

Borderline personality disorder triggers turmoil and rage

by Gail Johnson on Feb 16, 2011

For as long as she can remember, 26-year-old Tannis Jackson has found herself routinely slipping into fits of rage. After one particularly bad day at work, she became so infuriated she made her own head bleed.

"I remember being so angry I pulled out two fistfuls of hair and smashed my head against the wall," Jackson tells the *Georgia Straight* in a phone interview. "There was no other way to express how I felt."

Jackson (who requested anonymity), who works in a health-care field in the Interior, didn't know why she couldn't control her everyday emotions. She just knew that the most minor conflict would aggravate her delicate state of mind, leading to explosive outbursts. Imagine a cup of water filled to the rim: when everything is going smoothly, the water stays still and calm. But any slight disruption, such as a disagreement, has an effect like a tsunami, making the water churn and spill over, with devastating consequences.

"I wasn't able to cope with anything," she explains. "I would have temper tantrums, and I would take things out on myself. If I had a bad day at work, I figured everything was my fault. Every day was a struggle."

Four years ago, Jackson was diagnosed with borderline personality disorder. BPD—as misunderstood by the public as it is missed altogether by many doctors—is a serious mental illness marked by severe instability in moods, relationships, and behaviour.

Jackson had never even heard of BPD when her psychiatrist told her that was what was causing her relentless torment. But she couldn't deny that the telltale signs—including intense but stormy attachments and extreme emotional reactions—described her perfectly.

Although not as well known as schizophrenia or bipolar disorder, BPD is more common, affecting about two percent of adults, mostly young women, according to the National Institute of Mental Health, a division of the U.S. National Institutes of Health.

Vancouver is home to some of the world's leading research into and treatment of the condition. But local health professionals who specialize in the disorder say that BPD is grossly overlooked by the medical profession and funding bodies.

People with BPD often experience instantaneous shifts in their attitude toward people close to them, veering from idealization (love and admiration) to devaluation (anger and dislike). Although people suffering from depression typically endure the same low mood for weeks, those with BPD may experience intense bouts of anger, sadness, or anxiety that last just hours.

They often feel misunderstood or mistreated and lack a sense of identity. They might make desperate attempts to avoid being alone and act impulsively, spending excessive amounts of money or having risky sex. They can come across as manipulative, controlling, unwilling to change, and attention-seeking.

At the root of people's volatile, unpredictable mood swings is a fear of abandonment or rejection. Consequently, those with BPD can react with hostility to short-term separations such as a business trip or even a last-minute cancellation of plans.

Their cognitive distortions can lead to frequent changes in long-term plans, career goals, jobs, friendships, and personal values. Sometimes people with BPD view themselves as fundamentally unworthy or have issues with gender identity.

They tend to have other, compounding health problems, too, like substance-use issues, eating disorders, and even other mood conditions, such as bipolar disorder (which, once referred to as manic depression, is marked by extreme highs and lows).

BPD is also marked by chronic thoughts of suicide or actual attempts.

According to a 2005 issue of the *Canadian Medical Association Journal*, BPD presents some of the most difficult and troubling problems in all of psychiatry.

Vancouver psychiatrist John Livesley, who specializes in the illness, agrees that it is one of the most severe forms of psychopathology.

"About 10 percent of patients die, mostly through suicide," Livesley says in an interview at his UBC office. "Viewed as a disorder that affects young people with a 10-percent mortality rate, if it were any other condition, there would be a huge outcry from the public and from the [medical] profession to do more about it," he states. "But because it's a mental disorder, it doesn't attract the same concern. People haven't gotten used to the idea that mental disorders are just that: disorders. They aren't things people can just change."

He explains that people with BPD live in a constant state of fear.

"The world seems to them a threatening and frightening place," Livesley says. "As a result of this emotional instability, their relationships with other people tend to be chaotic too, and unstable." "They have endless fears linked to emotionality, which adds to the instability of life."

Those with the condition can act on those fears in physically damaging ways.

"There can be self-harm: they cut; they overdose; they hit or burn themselves," Livesley explains. "This is an attempt to control their feelings, as they haven't learned alternative ways to handle their emotions." "When emotions are this unstable, they're very difficult to handle."

However, Livesley maintains that treatment is effective and recovery possible. Getting there is the hard part.

"The condition has taken on a lot of negative connotations, so diagnosis is usually pejorative," Livesley says.

Much of the misunderstanding surrounding borderline personality disorder comes from the name itself. Historically, BPD has been seen as lying on the border between psychosis (having a severely distorted view of reality) and neurosis (a nonpsychotic mental condition marked by anxiety and distress).

But people who have BPD are no longer considered to be on the border of anything, UBC psychiatry professor Kerry Jang explains.

Jang, who has contributed to more than 100 published studies on personality disorders and is also a Vancouver city councillor, says it's no wonder people are confused about BPD. Researchers have defined five broad domains of personality (extraversion, openness to experience, conscientiousness, agreeableness, and neuroticism), yet at the same time, the current edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* lists 10 personality-disorder diagnoses (including narcissistic personality disorder, which is marked by a lack of empathy, and antisocial personality disorder, in which people have no regard for right and wrong). In fact, researchers from Michigan State University, among others, are proposing changes to the way personality disorders are classified in the next DSM, which comes out in 2013. To make matters worse, different researchers use different scales to measure those five personality dimensions, and diagnoses tend to overlap.

"Everyone has different levels of subtraits, and the severity of personality disorders varies," Jang says during an interview in his City Hall office. "It's a spectrum; it's not so black-and-white."

