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Living with Borderline Personality Disorder (BPD): Does the Diagnosis of BPD Warrant Stigma from Healthcare Staff?

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ABSTRACT

Background: Borderline personality disorder (BPD) has a high prevalence in the psychiatric care setting. Persons with BPD often struggle with the stigma of having a mental disorder, alcohol and substance abuse, and suicidal thoughts. Nursing care for this patient can be draining and burdensome, but the nurse should know how the disorder works to provide the best care possible. **Purpose:** The purpose of this review was to gain a better insight as to what BPD is, how it is treated, and the struggle that people have living with this disorder. **Method:** This was a thorough review of the literature on BPD. **Findings:** It is understood that BPD development depends on several factors, including neurobiology and external influences. The treatment is a combination of psychotherapy and medications to manage symptoms. **Conclusion:** Health care providers must help their patients recognize that this disorder is a disease process and that their symptoms do not define who they are.

1. INTRODUCTION

The Diagnostic Manual of Mental Health Disorders, 5th edition (DSM-5) classifies borderline personality disorder (BPD) as a cluster B disorder. Cluster B disorders are characterized by dramatic, emotional, and unpredictable/impulsive behaviors. As illustrated in Figure no. 1, BPD is predominantly characterized by instability of emotional control and regulation, impulsiveness, distorted perception of self, mood lability, and unstable relationships [1]. People who suffer from this disorder face many difficulties in their life, including but not limited to stigmatization, low self-esteem, inability to maintain relationships, alcohol and substance abuse, and suicide. The National Alliance on Mental Illness (NAMI) website has a page where people can share their stories of living with BPD. It is evident through them that people struggle deeply with the stigma surrounding mental health, feeling alienated, misunderstood, and the intensity of their emotions [2]. Hearing stories like these can make individuals wonder what it is like to live with BPD and its implications on one's life. This topic is vital for nurses to understand better how to provide care for this population based on their needs. The purpose of this paper was to explore how this disorder develops, how it is treated, what other challenges it proposes, and what this means for health care practice.

