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The Mystery of Borderline Personality Disorder

By John Cloud/Seattle

Doctors used to have poetic names for diseases. A physician would speak of consumption because the illness seemed to eat you from within. Now we just use the name of the bacterium that causes the illness: tuberculosis. Psychology, though, remains a profession practiced partly as science and partly as linguistic art.

Because our knowledge of the mind's afflictions remains so limited, psychologists — even when writing in academic publications — still deploy metaphors to understand difficult disorders. And possibly the most difficult of all to fathom — and thus one of the most creatively named — is the mysterious-sounding borderline personality disorder (BPD). University of Washington psychologist Marsha Linehan, one of the world's leading experts on BPD, describes it this way: "Borderline individuals are the psychological equivalent of third-degree-burn patients. They simply have, so to speak, no emotional skin. Even the slightest touch or movement can create immense suffering." ([See the Year in Health, from A to Z.](#))

Borderlines are the patients psychologists fear most. As many as 75% hurt themselves, and approximately 10% commit suicide — an extraordinarily high suicide rate (by comparison, the suicide rate for mood disorders is about 6%). Borderline patients seem to have no internal governor; they are capable of deep love and profound rage almost simultaneously. They are powerfully connected to the people close to them and terrified by the possibility of losing them — yet attack those people so unexpectedly that they often ensure the very abandonment they fear. When they want to hold, they claw instead. Many therapists have no clue how to treat borderlines. And yet diagnosis of the condition appears to be on the rise.

A 2008 study of nearly 35,000 adults in the *Journal of Clinical Psychiatry* found that 5.9% — which would translate into 18 million Americans — had been given a BPD diagnosis. As recently as 2000, the American Psychiatric Association believed that only 2% had BPD. (In contrast, clinicians diagnose bipolar disorder and schizophrenia in about 1% of the population.) BPD has long been regarded as an illness disproportionately affecting women, but the latest research shows no difference in prevalence rates for men and women. Regardless of gender, people in their 20s are at higher risk for BPD than those older or younger.

What defines borderline personality disorder — and makes it so explosive — is the sufferers' inability to calibrate their feelings and behavior. When faced with an event that makes them depressed or angry, they often become inconsolable or enraged. Such problems may be exacerbated by impulsive behaviors: overeating or substance abuse; suicide attempts; intentional self-injury. (The methods of self-harm that borderlines choose can be gruesomely creative. One psychologist told me of a woman who used fingernail clippers to pull off slivers of her

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skin."

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No one knows exactly what causes BPD, but the familiar nature-nurture combination of genetic and environmental misfortune is the likely culprit. Linehan has found that some borderline individuals come from homes where they were abused, some from stifling families in which children were told to go to their room if they had to cry, and some from normal families that buckled under the stress of an economic or health-care crisis and failed to provide kids with adequate validation and emotional coaching. "The child does not learn how to understand, label, regulate or tolerate emotional responses, and instead learns to oscillate between emotional inhibition and extreme emotional lability," Linehan and her colleagues write in a paper to be published in a leading journal, *Psychological Bulletin*.

Those with borderline disorder usually appear as criminals in the media. In the past decade, hundreds of stories in major newspapers have recounted violent crimes committed by those said to have the disorder. A typical example from last year was the lurid tale of an Ontario man labeled borderline who used a screwdriver to gouge out his wife's right eye. (She lived; he got 14 years.)

There are several theories about why the number of borderline diagnoses may be rising. A parsimonious explanation is that because of advances in treating common mood problems like short-term depression, more health-care resources are available to identify difficult disorders like BPD. Another explanation is hopeful: BPD treatment has improved dramatically in the past few years. Until recently, a diagnosis of borderline personality disorder was seen as a "death sentence," as Dr. Kenneth Silk of the University of Michigan wrote in the April 2008 issue of the *American Journal of Psychiatry*. Clinicians often avoided naming the illness and instead told patients they had a less stigmatizing disorder.

Therapeutic advances have changed the landscape. Since 1991, as Dr. Joel Paris points out in his 2008 book, *Treatment of Borderline Personality Disorder*, researchers have conducted at least 17 randomized trials of various psychotherapies for borderline illness, and most have shown encouraging results. According to a big Harvard project called the McLean Study of Adult Development, 88% of those who received a diagnosis of BPD no longer meet the criteria for the disorder a decade after starting treatment. Most show some improvement within a year.

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Still, the rise in borderline diagnoses may illustrate something about our particular historical moment. Culturally

speaking, every age has its signature crack-up illness. In the 1950s, an era of postwar trauma, nuclear fear and the self-medicating three-martini lunch, it was anxiety. (In 1956, 1 in 50 Americans was regularly taking mood-numbing tranquilizers like Miltown — a chemical blunderbuss compared with today's sleep aids and antianxiety meds.) During the '60s and '70s, an age of suspicion and Watergate, schizophrenics of the *One Flew Over the Cuckoo's Nest* sort captured the imagination — mental patients as paranoid heroes. Many mental institutions were emptied at the end of this period. In the '90s, after serotonin-manipulating drugs were released and so many patients were listening to Prozac, thousands of news stories suggested, incorrectly, that the problem of chronic depression had been finally solved. Whether driven by scary headlines, popular movies or just pharmacological faddishness, the decade and the disorder do tend to find each other.

