CHAPTER 19

Borderline Personality Disorder

Amanda Siegel was 22 years old when she reluctantly agreed to interrupt her college semester and admit herself for the eighth time to a psychiatric hospital. Her psychologist, Dr. Swenson, and her psychiatrist, Dr. Smythe, believed that neither psychotherapy nor medication was controlling her symptoms and that continuing outpatient treatment would be too risky. Amanda was experiencing brief but terrifying episodes in which she felt that her body was not real. She sometimes reacted by cutting herself with a knife to feel pain, so she would feel real. During the first part of the admission interview at the hospital, Amanda angrily denied that she had done anything self-destructive. The anger dissolved, however, and she was soon in tears as she recounted her fears that she would fail her midterm exams and be expelled from college. The admitting psychiatrist noted that at times Amanda behaved in a flirtatious manner, asking inappropriately personal questions such as whether any of the psychiatrist's girlfriends were in the hospital.

When she arrived at the inpatient psychiatric unit, Amanda once again became angry. She protested loudly, using obscene and abusive language when the nurse searched her luggage for illegal drugs and sharp objects, even though Amanda was very familiar with this routine procedure. These impulsive outbursts of anger were characteristic of Amanda. She would often express anger at an intensity level that was out of proportion to the situation. When she became this angry, she would typically do or say something that she later regretted, such as verbally abusing a close friend or breaking a prized possession. Despite the negative consequences of these actions and Amanda's ensuing guilt and regret, she was unable to stop losing control of her anger. That same day, she filed a "3-day notice," a written statement expressing an intention to leave the hospital within 72 hours. Dr. Swenson told Amanda that if she did not agree to stay voluntarily, he would initiate legal proceedings for her involuntary commitment on the grounds that she was a threat to herself. Two days later, she retracted the 3-day notice, and her anger seemed to subside.

Over the next 2 weeks, Amanda appeared to be doing quite well. Despite some complaints of feeling depressed, she was always well dressed and groomed, in contrast to many of the other patients. Except for occasional episodes when she became verbally abusive and slammed doors, Amanda looked and acted like a staff member. She adopted a "therapist" role with the other patients, listening intently to their problems and suggesting solutions. She would often serve as a spokesperson for the more disgruntled patients, expressing their concerns and complaints to the administrators of the treatment unit. With her therapist's help, Amanda wrote a contract stating that she would not hurt herself and that she would notify staff members if she began to have thoughts of doing so. Because her safety was no longer as big of a concern, she was allowed a number of passes off the unit with other patients and friends.

Amanda became particularly attached to several staff members and arranged one-to-one talks with them as often as possible. She used these talks to flatter and compliment the staff members and tell them that they were one of the few who truly understood her and could help her, and she also complained to them about alleged incompetence and lack of professionalism among other staff members. Some of these staff members Amanda was attached to had trouble confronting her when she broke the rules. For example, when she was late returning from a pass off grounds, it was often overlooked. If she was confronted, especially by someone with whom she felt she had a special relationship, she would feel betrayed and, as if an emotional switch had flipped, would lash out angrily and accuse that person of being "just like the rest of them."

By the end of the third week of hospitalization, Amanda no longer appeared to be in acute distress, and the staff began to plan for her discharge. At about this time, Amanda began to drop hints in her therapy sessions with Dr. Swenson that she had been withholding some kind of secret. Dr. Swenson addressed this issue in therapy and encouraged her to be more open and direct if there was something she needed to talk about. She then revealed that since her second day in the hospital, she had been receiving illegal street drugs from two friends who visited her. Besides occasionally using the drugs herself, Amanda had been giving them to other patients on the unit. This situation was quickly brought to the attention of all the other patients on the unit in a meeting called by Dr. Swenson. During the meeting, Amanda protested that the other patients had forced her to bring them drugs and that she actually had no choice in the matter. Dr. Swenson didn't believe Amanda's explanation and instead thought that Amanda had found it intolerable to be denied approval and found it impossible to say no.

Soon after this meeting, Amanda experienced another episode of feeling as if she were unreal and cut herself a number of times across her wrists with a soda can she had broken in half. The cuts were deep enough to draw blood but were not life threatening. In contrast to previous incidents, she did not try to hide her injuries, and several staff members therefore concluded that Amanda was exaggerating the severity of her problems to avoid discharge from the hospital. The members of the treatment team then met to decide the best course of action.

