WHAT WE KNOW AND WHAT YOU CAN DO ABOUT BPD

# Sometimes I Act Crazy

## Living with Borderline Personality Disorder

Jerold J. Kreisman, M.D., and Hal Straus

authors of *I Hate You, Don't Leave Me*

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*Hal Straus*


John Wiley & Sons, Inc.

*In memory of my father, Erwin Kreisman,*
*and*
*for my mother, Frieda Kreisman,*
*who taught us that—with unconditional love—all things are possible.*
—JEROLD J. KREISMAN, M.D.

*For Lil and Lou*
—HAL STRAUS



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# *A Note to the Reader*

Most books on health follow a number of guidelines (e.g., *The Publication Manual of the American Psychological Association*), which are designed to minimize the stigma of disease and to employ politically correct gender designations. Specifically, referring to an individual by an illness is discouraged; instead, reference is made to an individual who expresses symptoms of the disease. Additionally, gender-specific pronouns are avoided; instead, sentences are structured in a passive syntax, or "he/she, him/her" constructions are employed.

Though laudable in some respects, these recommendations complicate the communication of information. Although we abhor the implied disrespect and dehumanization of referring to people by their medical conditions ("Check on the gallbladder in the next room!"), we have nevertheless chosen, for the sake of clarity and efficiency, to often refer to individuals by their diagnosis. For example, we use the term "borderline(s)" as a kind of shorthand to represent the more precise designation—"human being(s) who exhibit(s) symptoms consistent with the diagnosis Borderline Personality Disorder, as defined by the American Psychiatric Association's *Diagnostic and Statistical Manual, 4th edition, text revision (DSM-IV-TR)*." For the same reason, we alternate pronouns throughout, rather than burden the reader with the "he/she" requirement. We trust that the reader will grant us this liberty to streamline the text.

The information in this book is true and correct to the best of our knowledge. The book is intended only as a general guide to a specific type of

personality disorder and is not intended as a replacement for sound medical advice from the reader's personal physician. The stories that begin many chapters, and other case history material throughout the book, have been developed from composites of several people and do not represent any actual person, living or dead. Any resemblance to any actual person is unintentional and purely coincidental. All recommendations herein are made without guarantees by the authors or the publisher. The authors and the publisher disclaim all liability, direct or consequential, in connection with the use of this information.

# *Preface*

When *I Hate You, Don't Leave Me: Understanding the Borderline Personality* was published in 1989, Borderline Personality Disorder (BPD) was relatively unknown among the general lay public and frequently misunderstood among many mental health care professionals. Only those who suffered from the affliction, their close family and friends, and those professionals who treated them really understood its complexity and pain.

Since then, BPD has become more widely recognized in the professional community and more understood in the general population. A sign of this widening recognition in our society is the increasingly frequent references to the illness in popular books, films, and television shows. On the Internet, many Web sites, bulletin boards, and chat rooms are devoted to exchanging information on BPD.

Over the decade since publication of *I Hate You,* I have received hundreds of calls and letters from readers. Some are from students asking for an update on information. Many are from therapists requesting consultation on a specific case. But most are from patients and the families of patients sharing experiences or asking for help. These communiqués are often desperate, sometimes shocking, and always emotional, relating the personal agonies of living with BPD.

The wide and growing interest in BPD and the responses to our first book validated my goals in its authorship: to increase awareness and understanding of this illness to both general and professional audiences by attempting to make complex scientific issues and data understandable to nonprofessionals, while simultaneously presenting current, well-referenced information for those in the mental health field. I have been pleased to learn that the first book has been utilized as a text in many graduate courses in the

social sciences. More profoundly, I have been deeply moved by the communications from those who have struggled with the disease, who want to share their stories and learn more. These correspondents have identified strongly with the case histories and have requested more. We have learned that people don't *have* borderline personality disorder. BPD has *them*!

