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An exploration of clinicians' experiences in the diagnosis and management of patients with Borderline Personality Disorder patients at Valkenberg hospital in the Western Cape region

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A [minor] dissertation submitted in [partial] *fulfillment* of the requirements for the award of the degree of Master of Psychology

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2007

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

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ABSTRACT

Disorders of personality are conceptualized along a continuum of severity. Among all diagnosed with a cluster B personality disorder, patients with Borderline Personality Disorder illness are believed to experience the greatest suffering. Always in a state of crisis, these patients are so named by different writers because they were believed to stand between a neurotic and psychotic personality organization. This complex diagnostic picture together with the illness's tendency to co-exist with some of Axis I psychiatric disorders has made the illness to be perceived as both difficult to diagnose and manage. Previous research indicates that many professionals are turned off by working with people with this illness because it draws on many negative feelings from the clinician.

This study sought to explore factors which assist clinicians in making the BPD diagnosis. It focuses at diagnostic processes utilized other than the DSM-IV-TR. Explanatory theories are also put forward in an effort to try and understand some of the issues experienced by the individual in the development of the illness. Participants' attitudes held towards these patients are also examined to see whether these have shifted. An understanding of these factors and recommendations are offered at the end.

Semi-structured interviews were conducted with seven white clinicians from Valkenberg hospital in the Western Cape region. The research design was qualitative and a phenomenological framework was used to inform the study. The interviews were taped, transcribed and typed. The data was then analysed according to broad themes emerging from the interviews.

A number of different factors impacted on the decision regarding in both making the diagnosis and management of BPD illness. These factors were discussed according to the following broad themes:

- * Diagnostic challenges
- * Demographic patterns in BPD diagnosis
- * Management issues

Key words: Borderline, personality disorder, personality structure, diagnosis, psychopathology and comorbidity.

Declaration

I declare that this thesis is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete references.

NOBUNTU W. GQIBA

ACKNOWLEDGEMENTS

I am eternally grateful to God my creator, for giving me strength when I was weak. This journey would not have been possible without His love and guidance.

I thank my supervisor Dr. Nokuthula Shabalala for her support, enthusiasm, and also for being accommodating of other demands placed on my professional development.

I am also deeply indebted to the invaluable help and co-operation I received from the Psychiatric and Psychology team at Valkenberg Hospital, most especially to Dr. Rob Bothwell who is a consultant psychiatrist at the Psycho-therapeutic Unit.

I would like to thank my late husband Mlamli Gqiba, for being the driving force and inspiration throughout my academic years. To my children Bulelwa and Viwe, thank you for your unfaltering support, love and understanding, you put my needs before yours and may God bless you for that.

My mother, the completion of this project owes a lot to your unrelentless belief and faith in me. To my friend Nomathemba Skweyiya, thank you for the love and support you showed during my time of need.

Last but not least, thank you very much to Debbie and Nadrah, everything you have done for me has never gone unnoticed.

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CHAPTER ONE: INTRODUCTION

1.1 Historical background

This dissertation explores the factors that are involved in the diagnosis of Borderline Personality Disorder (BPD) in patients admitted either in male or female wards at Valkenberg hospital in the Western Cape region. Different diagnostic tools other than the DSM-IV-TR criteria will be explored, and the effects that these have on the management process. Other issues explored were clinicians' counter-transference responses to their patients with BPD and the effect that this has on the management process.

The concept of Borderline Personality Disorder is shrouded in controversy, beginning with the definition of the concept, through diagnostic models, aetiological understandings, treatment modalities and even whether this diagnostic category should exist at all. According to Paris (1999) the term borderline personality is a misnomer. In his explanation, Paris states that these patients were described sixty years ago by psychoanalysts who noted that they did poorly in treatment, and therefore theorized that this is a form of pathology that lies on the border between psychosis and neurosis. Paris (1999) notes that although there is no underlying psychosis in BPD the name borderline has stuck.

Whilst some theorists continue to view this disorder as occupying an area between neurosis and psychosis, others suggest that this disorder exists as a clearly delineated entity, both marking the boundary between psychosis and neurosis, and possessing clearly definable borders. This schism underpins the central debates in the area and makes an understanding of this diagnostic category both complex and challenging. One is able to empathize with Michael Stone who feels haunted by the dark suspicion that the subject has gotten out of hand (Stone, 1986).