So, is borderline the illness of our age? When so many of us are clawing to keep homes and paychecks, might we have become more sensitized to other kinds of desperation? In a world so uncertain, maybe it's natural to lose one's emotional skin. It's too soon to tell if that's the case, but BPD does have at least one thing in common with the recession. As Dr. Allen Frances, a former chair of the Duke psychiatry department, has written, "Everyone talks about [BPD], but it usually seems that no one knows quite what to do about it."

Inside the Mind

To have coffee with Lily (a pseudonym), you wouldn't get much sense of how she has suffered. She is 40 but could pass for 30. She has blue eyes and long blond hair that falls across her shoulders in slightly curly tendrils. On the December day we met at a diner outside Seattle, she wore a pink wool cap pulled down tight and an Adidas jumper zipped all the way. She was friendly but not terribly expressive, and she carried an aura of self-protection.

At one point in the late '90s, Lily was taking five drugs that doctors had prescribed: three antidepressants, an antianxiety medication and a sleeping pill. Borderline patients are often overmedicated — partly because therapists see them as difficult — but for Lily, as for most borderlines, the meds did little. "Drug treatment for BPD is much less impressive than most people think," Paris writes in *Treatment of Borderline Personality Disorder*.

As a teenager, Lily felt little self-confidence. "Junior high and high school just sucks, right?" she said, laughing. "But I had a propensity to take it a little more seriously." With the help of therapy, she made it through high school and college, but in her late 20s, she became dissatisfied with her job selling specialty equipment. One October day, as she headed out for a mountain-biking trip, she looked at the dun sky and had the feeling that something was wrong. Bleakness massed around her quickly, much faster than it had when she was younger. Soon, nothing gave Lily much joy.

She recalled a talk show in which girls had discussed cutting themselves as a release, a way to relieve depression. "I was so numb," she said. "I just wanted to feel something — anything." So she took a knife from the kitchen and cut deeply into her left arm.

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If Lily had a hard time figuring out what was behind such dark emotions, she was in good company. When a psychoanalyst named Adolph Stern coined the term *borderline* in the 1930s, borderline patients were said to be those between Freud's two big clusters: psychosis and neurosis. Borderlines, Stern wrote rather poetically, exhibit "psychic bleeding — paralysis in the face of crises." Later, in the 1940s, Dr. Helene Deutsch said borderlines experience "inner emptiness, which the patient seeks to remedy by attaching himself or herself to one after another social or religious group." By 1968, when Basic Books published the groundbreaking monograph *The Borderline Syndrome*, the No. 1 characteristic of borderline patients was said to be, simply, anger.

Eventually, borderlines became pretty much anything a therapist said they were. Says Dr. Kenneth Duckworth, medical director of the National Alliance on Mental Illness: "If you hated the patient — if the patient was pissing you off — you would bandy this term about: 'Oh, you're just a borderline.' It was a diagnosis that was a wastebasket of hostility."

It was Linehan who changed all that. In the early 1990s, she became the first researcher to conduct a randomized study on the treatment of borderline personality disorder. The trial — which showed that a treatment she created called "dialectical behavior therapy" significantly reduced borderlines' tendency to hurt themselves as well as the number of days they spent as inpatients — astonished a field that had come to see borderlines as hopeless.

Dialectical behavior therapy is so named because at its heart lies the requirement that both patients and therapists find synthesis in various contradictions, or dialectics. For instance, therapists must accept patients just as they are (angry, confrontational, hurting) within the context of trying to teach them how to change. Patients must end the borderline propensity for black-and-white thinking, while realizing that some behaviors are right and some are simply wrong. "The patient's first dilemma," Linehan wrote in her 558-page masterwork, 1993's *Cognitive-Behavioral Treatment of Borderline Personality Disorder*, "has to do with whom to blame for her predicament. Is she evil, the cause of her own troubles? Or, are other people in the environment or fate to blame? ... Is the patient really vulnerable and unable to control her own behavior ...? Or is she bad, able to control her reactions but unwilling to do so ...? What the borderline individual seems unable to do is to hold both of these contradictory positions in mind."

Linehan's achievement was to realize that borderlines are, in fact, on the border between various dualities — dualities that they have to learn to accept and reconcile in order to change their lives. That's easy to say but seems impossible to do — until you see it work.

