Borderline Personality Disorder (BPD)

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Borderline Personality Disorder (BPD), sometimes also referred to as emotionally unstable personality disorder, can be seen quite often in psychiatric settings, but it is also quite common outside. Individuals suffering from BPD usually experience emotional impulsivity, periodic feelings of an inner ‘void’, a need to compartmentalize people in ‘good’ and ‘bad’ with little in between, existential fears in relationships and a tendency towards self-harm. Often, they have a sequence of unstable relationships and fragmented CVs. The term ‘personality disorder’ is insofar correct as people with BPD have communication patterns with their environment which leads to unstable relationships and considerable suffering.

The psychoanalytic origin of BPD: On the border between neurosis and psychosis

There is little from the biological corner to explain BPD. Most sensible explanations have come from the realms of psychology, psychoanalysis in particular. The term for the condition is derived from a psychoanalytic perspective in which this condition is seen as being on the 'border' between neurosis and psychosis. This sounds like an exact localization, but really allows for a spectrum of manifestations because there is little clear definition where neurosis ends and psychosis begins. The terms ‘neurosis’ and ‘psychosis’ are problematic anyway, because they imply that there are some mental conditions that are mostly ‘biological’ and some that are mostly ‘psychological’. However, in the brain, hardware and software cannot really be seen as two separate entities because they influence each other heavily. The high plasticity of the brain ensures up into old age that the hardware reconfigures itself in an adaptive way, depending also on the work the brain is used for.
Vice versa, one’s thought and behavior patterns are inseparable from the underlying ‘hardware’, the complex system of neural networks.

_The Fear of Disconnectedness, the Fear of Connectedness_

Since the suffering in BPD is caused by a fear of disconnecting from oneself and others I would describe it in terms of this fear itself. BPD can lead to lifelong suffering if it is not treated. It is associated with unstable relationships, unstable emotions and an unstable sense of self. Interestingly, this instability is caused by the fear that they may be unstable and lost easily. The problem with BPD is that the fear leads patients to behave in ways that put a strain on relationships, even though strong relationships can help someone with BPD considerably.

_High Co-Morbidity_

Substance abuse, depression, and eating disorders are commonly associated with BPD. [1] Up to one in ten patients die by suicide [2], illustrating the individual suffering that comes along with it and the severity of this condition. Usually there is a greater experience of emotional instability, which also translates into the perception of greater instability in the world around, particularly in the domain of interpersonal relationships.

_Symptoms_

BPD can manifest itself in a number of characteristic ways. Symptoms commonly include emotional instability and an unstable and often fragile sense of self. Quite characteristic is also the phenomenon of ‘splitting’, in which people and situations are "black or white", "bad or good", with nothing in between. There are many theories for this essential feature of the borderline syndrome. A problem with the information processing functions seems the most plausible explanation.

The indecisiveness of BDP is frequently seen as manipulation, but it is really an obvious deficit in BPD. It is largely irrelevant how much of this information processing deficit can be attributed to biology and how much to psychology. Since large-scale neurodegenerative processes are not part
of BPD and the brain remains in a state of high plasticity for an entire lifetime, what counts is that psychotherapy has shown to be effective. All the effective methods focus on how patients communicate with themselves, which then also translates into better communication patterns and more fulfilling interactions with the outside world. The objective of therapy is to build and strengthen this bridge between self and others.

Self-Harm

The tendency towards self-harming can in the more severe cases mean cutting oneself with a razor-blade. Most patients describe this as allowing them to feel themselves again. The impulsivity is often associated with fears of losing an important relationship. It is important to remember that this fear of a breach in a relationship is subjective and probably in large part due to the own perceived instability. Often relatives or friends of someone with BPD feel that he or she is unpredictable and destructive. This is, however, not the underlying intention. Just the opposite, the individual with BPD yearns for stable and firm relationships probably like no other. The fear of losing a relationship is to someone with BPD a greater threat, reaching existential proportions, than to most people not afflicted with BPD.

Strained Relationships

Unfortunately, the fears of abandonment often lead to strained relationships in the sense of a self-fulfilling prophecy, which just reinforces the patient’s deep-seated fears about the strength and resilience of relationships in general. This profound fear of loss can also lead to the collapse of a therapy if the existential dilemma the patient faces cannot be reflected on.

An Unstable Sense of Self

At the core of BPD is an unstable sense of the self, a mistrust towards oneself. The reason maybe traumata, in which emotions and thoughts have been experienced, that can no longer be integrated in one's personality and sense of self (which is related to the sense of the story of one's life). Underlining this are the dissociation and depersonalization which often occur in more pronounced
episodes of BPD. Self-medication or self-harming with drugs is not uncommon, when the emotions and thoughts become directed against the own person, and thus one's sense of self.

**Diagnosis**

The diagnosis is made by clinical observation, and in some cases by ruling out other disorders that may be present. Biologically the frontolimbic network of neurons seems to be involved [3]. BPD may be at least partially inheritable.

Psychological and social factors play a significant role, as may traumatic experiences in one's life history. Here it is important to remember that the effect of a trauma can be very different among people and is determined by individual perceptions and existing coping mechanisms. The same objective events can lead to very different emotional and cognitive effects in people, and also to very different mental conditions in the long-run, if at all.

The emotional instability and impulsiveness is associated with a pronounced sensitivity in relationships. People with BPD feel emotions more easily and more deeply. [4][5] It also seems that they experience the emotions for longer and it requires more time to return back to the baseline. Individuals with BPD can be very joyful and loving, while at other times reacting very distressed, impulsive and seemingly aggressive at others. The more intense reactions to rejection, criticism and perceived failure often seems to be based on fear or anxiety.

**Inner Void**

Borderline Disorder arises from a substantial inner stability and a loss of direction, which often manifests in the sense of ‘void’. Repeatedly existential fears are triggered that lead to great anxiety and emotional outpourings. However, the term is largely a misnomer. We are not really dealing with a border ‘line’ but with a spectrum. Appropriate communication can help fill the void. Exploring the deeper issues, the patient’s interests and values helps to rediscover stability. Again, these are concepts that remain relatively stable and that also point to activities that can mean greater happiness and fulfillment. It does not strengthen the need to see everything as ‘black’ and white’, rather it does the opposite. By given people a greater sense of what is stable in them, the need to
partition people and objects into one of two categories is reduced, along with the existential anxiety that actually causes it.

**Therapy**

An important element in therapy is thus to help the patient rebuild and strengthen his or her identity. This means identifying values, interests and aspirations the patient really feels strongly about. Especially looking at more basic values can be helpful because they are very stable under normal circumstances and give the patient a sense there are stable elements in the core of the self.

Many patients with borderline syndrome have traumata in their past, although it is important to remember that the effect of trauma is always subjective. Traumata are especially damaging when they strike at one’s fundamental values. They can do so, if one’s values depend more on external messages. If I see my values as socially programmed, society can change them, which throws the whole edifice into great uncertainty. Thus, the route back is not to turn the focus away from inner processes, but to focus on them. This can cause resistance and aggressiveness, especially in the countertransference, but it is here where a lot of fruitful work can be done.

Everyone has fundamental values and interests. Some values might be directly encoded, but to a large degree we are only born with the rudimentary communication patterns that help us work out our values. Strong ruptures in communication patterns can damage one’s value system. To heal the damage, it is necessary to focus on learning improved communication patterns with oneself and others, and this is what therapy is all about.

References

[1] "Borderline Personality Disorder". NIMH.


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