The increasing interest in BPD over the past decade has prompted significant new exploration in the field. Refinements in diagnosis have improved our conceptualization of BPD. Advances in biochemical, neurological, and genetic research have propelled our understanding of the disorder. Innovative treatment approaches have enhanced prognosis. The interest of our audience and the profound scientific advances of recent years have enticed my coauthor and me to offer this second book. While our first book used case summaries to illustrate didactic text, the case histories in this book are written in the form of personal stories. Each symptom chapter offers a brief glimpse into the mind of a borderline at a crucial life moment, so that the reader can gain insight not only into the principles involved but also *feel* what it's really like to live with—and close to—BPD.

Like our first book, this offering is directed for both the general and professional audiences. I have attempted to digest complex issues and sometimes inconsistent and even contradictory data into a form comprehensible to a nonmedical audience. However, the references for each chapter and a bibliography offer more sophisticated data for those requiring more detailed information. Readers of our first book will discover new information and expanded case material in the second. Readers of this book may be enticed to review our first, for a more historical elucidation of the borderline syndrome. Either work stands alone.

Although I have been deeply gratified by the interest *I Hate You* has generated, I have been disappointed that some have interpreted the material as presenting a pessimistic view of BPD. Although my intent was to instill a more positive perception by explicating the syndrome and describing productive treatment approaches, some readers shared their impression that the depicted outcome for borderlines seemed relatively hopeless. It is my hope that this book will unequivocally dispel that notion. I believe the most significant message of this work is that borderlines, despite tremendous struggles, do, indeed, get better. The pages of this book aspire to promote understanding; to provide comfort; and, most of all, to furnish hope.

— Jerold J. Kreisman, M.D.

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It is never possible to thank all of those who helped with the usually joyful yet often painful gestation of this work. With delivery comes great postpartum relief that makes it necessary to acknowledge those who were there to get us through the irritability, nausea, and breathing exercises that accompanied the labor and birthing of this book.

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Dr. Kreisman's wife, Judy, and children, Brett, Jenny, and Adam, did more than merely tolerate his frenzied intemperance. They offered useful suggestions and insights as he attempted to domesticate the often unruly materials with which he was struggling.

Most of all, Dr. Kreisman acknowledges the patients who entrust the medical profession with their very lives, and thus make any project such as this possible. It is his hope that this work is worthy of their courage.

Dr. Kreisman's coauthor, Hal Straus, would like to thank his children, Matt and Sarah, who exhibited more patience than their dad ever did in putting up with his endless hours on the computer.

Both authors wish to express their gratitude to their agent, the late Jane Jordan Browne, of Multimedia Product Development in Chicago, who never wavered in her support of this project, and to Jane's successor at MPD, Danielle Egan-Miller. Finally, Tom Miller, our editor at Wiley, provided wise and helpful suggestions, as did production editor Kimberly Monroe-Hill, all along the way.

# 1

# *Borderline Basics*

*There is in every one of us, even those who seem to be most moderate, a type of desire that is terrible, wild, and lawless.*

—PLATO, *The Republic*

Borderline Personality Disorder (BPD), the most common personality disorder seen in clinical settings, is excruciatingly painful to live with—both for the sufferer and those closest to him. Yet despite the prevalence of BPD, it may be the most misunderstood and underdiagnosed mental illness. This chapter provides a broad discussion of the disorder—from biological, genetic, and environmental causes, to the most current *DSM* diagnostic criteria, to the various forms of psychotherapeutic and medical treatments. The obstacles to properly diagnosing BPD, such as its stigma within the mental health profession and the vagaries of insurance coverage, also are examined. A "BPD Checklist" gives the reader a chance to detect BPD's early warning signs in himself and others.

## DIANA

In many ways Diana was a typical girl: she loved to play with her dolls and like her friends dreamed of someday marrying her Prince Charming, who would whisk her off to his castle, where they would live happily ever after. But somewhere along the way, Diana veered into a different dimension. She crossed the boundary from "ordinary" into *borderline.*

This change in direction might have been influenced by her mother, who was very close to Diana and who abruptly walked out on the family

when Diana was six years old. Her father was left to rear the children, but he was emotionally and often physically distant, leaving Diana and her siblings in the care of a nanny. Diana would be frantically anxious when he was gone, inquiring constantly as to when he would return.

