tasks because they are unable to raise their level of social interest. An individual with BPD who chooses to complete suicide collapses under psychological pain and suffering when they were confronted with challenging situations in life. They were discouraged, had no feelings of value and were unmotivated in life. From the individual with BPD’s subjective viewpoint, they feel successful because their choice of completing suicide accomplishes their last goal and is in their option in the present. Adler deemed the individual with BPD who chooses to complete suicide hurts loved ones by harming or killing themselves. Adler said, “One’s own death is desired, partly to cause sorrow in one’s relatives, partly to force them to appreciate what they have lost in the one they have always slighted… In later years,… a teacher, a beloved person, society or the world at large is chosen as the subject of this act of revenge (p. 19). Kurt Adler (1961) believed that, “The deviousness of suicide has been generally recognized; that people quickly try to forget suicides, shy away from talking about them… that no one will fill guilty on account of his action” (p. 66).
**Adlerian Treatment**

Before executing any interventions, Adler (1956) conducted a Lifestyle analysis. A Lifestyle analysis allows the therapist to gain a complete understanding of the individual with BPD and their symptoms. The Lifestyle analysis includes an early recollection ER, which is an early childhood memory that is significant to the individual with BPD. In individual’s with BPD, ER’s often contain memories of sexual abuse. An ER is not an accurate account of personal history, but it helps to reveal the Lifestyle. The Lifestyle analysis also includes a family constellation and sometimes dream interpretation. With the Lifestyle analysis, Adler could identify the life patterns and goal of the individual with BPD (Croake, 1989).

Adler (1956) used confrontation to allow the individual with BPD to reconsider their thoughts and beliefs through cognitive restructuring. Cognitive restructuring challenges the individual with BPD to question and potentially alter their Lifestyle convictions and method of movement to reach their goal. In individuals with BPD, cognitive restructuring can accomplish more open-mindedness and flexibility in thinking about self, others and the world (Croake, 1989). Cognitive restructuring can also assist the individual with BPD to feel secure and set personal boundaries. Adler combined cognitive restructuring with re-education and role-playing to help the individual with BPD learn new, acceptable and healthy ways of thinking and behaving.

Adler (1956) believed that there are three universal goals that every individual strives for including safety, significance and belonging. Regardless of the manifestation of the neurosis, Adler believed that helping the individual with BPD feel some sort of belonging was important because they always felt separate from others in the world. For the individual with BPD, new ways of finding a sense of belonging would be explored with a concentration on social interest (Croake, 1989).
Adler considered social interest to be extremely important in the treatment of BPD and used it as a barometer for mental health (Carlson, Watts & Maniacci, 2006). Even if a child’s learning of social interest was restricted in earlier years, it can always be expanded by the individual with BPD as an adult through continuous social interactions (Adler, 1956).

Encouragement and empathy in Adlerian therapy are also essential for raising social interest levels. Adler (1956) considered encouragement to be a main ingredient in human development. Encouragement helps develop feelings of confidence and pride and assist the individual with BPD in cooperating more in society (Stein, 2013). Adler said, “Altogether, in every step of the treatment, we must not deviate from the path of encouragement (p. 342). To emphasize encouragement, Adler believed the therapist should be empathetic, focus on the individual’s strengths and resources, use active listening and have a sense of humor (Adler, 1956; Dinkmeyer, 1972; Dinkmeyer, Dinkmeyer, & Sperry, 1987; Mosak & Maniacci, 1999; Neuer, 1936; Sweeney, 1998). Providing encouragement also strengthens the therapeutic relationship between the individual with BPD and the therapist (Adler, 1956).

