

LIVING WITH STIGMA: DEALING WITH THE DIAGNOSIS OF BORDERLINE PERSONALITY DISORDER

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OVERVIEW

Borderline Personality Disorder (BPD) is classified as a “Cluster B” personality disorder (dramatic, emotional, or erratic) in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5). BPD is characterised by intense emotional instability and/or outbursts, chaotic relationships, and impulsivity, among many other possible symptoms. Like other personality disorders, BPD is rarely diagnosed before age 18, as most therapists feel personalities are still considered to be forming before adulthood and do not believe a diagnosis would be accurate, though the validity of this belief has been debated by many other therapists and mental health professionals.

In many cases, therapists often misdiagnose BPD as bipolar disorder, as they share similar symptoms. Sometimes therapists don't realise their patient has BPD and the disorder goes undiagnosed altogether. Other times therapists *do* diagnose BPD, but simply never relay the diagnosis to the patient, as a majority of therapists do not want to deal with a case of BPD. This is usually due to a stigma surrounding the disorder in both the mental health community and the general public, as well as the difficulty and effort required in managing BPD.

In my case, my therapist made a diagnosis and then neglected to tell me for some time. In 2002, at 16, my therapist noticed that I was displaying patterns of behaviour that fell under many of the symptoms for BPD listed in the DSM-IV. She never once said a word to me about it, and, as I learned when I was around 20, only briefly mentioned it to my mother after a session, saying that I was “too young” to fully diagnose just then.

In the meantime, I first learned of the disorder when it was mentioned in my high school psychology class during junior year. Upon further research, I noticed how much of it seemed to describe me. When I brought the possibility up to my therapist in a session later that week, I was deflected away from the topic. Catching on to her reluctance, I dropped the topic for the time being, though I kept it in the back of my mind over the next few years.

Only when I was 19 did my therapist finally confirm the diagnosis for me, and even then she was always unwilling to discuss my disorder, preferring instead to focus on the other issues that had originally brought me to her at 14.

CAUSES & TREATMENT

As I’ve learned over the years of studying the disorder, there is no one particular cause for BPD. Initially, someone with BPD was thought to be in the “borderline” of neurosis and psychosis, hence the eventual name. However, researchers now know that genetic inheritability, brain abnormalities, traumatic childhoods, and other environmental factors can all be contributing factors to developing a borderline personality. Yet research is scarce, still in the earlier stages, and limited by the earlier misunderstandings of the disorder. Unfortunately, this also means there is no easy cure-all for BPD either. BPD cannot be cured, though it can be managed, and for many people the intensity of the symptoms fade as these individuals get older.

The most successful means of management happen when a person with BPD is aware and accepting of their diagnosis, and willing to put in an effort to manage the symptoms and behaviours with an equally willing and skilled therapist. For some people, anti-depressants can help manage the more intense emotions. For others, like myself, going through a variety of meds has no effect. Starting at age 14, I tried five different anti-depressants with little noticeable results before deciding at age 17 that medication was something that just wouldn't help me.

However, regardless of medication, talk therapy is also necessary. General Cognitive Behavioral Therapy (CBT), which I received throughout my years of therapy, is the primary method many therapists have used from the 1960s onward. While CBT works for many mental issues, such as depression and anxiety disorders, it is less effective in managing the emotional dysregulation that BPD causes. CBT largely aims to change the maladaptive thought processes of patients into healthier patterns that will lead to better decision making. In patients with BPD, many of them don't see anything wrong with their thought processes, and so see no reason to change.

However, psychologist and psychology professor Marsha Linehan developed a more effective method of talk therapy called Dialectical Behavioral Therapy (DBT). Linehan specifically designed DBT in the 1970s to help manage BPD. Later, in the early 2000s, she extensively studied the effectiveness of DBT versus CBT on borderline patients in a two-year trial, with the results showing DBT as the more effective therapy. A therapist can use DBT to teach their patients ways to manage and control their emotions, and react in less self-destructive and more appropriate ways to situations, which will help improve both their relationships with others and their quality of life in general.

For me, I realised early on that CBT did very little to help me. While I did eventually realise the problem with my own thought process once I began learning about my disorder, just knowing I was supposed to think “this way” instead of “that way” wasn’t enough, and every time I had a borderline-induced overreaction, I fell right back into my own ways. Understandably, this has made the past ten years of my life quite a struggle. It has only been in the past couple of years—since beginning to learn DBT through some online help sites—that I’ve successfully started to manage my symptoms.

SYMPTOM CHECKLIST & DIAGNOSIS

The DSM-5 lists nine main criteria for BPD, at least any five of which must be met and classified as a “pervasive pattern” to be considered for a diagnosis. Some online sites prefer to group them into “categories” of symptoms, but the DSM-5 itself lists them in no particular order. The symptoms as found in the DSM-5 are:

1. Frantic efforts to avoid real or imagined abandonment.
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
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., substance abuse, binge eating, and reckless driving).
5. Recurrent suicidal behavior, gestures, or 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.

