Communication and Borderline Personality Disorder

Terrel Hale

MBM 5522: Health Psychology: The Application of Psychological Concepts and Tools to Health

Instructor: Marina Smirnova, PhD

Saybrook University
Oakland, CA

Assignment 2

May 12, 2015

Abstract

This paper explores effective ways in communicating with those diagnosed with borderline personality disorder and how relaxation techniques benefit caregivers in their communication with those diagnosed with borderline personality disorder (BPD). It defines the condition and proposes mechanisms of action that inform the treatment choices and explains the observed benefits and addresses nonpharmeutical alternatives.

*Keywords:*Bipolar disorder, communication, relaxation techniques, complementary and alternative medicine (CAM), behavioral medicine, integrative health.

Communicating and Borderline Personality Disorder

How may relaxation techniques benefit the caregiver in communication with those diagnosed with borderline personality disorder (BPD)? How do nonpharmacological interventions cause a greater state of calmness, stress resilience, and even bonding, in terms of relationships and how do these nonpharmacological interventions facilitate communication? The purpose of this paper is to explore effective ways for caregivers to communicate with individuals diagnosed with borderline personality disorder (BPD). This paper begins with definitions, examines appropriate mechanisms of action that inform treatment options, looks at both communication and relaxation techniques, and then concludes with the viability of nonpharmaceutical alternatives.

Definitions

According to Kernberg and Michels (2009), "borderline patients have long been to psychiatry what psychiatry has been to medicine – a subject of public health significance that is underrecognized, undertreated, underfunded, and stigmatized by the larger discipline. As with psychiatry and medicine, this is changing" (p. 508). Bychowski (1953) described borderline personality disorder as the persistence of dissociated emotional states and the separation of parental images into good and bad. Zilboorg (1941, 1957), Hoch, and Polatin (1949) and Hoch and Cattell (1959) all believed that those manifesting these same characteristics were schizophrenic. These patients, according to Kernberg (1975), occupy a "borderline area between neurosis and psychosis" (p. 3). This diagnosis presents an organization of character that is neither neurotic nor psychotic and is characterized by Kernberg as "psychopathological constellations" (p. 3). For Perry (1974), this is the inner space where the individual finds [oneself] in turmoil, and is an astonishingly abundant cosmos, full of the potential of enriching and deepening emotional existence while at the same time being elusive (p. 2). In other words, these are clusters of defensive operations of ego, internalized

object relationships, and what Kernberg (1975) calls "descriptive, structural, and genetic-dynamic aspects of borderline personality organization" (p. 4). These patients do not have a specific, stable, pathological personality organization (Kernberg, 1975) since their personality organization is in a transitory state fluctuating between neurosis and psychosis. With this in mind, Kernberg reported that the organization of the thought processes of those diagnosed with BPD appeared intact. Frosch (1964) stressed that although borderline patients have alterations in both their relationships with reality and in their feelings of reality, their capacity to test reality is preserved.

Kernberg and Michels (2009) stated that patients exhibiting characteristics of borderline personality disorder lack integration, stability of relationships, and regulation of affect that are associated with neurotic patients. Histrionic, narcissistic, and antisocial behaviors are also indicative of this condition. Kernberg and Michels reported that personality development is complicated with this diagnosis because it always involves the interaction of nature and nurture, and in extreme cases, one or the other may predominate as the determinate pathology. So, for Kernberg and Michels (2009), a complex interaction is much more likely to occur when the outcome is less extreme. All of these make up the borderline characteristics (p. 506).

Kernberg and Michels (2009) demonstrated that those diagnosed with this disorder are very sensitive to what they perceive to be negative stimuli. When this is linked to hyperactivity, lack of the capacity for cognitive conceptualization, and decrease in mental functioning, significant neurobiological correlates of borderline personality disorder result (p. 506). This is important in communicating because increased activity with this lack of conceptualization results in a decrease in mental functioning, and all of this impairs effective communication. From a psychodynamic viewpoint, common features of BPD indicate a lack of integration of the concept of self caused by a coexisting disparity of both self-representations and object-representations under contradictory

loving and hateful states. The patient's subjective life remains contradictory and chaotic with severe identity problems. This also manifests in a related incapacity to integrate the perception of significant others, which motivates discontinuous, chaotic, contradictory social behavior. According to Kernberg and Michels (2009), all of these neurobiological and psychological assumptions correspond to clinical and empirical research (p. 506).

