EMOTIONS MATTER'S A NEW EDUCATIONAL FILM

THE MYTHS & FACTS ABOUT BORDERLINE PERSONALITY DISORDER

A VIDEO COMPANION TEACHING & DISCUSSION GUIDE

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Emotions Matter Inc. is a 501c3 non-profit organization with a mission to create a world in which every individual impacted by borderline personality disorder (BPD) has adequate resources, education and support to achieve a meaningful recovery. For more information about Emotions Matter and its programs, or to get involved, www.emotionsmatterbpd.org

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Our hope is that professionals and the general public find this new video helpful in learning more about borderline personality disorder to promote better access to care and recovery.

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Introduction

Since Emotions Matter's inception, our members have expressed anger, frustration and despair about the stigma surrounding BPD.

For people with lived experience, stigma can compound their symptoms of self-hatred, shame, rejection sensitivity and worthlessness. In some cases, the fear of rejection prevents them from seeking care when in a crisis which leads to worse outcomes.

For family members, the stigma leads to struggling in isolation as they navigate their loved ones' BPD symptoms and try to find them a proper diagnosis and treatment. They often spend years searching until they finally get a BPD diagnosis.

For professionals, stigma can lead to misdiagnosis, underdiagnosis, and unintentionally harming people by missing the right treatment recommendations, sometimes even putting lives at risk. Misunderstood symptoms of BPD can frighten professionals from treating individuals with BPD because they lack training or lead professionals to apply inappropriate treatment, usually in the form of excessive medication or sometimes in the form of electroconvulsive treatment (ECT).

One family in particular reached out to us in 2017. They lost their child, Michelle Monachino, to borderline personality disorder and suicide. Michelle's family made a charitable donation in Michelle's memory through the Michelle Rose Foundation. They asked for Emotions Matter to use this gift in Michelle's memory to address the BPD stigma, and that became seed funding for this project. Funds from this Video also came from our Walk for Borderline Personality in New York City in 2019. Each year, we walk to raise awareness about BPD to break the stigma.

This film is dedicated in memory of Michelle, and to all of those who live with BPD who save lives by courageously telling their stories, despite facing stigma and struggling to change attitudes. Stigma is often rooted in fear or lack of education. With this film, we hope that by debunking myths through interviews with professionals and people with lived experience, we can change attitudes and ultimately save and improve the lives of people with BPD.

The Misperceptions Addressed in this Film

In this film, we address seven of the most commonly held misperceptions about borderline personality disorder. The video is structured to introduce the myth and then correct the myth with the faces based on updated research and science.

Myth #1: BPD is not a real mental illness (1:01).
Fact: BPD has been in the DSM since 1980 and has reliable diagnostic criteria.

Myth #2: BPD is not a brain disorder like other mental illnesses (3:23).
Fact: BPD is caused in part by malfunctions in the emotion processing centers of the brain.

Myth #3: BPD is not a serious mental illness (5:47).
Fact: BPD is associated with self-harming behaviors, suicide, drug abuse, and poor functioning both vocationally and interpersonally.

Myth #4: Those diagnosed with BPD are attention-seeking and manipulative (7:45).
Fact: People with BPD sometimes utilize unhealthy behaviors to alleviate emotional pain.

Myth #5: BPD is not treatable (10:19).
Fact: There are multiple evidence-based treatments for BPD.

Myth #6: It's better not to tell someone they have BPD (13:15).
Fact: An openly-discussed BPD diagnosis saves lives and promotes recovery.

Myth #7: People with BPD are not able to maintain relationships or commitments (16:45).
Fact: With treatment, people with BPD can lead full, meaningful lives.

Because the 24-minute film is meant to introduce viewers to a cursory overview of misperceptions of BPD, we have created this Video Teaching Guide to provide supplemental material for further education on the topics presented in the film. For further reading, there is also a resources section and bibliography at the end.

Section 1 - Diagnostic Criteria for Borderline Personality Disorder

THE IMPORTANCE OF AN ACCURATE DIAGNOSIS
Frank Yeomans, MD, PhD

The current educational system for mental health professionals does not pay adequate attention to BPD or other personality disorders. One study has shown (Meyerson et al., 2009) that there is an average of a 10-year time gap between a borderline patient's initial presentation for treatment and an accurate diagnosis. The time gap in accurate diagnosis can also lead to tragic deaths --10% of cases of BPD end in suicide (Oldham, 2006; Stone, 1990).

Listed here in summary form are the DSM-5 criteria for proper diagnosis of BPD. The diagnosis of BPD can be made if a person has five or more of these criteria (American Psychiatric Association, 2013). We will also review an alternative model for diagnosing BPD that is included in the DSM-5.

1. Frantic efforts to avoid real or imagined abandonment (not including suicidal or self-

mutilating behavior covered in criterion #5).

2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation. This is called "splitting."
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, promiscuity, substance abuse, reckless driving, binge eating) (not including suicidal or self-mutilating behavior covered in criterion #5).
5. Recurrent suicidal behavior, gestures, threats, or self-mutilating behavior.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

The alternative model for diagnosing BPD that is included in section 3 of the DSM-5 is based on an increasing body of research into the nature of personality disorders (Sharp et al., 2015; Hopwood et al., 2011, Wright et al., 2012). This system emphasizes more the dimensional rather than categorical nature of personality and personality disorders. In other words, it emphasizes that personality traits exist to varying degrees from one individual to another. This alternative model also solves a problem from the more traditional DSM system: many individuals had multiple personality disorder diagnoses because of overlap between the disorders. In the alternative model, personality disorders all involve two core features: 1) difficulties in the sense of self in terms of identity and self-direction in life, and 2) difficulties in empathy and intimacy with others.

