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Challenges of Individuals Living with Borderline Personality Disorder

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ABSTRACT

Background: Borderline personality disorder (BPD) is characterized by emotional instability, feelings of worthlessness, and impulsivity. The causes of this disorder are not fully understood yet, but there has been a link to genetic predisposition and possible brain abnormalities. **Purpose:** The purpose of this review was to highlight the challenges of an individual living with BPD. **Method:** The use of a clinical experience case study, peer-reviewed articles, and journals were used as references for this topic. The question for a more thorough explanation was to identify: What are the challenges of an individual living with a borderline personality disorder? **Findings:** Many symptoms include depression, anxiety, and thoughts of suicide. There is an intense fear of abandonment and struggles with relationships and extreme mood swings. Struggles of this disorder include difficulty finding a proper medication regimen, problems finding alternative therapies for treatment, and access to quality mental health services. Many people with BPD report miscommunication among healthcare services, lack of urgency, misdiagnosis, stigma, and problems with personal recovery. **Conclusion:** The severity of this crippling disease supports a call to action by healthcare professionals to understand better the disease and the struggles it brings.

INTRODUCTION

The prevalence of a mood or personality disorder in adults is more common than not. When left untreated, it can lead to physical ailments such as diabetes and heart disease, along with an overall decreased level of functioning [1]. The main problems that people with BPD face are the extreme highs and lows of the disease [2]. They may have a short temper, trouble sleeping, trouble focusing due to racing thoughts, difficulty communicating or maintaining relationships, along with feelings of hopelessness that can lead to thoughts of death and even suicide [3]. A common report among people with BPD is dealing with the effects of intense and rapidly changing emotions. The extreme lows of this disease can lead to major depression. When this depression is not treated and there are not adequate interventions, it can lead to suicide. As illustrated in Figure 1, the severity of intense emotional episodes that a person with BPD has can lead to lethal struggles and other problems. Healthcare professionals need to understand the extent of these struggles to treat better and manage this disorder.

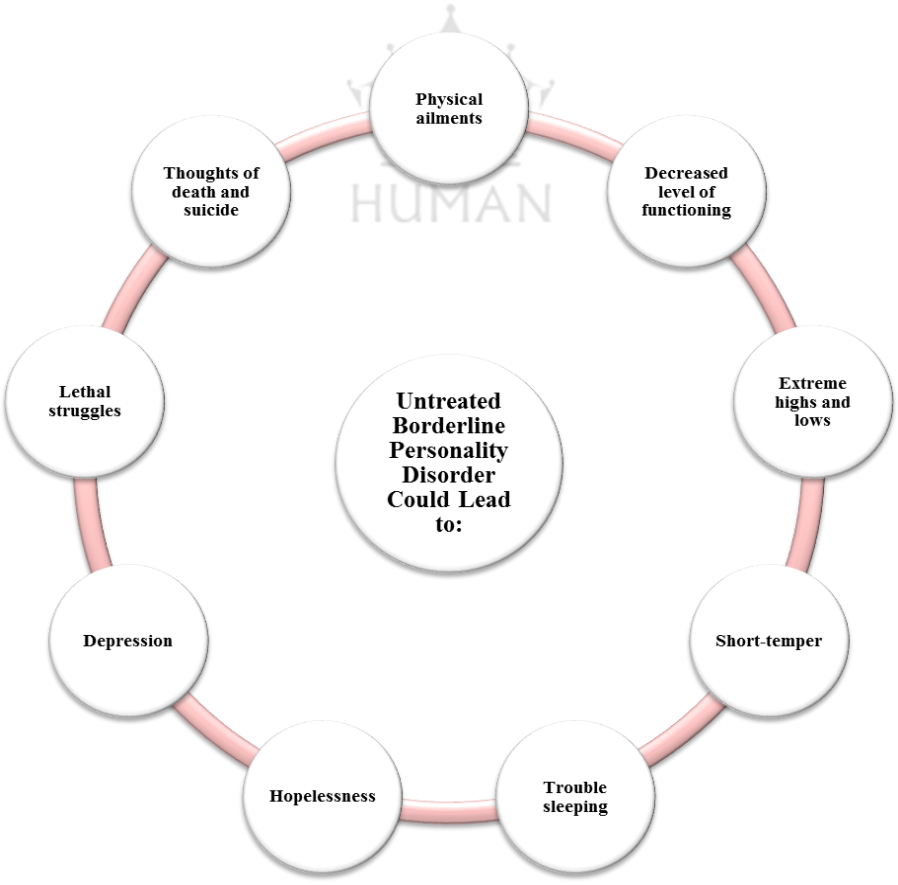

Figure No. 1: Untreated BPD can lead to several problems.