It can be hard for people to get help, Jang notes, because so many who have the disorder don't recognize the symptoms.

"Many people who have the illness don't think they're ill," he explains. "They can be the sweetest and nicest person in the world one minute, then mad as hell the next."

In some medical circles, the term borderline personality disorder isn't used; rather, the same set of symptoms goes by the name "emotionally unstable personality disorder". This is the name used by the World Health Organization's International Classification of Diseases, 10th Revision.

Jang's current research is focusing on causes of BPD. Specifically, he's been studying genetic and environmental factors, and the intersection thereof. He and a team of researchers from Harvard University recently had a paper accepted for publication by the Archives of General Psychiatry, an internationally renowned medical journal. In their study, the authors conclude that heredity has a role in the development of BPD.

"This large family study confirms that BPD is passed on within families," Jang says. However, although genetic factors likely play a part in BPD, no specific genes associated with the condition have yet been identified.

UBC psychiatry professor Kerry Jang discusses genetic links to borderline personality disorder.

Other risk factors for BPD include sexual or physical abuse.

According to the National Institute of Mental Health, 40 percent to 71 percent of BPD patients report having been sexually abused as children. Jackson says her brother sexually assaulted her repeatedly when she was growing up, a fact she says her parents brushed off when she finally told them years later. She now has no contact with her immediate family.

Neuroscientific research funded by the NIMH suggests that people who are predisposed to impulsive aggression have impaired regulation of the neural circuits that control emotion.

The most successful treatment for BPD appears to be dialectical behaviour therapy. A cognitive-behavioural treatment developed about 15 years ago by Marsha Linehan, a psychology professor at Seattle's University of Washington and director of its behavioural research and therapy clinics, DBT typically involves weekly individual or group-therapy sessions (or both) that focus on managing and coping with emotions, dealing effectively with interpersonal situations, and tolerating emotional distress. It also helps people practise "mindfulness", a way of paying full attention to the present moment.

SFU assistant professor and psychologist Alexander Chapman cofounded the Dialectical Behaviour Therapy Centre of Vancouver in 2007 with fellow registered psychologist John Wagner. The same year, Chapman coauthored *The Borderline Personality Disorder Survival Guide: Everything You Need to Know About Living With BPD* with Kim L. Gratz and Perry D. Hoffman.

"There was very little material for people with borderline personality disorder that was understanding," Chapman says of the book. "People with BPD are branded as out of control, extremely angry, and manipulative. Even treatment providers turn them away because they're deemed too difficult to work with."

"There's a stigma attached to BPD: if you've got BPD, your personality must be flawed; it must be a scar on your soul that will never go away. But research shows that people do get better over time. Impulsivity and suicidality tend to decrease with age; however, fear of abandonment and rejection do not."

"When it comes to being highly emotional, there's a positive side to that as well: some of the most compassionate people I've ever met are the people I've worked with," Chapman adds.

The DBT centre, which treats people with BPD as well as those with suicidal thinking, eating disorders, and self-destructive behaviour, among other things, offers weekly individual therapy. It provides skills training,

too, teaching people how to identify and cope with emotions, deal with stress, self-soothe, and be “in the moment”. The wait to get in is usually between three and eight weeks—not ideal for someone who’s desperate for support and change but shorter than the usual year or so it takes to see a psychiatrist.

“DBT is the well-researched therapy for BPD and related problems,” Chapman says. “The centre sees about 60 clients a week. There’s certainly high demand for treatment.”

Although DBT has shown great promise in treating borderline personality disorder, all too often people are prescribed a cocktail of pharmaceuticals that have potentially serious side effects. Experts in the field say medications are inappropriate for treating the disorder.

“The current evidence is that treatment is effective, and the primary intervention seems to be some type of psychotherapy,” Livesley says. “But that’s not how most patients are treated, especially here; most are treated with medication. American Psychiatric Association guidelines for treating BPD recognize psychotherapy as the main treatment and pharmacotherapy used as adjunctive treatment. Interestingly, the new guidelines out of the U.K. [the National Institute for Health and Clinical Excellence] don’t recognize medication at all for BPD.

“It’s a myth that we can’t treat this disorder,” he adds. “The evidence is that we can make substantial changes and improve quality of life.”

Livesley claims that government cutbacks to health care, in particular to day-treatment programs for those with mental illnesses, have made it harder for people to get help.

“We’re going backwards, in a way,” he says. “We’ve had so many cutbacks. Europe is doing more in terms of longer-term inpatient care for more severe patients. But that doesn’t fit the North American model of short-term admissions. Medications are an easy option.”

UBC psychology professor Don Dutton is equally stymied by the lack of resources being directed toward BPD.

“People have this emotional roller-coaster ride with extreme highs and lows. Some have trouble with the justice system: they might be dealing with out-of-control gambling or substance abuse,” he says. “It’s [BPD is] fairly problematic; it’s definitely a concern. It strikes me as strange that it’s received so little attention in Canada.”

Dutton says much more has been done south of the border: take the major funding being directed toward research by the U.S.’s National Institute of Mental Health. The institute is also collaborating with a private foundation to help attract new researchers to develop a better understanding of and better treatment for BPD.

For Jackson, treatment has turned her life around. She sees a psychiatrist for bimonthly psychotherapy. She has found ways to control her emotions. But she wants others to understand just how tormenting the condition can be.

“I’ve heard someone with BPD can be compared to someone with third-degree burns on their skin: emotionally, they’re that sensitive,” she says. “It’s so hard to realize you have a problem and then to find a way to deal with it.”

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