Introduction

"How is it that if Borderline Personality Disorder supposedly only affects 3% of the population that we always seem to find each other?"

Liz, an attractive, articulate 26-year-old asked me as she sat down in my office one day. "What do you mean?" I replied, knowing exactly where she was headed but awaiting the details anyway. She continued, "Last week, my friend Lindsay introduced me to a man named Eric. In the beginning, I was not attracted to him at all. After all, he was 20 years older than me, but the more time I spent with him that first evening, I increasingly felt like I'd known him my whole life.

"Our first date went so well that I called him back the next day and invited him over to cook dinner for him that night. I made us my variation of taco salad. The food proved delicious, and the meal was wonderful, in part because we shared fun, intellectually provocative conversation. We had a minor food fight and even took turns feeding each other. Dinner was playtime, as if we were children. Afterwards, I carried away our dishes and proceeded to wash them, cleaning up our food fight mess in between sinks full, subsequently returning to watch our first movie of the night, 'Stars Wars.'

"Sounds like a fun evening," I said.

"Wait, it got even better," she continued.

"As we watched the movie, Eric narrated in his radio voice persona, reliving his days as a disc jockey. I relished it. He had that quick wit that I fall for every time."

"It did get better. It sounds like you were having fun," I added.

"Until it got worse," she replied.

"He started out hilarious, but suddenly, he chose a dramatic, vulgar tone that made me uncomfortable and triggered my consciousness to quickly change. As I momentarily withdrew, he grew angrier and angrier so that he was enraged by the time my awareness returned. It happened so quickly, that I didn't even realize what had happened. In order to calm him down, I quickly initiated the one thing I knew would calm him: sex. Impulsive, guilt-laden, self-denigrating sex. It's always been my number one go-to to pacify guys.

"When it was over, he was crying over me, sobbing, begging me not to leave him, lavishing promises of change, excessive apologies and desperate pleas of me to forgive him and not leave him alone again as previous women had done. He felt bad for "guilting" me, and I felt responsible for the entire night's difficulties. He was afraid, and I, I was a self-loathing disaster. I followed his lead and apologized profusely as well. Afterwards, we hugged, made up, and decided to take a walk.

"As we walked in the crisp, fall night air, the tension now broken, the joking resumed. We walked briskly for about two hours, gaily bantering between ourselves, although I thought he enjoyed our time far more than I. The blaming, critical thoughts constantly running in the back of my mind prevented me from enjoying the fullness of our conversation and relaxing walk. As our time together concluded for the night, those same thoughts waged a war inside my mind." Liz paused a moment to breathe and steady herself for the remainder of her confession.

Knowing her and her patterns the way that I did, I suspected how this story might end, but asked her continue her tale.

"Upon my return home, I headed straight to my room, avoiding everyone. No eye contact; they'd know how shameful I had acted yet again. I knew I had to be punished, and so, I was ... by me."

Liz hesitated a moment, then looked up at me with a tear in her eye, and her tone turned in a slightly different direction.

Her mind had so easily overlooked the fun she had had earlier in the evening, choosing only to focus on the unhealthy choices she had made to engage in those risky and self-damaging behaviors. Despite knowing that the choices were all her own, they were all born from those horrible ideas poisoning her mind, a plague-like by-product of her Borderline Personality Disorder.

The further we explored this interaction with the two of them, it became apparent that she was right, and Eric had the same condition. He hated himself for how he had conducted himself that night. He apologized profusely. He begged for forgiveness, and pleaded for her not to leave him alone. Still, it was not enough for him... Unbeknownst to Liz, he went home that night and drank until he passed out because, "I couldn't bear the hatred I had for myself. I didn't intend to take advantage of her. I just got so enraged so quickly when her attention faded, so then, when she offered, I knew what I wanted in the moment. I never meant to hurt her."

Although Borderline Personality Disorder (BPD) is diagnosed three times more commonly in women than in men, it adversely affects the lives of millions of people all over the world. Roughly six million people in North America and 14 million people worldwide struggle with the disorder. It is more common than Schizophrenia and Bipolar Disorder. An estimated 10% of psychiatric outpatient populations and a staggering 20% of inpatient populations struggle with this diagnosis. Yet research and resources devoted to this condition continue to lag significantly and the condition remains somewhat misunderstood by primary care practitioners, the mental health community, and the public at large. Misdiagnosis remains common and quality treatment can be difficult to access.