CASE STUDY

Two individuals suffering from bipolar and schizoaffective disorders with BPD characteristics presented with struggles to manage their disease. Both had a history of suicide attempts, medication regimen issues, and reported severe depression. These case studies act as a brief presentation of the life of an individual struggling with the characteristics of BPD in addition to their primary diagnosis. Verbal consents were obtained prior to the case study.

Patient A

Patient A is a middle-aged female presenting to the emergency department from an attempted suicide with an overdose of Tylenol pills. Before admission, she was consulting a psychiatrist for medication treatment for her diagnosis of bipolar disorder with borderline characteristics. She told her psychiatrist she had a plan to kill herself, and the physician was petitioning to have her committed, but the paperwork had not gone through before her attempt. She stayed at an inpatient psychiatric unit for one week after her suicide attempt. Patient A reports she is on disability and has had trouble in the past keeping a job, custody of her two kids, and a relationship with her husband, who she is now separated from.

She took lithium to control her mood swings but could not afford the medication any longer, so she stopped taking it. When she stopped taking lithium, she spiraled into a severe episode and attempted suicide. Patient A denies attempting suicide and that she was taking Tylenol for her chronic arthritis pain. She presented with acetaminophen levels above the normal range. She was diagnosed with a mood disorder and BPD at the age of 30 after the birth of her second son and has documented history of medication noncompliance and multiple self-harm and suicide attempts. During the hospital stay, she experienced auditory hallucinations after two days without sleep. When asked how she managed her disease, she reported that she has never felt fully in control of the disease and has been on numerous medications that do not help. Patient A is an example of a person with BPD who struggles with maintaining relationships, a job, and affording medication that keeps her mentally stable.

Patient B

Patient B is a male in his early 70s who presented to the emergency department after auditory hallucinations told him to run into traffic outside his adult foster care home. He has a primary diagnosis of schizoaffective disorder with borderline characteristics. He has a history of auditory and visual hallucinations, violence, and suicide attempts. He stayed for two weeks in a psychiatric inpatient unit. He has a history of being transferred from multiple adult foster care homes due to homicidal ideations of staff and roommates, along with his hallucinations. His manic episodes result in his awake periods lasting longer than two days and his depressive episodes resulting in hallucinations and medication noncompliance. Patient B reports he is currently going through a stressful divorce from his wife of fifty years and that his son is the only one with whom he still has a relationship. He is estranged from his other son and daughter. He has a family history of BPD, and his mother and sister both committed suicide. He reports that he does not mind taking his medication when he feels bad, but when he feels good, he states he does not need it. Patient B is an example of a person with BPD who struggles with maintaining relationships, medication compliance, and coping with depressive episodes (see Figure 2).

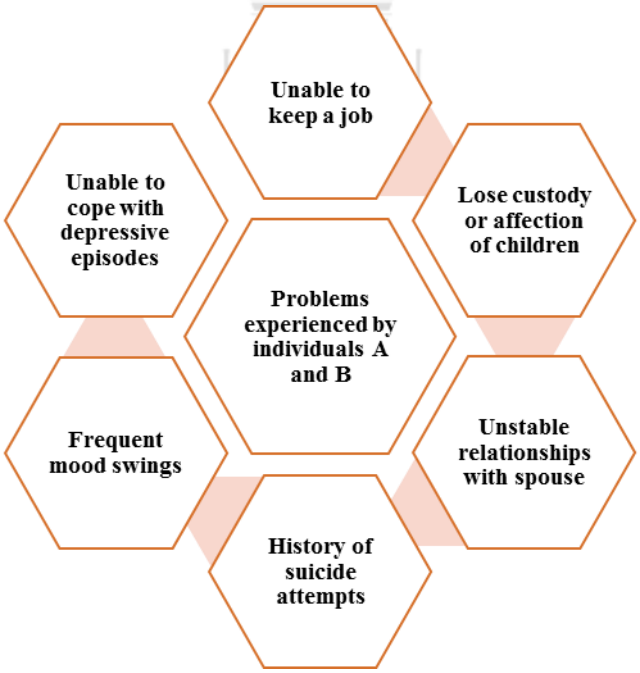

Figure No. 2: Problems experienced by the case study individuals.