So much literature has accumulated over too long a period on borderline conditions in psychiatry that an anthology was compiled by Stone (1986). In this anthology, prominent authors such as Kernberg, Gunderson, Jacobson, Erikson and others give their

contributions. Other authors like Freud, Kraepelin and Wilhelm Reich, though they had little to say on borderline conditions, also contributed in the compilation of the anthology. Articles of Deutsch (1942) and Knight (1953), for example, though written in the belief that borderline depicted an incipient or dilute variant of schizophrenia, are classics in the field, important not only in understanding how the term borderline has evolved but in appreciating the origins of object-relational and other non-orthodox psychoanalytical approaches (Stone, 1986). A survey of the important contributions to the borderline concept, particularly those that may be considered contemporary reveals something of interest about the transfer and spread of the ideas.

In the 1880s the concept of the BPD was just taking shape. The concepts of schizophrenia and manic depression were themselves new and imprecise. Meantime psychiatric taxonomists were busy inventing labels for every nuance of paranoid or otherwise delusory ideation (Stone, 1986). The forerunner of manic-depressive illness was just beginning to win wide acceptance. The realm of diagnosis consisted mainly of two nebulous concepts, about psychosis and neurosis. If there were to be a borderline case, it had to be found somewhere in the amorphous territory between these two indistinct concepts. Lombroso (1870) found it useful to describe certain cases of criminality as occupying the border between madness and normality. The first borderland or borderline cases were nondelusional sociopaths. A little later, as seen from the articles of Hughes (1884) and Rosse (1890), cases included chronic mental illness that fell short of outright madness, but never approached normality either. These were also seen as occupying the territory between the psychosis and neurosis.

Stone (1986) noted that although a number of articles and books appeared during the 1890s containing case descriptions of serious but nondelusional mental disorders, the term borderline or borderland were used rarely. He further explains that the case descriptions were often detailed enough to permit the reader, even a century later, to establish with some conviction that certain patients of that era were very much like borderline patients today (Stone, 1986). The histrionic moody women depicted by Klein (1975) and later by Liebowitz and Klein (1979), under the heading hysteroid dysphoria

are quite similar to the women of the 1890s presenting with what Falret (1890) was calling folie hysterique. The folie hysteriques of Falret was at the extreme of a continuum relating to hysterical character. The latter already embraced many of the items now recognized in the DSM as intrinsic to borderline personality disorder (Stone, 1986).

Falret (1890 cited in Stone, 1986) mentions lability of affect, impulsivity and an extreme contradictoriness of attitude such as Kernberg (1975) emphasized in his description. This contradictoriness, along with the duplicity, absorption in fantasy and rapid shift from one state of beliefs and values to another, constitutes the kind of identity disturbance and the “as – if” quality to the personality that authors such as Deutsch (1942) and Kernberg (1975) were to hold as central to the borderline concept.

According to Stone (1986) the 1920s were regarded as inauspicious in the history of the borderline concept. The term made a fleeting appearance in 1921 under the guise of an article called parataxis [or] certain borderline mental states by Moore (1921). After this tentative debut, the term fell inexplicably into a state of prolonged slumber from which it was not to reawaken for another 17 years. It subsequently appeared in Stern’s (1938) article in which he discusses his contact with patients who have BPD illness for the first time.

During the 1950s and 1960s the Borderline Personality Disorder concept was evolving and two main trends emerged. There was a shift in the spotlight from descriptive to more dynamic definitions, with a change of usage from traditional psychiatry where the term all but disappears to psychoanalysis where its popularity was beginning to take off. This was in part because hospital-based psychiatrists looked at psychosis with central vision (it was part of their daily work) and psychoanalysis (mostly office based) with peripheral vision (Stone, 1986). It was in Knight’s (1953 in Stone, 1986) paper that the process of decoupling the schizophrenia-concept from the borderline-concept got its major impetus. This process advanced at such a pace that to the person perched ten years down the time continuum, borderline would have begun to look not like a mere adjective denoting less-

than-classically-analyzable or a weak brand of schizophrenia, but would have looked, for the first time, like an entity in itself (Stone, 1986).

In the 1960s a number of the trends which have been alluded to began to converge in a key paper of Kernberg (1967). His goal was to assemble various conceptual fragments provided by his predecessors into a coherent picture, clinically more useful and diagnostically more precise than the amorphous descriptions of the past. The trend towards the establishment of Borderline Personality Disorder as constituting a separate and discriminable entity also finds its more coherent expression in Kernberg's writing called Borderline Personality Organization (Kernberg, 1967). His writing is equipped with inclusion and exclusion criteria. These were not perceived as rigorous as one might hope for, but were considered as workable (Stone, 1986). For example, a good capacity to test reality distinguishes the borderline level from the psychotic; a firm sense of identity distinguishes the neurotic from the borderline.