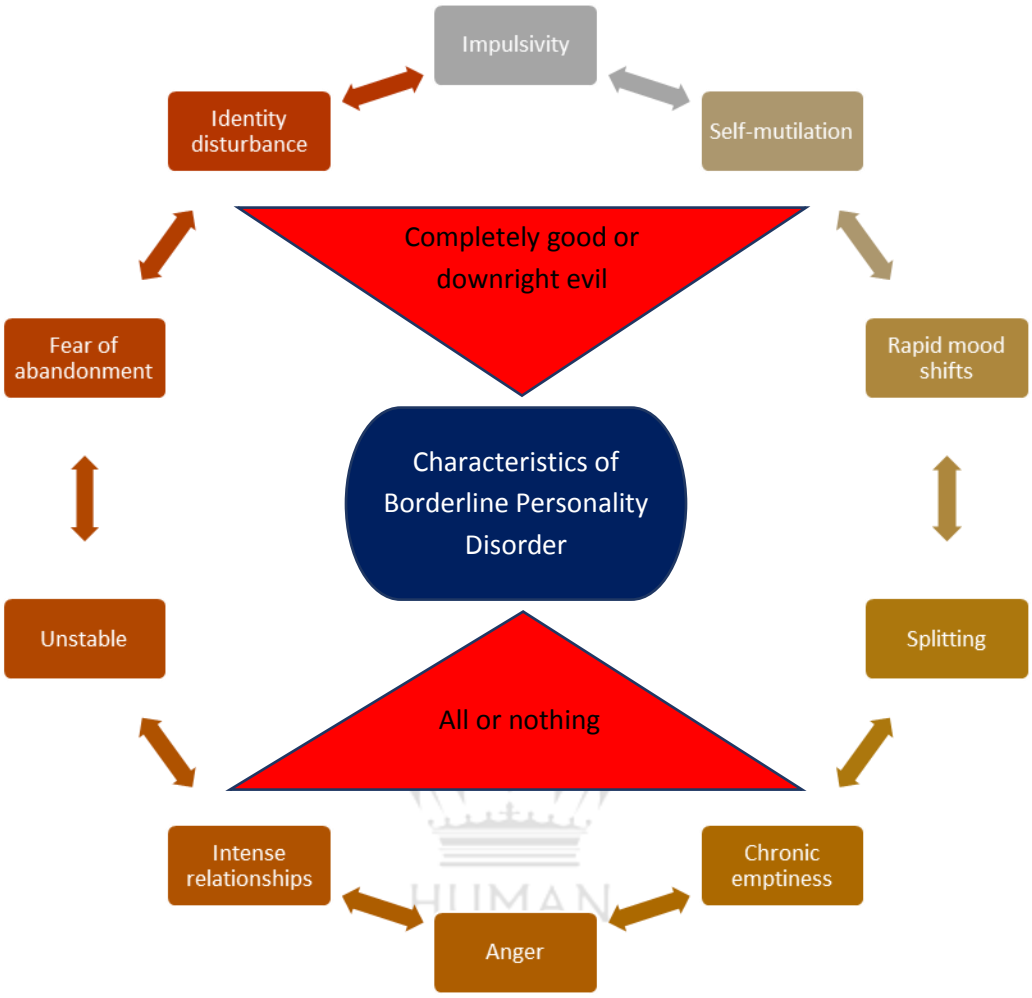

Figure No. 1: Characteristics of borderline personality disorder

2. CASE STUDY

A patient with BPD was hospitalized following an argument with her mother. She was a 19-year-old who recently dropped out of college because of the severity of her BPD symptoms and the issues that it caused in her life. After an argument with her mother, she drank heavily and decided to get behind the wheel of a car, resulting in a totaled vehicle. She only abstained a few minor injuries. After a visit to the emergency room, she voluntarily admitted herself for treatment. BPD patients are characterized as being emotionally unstable. They can take a small issue and react in a way that seems extreme and unreasonable to those without the disorder. She

stated that she is losing her friends and has trouble maintaining relationships, which is a key sign of borderline personality.

Another classic symptom she confirms is substance misuse, which is often a dual diagnosis in people with BPD. She shared that she has been drinking excessively every day as well as smoking marijuana. She had scars up and down her arms from repeated self-harm. She explained that she likes to cut herself with a razor blade because she believes she deserves it. She also stated that hurting herself makes the pain on the inside go away because she must focus on her cut from physical pain. She was involved in self-destructive behaviors and behaving recklessly. She stated that she does not care about the consequences and does not regard her own life. The patient recognizes that she has a problem and is willing to receive help. She aspires to obtain a degree in science but does not want the diagnosis of BPD to hold her back from her dream. Upon discharge, she planned on living with her friend. She decided that this would be a better living plan because she would not have to live with her mom, who also has the same diagnosis. She blamed her mother as a trigger to her extreme behaviors.

3. LITERATURE REVIEW

The university online library was used for scholarly sources along with other resources such as the *American Psychiatric Association,* the *DSM-5*. All the research utilized is recent and has been published between 2015 to 2020. The DSM-5, though published in 2013, is still considered to be a valid tool to diagnose personality disorders and is used in psychiatric facilities nationwide. To help locate applicable research, words, and phrases such as BPD, emotional regulation, impulsivity, suicide, substance use, and neurobiology were used.

Using the methods discussed above, several topics were found to be important in understanding BPD and its treatment. Topics that were found include the symptoms, risk factors, and treatment. Some behaviors and characteristics that BPD patients typically embody are discussed as well, and they include impulsivity, low self-esteem, substance use, and suicidal thoughts or threats. All these topics are discussed in further detail in the following portions. These ideas are essential for the health care team to consider providing appropriate treatment and support.