LITERATURE REVIEW

Many studies have been completed in relation to the effects of BPD. This literature analyzes how society views this illness and the stigma surrounding it, its impact on daily life, manifestations of other diseases, and the specific symptoms that complicate everyday life. This literature review serves to acquire more information about this topic and point out the difficulties that people living with BPD run into daily. By compiling data from many different case studies and multiple other reviews and accounts of BPD, a deeper understanding of the complications that many individuals face is uncovered. More excellent knowledge and information are brought upon the subject by addressing stigmas and focusing on the reactions and explanations from individuals diagnosed with BPD. This review also serves to share more knowledge on a diagnosis that is greatly misunderstood and often mistreated.

Healthcare delivery and its effects on individuals diagnosed with BPD are also assessed. Co-morbid conditions, including other mental health diagnoses, are highlighted, as treatment can be ineffective if the professional is not trained correctly. Self-assessment of personal stigma is illustrated, as thoughts can quickly become actions. Working relationships between individuals and their providers are discussed as crucial to providing care. Effects on daily life are also analyzed, as many individuals with BPD struggle to participate in everyday activities. Excessive stimulation, coping strategies, and reactions to other people are highlighted as interaction with another person is inevitable today. This review takes an inside approach to how individuals with BPD get through their day and explain how they react to situations.

Characteristics Create Barriers

As illustrated in Figure 3, at the baseline diagnosis of BPD, as defined by the DSM-V criteria, the patient will experience impulsivity, substance use, unusual sexual behavior, identity disturbance, and psychosocial functioning, creating instability in relationships, anxious attachments, mood swings, and rumination [4]. The manifestations of this disorder create barriers in daily life for people with BPD where society does not value or accept these characteristics. A study that explored the values that the patients sought during treatment showed that the clinical goals that are set to achieve in a treatment program do not align with the goals that the patients want to obtain for future success and quality of life. Relationships, health and wellbeing,

education, personal development, work, career, spirituality, recreation, leisure, and community involvement were identified as the skills needed to improve and succeed in life. It was concluded that individuals with BPD prefer treatment to support their life in society rather than specific treatments of their symptoms [5]. Living with symptoms like these makes functioning in the community difficult for the patient emotionally and behaviorally.

