Borderline Personality Disorder
the ‘facts’
(Or at the very least our best guess)

An article
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About the author

Stuart Sorensen is a registered mental health nurse with over 25 years experience (both pre and post registration) working in various social care settings. He began working with elderly people as a volunteer in the early 1980s and has since worked in residential and community settings with a wide variety of populations.

Stuart qualified as a registered mental nurse in 1995. In addition to his nursing registration Stuart also holds a diploma in counselling, a diploma in nursing studies and a post graduate diploma in PSI (psycho social interventions). His main interests include working with people with serious and enduring mental disorders, people with personality disorders and those with addictions or with dual diagnoses. He is also particularly interested in issues relating to deliberate self-harm.

Stuart is passionate about the possibility of recovery from mental disorders and much of his clinical and training work has been based around helping people to recover from serious mental disorders such as schizophrenia.

As a trainer Stuart is keen to help staff ‘at the coalface’ to find a balance between the conflicting (and seemingly impossible) rights of workers, carers and service-users. Based upon his years of experience as a worker and clinical specialist Stuart’s training has the feel of reality about it rather than the ‘ivory tower’ presentations that come from simply reading a book. Stuart understands the difficulties and dilemmas facing workers on the front line because he has faced them too.


About this article

Borderline Personality Disorder (the ‘facts’) is actually much more theoretical than the title suggests. The truth is that, in common with most areas of mental health and disorder, we don’t actually ‘know’ anything like as much as we would like to about the subject. What we have are theories and some evidence but that’s about all. Perhaps in another 100 years or so we’ll have real facts to play with but for now we’re still learning. It is only 2011 after all.

Unfortunately people are suffering today and can’t wait 100 years so this article, however limited, reflects the current state of knowledge. It does not focus upon biomedical understanding because it’s not aimed at medics – it’s written to offer some guidance and understanding to care and support workers who deal with day to day ‘human’ problems.

I hope you find it useful.

Stuart Sorensen
Borderline Personality Disorder: the ‘facts’

Increasingly social care workers are finding themselves responsible for the everyday care and treatment of people diagnosed as having a personality disorder, often without any real assistance from statutory health services. It can seem as though health service staff are content to label these people as ‘untreatable’ or ‘undeserving’ and then simply exclude them from services, thus passing the buck to other, less qualified or resourced workers.

This is at odds with the Department of Health’s guidance on the treatment of people with personality disorders (DoH/NIMHE 2003) but many professionals don’t seem to care about that. So what does the government say?

"There was strong agreement that there are not enough services available for people with personality disorder. In the main, experiences of general adult mental health services were negative. Unhelpful attitudes from staff were encountered, who would see “just the label”, and were often prejudiced about the condition, and belittling or patronising in manner.” (DoH/NIMHE 2003)

"Many clinicians are sceptical about the effectiveness of treatment interventions for personality disorder, and hence often reluctant to accept people with a primary diagnosis of personality disorder for treatment. However, a range of treatment interventions are available for personality disorder, including psychological treatments and drug therapy, and there is a growing body of literature available on the efficacy of varying treatment approaches. In a study commissioned for this report, Bateman & Tyrer conclude that whilst more research is needed, there are real grounds for optimism that therapeutic interventions can work for personality disordered patients.” (DoH/NIMHE 2003)

This little article explores the meaning of personality disorder and tries to offer both an explanation for the reaction of statutory services as well as providing some brief understanding for social care workers. None of these ideas are particularly new and few serious commentators would challenge them although many practitioners ‘at the coalface’ have yet to catch up with the research.
The International Classification of Disorders (10th edition) is the current diagnostic manual for psychiatrists. Published by the World Health Organisation, it describes currently recognised mental health problems including personality disorders.

According to ICD-10, Personality Disorders comprise:

“…..deeply ingrained and enduring behaviour patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations. They represent either extreme or significant deviations from the way the average individual in a given culture perceives, thinks, feels and particularly relates to others. Such behaviour patterns tend to be stable and to encompass multiple domains of behaviour and psychological functioning. They are frequently, but not always, associated with various degrees of subjective distress and problems in social functioning and performance.”