Source: DSM-5

Of course, you can't just look at a list of symptoms and decide that because it sounds like you, you must have borderline personality disorder. Many symptoms of other disorders overlap, and even professionals sometimes can be uncertain of a diagnosis. If you suspect you may have BPD, it is best to find a therapist who specialises in the disorder to either confirm or rule out the diagnosis, as many other therapists, such as my old one, are not overly familiar with BPD or reluctant to treat it.

A therapist who specialises in the disorder can determine if you have BPD by a thorough discussion with you on your symptoms, mental history, and family history of mental illness. Input from your family and friends on your behaviour, if you permit them to give input, may also be beneficial to receiving a diagnosis, because family may more readily notice extreme emotions or reactions that seem normal to you.

LIVING WITH BPD

Looking at the stark list of symptoms up above makes borderline personality disorder seem bad enough, but the reality of living with it is even worse. Living with Borderline Personality Disorder is living with a never-ending stream of intense moods and emotional reactions that are highly disproportionate to the event that caused them. Emotions, both positive and negative, come to those with BPD more deeply and easily than they do to those without it.

Conversely, BPD is also living with a stigma of being seen by the mental health community (and some of the general public who are aware of the disorder) as shallow, emotionless, and manipulative. It's being misunderstood or constantly told you just need to "calm down, it's not a big deal." It's being told you should never be in a relationship or don't deserve love because you're too crazy and others should run far, far away from you. It's going

through therapist after therapist because you're seen as hopeless, untreatable, or a bad person. It's knowing that your emotions are out of control, but somehow you just can't seem to get them in control, no matter how hard you try.

If all of that doesn't sound too bad to you somehow, imagine you're driving down a busy street of traffic and the car next to you suddenly cuts in front of you, causing you to momentarily slam on your brakes so you don't hit the idiot. Your reaction is probably one of mild annoyance, maybe a bit of grumbling, but chances are, five minutes later you've forgotten all about it.

If you had BPD, however, you very likely would have felt a sudden spike of rage that still hadn't dissipated ten minutes later. You might even have started screaming at the car in front of you, regardless of the fact that the driver couldn't hear you. You might have flipped the driver off, or leaned on your horn for a few minutes. If you were impulsive enough, you might have started driving recklessly yourself in an attempt to one-up the other driver because "he made you mad and he deserved it." These reactions sound "crazy" to read, but they wouldn't seem at all an inappropriate reaction to you until long after the event had ended and your rage and impulsiveness had faded enough for you to realise how out of control your reaction was. Now imagine pairing those two symptoms with at least three other symptoms of emotional dysregulation, happening with enough regularity that they are considered a pervasive pattern in your life.

I was diagnosed by meeting seven out of the nine criteria. The only two that I *don't* meet are "identity disturbance" and "impulsivity in at least two areas." So how do these symptoms translate into "real life," at least for me?

One — “Frantic efforts to avoid real or imagined abandonment.”

Those with BPD who suffer from this symptom are terrified of being abandoned. Something as simple as a loved one coming home late from work can set off this terror, and can subsequently trigger all sorts of behaviours—suffocating clinginess, petty jealousy, begging, to name a few—to keep this “abandonment” from happening. In high school, before I was aware of having BPD, I would go through intense bouts of jealousy and fear any time my best friend Serah hung out with someone else. It wasn’t that I didn’t want her to have other friends; instead, it was that I was afraid she’d find them better than me and leave me for them. It was entirely irrational, and of course she never did, but I was incapable of recognising that at the time, and my fears of abandonment led to many fights between us, which also led to the next symptom.

Two — “A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealization and devaluation.”

A borderline person’s life is often filled with chaotic relationships. BPD tends to lead to a “black and white” way of viewing people, also called “splitting.” Relationships with people often seem either perfect, where the other person can do no wrong and you practically place them on a pedestal, or else they seem terrible, where the other person does everything wrong and you have nothing but hate for them. Serah and I first became friends when we were 12 years old, and now, a month shy of 30, I still marvel sometimes at our surviving friendship, for “chaotic” seems too nice of a word to describe our many years as friends.

Three — “Identity disturbance: markedly and persistently unstable self-image or sense of self.”

While this one doesn’t apply to me, many people with BPD often have an uncertain idea of who they are as a person, or what they want out of life. Some feel that they take on the

personas of the people they are around, while others alternate between cycles of loving and hating themselves. Many frequently change their goals for life, or their jobs, or religious beliefs and moral values, or social identity.

Four — “Impulsivity in at least two areas that are potentially self-damaging.”

Yet something else I have little issue with, many of those who are diagnosed as borderline are often recklessly impulsive, seeking the momentary thrill these behaviours bring about as a way to relieve emotional pain. Engaging in unsafe sex, alcohol and/or drug abuse, reckless driving, binge eating, spending sprees, and committing petty crimes such as shoplifting are the most common impulsive behaviours, though by no means all.

Five — “Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour.”

