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# A STUDY OF BORDERLINE PERSONALITY DISORDER DISPOSITION AND AGGRESSION AMONG STUDENTS

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## Abstract

*An individual with Borderline Personality Disorder disposition has has extreme difficulties regulating their emotions and Aggression, a range behaviors that can result in both physical and psychological harm to oneself, other or objects in the environment, thatcan occur in a number of ways including verbally, mentally and physically. This trait is also directly related to aggression too. In the present study, an attempt was madae to study the relationship between these two variables. For this, a sample size of approximately 120 females of two age groups i.e., below 18 years and above 18 years was taken and given two scales related to the variable being measured .i.e to understand the role of aggression in people with high or low borderline personality disorder tendencies. The results show that the adults (above 18 years) with high aggression show no such tendencies to borderline personality disorder but, the youth (below 18 years) does show a significant range of tendencies to borderline personality disorder at high aggression levels. As per the hypothesis, females below 18 years have borderline personality disorder tendencies when there is high aggression. The implications for the same in parents and teachers are discussed.*

**Keyword:** *Borderline personality disposition, aggression, adolescents.*

## Introduction

The term aggression refers to a range of behaviors that can result in both physical and psychological harm to oneself, other or objects in the environment. This type of social interaction centers on harming another person, either physically or mentally. The expression of aggression can occur in a number of ways including verbally, mentally and physically. Psychologists distinguish between different forms of aggression, different purposes of aggression and different types of aggression. Aggression can be either physical or verbal, and behavior is classified as aggression even if it does not actually succeed in causing harm or pain.

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Behavior that accidentally causes harm or pain is not aggression. Property damage and other destructive behavior may also fall under the definition of aggression. Aggression is not the same thing as assertiveness. Aggression is a perplexing phenomenon.

Moyer (1976) argues that aggression may be no more than verbal or symbolic, but violence denotes "a form of human aggression that involves inflicting physical damage on persons or property."

The area from which all emotion originates is the brain. While scientists continue to test various areas of the brain for their effects on aggression, two areas that directly regulate or affect aggression have been found. The amygdala has been shown to be an area that causes aggression. Stimulation of the amygdala results in augmented aggressive behavior, while lesions of this area greatly reduce one's competitive drive and aggression. Another area, the hypothalamus, is believed to serve a regulatory role in aggression. The hypothalamus has been shown to cause aggressive behavior when electrically stimulated but more importantly has receptors that help determine aggression levels based on their interactions with the neurotransmitters serotonin and vasopressin.

Humanistic psychologists have made this distinction by classing aggression as:

Natural or positive aggression which is aimed largely at self-defense, combating prejudice or social injustice, or

Pathological aggression which results when an individual's inner nature has become twisted or frustrated.

## CAUSES OF AGGRESSION

Genetic: While the exact mechanism through which this behavior is passed down in unknown, unless there is concordance for a specific disorder, it has been recognized that those with first degree relatives who have aggressive behavior problems are more likely to develop them than those without a similar family history.

The Brain-Behavior Connection – Aggressive behavior is elicited when anger- inciting experiences are encountered, and the frontal lobes process this information. The frontal lobes are associated with functions such as impulse controls, behavioral inhibition, reasoning and decision making. If there is frontal-lobe damage aggressive behavior may result.

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Modeling – When children grow up in a home where aggression is a common expression of distress or impulsive reaction to misinterpretations, imagined slights or exaggerations of real circumstance they mimic this behavior pattern until it is internalized.

Other Disorders – In addition to the previously listed disorders, there are additional conditions which can lead to aggression including brain tumors and closed head injuries. Some of these disorders may include bipolar disorder, conduct disorder, schizophrenia, and ADHD.

Life Threatening Causes of Aggression – Since there are dangerous causes of aggression, any sudden behavior changes which include this symptoms should be evaluated immediately. Specific conditions include hypoglycemia acute delirium, mania, meningitis, stroke, alcohol or drug overdose or withdrawal or traumatic brain injury.