Periodic visits with her mother left both Diana and her mother in tears. During this time, Diana became more moody and insecure. She was afraid of the dark and of being alone. She was very sensitive and would cry easily. She clung to her menagerie of stuffed animals, which she called "my family." Diana tried desperately to please both of her parents, while secretly blaming herself for their divorce. She felt she was not good enough to keep them together and developed a fear that everyone she loved would eventually abandon her.

When she was fifteen, Diana became more concerned about her appearance and, like her older sister, began to induce herself to vomit after eating. She entered into a pattern of anorexia and bulimia, which intermittently plagued her for the rest of her life. The fractures in Diana's personality became more prominent during her adolescence. She could be charming, charitable, and remarkably empathic with friends at times, but on other occasions she exhibited an unpredictably cruel rage when these same friends disappointed her. Sometimes, during stressful periods, she appeared calm and stoic, but at other times she became irrationally emotional, alternating between inconsolable grief and ferocious anger.

At twenty, Diana married her prince—Prince Charles of England. Yet Princess Diana did not live happily ever after. As her fairy-tale marriage disintegrated, so did her manufactured facade of equanimity. She became more overtly impulsive and self-destructive. She threw herself into her charity work, perhaps hoping to derive for herself the kind of caretaking she was bestowing on others. The affliction of borderline personality plagued Princess Diana until her untimely death in 1997.

## Advances in Diagnosis and Treatment

Our previous book, *I Hate You, Don't Leave Me: Understanding the Borderline Personality,* originally published in 1989, was one of the first attempts to help those afflicted with Borderline Personality Disorder (BPD) to understand and cope with the condition. At that time, understanding of this disorder was in its infancy. Research studies were scarce,

and the few that did deal with the subject lacked the advantage of studying patients over long periods of time. Ideas on the root causes of the disease were more speculation than scholarship. Technology revealing the relationship of brain physiology to behavior and mental illness was still primitive.

The concept of borderline personality was insufficiently understood and accepted—even among those professionals trained to recognize and treat it. Many clinicians were hesitant to accept the newly defined concept and relegated it to the status of "wastebasket diagnosis"—a label to be used when the doctor simply did not understand the patient or could not "fit" the patient's symptoms into any other, more acceptable disorder. In many therapeutic settings the term became a diagnosis of frustration: a difficult patient who was uncooperative; demanding; clinging; confusing; angry; or, most important, failed to respond to the psychiatrist's ministrations was often labeled "borderline."

Structured treatment strategies also were in primordial stages. Psychotherapeutic techniques and medications used to treat related disorders generated inconsistent results when applied to BPD. Outcome studies following therapy interventions were minimal.

It is no wonder, then, that many readers of *I Hate You* came away from the book feeling that the prognosis for borderlines was dismal. Though they could understand what they—or their friends or family—were experiencing, some readers concluded that there was little hope for a cure. One reader wrote that although she found most of the book "informative and helpful, I was still left in tears at the end of it because of the gloomy outcome it suggested."

So what has changed over the past fourteen years? Breakthroughs on many fronts have led to significant leaps in our understanding and treatment of BPD. Geneticists, exploring the effects of individual chromosomes, have connected specific borderline behaviors to discrete locations on the genome. Scientists have discovered biochemical and anatomical alterations in the brain that are correlated with BPD behaviors. Psychotherapeutic techniques have been developed specifically to treat borderline patients, and new medications are more effectively controlling symptoms. Just as the synthesis of therapy and medication has provided relief for those suffering from schizophrenia, bipolar disorder, anxiety disorders, and depression, the same has happened with treatment approaches

to BPD. All of these advances have greatly improved the prognosis for these patients. In short, people with BPD can—and do—get better!

## Epidemiology and Demographics

BPD is the most common personality disorder seen in clinical settings, both in the United States and in cultures throughout the world. Depending on the study, BPD comprises between 30 and 60 percent of all patients diagnosed with any of the ten defined personality disorders. The prevalence of BPD in the general population, as strictly defined in the fourth and most recent revised edition of the American Psychiatric Association's *Diagnostic and Statistical Manual (DSM-IV-TR),* is conservatively estimated to be 2 to 4 percent. Many clinicians believe the real percentage to be higher. Most other countries apply the *DSM* in defining psychiatric illnesses and find similar results, confirming that BPD is not confined to Western cultures.

