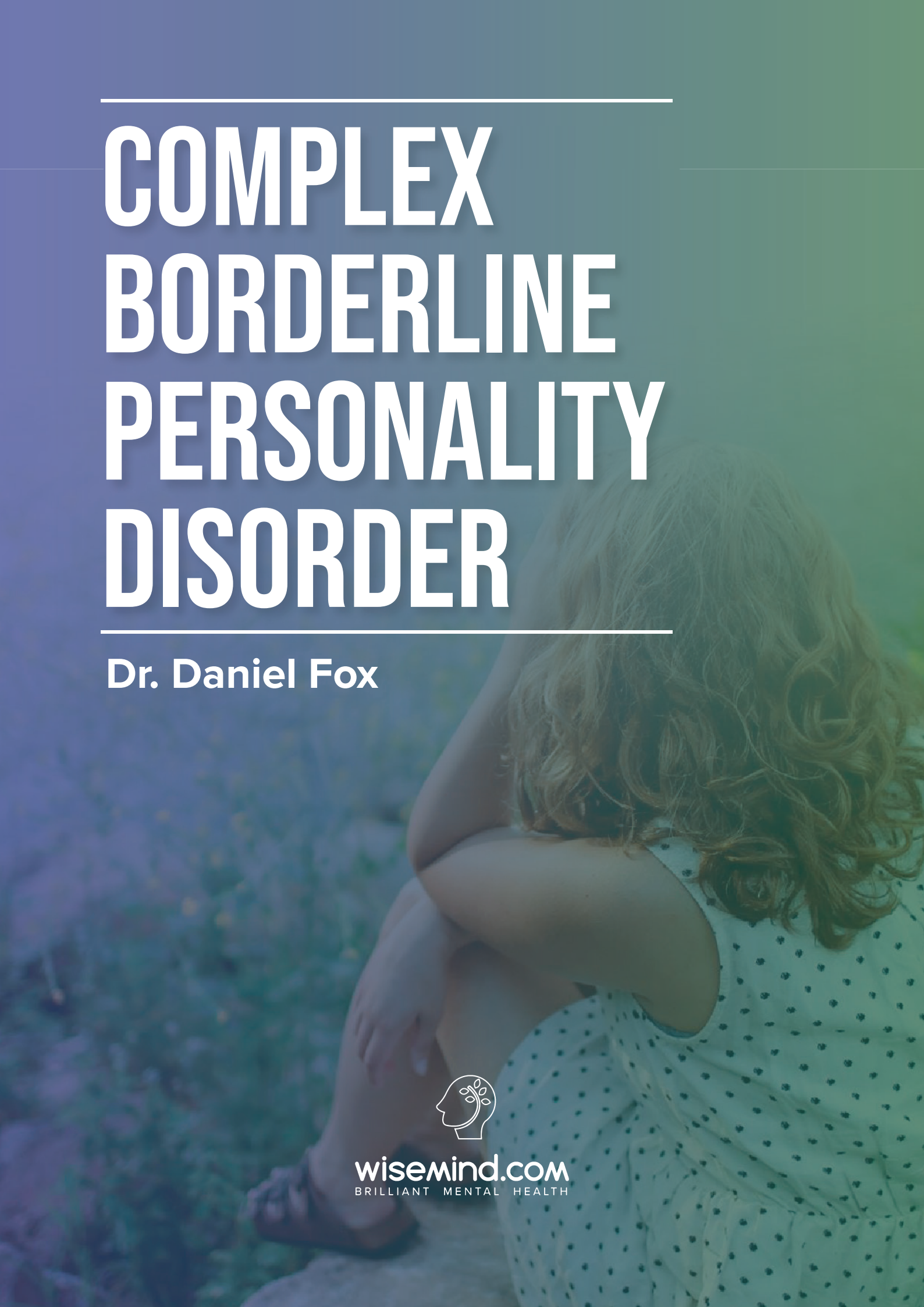
# COMPLEX BORDERLINE PERSONALITY DISORDER

Dr. Daniel Fox



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# Complex BPD Overview

This workbook provides a comprehensive guide to understanding and treating complex borderline personality disorder (BPD) and accompanies the series of the same name by Dr Daniel Fox on wisemind.com.