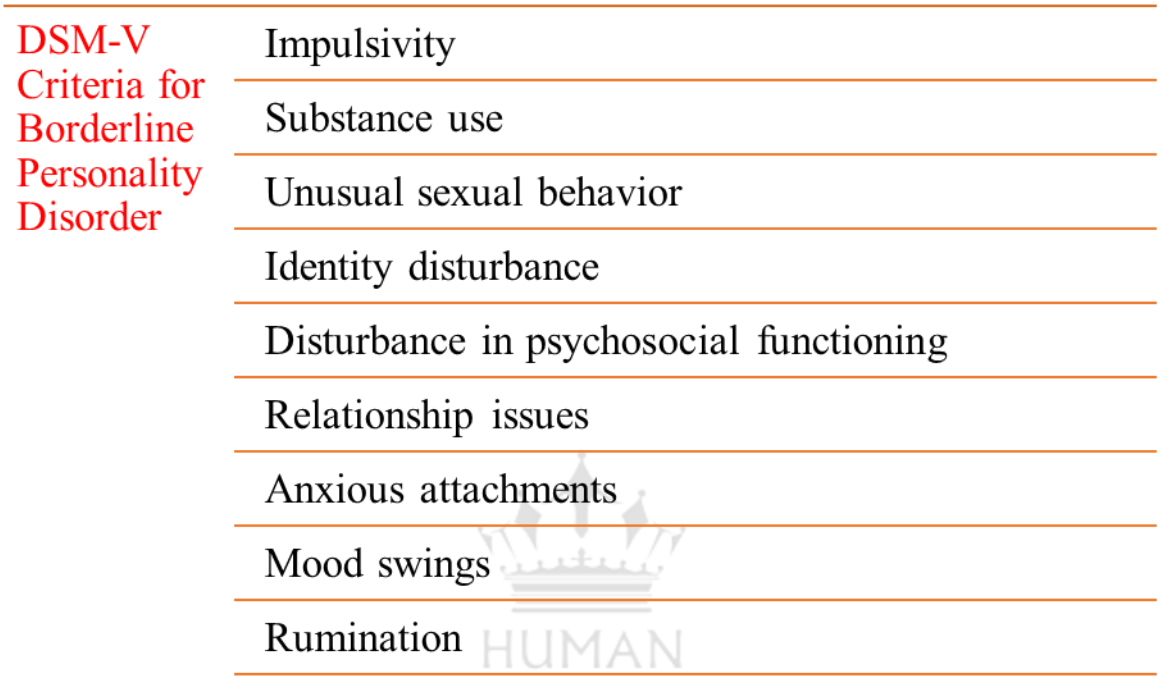

Figure No. 3: DSM-V criteria definition of borderline personality disorder.

BPD has primarily reactive emotional reactions to situations that hinder long-standing relationships and work successes. A daily life study of emotional reactivity in borderline patients determined that much of the abrupt emotional changes are caused by disappointment in others and an inability to react strongly to a critical situation [6]. This information describes specific triggers for people with BPD and how it will change their outlook; basing feelings on other people's actions is not conducive to successful social interactions.

Stigma Includes Being Treated Differently

Mental health is a sensitive topic that many people tend to avoid discussing. Upon hearing the words "borderline personality disorder," it is easy to be frightened or confused, especially if heard for the first time. As shown in Figure 4, BPD is one of the most misdiagnosed,

misunderstood, and stigmatized conditions that even professionals struggle to treat [7]. Those diagnosed with BPD have intense emotional responses, which are seen by the public as erratic and irresponsible. Individuals who have BPD may not disclose their diagnosis to others for fear that they will be treated differently. If not disclosed, it may seem appropriate to be annoyed by or correct these outbursts. Many people do not know that the emotions being portrayed by an individual with BPD feel normal and appropriate per situation. Another misconception is that people diagnosed with BPD have multiple personalities, which is not true.

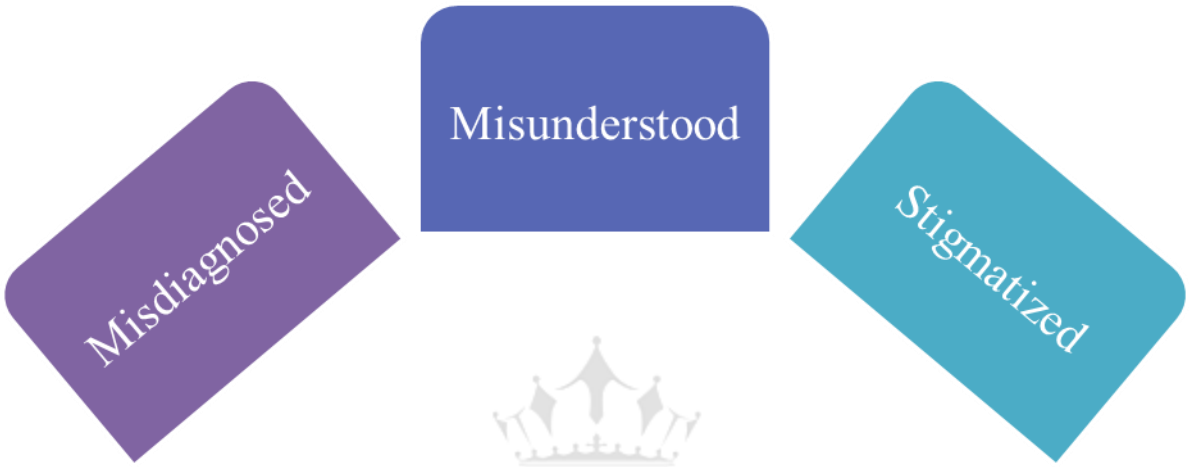

Figure No. 4: BPD is one of the most misdiagnosed, misunderstood, and stigmatized conditions.

It is typical to see distancing from those with mental health problems, especially those with BPD. Many people do not want to be associated with someone who cannot control their emotions or cannot handle their intensity. What is not realized is that by distancing from individuals with BPD, patients may resort to acts of self-harm because they feel and fear rejection [8]. People tend to think that individuals with BPD dislike interacting with others. Because of this stigma, many people will avoid individuals who demonstrate extreme and intense behavior, as they perceive it as wanting to be left alone. There is also a barrier in the mental health field between patients with BPD and the healthcare provider; a structural stigma is enforced at many institutions through policies, cultural norms, and practices that may limit a person with BPD access to health services and the quality of care [9]. It was concluded in the study that consumers with BPD in a crisis are more negatively affected than those with different mental illnesses.