According to my daughter Margo, who was diagnosed with borderline personality disorder when she was in high school and who has been living with her mother and me most of her adult life, the symptoms of BPD can be described as manifesting in extreme reactions to events or people, very much like Post Traumatic Stress Disorder (PTSD), and include problems with identity (M. Hale, personal communication, April 4, 2015). People with borderline personality disorder struggle with fear of abandonment, which affects their interpersonal relationships. BPD is more environmental because it is an attachment disorder.

Attachment theory helps clarify some of the attachment issues with BPD. The quality of attachment is experienced by the primary caregiver and is a function of the child's temperament. The caregiver's attunement to the child's needs and what kind of temperament the child manifests are also considerations. This interaction produces a cycle of arousal and relaxation. The child cries because he or she is hungry, wants physical closeness, is tired, or has a wet diaper. Most caregivers cannot quite read the child's signals accurately. When the child's need is met, he or she goes back into the relaxed state. The completely attuned caregiver facilitates a child's secure attachment. Otherwise, a child develops an attachment style ranging from secure to insecure. Attachment underlies or relates to borderline, and there is also a generic component that is genetically predisposed (A. Craig-Van Grack, personal communication, April 13, 2015).

Communication

According to Allen et al. (2005), contradictory communication within the family may have a role to play in reinforcing BPD behavior (p. 340). This study is based on what the authors call "deviant communication" (Allen et al., 2005 p. 340) and "high expressed emotion" (p. 340) within a family setting. Allen and his colleagues further posit that what they call "contradictory communications" (Allen et al., 2005, p. 341) manifest themselves differently from family to family. Furthermore, those with BPD experience this contradictory communication in their parents. These researchers suggest that this contradictory communication pattern within a family setting should be considered in models of ongoing reinforcement for BPD behavior (p. 342) and further suggest how the patient's perception of contradictory responses from their parents correlates with their diagnosis (p. 346).

According to Allen et al. (2005), adult BPD patients perceive their parents' behavior as contradictory with regard to some, but not all areas of their own autonomous functioning, and this may help clarify the precise nature of the invalidating family environment. Such perceptions may also help clarify mechanisms by which the borderline behavior is perpetuated. In other words, attempts of a BDP patient to individuate lead to depression, which then triggers typical BDP defenses. The parents' confusing reaction to such attempts might be an ongoing trigger for this process (p. 346). BDP patients who are given mixed messages by family members may internalize this confusion, and this can help create identity problems that are characteristic of BDP; and as a result of being in this kind of situation within a family setting without a clear means for changing such confusion, can lead to negative reactions. According to Allen et al. (2005), such reactions could be an important factor in the "affective storms and dysregulation that are characteristic of the disorder" (pp. 346-347).

Linehan (1993) posited that what she calls "reciprocal communication" (p. 49) occurs when the therapist makes herself or himself vulnerable while working with their clients, and this helps to facilitate the client's feeling understood (p. 49). For example, expressions of vulnerability address the power imbalance, as well as serving as an important modeling event. According to Linehan, these appropriate expressions of vulnerability can help teach clients how to best draw a line between privacy and sharing, as well as how to experience vulnerable states without shame and how to cope with their own limitations. These expressions of vulnerability can also help provide a "glimpse into the world of so-called 'normal' people, thus normalizing vulnerability and life with limitations" (Linehan, 1993), pp. 49-50).

For Harvey and Rathbone (2013), however, by the time caregivers bring the patient diagnosed with BPD to a Dialectical Behavior Therapy (DBT) practitioner, they have already experienced years of intense emotions and behaviors at home and have already tried numerous types of treatment and therapy. Caregivers have often received contradictory professional advice and guidance that has proven ineffective. This also affects communication.