Beyond these core features, the different disorders are distinguished by specific personality traits. A diagnosis of BPD is made if the above difficulties regarding self and others are accompanied by 4 or more of the following 7 personality traits: emotional lability, anxiousness, separation insecurity, depressivity, impulsivity, risk-taking, and hostility.

As mentioned above, it is essential for clinicians to conduct an adequate diagnostic screening for BPD and other personality disorders whenever assessing a new patient.

Sections 2 - The Severity of Borderline Personality Disorder

BPD is a Serious Condition

Individuals with BPD experience intense feelings of self-hatred, anger, depression, or anxiety that are often scary, overwhelming and difficult to control. In the midst of intense emotions, individuals with BPD can act impulsively to alleviate emotional pain, self-soothe, or communicate emotional distress.

BPD, Self-Harm and Suicidality

Self-harm and suicidality are common symptoms of BPD. 80% of those hospitalized with BPD have engaged in self-harm, including behaviors such as self-cutting, burning of the skin, self-hitting, self-biting, head banging, scratching, skin carving, and needle sticking. Sometimes, people accidentally inflict more harm upon themselves than they intended. Up to 10% of individuals with BPD lose their lives to suicide.

Functional Impairments

Even with the care given to defining the diagnosis, it is important to note that, like many conditions, BPD can exist at different levels of severity in different individuals. The level of severity has an impact on the ability of the individual to deal with life tasks (work, leisure) and with related human impulses (love, sexuality, interdependence, and aggression.)

Functionally, individuals will BPD suffer with a myriad of difficulties and many experience profound impairment in occupational and social functioning that impedes school and work performance (Cruitt & Oltmanns, 2019; Javaras, et al., 2017; Juurlink, et al., 2018).

Examples of functional impairments associated with BPD, which may vary according to the severity of the individual case, are:

- maintaining regular attendance and structuring time, taking tests
- undergoing performance evaluations
- transitioning between tasks, especially if there are multiple ongoing tasks
- managing expectations and feedback from teachers or supervisors
- advocating for or accessing resources
- communicating with peers, coworkers, teachers, or supervisors
- forming a healthy relationship with social media
- regularly completing self-care, such as grooming and bathing

These are just some of the ways that BPD can influence the functional aspects of a person’s life. Fortunately, there are many accommodations and resources available to help individuals with BPD manage the effects of this condition and continue to live their life happily and productively.

Areas of greater or lesser severity within the range of BPD include: school or work functioning, quality of interpersonal relationships, severity of aggressive feelings/behaviors, and

quality of moral functioning. In addition, BPD patients can differ in terms of whether they tend to internalize their difficulties (e.g., suffer depression and demoralization internally) or externalize their problems (e.g., put their emotions into actions such as self-harm or angry outbursts).

Given the range of severity of BPD: some individuals with the diagnosis function relatively well vocationally but experience internal suffering and difficulty finding satisfying interpersonal relationships, some suffer primarily internally, some engage in "acting out"[1] in dramatic ways, and, at the lowest end of severity, those with antisocial features may engage in dishonest, aggressive, and destructive behaviors. Unfortunately, the latter group of individuals with BPD, the most severe ones, are often those who, as patients, make the strongest impression on others, including health care providers, and thus contribute to creating the stigma around BPD.

Related to the issues of levels of severity is a list of features of BPD that are associated with a worse treatment outcome. They are, in order of importance: level of aggression, antisocial features (dishonesty), secondary gain of illness (receiving unwarranted special treatment because of illness), a very limited range of interpersonal relations, absence of intimate relations, and lack of involvement in life activities (Stone, 1990).

Sections 3 - Factors that Delay an Accurate BPD Diagnosis

There are several factors that delay the accurate diagnosis of BPD including:

- **Psychiatrists' Primary Reliance on Pharmacological Treatments:**
  Psychiatry's current emphasis is on pharmacological treatments in contrast to more complex bio-psychosocial treatments. The field tends to focus more on symptoms than on the person as a whole. Doing the latter can be complicated, but neglecting to do so can lead to unnecessary treatments that can postpone necessary ones. It can also cause harm in terms of side effects or other treatment effects, and possibly lead to a tragic outcome. BPD is the only psychiatric condition for which the official American Psychiatric Association guidelines recommend psychotherapy as the first line of treatment (Oldham, 2001). Clinicians who take BPD patients into their care must know this.

- **The Desire to Make a "Clear Cut" Diagnosis:**
  Unfortunately, when attempting to diagnose the BPD patient, clinicians tend to make a clear cut and straightforward diagnosis, such as depression or anxiety, which in turn leads to pharmacological treatments standard for those conditions. The specialized treatments for BPD (see the section of this text describing those treatments) have been criticized for

[1] **It is important to remember that "acting out" has a specific meaning: to discharge emotions that are difficult to tolerate into actions in a way that may temporarily relieve the individual of the emotion but is not a solution to the problem.**

taking too long and being too costly. However, the investment of resources is highly cost-effective when patients are helped to move from being a chronic patient at risk of death to living a functioning life. The alternative is most often an unending series of non-specific acute treatments that help a patient survive from crisis to crisis.