During the 1970s and 1980s under the influence of Kernberg (1975), the term borderline became more widely used than ever before, not only among American psychoanalysts grappling with their most challenging office patients but also among psychiatrists, whether analytically trained or not, working with hospitalized patients. Borderline disorder began to fill in the space between existing and more sharply discriminable entities like schizophrenia and manic depression. The widening popularity of the term stimulated research and reformulations on a broad front, so much so that it became easier to discuss these recent developments according to some coherent outline. Efforts to achieve uniformity in the characterization of these difficult patients have led to more precise approaches to the definition of the term borderline pathology. The most narrow approach is represented by the concept Borderline Personality Disorder (BPD) as defined by the American Psychiatric Association (APA) in its Diagnostic and Statistical Manual of Mental Disorders (DSM III) in 1980 and its later revisions, (DSM III-R) in 1987, then DSM IV (1994) and currently the DSM IV-TR (2000).

1.2 Rationale of the Study

Most of the research in the practice of psychology is focused primarily on the psychological risk factors in the developmental process of Borderline Personality Disorder illness (Linehan & Koener, 1993). Rather, psychological risk factors may be precipitants for a predisposition that is based in biological vulnerabilities. The fact that writers such as Akiskal (1981), Akiskal, Chen, Davis et al. (1985) have highlighted impulsivity and affective instability as one of the core dimensions for BPD deserves systematic testing. Similarly, other writers such as Cloninger (2002), Siever, Torgersen and Gunderson (2002) and Torgesen (2000) have also noted how recognition regarding the complex process of gene-environment interaction is involved in the determination of personality types and disorders. A general stress vulnerability conceptual framework is therefore useful in considering varying combinations of predisposing genetic risk factors and stressful life experiences (Paris, 1999). A reduction in central nervous system serotonin levels has been correlated with impulsive aggression in patients with BPD (Hansenne, Pitchot & Pinto, 2002).

Although most people in this field are aware of the difficulties experienced during the diagnostic and management process of borderline illness, so far there has been little attempt to explore other possibilities such as the neurobiology of BPD in an attempt to augment the DSM-IV-TR diagnostic criteria of mental disorders. This may be due to the fact that there have been few studies conducted in this area. Those studies available have also indicated that findings to date are relatively nonspecific. Therefore, the rationale for conducting this study is to generate information in this area and to provide the Department of Psychology at the University of Cape Town with possible suggestions to implement in future around diagnosis. These could possibly help with better management of the illness.

1.3 Thesis layout

Chapter two reviews the literature in the following areas: 1) the definition of BPD illness as described in the DSM-IV-TR (APA, 2000) and in other contexts; 2) the evolution of the disorder with a view to give some insight as to where the literature is at with regards

to research issues; 3) demographic patterns in BPD diagnosis with reference to the stereotypes that perpetuate the negative assumptions thereof; 4) issues of personality are defined; 5) an attempt is then made to understand BPD characteristics and issues of comorbidity, taking into consideration those that mimic the BPD illness; 6) different diagnostic processes are described, including less easily defined understandings not included in the DSM; 7) lastly, a theoretical discussion on the explanatory models such as psychodynamic and biopsychosocial issues.

Chapter three presents a brief overview of qualitative research and rationale for its selection. The aim of the study, issues of reliability and validity, sample selection, instruments, procedure of data gathering and analysis are also explored. Finally, information on participants and reflections on the research process are presented. A thematic content analysis is used in order to interpret and give meaning to the data. Common themes as well as contradictions between and within the participants' experiences are explored.

Chapter four reports on the results and themes emerging from the data.

Chapter five discusses the findings of data. It also provides the conclusion of this research, reflects on limitations of the study and some proposed recommendations.

CHAPTER TWO: LITERATURE REVIEW

Introduction

Borderline Personality Disorder (BPD) is a complex and serious mental disorder characterized by a pervasive pattern of instability in regulation of emotions, interpersonal relationship, self-image and impulse control (APA, 1994). The ICD-10 (1994) refers to BPD as the Emotionally Unstable Personality Disorder, which is characterized by impulsivity, unpredictable moods, outbursts of emotions, behavioural explosions, quarrelsome behaviour and conflicts with others. It divides this category into two types: the impulsive type (characterized by emotional instability and lack of impulse control) and the borderline type (characterized by disturbances of self-image, aims, and internal preferences; chronic feelings of emptiness; intense unstable interpersonal relationships and self-destructive behaviour).