## SIGNS AND SYMPTOMS

Aggression may associated with other symptoms that are determined by the underlying disorder or illness. Ailments that influence behavior often also have psychological, cognitive, and physical symptoms. Some additional signs and symptoms may include:

- Anxiety
- Moodiness
- Agitation
- Disorientation or memory problems
- Depression or flat affect
- Trouble with concentration and attention
- Trouble thinking in an organized manner,
- Poor communication skills due to overt negative affect
- Trouble with language comprehension, writing or reading
- Hallucinations
- Delusions
- Hyper-arousal or acute awareness of the environment
- Personality fluctuations
- Impaired judgment and decision making
- Insomnia
- Social withdrawal
- Being a danger to yourself or others
- Threatening behavior

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- Alterations in mental status
- Confusion, disorientation, delirium, lethargy,
- Trauma, such as bone deformity, burns, scar tissue, eye or ear damage and other injuries.

## BORDERLINE PERSONALITY DISORDER

Borderline personality disorder is a disorder where individuals have extreme difficulties regulating their emotions. Problems include intense anger, chaotic relationships, impulsivity, unstable sense of self, suicide attempts, self-harm, shame, fears of abandonment, and chronic feelings of emptiness.Borderline personality disorder is a mental health disorder that impacts the way you think and feel about yourself and others, causing problems functioning in everyday life. It includes a pattern of unstable intense relationships, distorted self-image, extreme emotions and impulsiveness. With borderline personality disorder, one has an intense fear of abandonment or instability, and one may have difficulty tolerating being alone. Yet inappropriate anger, impulsiveness and frequent mood swings may push others away, even though you want to have loving and lasting relationships.

Historically, the term "borderline" has been the subject of much debate. BPD used to be considered on the "borderline" between psychosis and neurosis. The name stuck, even though it doesn't describe the condition very well and, in fact, may be more harmful than helpful. The term "borderline" also has a history of misuse and prejudice—BPD is a clinical diagnosis, not a judgment.

Borderline personality disorder usually begins by early adulthood. The condition seems to be worse in young adulthood and may gradually get better with age.

## SIGNS AND SYMPTOMS

- An intense fear of abandonment, even going to extreme measures to avoid real or imagined separation or rejection
- A pattern of unstable intense relationships, such as idealizing someone one moment and then suddenly believing the person doesn't care enough or is cruel
- Rapid changes in self-identity and self-image that include shifting goals and values, and seeing yourself as bad or as if you don't exist at all
- Periods of stress-related paranoia and loss of contact with reality, lasting from a few minutes to a few hours

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- Impulsive and risky behavior, such as gambling, reckless driving, unsafe sex, spending sprees, binge eating or drug abuse, or sabotaging success by suddenly quitting a good job or ending a positive relationship
- Suicidal threats or behavior or self-injury, often in response to fear of separation or rejection
- Wide mood swings lasting from a few hours to a few days, which can include intense happiness, irritability, shame or anxiety
- Ongoing feelings of emptiness
- Inappropriate, intense anger, such as frequently losing your temper, being sarcastic or bitter, or having physical fights

## CAUSES OF BORDERLINE PERSONALITY DISORDER

Research on the causes and risk factors for BPD is still in its early stages. However, scientists generally agree that genetic and environmental influences are likely to be involved. Imaging studies in people with BPD have shown abnormalities in brain structure and function, evidence that biology is a factor. In people with BPD, more activity than usual has been seen in the parts of the brain that control feeling and expressing emotions. Certain events during childhood may also play a role in the development of the disorder, such as those involving emotional, physical and sexual abuse. Loss, neglect and bullying may also contribute. The current theory is that some people are more likely to develop BPD due to their biology or genetics and harmful childhood experiences can further increase the risk.

As with other mental disorders, the causes of borderline personality disorder aren't fully understood. In addition to environmental factors — such as a history of child abuse or neglect — borderline personality disorder may be linked to:

Genetics: Some studies of twins and families suggest that personality disorders may be inherited or strongly associated with other mental disorders among family members.