Origins in Childhood Early Experiences

There is a significant connection between developing BPD and childhood early experiences, particularly emotional invalidation from the caregiver, leading to few opportunities to learn how to control differing emotional states. It was found in a meta-analysis that 71.1% of participants with BPD have had at least one adverse childhood experience where physical neglect was the largest category experienced, followed by emotional abuse, physical abuse, sexual abuse, emotional neglect. The explanation for this high correlation could be explained by the overlap between post-traumatic stress disorder (PTSD) and BPD criteria as co-morbid conditions [10].

It is shown in some studies that the association between BPD and childhood trauma may be accounted for by reduced oxytocin, dissociation, and emotion regulation. Frias et al. [11] identified that BPD patients reported greater emotional, physical, and sexual abuse and a higher preoccupied-anxious attachment level than other personality disorders. There is a significant disadvantage to socialization with an anxious attachment style that may create barriers to forming healthy relationships, essential for personal growth and happiness.

Intense and Unpredictable Mood Swings

Individuals with BPD tend to have intense and unpredictable mood swings, making them as sensitive as a livewire (see Figure 5). Many times, those with BPD are aware when their reactions elicit an inappropriate response from others. Unfortunately, those around them may not understand BPD and make dismissive comments that can trigger an emotional outburst. Though these emotions are intense, not all are negative. People with BPD can experience happiness, excitement, joy, and even love. The downside to these positive emotions is that they are highly intense and need constant support and validation. If BPD individuals do not receive the acknowledgment they need, fear of abandonment and rejection begin to happen instantaneously [12]. These feelings become so intense that individuals may start to act out, exhibit aggression towards others, threaten, or commit self-harm.

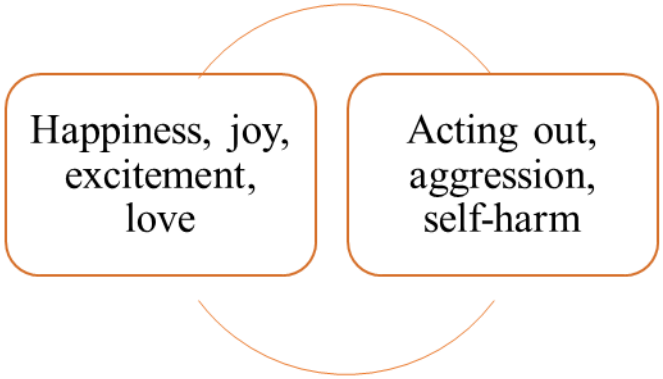

Figure No. 5: Individuals with BPD tend to have intense and unpredictable mood swings.

Carpenter and Trull [13] found that BPD individuals engage in maladaptive cognitive strategies like rumination and thought suppression to reduce negative affect, though it increases it. This phenomenon is because BPD can self-regulate and identify emotions. Since BPD individuals are deemed emotionally sensitive from birth, it is difficult for them to develop proper coping and emotional strategies, creating a cycle of dysregulated behaviors. This cycle then becomes a habit that sets BPD individuals up for failure when forming relationships with others.

Impacts Relationships

BPD can make life very difficult if appropriate treatment is not sought. Individuals with BPD have a hard time building relationships and coping with even the simplest of situations. For example, a teen who has BPD may ask a classmate if they want to work on homework together after school. The classmate wants to but has already promised to run errands for her mother after school, so she politely declines and explains the situation. The teen with BPD understands the problem but still gets very angry, shouts at her friend, and storms off. For the rest of the day, this individual talks to no one and constantly think about how her friend blew her off and did not care about her. Later that evening, the individual contemplates suicide as she feels she has no friends, nobody who cares about her, and all alone. The next day the individual with BPD is happy and chatty with her family in the morning.

While this is a hypothetical scenario, it demonstrates a few moments in the life of someone with BPD. It is found that BPD is more common in women than in men; however, tendencies toward

ineffective coping strategies such as self-harm show the same prevalence [14]. Since BPD individuals are very intense, it may be hard for others to attend to their needs. This puts BPD individuals at risk for developing high stress levels, trouble seeking professional and non-professional help, and not receiving proper treatment due to the frustrations of healthcare providers.

