**Research Paper (Borderline Personality Disorder)**

[Name of Writer]

[Name of Instituion]

**Abstract:**

Borderline Personality Disorder is among cluster B of personality disorders in the DSM. It has been identified as one of the most prevalent personality disorders to exist. It has been determined that there are genetic and environmental factors behind the pathological symptoms of BPD. There are several agreed upon diagnostic criteria for clinical identification and confirmation of BPD. However, recently a debate has been struck to decide whether the current definition of BPD is the correct one. This confusion has coupled with the stigmatization BPD patients faced due to resistance to treatment, anger and instability. There is also a moral conundrum associated with the proper response by healthcare professionals to disruptions caused by BPD patients. Together, these have led to a less than favorable condition for BPD patients. There should be improvements in therapeutic strategies and there should be consensus on clinical definition of BPD.

Borderline Personality Disorder has been placed within cluster B of personality disorders in the DSM (Diagnostic and Statistical Manual of Mental Disorders). This means that people diagnosed with BPD tend to be overly erratic, irrational and dramatic. The prevalence of BPD in the population of USA is 2% in the community and 20% in inpatient settings while it is 10% in outpatient settings. (Torgersen S. , 2014) BPD is the fourth most prevalent personality disorder according to the third and fourth editions of DSM by American Psychiatric Association.

Even after years of research into the symptoms and diagnostics of borderline personality disorder, its understanding is limited. Wrong BPD diagnoses can not only lead to complications with patients, but it also becomes a source of distress for people that have BPD. There needs to be more awareness on what constitutes BPD and a binding consensus on the clinical definition of BPD.

Borderline Personality Disorder is one of the most stigmatized and poorly understood personality disorders. BPD was defined in 1978 and it got added to the third edition of DSM in 1980. Ten years later, BPD was included in the ICD (International Classification of Diseases). It is defined by volatile and impulsive behavior aggravated by a poor sense of self and a display of excessive sensitivity over small mistakes by others. Since this disorder also inculcates anger and aggression in the patient against any caregiver trying to get to them, healthcare providers can be reluctant in taking BPD cases. Suicidal tendencies are coupled with anger in BPD and this exponentially increases difficulties in handling BPD patients. As a result of these, BPD patients can face severe alienation not only in the outside world but also inside the medical and psychological facilities meant to help them. These complications create a stigma around BPD which have led to a biasness in traditional conclusions that BPD is untreatable. (Donald W. Black, 2011)

The prevalence BPD in the general population is enough to raise alarm. The prevalence of BPD in the general public does not display a significant difference from that of other personality disorders. There is, however, serious discrepancy between statistics of other personality disorders and those of BPD among patients already in psychiatric treatment facilities. This percentage is a staggering 15-28% among psychiatric outpatient populations. (Korzekwa, 2008) Borderline personality disorder can show recurrence in patients in the form of waves. Diagnosis and prognosis cannot always be satisfactory in every consecutive wave. This means that the difficulties generally associated with identifying the presence of BPD and devising a therapeutic strategy can prove to hinder diagnosis in more than one occurrence of BPD in the patient. BPD can occur in children and diagnosis is as reliable in children as it is for adults. Contrary to popularly held belief that BPD appears thrice as much in women as men, the prevalence of this disorder is actually not significantly different in men and women. (Tomko, 2014)

The factors that may lead to development of BPD are multidimensional. Like most personality disorders, it has now been established that BPD also has a genetic predisposition. (Torgersen S. S., 2000) It is therefore dependent on a certain group of genetic markers that can be provoked into disarray by environmental influence. Borderline personality disorder is a maldevelopment of brain due to an amalgamation of neuropeptides and hormones. The biological pathways that create the disorder depend on external factors (for example relationship with parents) and once activated, can stay stable for a long period of time. One of the most important factor here is genetic heritability. In early studies, it was difficult to establish a linkage as studies involving twins rarely led to a conclusion on the genetic predisposition of BPD. However, the first GWAS (genome-wide association study) that checked the whole genomes of patients for any polymorphisms that showed association with BPD established genes that were unusually linked to BPD. Most of these overlapped with the genetic map that led to other disorders including schizophrenia and bipolar disorder. (Witt, 2017) A general outlook of these genes indicates that these are the genetic precursors for basic neuro-generative functions; for example, the covering of neurons with myelin sheath. Other genes like SLC6A4, PKP4 and DPYD directly encoded for hormones that were responsible for the emotional upheaval in BPD. These genetic factors, however, need a relationship with environmental factors in order for the instability to morph into BPD. It has been described in detail that trauma and adversities experienced during childhood has a strong correlation with development of BPD later in life. Studies have been performed to show that maltreatment of children including physical or sexual abuse as well as neglect can become deciding factors for a BPD diagnosis. (Johnson, 1999) Disrupted relationship with a caregiver or extreme dependence on a caregiver may also produce enough problematic mess to conclude in BPD. Glitches in neural circuitry, pain-processing circuitry and hormonal instability are all physical manifestations of the gene-environment interaction. These are also the pathological symptoms of BPD.

The presence of borderline personality disorder has been linked with other psychoanalyses. There is an apparent relationship between BPD and substance abuse. Previous studies have marked this link with samples from general population as well as from clinical settings. Substance use disorders (SUD) generally invoke a similar pattern of genetic and biological pathology as the borderline personality disorder. An overlapping of the factors that might lead to these disorders therefore becomes the reason why the linkage is so strong. Focus is also being lent to the relationship between BPD and opioid misuse. Apart from a staggeringly apparent relationship between heroin and BPD, there is also correspondence between BPD and opioids that are generally used and prescribed as medicinal drugs. (Vest, 2019) One of the reasons underlying the relationship between BPD and prescription opioid misuse is the fact that BPD patients are prescribed medicinal opioid. The impulsivity and the proclivity for self-harm provoked by the feelings of guilt after anger and aggression can easily lead a BPD patient down the path of substance abuse. Surprisingly, it has been observed that BPD patients have an even higher risk of misusing medicinal opioids prescribed to them than the risk of alcohol or cannabis misuse. On top of other problems currently related to BPD patients, it is important to remember that substance abuse should get attention while devising therapeutic strategy for a disorder as delicate and dangerous as BPD.