Brain abnormalities: Some research has shown changes in certain areas of the brain involved in emotion regulation, impulsivity and aggression. In addition, certain brain chemicals that help regulate mood, such as serotonin, may not function properly.

Hereditary predisposition: You may be at a higher risk if a close relative — your mother, father, brother or sister — has the same or a similar disorder.

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Stressful childhood: Many people with the disorder report being sexually or physically abused or neglected during childhood. Some people have lost or were separated from a parent or close caregiver when they were young or had parents or caregivers with substance misuse or other mental health issues. Others have been exposed to hostile conflict and unstable family relationships.

Personality: Personality traits that include impulsiveness and aggression may play a role in the development of borderline personality disorder.

## REVIEW OF LITERATURE

Recent neuroimaging studies show differences in brain structure and function between people with BPD and people who do not have this illness. Some research suggests that brain areas involved in emotional responses become overactive in people with BPD when they perform tasks that they see as negative. People with the disorder also show less activity in areas of the brain that help control emotions and aggressive impulses and allow people to understand the context of a situation. These findings may help explain the unstable and sometimes explosive moods seen in BPD.

Another study showed that, when looking at emotionally negative pictures, people with BPD used different areas of the brain than people without the disorder. Those with the illness tended to use brain areas related to reflexive actions and alertness, which may explain the tendency to act impulsively on emotional cues.

Wagner S.et al. (2009) found various interesting things in his study while modulating effects of BDNF (brain-derived neurotrophic factor) Val66Met polymorphism on the effects of physical maltreatment, rape and childhood sexual abuse on impulsive aggression where theChildhood sexual abuse accounted for 23.6% ofthe variance of BDHI sum score that increases the frequency of adult violent suicide attempts.

Critchfield et al. (2004) documented in the context of aggression in borderline personality disordershow significant association between more fearful forms of attachment (simultaneous presence of relationship anxiety and avoidance) and the more reactive form of aggression involving expectation of hostility from others.Self-harm was significantly associated only with relational avoidance while anger and irritability were associated only with relational anxiety.

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Goodman and New (2000) in his study said that Impulsive aggressive behaviors that include physical aggression directed towards others, self-mutilation, suicide attempts, domestic violence, substance abuse, and property destruction account for a substantial portion of the morbidity and mortality associated with personality disorders, in particular borderline personality disorder (BPD)..

Doughertya M. Donald et al. (1999) in their study with aggressive and impulsive behavior of 14 hospitalized women with borderline personality disorder (BPD) was compared with that of 17 controls.In an impulsivity task, subjects experienced two sets of 50 trials during which they could choose a smaller, immediate monetary reward or a larger but progressively delayed reward. In a separate task (PSAP), subjects earned monetary reinforcers with repeated button presses, and were provoked by the subtraction of money which was blamed on a fictitious other participant.Aggressive responding rates were correlated positively with BDHI scores and the results extend previous findings that negative affect in women is reflected in laboratory behavioral measures.

Rocco Paola et al. (2002) in their study took fifteen BPD outpatients with prominent histories of aggressive behavior were included in an 8-week open-label study with risperidone at low-to-moderate doses.Evaluations were carried out at baseline and at the end of the treatment. Thirteen patients completed the trial; 2 patients dropped out because of lack of compliance. Final mean dose of risperidone was 3.27 mg/day. There was significant (p=.0057) reduction in aggression based on Aggression Questionnaire scores. The amelioration was coupled with an overall improvement, including a reduction in depressive symptoms and an increase in energy and global functioning.Risperidone at low-to-moderate doses can improve BPD symptomatology. Further studies are needed to explore the efficacy of risperidone versus placebo as well as in comparison to other potential treatments for BPD.

Latalova and Prasko (2010) examined aggressive behavior in Borderline Personality Disorder (BPD) and its management in adults.Aggression against self or against others is a core component of BPD. Impulsiveness is a clinical hallmark (as well as a DSM-IV-TR diagnostic criterion) of BPD, and aggressive acts by BPD patients are largely of the impulsive type.Recent studies indicate that many medications, particularly atypical antipsychotics and anticonvulsants, may reduce impulsivity, affective lability as well as irritability and aggressive behavior. But there is still a lack of large, double blind, placebo controlled studies in this area.