Not everyone agreed about Amanda's motivation for cutting herself. She was undoubtedly self-destructive and possibly suicidal and, therefore, needed further hospitalization. But she had been sabotaging the treatment of other patients and couldn't be trusted to keep from doing so again. With members of her treatment team split on whether or not Amanda should be allowed to remain in the hospital, designing a coherent treatment program would prove difficult at best.

Social History

Amanda was the older of two daughters born to a suburban middle-class family. She was 2 years old when her sister Megan was born. Amanda's mother and father divorced 4 years later, leaving the children in their mother's custody. The family had significant financial difficulties because Amanda's father provided little child support. He remarried soon afterward and was generally unavailable to his original family. He never remembered the children on birthdays or holidays. When Amanda was 7 years old, her mother began working as a waitress. Neighbors would check in on Amanda and Megan after school, but the children were left largely unattended until their mother returned home from work in the evening. So at a very early age, Amanda assumed a caregiver role toward her younger sister. Over the next few years, Amanda took on a number of household responsibilities, such as regular meal preparation and shopping, which were more appropriate for a teenager. She did not complain about the situation and behaved well at home and in school. However, she remained distressed about the absence of her father. Had she somehow had something to do with the divorce? How much better would her life have been if her father were with her?

When Amanda was 13 years old, her mother married a man she had been dating for about 3 months. The man, Arthur Siegel, had a 16-year-old son named Mike, who joined the household on a somewhat sporadic basis. Mike had been moving back and forth between his parents' houses since their divorce 4 years earlier. His mother had legal custody but could not manage his abusive and aggressive behaviors, so she frequently sent him to live with his father for several weeks or months at a time. Because Amanda still secretly hoped that her parents would remarry, she resented the intrusion of her stepfather and stepbrother into the household and was upset when her mother changed their last name to Siegel. She also resented the loss of some of her caregiving responsibilities, which were now shared with her mother and stepfather.

Soon after her mother and stepfather married, Mike began sexually abusing Amanda. Mike told her that it was important for her to learn about sex and, after raping her, threatened that if she ever told anyone, he would tell all her friends that she was a "slut." When this occurred, she had not been sexually active with anyone. This pattern of abuse continued whenever Mike was living with his father. Even though Amanda was traumatized by the abuse, she felt unable to refuse or to tell anyone what was happening.

Amanda's behavior began to deteriorate. She had been doing very well academically in the seventh grade and then began to skip classes. Her grades fell precipitously over the course of a semester, and she began spending time with peers who were experimenting with alcohol and street drugs. Amanda became a frequent user of these drugs, even though she experienced some frightening symptoms after taking them (e.g., vivid visual hallucinations and strong feelings of paranoia). By the end of the eighth grade, Amanda's grades were so poor and her school attendance so erratic that she was recommended for a psychological evaluation to see if she should be held back for a year. Amanda was given a fairly extensive battery of intelligence, achievement, and projective tests. She was found to be extremely intelligent, with an IQ of 130. Projective test results (Rorschach, Thematic Apperception Test) were interpreted as reflecting a significant degree of underlying anger, which was believed to be contributing to Amanda's behavioral problems. Of more concern was that she gave a number of bizarre and confused responses on the projective tests. For example, when people report what they "see" in the famous Rorschach inkblots, it is usually easy for the tester to share the client's perception. Several of Amanda's responses, however, just didn't match any discernible features of the inkblots. The psychologist, although having no knowledge of Amanda's home life, suspected that her problems may have reflected her difficulties at home and recommended family therapy at a local community mental-health center.

Several months later, Amanda and her mother and sister had their first appointment with a social worker at the mental-health center. Mr. Siegel was distrustful of the prospect of therapy and refused to attend, stating, "No shrink is going to mess with my head!" During the therapy, the social worker first took a detailed family history. She noticed that Amanda was very guarded and was reluctant to share any feelings about or perceptions of the events of her life. The next phase of family therapy was more educational in nature, consisting of teaching Mrs. Siegel more effective methods of discipline and helping Amanda to see the importance of attending school on a regular basis.