3.1 Symptoms Include Extreme Emotional Reactions

Signs and symptoms of BPD typically begin to present in later childhood and young adult years. BPD patients are marked as engaging in impulsive and harmful behavior such as substance abuse, self-harm, or reckless spending, with suicide being a leading risky behavior [3]. Symptoms can include poor boundaries, impaired emotional regulation, extreme emotional reactions, maladaptive coping mechanisms, repeated attempts of self-harm, suicide threats, anger, poor sense of self, unstable interpersonal relationships, impulsivity, and risk-taking [4]. Diagnosis is based on symptoms that indicate widespread instability of interpersonal relationships, self-image, and emotional expression and marked impulsivity that begins in early adulthood. To determine if this is present, the patient must have five of the following: Frantic efforts to avoid abandonment (real or imaginary), the pattern of unstable and intense relationships characterized by extremes of idealization and devaluation, marked and persistently unstable self-image or sense of self, impulsivity in two areas that could cause self-damage (not self-harm or suicide), recurrent suicidal behaviors or self-mutilation, affective instability, chronic feelings of emptiness, intense and inappropriate behavior or difficulty controlling it, and intermittent stress-related paranoid ideation or severe dissociative symptoms [1].

3.2 Internal Factors may Exacerbate Symptoms

The physical changes that occur in the brain with BPD are complex and closely intertwined with external factors. Genetics play a role in the development of BPD by predisposing the patient. It has been made evident through familial studies that heredity is a factor, though the specific genes involved have not been thoroughly investigated. It is thought that genes on chromosomes 1, 2, and 9 are associated with BPD [5]. The serotonin transmitter gene is also thought to be affected, which causes a decrease in serotonin; therefore, increasing aggression, destructiveness, and depression. It is also thought that there could be norepinephrine and dopamine dysregulations, but this is a topic that needs further research [6].

Other neuropeptides and neurotransmitters have also been found to impact BPD as well. There has been evidence to support lower basal opioid levels and increased sensitivity of opioid receptors. This could contribute to the sense of dissatisfaction often seen in BPD. Oxytocin is a neuropeptide that is a social relationship regulator. People with this disorder have oxytocin

dysregulation, contributing to their struggle with hypersensitivity in interpersonal relationships, distrust, and misinterpreting social cues [5]. Imaging of the brain has also been done to understand this disorder better. The amygdala is a part of the limbic system and the hippocampus, thalamus, and other structures. It has been found that the amygdala is affected in BPD and contributes to the emotional dysregulation along with the prefrontal cortex. Specifically, amygdala habituation is impaired, meaning that the amygdala cannot decrease its response to repeated stimuli, leading to overstimulation associated with heightened anxiety, aggression, and lability [5]. The prefrontal cortex, which helps the brain adapt, focus, and achieve goals, also shows decreased regulation, leading to extreme negative emotions [6]. MRI studies have shown that persons with this disorder may even have reduced brain volume in the brain structure associated with emotion regulation [5].

3.3 External Factors may Exacerbate Symptoms

External factors also affect the development of BPD. Mahler developed a framework to help understand psychological disorders and how childhood is strongly involved with their development. She proposed that interference of separation-individuation in childhood can cause disorders later in life, such as BPD. Another theory by Kerberg suggests that in the early years, a child can build up positive relationships separately than negative ones. This causes them to view different aspects (good vs. bad) of the caregiver as two distinct beings. Normally, these two will integrate, and the child will view the individual as a single being; however, splitting can occur if this does not happen [7]. Splitting is a defense mechanism used to see others in a black and white manner, as either completely good or downright evil. This view of others is characteristic of BPD and can instantly change if they are let down by someone [6].

The psychological deficits related to BPD are likely to become more apparent in adolescence as independent emotional regulation strategies take over [3]. A retrospective chart review was used to identify clinical features and risk factors present in adolescents meeting the criteria for borderline personality traits [3]. A psychiatrist was paired with an adolescent with the use of dialectical behavioral therapy (DBT). The study was conducted between 2011 to 2015 and assessed for difficulties with coping, emotion regulation, and self-harming in persons was BPD. The study consisted of adolescents between 16 and 19 years of age meeting criteria either for

BPD or for borderline personality traits. It also included a control group of 30 mood and anxiety subjects who had taken part in a cognitive behavioral therapy (CBT) group. The review looked explicitly at information organized into six categories: demographics, patient history, family history, presenting symptoms, developmental history, and diagnostic history.