Carl Salzman et al. (1995) examined the effect of fluoxetine on anger in symptomatic volunteers with Borderline Personality Disorder, and the clinical data and uncontrolled observations have suggested that fluoxetine is helpful in some patients with borderline

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personality disorder. A 13-week double-blind study of volunteer subjects with mild to moderately severe borderline personality disorder. Thirteen fluoxetine recipients and nine placebo recipients received treatment. Pretreatment and posttreatment measures were obtained for global mood and functioning, anger, and depression therefore, found a clinically and statistically significant decrease in anger among the fluoxetine recipients. This decrease was independent of changes in depression. This data supports that fluoxetine may reduce anger in patients with borderline personality disorder. The number of subjects were small, the placebo responsiveness was high, and the clinical characteristics of the patients were in the mild to moderate range of severity. The data cannot be extrapolated to more severely ill borderline patients, but later fluoxetine and other selective serotonin reuptake inhibitors is indicated in this population

McCloskeya Michael et al. (2009) said Borderline personality disorder (BPD) is marked by aggression and impulsive, often self-destructive behavior. Despite the severe risks associated with BPD, relatively little is known about the disorder's etiology.Identification of genetic correlates (endophenotypes) of BPD would improve the prospects of targeted interventions for more homogeneous subsets of borderline patients characterized by specific genetic vulnerabilities. Resulted that BPD subjects demonstrated more aggression and motor impulsivity than HV (but not OPD) subjects on behavioral tasks. In contrast, BPD subjects self-reported more impulsivity and aggression than either comparison group. Subsequent analyses showed that among BPD subjects behavioral aggression was associated with self-reported aggression, while behavioral and self-report impulsivity measures were more modestly associated. And results provide partial support for the use of behavioral measures of aggression and motor impulsivity as endophenotypes for BPD, with stronger support for behavioral aggression measures as an endophenotype for aggression within BPD samples.

Gurvits Irene et al. (2000) concluded that Borderline personality disorder (BPD) is a severe personality disorder characterized by potentially self-damaging impulsivity, inappropriate or uncontrolled anger, recurrent suicidal threats or gestures, physically self-damaging acts, and disturbances in identity and interpersonal relations. It is associated with high levels of distress, significant impairment in social and occupational functioning, and a 10% lifetime risk for suicide. Approximately 2% of the population meets criteria for BPD. It is more often diagnosed in women and is more widespread among first-degree relatives of those with the disorder.

BPD and the other personality disorders have traditionally been understood in the context of psychodynamic, psychosocial, or behavioral approaches. Research over the past 2 decades has demonstrated the significance of biological factors and traumatic early life experiences that may

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have long-lasting biological sequelae. BPD is one of several disorders associated with a history of childhood physical or sexual trauma.25, 31 and 69 Also, several neurobiological correlates of BPD have been identified. Two potentially biologically mediated traits may contribute to BPD— affective instability and impulsive aggression. Although some studies have shown that BPD runs in families,47 twin studies suggest that BPD per se is not inherited, but its components, impulsive aggression and affective instability, are partially heritable.77 Evidence from neurochemical assays, receptor-density studies, neuroendocrine-challenge paradigms, functional neuroimaging studies, and candidate-gene studies have converged to identify several neurotransmitter systems that may be associated with the neurobiology of BPD. They examine the neurotransmitter systems associated with impulsive aggression and affective instability of BPD.

Impulsive aggression in patients with BPD is characterized by self-destructive acts, including suicidal and parasuicidal behavior, and outwardly directed aggression. Affective instability is defined by DSM-IV as "intense episodic dysphoria, irritability, or anxiety, usually lasting a few hours and only rarely more than a few days." 1a Psychosocial cues, most typically frustrations, humiliations, losses, separations, and rejections, often trigger the affect swings in BPD. It may be useful to look separately at two components of affective instability, one encompassing the lability of affect, and the other, the reactivity to environmental cues. Affective instability may interfere with the ability to develop a stable perception of self or others and may result in difficulty in maintaining self-esteem. An interaction may exist between affective instability and poor impulse control, in which intense affective storms trigger impulsive behavior.