As caregivers are oriented to DBT, they learn to accept that the person with BPD is doing the best he or she can in the moment (Linehan, 1993) as a way to lessen their emotional reactivity and begin to work on acceptance. This relaxation and acceptance also affects the quality of communication. Caregivers are introduced to the idea that even though the person with BPD may not have caused all of her or his problems, they are the only one who can solve them (Linehan, 1993). This idea further helps the quality of communication.

Caregivers have often been taught that it is their responsibility to take care of the person with BPD, and they believe it is their job to make him or her better. It can be very painful for caregivers to learn that only the person with BPD can make changes in their own life, and are the ones to

choose to commit to, and make use of, treatment. Caregivers, who may be well-intentioned or desperate, need to learn their own limits and what they can and cannot control. This is why relaxation is important.

The validation and sensitivity on the part of the DBT practitioner to the caregiver is also important because when caregivers experience the power of being accepted by the DBT practitioner, the caregiver is better able to communicate and relax with the one diagnosed with BPD. According to Linehan (1993), teaching caregivers to communicate more effectively to the one diagnosed with BPD and to effectively respond to the intense emotions benefits the one diagnosed and interrupts the escalating cycle of emotions (pp. 107-108).

Harvey and Rathbone (2013) referenced biosocial theory to describe that an invalidating environment exacerbates the emotional dysregulation of the one diagnosed with BPD. When caregivers are able to create a more validating environment, the diagnosed feels heard and better understood. This leads to more communication between the caregiver and the one diagnosed, fewer emotional outbursts, and a calmer and healthier environment for the entire family (Fruzetti, 2005).

The idea of validation resonates with caregivers who understand that their charge accuses them of "not getting it" or "not understanding." Even though validation within a family can be quite healing, there are many reasons why it is hard for caregivers to validate. For example, they may find it stressful to acknowledge the pain their charge experiences. This is necessary to genuinely validate the one diagnosed. In addition, caregivers often want to fix problems or make them go away, especially if they are accomplished in other areas of their lives, or feel it is their responsibility to resolve their charge's problems. Caregivers may hope to minimize the pain by dismissing the problem. Caregivers can become frustrated because what they see as attempts at being helpful may actually be experienced as invalidating by the one who is diagnosed with BPD and, therefore,

ineffective, often leading to more emotional outbursts. Caregivers have to use trial and error to find ways to let their charge know that they are truly listening, trying to understand, and are taking the concerns seriously.

Some of the ways caregivers validate their charge is listening without speaking, relating what the diagnosed is feeling to what others might feel, thereby normalizing it, repeating back what the one diagnosed is saying in different words, and acknowledging the affect behind the words. These all help the caregiver communicate more effectively. Caregivers are sometimes hesitant to validate their charge because they confuse it with agreeing with them. According to Linehan (1993), validating does not mean agreeing, it means genuinely acknowledging that the feelings of the one they take care of make sense, given their experiences. Practitioners model validation for the caregiver by validating them. Caregivers recognize how satisfying it is to be understood and acknowledge how important validating their charge might be to him or her (p. 110).

Brune, Kolb, Ebert, Roser, and Edel (2015) looked at the effect of oxytocin (OT) on nonverbal communication in patients with BPD. According to Brune et al. (2015), interpersonal dysfunction is central to BPD, and research into the biopsychosocial underpinnings of interpersonal difficulties in BPD suggests that patients frequently develop mistrustful inner working models that lead them to experience others as untrustworthy and rejecting, which is frequently linked to adverse experiences in childhood. This has a direct implication on communicating with them because interpersonal dysfunction is central to BPD. Brune et al.'s study sought to examine the nonverbal behavior of patients with BPD during a clinical interview in comparison with psychologically-unaffected controls. In this study, patients with BPD showed fewer nonverbal communicative signals inviting social interaction than did the nonclinical controls.