The risk factors for BPD were identified through chart reviews. Patients meeting BPD criteria were compared to patients meeting borderline personality traits, and then both groups were compared to the control group. The results showed that history of sexual abuse, pre-natal or peri-natal stress, bullying, suicidal ideation, externalizing symptomatology, impulsive behaviors, and substance misuse are predisposing risk factors identified in adolescents with BPD [3]. These risk factors are associated with risky behavior. It has been suggested that child temperament formulations are likely antecedents to later adult personality disorders. Healthcare providers need to conduct a thorough assessment for a history of abuse, childhood stress or history, or risk for suicide.

In another study, Fatimah *et al.* [8] investigated if marriage, divorce, and parenting factors contribute to children developing BPD. They discovered that parents that already have a mental disorder, such as BPD, or substance abuse, are predisposed to having offspring who develop BPD. Environmental factors such as parental practices can contribute to BPD traits. They also found that parents who have a history of childhood trauma or substance misuse are more likely to develop aggressive behaviors towards their offspring. Adoptive children were reported to have a higher prevalence of borderline personality traits. Parents with a lack of involvement and lack of regard were more likely to have a child developing BPD traits. The lack of interpersonal relationship skills and inability to maintain/form relationships characteristic to BPD was found to be connected to having a poor bond with parents. The authors realized that to better understand the etiology of BPD, the development of effective prevention and intervention strategies to improving parenting skills is necessary to decrease the likelihood of BPD traits [8]. It is important to consider assessing the parents' mental status, the risk for substance misuse, disciplinary actions, and available support system. Educating parents on managing their anger and setting aside time to bond with their children could be beneficial.

3.4 Impulsivity may Result in Self-Harm

Impulsivity in BPD patients manifests in a range of dangerous and self-destructive behaviors such as drug misuse, self-harm, and suicidal behavior, leading to serious consequences [9]. This study was conducted to evaluate behavior and self-impulsiveness in individuals with BPD and attention deficit hyperactivity disorder (ADHD) and compared them to healthy individuals. The study consisted of 39 patients with BPD, 25 ADHD patients, and 55 healthy persons. Each BPD and ADHD patient was paired with a healthy person. All participants completed a clinical and behavioral test conducted by a psychiatrist for two hours. The test consists of categories that measured “lack of premeditation, lack of perseverance, sensation seeking, negative urgency, and positive urgency” [9]. Higher scores indicated higher impulsivity. The results showed that BPD and ADHD individuals have a "lack of premeditation, lack of perseverance, negative urgency, and positive urgency with no sensation seeking" [9]. It was concluded that BPD and ADHD patients only differed in negative urgency, which the BPD patients scored higher. Negative urgency is associated with negative behavior, such as suicidal behavior or self-harm. BPD patients displayed a higher preference for immediate reward resulting in the reduced ability to learn from consequences. BPD patients were shown to stop premature actions and ongoing actions showing that they are cognitively aware of their actions, unlike individuals with ADHD [9].

3.5 Lower Levels of Self Esteem is Evident

BPD patients are reported to have lower levels of self-esteem and self-love, increased levels of self-blame and self-neglect, and unstable relationships compared to healthy individuals. They view others as dangerous or negative. A more negative pattern could result from reduced integration of desirable feedback or enhanced integration of undesirable feedback. Korn *et al.* [10] evaluated the effectiveness of social feedback on BPD patients' self-esteem through social interaction. Persons with BPD and healthy persons were recruited to study how BPD patients react to social feedback. The patients were told the goal of the study was to get to know each other through a game. Neither of the groups was told of the medical condition. They were informed that they were going to rate each other on several trait descriptions after the game and that these ratings were going to be shown anonymously to the respective fellow players. After