**Present Interventions**

BPD has been described as one of the most challenging and complex personality disorders to treat (Chapman, 2010). Rapidly shifting emotional states and behaviors (parasuicidal and substance use and others) cause difficulty for the clinician during treatment (Craighead, Miklowitz & Craighead, 2003). It is estimated that 60-80% of BPD clients use parasuicidal behaviors while in therapy (Bateman & Fonagy, 2003). A parasuicidal behavior is a suicide attempt or self-harm act that does not result in death (American Psychiatric Association, 2013). Clinicians also are challenged by suicide attempts (mean lifetime rate of 3.4 percent) and suicide completions of 10% in all BPD clients (Soloff, Lis, Kelly, Cornelius, & Ulrich, 1994). Splitting behav-
iors can be very challenging, especially when directed towards the clinician in therapy (Chapman, p. 347, 2010). Splitting is a defense mechanism that allows dichotomous (all good or all bad) thinking about situations or others (Gunderson, 2009). An example of splitting is when an individual with BPD idolizes their partner and perceives them as perfect and then alters their view and perceives them as their worst enemy.

In the past, BPD was thought to be an untreatable refractory disorder, but current studies show more positive treatment outcomes (Chapman, 2010). Zanarini, Frankenberg, Hennen and Silk (2003) conducted a 6-year longitudinal follow-up study with BPD patients who were hospitalized for psychiatric reasons. Results showed that 74% of BPD patients experienced remission with 94% never meeting criteria for diagnosis after 6-years. More current research also shows that BPD is not a chronic disorder. A 10-year longitudinal PD study showed an 85% remission rate in men and women age 18-45 diagnosed with BPD in inpatient and outpatient settings (Gunderson et al., 2011). No difference in gender was found, but younger patients and patients educated on BPD experienced higher remission rates. During the study, all interventions including medications were considered.

**Medications**

The use of medication in the treatment of BPD is not uncommon. According to the National Institute for Health and Clinical Excellence (NICE), drug treatments should only be used as a short-term intervention for individuals diagnosed with BPD with a co-morbid diagnosis or a crisis situation (NICE, 2009). Medications may be used to stabilize emotions, increase reasoning, and prevent impulsive behaviors by decreasing emotional reactions (Friedel, 2014). There are many contradictory studies on the use of medications in the treatment of BPD.
In a Cochrane systematic review of pharmacotherapy for BPD, Lieb et al., (2010) showed evidence of the benefits of second-generation antipsychotics, olanzapine and aripiprazole, in the treatment of BPD. Mood stabilizers including lamotrigine, valproate and topiramate were found to be effective medications for treating BPD. Other studies demonstrated improvement in individuals diagnosed with BPD in impulsivity, anger and affective instability using selective serotonin re-uptake inhibitors (SSRI’s) and irreversible monoamine oxidase inhibitors including topiramate, olanzabine and antipsychotics (Stephan, Krawitz & Jackson, 2007). These studies also showed the same improvements using sodium valproate, omega 3 fatty acids, carbamazepine, lithium and aripirrazone. In a similar study, the use of SSRI’s showed improvement in dysphoria, anxiety and anger dysregulation (Gabbard & Ball, 2009). Gabbard and Ball described the use of SSRI’s with individuals diagnosed with BPD as “reducing the affective noise” and argued that this allows the patient to have more engagement in psychotherapy.

Some researchers argue that the previously mentioned studies show inconclusive results that indicate little reliability with measuring the efficacy of psychotropic medications as an intervention method for individuals diagnosed with BPD (Bellino et al., 2008). Bateman and Tyrer's (2002) systematic literature review showed limited generalizability and unknown efficacy with the use of mood stabilizers and antipsychotics for treatment of BPD. Even without evidence of the effectiveness of psychotropics as a treatment for BPD, Sansone, Rytwinski and Gaither (2003) discovered that compared to other personality disorders of individuals without a diagnosis, BPD individuals were prescribed significantly more psychotropic medications.

How do individuals diagnosed with BPD feel about being treated with medications? Staphan, Krawitz & Jackson (2007) believe that medications can represent many symbolic functions including disempowerment, empowerment, assault, being cared for and not being cared for.
In a recent qualitative study, Rogers and Acton (2012) found that patients with a diagnosis of BPD had an overall negative view on being prescribed medications to treat their symptoms and stated they feel like “guinea pigs.” This feeling of being the subject of experimentation is associated with some medical or mental health professionals not having the necessary knowledge and having negative and dismissing attitudes about treating BPD. Inadequate knowledge also contributes to the patient’s feelings of being put through the “trial and error” process with treatment interventions. Some patients disclosed feelings of hopelessness from being told there were few treatment options for their BPD diagnosis. If drug treatments are deemed necessary as an intervention, NICE (2009) recommends that psychotherapy should be the primary method of treatment for individuals diagnosed with BPD. Specific psychotherapy methods have also been successful in treating BPD.