## OBJECTIVE

To understand the relationship between aggression and borderline personality disorder disposition between two age groups of females i.e., below 18 years and above 18 years.

## HYPOTHESIS

- High aggression in females of age group below 18 years will have Borderline Personality Disorder or high tendency of Borderline Personality Disorder.
- High aggression in females of age group above 18 years will have Borderline Personality Disorder or high tendency of Borderline Personality Disorder.

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## SAMPLE

The subjects were taken from primary and senior secondary schools, school teachers, and housewives for age groups below 18 years and above 18 years respectively.

The sample size consists of 122 subjects in the study i.e., 61 subjects of below 18 years and 61 subjects of above 18 years.

## TOOLS

McLean Screening Instrument – Borderline Personality Disorder (MSI-BPD): A commonly used 10-item measure to screen for BPD.

Aggression Questionnaire: A new questionnaire on aggression measuring it and that yields four scales – physical aggression, verbal aggression, anger and hostility.

## PROCEDURE

- The participants of the study were chosen on the basis of certain factors that are age and gender.
- The children were taken from primary and secondary schools for sample of age range below 18 years, and females from house hold and some college students for sample of age range above 18 years.
- Then an interview was conducted with the subjects to build a rapport and take their consent for filling the questionnaires.
- Before, making them fill the questionnaires they were informed about both the questionnaires.
- Then they were told about the aim of the research that involves subject's co-operation and most genuine responses.
- After the subjects have filled the questionnaires they were given their results and interpretationof the result through email (the ones who wanted their results).
- All these people who participated were thanked for their co-operation and support.

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**RESULTS**

The results are shown in the following tables below:

TABLE 1 –

Shows the correlation between aggression and borderline personality disorder in youth and adult

Correlations

| | | aggyouth | bpdyouth | aggadult | Bpdadult |
|---|---|---|---|---|---|
| Aggyouth | Pearson Correlation | 1 | .277* | -.102 | -.208 |
| | Sig. (2-tailed) | | .047 | .474 | .138 |
| | N | 61 | 61 | 52 | 52 |
| Bpdyouth | Pearson Correlation | .277* | 1 | -.087 | -.123 |
| | Sig. (2-tailed) | .047 | | .541 | .385 |
| | N | 61 | 61 | 61 | 61 |
| Aggadult | Pearson Correlation | -.102 | -.087 | 1 | .166 |
| | Sig. (2-tailed) | .474 | .541 | | .240 |
| | N | 61 | 61 | 61 | 61 |
| Bpdadult | Pearson Correlation | -.208 | -.123 | .166 | 1 |
| | Sig. (2-tailed) | .138 | .385 | .240 | |
| | N | 61 | 61 | 61 | 61 |

*. Correlation is significant at the 0.05 level (2-tailed).

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TABLE 2 -

Shows the comparison between youth and adult in aggression

Group Statistics

| | aggyouth | N | Mean | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|---|
| aggadult | 1 | 61 | 3.7213 | .66159 | .08471 |
| | 2 | 61 | 3.0820 | 1.03755 | .13284 |

TABLE 3 –

Shows the t-test results for the comparison of aggression in youth and adult

Independent Samples Test

| | | Levene's Test for Equality of Variances | | t-test for Equality of Means | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | F | Sig. | t | df | Sig. (2-tailed) | Mean Difference | Std. Error Difference | 95% Confidence Interval of the Difference | |
| | | | | | | | | | Lower | Upper |
| aggadult | Equal variances assumed | 3.913 | .050 | 4.058 | 120 | .000 | .63934 | .15755 | .32740 | .95129 |
| | Equal variances not assumed | | | 4.058 | 101.870 | .000 | .63934 | .15755 | .32683 | .95186 |