the game, everyone was given a questionnaire with 40 positive and 40 negative traits to assess their self-esteem and mood as well as the other players. It was discovered that BPD persons negatively received social feedback from themselves and others compared to healthy persons. The negative evaluations in BPD have been related to maladaptive behavioral strategies such as outbursts of anger and suicidal behaviors. The authors suggested that undesirable social feedback may contribute to self-destructive behaviors in BPD. Individuals with BPD are unable to receive criticism constructively. BPD patients rated themselves and other BPD patients as less favorably than healthy persons. Therefore, the proposal was that therapy should promote self-esteem and discourage negative processing because it can lead to self-destructive behaviors [10].

3.6 Substance and Alcohol Misuse are Common

It is very common for people who are affected by BPD to be at risk for misusing substances and alcohol. Some of the key symptoms of this disorder include emotional dysregulation and impulsive behaviors, contributing to the increased risk of misusing substances. Individuals with BPD have also been associated with comorbid conditions such as depression and anxiety, increasing this risk [9]. The pharmacologic vulnerability model shows a strong link between impulsive behaviors and addiction to the stress-reducing effects of alcohol. Multiple factors can contribute to a person with BPD to use alcohol. Substance misuse in this specific population is much worse than in people without any psychiatric disorders. The impulsive behaviors of these patients make it difficult to say no when craving a substance. These cravings are more severe in these patients, making it difficult for a person to stop due to the emotional dysregulation and impulsive behaviors associated with BPD.

It was interesting to note that social interactions and being around people, even if it is at work, cause people with BPD to have more cravings, often for alcohol. Studies showed that BPD patients stated they have more cravings at school, bars, and work than when they are alone. This could have a detrimental effect on their social and academic or professional life. It is already difficult for a person with this disorder to maintain healthy relationships, so adding inappropriate drinking or other substance use can further alienate these people and further strain their already unstable relationships [11].

3.7 Suicide Ideations Manifests Differently with BPD

BPD is directly linked to suicidal tendencies and self-harm. It is calculated that 10% of patients with this disorder commit suicide. BPD patients have an average of three attempts throughout their lifetime, with most attempts coming from an overdose [12]. Patients often describe the reasoning for their suicide attempt as a "way to escape," usually after a stressful life event such as an argument or death of an individual close to them. Typically, borderline personality patients are at a higher risk for suicide during later stages of the illness, in adulthood, and when they have frequent visits to the emergency room. The most effective therapy to prevent suicide for the BPD patient population is psychotherapy rather than using medications. This creates difficulty when predicting fatal outcomes. Physicians lack the algorithm to predict these events most of the time since BDP patients are highly unpredictable and impulsive. Suicidal ideation in people diagnosed with BPD manifests differently compared to patients diagnosed with mood disorders.

Other patients with suicidal ideation typically have suicidal thoughts during a depressive episode and then erase those thoughts in remission. BPD patients may consider suicide for months to years but do not go into remission until much later. Most patients with BPD do not commit suicide despite having suicidal thoughts frequently. This makes it difficult for people to provide care for this patient population. No one wants to downplay a threat of suicide because the care provider believes the individual will not do it; however, this can be very draining for therapists. For borderline personality patients, hospitalization has been shown to help temporarily, but once discharged, suicidal thoughts continue. Based on the evidence, it is better to treat borderline personality patients on an outpatient basis with specialized forms of psychotherapy. Hospitalizations will likely lead to repetitive admissions. The goal is to avoid crises and have continuous day treatment for the patient and someone they can always reach for resources to help them when needed [12].