**Therapy Interventions**

Dialectic behavioral therapy. Of the available treatment methods for individuals diagnosed with BPD, Dialectic Behavioral Therapy (DBT) has been found to be one of the most effective interventions with at least a dozen randomized controlled trials (RCT) that confirm its efficacy (Rizvi, Steffel & Carson-Wong, 2013). One of the earliest RCT’s compared interventions of treatment as usual (TAU) to DBT in a 12-month period (Koons et al., 2001; Linehan et al., 1999; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Verheul et al., 2003). Results showed a reduction in frequency of duration of inpatient hospitalizations, parasuicidal behaviors, treatment withdrawal and severity and frequency of inpatient hospitalization. Results also showed improvement in suicidal ideations, alcohol abuse, depression, hopelessness and a reduction or anger feelings. Other 6-month replication studies on the effectiveness of DBT showed similar results including reductions in parasuicidal behaviors, feelings of depression and hope-
lessness and amounts of inpatient hospitalizations (Carter, Willcox, Lewin, Conrad & Bendit, 2010; Koons et al., 2001; Stanley, Brodsky, Nelson, & Dulit, 2007). DBT is also the only treatment method that has demonstrated at least a 50% decrease in suicidal behaviors in BPD individuals (Manning, 2011).

What is DBT? Developed by Marsha Linehan (1987), DBT is an empirically supported outpatient cognitive-behavioral treatment designed to specifically treat individuals with BPD. DBT has four modes of treatment including weekly psychotherapy and skills training sessions in a group setting, individual therapy, phone consultations as needed, especially in a crisis, and therapist consultations outside of sessions (Rizvi, Steffel & Carson-Wong, 2013). There are five functions of treatment in DBT including increasing motivation to change, enhancing abilities, generalizing gains in larger environment, providing structure to environment to reinforce gains and increasing therapists feelings of competence and motivation.

What is the “magic formula” of DBT and why is it so effective? DBT treatment emphasizes validation that often was absent in the BPD individual’s childhood family environment and teaches ways to accept and cope with uncomfortable and painful thoughts, behaviors and emotions (National Alliance on Mental Illness, 2013). Acceptance of these painful elements experienced by individuals with BPD opens the doors to make changes and transformations in the real world. DBT requires the execution of skills using real word application in the form of interpersonal and behavioral homework after individual or group sessions.

DBT is divided into four different stages (Rizvi, Steffe & Carson-Wong, 2013). Stage one is for clients who are behaving in a way that threatens their survival and reduces their quality of life. The main goal in stage one is to help clients reduce behavior dyscontrol through specific targets in the exact order of reducing behaviors that threaten survival (parasuicidal behaviors).
Other goals are to reduce behaviors that interfere with therapy (tardiness to session or failure to complete assigned homework), decrease quality of behaviors that interfere with life functioning (feelings of depression or substance use) and increase necessary behavioral skills. Based on the client’s diary cards that keep daily monitoring of client’s problem behaviors and emotions and DBT skills used, DBT therapists decide which target is priority during the session. In stage one, DBT therapists also use a behavior chain analysis to help the client identify thoughts, feelings, behaviors, triggering external events and behavioral consequences that led to their use of problematic and harmful behaviors. Using the behavior chain analysis, the DBT therapist collaboratively creates a solutions analysis to identify specific interfering points that would prevent the problematic behavior leading to the behavioral consequences. DBT skills are then introduced, practiced and reinforced as interference to prevent problematic or unsafe behaviors. Individual therapy also has a higher emphasis in stage one to ensure the client is ready for the next stages.