While some stigma associated with the diagnosis remains, perception of BPD and its treatability has greatly improved over the last 10 to 15 years. Studies that are more recent have shown that the prognosis for most individuals with BPD is actually quite good. New treatments such as DBT (Dialectical Behavior Therapy), SFT (Schema Focused Therapy) and even some concepts out of traditional CBT (Cognitive Behavioral Therapy) have emerged – pioneering a new era in treating BPD, replacing age-old psychoanalytic ideas. One of the main themes of this book is that **There is Hope!** Many people with Borderline Personality Disorder, who find a competent therapist and are willing to put in the work, recover to a significant degree.

SO WHY ANOTHER SELF-HELP BOOK ON BPD?

REASON #1: The others are too complicated. Many books on BPD have been written by academicians who spend most of their lives in university settings doing studies funded by grants that require people to meet multiple requirements to participate in their research. By the time everyone has been ruled out for research purposes, there are often few left to benefit the "real world" person with BPD. Their language can often be so clinical or academic that it is difficult to understand what it means in plain English.

REASON #2: The others are often based on generalizations and stereotypes unfair to people who suffer from Borderline Personality Disorder. One of the themes of this book is that no two people with BPD are the same in every way. Many of the books portray the worst case scenario individual who is often depicted on shows like "Law and Order" where the character who supposedly has BPD kills herself and her three children. Many sick chatrooms exist that extend this image that represents few "real world" people with BPD. Although well intentioned, these often can have a harmful effect. Many people who have BPD that "looks different" see these horror stories they cannot relate to and assume they have something else and move on and never get the help they need.

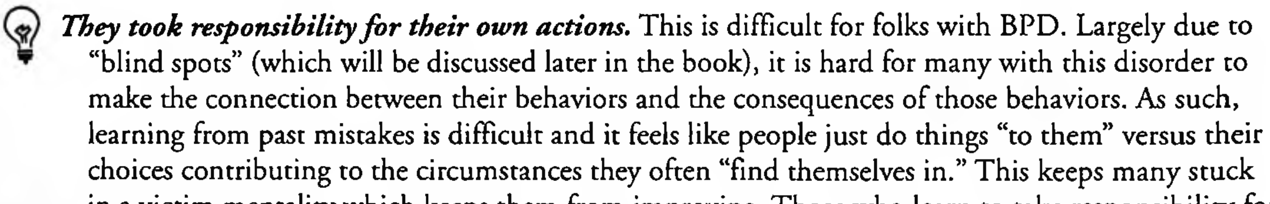
REASON #3: The others are incomplete. Many "symptom management" approaches exist with the purpose of helping you "manage" your Borderline Personality Disorder or learn to behave better. We want you not only to behave differently but to feel better as well and accomplish not only surface level coping but meaningful change.

REASON # 4: The others are limited. A number of good self-improvement/motivational books for BPD exist that have been written by consumers from the perspective of the client with BPD. While this is a valuable perspective, it is only one side of the equation. Although many contain a legitimate viewpoint of Borderline Personality Disorder individuals who in some ways have overcome their symptoms, they are still often full of distortions in perception and generalizations based upon their specific experience and offer only one side of the equation.

This book is intended to give you a balanced overview of BPD. It is true that many times BPD is mischaracterized in the media, public opinion and by many mental health professionals themselves. Many people with Borderline Personality Disorder are charming, engaging, and genuinely want help for themselves and are willing to work very hard at their recovery. There are also people with BPD who blame others, aren't willing to work in therapy and engage in behaviors that are extremely hurtful to others. I have even had patients and their sick family members accuse others of horrible lies, including rape, in an attempt to damage someone they had a misperception of.

So whether you are a person who suffers from BPD yourself, a mental health professional, or a friend or a family member of someone with BPD, this book is intended to give you a balanced view of current research about the disorder. And more importantly, it is intended to give you some valuable tools to use with your provider that can help you overcome your BPD and take the next big step down your road to recovery.

A number of years ago, Paul Mason and Randi Kreger wrote a popular self-help book for friends and family members of people with Borderline Personality Disorder, *Stop Walking on Eggshells.* They describe results from three years of interviewing many people who had recovered from BPD. These are strikingly similar to the informal findings of my 10 years of running borderline personality disorder-specific treatment programming. Individuals with BPD who got significantly better had the following things in common:



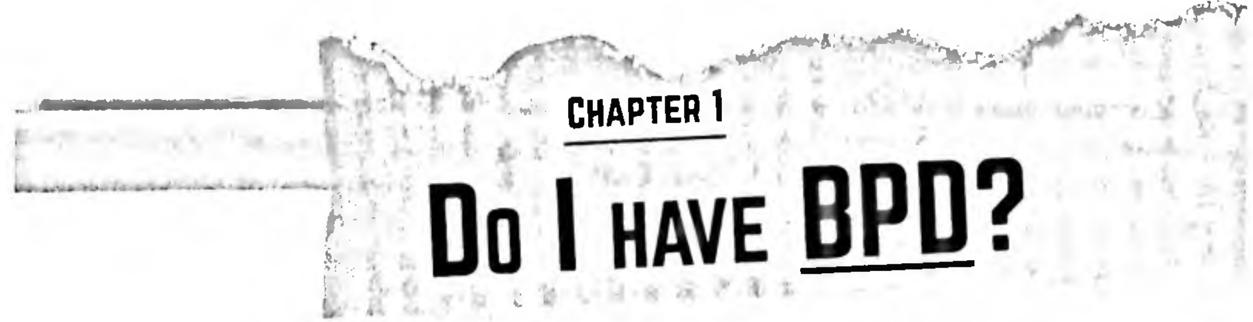
- ***They took responsibility for their own actions.*** This is difficult for folks with BPD. Largely due to "blind spots" (which will be discussed later in the book), it is hard for many with this disorder to make the connection between their behaviors and the consequences of those behaviors. As such, learning from past mistakes is difficult and it feels like people just do things "to them" versus their choices contributing to the circumstances they often "find themselves in." This keeps many stuck in a victim mentality which keeps them from improving. Those who learn to take responsibility for their actions have a much better chance of recovery.

- ***They were willing to work through inner pain.*** It is easier to avoid really working through your issues. Some go to therapy with no intentions of being honest, especially when it is difficult to trust others. Some make superficial efforts, but continue to avoid the real work. Rather than feel the tough emotions necessary to feel to get better, they continue deflecting or dealing with pain through other means, such as alcohol, smoking pot, self-injuring, or some other "numbing" method that provides comfort in the moment, but keeps the person from true recovery.

- ***They had faith in themselves and believed God or others believed in their value.*** Borderline Personality Disorder at its core contains a belief that one is worthless, damaged, or defective. You will never meet a BPD sufferer who has healthy self-esteem. Learning to see value in oneself is essential for recovery from BPD. It is worth noting that most who come to believe this begin treatment believing this is NOT possible. Having a faith or important people in your life to help instill in your belief system that you have value and meaning is a powerful means for integrating that into your beliefs about yourself.

- ***They had access to continued therapy with a competent provider.*** A typical course of treatment for BPD is *one to four years.* Having a trained provider who is willing to stick with you through thick and thin is important. Progress is hard to come by for those who continually change service providers.

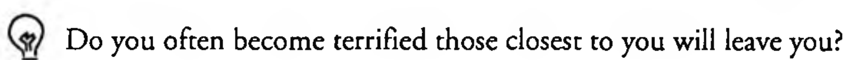
These are the common characteristics of those who improve from their Borderline Personality Disorder. I encourage you to keep them in mind and work to cultivate these characteristics as you pursue your own journey to recovery.



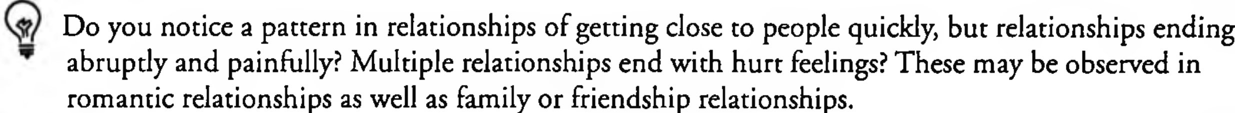
CHAPTER 1

DO I HAVE BPD?

There are many indicators a person may have BPD. There are also many checklists of this nature available in various resources. The problem is that the items on many of these lists may also be present in other types of problems. One thing that separates this from many other lists is these are ***distinctly borderline behaviors and experiences.*** The more of the following you identify with, the more likely it is that you have BPD.



- Do you often become terrified those closest to you will leave you?



- Do you notice a pattern in relationships of getting close to people quickly, but relationships ending abruptly and painfully? Multiple relationships end with hurt feelings? These may be observed in romantic relationships as well as family or friendship relationships.
- Have you ended relationships prematurely so others would not end them first?
- Can you meet someone, think they are the most wonderful person you have met, and soon be furious with them (hatred or disinterest)?
- Have you quickly taken on the values, hobbies, or behaviors of those around you rather than having stable, consistent things that you truly believe and enjoy?
- Do you feel like there is a “black hole” in you? A void that can seemingly never be filled?
- Do you feel lonely even when in a relationship or in a room full of people that in your “head” you know love you?
- Do you experience multiple intense mood swings in any one day?
- Do you have trouble being alone?
- Do you experience intense emotions related to guilt, self-hatred, self-loathing, or shame?
- Do you experience episodes of rage that are often followed by feelings of guilt and shame?