Approximately 10 percent of the entire clinical population evaluated in outpatient mental health clinics, and more than 20 percent of all inpatients, satisfy BPD criteria. Three times as many women as men are diagnosed with BPD, a prevalence that has remained stable over the past two decades. Patients with the diagnosis of BPD are more likely to receive all forms of psychosocial therapy and to utilize more psychotropic medications than patients with depression or any other personality disorder.

The intensity of borderline symptoms may be related to life situations. One large study indicated that more severe pathology was correlated with students or the unemployed, separated (but not divorced) individuals, atheists, people with a criminal record, and those who lost a parent through death or divorce. These associations held for blacks and whites equally. There was no correlation with the level of education.

## The Borderline Life Cycle

Typically, borderline behavior is first observed from the late teens to the early thirties, though severe separation problems or rage outbursts in younger children may be harbingers of the diagnosis. A borderline state may emerge from a parental relationship that is at one of two extremes—either too dependent or too rejecting. As described in detail in our previ-

ous book, disruption of normal child development, particularly during the crucial rapprochement age (sixteen to twenty-five months), may hinder development of a constant, separate identity, one of the prominent symptoms of BPD.

Most adolescents are *already* grappling with such issues as identity, moodiness, impulsivity, and relationship insecurities that are at the core of BPD. (Indeed, some might argue that the term "borderline adolescent" is a redundancy!) However, normal, volatile adolescents do not exhibit suicide attempts, violent rages, or excessive drug abuse observed in borderline teenagers.

During their third and fourth decades, many borderlines achieve some stability in their lives. Borderline behaviors may be curbed or no longer significantly hamper daily activities. Thus many former borderlines, with or without treatment, may emerge from the chaos of their lives to a relatively stable midlife functioning that no longer satisfies defining criteria for the BPD diagnosis. BPD does persist in the elderly but at a much lower rate.

## Crossing the Border: A Brief Historical Background

The term "borderline" was first employed more than sixty years ago to describe patients who were on the border between psychotic and neurotic but could not be adequately classified as either. Unlike psychotic patients, who were chronically divorced from reality, and neurotic patients, who responded more consistently to close relationships and psychotherapy, borderline patients functioned somewhere in between. Borderlines sometimes wandered into the wild terrain of psychosis, doctors observed, but usually remained for only a brief time. On the other hand, borderlines exhibited several superficial neurotic characteristics, but these comparatively healthier defense mechanisms collapsed under stress.

Over the years, such terms as "pseudoneurotic schizophrenia" and "as-if personality" were employed to describe the condition. Revisiting some of Freud's early case histories of neurosis, many theorists reinterpreted such cases as "The Wolf Man" and "Anna O." as examples of borderline functioning. For decades psychiatrists recognized the existence of this "border" illness but were unable to arrive at a consensus definition.

Finally, in 1980, the third edition of the American Psychiatric Association's *Diagnostic and Statistical Manual (DSM-III)* classified the BPD diagnosis, for the first time utilizing specific, descriptive symptoms.

## *Defining BPD*

Borderline Personality Disorder is the most prominent of the ten personality disorders defined and described in *DSM-IV-TR*. A "personality disorder" is defined as a cluster of long-standing, ingrained traits in an individual's demeanor. Typically detectable by the time of early adulthood, adolescence, or even earlier, these traits are relatively inflexible and result in maladaptive, destructive patterns of behaving, perceiving, and relating to others. The diagnoses of personality disorders are separated from those of most other psychiatric illnesses by placement on a separate classification level (Axis II). Other psychiatric illnesses, such as depression, schizophrenia, substance abuse, and eating disorders, are defined on Axis I. Whereas Axis II personality disorders are perceived as long-standing, chronic maladaptations in behavior, Axis I afflictions are traditionally seen as time-limited, more biologically based, and more amenable to medications. Axis I symptoms usually recede, allowing the person to return to "normal" functioning between exacerbations of illness. People with diagnosed personality disorders usually continue to express characteristics of the dysfunction even after the acute problem resolves. Cure usually requires a longer time, since it involves significantly altering enduring behavior patterns. Personality disorders, especially BPD, have been demonstrated to elicit more severe functional impairment in day-to-day living than some Axis I disorders, including major depression.