The following three stages focus less on critical dysfunctioning (Rizvi, Steffe & Carson-Wong, 2013). Stage two focuses on underlying feelings that fuel problematic behaviors such as “quiet desperation” and misery. Next, Axis I disorder symptoms are processed including latent grief, invalidation, boredom and emptiness. Stage three is less pathological and focuses on skills of increasing the client’s quality of life and helps to increase feelings of self-respect. The final stage of DBT focuses on the client’s self-concept of spirituality, feelings of not being a whole person and self-awareness. Similar to the seven stages of grief, the DBT stages are often underlined with stages overlapping or a relapse occurring where the client must return to a previous stage. Once all stages have been completed in full, the client is ready to graduate from DBT and continue to use learned skills in the real world.
Cognitive behavioral therapy. Cognitive Behavioral Therapy (CBT) is a therapeutic approach developed by Dr. Aaron T. Beck in the 1960’s that combines cognitive therapy and behavioral therapy. While DBT concentrates on emotion regulation techniques, CBT focuses on the perception of the world made up of individual schemas (Pretzer, 2004). Arthur Freeman EdD, ABPP (2014) explains that schemas are rules of life that effect an individual’s thoughts, feelings and actions. In individuals with BPD, these schemas tend to be maladaptive and often destructive. Schemas are adaptable through assimilation and alteration. Schemas are developed early in life, are neutral and are only seen as adaptive or maladaptive. The earlier the schema was developed in life and the more active, the more difficult it will be to adapt. In addition, the more a loved one reinforced a schema, the harder it will be to change (Freeman, 2014). Schemas only become a problem when they no longer hold value for the individual with BPD.

In therapy, the goal is to help the individual with BPD modify their schema through adaptation to increase healthy functioning (Freeman, 2014; Beck, 1995). Freeman argues that the therapist should focus on the presented problems rather than complaints of the individual with BPD and take a direct, problem focused, psycho-educational, structured, solutions-focused and collaborative approach. The focus should be on the therapeutic relationship and the therapist must maintain sensitivity and neutrality and avoid judgmental statements (Beck, 1995). Rapport between the therapist and individual with BPD is absolutely essential and begins with first contact all the way to the end of therapy. It is suggested that the therapist should control sessions and implement boundaries (Arntz, 1994). The therapist should present as a role model and emulate healthy values, behaviors and beliefs (Bandura, 1969). The therapist should expect and be trained to handle arising conflicts during sessions and avoid using interpretations (Arntz, 1994). In addition, therapy should operate on parsimony and cost-effectiveness (Freeman, 2014).
Therapists help the individual with BPD by choosing the appropriate intervention based on readiness and willingness to change using a hierarchical list of five different options (Freeman, 2014). The first intervention option is schematic construction where a dysfunctional, outdated schema is identified and broken down to create space for new ways of thinking. The second intervention requires a new schema to be formed through schematic construction to replace the old one. The intervention, schematic modification, is where the original schema is kept in place but modified. The fourth intervention is schematic reinterpretation where the original schema is used to make adaptations. The final intervention is schematic camouflage. This is the most appropriate intervention when an individual with BPD is aware of their original schema, chooses to camouflage or hide it, but still makes an adaption to develop a new schema. Because little value is seen in the new schema, the therapist will attempt to help the BPD patient realize that embracing and adapting the new schema will produce positive outcomes. Regardless of the intervention used by the therapist, Freeman believes that therapists should expect some difficult behaviors from the BPD patient and keep a helpful metaphor in mind:

A metaphor for dealing with patients with BPD involves patients perceiving themselves as balancing precariously at the apex of a mountain. They are at the mercy of every stray breeze and drop of rain. All of their energy and concentration is spent on maintaining their balance. If they lose their balance, they fall to their deaths, or experience severe injuries. There is no room on the mountaintop for others, so they suffer alone. They grasp at straws in the attempt to avoid damage and destruction. (Freeman, 2014, p. 460)

In ARMHS, a client with BPD may have the schema, “I must protect myself at all times because everybody hurts me.” It may be effective to use schematic construction to help the client identify
this schema and to point out situations where the client did not get hurt in relationships. This would initiate the process of breaking down the existing schema to create space for a new one. It would be beneficial to help the client modify this schema through schematic restructuring: “I need to have healthy boundaries and build positive relationships to reduce the chance of being hurt.” This modification still acknowledges the client’s original schema but incorporates updated thinking.