Relaxation Techniques

According to Harvey and Rathbone (2013), even though caregivers learn that the diagnosed must be responsible for changing himself or herself, they also learn that there is a very important role they can play in structuring the appropriate environment, by being less reactive and by decreasing their charge's emotionality. Relaxation techniques help the caregiver do just this.

Caregivers learn they can change the way they respond to their charge, and their mindful responses can help bring about changes in their relationship, as well as in the emotional level of both their home and of their charge. In homes in which a charge has emotional dysregulation, the caregivers have often been conditioned by the one diagnosed with BPD to respond ineffectively to high-risk behaviors because they are afraid their charge may do something dangerous. Those diagnosed with BPD may threaten to harm themselves if they not get the privileges they demand or are not allowed to do what they want. They may have emotional outbursts that "punish" the caregiver. The one diagnosed may also calm down and act in a more loving way when the caregiver lets her or him do what he or she wants, reinforcing this behavior, leading to an attitude of gross entitlement. Caregivers often become overly lenient and conciliatory in order to lessen conflict and behavioral outbursts, or they may become overly authoritarian as a way to maintain control. Caregivers need to learn how to create an environment that is more balanced and more conducive to learning safe and skillful behaviors (Linehan, 1993, p. 109), and relaxation techniques can help facilitate this.

According to Linehan (1993), these mindfulness skills are central to DBT and are the first skills taught. They are psychological and behavioral versions of meditation practices that are compatible with most Western contemplative and Eastern traditions (Linehan, 1993, p. 63). These

skills include learning to observe, to describe, and to participate, with a goal to create a lifestyle of awareness. For Linehan (1993), a premise of DBT is that participation without awareness is a sign of "impulsive and mood dependent behaviors" (p. 63). The point is to experience the emotion without any judgment, according to Linehan (1993). In other words, a patient can be exposed to negative emotions, but without the association of the negative consequences. This can help the patient remain nonjudgmental whenever he or she feels distressed.

One of the best-known writers on relaxation techniques for those diagnosed with BPD is Jon Kabat-Zinn. His relaxation technique fosters this same kind of mindfulness. Kabat-Zinn (2005) defined mindfulness as "examining who we are…questioning our view of the world and our place in it, and…cultivating some appreciation for the fullness of each moment we are alive" (p. 3). Kabat-Zinn (2005) also sees mindfulness as "a systematic approach to developing new kinds of control and wisdom in our lives, based on our inner capacities for relaxation, paying attention, awareness, and insight" (p. 2) and believes that "meditation helps us wake up from…automaticity and unconsciousness, thereby making it possible for us to live our lives with access to the full spectrum of our conscious and unconscious possibilities" (p. 3).

In other words, according to Kabat-Zinn (1990), how one goes about the practice of paying attention is important because the process is more than the end point. Calming the mind is integrated in relaxing the body and leads to being able to see more clearly. Such calmness and relaxation needs to be cultivated with consistency. For Kabat-Zinn, cultivating this meditative awareness requires a different way of learning because we try to control things to make them turn out our way, the way we want them.

Such an approach is directly opposed to both awareness and healing because awareness only requires that we see things the way they are. For Kabat-Zinn (1990), it doesn't require that we

change anything because healing only requires receptivity and acceptance. By relaxing into this frame of mind we become more connected and more whole, and because none of this can be forced, Kabat-Zinn (2005) suggested, "you have to create the right conditions and then you have to let go" (p. 31). For Kabat-Zinn, it is the same for relaxation because it cannot be forced. Such an effort can only produce tension and frustration (p. 32).

Psychopharmacological Interventions and Borderline Personality Disorder

Kernberg and Michels (2009) reported that the concept of BPD was initially developed to explain how patients are seen as candidates for psychodynamic psychotherapy. These troubled patients had both a wide range of strong emotions and intense relationships. The development of depression, rage attacks, pervasive anxiety, and dissociative symptoms stimulated the utilization of psychopharmacological interventions like anxiolytic, antidepressants, and mood stabilizing drugs, as well as the use of low-dose atypical neurolyptics (p. 507).