3.8 Labeled as Borderline Personality Warrants Stigma from Healthcare Staff

Just like other psychiatric disorders, there is a stigma around BPD. People with this disorder face stigma, making it more challenging to handle. Even healthcare providers that are supposed to help patients with BPD have their own biases. In a study, Ring and Lawn [13] found that patients with BPD felt that being labeled as having BPD warranted negative reactions from healthcare

staff. Healthcare staff would ignore the patients, causing them to feel as if their concerns were not being taken seriously. It was found that many healthcare providers viewed BPD as not a "real" disorder. Many parents diagnosed with BPD are reluctant to seek care for the fear that if they share their disorder, their children's custody may be at risk. Healthcare providers may also be ambiguous with the diagnosis of BPD. Instead of labeling someone with this disorder, the provider might use euphemistic terms or focus on the comorbidities such as depression or PTSD because these comorbidities have less stigma attached to them. Some believe that avoiding the diagnosis of BPD has created negative consequences. Withholding the BPD treatment to reduce stigma may act oppositely, reinforcing stigma by reinforcing paternalism towards them. Once patients are aware of the diagnosis, it has been found that patients feel more alienated from treatment.

Most of the stigma arises from a strong sense that the BPD individuals are powerless to change. Many people, including healthcare professionals, have fixed negative beliefs towards this population group to “protect” themselves from manipulation and projection from the patient. This preconceived notion that people with BPD are manipulative contributes more to the stigma around them. People need to understand that the process is not “bad behavior," but it is an "illness behavior" that can be corrected. We are all human and are prone to have moments of being uncompassionate, and in these cases, it may be to protect ourselves. To overcome this stigma, healthcare providers and others must be accepting the patient for who they are and seeing beyond their symptoms. Recognize that they are ill and that their behavior should not be taken personally is essential to provide quality care [13]. Figure 2 illustrates emerging themes from the literature regarding BPD.