Through the process of therapy, BPD patients often feel high levels of anxiety when altering their schemas and may become defensive or go into security-modes of fight, flight or freeze (Freeman, 2014). Out of defense, individuals with BPD will display safety-seeking behaviors including splitting, self-injury, affect avoidance, switching therapists and aggressive actions. These behaviors may appear to be resistance, but they a way of protecting themselves from stepping out of their comfort zone. It is recommended that therapists avoid minimizing the behaviors or treating them like a crisis. Instead, therapists should identify the core of the behaviors. Individuals with BPD may also change the subject when a particular topic gives them discomfort. In this case, it is wise for the therapist to create a signal to when they need to take a time-out from the discussion (Arntz, 1994).

CBT is an evidence-based intervention for treating BPD. The first randomized controlled BOSCOT study evaluated CBT’s effectiveness with BPD (Freeman, 2014). In the study, 106 participants were either treated with TAU (community-based medication management and emergency services) or TAU combined with a maximum of 30 individual sessions of CBT over a 1-year period. Initial CBT sessions provided psycho-education and later sessions focused on cognitive restructuring and behavior modification. During the study, participants treated with TAU and CBT reported decreases in dysfunctional conditions, anxiety and symptom distress. These
participants also experienced fewer suicide attempts over the course of the study. In a 1-year randomized controlled trial (RCT), CBT was compared to Rogerian client-centered therapy with 65 patients diagnosed with BPD (Cottraux, Note, Boutitie, et al., 2009). Outcome measures were global functioning levels and patient reported levels of helplessness. Results concluded that patients treated with CBT experienced faster improvements and remained in treatment longer than patients treated with Rogerian client-centered therapy. Results also showed a significant increase in global functioning with the patients treated with CBT. Because of CBT’s effectiveness with individuals with BPD, technical elements are utilized in other treatment modalities (NICE, 2009).

**Dynamic deconstructive therapy.** There is some evidence that a combination of different psychotherapy techniques is effective in the treatment of BPD (Goldman & Gregory, 2009). Goldman and Gregory believe that treatment modalities for BPD overlap, especially with alcohol-use disorder. One of these combination modalities is Dynamic Deconstructive therapy (DDP).

DDP is a manual-based individual psychotherapy intervention utilized when a patient is especially resistant to other treatment methods with a diagnosis of BPD and substance use disorders (Goldman & Gregory, 2009). The DDP model operates on the deduction that individuals diagnosed with BPD and substance use are deficient of three specific neurocognitive capacities including *attribution* (ability to comprehend that individuals have unique, multi-faceted motivations and emotions), *association* (ability to identify, order and process emotional experiences) and *alterity* (ability to objectively reflect on self and others using reflections). develop the neurocognitive capacities, the individual with BPD, the therapist uses a role-playing technique where they act as the *ideal other* and *real other* in sessions. When a therapist role-plays the *ideal
other, they act as a mirror that reflects the clients emotional experiences and affect. In later sessions, the therapist switches to role-playing the real other where they assist the BPD individual to differentiate and begin to identify their own emotions and experiences.

Goldman and Gregory (2009) hypothesized that strengthening the three specific neurocognitive capacities and using the ideal self and real other role-plays in therapy sessions would improve BPD symptoms. Results showed that increased capacity in attribution improved depression, core BPD symptoms and institutional care. BPD symptoms of increased capacity in association improved BPD symptoms of dissociation, alcohol misuse and limited social support. Increased capacity in alterity improved social support, parasuicidal behaviors and institutional care. Some of Goldman and Gregory’s findings are similar to Schema-Focused therapy (SFT).

**Schema-focused therapy.** SFT is a therapy intervention developed by Jeffry Young PhD in the mid-1980’s for treating BPD that incorporates attachment theory, Gestalt therapy techniques and CBT. Young created SFT when he found that his patients were unresponsive to other interventions based mostly on their need for connection with a therapist (American Psychiatric Association, 2013).