“Personality disorders differ from personality change in their timing and the mode of their emergence: they are developmental conditions, which appear in childhood or adolescence and continue into adulthood.”

(WHO 1992 p.200)

This seems to be quite straightforward in many ways. It’s a description of lifelong problems that show up in all situations that individuals find themselves in. To put it another way...

**Wherever you go – you always take yourself with you**

The notion of personality disorder is controversial however because it does not describe an illness so much as a faulty person. Many people think that this is inappropriate for medicine. Personality disorders are diagnosed by behaviour and the distress that people feel or cause. This behaviour must be at odds with cultural norms and so the diagnosis is very heavily based upon value judgements about people rather than any form of biological signs of illness. In fact there is little reliable evidence of any bio-medical basis for personality disorder whatsoever.

Instead the diagnosis is made by deciding whether or not the person’s behaviour is ‘normal’.
What is normal anyway?

The problem with this idea of ‘normality’ is that it’s very hard to define. Before we can know whether or not a person behaves ‘normally’ we must first decide what we think is normal for their particular society and culture.

We must decide what causes that behaviour (and it may not be down to a disorder).

We must decide whether the abnormality is actually a problem.

We must then decide if the problem matches any known category of mental or personality disorder. This can be very tricky, particularly since the guidelines for what makes up a diagnosis differ in different parts of the world and at different times.

Very often people with personality disorders fall between services. The other term for this is ‘falling through the net. Essentially, because people with personality disorders tend to exhibit a range of difficulties different specialist services tend to argue about which service is the most appropriate to deal with them.

The most obvious example of this is the way that people with personality disorders are passed between substance misuse services and general psychiatry although this is not the only example of this situation.

There are many reasons for this, some practical and some philosophical, but none of them are acceptable. Let’s examine the main arguments for this phenomena:

Personality Disorder is untreatable...

This is the most common argument for not treating personality disorder. The basic notion is that because personality disorders are not to do with medical difficulties so much as they are personality traits (who the person is) then medical treatments are not appropriate.

Unfortunately this argument ignores the fact that all people have a personality (disordered or not) and that the problems they experience (depression, anxiety, psychosis etc) are just as treatable in personality disordered individuals as they are for everyone else. The task is not to treat the personality – the task is to treat the mental health problem. People with personality disorders may require more time or they may need different interventions but the work can be done.
Not ‘mad’ but ‘bad’...

This is a value judgement and it has no place in health or social services. If people break the law then the courts will deal with them. Until then they are no different from anyone else. All British citizens have the right to receive health care that is ‘free at the point of service’ regardless of their personality type.

Borderline Personality Disorder

This may well be the most commonly encountered personality disorder in British social care today. It’s a diagnosis fraught with assumption and judgement along with some very unfortunate implications for those diagnosed with it. The criteria from ICD-10 are as follows:

‘a lifelong tendency to quarrel and create conflict’ and at least four of the below (at least two of those printed in bold).

§ A marked tendency to act unexpectedly without considering consequences.

§ Outbursts of anger or violence, & inability to control resulting behaviour.

§ Difficulty in working towards long term goals.

§ Unstable mood.

§ Uncertainty about self-image and identity (including sexual).

§ Intense and unstable relationships, often leading to emotional crises.

§ Excessive efforts to avoid abandonment/rejection.

§ Repeated threats or acts of self-harm.

§ Long-lasting feelings of emptiness.

Adapted from:

World Health Organisation (1992)

It has been said that many of these symptoms are descriptions of adults who behave like children. Let’s see how this happens:
Marsha Linehan, a Seattle-based clinical psychologist coined the term ‘invalidation’ and ‘the invalidating environment’ to describe the sort of chronic trauma that typifies the early history of many people diagnosed with borderline personality disorder (Linehan 1993 1&2). Invalidation can be described as:

- Erratic, inappropriate responses from significant others to the individual’s thoughts, beliefs and emotions.
- Oversimplifying the ease with which problems can be solved.
- Blaming the individual for not solving difficulties with ease.
- A chronic and classical ‘double bind’ scenario in which the individual cannot ‘win’ whatever he or she does.