In addition to an association between clinical BPD and substance use disorders (SUD), the pathological symptoms and causative factors may spill onto areas responsible for other psychological arenas. Ongoing research has also attempted to establish a relationship between sexuality and BPD. This relationship has been mainly elucidated to understand a BPD patient and to devise a strategy that might work for that particular patient. It is imperative in this case because the sexual experience of an adult may be indicative of their behavioral patterns. Earlier research in this area circled around promiscuity and whether BPD patients had a higher tendency to have sex with a large number of partners. However, as times have progressed, other studies have discarded this association. More recent studies for determining a relationship between adult sexual experiences and the likeliness of contracting BPD revolve around sexual trauma. Sexual assault has been studied as a significant determinant in whether a person can develop BPD. Moreover, it has been shown that BPD patients can also show a greater than normal tendency to end up as sex offenders. This can have various explanations. On one hand, sexual abuse in childhood may lead to an adult BPD patient avoiding sexual encounters as it may invoke memories of said trauma. However, on the other hand, it is also possible for BPD patients who were previously victims of sexual abuse to re-enact the scenario with themselves playing the dominant role this time. (Wiederman, 2009)

There are several biological morbidities associated with BPD. Individually, these aberrations can occur in other disorders or even in healthy individuals. It is the presence of all the aberrations at once that describe the pathology of borderline personality disorder. These phenotypes that together form BPD can be classified in several groups. BPD patients have extremely unstable personal relationships due to fear of abandonment and can have severely dysregulated emotions of anger and emptiness. Those with BPD may also develop prefronto-limbic dysfunction. There are alarming levels of impulsiveness in the patients which leads to them being critically suicidal. There are also symptoms of dissociation and a severe loss of the patient’s sense of self.

Successful diagnosis of borderline personality disorder is a tricky road to tread on. There is currently an ongoing debate on altering the official definition of BPD. This highlights the lack of consensus or clarity in defining absolute boundaries for clinical BPD. It also goes on to suggest that diagnosing BPD can be complicated due to this grey area brought about by confusion around what BPD is. However, there are three basic psychotherapeutic criteria that can help the physician diagnose a patient with BPD. One of the most prominent is a history of severely troubled personal relationships often bringing a feeling of ‘emptiness’. Another is mood lability. This is amplified by a crippling fear of abandonment. The final criterion is emotional disarray as visible via impulsiveness, self-harm or suicidal tendencies. It must be noted that statistically, 10% of BPD patients take their suicidal goal to completion. (Hall, 2017) It is a sad reality and reinforces the importance of timely and accurate diagnosis of BPD. The fifth edition of DSM by American Psychiatric Association also lists diagnostic criteria for BPD. These include a 95% incidence of instability, 87% inappropriate anger, 81% impulsivity, 79% unstable relationships, 71% feelings of emptiness, 68% dissociation or paranoia, 61% identity disturbance, 60% abandonment fears while 60% suicidality or self-injury. (Zimmerman, 2017)

Treatment strategies for borderline personality disorder have seen a colorful timeline over the decades. Identification of BPD was initially only linked to the aggression and resistance these patients showed to healthcare providers. Disruptions in hospitals and psychotherapy were linked with BPD in early 20th century. BPD was later thought to be a sub-category of schizophrenia in the 60s. Proper definition came in 1978 and the declaration of BPD as a treatable disorder came in 1993. Evidence-based therapies became the focus of research in the 2000s as studies around genetic predisposition for BPD led to identification of several genes that could be responsible for the disorder. Identification of genes led to discovery of biochemical pathways in BPD prognosis. The treatment strategies for BPD have therefore, come a long way. Mentalization based treatments is one of the currently popular treatment options for BPD. It involves enhancing the capacity of BPD patients to critically analyze the actions taken by themselves and by other people in the context of personal desires, feelings, needs and beliefs. Successful administration of this therapeutic strategy has brought positive outcomes for BPD. Studies are now being conducted to expand the influence of this type of psychotherapy. (Laurenssen, 2018)

There was traditionally a significant exasperation when dealing with BPD patients and this ideology has continued to seep into current therapeutic scenarios. Much of it is dependent on the moral dilemma faced by healthcare professionals when dealing with BPD patients. Containment or tolerance towards dangerous anger displayed by BPD patients can both lead to adverse outcomes. Crisis intervention hence becomes tricky and inadvertently leads to further alienation of BPD patients. (Warrender, 2017) Although it is worthy to note that much has been improved as far as alienating or antagonizing BPD patients is concerned; it should also be remembered that we have not been able to completely purge the psychotherapy department of this prejudice. Reluctance in accepting new cases of BPD still persists. It is extremely vital to note that this hesitation could lead to critically adverse consequences for the patient. The mortality rate from suicides done under the influence of BPD is too high to be ignored. It is, therefore, crucial to prioritize awareness around BPD in order to combat the stigma. It is also important to incorporate preference for BPD patients in psychotherapeutic settings especially when professionalism and patience is required. Most of all, it is essential for the scientific community to reach a binding consensus on the clinical definition and diagnostic perimeters for BPD. Only then will it be possible to devise therapeutic strategies strong enough to fight off borderline personality disorder on all fronts.

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