- **The Stigma Surrounding Personality Disorders:**
  There continues to be a shame associated with personality disorders when compared to other psychiatric disorders. Many people feel the person with a personality disorder is somehow responsible for it; nothing is further from the truth. This misconception – common to clinicians, patients, and families – is something that we must strive to overcome. Many people feel the person with a personality disorder is somehow responsible for it; nothing is farther from the truth.

  The stigma involves at least two factors. One has to do with a misconception that a personality disorder reflects a moral failing of an individual rather than the reality of it being a "purely biological" condition, such as depression or schizophrenia. As discussed above, psychiatric conditions in general are biopsychosocial conditions involving the individual's biological make-up and the interaction of biology and environment. As also noted above, there is an increasing body of evidence describing the role of biological factors in BPD.

  The second factor underlying the stigma has to do with the application of treatments that are not specific to the disorder and that do not address it adequately. Until the advent of specialized treatments, and even now in settings that do not provide them, BPD patients are considered and often referred to as "difficult." However, we now know that within the appropriate treatment setting BPD patients can improve significantly, both in terms of their symptoms, and in the most successful cases, in terms of finding satisfaction in work, leisure activities, and love.

- **Improving Skills in Diagnosing BPD:**
  An early and still valuable effort to focus diagnostic attention on BPD was described in Kernberg's writings about the structural interview (Kernberg, 1986). The field now also offers more programmed diagnostic interviews, such as Gunderson's Diagnostic Interview for Borderlines (DIB) (Kolb & Gunderson, 1980), and Zanarini's revised version of it (Zanarini et al., 1989), and Stern et al's Structured Inventory of Personality Organization (STIPO; Stern et al., 2010). Other options include the Diagnostic Interview for Personality Disorders (DIPD; Zanarini et al., 1996), the Structured Clinical Interview for DSM-5 (SCID-II; First et al., 1994), and the International Personality Disorder Examination (IPDE; Loranger et al., 1997).

Considerations of Differential Diagnosis and Co-morbid Diagnoses

Differential diagnosis involves carefully establishing the correct diagnosis when a person's clinical presentation might connect with different specific disorders. Comorbidity occurs when a person suffers from two or more specific diagnoses. We will briefly discuss each.

Persons with BPD are often misdiagnosed with either depression or bipolar disorder. With regard to people who present with depressive moods, it is important to distinguish between people suffering from a major depressive episode and those suffering from BPD. The former is:

1. characterized by specific neurovegetative signs and symptoms: no appetite, decreased concentration, a pattern of insomnia with early morning awakening, no interest in activities that usually give the person pleasure, no sex drive, and a general slowing of physical and mental functioning ("psychomotor retardation").
2. constant over a period of time, usually weeks, with, in most cases, an eventual remission.

Depression as it is seen in BPD patients who do not have a comorbid major depressive episode does not usually have the neurovegetative signs and symptoms and is more reactive to events in the person's life (e.g., a disappointment provokes depression), but a positive experience can shift the person to a more positive mood. Therefore, the depressed mood is often not as unremitting for weeks at a time as is the case with a major depressive episode.

The diagnostic distinction is important because a major depressive episode is more likely to respond to antidepressant medication or, in the most severe cases, ECT, whereas BPD cannot be treated by medication alone but, because of the interaction between neurobiological emotional reactivity and interpersonal sensitivity, requires one of the treatments developed specifically for BPD.

Bipolar disorder and BPD can be confused because, for those suffering from each condition, life can be like an emotional roller coaster. However, in bipolar disorder, the "mood swings" are sustained for longer periods of time, usually weeks at a time. In BPD, the "mood lability," or rapidly shifting emotions, can occur in the course of a day (sometimes lasting even just a few minutes or hours). The shifts in BPD are, as stated above for depression, more likely to be in reaction to an event that occurred or an interaction with someone else. In addition, a person with bipolar disorder often experiences periods of emotional stability between the depressive and manic episodes. In contrast, the emotional lability of BPD is continuous over time. Another distinguishing feature can be the quality of interpersonal relationships in each illness. A person with bipolar disorder may, during periods of stability, establish in-depth commitments with others that have some stability. In contrast, due to the continuous emotional lability of people

with BPD and their difficulty reading interpersonal cues, relationships tend to be characterized by ongoing storminess with a difficulty establishing deep, stable commitments.

Readers can find more complete discussions of differential diagnosis in articles by Kernberg and Yeomans (2013) and by Paris (2018).

Comorbidity with other illnesses

Many psychiatric patients have more than one diagnosis. It is possible that a person with BPD may also have major depressive episodes, bipolar illness, or other psychiatric conditions (e.g., substance abuse, an eating disorder). In cases of comorbidity, research has shown that attempts to treat major depression or bipolar illness in a person with BPD without treating the BPD itself do not succeed. This is important because many clinicians focus on treating “Axis I” conditions like major depression and bipolar without addressing the BPD (and often without recognizing it). It is likely that many cases of “treatment-resistant depression” involve unrecognized BPD.

Section 4 - Specialized Treatment for Borderline Personality Disorder

BORDERLINE PERSONALITY DISORDER TREATMENT AND ETIOLOGY

Sara R. Masland, Ph.D.

Recent decades have seen significant progress in the development of effective treatments for BPD (for a review of what works in the treatment of BPD, see Choi-Kain et al., 2017). A number of specialized treatments now have significant research support. These include Dialectical Behavior Therapy (DBT; Linehan, 1993), Mentalization-Based Therapy (MBT; Bateman & Fonagy, 1999), and Transference-Focused Psychotherapy (TFP; Yeomans et al., 2015). Lesser studied, but still highly promising specialized treatments include Schema-Focused Therapy (SFT; Giesen-Boo et al., 2006), Cognitive Analytic Therapy (CAT; Ryle et al., 1997), and Systems Training for Emotional Predictability and Problem Solving (STEPPS; Blum et al., 2008).