This sort of invalidating environment seems to be significantly more common than the more dramatic acute trauma typified by physical or sexual childhood abuse. However both types of abuse lead to similar difficulties as both involve conflict and a lack of compassion or understanding.

A child who grows up with conflict doesn’t learn other ways of dealing with problems or disagreements;

A child who is criticised or punished whatever s/he does doesn’t learn appropriate behaviours because everything is seen as equally inappropriate. They don’t follow ‘normal’ rules because they don’t really know what those rules are. Their behaviour appears erratic and unexpected to other people.

There is a wealth of research evidence going back decades that demonstrates an extremely strong link between trauma of one kind or another and Borderline Personality Development. It is well known that children facing overwhelming trauma often ‘dissociate’ away from that trauma. They don’t face it because it’s too painful.

**Dissociation**

Dissociation is an interesting phenomenon. It’s what happens when people are faced with traumas that they are not able to cope with, perhaps because they are too young to face such ‘heavy’ problems or simply because they have never developed adult coping skills in the first place.
Instead of facing and dealing with the problem they avoid it. This is not unusual in itself. However the way that people who dissociate avoid problems is to remove their consciousness from the situation altogether. It’s not just a case of distraction – they really aren’t consciously ‘there’ any more.

It’s the origin of the rather less than respectful expression “the light’s on but nobody’s home”. In that sense dissociated people really aren’t ‘at home’.

Most people who have driven long distances can get a mild sense of dissociation. It’s what happens when you remember getting in the car and you remember getting out of it but you don’t remember anything in-between. That’s because you dissociated away from the journey.

It was boring (motorways are) and so you went on to ‘auto-pilot’. Your body was there and functioning but your ‘essence’ had gone somewhere else. You escaped the boredom by thinking about and ‘being’ somewhere else.

Dissociation away from trauma is the same thing – just more extreme. People distract themselves from the painful situation by thinking about and ‘being’ somewhere else. That’s why people often can’t remember painful or traumatic situations – they genuinely weren’t there when it happened. They’d dissociated.

Unfortunately it is only by facing our difficulties that we learn how to deal with them and so develop adult coping skills and emotional control. So traumatised children fail to develop emotional coping skills. They are often overwhelmed by emotion and experience extreme emotions like anger, rage, ‘hysterical’ upset etc. This can lead to extreme behaviour and unstable mood swings. Any future attempt to face emotional difficulties leads to the same degree of trauma with the same, immature coping skills. Even as adults it remains extremely difficult for them to face their emotional issues and develop normal coping skills.

Working toward long term goals requires patience and the ability to delay gratification (wait for the rewards of their effort). This means tolerating frustration (can’t have what you want when you want it). Lack of emotional control and frustration tolerance makes it difficult to stick to long term projects which are inherently frustrating and hard to tolerate.
Chronic invalidation makes it hard for people to trust their own judgement and opinion. This makes it hard for them to form concrete opinions about their own preferences and values. In short it’s hard to know who you are when you can’t rely upon what you think or what you know.

All the above problems make it difficult for people to maintain long-term relationships. So break-ups are common. However, the fear of abandonment (because they can’t trust their own judgement and so fear being left to cope alone) means that they then work hard to save the relationship and the pattern repeats. “I hate you – don’t leave me!”

The process of dissociation in response to trauma produces a bewildering emotional state that has been described as feeling all emotions at the same time and no emotions in particular.

Overleaf is a symbolic description of dysthymia and deliberate self harm written by a lady with a long history of deliberate self harm who was ‘written off’ as ‘attention-seeking’ by services. She adopted the name ‘Cassandra’ because in Greek mythology the curse of Cassandra was never to be believed.

This lady first began cutting herself at the age of 15. Now in her early forties she has not self-harmed for seven years (and counting) at the time of writing.
The Merry-go-round by 'Cassandra'

"Imagine you're watching a merry-go-round. One of the old Victorian ones with brightly painted horses that rise and fall, swaying sedately in lazy, slow, shallow arcs as it turns round and round. All wear gold painted sashes bearing names like 'Billy', 'Dancer' and 'Merry Legs'.