BPD shares several characteristics with other personality dysfunctions, especially histrionic, narcissistic, antisocial, schizotypal, and dependent personality disorders. However, the constellation of self-destructiveness, chronic feelings of emptiness, and desperate fears of abandonment distinguish BPD from these other character disorders.

The primary features of BPD are impulsivity and instability in relationships, self-image, and moods. These behavioral patterns are pervasive, usually beginning in adolescence and persisting for extended periods. The diagnosis, according to the *DSM-IV-TR* (and generally accepted worldwide), is based on the following nine criteria. An individual must exhibit five of these nine symptoms to receive the BPD diagnosis.

**BPD Criteria**

1. Frantic efforts to avoid real or imagined abandonment
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
3. Identity disturbance: markedly and persistently unstable self-image or sense of self
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating)
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
6. Affective (mood) instability and marked reactivity to environmental situations (e.g., intense episodic depression, irritability, or anxiety usually lasting a few hours and rarely more than a few days)
7. Chronic feelings of emptiness
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
9. Transient, stress-related paranoia or severe dissociative symptoms (feelings of unreality)

As we will see when we examine these criteria more closely in later chapters, the latest *DSM-IV-TR* makes only minor revisions to defining symptoms. The most significant change is the addition of the ninth criterion, which recognizes occasional, fleeting episodes of psychosis.

This constellation of nine symptoms can be subdivided into four primary areas, toward which treatment is directed:

1. Mood instability (criteria 1, 6, 7, and 8)
2. Impulsivity and uncontrolled behaviors (criteria 4 and 5)
3. Interpersonal psychopathology (criteria 2 and 3)
4. Distortions of thought and perception (criterion 9)

Mood changes and impulsivity are the most important factors in risk for suicide.

A collaborative, longitudinal study by researchers from across the country grouped these defining criteria into three categories for classification

purposes. After interviewing hundreds of BPD patients and testing and categorizing the criteria, these investigators reestablished the validity of the *DSM* factors that define BPD. The three factor groupings developed are: disturbed relationships, uncontrolled behavior, and mood irregularity (see table 1).

*Disturbed relationships* encompass problems relating to oneself, as well as to others. Identity disturbance (see chapter 4) will naturally proceed into relationship difficulties (see chapter 3). When identity insecurity persists, there often develop feelings of emptiness and meaninglessness (see chapter 8). When the sense of self disappears altogether, dissociation from reality occurs (see chapter 10).

*Uncontrolled behavior* covers destructive impulsivity (see chapter 5) and self-destructive behavior (see chapter 6).

*Mood irregularity* encompasses the remaining criteria. Mood instability (see chapter 7) often leads to frustration and the expression of inap-

TABLE 1 Categorizing BPD Symptoms

| *Criteria* | *Disturbed Relationships* | *Uncontrolled Behavior* | *Mood Irregularity* |
|---|---|---|---|
| 1 | | | Abandonment fears |
| 2 | Unstable relationships | | |
| 3 | Identity disturbance | | |
| 4 | | Destructive impulsivity | |
| 5 | | Self-harming behavior | |
| 6 | | | Mood instability |
| 7 | Emptiness | | |
| 8 | | | Anger |
| 9 | Dissociation from reality | | |

propriate anger (see chapter 9). These intense emotions alienate others, leaving the individual alone and abandoned (see chapter 2).

These *DSM* criteria define a *categorical* paradigm for defining BPD; that is, a person either *has it* (embracing at least five of the criteria), or he doesn't (with four or fewer symptoms). This conceptualization allows for objective, measurable determinants. However, it embraces all nine criteria as being equally contributory and allows for the seeming paradox that someone with the supposedly enduring diagnosis of BPD could suddenly be "cured" of the illness by overcoming even one defining criterion. In contrast, some authors have argued that personality disorders, which are enduring traits, should be defined in a *dimensional* way. This model proposes that there are *degrees* of personality functioning, much like there are degrees or levels of addiction. Rather than concluding that an individual is borderline or is not, these authors argue that the disorder should be recognized along a spectrum by the *intensity* of exhibited symptoms and by weighting certain criteria and background information proportionately. For example, consider that the determination that one is male or female is categorical, identified objectively by several criteria. Alternatively, designations of masculinity or femininity are dimensional considerations, influenced by personal, cultural, and other less objective criteria. Proposals for the future *DSM-V* include consideration of redefining personality (Axis II) disorders utilizing dimensional models.