Dialectical Behavior Therapy (DBT): The development of DBT in the 1990s radically changed the treatment landscape for people with BPD. The treatment has gained wide popularity, and is currently the most well-known and easily accessible of the evidence-based treatments for BPD. DBT focuses on emotion dysregulation as the core driver of BPD symptoms, and seeks to find balance between acceptance (of emotions, the present

moment, etc.) and change. The treatment includes individual therapy (1 hour/week), phone coaching, and group skills training sessions (2 hours/week). Patients keep a diary card to track problematic behaviors and symptoms, and learn specific skills based in cognitive-behavioral and mindfulness techniques. The treatment is highly structured and manualized, and include four primary modules: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. DBT training is available through Behavioral Tech, a corporation established by DBT's founder, Marsha Linehan, and is intended for teams of clinicians, who participate together in a "consultation team."

Mentalization-Based Therapy (MBT): Mentalizing is the capacity to make sense of interpersonal interactions through the nuanced understanding of the mental states of oneself and others. The ability to mentalize develops, in part, in the context of secure early attachment relationships. According to MBT, BPD symptoms arise when mentalization is disrupted or develops in the context of early life adversities. The central goal of MBT is to nurture the capacity to mentalize in the context of the therapeutic relationship. Unlike DBT, MBT does not have a specific structure or manual. Instead, the therapist supports a flexible treatment space in which the patient is encouraged to slow down and remain curious about their own mental states and the mental states of others. Treatment includes one 50-minute session each week, as well as 75 minutes of group therapy. In group practice settings, MBT clinicians participate in a team meeting, where they practice mentalizing in the context of treatment provision.

Transference-Focused Psychotherapy (TFP): This manualized, psychoanalytically-oriented treatment is based on Otto Kernberg's conceptualization of borderline personality organization. A contracting period sets the frame for expectations of the patient and of the therapist. Contracts focus on individual stated problems, goals, and foreseeable obstacles to the treatment's success. Then treatment, which includes twice-weekly individual sessions, involves emotional exploration of the patient's implicit images of both self and others (in the context of the psychotherapeutic relationship). The premise is that the suffering and symptoms associated with BPD are rooted in the patient's lack of a coherent sense of identity. The BPD patient forms extreme mental images of oneself and others that are connected to intense emotional states. The treatment consists of the observation and understanding of these intense mental states as they are "transferred" into the relation with the therapist. TFP focuses on patients' intense feelings of aggression and love, as they learn to verbalize, rather than act out, these feelings. The ultimate goal is to integrate both 'good' and 'bad' aspects of self and others into a healthy and balanced experience.

Schema-Focused Therapy (SFT): As an integrative cognitive therapy, SFT sits at the nexus of psychodynamic and cognitive-behavioral systems. The treatment seeks to

catalyze structural changes to a patient's personality/automatic belief systems, which enable them to react adaptively to new situations. The attachment between patient and therapist is centralized in SFT, and important for the experience of "limited re-parenting." SFT primarily focuses on schemas that are central to BPD, including the detached protector, punitive parent, abandoned/abused child, and angry/impulsive child. Although patients with BPD may have developed these schemas in a way that promoted adaptive function during development, they become maladaptive in adulthood. In twice-weekly individual therapy sessions, SFT seeks to reshape and/or replace these central schemas to promote adaptivity.

Cognitive Analytic Therapy (CAT): CAT integrates psychoanalytic, cognitive, and constructivist theory and technique and is designed to operate within a relatively brief, pre-specified time frame. CAT seeks to formulate and modify dysfunctional procedural systems that patients use to navigate intra- and interpersonal relationships,including the polarization of behaviors and views, negative automatic assumptions, and the abandonment of goal-oriented behavior in the face of obstacles. Although CAT has few specific techniques, and instead allows for the integration of tools from various psychotherapeutic models, therapists and patients work collaboratively to formulate the patient's problems using written accounts (e.g., a reformulation letter) and diagrams (e.g., a sequential diagrammatic reformulation), build awareness of dysfunctional procedures, and support the development of new systems. Therapy focuses on understanding and modifying procedural systems in the context of the whole person, rather than on specific symptoms or behaviors.

Systems Training for Emotional Predictability and Problem Solving (STEPPS): STEPPS was developed as a supplementary or adjunctive treatment, which can be added to other treatment packages. The treatment is brief (2-hour group sessions each week for 20 weeks), and includes skills training, cognitive behavioral techniques, and a systems-level component (families are invited for a single 2-hour psychoeducation and skills training session). More specifically, groups cover psychoeducation, emotion management skills, behavior management skills, and interpersonal effectiveness. Each group session follows a detailed lesson plan.

Section 5 - Generalized Treatments

Specialized treatments hold great promise for people with BPD. However, they are not accessible to many people due to financial concerns and the limited number of practicing clinicians relative to the number of people with BPD (Iliakis et al., 2019). Fortunately, new generalized therapies have the potential to increase treatment accessibility and also have

promising supporting evidence. These include general psychiatric management (GPM; Gunderson, 2014) and structured clinical management (SCM; Bateman & Krawitz, 2016). Additionally, a recent meta-analysis suggests that seeking treatment for BPD is likely to be helpful, even if it is not BPD-specific (Finch et al., 2019). Although BPD-designed treatments are much more likely to be helpful, when they are not accessible, any treatment is likely to be better than no treatment.