A Life Redeemed

After she cut herself, Lily was horrified. In a panic, she called her father, who took her to the hospital. When she was released, she and her parents redoubled their efforts to find her good psychiatric treatment. Through a friend

at the University of Washington, they heard about Linehan and contacted her Behavioral Research & Therapy Clinics, which are housed in a homey little annex on the UW campus, where you might find little foil-wrapped chocolates next to the coffee and tea.

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Linehan, who grew up in Tulsa, Okla., and spent several years as a nun before becoming a psychologist, embodies several dialectical contradictions: a nun who has never lived in a convent; a careful scientist whose most engaging feature is her wry irreverence; a 65-year-old who has a maternal steeliness but was never a mother. It doesn't pay to underestimate Marsha Linehan. In *Cognitive-Behavioral Therapy for Borderline Personality Disorder*, she writes, "If the patient says, 'I am going to kill myself,' the therapist might reply, 'I thought you agreed not to drop out of therapy.' "

In one intense session a few years ago, a patient told Linehan that her work stress was going to lead her to suicide. The patient said Linehan could never understand this stress because she was a successful psychologist. Suicidal borderline patients often confront and alienate therapists in this fashion; for many years, this kind of confrontation was seen as a defining characteristic of the disorder. Linehan believes that borderlines are hurting, not manipulating, but that doesn't mean she indulges them. In this particular confrontation, Linehan responded, "I do understand. I live with a similar amount of stress ... You can just imagine how stressful it is for me to have a patient constantly threatening to kill herself. Both of us have to worry about being fired!"

Such in-your-face tactics were highly controversial when Linehan started out. Other mental-health professionals accused her in public meetings of being heartless, even unethical. But her therapy has saved so many lives and worked so well in randomized trials that few criticize her today. For Lily, who calls Linehan's therapy "Zen philosophy meets tough love," Linehan was the first therapist to understand that managing Lily's illness would require Lily to take a new kind of responsibility — a willingness to grow the emotional skin she never had.

In the beginning, Lily resisted Linehan's assistance. She felt no one could truly understand the depths of her pain. But Linehan was the first therapist who responded to Lily with more than just endless psychoanalysis and pills. Instead, Linehan taught her practical methods of getting by day-to-day. Once, just after she started with Linehan, Lily locked herself in her parents' bathroom and swallowed six or seven antidepressants in a half-hearted suicide attempt. Her father broke the door down; her mother called the police. Lily never lost consciousness, but the cops said she had to go to the hospital anyway. Linehan advised Lily's parents not to accompany her. She also told them they needed to get Lily to work the next day. Lily learned that she wouldn't be cosseted.

Linehan also taught Lily various skills to regulate her emotions. Among the most important is one Linehan calls the "wise mind" — a kind of calm, Zen state that Linehan insists even the most debilitated patients can achieve. "Generally," she writes, "I have patients follow their breath ... and try to let their focus settle into their physical

center, at the bottom of their inhalation. That very centered point is wise mind." Lily remembers this sensation clearly; she came to feel that her dark moods had a physical location in her body — her solar plexus — and when she focused on it, she could deactivate a destructive emotion.

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Another skill Linehan taught Lily (and many others, via a popular DVD called *Opposite Action*) was an anti-anger technique for social situations: "Don't make the situation worse," Linehan counsels on the DVD. "And if possible, be a little tiny bit on the kind side. O.K.?"

If some of this sounds like advice you heard in kindergarten, it should. Remember that borderlines have never learned to regulate their emotions. It's important to note that Linehan doesn't just practice tough love with her patients; she also tells them she knows they are hurting and doing the best they can. She emphasizes that she believes in them even though many therapists have tossed them aside. "Clients cannot fail," she says. "But both treatment and a therapist can fail." Both compassion and irreverence, both validation and tough love — these are the dialectics at the heart of Linehan's approach.

One criticism of Linehan's Zen-derived method is that for some patients, it seems too foreign, too removed from Western experience. Linehan knows her therapy works for most people, but that doesn't mean she's unwilling to list its faults. "It takes too long. There are too many components. It takes too much training for therapists," she says.

Such shortcomings have not dissuaded other therapists from learning Linehan's techniques. Some 10,000 of them have been trained in dialectical behavior therapy, and Linehan, to her dismay, has become something of a cult figure. "Cults in psychology hurt patients," she says. "People should try whatever works, not my therapy because it has my name on it."

Lily, for one, is glad that it's the therapy she did try. One of her favorite films used to be James Mangold's 1999 adaptation of *Girl, Interrupted*, in which Winona Ryder plays a real-life borderline author. When Ryder's character learns she has received a diagnosis of borderline personality disorder, she indignantly asks, "Borderline between *what* and *what*?" It's a question that weighed on Lily for years and one that many of us may start asking if borderline diagnoses continue to increase. But today Lily is able to laugh about the film because she knows, finally, that the answer doesn't really matter. The key is not defining that uncertain borderline but learning to be happy there.

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