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Reasons for Change in Borderline Personality Disorder (and Other Axis II Disorders)

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Abstract

Borderline personality disorder (BPD) is a slow moving disorder. Most patients with BPD improve over time. The reasons for this change are unclear. Both therapy as usual and the reparations that adult life offers can facilitate these changes.

Borderline personality disorder (BPD) was long thought to be a chronic condition that affected most or, at least, many parts of a person's personality and functioning. Recent research has found that change is to be expected for many borderline patients over time—both in the symptomatic and psychosocial realms.

More specifically, two large-scale studies have prospectively studied the longitudinal course of BPD (1,2). The longer running of these studies—the McLean Study of Adult Development (MSAD)—has published findings pertaining to the 10-year course of BPD (3,4). The shorter running of these studies—the Collaborative Longitudinal Personality Disorders Study (CLPS)—has published findings pertaining to the four-year course of BPD (5,6).

Symptomatic Change

In terms of symptomatic outcome, the MSAD study has found that remissions are common and recurrences are relatively rare. More specifically, 88% of the subjects in the MSAD study have experienced a remission of their BPD by the time of their 10-year follow-up but less than 20% have experienced a recurrence of BPD (3).

Equally importantly, the MSAD study has found that half of the 24 symptoms of BPD studied could be called acute symptoms and half could be called temperamental symptoms (4). In this view, acute symptoms are the symptoms that remit relatively rapidly, are the best markers for the disorder, and are often the main reason for costly forms of psychiatric treatment, such as inpatient stays and day programs. For these reasons, it has been suggested that acute symptoms are akin to the positive symptoms of schizophrenia.

In contrast, temperamental symptoms remit relatively slowly, are not specific to BPD, and are associated with ongoing psychosocial impairment. For these reasons, it has been suggested that temperamental symptoms are akin to the negative symptoms of BPD.

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Some acute symptoms reflect areas of core impulsivity, such as self-mutilation and suicide attempts. Other acute symptoms, such as stormy relationships or problems with devaluation/manipulation/sadism, involve active attempts to manage interpersonal difficulties. Temperamental symptoms tend to fall into two groups as well. The first group involves chronic feelings of dysphoria, such as anger or loneliness/emptiness. The second group involves interpersonal symptoms that reflect abandonment or dependency issues, such as intolerance of aloneness or counterdependency problems.

It is important to note that 10-year MSAD findings concerning the symptomatic course of BPD have been confirmed by the two-year results of the CLPS study. The MSAD finding that symptomatic improvement is common was confirmed (7,8) as was our finding of two types of borderline symptoms (9). In the CLPS study, acute symptoms are called symptomatic behaviors and temperamental symptoms are called traits.

Psychosocial Change

The MSAD study found that the psychosocial functioning of many borderline patients improved with time, with more reporting a life partner, children, friends, good relationship with a parent, and the ability to work and/or attend school effectively and in a sustained manner as the years progressed (10). However, it was notable that their social functioning was better than their vocational functioning. In addition, axis II comparison subjects showed a higher level of vocation adaptation than borderline patients.

In contrast, the results of the CLPS study suggest that the psychosocial functioning of many borderline patients does not improve much with time, particularly in the social realm (11). The results of this study also suggest that the psychosocial functioning of borderline patients is less adaptive than that of depressed comparison subjects (who have no substantial axis II psychopathology).

Psychiatric Treatment

The results of the MSAD study suggest that treatment over time is the rule rather than the exception for borderline patients (12). Even after 10 years of follow-up, roughly 70% of borderline patients (and 45% of axis II comparison subjects) report being in individual psychotherapy and taking standing medications. They also report high rates of aggressive polypharmacy, with 40% taking three or more standing medications, 20% taking four or more, and 10% taking five or more. Not surprisingly, this high rate of polypharmacy has been linked in this sample to a high rate of obesity and obesity-related illnesses (13).

In contrast, borderline patients in the CLPS study reported using declining rates of outpatient treatment, with 64% reporting being in therapy and 68% reporting taking medications after three years of follow-up (14). Comparable MSAD figures at two-year follow-up were 94% and 86% respectively.