The horses on my merry-go-round have names like Happy, Peace, Serene and Calm. In the centre there is an organ playing happy carnival music. Now, press fast forward, not just the picture, speed up the music too. Until everything is a spinning blur and the music is beyond your ability to understand.

Now imagine you are standing in the stationary centre of the merry-go-round, but still in real time. You can see everything. The spinning colours, the hectic movement and a brief glimpse of flashing hooves and flying tails.

You can feel everything. The rumble under foot from the straining mechanical turntable. The wind generated by the spinning horses.

You can hear everything. The noise of the stressed wood and machinery, that will surely split and tear apart if it goes on for too long. The disjointed, super fast organ music.

But even though you can see, hear and feel you can't make anything out. You can't pick out or focus on one thing in all that chaos that makes sense

And beyond all that you can see real time, real life, carrying on as if none of this is happening. You can't shout. Who would hear you when you can't even hear yourself? You can't even step out of it. You're trapped.

What would you do? How would you stop all that movement, all that sound, all that confusion? Standing there in your little dead zone, all your feelings and emotions spinning out of control. Desperate to feel something, anything but the big blank you have right at that moment. What would you do?

I cut myself to make it stop. Not deep. Just deep enough to draw blood. Just deep enough to feel it. Just deep enough to make the merry-go-round slow down. I've had the mechanics of self-harm explained by Stuart and I know the brain kicks out endorphins as a result of the pain. That is where the spaced out feeling comes from. I'm not sure I
understand the chemistry bit. All I know is, if the kick has been good enough, the merry-go-round slows down enough that sometimes you can even choose the horse you want to get on.”

'Cassandra' 2007

This is often what Deliberate Self Harm is all about. Physical trauma produces endorphins (the body's response to injury) which help to stabilise mood when under pressure. It is a way of dealing with emotional distress and not an attempt to seek-attention or to manipulate medical and nursing staff.

However many professional and non-professional staff think that deliberate self harm is exactly that – an attempt to manipulate them or to get their attention.

I suggest that you pose the following questions whenever you come across workers with this attitude:

- Do these people really not know how to ask for help?
- If not – why not?
- What sort of help can you offer them that is worth self-mutilation in order to achieve it?
- Are you really that special?
- How good are you at noticing people’s distress if they need to resort to self-harm to get your attention?
- What’s wrong with your access policies?
- How good are your listening skills?
- How ‘accessible’ are you if people can’t just talk to you and ask for what they want?
- What does this say about you as a professional and as a person?

Another myth is that self harm is an attempt to manipulate or emotionally blackmail professionals.

- Do we really believe ourselves to be so important that people will mutilate themselves just to influence our thoughts, feelings and behaviours?
- Is deliberate self-harm really all about us as professionals or is it more to do with the personal needs of the client?
Interestingly, even the Royal College of Psychiatrists is coming around to this way of thinking:

“They may be an attempt to communicate with others, to influence or to secure help or care from others or a way of obtaining relief from a difficult and otherwise overwhelming situation or emotional state. Paradoxically, the purpose of some acts of self-harm is to preserve life. Professionals sometimes find this a difficult concept to understand.

One particular intention or motive might predominate or all might co-exist. This means that a person who self-harms repeatedly might not always do so for the same reason each time, or by the same method. Thus assumptions about intent should not be made on the basis of a previous pattern of self-harm; each act must be assessed separately to determine the motivation behind it. Failure to do this can result in the meaning of the act being misunderstood and in an interpretation that the service user finds judgemental or dismissive. This will inevitably lead to a breakdown in the therapeutic relationship, as well as making it less likely that appropriate help will be offered at times when a person is at high risk of suicide.

Consistent with these differences in intention and motive, people who self-harm might have very different expectations about how health services should respond and what constitutes a good outcome. In particular, people who harm themselves as a way of relieving distress (through cutting, for example) might be compelled to do this as a coping and suicide prevention strategy. They are likely to continue to need to do this until they receive appropriate and sufficient psychotherapeutic interventions and support.”