General Psychiatric Management (GPM): GPM was designed to increase access to care for people with BPD. For clinicians trained in other modalities, the "common sense" principles of GPM can be learned from brief training. GPM's central goal is to catalyze the natural process of improvement in BPD, and it relies on a case management approach, which focuses on building a life outside of treatment. Some of the central elements of GPM include diagnostic disclosure, psychoeducation, conservative medication management, the importance of "work before love" for building a stable life, the expectation of improvement, and the agreement that treatment will continue only so long as it is helpful in progressing toward collaboratively articulated goals. Interventions and psychoeducation are organized around an interpersonal hypersensitivity model, in which BPD symptoms are understood as arising from interpersonal stressors and the way they are perceived. Generally, GPM includes a once-weekly (or biweekly) individual appointment, and is highly compatible with couples, family, or group therapy.

Structured Clinical Management (SCM): SCM is primarily available in the UK. Like GPM, its use requires little additional training for mental health clinicians. Also similar to GPM, principles include a case management approach with diagnostic disclosure, psychoeducation, and limited reliance on medications. SCM encourages family involvement, includes safety planning, and recognizes the importance of a patient-therapist alliance in which both parties agree on treatment goals and trust one another. In contrast to GPM, SCM is rooted in psychodynamic principles similar to MBT, and allows and encourages significant inter-session contact.

Section 6 - Etiology of Borderline Personality Disorder

Relative to disorders like bipolar disorder and schizophrenia, research on BPD is limited and underfunded. Still, recent decades have provided significant breakthroughs in how we understand the disorder. The causes of BPD are complex. Here, we outline some of the main neurobiological and environmental causes and pathophysiological mechanisms (which may be both cause and consequence of the disorder).

6.1. Heritability and Genetics

Aggregation studies suggest that BPD runs in families. In one study, Gunderson and colleagues (2011) compared the prevalence of BPD in people with relatives who have BPD

to people who do not have BPD in their families. In participants with no BPD relatives, the prevalence was much lower (4.9%) than in relatives of people with BPD (14.1%). The risk of developing BPD was 3-4 times higher for people who have relatives with BPD. However, family aggregation is not enough on its own to understand what is causing BPD, because both environmental and biological factors may contribute to BPD within family systems. Twin studies have offered further insight, by comparing the concordance (match) rates of dizygotic (fraternal) and monozygotic (identical) twins. The concordance rate for monozygotic twins is much higher (35%) than for dizygotic twins (7%), which suggests that genetics are certainly at play (Torgersen et al., 2000).

Overall, heritability estimates for BPD range from approximately 32%-72% (Czajkowski et al., 2018; Kendler et al., 2008; Reichborn-Kjennerud et al., 2015; Torgersen et al., 2008). The best general heritability estimate for BPD is approximately 50% (Skoglund et al., 2019), which is higher than heritability estimates for major depressive disorder (see Flint & Kendler, 2014). This number is somewhat tricky to interpret. It does *not* mean that 50% of BPD is due to genetics, nor does it mean that a person has a 50% chance of inheriting the disorder or of "passing it on." Rather, it means that 50% of the variance in BPD *in the general population* is attributable to genetics, and 50% to the environment. Heritability estimates vary based on how much the environment of a particular study population varies, and cannot be interpreted on the level of the individual. Nevertheless, 50% heritability suggests that genetics play a significant role in BPD's etiology.

What exactly is inherited is somewhat unclear. BPD is certainly not a disorder controlled by a single gene. However, the serotonin transporter gene (5-HTT) has a role in regulating suicide, impulsivity, and emotional lability (Bondy et al., 2000; Frankle et al., 2005; Hoefgen et al., 2005), and is associated with BPD (Maurex et al., 2010; Ni et al., 2006). Other genes may be implicated, including the dopamine transporter gene (DAT1; see Cloninger, 2000; Joyce et al., 2009; Joyce et al., 2014), genes responsible for dopamine production, and receptor genes for oxytocin, including OXTR rs53576 (e.g., Cicchetti et al., 2014; Hammen et al., 2015). Moreover, many of the specific elements of BPD are significantly heritable, including affective instability, neuroticism, anxiety (Jang et al., 1996; Livesley et al., 1993; Lubke et al., 2014), and impulsivity (Goodman et al., 2004).

6.2. Neurobiology

Research linking specific neurotransmitter dysfunction to BPD is currently inconclusive. However, there is strong evidence that several neurotransmitters likely influence the expression of BPD symptoms. For example, low levels of a metabolite of serotonin, hydroxyindoleacetic acid (5-HIAA), are linked to increased impulsive aggression (Coccaro et al., 1989; Goodman et al., 2004) and highly lethal forms of suicide (Asberg, 1997). In monkeys, low 5-HIAA is also linked to alcohol consumption (Suomi, 2003). Moreover, early childhood stressors can alter

serotonin systems in the brain for people with BPD (Rinne et al., 2000). Other neurotransmitters are likely implicated. Norepinephrine is associated with dissociation in BPD (Simeon et al., 2007) and with aggression in men with BPD (Coccaro et al., 2003). Given that antipsychotic medications often offer modest benefits for people with BPD, and that dopamine is associated with impulsivity, cognitive distortions, and emotion processes (Friedel, 2004), further research on dopamine is likely to elucidate associations with BPD.