Core Problem of BPD

A number of models of borderline psychopathology have been suggested by leading theorists in the field. Linehan has suggested that BPD is best understood as a disorder of emotional dysregulation (15). In this model, the quick reactivity of borderline patients (and the lack of strategies to handle this deficit) is the core feature of BPD. Gunderson has suggested that BPD is best understood as a disorder of attachment (16). In this model, fears of aloneness and abandonment are the core conflicts from which patients with BPD suffer and are the most salient features of the disorder.

We believe that there are two key features of BPD. The first of these features is the intense inner pain that they live with on a chronic basis. This pain is distinguished from the pain of others by its multifaceted nature and its overall amplitude (17). It consists of both dysphoric affects (e.g., I feel grief-stricken, I feel completely panicked) and dysphoric (or distorted) cognitions (e.g., like I'm being tortured, like I am damaged beyond repair) that are quite specific to BPD. More recently, another group (18) has also found that severe inner pain is both characteristic and distinguishing for borderline patients.

The second feature, which is perhaps better known to clinicians, is the awkward nature of the efforts that borderline patients make to both hide this pain and to express it. Some of these efforts are behavioral or impulsive in nature. The most troubling impulse action patterns are self-mutilation and help-seeking suicide threats and gestures. However, substance abuse, promiscuity, and disordered eating are also common and ultimately, destructive in nature.

Other efforts to obtain needed comfort and support are interpersonal. They include such maladaptive patterns such as devaluation, manipulation, and demandingness. While the impulsive acts tend to frighten clinicians, these interpersonal patterns tend to anger them. In fact, inexperienced clinicians often think of them as forms of misbehavior. We think it is less pejorative and more accurate to describe them as outmoded survival strategies

Two key questions emerge. First, what caused the intense inner pain of borderline patients? Second, why do they handle it in such a self-defeating manner? In terms of the first question, we had assumed about a decade ago that only serious adversity, such as childhood abuse and neglect, would have resulted in the intense inner pain that both characterizes and distinguishes borderline patients from those in other diagnostic groups (19). We now believe that many borderline patients are so temperamentally vulnerable that much more subtle experiences can engender the suffering that they both insist that others pay attention to and of which they are so ashamed.

Attempting to be more specific, we have suggested that their temperament could be conceptualized as being hyperbolic in nature (19). In this view, borderline patients are uncommonly insistent and persistent that the intensity of their inner pain be recognized and acknowledged by others on whom they depend, such as family members, spouses, and mental health professionals. Statements such as, "I am in the worse pain since the history of the world began" are not uncommon and suggest how isolated and alienated many borderline patients feel.

Of course, the question arises as to why borderline patients rely on interpersonal strategies that are so counterproductive? Or why they have such difficulty being straightforward and simply asking directly for the support and comfort they so desperately seek and genuinely seem to need?

There is no clear answer for this and certainly not one backed up by much data. However, it seems likely that much of the problem has arisen from the long latency between this tremendous burden of inner pain first arising in late latency or early adolescence and the cognitive map of a borderline diagnosis not being applied until a decade or more latter (20). Child psychiatrists and psychologists often mistakenly believe that the DSM-IV system prevents them from giving someone under the age of 18 a diagnosis of BPD. Even more perplexing is the tendency of many mental health professions to resist giving an adult patient, albeit often a young adult, a diagnosis of BPD because of the mistaken belief that it is a hopelessly chronic condition. In these cases, often diagnosis is not mentioned or a co-occurring condition becomes the focus of treatment. Sometimes the co-occurring disorder is one from which the patient actually suffers. But other times, the patient is aggressively treated for a disorder, such as bipolar disorder, which the patient has never manifested.

In the ideal world, both parents and their preborderline child would be told of the borderline diagnosis and learn all of the latest information about the condition, including the fact that it has a relatively good prognosis. This would short-circuit the process of harmfully self-destructive behavioral or interpersonal strategies from developing or at least, interrupt their hardening into reflexive reactions to less than optimal parental responses to their child's pain and distress.