## Difficulties in Diagnosis: Coexisting and Related Illnesses

Studies over the past decade have confirmed that BPD is linked with other psychiatric illnesses much more frequently than previously thought. Unlike the cheese in "The Farmer in the Dell," BPD rarely stands alone. Some of the defining symptoms are identical to criteria for other illnesses. For example, as with borderlines, many individuals with attention-deficit hyperactivity disorder (ADHD) display impatience, impulsivity, quickness to anger, fractured relationships, poor self-esteem, and frequent substance abuse. Impulsivity and outbursts of anger characterize persons with antisocial personality disorder. The most common "fellow traveler" with BPD is depression. More than 95 percent of BPD patients also satisfy

criteria for this disorder. Almost 90 percent of borderlines also meet criteria for anxiety illnesses, especially post-traumatic stress disorder, panic disorder, and social anxiety disorder. Although depression and anxiety are seen equally in both genders, substance abuse and sociopathy are seen significantly more often in male borderlines, while eating disorders and post-traumatic stress disorders are correlated more often in female borderlines. All of these illnesses are found much more often in borderlines than in those with other personality disorders.

Since borderlines usually present with several afflictions, the clinician must address the most disabling symptoms first. And she must juggle the effects that treatment may have on accompanying problems. For example, many borderlines have accompanying ADHD symptoms. If she initiates treatment for the poor concentration and distractibility of the attention deficit with stimulant medicine (such as Ritalin), will the borderline symptoms of rage and mood swings be exacerbated? Conversely, if she engages the patient in an intensive psychotherapy, will he be able to sustain attention adequately to usefully benefit from the treatment? Accurate diagnosis of all disorders is necessary to ensure thorough and balanced treatment.

BPD also can imitate other illnesses. Mood changes may be erroneously diagnosed as bipolar disorder. Transient psychosis may mimic schizophrenia. When an accompanying disorder such as depression or alcoholism is prominent, it may camouflage the significant, underlying BPD.

Although BPD may accompany other illnesses, it is important to differentiate it from other disorders. Borderline depression and mood swings are usually related to environmental situations and, consequently, can change within hours. Major depressive and bipolar disorders more often last for days, or for more extended periods, and may be unrelated to stimuli in the individual's life. Further, between episodes, a person with affective disorder usually functions well, whereas the borderline may continue to engage in destructive behaviors.

Transient, stress-related psychosis in the borderline can acutely resemble paranoid schizophrenia. However, in BPD the psychosis is short-lived and may dissolve, sometimes within hours; schizophrenic psychosis is usually chronic and less related to external stressors.

Although borderlines often experience traumas, post-traumatic stress disorder (PTSD) is defined by characteristic reactions to specific, severe

crises. These reactions include recurrent intrusive thoughts about the event, avoidance of associated places or activities, and hypervigilance with exaggerated startle response, which usually are not characteristic of BPD. Physiological distinctions suggest that patients with BPD respond more strongly to themes of abandonment, whereas PTSD patients exhibit a more extreme response to presentations emphasizing trauma.

## Diagnostic Bias

Despite its frequency, BPD is often misdiagnosed or underdiagnosed. Primary care physicians, who usually are the first professionals to be consulted for psychiatric problems, are able to accurately recognize and treat BPD less than half of the time.

Coexisting illnesses may contribute to the underdiagnosis of BPD in several ways. When another disorder is primary, many clinicians will ignore Axis II diagnoses, concentrating only on treating the Axis I malady (which usually is easier to treat, since the emphasis is on medication and not on complicated, extended psychotherapy). Additionally, managed care companies sometimes discourage continued therapy for personality disorders, since such patients characteristically require more intensive—and more expensive—long-term treatment. Some insurance companies will disallow coverage for BPD altogether, stating that the required, expensive treatment is not part of the policy. Paradoxically, some insurance case managers refuse certification based on the erroneous assumption that borderline patients never get better, that therapy doesn't help, and therefore treatment attempts waste resources. Thus many doctors avoid the borderline label to minimize hassles with managed care companies.