Benjamin (1993) notes that individuals with BPD often suffer from thought, affective, dissociative disturbances, alcohol and substance abuse, eating and anxiety disorders. She suggests that with BPD, everything that can go wrong has gone wrong, involving every domain of function, namely, cognition, mood and behaviour. The Work Group on Borderline Personality Disorder (2001) notes that the illness is characterized by severe impairment, substantial treatment utilization and mortality rate by suicide of almost 10% - 50% higher than the rate in the general population. Recently, through the efforts of the American National Institute of Mental Health, the Borderline Personality Research Foundation, and family advocacy group, borderline personality disorder is becoming a focus of intensifying study (Skodol, Gunderson, Pfohl, Widiger, Livesley & Siever, 2002).

From the above mentioned description of the borderline characteristics, one can get an understanding of how these patients, as noted by Kernberg, Selzer, Koenigsberg, Carr and Appelbaum (1989), represent a great portion of the most difficult to treat clients in psychiatry. Stolorow and Brandchaft (1994) support this statement by explaining that the 'borderline' patient places the therapist in a dilemma which often results in a diagnostic

act which is more a reflection of the therapist's internal dynamics than of the patient's pathology. They go on by saying that.... "In the treatment of these difficult patients, the therapist commonly experiences an acute and painful awareness of frustration followed by feelings of helplessness and inadequacy" (Stolorow & Brandchaft, 1994, p.94).

The first section of this literature review will examine the psychopathology of the disorder, beginning with the background history of the disorder, prevalence rates, and the personality structure. The next section will focus on comorbidity of BPD with other personality disorders, comparing BPD with other disorders Axis I and Axis II, which complicates the process of diagnosis. This will be followed by how the diagnosis is made, highlighting the different processes involved. The last section in the chapter will present theoretical understandings of the disorder, ending with biopsychosocial model, which combines elements of previous ones.

2.1 Origins and Evolution of the Borderline Diagnosis

Following the seminal clinical accounts of borderline patients by Stern (1938) and Knight (1953), Kernberg (1967) made an effort to define their intrapsychic features. Although the term borderline has been in clinical use since the 1930s, it only became an official Axis II diagnosis with the publication of DSM-III (APA, 1980). Stern (1938) first came into contact with a group of patients in therapy that he found extremely difficult to handle using the usual psychoanalytic therapy. The majority of the patients were not benefiting from therapy, regardless of having had lengthy course of treatment. He coined the term "Border Line" to refer to this group of patients (Stone, 1986, p.54). The difficulties he encountered in treating these patients motivated him to study them more closely. His focus was to look on what aspects of the clinical picture were unaffected by methods successful in the usual run of patients described as psychoneurotics. He discovered that among other things, the borderline group of patients showed a fairly definite clinical picture and symptoms. On the basis of their history and the transference relationship as it evolved in therapy, he enumerated 10 clinical symptoms under the heading of reaction formation or character traits, with narcissism being the basic underlying character component in patients with this type of personality. Stern (1938, as cited in Stone, 1986)

attributed this character component to early childhood factors which adversely affected the normal narcissistic development. He indicated that in at least seventy-five percent of this group, the histories showed that there were, among other things, the presence of a mother who was a decidedly neurotic or psychotic type, in more than one instance developing a psychosis or psychotic episodes of short duration. These mothers inflicted psychic injuries on their children by virtue of a deficiency of spontaneous maternal affection. Some cases were characterized by parental conflict, repeated outbursts of temper between parents or directed at the children. In some of the families divorce, separation of the parents or desertion by one of the parents before patients were seven years old, acted as added sources of great insecurity at a time when these children were already in a state of affective deprivation because of discord between the parents before the separation took place (Stern, 1938, as cited in Stone, 1986).