6.3. Frontolimbic Systems

The limbic system includes a set of brain structures that process emotion and memory. The most well-known of these structures, which are also the most relevant to BPD, include the amygdala and the hippocampus.

There is accumulating evidence that the limbic system functions differently in people with BPD compared to people without BPD. For example, people with BPD have greater activation (Donegan et al., 2003; Herpertz et al., 2001) and more sustained activation (Kamphausen et al., 2013) in the amygdala when exposed to negative emotional information. Importantly, there is also evidence that the way the frontal lobes regulate activation in the amygdala and other limbic systems may be dysregulated (e.g., Brendel et al., 2005; New et al., 2007; Salvador et al., 2014; Schmahl & Bremner, 2006). In other words, people with BPD are more impacted neurobiologically by negative emotional experiences and have greater difficulty regulating their emotional response, also on a neurobiological level. This helps account for difficulties with emotion regulation or affective lability.

People with BPD also have smaller hippocampal and amygdala volume (Driessen et al., 2000; Nunes et al., 2009; O'Neill et al., 2013; Schmahl et al., 2003; Tebartz van Elst et al., 2003). The frontal lobe regions that regulate limbic activity, including the prefrontal cortex, dorsolateral prefrontal cortex, orbitofrontal cortex, and anterior cingulate cortex, may also be smaller in people with BPD (Hazlett et al., 2005; Tebartz van Elst et al., 2003). While volume differences do not necessarily indicate impairment or dysfunction, they do suggest that neurophysiological differences may underlie BPD symptoms. Importantly, diminished volume of the anterior cingulate cortex has been linked to self-harming behavior, fear of abandonment, and impulsivity (Whittle et al., 2009).

Additionally, the orbitofrontal cortex has also been shown to be less metabolically active in people with BPD (Putnam & Silk, 2005). This brain region is implicated in emotion regulation, impulse control (Berlin et al., 2005), and response inhibition (Davidson et al., 2000). More specifically, it seems to be the case that reduced serotonin activity in the orbitofrontal cortex may help explain impulsivity and aggression in BPD (see Hooley & Masland, 2017).

6.4. Hormone Systems

The hypothalamic-pituitary-adrenal (HPA) axis is a distributed system that plays a significant role in stress regulation. Overall, evidence suggests dysfunctional HPA axis activity in BPD (Zimmerman & Choi-Kain, 2009). Because many studies include participants who have both BPD and other disorders characterized by dysregulated stress response, the exact role of the HPA axis in BPD is unknown. However, women with BPD seem to have greater HPA axis reactivity than women without psychopathology, which results in higher cortisol levels (Lieb et al., 2004). This may be more pronounced in people with BPD who have experienced trauma (Rinne et al., 2002), regardless of whether they have comorbid PTSD. What this means is that when people with BPD experience stress, they are less able to regulate its effects on a hormonal level. Greater cortisol response likely reinforces the emotional experience of stress, prolonging and exacerbating negative emotion.

In the past decade, BPD researchers have become interested in the role of oxytocin (OXT), a neuropeptide commonly referred to as "the love hormone" because of its role in attachment and bonding. Although the initial expectation was that administering OXT to people with BPD would have clinical benefits, results have been paradoxical. OXT increases trust and cooperation in people without BPD (Kosfeld et al., 2005; De Dreu, 2012; Keri & Kiss, 2011), but has the opposite effect--worsening trust and difficulties with cooperation--in people with BPD (Bartz et al., 2011; Ebert et al., 2013). This has sparked significant interest in OXT, as well as other neuropeptides including vasopressin. We are likely to see significant insights emerge from research on these neuropeptides in the near future. What we know so far suggests that when attachment systems are activated (as is the case when people with BPD are administered OXT), distrust and other negative emotions may result. This may help account for why people with BPD have difficulty forming stable interpersonal relationships.

6.5. Environment

The most well-known environmental contributor to BPD is the experience of childhood abuse or neglect, which is reported by 20-75% of people with BPD (Herman et al., 1989; Ogata et al., 1990; Salzman et al., 1993). Among people with the most severe forms of BPD, up to 76% report a history of early sexual or physical abuse (Zanarini et al., 2000), and adults who experienced abuse as children are approximately 8 times more likely to develop BPD (Johnson et al., 1999).

It is important to keep in mind that although the experience of childhood abuse or neglect is commonly reported by people with BPD, it is not required for the development of BPD, nor is it sufficient in itself to cause BPD (Bandelow et al., 2005; Fossati et al., 1999). Other environmental influences are certainly at play. Very commonly, there is a "mismatch" between well-intentioned parents and a child who is born with significant emotional vulnerability. Parents and children affect one another reciprocally (Stepp et al., 2014), which means that the stress of parenting emotionally vulnerable children can lead parents to inadvertently alter their parenting

in subtle ways that invalidate or exacerbate negative emotional experiences. This then creates further anxiety or stress for parents, who may again react in ways that are not ideal, and a cycle develops. Emotionally vulnerable children have different needs, and what works for a child without emotional vulnerability may not work well for one who is at risk of developing BPD.

Section 7 - The Longitudinal Course of Borderline Personality Disorder

A number of longitudinal studies of BPD have examined the disorder's course from childhood through adulthood. Two large-scale studies, the Children in the Community (CIC) study (Cohen & Cohen, 1996) and the Pittsburgh Girls Study (PGS; Keenan et al., 2010) have identified how BPD manifests in childhood, its precursors, and its developmental trajectory. Two additional large-scale studies, the McLean Study of Adult Development (MSAD; Zanarini et al., 2005) and the Collaborative Longitudinal Study of Personality (CLPS; Gunderson et al., 2000) have examined the course of BPD in adulthood.