Since these chronic cycles are so hindering to individuals with BPD, daily living takes a toll. Going to the grocery store can become a dreaded task as a BPD individual may fear interaction with someone at the store could cause an outburst. The same scenario can be applied to family gatherings, attending school, church, and social events. Driving may become a problematic and dangerous activity if the individual with BPD experiences road rage.

Individuals with BPD struggle to create close and trusting relationships. This can inhibit their ability to find a significant other to spend their life with or destroy relationships with family members, significant others, even their children, depending on when the diagnosis is made. Not only does it affect life at home, but a BPD individual may not be able to collaborate with colleagues at work as they fear social rejection, which could cause them to lose their job. These individuals also struggle with trusting healthcare professionals as they tend to feel misunderstood, unimportant, and overlooked.

Manifests in Eating Disorders and Other Diseases

Along with the tumultuous symptoms of having BPD, there is a higher incidence of acquiring eating disorders, PTSD, ruminating thoughts, anxiety, depression, and suicidal ideation. In a study that examined the relationship between bulimia nervosa (BN) and anorexia nervosa (AN), there were higher reported incidences of BN and AN symptom that accompanied a BPD diagnosis; 17.8% of treatment-seeking women with BPD also have an eating disorder [15]). The hallmark symptoms of impulsivity, anger and affective instability had high associations with BN, while identity disturbances favored AN.

Rumination and PTSD are mood disorders that have a strong correlation with BPD [16]. When experiencing a negative emotion, ruminating creates a depressive environment by exacerbating the feelings and thoughts rather than creating solutions; along with connection to major

depressive disorder, rumination may also create a PTSD comorbid condition. This conclusion brings about a necessary piece of information that trauma-related symptoms are linked to BPD and need to be understood to treat the patient effectively.

A comparative study investigated the prevalence of suicidal ideation and behavior connected with a major depressive disorder with a co-morbid personality disorder. The results showed that 60% of BPD patients in the study had attempted suicide [17]. A lifetime prevalence of attempts exceeds 90%; a history of severe BPD symptoms and younger age are independently correlated with a higher risk of suicidal ideation and attempts [17]. Hopelessness was identified as the major lifetime risk factor that connected BPD and suicide attempts/ideation. This information should enhance the clinical assessments of borderline personality and enact prevention strategies; living with suicidal ideation impacts detrimentally a person's quality of life, mainly affecting someone diagnosed with BPD.

If co-morbid conditions cannot be managed, individuals with BPD are at a much higher risk for mortality. Healthcare professionals need to take the time to listen to these individuals. By validating their experiences and establishing a trusting, working relationship, healthcare professionals have a much higher rate of successful treatment. The relationship established between BPD individuals and their providers is crucial in continuing care.

DISCUSSION

Reflecting on the information gathered from the literature review, living with BPD is more than challenging. Not every individual with BPD experiences symptoms the same. Those who can seek and continue successful treatment often have a better ability to control their emotions. They can also maintain safe and healthy relationships and overall health.

It is vital for healthcare providers and significant others to reflect on their beliefs about BPD and research questions or thoughts that may arise from stigma. While it is acceptable to have individualized personal thoughts and feelings towards any given topic, disorder or disease, or person, it should not affect the quality and ability to help or treat individuals with BPD. Projecting negative thoughts and actions towards these individuals creates an environment that fosters betrayal, anxiety, and self-destructive tendencies. Everyone with BPD will present

differently, so taking the time to listen to, validate, and support their emotional states, even when excessively intense, fosters a conducive environment allowing for treatment and growth of the individual.

Mental illness, to any extent, can cause co-morbid health conditions. Individuals who are diagnosed with any disease must maintain their health to the best of their ability. Since eating disorders are common among those with BPD, eating habits should be managed appropriately by providing access to and adequately equipped resources to deal with BPD individuals. If co-morbid conditions can be controlled and managed, there is the opportunity for individuals to stay healthy enough to seek and stick to treatment for BPD.