The workbook delves into various aspects of complex BPD, including coexisting conditions, core and surface content, subtypes, and differentiating BPD from other disorders like bipolar disorder, depression, ADHD, PTSD, and substance abuse.

Throughout the workbook, there are 20 lessons that cover essential topics related to complex BPD. It emphasizes the importance of identifying core content in individuals with BPD, building insight, and establishing a collaborative therapeutic relationship. Strategies and techniques for treating complex BPD, especially when substance abuse is involved, are highlighted to aid therapists in providing effective care to their clients.

One key aspect discussed in the workbook is the concept of connecting values with core content to help individuals internalize positive core beliefs. By aligning goals with how a client lives their life and operationally defining steps for change, therapists can guide clients in making behavioral adjustments and fostering personal growth. Regularly revisiting values and steps throughout the treatment process is also emphasized to facilitate progress and development in managing complex BPD effectively.

Lesson 1:

# What Is BPD and What Makes It a Disorder?

1.1

## What is Borderline Personality Disorder?

Using the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; 2013) there are nine criteria in all, and the individual must exhibit at least five of them. These criteria fall into one of four domains that I've listed and described below.

| DOMAIN | SYMPTOMS / TRAIT |
|---|---|
| **Affective** | Instability due to intense mood sensitivity and responsiveness that may range from dysphoria to irritability, rage, panic, or anxiety. Loneliness and emptiness are common affective experiences. |
| **Impulsive** | Acting and reacting without consideration for shortterm and/or longterm determent to self or other. Common impulsive acts include substance abuse, harm to self or other, suicidal threats, gambling, spending, binge eating and sexual promiscuity. |
| **Interpersonal** | Relationships are tumultuous due to inconsistency in how they see themselves, others, and situations. Perceived abandonment and/or rejection are often triggers for interpersonal disruptions. |
| **Cognitive** | Psychotic and dissociative symptoms are common and manifest as brief periods of psychosis (hallucinations or delusions), depersonalization (i.e., the sensation that a person's body or self is unreal or altered in a strange way), derealization (i.e., the experience that the external world is bizarre and unreal) and illusions, which are misperceptions of existing stimuli. |

However, there are more than just the nine criteria and four domains but most mental health providers get locked into only considering these without taking into account other critical facets, which I've listed below.

- Behaviors and traits must be exhibited across multiple contexts with a variety of other people.
- Exhibits intensive attachment to inanimate or transitional object, such as a stuffed animal

- Has experienced an “out-of-body” experience as a stress reaction
- Feels victimized and “broken”
- May be overprotective and isolate others
- Evokes guilt and anxiety in others
- Those around him or her tend to emotionally sacrifice to keep BPD individual calm
- Harbors intense fear that is overtly displayed as hostility
- Seductive towards atypical figures and in atypical situations (e.g., therapist and therapist’s office)
- Demands loyalty, though shows little in return
- Intrusive and tendency to violate boundaries of others
- Mood lability with definable trigger

Exhibits lack of emotional permanence (e.g., feels abandoned and rejected when trusted other is not immediately available or visually present)

Use these domains and facets to help you more accurately identify BPD. BPD is a complex disorder, so we also must be aware of the challenges in making an accurate diagnosis, and recognizing common age of onset can help in this regard.

## 1.2
## Age of Onset

BPD can occur early in life, but we have to be aware that inherent and universal issues of puberty and early adulthood complicate the issue. BPD can be diagnosed in people as young as sixteen (Kaess, Brunner, and Chanen, 2014), but this diagnosis must meet very strict criteria.

This is because many beliefs, behaviors, and patterns aren’t fully formed during the teenage years, and diagnosing someone with a personality disorder who doesn’t have one can be severely detrimental to their development (Fox, 2022).

The following risk factors are often first exhibited in adolescence or early adulthood:

- low socioeconomic status
- stressful life events
- family adversity
- maternal mental illness
- cold, hostile or harsh parenting
- exposure to physical or sexual abuse or neglect
- low IQ
- high levels of negative affectivity and impulsivity
- identity issues

In addition to these factors, depression, anxiety and dissociation (internalizing symptoms and issues), as well as attention-deficit hyperactivity disorder, oppositional defiant disorder, conduct disorder, and substance use (externalizing symptoms and issues) become evident.