Have you injured yourself in some way in response to intense feelings of guilt or shame, or to make other intense emotions go away?

Feel completely empty inside?

Do you feel like contact with any person causes you too much stress?

Have you cut off more than one person in your life by refusing to talk to them?

Have you engaged in alcohol or drug use, promiscuous sex, binge eating, reckless driving, or shopping sprees in an impulsive manner in order to "numb out," feel better or create a "rush"?

Done other risky things on the spur of the moment?

Have you ever felt as though you did not even exist?

Changing ideas about who you are? Career? Hobbies? Beliefs?

Have you cut, burned, or otherwise hurt yourself *on purpose, but with no intent to die?*

Have others accused you of being paranoid?

Have you had periods of time you can't account for? Evidence you did something you don't remember doing?

FINDING A PROVIDER

Finding a provider who is competent to treat Borderline Personality Disorder can be difficult. Many clinicians lack education about the disorder. Some may be able to recognize it, but do not know how to treat it. Still others may have an "old school" mentality about the disorder and believe that it is "untreatable" or have other misconceptions about the condition. Some may have beliefs about the diagnosis that make it impossible for them to effectively treat BPD. You may find the following suggestions helpful in locating a provider who is best for you.

1. ***DO YOUR RESEARCH.*** Look at what clinician reviews say. Find his/her provider profile online. Those clinicians who have a list of what they "specialize in" that lists 50 things likely do nothing well. Find someone who is specifically knowledgeable about Borderline Personality Disorder.

2. ***GET REFERRALS.*** Talk to other people with BPD. See which providers they have found helpful. Talk to other people without BPD who have sought therapy for another reason. Competent therapists typically know other competent therapists. Even if that person's clinician does not specialize in treating BPD, they likely will know another provider/treatment facility in the area that does.

3. ***ASK QUESTIONS.*** Interview potential therapists. Some may do this on the phone. Others may require you to come in and pay for an initial visit. It is worth it to find someone who you believe is qualified and who you may be able to develop a trust in to work with. A good "fit" is just about as important as someone who is highly qualified. Some important questions to ask might include:

Do you treat people with personality disorders? How many people with BPD have you treated?

It is obviously preferable to have someone who has some familiarity with the disorder. Some may say they treat BPD, but they only have worked with one or two people with the diagnosis. If they have limited experience treating the diagnosis but are in a peer consultation group with others who have, this can be helpful as well.

How do you conceptualize BPD? In a nutshell, what can you tell me about what this condition is?

Make sure the therapist does not just think BPD is "complex PTSD." As will be discussed in the etiology section, many people with BPD don't have trauma in their backgrounds. Even if you do have a background that includes trauma, treating PTSD and treating BPD are very different. Also make sure the clinician does not just think it is a variant of bipolar disorder. Ensure they view BPD as a distinct diagnosis and that they have a method of treatment specifically for it. Screen out any potential therapist who attempts to steer you away from the diagnosis or wants to call it something else.

What type of treatment approach do you use with BPD?

This is a piggy back off of the last question. Bipolar disorder is treated primarily with medications. PTSD is treated primarily with exposure and response prevention, grounding and other management strategies. Make sure they have a clear treatment approach for BPD. Effective treatments for BPD include Dialectical Behavioral Therapy, Cognitive Behavioral Therapy, Schema Focused Therapy, and Mentalization-Based Therapy. Make sure the person doesn't say a version of, "I'm eclectic – I use a mix of things with different people." Usually being "eclectic" means they don't have specific training in anything. There are very specific approaches to treating BPD and having a structured, intentional approach is important. You do not want someone who does "a little yoga and a little art therapy."

What can you tell me about the research in the area of BPD?

Most clinicians probably won't be able to cite research off the top of their heads, but you can often get a sense by their answer if they are competent enough to have a general idea of what is going on in the area. They should know one of the modalities mentioned above has been demonstrated to be effective and be able to tell you something about your prognosis. When I went on medical leave, one of my clients' insurance companies required her to see a clinician who knew nothing about the research, was not interested in helping her monitor her target behaviors, and instead insisted she use his model that required her to punch his fist and yell profanities (not once asking about her destructive behaviors).

What are your qualifications?