Family therapy ended after 3 months with only marginal success. Although Mrs. Siegel had been highly motivated and diligently followed the therapist's suggestions, Amanda remained a reluctant participant in the therapy and was unwilling to open up. She never disclosed the sexual abuse she was experiencing. She felt depressed and guilty, with a very low opinion of herself.

When Amanda was 15 years old, her mother and Mr. Siegel divorced, ending the sexual abuse. When Amanda began high school, she continued her association with the same peer group she had known in junior high. They all regularly abused drugs. Amanda had her first experiences of feeling unreal and dissociated from her surroundings while intoxicated. She felt as though she were ghostlike, that she was transparent and could pass through objects or people.

Amanda also began a pattern of promiscuous sexual activity. She felt guilty for engaging in sex, but, as happened when she was being abused by her stepbrother, she was unable to refuse sexual advances, from either men or women.

She was particularly vulnerable when under the influence of drugs and would, under some circumstances, participate in sadomasochistic sexual activities. For example, Amanda was sometimes physically abused, such as being punched in the face, by her sexual partners while having sex. She didn't protest and, after a while, expected such violence. Sometimes Amanda's sexual partners would ask her to inflict some kind of pain on them during sexual activity, for example, biting during fellatio or digging her nails into her partner's buttocks. Even though these activities left Amanda with a sense of shame and guilt, she felt unable either to set limits or break off these relationships.

By the time Amanda was 16 years old, she never wanted to be alone. She was often bored and depressed, particularly if she had no plans for spending time with anyone else. An important incident occurred at about this time. One night while cruising in a car with friends, they were pulled over by the police because the car had been stolen by one of her friends. Street drugs were also found in the car. Amanda claimed that she had not known that the car was stolen. The judge who heard the case was concerned about the progressive deterioration in Amanda's academic performance and social functioning. Because previous outpatient treatment had failed, he recommended inpatient treatment to help her gain some control over her impulses and prevent future legal and psychological problems. Amanda was being offered a choice between being prosecuted as an accessory to car theft and for possession of illegal substances, or signing into a mental hospital. Reluctantly, she chose the hospitalization.

During this first hospitalization, Amanda's mood swings seemed to intensify. She vacillated between outbursts of anger and feelings of emptiness and depression. She showed signs of depression, such as lack of appetite and insomnia. Antidepressant medication was tried for several weeks but was ineffective. She spent most of her time in the hospital with a male patient. To any observer, their relationship would not have seemed to have a romantic component. They watched TV together, ate together, and played various games that were available on the ward. After only a couple of meetings with him, Amanda had revealed the most intimate details of her life. There was no physical contact or romantic talk. Nonetheless, Amanda idealized him and had fantasies of marrying him. When he was discharged from the hospital and broke off the relationship, Amanda had her first nondrug-induced episode of feeling unreal (derealization) and subsequently cut herself with a kitchen knife in order to feel real. She began making suicide threats over the telephone to the former patient, saying that if he did not take her back, she would kill herself. She was given a short trial of an antipsychotic medication, which was also ineffective.

While in the hospital, Amanda started individual psychotherapy, which was continued after her discharge. The therapy was psychodynamically oriented and focused on helping Amanda to establish a trusting relationship with a caring adult (her therapist). The therapist also attempted to help Amanda understand the intrapsychic conflicts that had started very early in her life. For example, the therapist hypothesized that her biological parents' divorce, and Amanda's idea

that she was somehow responsible for it, led to her fear of being abandoned by people who were important to her. One of the therapist's goals was to show Amanda that he would still be available and would not leave her regardless of how she behaved. It was hoped that this would help Amanda to feel more secure in her interpersonal relationships.

Despite these therapy sessions, which she thought were helpful, Amanda continued to experience problems with drug abuse, promiscuity, depression, feelings of boredom, episodes of intense anger, suicide threats, derealization, and self-injurious behavior, such as cutting herself. Several hospitalizations were required when Amanda's threats and self-injurious behavior became particularly intense or frequent. These were usually precipitated by stressful interpersonal events, such as breaking up with a boyfriend, or discussing emotionally charged issues, such as the sexual abuse by Mike, in psychotherapy. Most of the hospitalizations were relatively brief, lasting 1 to 2 weeks, and Amanda was discharged after the precipitating crisis had been resolved. She received a number of diagnoses during these hospitalizations, including brief psychotic disorder, major depressive episode, atypical anxiety disorder, adjustment disorder with mixed emotional features, substance-use disorder, adjustment disorder with mixed disturbances of emotion and conduct, and borderline personality disorder.