However, the most important finding in regard to psychopharmacological interventions has been that some borderline patients respond to one or another of a broad spectrum of medications, even though only 30% respond satisfactorily over an extended period of time (Lieb, Vollm, Rucker, Timmer, & Stoffers, 2010). This means that after a period of time, patients who initially responded favorably tend to experience a loss of the medication's effectiveness, and the underlying structural predisposition to their affective symptomatology seems to override the effects of the treatment. The major role of medication is that of an auxiliary treatment in the context of psychotherapeutic treatment because such interventions have only marginal value (Lieb, Vollm, Rucker, Timmer, & Stoffers, 2010).

On the other hand, many supplements can cause a greater state of calmness, stress resilience, and even bonding, in terms of relationships. For example, nonpharmacological interventions were

discussed at the Harvard Psycho Pharmacology Conference in April 2014.At this conference, a review of the mechanisms and clinical applications of psychotropic drug treatments with particular emphasis on difficult-to-treat patients, as well as on metabolic issues that can help explain instability that can affect mood, were discussed. Taurine is an amino acid and a natural mood stabilizer, the backbone amino acid for making GABA (gamma-aminobutyric acid). This is the main neurotransmitter for calmness, a natural and nonpharmacological way for mood modulation (Flor-Henry, 1986; Gariballa, 2011; Gariballa, 2013; Gonzales-Maeso, Rodriguez-Puertas, Meana, Garcia-Sevilla & Guimon, 2002; Scarr & Dean, 2012). However, according to my daughter Margo, depending on the severity of the emotions and the anxiety, an antidepressant or an anti-anxiety drug is usually prescribed (M. Hale, personal communication, April 4, 2015).

Conclusion

Research (Allen, Abramson, Whitson, Al-Taher, Morgan, Veneracion-Yumul, . . . Mason, 2005; Brune, Kolb, Ebert, Roser, & Edel, 2015; Dimeff & Koerner, (Eds). 2007; Fruzetti, 2005, October; Harvey & Rathbone, 2013; Harvey & Rathbone, 2013; Kernberg, 1975; Kernberg & Michels, 2009; Lieb, Vollm, Rucker, Timmer, & Stoffers, 2010; Linehan, 1993) shows the major symptoms that define borderline personality disorder respond to well-structured forms of cognitive behavior or psychodynamic psychotherapy, but the basic underlying chronic personality dispositions may remain unchanged. Borderline patients, even 20 or 30 years after completion of treatment could show impoverishment of their personality. This means there is a noticeable lack of effectiveness and satisfaction in their lives and in their professions, a lack of stability in intimate love and sexual relationships, in establishing families, and difficulty overcoming social isolation. The focus on the long-range course of borderline psychopathology and the effect of interventions on modifying it,

according to Kernberg and Michels (2009), constitutes to be a major challenge for future work (p. 508). Deciding not to use pharmacological drugs, but more natural supplements, will be part of this.

Caregivers who learn to communicate more effectively with those diagnosed with BPD can help facilitate a less combative home environment. As the caregivers also learn relaxation techniques, communication will also improve. Nonverbal communication between the one diagnosed with BPD and others is also significant. Mindfulness is a major part of both communication and relaxation, and as the caregiver understands and experiences mindfulness, both the communication improves and the relaxation becomes easier.

References

Allen, D. M., Abramson, H., Whitson, S., Al-Taher, M., Morgan, S., Veneracion-Yumul, A., . . . Mason, M. (2005). Perceptions of contradictory communication from parental figures by adults with borderline personality disorder: A preliminary study. *Comprehensive Psychiatry 46*, 340-353. doi:10.1016/j.comppsych.2005.01.003

Brune, M., Kolb, M., Ebert, A., Roser, P., & Edel, M. A. (2015). Nonverbal communication of patients with borderline personality disorder during clinical interviews: A double-blind placebo-controlled study using intranasal oxytocin. *The Journal of Mental and Nervous Disease 203*(2), 107-111.