Overall, the results of these studies contradict the notion that BPD is inflexible across time. Symptoms and severity can and do change.

From the childhood studies of BPD, the primary takeaways include 1) early manifestations or precursors of BPD can be identified in childhood and may be appropriate targets for early intervention or prevention; 2) normal maturational processes affect BPD symptoms, which begin in childhood, peak in adolescence, and then decline into adulthood; and 3) children who start off with more BPD symptoms remain at greatest risk and become more extreme relative to their peers over time, indicating the need for early intervention.

Adult longitudinal studies of BPD show that 1) BPD has a high rate of remission, with low rates of relapse, meaning that many people experience improvement and maintain that improvement; 2) despite symptom remission and relapse rates, BPD is a serious illness with significant impairment, medical and psychiatric co-morbidity, and suicide risk; and 3) it is essential for clinicians to recognize and treat BPD.

For a recent review of the longitudinal course of BPD with recommendations for clinicians, see Choi-Kain et al. (2020).

Recovery and Hope

Unlike other mental illnesses, where the symptoms can be fixed and unchangeable, research shows borderline personality disorder symptoms can be flexible and changing over time.

Individuals impacted by BPD, however, self-report varied personal experiences of recovery. Some define recovery as managing symptoms, achieving stability in relationships or work, achieving a life worth living, or symptom remission.

Others struggle with chronic internal or external symptoms of BPD for the duration of their illness, often in combination with other chronic or comorbid health issues. They do not feel recovered, while their symptoms can present differently over time.

Research demonstrates that early diagnosis and treatment intervention when symptoms often emerge during adolescence can help improve outcomes. Family treatment can contain the environment and improves communication to support recovery.

Studies show that access to evidence-based treatment, psychoeducation, and community support can improve overall short-term and long-term outcomes, empowering those with borderline personality disorder to live meaningful, productive lives.

Section 8 - Resources

Finding a BPD Therapist or Treatment

New York-Presbyterian Hospital Borderline Personality Disorder Resource Center**.** 1-888-694. Email: bpdresourcecenter@nyp.org. website: www.nyp.org/bpdresourcecenter The BPDRC maintains the largest database in the world of BPD trained clinicians. You can contact them toll free for referrals and question about BPD resources in your area.

Behavioral Tech**.** Dialectical Behavioral Therapy is a specific BPD treatment developed by Dr. Marsha Linehan. For a list of dialectical behavioral therapy (DBT) therapists, go to www.behavioraltech.org

Information about BPD and Family/Peer Resources

McLean Hospital in Boston, MA offers information about BPD on their website: https://www.mcleanhospital.org/borderline-personality-disorder

The National Educational Alliance houses the world's largest online video library for BPD education and offers the Family Connections Program: www.borderlinepersonalitydisorder.org

Emotions Matter offers peer resources on its website and peer support programs for those with lived experience of BPD: https://emotionsmatterbpd.org

Treatment and Research Advancements for Borderline Personality Disorder provides workshops, educations and referrals for BPD. 1-888-4-TARA APD. www.TARA4BPD.org

Information about Clinical Training in BPD Treatments

For trainings in Dialectical Behavior Therapy (DBT) Behavioral Tech - www.behavioraltech.org

For trainings in Transference-Focused Therapy (TFP) throughout North America TFP-New York: https://www.tfpny.com

For in-depth TFP training: the Columbia Psychoanalytic Center: https://www.psychoanalysis.columbia.edu/train/psychotherapy-programs/transference-focused-psychotherapy-program

For international trainings, the International Society for TFP (ISTFP): https://istfp.org

For Mentalization Based Treatment therapy training in the United States and internationally: The Anna Freud Centre. https://www.annafreud.org/training/mentalization-based-treatment-training/

For General Psychiatric Management therapy training: McLean Hospital. https://home.mcleanhospital.org/ce-gpdi

For STEPPS training, http://www.steppsforbpd.com/

Appendix A - Symptoms of BPD Explained

By Brittany Ferri,OTR/L, CPRP, Kellyann Navarre, BA, and Rosa Nouvini, MD

Chronic Emptiness

Individuals with BPD often report that they feel there is a hole or a void that never goes away. This feeling of emptiness also often contributes to a poor self-image, since it can prevent people from developing confidence and positive self-esteem. It is not uncommon for this emptiness to trigger impulsivity in individuals with BPD, leading them to engage in reckless behaviors to provide a stimulus and rid themselves of the empty feeling. Unfortunately, these behaviors do not fix the emptiness, which may cause individuals to develop a dependence on drugs, alcohol, or other dangerous behaviors in an attempt to numb this feeling.

Unstable Relationships

Because of the intense emotions, frequent mood changes, and tendency to interpret others' actions toward them as negative, individuals with BPD often have unstable, short-lived relationships or ongoing relations marked by conflict. This often presents as:

- Falling in love quickly (also called infatuation or idealization)

- Believing that another person can be perfect, will make you whole, and will eliminate feelings of emptiness
- Black-and-white thinking (either loving or despising the other person in response to the last thing they did)
- Frequent feelings of anger with significant other
- Alternating between extremes of overinvolvement with and withdrawal from other people

Fear of Abandonment

Individuals with BPD often have an intense fear of abandonment and rejection. For many individuals, this fear surrounds the loss of relationships or friendships and the perception of negative criticism from loved ones, supervisors, or teachers, even when it may not be there. But others may experience an intense fear of events they view as a form of abandonment, such as being apart from those they love for even short periods of time. This causes many individuals to behave frantically or erratically to avoid experiencing any type of abandonment or rejection.