Similar to DDP, SFT uses its own interpretation of ideal self and real other techniques to help the BPD individual create a corrective emotional experience by helping the client deconstruct and reconstruct maladaptive schemas of the world (http://www.apa.org, 2014). Encouraging the patient to form an attachment to the therapist using “limited re-parenting” creates a safe place to confront emotional traumas from childhood.

Evidence shows SFT is effective for treating BPD and BPD symptoms. SFT is on the Substance Abuse Mental Health Services Administration (SAMHSA) and is considered to be one of the National Registration Evidence-Based Programs (Nrepp.samhsa.gov, 2014). The effec-
tiveness on psychosocial treatments on suicidality in PDs was evaluated from thirty international and United States studies from years 1991-2006. Results showed that SFT was effective in reducing suicidal, parasuicidal and self-injurious behaviors in adults with BPD (McMain, 2007). In a 2006 study, Dutch researchers compared the interventions of SFT and transference-focused psychotherapy (TFP) on a group of 86 participants diagnosed with BPD for 50-minute sessions twice per week (Giesen-Bloo et al., 2006). One year into the study, participants from both intervention groups were assessed using a Borderline Personality Disorder Severity Index (BPDSI) to measure levels of functioning in self-perception, other-perception, self-mutilation and social relationships. Results showed that 29 percent of TFP and 52 percent of SFT participants no longer fit the BPD diagnosis based on their score on the BPDSI and were considered to be fully recovered. The SFT participants also made improvements in all areas of functioning and had a 27 percent dropout rate when compared to the TFP group.

**Mentalization-based therapy.** Developed by Anthony Bateman and Peter Fonagy (2004), Mentalization-Based Therapy (MBT) is a psychodynamic approach incorporating cognitive psychology and Bowlby’s (1973) attachment theory. Mentalization can be described as recognizing and interpreting thoughts, emotions, desires and needs in self and others (Bateman & Fonagy, 2004). Mentalization also requires the ability to separate these elements from self and others using symbolic functioning to represent mental states. Symbolic functioning allows for healthy emotion regulation by helping the individual not feel overwhelmed in intense, emotional states. Individuals with BPD are impaired in metallization and symbolic functioning, causing impulsive behaviors, emotional instability and vulnerability in social and interpersonal interactions with others.
In secure attachment, an infant’s mental state is understood by attentive, caring and safe adult figures, allowing for a greater understanding of self and others (Bowlby, 1973). It is believed that BPD individuals were vulnerable or exposed to psychological trauma early in life or in late childhood resulting in a disorganized attachment style (Bateman & Bonagy, 2010). Psychological trauma of BPD individuals occurs through neglect or incongruent emotional experiences from mirroring with a caregiver. Psychological trauma causes hypersensitivity in attachment systems and impaired cognitive and social abilities for mentalizing. Inadequate metallization causes problems in control, emotion regulation and attention. Fortunately, Bateman and Fonagy believe that metallization can still be developed later in life through MBT.

The overall goal of MBT is to improve the BPD individual’s ability to mentalize through stabilization of sense of self (Bateman & Fonagy, 2010). Stability in emotions must be accomplished before internal representations can be dealt with to ensure safety of the individual with BPD and to increase therapeutic effectiveness. The MBT therapist must maintain a controlled attachment with a modified amount of intensity. Overly stimulated attachment between individual with BPD and the therapist may result in hospitalization and poor long-term outcomes in the metallization process.

MBT allows for more flexibility in the use of interventions than other approaches (Bateman & Fonagy, 2010). This allowance of flexibility makes MBT popular to inexperienced therapists and therapists with different theoretical orientations. Bateman and Fonagy (2010) explain,