Patients with this type of disorder were also identified in other contexts by different practitioners. In 1941 Zilboorg described a group of patients as having ambulatory schizophrenia, indicating that they manifested a variant of schizophrenia that did not necessarily require hospitalization and were better functioning than schizophrenic patients. Deutsch (1942) talked of patients who were prone to mild depersonalization and who lacked genuineness. She described them as having an “as if” personality structure and suggested that this personality may represent a phase of schizophrenic process before “it built up to the delusional form” (Deutsch, 1942, p. 78). Similarly, Schmideberg (1947) spoke of patients with schizophrenia-like symptoms and who manifested both narcissistic and schizoid features. She saw these patients as falling in the border between neurosis and psychosis and described them as “stable in their instability” (Schmideberg, 1947, p. 93). However, Hoch and Polatin (1949, as cited in Stone, 1986) were more systematic in their description of this group of patients, indicating that their borderline categorization was not an ill-defined type falling between neurosis and psychosis. They saw it as a new syndrome, which they termed pseudoneurotic schizophrenia.

There has been a shift over the years as a body of literature has evolved describing borderline phenomena, leading to an understanding that the disorder being examined was

not a variant of schizophrenia but was, in fact, a personality disorder (Kernberg, 1967). Kernberg described borderline personality organization (BPO) as an intermediary level of internal personality organization, framed on one side by more severe psychotic personality organization and on the other by less severe neurotic organization. The BPO construct encompasses serious forms of personality disorder and is characterized by three intrapsychic characteristics: identity diffusion; primitive defenses (e.g. splitting [devaluation and idealization], denial, projection, and projective identification); and intact reality testing that was vulnerable to alterations and failures. It was largely due to the contributions of Kernberg in the 1960s that the borderline phenomenon came to be seen as a personality disorder. He suggested a specific type of psychoanalytic psychotherapy for borderline patients in which transference issues are interpreted early in the process (Kernberg, 1960 as cited in Kaplan & Sadock, 1994).

Over the last decade, there has been a lot of research done on diagnostic issues around Borderline Personality Disorder. The focus has now moved to boundaries of the disorder with other Axis I clinical disorders.

2.2 Prevalence

The prevalence of BPD is estimated to be about 2% - 3% of the general population (Bockian, Porr & Villagran, 2002; APA, 1994). Bockian et al. (2002) feel that there are enough people among the general population for it to be called a common disorder, indicating that up to 15% of the population struggles with some aspects of the disorder, which is nearly one person in seven. According to the American National Alliance for Research on Schizophrenia and Depression (NARSAD) (2004), BPD is the most common personality disorder in clinical settings, with the APA (1994) estimating it at 30% to 60%.

There is an estimation of about 10% among individuals seen in outpatients mental clinics, and about 20% among psychiatric inpatients (APA, 1994). However, there are gender and racial differences in the occurrence of the disorder, with literature indicating more occurrences in women than in men, and higher prevalence in certain racial groups.

2.2.1 Gender

The DSM-IV -TR (APA, 2000) states that borderline personality disorder is “diagnosed predominantly (about 75%) in females” (p.708). This figure makes it to be occurring 3 times more often in women than in men. This has led to considerable debate and speculation about the cause of this gender difference. Skodol and Bender (2003) attribute this to problems in the diagnostic processes and procedures, as well as socio-cultural factors. The latter will be discussed later.

Explanations of gender differences in prevalence

Gender bias
↓

A number of authors have attributed the overdiagnosis of BPD to problems in diagnostic criteria laid out in DSM-III. Kaplan (1983) argued that the diagnostic experts, mostly men, who served in the DSM-III Task Force had codified certain masculine-based assumptions about what behaviours were healthy and what were abnormal. Among other things, women who over-conformed to certain sex roles stereotypes would be labelled as pathological (Chesler, 1972). Kaplan’s two primary examples of gender-biased diagnoses were histrionic and dependent personality disorders (PDs) but she also noted that BPD was potentially biased. Widiger (1998) described six ways in which sex bias can occur. These are biased sampling of persons with the disorder, diagnostic constructs, diagnostic criteria, diagnostic thresholds, application of diagnostic criteria and instruments of assessment.

Biased sampling refers to the possibility that the perception of a higher rate of a disorder among women in a clinical setting may simply reflect a high rate of women receiving treatment in that setting since women are more likely than men to seek help for psychological problems (Widiger, 1998). Research from Scandinavia by Jackson, Whiteside, Bates et al. (1991) showed that of five empirical studies done to test for gender differences, only one found that the rate of BPD differed by gender. However, in a review study of 225 depressed outpatients done by Carter, Joyce, Mulder et al. (1999) BPD was found to occur more often among men. Thus, the elevated base rate of women in clinical settings may be the reason why clinicians perceive more women to have BPD.

