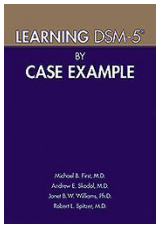

18.1
BORDERLINE PERSONALITY DISORDER

Borderline Personality Disorder is defined by "a pervasive pattern ofinstability in interpersonal relationships, self-image, and affects, and marked impulsivity" (DSM-5, p. 663). Central to the psychopathology of this disorder are an impaired capacity for attachment to others and maladaptive behavior problems related to separation from others on whom the individual depends. People with this disorder have a significant identity disturbance characterized by a markedly unstable self-image or sense of self. They chronically feel "empty" inside. Individuals with Borderline Personality Disorder make frantic efforts to avoid real or imagined abandonment. They have a pattern of unstable and intense interpersonal relationships, characterized by alternating between idealization (another person can do no wrong), when they feel cared for and supported by another person, and devaluation (another person can do no right), when they feel rejected or abandoned. People with Borderline Personality Disorder are subject to intense affective instability or lability, in which they experience mood swings characterized by intense episodes of dysphoria (a state of feeling unwell or unhappy), irritability, or anxiety for hours or a few days at a time, often in reaction to disappointing interpersonal events or encounters. They may also experience intense anger and have problems controlling anger. People with Borderline Personality Disorder are subject to transient dissociative or paranoid reactions when under stress. They may engage in recurrent suicidal behavior, gestures, or threats, and in self-mutilating behavior. They may also have other problems with impulsivity and engage in other potentially self-damaging acts, such as having indiscriminate sex, abusing substances, driving recklessly, binge eating, or overspending.

Borderline Personality Disorder is included as a specific Personality Disorder in the Alternative DSM-5 Model for Personality Disorders (DSM-5, p. 766). The proposed diagnostic criteria describe disorder-specific impairments in personality functioning (e.g., poorly developed and unstable self-image,

instability in goals and values, compromised ability to recognize the needs and feeling of others associated with interpersonal hypersensitivity, and intense and unstable close relationships) and pathological traits in the domains of Negative Affectivity (the traits of emotional lability, anxiousness, separation insecurity, and depressivity), Disinhibition (the traits of impulsivity and risk taking), and Antagonism (the trait of hostility).

Borderline Personality Disorder is a relatively common Personality Disorder, and is particularly prevalent in clinical populations. The median population prevalence of Borderline Personality Disorder is estimated to be 1.6% but may be as high as 5.9%. The prevalence of Borderline Personality Disorder is about 10% among individuals seen in outpatient mental health clinics, and about 20% among psychiatric inpatients. The course of Borderline Personality Disorder is waxing and waning. Over time, many patients improve, especially with appropriate treatment. It is one of the most impairing of the Personality Disorders, however, with significant negative impacts on social relationships and work functioning.

EMPTY SHELL

Zoe Barnes is a 23-year-old veterinary assistant admitted for her first psychiatric hospitalization. She arrived late at night, referred by a local psychiatrist. She stated, “I don’t really need to be here.”

Three months before admission, Zoe learned that her mother had become pregnant. She began drinking heavily, ostensibly to help her sleep at night. While drinking she became involved in a series of “one-night stands.” Two weeks before admission, she began feeling panicky and having experiences in which she felt as if she were removed from her body and in a trance. During one of these episodes, she was stopped by the police while wandering on a bridge late at night. The next day, in response to hearing a voice repeatedly telling her to jump off a bridge, Zoe ran to her supervisor and asked for help. Her supervisor, seeing her distraught and also noting scars from a recent wristslashing, referred her to a psychiatrist, who then arranged for her immediate hospitalization.

At the time of the hospitalization, Zoe appeared as a disheveled and frail, but appealing, waif. She was cooperative, coherent, and frightened. Although she did not feel hospitalization was needed, she welcomed the prospect of relief from her anxiety and depersonalization. She acknowledged that she had had feelings of loneliness and inadequacy and frequent brief periods of depressed mood and

anxiety since adolescence. Recently, she had been having fantasies that she was stabbing herself or a little baby with a knife. She complained that she was "just an empty shell that is transparent to everyone."

Zoe's parents divorced when she was age 3, and for the next 5 years she lived with her maternal grandmother and her mother, who had a severe drinking problem. Zoe had night terrors during which she would frequently end up sleeping with her mother. At age 6, she went to a special boarding school for a year and a half, after which she was withdrawn by her mother, against the advice of the school. When she was age 8, her maternal grandmother died; Zoe recalls trying to conceal her grief about this from her mother. She spent most of the next 2 years living with various relatives, including a period with her father, whom she had not seen since the divorce. When she was age 9, her mother was hospitalized with a diagnosis of Schizophrenia. From age 10 through college, the patient lived with an aunt and uncle, but had ongoing and frequent contacts with her mother. Her school record was consistently good.

Since adolescence, Zoe has dated regularly, having an active but rarely pleasurable sex life. Her relationships with men usually end abruptly after she becomes angry with them when they disappoint her in some apparently minor way. She then concludes that they were "no good to begin with." She has had several roommates but has had trouble establishing a stable living situation because of her jealousy of sharing her roommates with others and her manipulative efforts to keep them from seeing other people.

Since college Zoe has worked steadily and well as a veterinary assistant. At the time of admission, she was working a night shift in a veterinary hospital and living alone.

When she left the hospital, Zoe resumed work and saw a woman therapist on a twice-weekly schedule. Her therapist felt that it was a tenuous relationship in which the patient sometimes seemed to seek nurturance or special favors and at other times was belligerent and viewed therapy as useless. After 3 months, Zoe became involved with a new boyfriend and soon thereafter quit therapy, with the complaint that her therapist "didn't really care or understand her."

Discussion of "Empty Shell"

Zoe demonstrates the characteristic features of Borderline Personality Disorder (DSM-5, p. 663). She clearly has a pattern of unstable interpersonal relationships, self-image, affects, and control over impulses. Her relationships with men have been intense and unstable, and the relationships end when she becomes angry and devalues them. She reports that she is an "empty shell," evidence of her chronic

feelings of emptiness and distorted self-image. Affective instability is suggested by her having frequent brief periods of depressed mood and anxiety since adolescence. In addition, at least during the present episode, she demonstrates impulsivity (drinking and sex) and suicidal gestures or self-mutilating acts (slashing her wrists). It is quite likely that these characteristics have also been present during periods of stress in the past.

Zoe's recent symptoms present reasons to consider other DSM-5 disorders. In the last 3 months, since hearing of her mother's pregnancy, Zoe has begun drinking heavily, has had several episodes of what appears to be depersonalization, and has been anxious, depressed, and suicidal. These symptoms might suggest co-occurring Anxiety or Depressive Disorders, but the symptoms are too transient for one of these disorders to be diagnosed and are reflections of the characteristic affective instability of Borderline Personality Disorder. In addition, she briefly had auditory hallucinations telling her to kill herself. The diagnosis of a Psychotic Disorder, such as Other Specified Schizophrenia Spectrum and Other Psychotic Disorder (see Section 2.8), for the current episode is not warranted because the brief hallucination and her reaction to it (i.e., knowing that it was not real) is an example of the transient stress-related psychotic experiences that are often a feature of Borderline Personality Disorder. For the same reason, the diagnosis of Depersonalization/Derealization Disorder (see "Foggy Student" in Section 8.3) to account for her recent symptoms of depersonalization is superfluous.