This question is not designed to elicit the specifics of where they went to graduate school or where they finished in their class. The best academics are not necessarily the best clinicians. The particular license they hold is not even that important (although in general, social workers tend to have a broader education but less actual therapy training than psychologists, LPCs, or LMFTs). You are looking for any specialty training they have. Professionals who have an interest in treating BPD have generally sought out some advanced training or specialty certification in an approach proven to treat BPD. Those who have gone out of their way to receive additional continuing education on a particular population often have a "heart" for those people and they likely may have more interest in working with you and be more invested in your recovery.

Trusting someone requires vulnerability, which is inherently difficult for people who have been hurt. But you will not come to believe that you are worthwhile and that others can be faithful/loyal/not leave you without gradually being willing to let your walls down. Occasionally (but very rarely) people with milder cases can find a sponsor, a trusted coach, or even a healthy and nurturing romantic relationship that can foster similar changes.

3. VALIDATION.

People with BPD feel like nobody else can understand them, like no one knows where they are coming from. It is true that most have not had the exact experiences, so few can know exactly what it is like to have this disorder. Due to these past experiences and the extreme emotions experienced in adulthood as a result, it is important for people with BPD to feel heard. . . to feel like their experiences from the past or emotions in the moment are heard, acceptable, and to some degree understood. Approaches that are only directive and challenging in nature do not work.

4. A METACOGNITIVE COMPONENT.

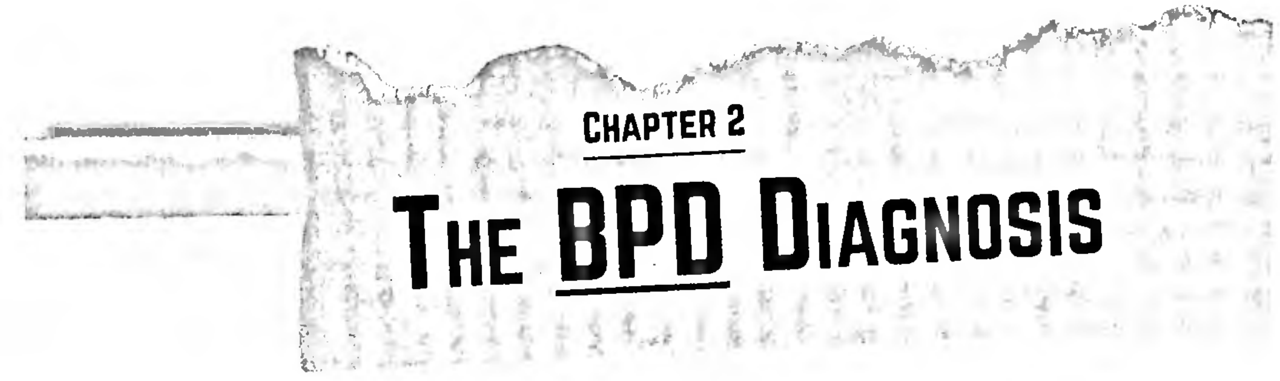
Even before mindfulness was all the rage, the ability to notice one's thoughts and behaviors was an important feature of successful treatments of BPD. In order to challenge dysfunctional or distorted thoughts, one must first be able to recognize what thoughts they are having, label them as thoughts, and then demonstrate the ability to "do" something different with them. More contemporary forms of mindfulness, mentalization, and acceptance-based approaches place less emphasis on even changing thoughts. They will want you to learn to "just notice" thoughts and learn to detach from them. Whether the modality actually wants you to learn to think differently over time or not, an ability to recognize and describe one's thoughts is vital.

5. PRESENT DAY PROBLEM-SOLVING VERSUS AN EMPHASIS ON EARLY CHILDHOOD EXPERIENCES.

In the same way that overly challenging or confrontational approaches are not helpful with BPD, styles that never confront will not succeed either. Approaches that sit back and say "hmmmmm – I'm wondering why you are curious about that," or wanting to remain focused on what happened before you were five rather than answering your questions or taking a more direct approach to problem-solving with you are not helpful either.

6. SKILL BUILDING.

This is what this book is all about. It has taken the best of the tools from the most evidence-based approaches and described them in one, practical, easy-to-use workbook. Use these with your therapist or by yourself in between sessions to continue to build your mastery over intense emotions so that you can feel better, make more effective decisions, and live the life that you desire!



CHAPTER 2 THE BPD DIAGNOSIS

Borderline Personality Disorder is actually one of 10 of what *The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition®* [or DSM-5®] (APA, 2013) calls "personality disorders." A personality disorder is technically characterized by a *pervasive and enduring pattern of inner experience, behavior, and cognition that deviates markedly from the individual's culture.* These patterns begin at an early stage of development, are *enduring and inflexible,* and lead to significant clinical distress or impairment. The DSM–II described personality disorders as "ego-syntonic."