Put more simply, most children who go on to develop full-blown cases of BDP do try to tell their parents of their anguish and misery. But often times, their parents downplay the seriousness of their complaints. Rather than realizing their parents are doing their best, many borderline patients believe that their parents do not love them because they are less than perfect children or that their parents derive pleasure from their suffering. In our experience, parents often fail to recognize their child's suffering and fragility due to their own limitations but rarely are deliberately malevolent.

Compounding this scenario is the fact that borderline patients are often perceptive but lack insight. They tend to believe that they are masterful in conveying their distress, which unfortunately is not true. They also tend to be oblivious to the covert reproaches that they make of the behavior of others—that they are mean or selfish or totally self-absorbed. They see themselves as truth tellers when in reality they are behaving in a self-righteous manner that can offend and enrage others.

Psychosocial Treatments

Currently, there are four comprehensive psychotherapies with some proven efficacy for the treatment of BPD or at least some of its symptoms. Two of these are cognitive behavioral in nature: dialectical behavioral therapy (DBT) (21) and schema-focused therapy (SFT) (22). The other two are psychodynamic in nature: mentalization-based therapy (MBT) (23) and transference-focused psychotherapy (TFP) (24). All require at least a year of treatment and quite highly trained clinicians.

DBT is the only one of these treatments to have its findings replicated multiple times (25). It is also the only one to have numerous adherents in the US. However, it is costly to provide as it involves skills groups, individual therapy, and a consultation team consisting of at least several providers. For this reason, most sites that provide a DBT program provide a less intensive version of DBT than that suggested by Linehan—DBT-like treatment.

The reality is that most borderline patients do not receive a manualized form of psychotherapy that has proven efficacy. Rather, they receive treatment that is eclectic in nature. It is our experience that this type of treatment, which in itself is difficult to find and pay for, is probably “good enough” for the majority of borderline patients—who are neither desperately ill inpatients nor chronic outpatients.

Pharmacological Treatments

The results of 21 randomized double-blind, placebo or comparator controlled trials have been published or presented (26). Six studies have assessed the efficacy of antidepressants (phenelzine [N=1], tranylcypromine [N=1], amitriptyline [N=1], fluoxetine [N=2], and fluvoxamine [N=1]). Nine have assessed the efficacy of mood stabilizers (carbamazepine [N=1], valproate [N=3], topiramate [N=3], lamotrigine [N=1], and omega-3 fatty acids [N=1]). Eleven have assessed the efficacy of antipsychotics (trifluoperazine [N=1], haloperidol [N=2], aripiprazole [N=1], risperidone [N=1], and olanzapine [N=6]).

In general, each of these classes of medication has been found to be somewhat efficacious. They have also been found to affect overlapping symptom domains. However and not surprisingly, none have been found to be curative. Rather, all but one (risperidone) seem to take the edge off BPD. This is no small achievement but not the magic bullet for which some hope.

Pathways to Feeling Better and Functioning More Effectively

Three things need to happen for a borderline patient's symptoms to lessen in intensity and for a borderline patient to begin to function more effectively in the psychosocial realm. The first is to help the patient find a way to less his or her subjective inner pain, which can be of tremendous intensity and highly disabling. The second is to help the patient find a way to be more straightforward and direct in expressing his or her wishes or needs. The third is to help the patient find a way to be more future oriented and less obsessed with the past and all of its many disappointments.

Lessening the Pain of Borderline Patients

What Linehan termed validation is an essential aspect of efforts to help lessen the pain of BPD. Patients need to feel that someone understands their pain and is neither frightened nor disgusted by it. This type of acceptance can come from a therapist. It can also come from a friend or a romantic partner. However, this ability to listen and empathize can be distorted in non-useful or even destructive ways. Some companions in the process of acceptance of what can seem like unending pain can begin to convey an acceptance of the patient's "theory of the case" or the maladaptive ways that the patient has handled his or her pain. This is less than fortunate as it interferes with a borderline patient's ability to forgive both him or herself and those who have disappointed and/or frustrated him or her. This type of inappropriate acceptance is also less than fortunate in that it may serve to "harden" maladaptive behaviors, such as being excessively dependent on others or extortionate with them.