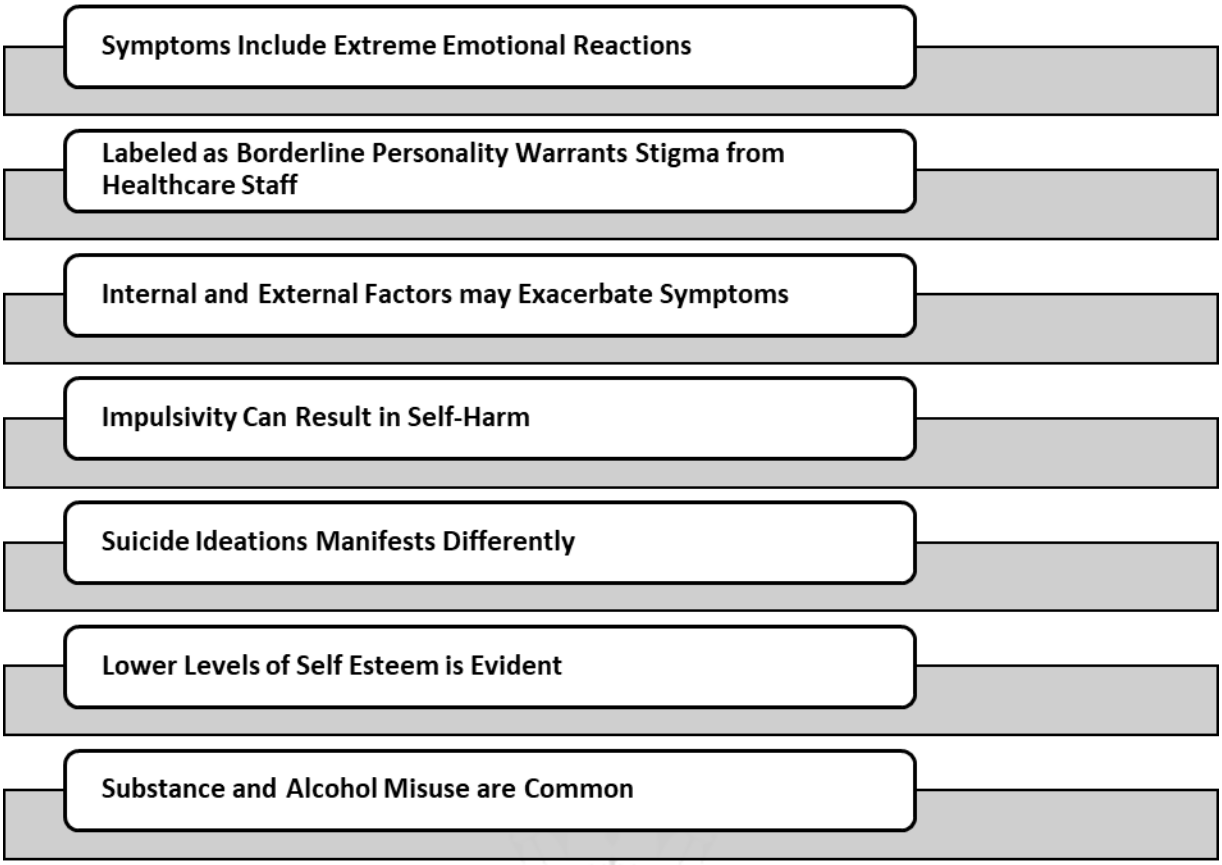

Figure No. 2: Emerging themes from the literature regarding BPD

3.9 Evidence-Based Treatment Options

Psychotherapy is an essential means of treating BDP. Dialectical behavior therapy (DBT) is the main form of this treatment and is the only evidence-based therapy for this disorder (see Figure 3). It is the blend of cognitive and behavioral therapy with mindfulness and its focus on the following four areas: mindfulness, interpersonal effectiveness, regulation of emotions, and the ability to manage stress effectively [4]. The cognitive aspect focuses on the self-recognition of negative thoughts, while the behavioral part focuses on what self-destructive actions interfere with their healing. DBT enforces the theory that two opposing behaviors (good vs. evil) can be true simultaneously. They are taught how to recognize this as true of others as well as themselves. They learn how to accept themselves without criticism while also accepting the need for change and learn better coping mechanisms. Using DBT requires frequent sessions (typically

lasts a year with sessions at least once a week), contact with the healthcare team members outside of the office, and homework to help develop the new skills [14].

There are no specific medications to directly treat BPD, so pharmacological treatment is used for anxiety and depression, which often come with the disorder. One medication class that is commonly used is selective serotonin reuptake inhibitors (SSRI's). Low doses of antipsychotic medications have also been shown to help with symptoms such as psychosis, agitation, and impulsivity. These are typically only used as a second-line medication compared to SSRI's, and if they need to be used, atypical antipsychotics are favored. Interestingly, naltrexone has been shown to reduce self-harm behaviors since it is an opioid receptor antagonist.

In a previous section, it was discussed how basal opioid levels are lower and increased sensitivity at the opioid receptors. Naltrexone, therefore, blocks the sensitivity at these sites and is thought to decrease the rewarding effects that follow these injurious behaviors [5]. Any medication must be considered and prescribed carefully since patients with BDP are at an increased risk of attempting overdose due to impulsivity and repetitive threats of suicide. Because of this, tricyclic antidepressants, lithium, and others are usually not prescribed unless there is a clear need for them and frequent patient-care provider contact [4].