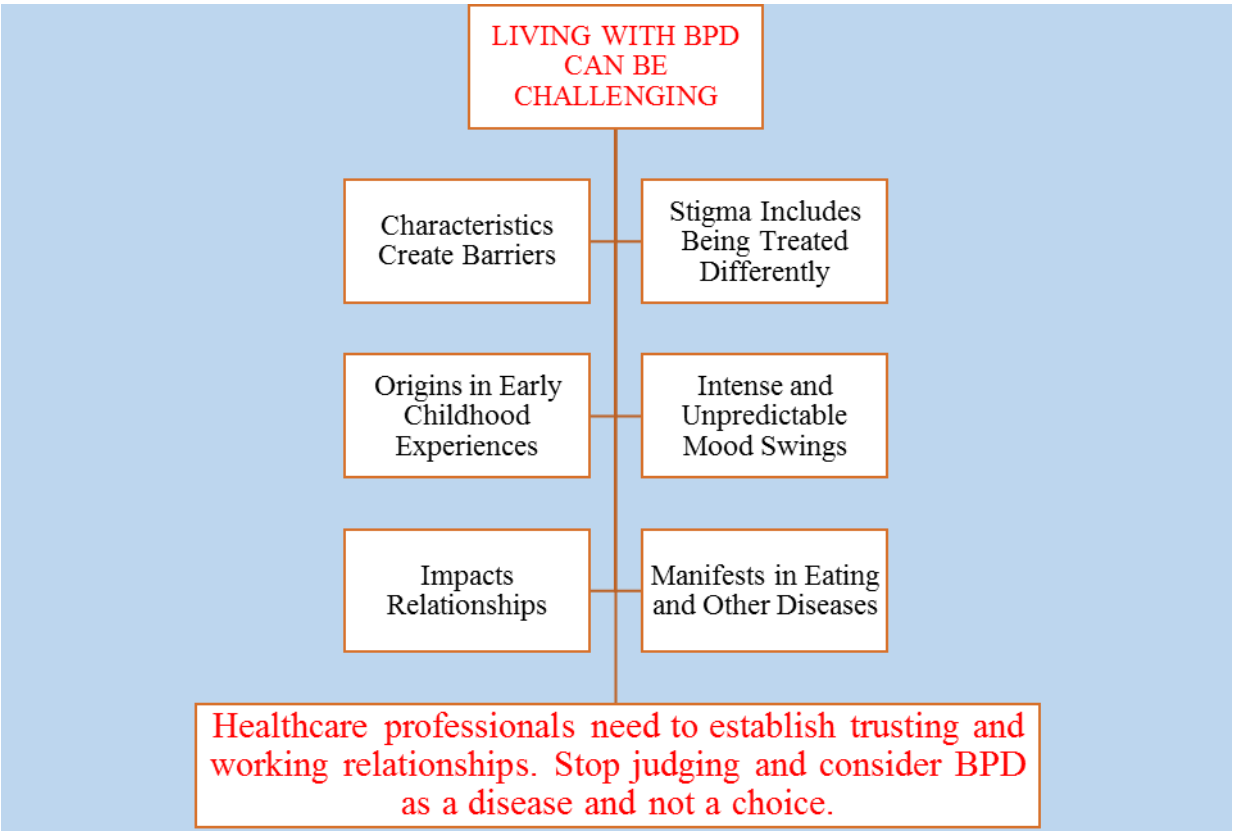

Figure No. 6: Challenges of living with borderline personality disorder and possible intervention

CONCLUSION

The challenges of living with BPD include the inability to conform to societal stands; emotional turmoil, stigma, compulsivity, anxiety, depression, and antisocial behavior are barriers to their health. In addition to the rigid standards of life, these uncontrollable symptoms will create greater health issues in the patient that may lead to self-harm or suicide. BPD is a disorder where the symptoms manifest into other problems and develop stigmas from health providers or the public that causes more difficulty with leading a happy and everyday life. This review highlighted the challenges of an individual diagnosed with BPD. Through clinical experiences and peer-reviewed articles, the many facets of BPD were explored and explained to garner more insight into the daily struggles of assimilation.

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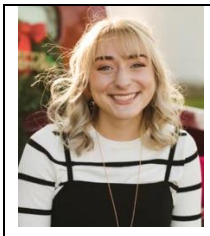	**Annie N. Hoffman** *Bronson School of Nursing, Western Michigan University, Kalamazoo, Michigan, USA*
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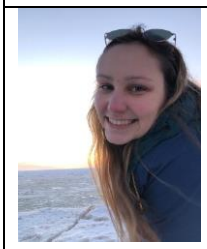	**Megan E. Robbins** *Bronson School of Nursing, Western Michigan University, Kalamazoo, Michigan, USA*
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