The aim and the actual outcome of an intervention are more important in MBT than the type of intervention itself. The primary aim of any intervention has to be to reinstate mentalizing when it is lost or to help to maintain it in circumstances when it might be lost or is being lost. Any intervention that succeeds in these aims may be used in MBT. (p. 13)
In order for MBT to be effective, the therapist must take a specific stance beginning with support, empathy and making clarifications when needed (Bateman & Fonagy, 2010). The therapist’s stance should also include humility using a “not knowing,” patience, acceptance of different perspectives, active questioning of the BPD patient’s experience avoiding “why” questions and focusing on “what” questions and asking for clarifications. The therapist must also know that working with a BPD individual incapable of mentalizing puts them at risk for losing their own metallization ability and they must consistently monitor their own metallization processes. If the therapist experiences lower levels or loss of mentalization, they must take a step back and collaboratively process the incident with the individual with BPD. Bateman and Fonagy advise therapists to be aware that the sensitivity in an individual with BPD’s interpersonal interactions will inflict high anxiety and emotional states because of feelings of loss of self when learning to mentalize. However, Bateman and Fonagy believe that increasing mentalization capacity will improve interpersonal functioning and decrease BPD symptoms.

TWO RCT’s demonstrate the efficacy in MBT (Bateman & Fonagy, 2004). The studies concluded that MBT showed significant effects in improving interpersonal and social functioning. The studies also showed that MBT had significant results in decreasing depressive symptoms, self-injurious behaviors and suicide attempts. In a more recent study, Fossati, Feeney, Maffei and Borroni (2014) examined the effects of in-patient MBT on adolescents diagnosed with BPD. Outcome measures showed improvement in lifestyle functionality and decreased BPD symptoms. Adolescents with BPD also reported a higher quality of life one-year after the study.

Some research studies show the Family therapy (FT) may also be a useful intervention (National Alliance on Mental Illness, 2014). Family members receive education on the disorder and become aware of useful tools to help understand their loved ones. Effective communication
is learned and practiced and alienation between family members is decreased resulting in less family conflicts. Family members may be introduced to BPD advocacy programs like NAMI, Mental Health Association (MHA) and the National Education Alliance for Borderline Personality Disorder (NEA-BPD). Family support groups like NAMI’s Family to Family and NEA-BPD’s Family Connections may also be recommended.

**Alternative Treatment Methods**

Omega-3 fatty acids have shown to be effective for treating BPD symptoms (Zanarini & Frankenburg, 2003). Zanarini and Frankenburg conducted an 8-week placebo-controlled double blind study measuring the effects of ethyl-eicosapentaneoic acid (E-EPA) found in omega-3 fatty acids on twenty women’s BPD symptoms. Fifty percent of women randomly assigned 1g of E-EPA daily showed improvements in depressive symptoms and depression symptoms with no reported clinical side effects compared to the control group. Zanarini and Frankenburg concluded that omega-3 fatty acids may be a safe mono therapy treatment for women with moderately severe BPD symptoms. In a more recent double-blind, randomized control trial, 15 adolescents were assigned to take 1200 mg of omega-3 fatty acids or a placebo for 3-months (Amminger et al., 2013). Results showed that a decrease in BPD symptoms and improved functionality in adolescents who took the omega-3 fatty acids compared to the control group.

Other alternative therapies may be a helpful supplemental intervention for reducing BPD symptoms (Clearviewtreatment.com, 2014). There is no evidence suggesting this, but several treatment centers for individuals diagnosed with BPD have a holistic, alternative therapy approach for treating symptoms. One BPD day-treatment program called Clearview located in Los Angeles, CA, offers a holistic, mind-body approach by incorporating yoga, healthy nutrition, therapeutic massage, acupuncture and leisurely outdoor activities in treatment.
Preventions/Advocacy

Early Interventions

Precursor symptoms of the development of BPD often emerge in adolescence (Yasgur, 2013). Other diagnoses of oppositional defiant disorder (ODD), substance use, depression, conduct disorder (CD) and emotion regulation and attention disturbances in childhood or adolescents may be early detection signs of BPD. It has also been found that 30% adults diagnosed with BPD use self-harming behaviors in childhood or adolescence (Zanarini et al., 2006). Though adolescents seek help from professionals, their symptoms are often not taken seriously because PD diagnoses are controversial during this developmental period. However, it has been discovered that diagnostic criteria for BPD has the same reliability, stability and validity in adolescence and adulthood. Because of this, early interventions have been found to be effective in this age group (Chanen, McCutcheon, Jovev, Jackson & McGorry, 2007).