Bychowski, G. (1953). The problem of latent psychosis. *Journal of the American Psychoanalytic Association 1*(3), 484-503.

Dimeff, L. A., & Koerner, K. (Eds). (2007). *Dialectical behavior therapy in clinical practice: Application across disorders and settings*. New York, NY: The Guildford Press.

Flor-Henry, P. (1986). Observations, reflections and speculations on the cerebral determinants of mood and on the bilaterally asymmetrical distributions of the major neurotransmitter systems. *Acta Neurologica Scandinavica. Supplementum*, 10975-10989.

Frosch, J. (1964). The psychotherapy character: Clinical psychiatric consideration. *Psychiatric Quarterly, 38*, 81-96.

Fruzetti, A. E. (2005, October). *Validating and invalidating responses in families*. Paper presented at the NEA-BPD Borderline Personality Disorder: Historical and Future Perspectives Conference, McLean Hospital, Burling, MA.

Gariballa, S. (2011). Testing homocysteine-induced neurotransmitter deficiency, and depression of

mood hypothesis in clinical practice. *Age And Aging, 40*(6), 702-705. doi.10.1093/ageing/afr086

Gariballa, S. (2013). Extending the homocysteine-induced neurotransmitter deficiency and depression of mood hypothesis to quality of life in older patients. *International Journal of Geriatric Psychiatry, 28*(8), 878-879. doi:10.1002/gps.3922

Gonzalez-Maeso, J., Rodriguez-Puertas, R., Meana, J. J. Garcia-Sevilla, J. A., & Guimon, J. (2002). Neurotransmitter receptor-mediated activation of G-proteins in brains of suicide victims with mood disorders. Selective supersensitivity of alpha(2A)-adrenoceptors. *Molecular Psychiatry, 7*(7), 755-767.

Harvey, P., & Rathbone, B.H. (2013). *Dialectical behavior therapy for at-risk adolescents: A practitioner's guide to treating challenging behavior problems*. Oakland, CA: New Harbinger.

Hoch, P.H., & Polatin, P. (1949). Pseudoneurotic forms of schizophrenia. *Psychiatric Quarterly 23*, 248-276.

Hoch, O.H., & Cattell, J.P. (1959). The diagnosis of pseudoneurotic schizophrenia. *Psychiatric Quarterly, 33*, 17-43.

Kabat-Zinn, J. (1990). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness.* New York, NY: Delta, Bantam Dell.

Kabat-Zinn, J. (2005). *Wherever you go there you are: Mindfulness meditation in everyday life.* New York, NY: Hyperion.

Kernberg, O. (1975). *Borderline conditions and pathological narcissism*. New York, NY: Jason Aronson.

Kernberg, O., & Michels, R. (2009). Borderline personality disorder. *American Journal of*

Psychiatry 166(5), 505-508.

Lieb, K., Vollm, B., Rucker, G., Timmer, A., & Stoffers, J.M. (2010). Pharmacotherapy for borderline personality disorder: Cochrane systematic review of randomised trials. *British Journal of Psychiatry, 196*(1), 4-12.

Linehan, M. M. (1993). *Skills training manual for treating borderline personality disorder*. New York, NY: The Guilford Press.

Perry, J. W. (1974). *The far side of madness*. Englewood Cliffs, NJ: Prentice-Hall.

Scarr, E., & Dean, B. (2012). Altered neuronal markers following treatment with mood stabilizer and antipsychotic drugs indicate an increased likelihood of neurotransmitter release. *Clinical Psychopharmacology And Neuroscience: The Official Scientific Journal Of The Korean College of Neurospsychopharmacology, 10*(1), 25-33. doi:10.9758/cpn.2012.10.1.25

Zilboorg, G. (1941). Ambulatory schizophrenias. *Psychiatry 4*, 149-155.

Zilboorg, G. (1957). Further observations on ambulatory schizophrenia. *American Journal of Orthopsychiatry 27*, 677-682.