During one of these hospitalizations, Amanda decided that she wanted to change therapists, and after careful consideration, her treatment team decided to grant her request. When Amanda was 19 years old, she was introduced to Dr. Swenson, a psychologist, and began individual behaviorally oriented psychotherapy.

Conceptualization and Treatment

As opposed to Amanda's previous therapist, Dr. Swenson's approach was more focused and directive, concentrating on helping her solve specific problems and behave in ways that would be more personally rewarding. At the same time, Dr. Swenson did not try to force change on her. He was empathic and accepting and gave her the opportunity to identify areas that she wanted to work on. Over a number of sessions, Amanda and Dr. Swenson identified several problem areas: (a) lack of direction or goals, (b) feelings of depression, (c) poor impulse control, and (d) excessive and poorly controlled anger. Specific interventions were designed for each of these areas. Concerning the first problem, Amanda had done so poorly in her schoolwork and was so far behind that going back to high school to graduate was not realistic. Amanda therefore decided to study to take an examination for a General Equivalency Diploma (GED), which would then allow her to pursue further education or job training. Amanda passed the exam after studying for approximately 4 months. This success enhanced her self-esteem because she had never before maintained the self-discipline necessary to accomplish any but the most short-term goals.

Because antidepressants had not helped in the past, her depression was treated with cognitive therapy based on the assumption that people's thoughts can influence their mood. To help Amanda become more aware of the thoughts that might make her more vulnerable to depression, she was asked to keep a written record of her mood three times daily. Next to her mood, she wrote down what she was thinking, particularly those thoughts that involved predictions about how a given situation might turn out. Through this exercise Amanda came to realize that she often made negative predictions about how events would turn out and subsequently felt sad and depressed.

To learn to restructure or "talk back" to these negative thoughts, Amanda was given another exercise. When faced with an anxiety-provoking situation, Amanda was asked to write three different scenarios for the situation: (a) a worst-case scenario in which everything that could go wrong did go wrong, (b) a best-case scenario in which events turned out just as she wanted, and (c) a scenario that she believed was most likely to occur. The actual outcome was then compared with the three different predicted outcomes. More often than not, the actual events were markedly different from either the best-case or worst-case predictions. With time, this exercise helped Amanda control some of her more negative thoughts and replace them with more adaptive and realistic ways of thinking that were based on her own experiences.

One example of the cognitive therapy had to do with Amanda's difficulties keeping a job. She held numerous part-time jobs that lasted for 1 or 2 months before she quit or was fired for not showing up to work. She typically believed that people at work, especially her supervisors, did not like her to begin with and were looking for excuses to fire her. After the smallest of negative interactions with someone at work, she assumed that she was about to be fired and stopped showing up to work, creating a self-fulfilling prophecy. Through monitoring her mood, she came to see that the predominant emotion she experienced in these situations was fear that she would be rejected by either her coworkers or supervisors. To prevent that, she typically rejected them first. After Amanda obtained a part-time job in a supermarket, her therapist had her write out the three scenarios mentioned, prior to actually starting work. Her scenarios were

> [worst case] I'll show up to work and nobody will like me. Nobody will show me how to do my job, and they will probably make fun of me because I'm new there. I'll probably quit after one day.
>
> [best case] This will be a job that I can finally do well. It will be the kind of work I have always wanted, and I'll be promoted quickly and earn a high salary. Everyone at work will like me.
>
> [most likely] I'm new at work, but everyone else was new at one time, too. Some people may like me, and some may not, but that's the way it is with everyone. Some conflict with other people is inevitable. I can

still do my job even if everyone does not like me. One bad day at work does not mean I have to quit.

She was encouraged to rehearse mentally the "most likely" scenario daily, especially when she felt like quitting. This helped her to keep the part-time job in the supermarket for 18 months, substantially longer than she had kept previous jobs.