The term ego-syntonic is not used in the current DSM and has not been for many years. When the DSM–II came out in 1968, Freudian psychoanalytic/psychodynamic thought still dominated the psychological landscape. Much of this theory has now been shown to be flawed (the evidence supports very little of these initial ideas) and current DSM language is ***atheoretical,*** meaning the criteria are descriptive in nature and do not use language from any one psychological *theory.* Although outdated, this term ***ego-syntonic*** came from the Freudian concept of the "observing ego." Freud said this group of individuals lacked the ability to "step outside themselves and observe their own behavior objectively." [Comer, 1988] We might say they have, "poor insight." Perhaps you have heard the term "blind spots" in personality - parts of our personality we have difficulty seeing in ourselves that others are able to see. Although all people have these "blind spots," for individuals with personality disorders, these spots are typically much larger. So behaviors often are not seen as a problem by the individual with BPD but are viewed as a problem by significant others in their lives. Thus developing this initial insight that is lacking in many is a crucial first step to recovery from Borderline Personality Disorder (as well as any other personality disorder).

Flexibility is a key component of what is considered an ***adaptive*** personality. John Oldham used the phrase, "the magnificent variety of non-pathological behaviors." People who have flexibility in personality are able to 'be different in different situations,' or wear different 'hats' depending upon what the circumstances call for. For instance, they are able to be assertive if someone makes an unreasonable request, but they are also able to be submissive if someone in authority is ordering them to do something. They are able to be fun and spontaneous at social events, but serious in business meetings or funerals. They can have sufficiently high standards without being unreasonable. They can be organized and tidy when the situation calls for it, yet flexible and let the kids mess up the house while opening presents on Christmas morning. Individuals with personality disorders tend to be more rigid. However their particular sets of traits predispose them to "be", they have difficulty being any other way. Thus, they end up being ***maladaptive,*** or not working well in certain settings, because the same way to be does not work in every setting. Behaving the same way in an amusement park that you do at a funeral does not work in both settings. Thus, another major goal for the personality disordered individual is to learn to develop some flexibility.

The term ***enduring*** means that these traits are stable over time. If you have a personality disorder (and you have developed a little insight), you will be able to see these behaviors having begun in early adolescence (or before) as you look back on your life. Nobody develops a personality disorder for the first time at age 30. We will discuss some differential diagnosis considerations at the end of this chapter, but often people may experiment with a

substance, go through a time of grieving after a divorce, or any other temporary life stressor and develop some qualities that look like personality disordered behaviors, but these are not grounds for a diagnosis if these are not patterns that have persisted over time.

Finally, this definition includes patterns of inner experience, behavior, and cognitions that pose significant emotional distress. ***Perception*** is a term that refers to how one receives information. How we "hear" things or perceive things is filtered by our beliefs/cognitions. When these are distorted, we view things in extreme and skewed ways that lead to intense emotions and oftentimes disagreements with others who do not view situations in the same way. Intense feelings and unstable relationships often accompany personality disorders. Due to the varying nature of different types of personality disorders, individuals with different diagnoses perceive themselves and others differently.

People with **Narcissistic Personality Disorder** overestimate their own importance, abilities, etc. and often dismiss, diminish, put down, or belittle others.

Those with **Dependent Personality Disorder** have difficulty even voicing appropriate disagreements with others and view themselves as incapable.

Individuals with **Histrionic Personality Disorder** overvalue physical attractiveness and undervalue other qualities in themselves and others.

Those with **Obsessive-Compulsive Personality Disorder** have issues with perfectionism and place unrealistic value on orderliness, being on time, and doing things "the right way." They live their lives in a state of perpetual annoyance and frustration due to their unrealistic expectations of others and themselves.

People with **Antisocial Personality Disorder** violate social norms, laws and other people. They have little to no empathy, they lack remorse for any of these violations, and they can be violent.

Individuals with **Paranoid Personality Disorder** believe others are out to get them or hurt them in some way when, in reality, they are not in danger.

So the specific perceptual errors are different with each specific disorder, but the role of perception distorts how these people view themselves, others, and society and that has a profound impact on their feelings (inner experience) and behaviors. This is just a glimpse of a few of the core issues of personality disordered individuals. Borderline Personality Disorder is just one of the 10 disorders and it is characterized by a very specific type of maladaptive (unhealthy) thinking and behaving.