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TABLE 4 –

Shows the comparison between borderline personality disorder youth and adult

Group Statistics

| | bpdyouth | N | Mean | Std. Deviation | Std. Error Mean |
|---|---|---|---|---|---|
| bpdadult | 1 | 61 | 1.1639 | .37329 | .04779 |
| | 2 | 61 | 1.1475 | .35759 | .04578 |

TABLE 5 –

Shows the t – test table for the comparison between borderline personality disorder youth (below 18) and adult (above 18)

Independent Samples Test

| | | Levene's Test for Equality of Variances | | t-test for Equality of Means | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | 95% Confidence Interval of the Difference | |
| | | F | Sig. | t | df | Sig. (2-tailed) | Mean Difference | Std. Error Difference | Lower | Upper |
| bpdadult | Equal variances assumed | .246 | .621 | .248 | 120 | .805 | .01639 | .06619 | -.11465 | .14744 |
| | Equal variances not assumed | | | .248 | 119.779 | .805 | .01639 | .06619 | -.11465 | .14744 |

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**DISCUSSIONS**

The results of the research through these tables above show that:

- The youth (below 18 years) responses to the questionnaires and their interpretations and further correlations and t – test conclude that the youth with high aggression might have or have high BPD tendencies. As depicted in the correlations at TABLE 1 (by the star at .277 in the table). Which is significant at the 0.05 level.

- But no such interpretation or result takes place for adult (above 18 years) that conclude that high aggression in adults night lead to high BPD tendencies.

- Therefore, one hypothesis is proved and the other is not.

- However, the comparison tables that are TABLES 2, 3, 4, and 5.

- Tables 2 and 3 show comparison between aggression in youth and borderline personality disorder that concludes to be significant at 99%.

- Tables 4 and 5 show the comparison between BPD youth and adultsthat concludes not to be significant at any level.

These results have the following implications for the individual, parents and teachers which are discussed herein.

**IMPLICATIONS** – What needs to be done and what parents and teachers must know.

Counselling is practised with persons with borderline, mild and moderate disability. To the extent that counselling includes various behavioural methods such as relaxation training, problem-solving and anger-management skills, it is possible that counselling

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may be effective. However, there is no evidence that either non-directive or supportive counselling methods are effective in treating aggression with this population. Counselling methods are almost always contraindicated with persons with moderate through to profound intellectual disability.

Cognitive therapies

In cognitive therapy the therapist hopes to improve behaviour by changing the client's beliefs and perceptions of the world.

Sensory-integration therapies

Sensory-integration therapy (SIT) is based on the hypothesis that challenging behaviours, such as aggression, are due to lack of adequate sensory stimulation in persons with intellectual disabilities. Recently, a meta-analysis of SIT studies was published that found little evidence of its effectiveness. Indeed, there is evidence that in some cases SIT may increase challenging behaviours. Thus, SIT has been evaluated relatively well, but the results indicate that it is not effective.

Anticonvulsants

Some antiseizure medications, such as carbamazapine and valproate, are sometimes used as mood stabilisers in persons with aggression. Under clinical indications there is no discussion of these medications and aggression. Moreover, there have been no methodologically adequate studies of aggression in this population.

Anxiolytic and sedative medication

Benzodiazepines have been shown to be effective in reducing anxiety in persons with anger issues. It is therefore possible that, when aggression is mediated by anxiety or when aggression functions to reduce anxiety, benzodiazepines may be appropriate. However, it is important to balance the benefits against the potential problems of sedation and tolerance to benzodiazepines. There is little support for the use of antihistamines to manage acting-out or hyperactive behaviour. There has been one controlled study of buspirone. This study found reductions in aggression and self-injury, but not anxiety, in five out of six cases. Reductions ranged from 26% to 63% of baseline rates of aggression. In one uncontrolled study, similar results were found. Some authors have concluded that the use of buspirone for aggression appears to be promising. However, this tentative conclusion is based on relatively few studies with this population.

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Neuroleptic medications

There have been a few studies of the use of chlorpromazine and haloperidol for aggression. These indicate that decreases in aggression in children with hyperactivity or conduct disorders may occur. Of three studies that have used sound methods, one showed an increase, one a decrease and one no effect on aggression.