While validation can halt the slide into ever deeper and perhaps dangerous levels of painful feelings and cognitions, it will not by itself lessen the pain of being borderline. This is so because some of this pain is the result of failed attempts to live as a competent adult in the real world, where failure and lack of support are real options for everyone. As noted before, much of the pain that borderline patients experience is due to less than perfect parenting of a temperamentally vulnerable child and adolescent. This might be thought of as primary pain. However, a good portion of this pain is secondary in nature and the result of unsuccessful efforts to make friends, find a life partner, and/or establish a record as a competent adult in the vocational realm.

For most patients who are still functioning in the world of work or school, every effort should be made to support their continuing in these adult roles. For those who have recently given up this level of functioning, every effort should be made to support the patient's often wavering and ambivalent determination to return to work or school, even on a part-time basis. Perhaps the worst thing that a mental health professional or family member can do is to encourage or even insist that a patient go on social security disability. While this is often ostensibly done to get the patient the accompanying federal health insurance that comes with being disabled, it often signals to the patient that people are giving up on him or her and expect only the adaptation of a chronic patient. And once this role is accepted, it becomes a herculean task to help the patient move toward a more autonomous stance. However, this task is not impossible and needs to become a condition for the therapy to continue.

Much the same process can and should occur in the social realm. Here there are three different types of relationships to maintain or to attain: friendships with peers, relationships with parents

and siblings, and romantic partners. Many borderline patients have a history of relatively good relationships with peers. However, relationships with parents and romantic partners are often much more problematic. Many borderline patients have conflictual relationships with their parents, others have relationships marked by neglect and distance, and some have relationships that oscillate between being chaotic and disengaged. Many borderline patients who have romantic partners have very stormy relationships with them, oscillating between being needy and fleeing from the pain of honest intimacy.

As mentioned above, many borderline patients blame their parents for their difficulties. They may also blame their romantic partners and spouses. This is often far easier than to accept responsibility for one's own failures. This is particularly so because many borderline patients have such a negative self-view and such a harsh superego that they cannot see that failure is about having difficulty completing a task and not an indictment of one's entire being. One can have trouble functioning without being a bad person who should be dead.

Learning To Be More Straightforward

In our experience, clarifications are the best therapeutic technique to use to comfort a borderline patient (or to validate his or her pain). Clarifications are also the best therapeutic technique to use to help borderline patients learn to be more straightforward and direct in expressing their wishes or needs. Rather than aggressively confronting a patient about being devaluative, one might say: "Sometimes it is hard to believe that anyone is actually willing and able to help." This type of statement reflects the desperation that the patient was trying to convey without confronting his or her shaky self-esteem. It also conveys that language can be both useful and direct. This is important as BPD is, in part, a language disorder and those clinicians who can quickly translate what seems like (or is) a reproach into the statement of distress that the patient thought he or she was making will be able to maintain the emotional tone of the relationship.

However, this type of intervention will need to be repeated over and over again before a borderline patient will begin to "get it."

Vocational responsibilities and relationships can also be helpful in teaching a borderline patient to be more straightforward. Work or school can often be laboratories where a borderline patient who is not acutely overwhelmed with negative feelings can observe which interpersonal strategies are rewarded and which lead to undesired negative consequences, such as being criticized or fired. It is also an arena that makes it plain that life is unfair—something most borderline patients know in theory but do not believe applies to them.

Relationships can also be very helpful in comforting borderline patients and in helping them to learn to be more direct in dealing with other people. This is particularly so if the family member, friend, or romantic partner is somewhat more mature than the borderline patient in question. Such a person may well have compassion for a person with BPD and realize that he or she is doing his or her best at that moment in time. Such a person may also be helpful in setting an example of how to be more direct. If a patient has been very critical but does not seem to realize it, such a friend might say: "I don't think you know it but you are hurting my feelings. I wish you would stop so that we can be as close as we usually are." Such a comment will capture the attention of someone with BPD without seeming like an unfair or unbearable criticism. Chances are that it will be perceived as a useful piece of information that is meant to be helpful.