- Preoccupation with real and perceived abandonment
- Repeated attempts to contact someone
- Continually begging someone not to leave them
- Hiding or withholding possessions
- Blocking or clinging to another person to prevent them from leaving

Distorted Self-Image

This symptom may be difficult for some people to understand. When put simply, individuals with BPD often do not have a firm, consistent view of themselves. They often lack a clear sense of purpose and direction in their lives. This results in low confidence and an inability to identify or understand what makes them special and unique.

This may appear as:

- Excessive self-criticism
- Difficulty talking about how they feel and how others feel
- Trouble recognizing when to sympathize or apologize to others
- Struggling to remember their own positive qualities (often leading to view themselves as evil or worthless with inconsistent self-esteem)
- Difficulty setting goals and committing to a consistent vision for their life

Impulsivity

This is a hallmark feature of BPD that may cause individuals to engage in some of the following dangerous behaviors:

- Reckless driving
- Gambling
- Excessive spending
- Self-injury (cutting, skin picking, burning, etc.)
- Misuse of drugs and alcohol
- Unsafe sex
- Binge-eating

While suicidality may underlie self-injury in some instances, many people misinterpret all self-injury or drug use as suicide attempts. However, they can also be attempts to numb the emotional pain that individuals with BPD experience.

Non-suicidal Self-Injury

While self-injury can be an act of impulsivity, this behavior can also be planned, deliberate, or habitual in nature. This is called *non-suicidal self-injury.* The root cause of this varies, and can stem from emotional dysregulation, the need to punish oneself, or feelings of abandonment or rejection. Non-suicidal self-injury can include behaviors such as:

- Burning
- Cutting
- Skin-picking or skin-carving
- Scratching
- Punching or hitting
- Biting
- Pinching
- Bone-breaking

When individuals describe episodes of self-injury, many say that they do not realize they have done this until the episode is over. The emotional pain is so tremendous that their mind shuts down until it is completely distracted by physical pain.

Rapid, Intense Mood Swings

Individuals with BPD may report or experience some of the following emotions:

- Boredom
- Anxiety
- Worry

- Depression
- Anger
- Sadness
- Hostility

While these mood swings are intense, they typically last a few hours or days. This sets BPD apart from other forms of mental illness such as bipolar disorder and major depressive disorder, which have longer periods of unstable mood. Moreover, the mood swings in BPD do not include prolonged periods of elevated mood (known as hypomania or mania) since they are usually the result of interpersonal triggers, such as feeling criticized or rejected.

Stress-Related Paranoia & Dissociation

Feelings of anxiety and anger toward others can stem from (or cause) paranoia. Individuals with BPD may question others' motives, a behavior that often worsens with stress and can even result in out-of-body feelings or dissociation. While dissociation can develop from an individual's paranoia, this symptom can also occur on its own. Individuals who are increasingly paranoid may experience:

- Difficulty concentrating
- A lack of connection with reality
- Frequent conflicts, arguments within relationships
- Social isolation
- The feeling of being watched or followed
- Suspicions of other peoples' motives and intentions
- Difficulty working with others at work or school

Appendix B - Emotions Matter Video Discussion Guide
"The Myths and the Facts about Borderline Personality Disorder"

For discussion among community members, classrooms, professionals, or between friends and family.

1. What have you previously learned about BPD, and how was it similar or different from the video? Did the video challenge any myths you may have previously learned?

2. Have you ever witnessed stigma toward people with BPD in the community, classrooms, media or other contexts? How did or can you effectively address it?

3. The first 2 myths discuss BPD biological factors and the assumption that BPD is not "real." Why do you think there are discrepancies between some beliefs and research

about BPD? How do you think people impacted by BPD feel when they sense their condition is not taken seriously?

4. Myth number 3 discusses the severity of BPD, including suicidality, self-harm, and drug abuse. Were you aware of the severity of BPD before watching this video? What could you do if someone you know with BPD might feel suicidal?

5. Myth number 4 states that people with BPD are attention seeking and manipulative. The clinicians address this myth by explaining that people with BPD are really seeking understanding and support, but they need to learn other ways to express emotional pain. How else can we reframe judgmental perceptions of BPD to be more validating and understanding?

6. There are multiple evidence-based treatments for BPD that the video emphasizes in myth number 5. What are some other ways someone with BPD can be supported (e.g., support groups, activities, or validation)? What roles can families, friends, or the community play?

7. Myth number 6 addresses the belief that it is better not to tell someone they have BPD. Why might some clinicians be reluctant to disclose a BPD diagnosis? Do you think stigma or lack of education plays a role? How would you feel if you found out your doctor withheld any diagnosis from you?

8. Institutional ableism is a form of discrimination that operates in systems through structures, practices, and unquestioned beliefs. The video discusses some examples of this, such as the false belief that people with BPD are untreatable. How might these practices and beliefs impact the quality of care people with BPD receive or their access to treatment?

9. There were three lived experience speakers in the video who described how they learned to maintain fulfilling relationships, jobs, and an education. Before this video, were you aware that BPD can be effectively treated with the appropriate care and supports? Did any of the narratives strike you the most and why?

10. How will watching this video change some of your ideas about BPD and your behavior? Was there anything that was surprising? Did it inspire you to do anything differently?

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