Amanda had a number of problems with impulsiveness, drug abuse, self-mutilation, promiscuity, and anger. Dr. Swenson convinced her to join Narcotics Anonymous (NA), a nonprofessional self-help group for drug addicts based on the same principles as Alcoholics Anonymous. Whenever she had an impulse to use drugs, she was to use a technique called time delay. This involves a commitment not to use drugs for at least 15 minutes and during that time to engage in an alternative activity. This alternative activity could be telephoning another member of NA for help in controlling the impulse to use drugs. A similar approach was taken with Amanda's self-mutilating behaviors; she was instructed to telephone Dr. Swenson or go to a hospital emergency room if she thought she could not control the impulse on her own. Her anger was problematic because she impulsively acted it out, so this was handled with similar procedures. Dr. Swenson encouraged Amanda to see anger not as a negative emotion but as a positive emotion that becomes destructive only when it is too intense. He then taught her time-delay procedures to help her wait before expressing anger. During the waiting period, the intensity of the emotion declined, and she had an opportunity to think over different ways of dealing with the situation, helping to result in a more appropriate expression of anger.

Amanda made noticeable progress over the first few months of therapy with Dr. Swenson, showing a marked decline in her symptoms. She felt optimistic for the first time in a long while. However, this optimism soon deteriorated in the face of conflicts at home. For example, Amanda did not want to help maintain the household, either financially or by doing work around the house. She insisted that it was her mother's responsibility to take care of her. She also wanted her boyfriends to be able to spend the night with her, which her mother would not allow. Amanda's mother then asked her to move out of the house, but Amanda refused. Instead, she threatened suicide, superficially cut her wrists with a razor blade, and had to be rehospitalized. Amanda followed this same pattern over the next few years, making apparent gains in therapy for a month or so and then falling back in the face of interpersonal conflict. Each time her problems returned, they seemed increasingly stressful for Amanda because she usually came to believe during her periods of relative stability that her problems had been "cured."

When Amanda was 22 years old, she decided to attend college on a full-time basis while living at home. Dr. Swenson was opposed to this because Amanda had not shown enough psychological stability to complete even a semester of college, let alone a degree program. She went to college anyway and soon became sexually involved with another student. As with previous

relationships, Amanda idealized this boyfriend and became dependent on him. She had to be the sole focus of his attention and couldn't tolerate the times when they were apart. After an argument in which Amanda smashed plates and glasses on the floor, her boyfriend left her. Amanda once again became suicidal and self-destructive. This episode led to the hospitalization described at the beginning of this chapter.

Amanda's treatment team at the hospital noted that none of the therapeutic interventions attempted with her (e.g., medication, insight-oriented psychotherapy, behavior therapy) had had any lasting impact. She had a poor employment history and showed little evidence that she would be able to support herself independently in the foreseeable future. It was also feared that she might continue to deteriorate, perhaps winding up in a state hospital on a long-term basis. It was decided that Dr. Swenson needed help in working with her, especially because her symptoms tended to worsen after dealing with difficult issues in therapy. She was referred to a day-treatment program at a local hospital, where she would have regular access to staff members who could provide therapy and support, while living outside the hospital and possibly working part time at an entry-level unskilled job. The treatment team realized that it would require a great deal of work to convince Amanda to accept these recommendations because accepting them would be an admission that she was more seriously disturbed than she cared to admit. Even if she did follow the recommendations, Amanda's prognosis was guarded.

Discussion

As an Axis II diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV-TR*; APA, 2000), *borderline personality* describes a set of inflexible and maladaptive traits that characterize a person's long-term functioning. People with borderline personality disorder (BPD) have instability in relationships, behavior, mood, and self-image (Sanislow, Grilo, & McGlashen, 2000). For example, attitudes and feelings toward others may vary considerably and inexplicably over short periods of time. Emotions are also erratic and can shift abruptly, particularly to anger. People with BPD are likely to experience episodes of rage that are triggered by perceptions that important others are being rejecting or withholding (Berenson, Downey, Rafaeli, Coifman, & Paquin, 2011). A key feature of the disorder is emotional dysregulation, including difficulty understanding, being aware of, and accepting one's emotions; poor strategies for managing one's emotions; and avoidance of situations that elicit emotional distress (Gratz, Rosenthal, Tull, Lejuez, & Gunderson, 2006). They are hypersensitive to negative emotion and focus on their bad feelings, and this exacerbates the intensity of the negative experience and puts them at risk for engaging in some extreme behavior, such as substance abuse or self-injury, to distract them from these feelings (Selby, Anestis, Bender, & Joiner, 2009). Amanda certainly had these difficulties and struggled to cope with and tolerate