Finally, many clinicians hesitate to diagnose BPD because of its stigma within the profession. Among many professionals, borderline patients are the most dreaded. They bear a reputation for being overly demanding, with frequent phone calls and agitation for attention. They are the most litigious group of psychiatric patients. When disappointed, their rage is difficult to tolerate. Constant threats of suicide can be difficult to manage. Treatment requires much patience and, even more, much time, which, in today's climate, often is not adequately recognized or reimbursed. Thus many patients with the BPD diagnosis are unable to engage capable clinicians willing to accept them in treatment.

## ACTION STEPS: *A Quick BPD Checklist*

Do you have BPD? Or do you think you know someone who does?

Without professional help, of course, there is no way to know for sure if an individual is borderline, but there are "clues" and "early warning signals" for mental illnesses, just as there are for physical conditions. The following life events and behaviors may be clues to the presence of BPD. *Caution: Just as you should not try to diagnose your own heart condition, you should not attempt to diagnose your own mental disorder. If you check more than a few of the following boxes, and they are interfering with your normal day-to-day functioning, you should consult your physician.*

- ☐ traumatic childhood experiences (especially physical or sexual abuse)
- ☐ self-sabotaging behaviors (such as ruining a job interview, destroying a good relationship)
- ☐ history of disappointing relationships, jobs, or other commitments
- ☐ frequent changes in jobs, schools (and majors), relationships (several divorces, separations, and remarriages)
- ☐ history of hurtful relationships (e.g., several marriages to alcoholics who are abusive) or relationships with controlling, narcissistic partners that result in conflict
- ☐ utilization of transitional objects (relying on a multitude of dolls and teddy bears for comfort)
- ☐ dangerous behavior that may be perceived as exciting (such as drug abuse, promiscuity, shoplifting, bulimia, anorexia)
- ☐ frequent conflicts (especially with important figures such as bosses, colleagues, friends, family)
- ☐ repeated history of violence, either as perpetrator, victim, or both
- ☐ severe changes in attitude (e.g., idealizing a friend and later reviling him; purporting to love a book and later declaring it boring)
- ☐ attraction to extremist organizations (such as religious or political cults)

- ☐ functioning better in structured situations (e.g., performing poorly in college but succeeding brilliantly in the army)

## The Roots of BPD

The theoretical precursors in the development of BPD were explored in our previous book. Several methodologies have been used to research the causes and roots of BPD. Family studies have confirmed that most borderlines experienced severe disruption in their development, pointing toward environmental causes.

More recent genetic and neurological studies have theorized that there may be heritable, biological underpinnings. A significant subgroup of borderlines has a history of perinatal or acquired brain injury.

A new line of research posits that predisposing genetic/biological vulnerabilities combine with environmental traumas to produce borderline coping mechanisms. One model suggests that inherited tendencies (called temperament) intersects with developmentally based values (character) to produce personality. Thus temperament + character = personality. Further, specific temperaments can be discerned and correlated with biological imbalances and sensitivities. Models of temperament form early in life and are perceived as instinctual or as habits. Character styles are gradually shaped and culminate in adulthood.

### *Biological and Anatomical Correlates*

Some of the most exciting recent discoveries in BPD research employ modern medical tools to explore the brain's mechanics, such as monitoring chemical changes and observing anatomical alterations. Some researchers have demonstrated that abnormal levels of the neurotransmitter serotonin (a chemical involved in nerve conduction throughout the body but especially in the brain) may result in the increased impulsivity and aggression associated with BPD. Interestingly, such sensitivity is seen more frequently in women, who comprise 75 percent of borderlines. One study utilized positron emission tomography (PET) scanning to demonstrate lower levels of serotonin activity, which correlated with increased impulsivity, in the brains of men and women with BPD. Other neurotransmitters, such as dopamine and gamma-aminobutyric acid (GABA), also may be implicated in the regulation of impulsive aggression. The