The British Psychological Society
& The Royal College of Psychiatrists (2004)

The feeling of emptiness comes from being unable to deal with emotions – so the person dissociates and locks their feelings away. They have nothing left to feel apart from emptiness and/or boredom. Boredom is hard to tolerate because there’s no immediate ‘reward’ and so they seek activity – hence the impulsiveness and ‘unexpected’ behaviour described above.

It is no coincidence that many clinicians are coming to think of Borderline Personality Disorder as a form of ‘Complex Post Traumatic Stress Disorder’.
“Post-traumatic stress disorder occurs when an individual has been overwhelmed by terror and helplessness. It is manifest as reliving traumatic events, avoidance of remembering the trauma, and heightened arousal linked to perceived threat. Many people abused in childhood have been placed in terrifying situations where they have felt helpless. Therefore, it is not surprising that in clinical settings many individuals with personality disorder, particularly borderline personality disorder, are observed to suffer from post-traumatic stress disorder.”

(Herman, 1992).

“Self-harm occurs in all sections of the population but is more common among people who are disadvantaged in socio-economic terms and among those who are single or divorced, live alone, are single parents or have a severe lack of social support.

Life events are strongly associated with self-harm in two ways. First, there is a strong relationship between the likelihood of self-harm and the number and type of adverse events that a person reports having experienced during the course of his/her life. These include having suffered victimisation and, in particular, sexual abuse. Second, life events, particularly relationship problems, can precipitate an act of self-harm.

Many people who self-harm have a physical illness at the time and a substantial proportion of these report that this is the factor that precipitated the act.”

(The British Psychological Society & The Royal College of Psychiatrists, 2004)

Traditional views of people diagnosed with Borderline Personality disorder as undeserving or ‘time-wasters’ tend only to recreate the invalidation of the past. The notion that these people can somehow overcome their immense emotional difficulties is a gross over-simplification of their true problems and the subsequent description of them as ‘undeserving’ is equally invalidating. This sort of attitude tends only to make future impulsive or self-harming behaviour more likely as it creates overwhelming emotional turmoil in the service-user.

In England and Wales the Care Standards Act 2002 defines abuse. One of the categories is psychological/emotional abuse, a form of behaviour that leads people to experience psychological or emotional trauma. It would be hard to argue that repeated invalidation
of people with borderline or other personality disorders is not a form of psychological/emotional abuse. Additionally, given that the Department of Heath clearly states that personality disorder is not a reason to withdraw services, failure to offer appropriate help might well constitute negligence and a failing in the worker's duty of care. This is especially so in relation to statutory service providers.

In Scotland the Adult Support & Protection (Scotland) Act 2007 goes even further. It includes behaviour likely to cause self-harm as a distinct form of abuse and carries strict legal penalties for abusive workers or others:

Section 3(1) defines “adults at risk” as adults who:

- "are unable to safeguard their own well-being, property, rights or other interests;  
- are at risk of harm; and  
- because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected”

Risk of harm:

Section 3(2) makes clear that an “adult” is at risk of “harm” if:

- "another person’s conduct is causing (or is likely to cause) the adult to be harmed, or  
- the adult is engaging (or is likely to engage) in conduct which causes (or is likely to cause) self-harm”

Harm:

Section 53 states harm includes all harmful conduct and, in particular includes:

- "conduct which causes physical harm,  
- conduct which causes psychological harm (for example by causing fear, alarm or distress),  
- unlawful conduct which appropriates or adversely affects property, rights or interests (for example theft, fraud, embezzlement or extortion),  
- conduct which causes self-harm.”

Adult support & Protection (Scotland) Act 2007

We can see then that failure to take people seriously because of a diagnosis of personality disorder not only goes against the principles laid down by government, it also constitutes a serious failure of the duty of care that applies to all social care workers.
This is especially so if the individual is working as part of statutory services.

This attitude of untreatability reflects much more than a training need. It leads to negligence and neglect - both of which can lead to criminal charges being brought. It is time for workers in all sectors of health and social care to move on from past prejudices.

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