Clearly, such comments are clarifications. In our experience, borderline patients first learn from friends. Then they make peace with their family members. Only with this level of support, will they be able to establish an enduring relationship with a romantic partner.

Often times, borderline patients who have been sexually abused believe that they can never have an intimate relationship and some therapists support this position. There is no doubt that such a history can make a sexual adjustment difficult—with some patients avoiding sexual intimacy, others becoming symptomatic after having sex, and yet others suffering from both reactions (27). Yet, it is difficult to deny that the emotional intimacy of a relationship with a reasonable and committed life partner can help to assuage the wounds of BPD.

In many ways, the comfort and instruction that a borderline patient wants and needs is better provided by those without a professional relationship to the patient. They have chosen to be close and are not being paid to spend time with the patient. They can and do expect a reciprocal relationship with the patient and one where power is often not a particularly pressing issue.

Experience suggests that therapy is best thought of as being adjunctive to life and not a substitute for it. This thinking goes against what many mental health professionals believe. In this view, therapy is essential to lay the groundwork for a better, less painful life. In some cases, therapy even turns into a life style and is the most important element in a patient's life.

We share the belief that therapy can and often does encourage and facilitate change. We also share the belief that it can be essential in helping to consolidate changes in the patient's life. But we believe more strongly than many observers that adult life offers patients with BPD reparations for the hurt and adversities that they have endured.

Toward a Future Orientation

However, there is no denying that many borderline patients are very attached to their past and have a difficult time seeing the value of or even the possibility of a forward-leaning orientation. This is so for two reasons. First (and less important) is the fact that many borderline patients are bitter about the pain they have had to endure and angry at the people (often their parents) who they believe did not do enough to alleviate their suffering. In time and with the help of their friends (and treaters) they may come to the realization that each of us only gets one childhood and that no one can change the past. With an acceptance of life as it has played out for them and the realization that their parents did what they could, come both grief and the energy to pursue a real life in the real world.

The second (and more important) reason for their devotion to the past is that their pain represents to a large extent lost loves that have gone awry. It is part of their identity and they are afraid that it will never end and that it will end too soon. Looked at another way, most borderline patients were not unloved but loved in a manner that was too inconsistent for them. They are reluctant to give up the search for the "restoration" that they believe will make them whole. They look for this restoration in all the wrong places, including assuming that their therapist is withholding emotional supplies from them that are definitely curative in nature.

The best strategy for dealing with their initial lack of interest in a future is to encourage them to "get a life." Plainly, real life can offer better reparations than the limited but important relationship that a patient can have with his or her therapist. But these reparations bring with them the real possibility of new heartache. They also offer the real possibility of a "restoration" of some kind of peace and comfort that can only come with accepting life on its own terms. In the end, there is no point to "bargaining" with life as the "rules" of life apply equally to all of us. Trying to "wring" reparations from unwilling and unwitting others because of prior adversity is only a path to defeat and humiliation.

Other Personality Disorders

Antisocial personality disorder (APD) is the only other personality disorder that has been validated according to the rigorous criteria of Robins and Guze (28). Patients with APD have also been found to make progress over time (29). However, it is not clear how these processes of change occur.

The CLPS study has also found that patients with schizotypal, avoidant, and obsessive-compulsive personality disorders make symptomatic progress (7,8). However, here too it is not clear why this progress occurs.

Conclusions

Most people meeting criteria for BPD change slowly over time. While researchers have developed comprehensive psychosocial treatments for BPD, most patients improve with the help of treatment as usual as well as the support and guidance of those who care about them. The evidence suggests that BPD is a good prognosis diagnosis. While these individuals can be difficult and challenging, they deserve our respect for their struggles to achieve a better and less painful adaptation to the life they were given.

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