Staff and parent training

Since aggression is mediated by the behaviour of other people, behaviouralinterventions require that the people around the client change their behaviour. Unfortunately, part of the challenge is that the client has enormously powerful consequences for these people. The client'sbehaviour may powerfully shape counter-habilitative practices in staff, such as not placing demands on the client wherever possible. There has been extensive research on staff and parent training. Generally, verbal training, reading and courses alone may lead to improvements in knowledge. However, such an approach does not lead to improvements in skills orimplementation of recommended interventions. To change staff and parentbehaviour, direct training using brief instruction, modelling, rehearsal to masterycriterion and feedback may lead to the initial acquisition of the skills. After initial training, considerable effort is needed to ensure maintenance of staff and parent behaviour. The most effective format for this is through direct observation of implementation, feedback on performance and periodic retraining.

Borderline Personality Disorder

Treatments

BPD is often viewed as difficult to treat. However, recent research shows that BPD can be treated effectively, and that many people with this illness improve over time. BPD can be treated with psychotherapy, or "talk" therapy. In some cases, a mental health professional may also recommend medications to treat specific symptoms. When a person is under more than one professional's care, it is essential for the professionals to coordinate with one another on the treatment plan.

The treatments described below are just some of the options that may be available to a person with BPD. However, the research on treatments is still in very early stages. More studies are needed to determine the effectiveness of these treatments, who may benefit the most, and how best to deliver treatments.

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Psychotherapy

Psychotherapy is usually the first treatment for people with BPD. Current research suggests psychotherapy can relieve some symptoms, but further studies are needed to better understand how well psychotherapy works. It is important that people in therapy get along with and trust their therapist. The very nature of BPD can make it difficult for people with this disorder to maintain this type of bond with their therapist.

Types of psychotherapy used to treat BPD include the following:

Cognitive behavioral therapy (CBT): CBT can help people with BPD identify and change core beliefs and/or behaviors that underlie inaccurate perceptions of themselves and others and problems interacting with others. CBT may help reduce a range of mood and anxiety symptoms and reduce the number of suicidal or self-harming behaviors.

Dialectical behavior therapy (DBT): This type of therapy focuses on the concept of mindfulness, or being aware of and attentive to the current situation. DBT teaches skills to control intense emotions, reduces self-destructive behaviors, and improves relationships. This therapy differs from CBT in that it seeks a balance between changing and accepting beliefs and behaviors.

Schema-focused therapy: This type of therapy combines elements of CBT with other forms of psychotherapy that focus on reframing schemas, or the ways people view themselves. This approach is based on the idea that BPD stems from a dysfunctional self-image—possibly brought on by negative childhood experiences—that affects how people react to their environment, interact with others, and cope with problems or stress.

Therapy can be provided one-on-one between the therapist and the patient or in a group setting. Therapist-led group sessions may help teach people with BPD how to interact with others and how to express themselves effectively.

One type of group therapy, Systems Training for Emotional Predictability and Problem Solving (STEPPS), is designed as a relatively brief treatment consisting of 20 two-hour sessions led by an experienced social worker. Scientists funded by NIMH reported that STEPPS, when used with other types of treatment (medications or individual psychotherapy), can help reduce symptoms and problem behaviors of BPD, relieve

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symptoms of depression, and improve quality of life. The effectiveness of this type of therapy has not been extensively studied.

Families of people with BPD may also benefit from therapy. The challenges of dealing with an ill relative on a daily basis can be very stressful, and family members may unknowingly act in ways that worsen their relative's symptoms.

Some therapies, such as DBT-family skills training (DBT-FST), include family members in treatment sessions. These types of programs help families develop skills to better understand and support a relative with BPD. Other therapies, such as Family Connections, focus on the needs of family members. More research is needed to determine the effectiveness of family therapy in BPD. Studies with other mental disorders suggest that including family members can help in a person's treatment.

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APPENDIX

i. Aggression Questionnaire.
ii. McLean Screening Instrument – Borderline Personality Disorder.
iii. Sample Questionnaires.

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