Before we get to the BPD criteria, a quick word on the difference between a "trait" or a "feature" and a "symptom." A symptom is defined as "a departure from normal functioning, noticed by the patient, reflecting the presence of an unusual state or disease." A trait or feature has to do with a characteristic or attribute that makes someone or something unique. The short of it: A symptom is always a bad thing, a trait or a feature is not. You probably never want a bloody nose, high blood pressure, or to have a panic attack. Suspiciousness, however, can be a good thing (adaptive). If you work in the CIA or for Homeland Security, some degree of suspiciousness can serve you well. If you don't work for Homeland Security, but you believe you do, you are delusional! If you tell people you do, but you know that you really don't, you are a psychopath. If you don't work in a setting like this and you believe everyone is out to get you, your suspiciousness is out of control and the paranoia is considered dysfunctional. So when you hear the terms symptoms vs. traits, know that traits can be more or less helpful based upon the context a person is in, and if harnessed in an effective manner, can actually be strengths. And know that you probably never want a symptom if you can help it.

Limits to categorical models. Personality disorders are currently classified using what is called a categorical model. This means that if you meet the identified number of criteria, you have the disorder. If you don't, you do not. There isn't much room for grey. The reality is that most people do not have an obvious personality disorder or nothing at all. Most people have more or fewer of these traits. It is also somewhat subjective to identify what we mean when we say a person "meets criteria." DSM-5 requires that an individual meet 5 of the 9 criteria to be diagnosed with the disorder. In the real world, few people meet all 9 criteria strongly. To further illustrate the problem, one person could meet all 9 of the 9 criteria in a very mild way; so technically, he qualifies for the disorder, but may be very high functioning. Another person could meet only 4 of the 9 criteria, but meet the 4 that she does meet very strongly and be a very sick individual, yet technically not even qualify for the diagnosis. Like any other diagnosis, you can be "a little BPD" or "severely BPD." There are different sub-types. There are different levels of severity. There are different manifestations in different people. So, practically, what this means is that *BPD looks very different in different people.*

There has been a movement for a number of years to characterize personality disorders drastically differently than we do now. These models are called dimensional models, which also have some pros and some cons. Many believed dimensional models were going to play a much more significant role in DSM -5 in terms of how we characterize personality disorders. However, the work group failed to incorporate these concepts in a helpful way for people in the clinical setting. Some of this *trait-specific methodology* was put in section 3 of the DSM-5 as an area for further research, so they can be referenced by people curious to know what these changes were proposed to look like. The five factor model is among the most popular dimensional model for those who have an interest in further research. Just be aware that future versions of DSM may describe these conditions differently. But this will not mean that our current models are not valid. Don't think, "Oh they had it all wrong – what I read before is no longer relevant — maybe I don't have this." These are just academic people attempting to make the process more scientific.

BPD CRITERIA MADE EASY

Most people who have had this diagnosis even mentioned to them, whether it has been confirmed or not, have gone onto the internet and read these criteria. This clinical lingo, however, is very often not fully understood by individuals or family members curious to discover if this is in fact the condition they are dealing with. Here are these criteria, with detailed explanations of what they mean, accompanied by "real world" manifestations. Read them carefully. Many find it a useful exercise to rate each criterion on a scale of 0-10, where zero means "I don't see any of this criterion in me," and 10 means "this criterion describes me perfectly." This is obviously somewhat subjective as well, but at the end of the exercise, you will have a decent idea of how many criteria you likely meet and how strongly. This is usually a conversation best had with your psychiatrist or therapist. Also because of the "blind spots" previously referenced, it may be helpful to have someone who knows you well answer how they view you on a scale of 0-10 in each area.

BPD DESCRIPTIVE ADDITIONAL FEATURES – DSM-5

The latest version of the DSM-5 adds the following descriptive language for Borderline Personality Disorder: A pattern of self-undermining just prior to goal completion (i.e., dropping out just prior to obtaining a degree, having an affair just prior to wedding or engagement, etc.).

FRANTIC EFFORTS TO AVOID REAL OR IMAGINED ABANDONMENT

As mentioned above, people with BPD can have many combinations of these diagnostic criteria; inasmuch, many people with BPD will not have many of these. But this abandonment criterion is met by just about everybody with BPD. The majority of individuals with BPD have some version of thoughts constantly running through their minds that significant others in their life will leave them, or that they won't be there to meet their needs. This manifests differently in different people. In an attempt to ensure that they are not

something for a while and then they get bored. For some people, this identity criterion manifests in terms of frequent changes to physical appearance. Multiple tattoos, body piercings, and/or frequently changed hair color may be ways this manifests in different individuals.