Early detection of BPD allows for earlier interventions (Yasgur, 2013). Current research shows that the adolescent period is the “key developmental period” for interventions. In Australia, the Helping Young People Early (HYPE) model was used as an intervention for adolescents diagnosed with BPD and BPD with co-occurring disorders (such as depression). The HYPE model ranges between 16-24, team-oriented, comprehensive sessions and adapts adult BPD interventions to the understanding of adolescents’ ages 15-25 years old. The HYPE model includes an integrative approach incorporating psychiatric care, case management, psycho-education, interventions for family members and cognitive analytic therapy (CAT) (Chanen, McCutcheon, Jovev, Jackson & McGorry, 2007). CAT is the combination of psychodynamic psychotherapy and CBT (Bateman et al., 2007; Ryle & Kerr, 2002). Studies showed that a combination of CAT and the HYPE model resulted in more rapid improvements and positive effects
after a 24 month follow up session in adolescents with early signs of a BPD diagnosis compared with CAT and TAU (Chanen, Jovev, et al., 2008). Another study showed that a combination of CAT and the HYPE model produced faster and more significant improvements in internalizing (such as feelings of chronic emptiness) and externalizing (such as parasuicidal behavior) symptoms compared to TAU and the HYPE model after a 24 month follow up (Chanen et al., 2009). Results of both of these studies demonstrate the effectiveness of the HYPE model as an early intervention for adolescents with early signs of BPD. Unfortunately, stigmatization in both adolescents and adults sometimes silences cries of help from sufferers of BPD.

**Stigmatization**

It is no mystery that a client diagnosed with BPD often makes a clinician cringe. In my history as a student and a working professional in ARMHS, clients with BPD can be very challenging. Intense emotions and parasuicidal behaviors can be very frightening and exhausting for clinicians (Aviram, Brodsky & Stanley, 2006). Progress can also seem very slow moving when treating individuals with BPD due to constant fluctuations in functioning. According to Aviram, Brodsky and Stanley, a prototype of an individual with BPD has been created that reflects clinicians experiences. This prototype is made up of derogatory terms clinicians use when describing their experience with individuals with BPD including “manipulative,” “attention seeking,” “demanding,” “difficult” and “treatment resistant”. Aviram, Brodsky and Stanley inform that although these descriptive words can reflect parts of BPD, they set expectations for clinicians that lead to stigmatization.

Stigmatization may cloud the clinician’s judgment when treating individuals with BPD (Aviram, Brodsky & Stanley, 2006). A clinician may interpret lower levels of functioning as being purposeful, in their control or as a form of manipulation. Stigmatization may also cause the
clinician to use distancing as a form of self-protection when reacting to an individual with BPD in therapy. Unfortunately, individuals with BPD may perceive the clinicians distancing behaviors as a form or rejection or abandonment and may react by withdrawing from therapy or using self-injurious behaviors. In addition, some clinicians may feel anger when working with an individual with BPD and refrain from giving the correct diagnosis in effort to avoid treatment. Clinicians may even go as far as to avoiding individuals with BPD altogether out of fear (National Alliance on Mental Illness, 2014)

Conclusion

This paper examines the clinical symptoms, history and development of borderline personality disorder (BPD) with and without childhood abuse. This paper also examines the Adlerian interpretation, present interventions and stigmatization of BPD. Awareness of the different etiological factors BPD can improve the quality of care provided to clients by adult rehabilitative mental health services (ARMHS) practitioners. Understanding the factors that contribute to the etiology of BPD can help ARMHS practitioners have more empathy while working with clients diagnosed with BPD. Having knowledge of present interventions for clients diagnosed with BPD allows ARMHS practitioners to adapt their treatment plans (TP) to coincide with their client’s current mental health wellness plan. Because several studies have shown that BPD is treatable, practitioners can help raise confidence levels in their clients so that they can increase their life functioning levels. Awareness of stigmatization associated with BPD can also help ARMHS practitioners be aware of their own personal bias.
References


THE EFFECTS OF CHILDHOOD ABUSE ON THE ETIOLOGY OF BPD