The presence of these issues does not always equal BPD, as they're often seen in many other mental health disorders during the prodromal phase. However, when these factors are present with co-occurring identity issues, the probability of BPD significantly increases.

## 1.3
## Remission and Resurgence of Symptoms

BPD used to be seen as an untreatable disorder, however research shows that this old belief is false and one that the mental health community needs to embrace more fully. I've listed the research findings below (Gunderson, et a., 2011; Zanarini, et a., 2005):

- 50% of participants achieved recovery from BPD, which was defined as remission of symptoms and having good social and vocational functioning during the previous 2 years.
- 93% of participants attained a remission of symptoms lasting at least 2 years,
- 86% attained a sustained remission lasting at least 4 years.

Of those who achieved recovery, only 34% relapsed, which means when looked at from the other side, that 66% did not relapse.

Of those who achieved a 2-year remission of symptoms, 30% had a symptomatic recurrence, and of those who achieved a sustained remission, only 15% experienced a recurrence. These data show that we should hold a hopeful and promising outlook on this complex disorder. However, sometimes, the greatest challenge to working with individuals with BPD, comes from us in the form of the confirmation bias.

## 1.4
## Confirmation Bias

Confirmation bias is a genuine determent to success with all clients, particularly those with BPD. Confirmation bias is when we favor information that confirms our preexisting beliefs, which can include race, gender, foods, locations, and others, and most certainly mental health disorders. Confirmation bias not only impacts how we perceive others, but also how we behave towards them in order to elicit the sought-after behavior to prove ourselves correct.

1.4

## A Beating the Bias

I've listed five strategies below that can help you be more cognizant of the confirmation bias. When we heighten our awareness of our biases, we are less likely to fall prey to them.

1. Acknowledge that we all hold biases.
2. Remember, the prevalence of the full disorder.
3. Remove clinical terms from your colloquial use.
4. Challenge your assumptions with facts that motivate you to find simple explanations for maladaptive behaviors.
5. Monitor for countertransference and use an objective lens.

1.5

## Case Study – Confirmation Bias Cathy

Cathy is a 22-year-old female who was referred to your office by a colleague you met once at a conference. She shows up five minutes late and is sweating profusely. She gets her initial session paperwork and seems to be taking her time filling it out, as you wait in your office to see her. As time keeps ticking away, you watch the clock wondering what is taking her so long to complete the form. Ten minutes later, you get a call from your administrative assistant who tells you she is ready. You look at the clock and think, "Well, she's only got 30 minutes now."

You go out to the waiting room, pick up her forms and escort her back to your office. You look through the forms on your walk to the office and see her prior diagnoses include depression, panic disorder, and borderline personality disorder. You mmediately think, "Oh great, another borderline who doesn't show up on time, is going to be a nightmare to work with, and is going to demand the full hour when she was late to the session and slow to complete the paperwork."

When Cathy sits down you see multiple scrapes along her forearm that look recent, as they are red, scabbed over, and raised. You think, "Oh great, she's a self-harmer too." For the next 30 minutes, you probe for past abuse, but Cathy denies childhood abuse of any kind. You explore her relationships, which are tumultuous and she tends to get into relationships with married partners. When you ask about previous work experience, she tells you that she's been fired from multiple jobs for acting out aggressively toward her boss and coworkers and having panic attacks. Her depression has prevented her from showing up to sessions and on time for work in the past. At the end of the session, you feel confident that she meets criteria for BPD, and substantiate it.

Confirmation bias has certainly influenced you here. Based upon this information so far, Cathy would not meet criteria for the BPD disorder. She may have traits but in the first session, it's an overreach to diagnose a personality disorder. Confirmation bias drove you to look for abuse when there wasn't any, misconstrue her attitude toward session, discount her panic and depression, and misinterpret her scrapes as self-harm, as they were actually from falling off a scooter tour she was on two days before with her mom.

I hope you found this lesson helpful and that it provided clarity that lessens your confusion pertaining to BPD. The next step is an important one that builds upon the foundation we have set here, which is where does BPD come from?

## References

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