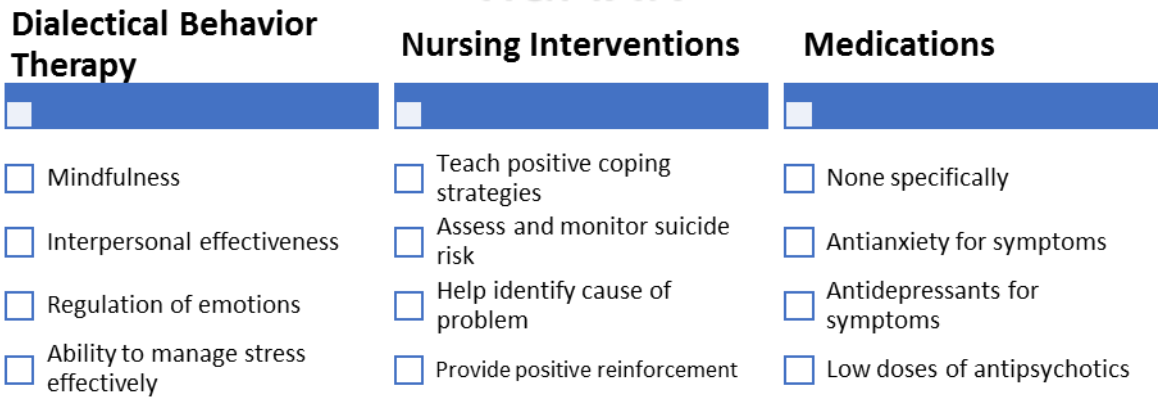

Figure No. 3: Evidence-based therapy and other interventions

3.10 Summary of the Literature Review

Research suggests that genetic and environmental factors such as poor parenting skills or having a parent diagnosed with a mental disorder can predispose a child to develop BPD. BPD is

characterized by impulsivity that could lead the individual to engage in risky behaviors. These risky behaviors could lead to substance or alcohol misuse, impulsive buying, gambling, or suicide attempts. Other symptoms characterized are unstable interpersonal relationships, low self-esteem, and dysregulation of emotions. Diagnosis of BPD is based on the signs and symptoms of the patient who meet the criteria. It is suggested that DBT is considered the best form of treatment for individuals with BPD because it focuses on establishing commitment and increasing motivation for change. There are no medications to treat BPD, only medications for treating symptoms such as anxiety or depression. Stigmas associated with BPD can lead to misinterpretations of the disorder, causing the individual to be reluctant to seek care. It is important for healthcare professionals to provide proper care through social interaction and to increase their education on common misconceptions of the disorder.

4. DISCUSSION

BPD management includes a combination of psychotherapy and pharmacology. The nurse's role is to assist the patient with controlling impulsive behavior by finding positive coping strategies. For instance, meditation, journaling, and sports are positive outlets for people with BPD. The nurse should assist the patient in identifying the cause of the problem. Identifying the cause helps to explore strategies to manage impulsive behavior. It is also essential to provide the patient with positive reinforcement. It encourages the patient to engage in positive behaviors because it increases their confidence. Encouraging the patient to self-reward helps to increase self-esteem and decrease the likelihood of engaging in risky behavior. The nurse should identify triggers to help limit frustrating situations. When the patient understands their triggers, they know to avoid stressful situations. The nurse wants to assess whether the patient has a history of risk for suicide. If the nurse finds that they have a suicide plan, they should ask what it is to determine its lethality. Discovering the history of suicide encourages a safe environment, identifying risk factors, and builds a trusting relationship between the patient and the nurse.

BPD patients are known for impulsive behavior. Identifying the consequences of inappropriate expression of impulsiveness help to manage emotions and behaviors. There are no approved medications to treat BPD itself, but only the associated symptoms. For instance, medications are given for suicidal thoughts, affective instability, impulsiveness, aggression, transient psychosis,

or cognitive, perceptual disturbances [15]. The nurse's role is to monitor for effectiveness, adverse effects, and dependence on the medication. Health professionals must perform a thorough assessment to identify risk factors that could contribute to the diagnosis. Nurses need to understand the signs and symptoms of BPD to be a better advocate for the patient and provide appropriate care.

5. CONCLUSION

In this review, several resources were utilized to gain more in-depth knowledge about BPD and further understand the debilitating effect on those with this psychiatric diagnosis. Having a clear understanding of the manifestations, treatments, and progressiveness of this disorder is essential for those who provide care for this patient population. Whether a healthcare professional is on a psychiatric unit or a surgical floor, they will likely encounter a BPD patient. Knowing exactly how to care for them is critical. Most importantly, health care providers must help their patients recognize that this disorder is a disease process and that their symptoms do not define who they are.

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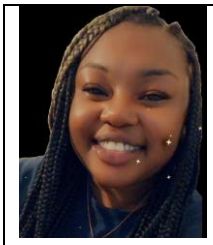	**Rantaea D. Carter** *Bronson School of Nursing, Western Michigan University, Kalamazoo, Michigan, USA*
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