Most borderlines that engage in self-harming behaviour, somewhere between 65-80% (“What Predicts Self-Harm”), do so in a manner known as non-suicidal self-injury (NSSI). This means that they are not looking to commit suicide; rather, the NSSI is done as a way of regulating their emotions, though the exact reasons why vary greatly from person to person. Cutting, scratching, and burning themselves are a few examples of the most common methods self-harmers use. Most of the injuries self-harmers inflict on themselves are minor enough not to require outside medical care, and are usually self-treated.

However, about 9% of borderlines that engage in self-harming behaviour do go on to commit suicide (BPD Demystified), with more attempting suicide but failing, either because they were saved in time or just didn’t commit a serious enough injury to cause death. While I personally have never attempted suicide, I do have my own past scars to tell a story, though thankfully these days I have found healthier ways to cope with distressing emotions.

Six — “Affective instability due to a marked reactivity of mood.”

This is one of the biggest symptoms of BPD. Not only are emotions intense, but they are characterised by rapid cycling that often doesn't last more than a few hours, or occasionally a few days. A non-BPD person may spend the majority of one day happy, with a few minor annoyances or inconveniences here and there. A BPD person may have two hours of bursting to the brim with euphoria followed by three hours of soul-crushing depression followed by an hour of wall-punching rage followed by half an hour of nausea-inducing anxiety, all of which were set off by something minor happening. Alongside the fear of abandonment, I struggle daily with my emotions, fighting against my automatic responses to realise when my reactions to something are too extreme, and not to let the mood swings take over.

Seven — “Chronic feelings of emptiness.”

Many borderlines often complain of constantly feeling empty and/or bored. They describe the feeling as a hole inside them that seems like it can never be filled, no matter what they attempt to fill it with—friends, food, drugs, hobbies, sex. These things may work for a little while, and provide a suitable distraction. But once the food is gone or the high over, that emptiness comes right back. I feel like my own days are often just spent existing in a perpetual state of boredom that I futilely attempt to fill with food, fanfiction, gaming, or Netflix. Unfortunately, food just makes me gain weight, and the other three only work as long as my interest in them holds, which is rarely long enough to get me through a day.

Eight — “Inappropriate, intense anger or difficulty controlling anger.”

I have a temper. I like to hand-wave it away with an excuse of “I'm Italian.” Sure, I'm part Italian. Sure, my heritage probably contributes a bit. But the largest source is inevitably

being borderline. And “temper” is putting it lightly. For many with BPD, like the rest of their emotions, anger when it comes is intense, and sometimes hard to control. It manifests in different ways for different people—some shout and scream, some punch walls or pillows, some just throw whatever comes to hand. Some, like myself, may use all of these methods at different times throughout their life, depending on how angry they are. Many will also often direct that anger towards themselves, because they don’t want to hurt others or because it’s themselves that they’re angry at.

Nine — “Transient, stress-related paranoid ideation or severe dissociative symptoms.”

When I find myself in extremely stressful situations—oftentimes when I’m intensely arguing with Serah or my boyfriend James—a funny thing sometimes happens. I’ll be a foot or two away from them, but suddenly I feel like there’s fifty feet between us. In addition, I also feel like I’m fifty feet away from *myself*. It’s a hard sensation to describe, but it makes the world feel a little less real for a while. This sensation is called derealisation. Derealisation is a form of dissociation, which is common among those with BPD. However, even though it is often a very scary and distressing sensation, it is not permanent, and usually goes away when the source of stress goes away.

However, not everyone with BPD experiences dissociation during stress. Some may fall into “paranoid ideation,” which is just a fancy term for episodes of paranoid thinking and beliefs. Unlike psychotic disorders such as schizophrenia where the paranoia is a long-term delusion, paranoid ideation in BPD patients occurs strictly during times of high stress. Once the stressful incident has ended, the paranoid ideation also ends.

DEALING WITH THE DIAGNOSIS

Living with borderline personality disorder is a daily challenge. Even though I've learned to manage many of the symptoms, it never fully goes away. I have to analyse every emotional reaction I have, and attempt to recognise whether that reaction is disproportionate or appropriate to what caused the reaction. If I get in an argument with James, I have to take twenty minutes afterwards to reassure myself that he's *not* going to abandon me just because I disagreed with him. If Serah does something I don't like that upsets me, I have to quell that initial "I hate you" reaction, and remind myself there *is* a grey area.

It's tough. I don't always succeed. The stigma around BPD especially sucks. There are days when I rage at the unfairness of having such a disorder, and others where I collapse in bed at night feeling defeated because the disorder won that day. Nevertheless, in the end, I always get back up and try again. I refuse to let my BPD beat me.

ABOUT THE AUTHOR

Amanda Young is an undergraduate student and aspiring editor currently working towards a Bachelor's Degree in English with a minor in Sociology at East Tennessee State University. When she's not dealing with the intense emotions caused by her borderline diagnosis, she often enjoys cooking new recipes, writing fanfiction, and playing video games. Originally from Memphis, TN, she now resides in Johnson City, TN, with her boyfriend James and their two cats Max and Smokey.



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