Because of this lack in core identity, people with BPD are often overly susceptible to environmental influences. If someone seems critical, you feel awful; if somebody praises, you feel wonderful for the moment. If a friend suggests you do something that evening, you likely will agree. When I ask the question, "What do you do for fun?" another patient responded, "*I never really have had any hobbies. I never really knew what I liked, so I have just always kind of been like the chameleon doing what everybody else wanted me to do. I used to mountain bike because my boyfriend did, but once I broke up with him, I haven't done it since. I also used to be a part of a knitting club because two of my friends from the job I had at the time were in it. But now that I am not hanging out with them anymore, I haven't knitted since – and I don't miss it a bit.*" Some patients with BPD even struggle with core values or existential or religious beliefs. These can seem to fluctuate from moment to moment as well.

It is important to recognize that is a quality of BPD and is NOT a sign that you have no values. It usually just means that you are less solidly anchored to the values than some.

Another patient described this manifestation for her in the following way:

> *"Having BPD does mean that I have an unstable identity. You may notice my instability when I conform to the interests of you and others involved in my life. I may change who and what I like and want because I do not know, because I feel unlovable/ worthless/ bad/ undeserving of my own feelings and interests, and because I desperately want to belong somewhere, anywhere in life. I am doing it so that I can be someone I believe is worthy of friends, family, and life. I am not manipulating you; rather, in these times, I am emulating you because I want to be like you, you are important to me."*

So although identity struggles of some kind are common in people with Borderline Personality Disorder, these show up in drastically different ways in different people. Any behavior that might be considered developmentally-appropriate for adolescents, but not for 45-year-old adults, may be commonly manifested. This is simply another demonstration of how no two people with BPD are alike in every way.

Based upon this description, do you see this in yourself? If so, how do you see this in yourself? If you are having this conversation with a family member or friend, do they see this in you? If so, how strongly?

IDENTITY RELATED ISSUES

0 -- **10**

Not at all **Very strongly**

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injurious behavior, but there are many ways people with BPD may choose to hurt themselves including burning, head banging, skin picking, and other methods.

It is important for friends and family members to realize that most self-injurious behaviors are not suicide attempts in the BPD person's mind. Their intent is not to die. Most BPD individuals who engage in parasuicidal behavior are doing it as a coping skill, not a suicide attempt. They don't want their life to end; they just want the emotional pain to end. Because of this, these events are typically not best characterized as "suicide attempts." It is also important to note that, although the motivation for these behaviors is not to die, many times self-injurious behaviors may result in accidental death. So even if a friend, family member, or health care professional understands that the individual's motive does not involve a wish to die, it is important to recognize that these behaviors still pose significant risk. In addition to accidental death, infections and other medical complications can result from parasuicidal behavior.

So if the motive of self-harming is not to die, then what is it? Well, there is not one *IT*. Actually eight motivations for parasuicidal behavior have been commonly given by individuals with BPD as to why they hurt themselves.

Consider the following motivations and check the boxes that apply to the reasons that you can relate to:

- ☐ **To make one's anguish known to others.** People with BPD suffer intense emotional pain, incomprehensible to the general public. Many are used to hearing things like, "you look so cute, you are so smart, you look fine, and there should be nothing wrong with you." For some people with Borderline Personality Disorder, self-harming behaviors are a way to *externalize internal pain*. "When people see blood running out of my arm, then they can see how much I really hurt and how sick I really am," one of my patients explained. This is a common expression for people with BPD.

- ☐ **To end an argument.** Some people simply say, "If I hurt myself, he/she will get off my back/ stop criticizing me." This is probably less common but self-harming behavior can just serve the function of ending a fight or disagreement when it has reached the point where the person cannot handle any more stimuli.

- ☐ **To elicit a sympathetic response.** Here is the one "attention-seeking" motive. As we have covered, people with BPD have often felt invalidated during their childhood. Many have learned over the years that one way to get validation or caretaking responses is by self-harming. It is a natural instinct for most caring people when they see someone hurting/bleeding, etc. to come and help them or take care of them. While these responses intuitively seem "right," and feel good to the person who sought them out, it is important to note they are actually counterproductive to recovery. Caring responses to unhealthy coping attempts continue to reinforce them. The BPD individual interested in recovery will work with his/her therapist and support system to develop alternative ways to get the responses they need.

- ☐ **Numbness.** "I'd rather feel something than nothing," and, "I'd rather feel physical pain than emotional pain," are common statements from people with BPD. Self-injurious behaviors can serve this function for some clients as well.

- ☐ **To improve problem-solving.** This motive is probably less common as well. But some people with BPD will describe a sense of clarity of thought after self-harm; "like my head clears up and I have a better sense of what to do," one patient described. One of my male BPD individuals said, "It's just kind of like I reach up and hit reset on the video game – like I get to start over."