A difference in the rates of BPD between men and women may only be determined accurately from the general population. Research from a Norwegian community sample by Torgersen, Kringlen and Cramer (2001) found no difference in the prevalence by gender. They attributed these results to perhaps the effects of culture on the expression of psychopathology in that country. They suggest that more epidemiological studies of BPD in diverse populations of the world will be needed before the true prevalence by gender can be determined.

Biased diagnostic criteria refer to the possibility that behaviours consistent with one's gender role may be viewed as less pathological, the opposite of the sexual stereotyping argument. In a study done in the New York State Psychiatric Institute by Henry and Cohen (1983) among normal men and women who were given an equivalent number of symptoms, there was no difference found in the rate of BPD diagnosed in the female vs. the male versions of the case. The second part of the study, which was done on students, looked at their character traits. The authors found that male students (presumed to be normal) exhibited more BPD characteristics than female students. They concluded that the labelling of certain behaviours as pathological only when they occur in women may contribute to an increased rate of BPD in women.

The threshold for diagnosis may be biased if there is a different point at which a diagnosis would be given to women vs. men, perhaps reflected in a different assumption about the degree of impairment associated with the personality traits or behaviours as compared to men. Research with Columbia University undergraduate students showed that inappropriate, intense anger was rated more abnormal for a woman than for a man (Sprock, 1996). In addition, men rated women with the criteria as more abnormal than men with the same criteria. Thus, among the general public, a difference in the threshold for abnormality of BPD criteria between men and women seemed to exist. Two studies by Funtowicz and Widiger (1999), which also addressed the question of bias in the threshold for diagnosis of BPD, included college students and the second study included clinical psychologists as participants. The study done on the college students showed no indication that the degree of impairment was lower for persons who were at the

diagnostic threshold for PDs (usually said to be women) than for persons at the threshold for male-type PDs. Overall it was found that the level of dysfunction for male-type PDs was lower in some instances, suggesting that it might be relatively easier to obtain a male-type than a female-type PD diagnosis. Similarly, the second study done on clinical psychologists showed no significant differences in average impairment associated with BPD or other female-type PDs.

It thus appears that the different prevalence rates commonly observed in clinical settings are largely a function of sampling bias. Due to the paucity of data from representative general population studies, the true prevalence of BPD and its true gender ratio is unknown. Some modest empirical support for diagnostic biases of various kinds exists, but not of a magnitude that would be necessary to account for a wide difference (e.g., a 3:1 ratio) in prevalence between genders (Morey & Ochoa, 1989).

2.2.2 Race

Research from California (Akhtar, Byrnè & Doghramji, 1986) found that a significant preponderance of patients with the disorder were young, white and female. However, this finding was not considered conclusive because data were pooled from studies with questionable sampling techniques. These researchers feel that this demographic profile warrants further investigation because it may imply diagnostic biases or actual differences in the prevalence of Borderline Personality Disorder among various groups.

2.2.3 Age

The DSM-IV-TR (APA, 2000) states that borderline features begin by early adulthood and that adolescents and young adults with identity problems (especially when accompanied by substance use) may transiently display behaviours that misleadingly give the impression of Borderline Personality Disorder. A Swedish urban community study by Runeson and Beskow (1991) that examined the rate of suicide in adolescents and young adults (ages 15 to 29 years) found borderline personality disorder in 33% of the subjects. When compared with subjects with other disorders, BPD subjects showed more antisocial traits and substance use disorders.

Bockian et al. (2002) explain that many of symptoms of BPD experienced in early adulthood echo the turmoil of adolescence, such as identity problems as mentioned by the DSM-IV-TR (APA, 2000), existential anguish, poor judgement, risky behaviour, pessimism, extreme sarcasm, feelings of emptiness, suicidal thoughts, and rebelliousness alternating with overdependency. They go further to say that, due to these similarities, it is important to evaluate long-term patterns of affect and behaviour in diagnosing BPD, especially in young adults. With regards to adults, Bockian et al.'s (2002) explanation is that, for some people with BPD, the illness tends to run its course by middle age. This assumption is echoed by Stone (1986) whose impression is that certain characteristics (i.e. turbulent relationships, suicide gestures impulsivity) by which patients with BPD are initially diagnosed become rarer or fainter with advancing years. People in their forties usually have worked out a satisfying relationship with someone or else given up on intimacy altogether. He further suggests that by age 45, a small minority of patients with BPD have either died by suicide or have stopped making suicidal acts because of biochemical and/or psychological changes. Bockian et al. (2002), on the other hand, caution that for others the disorder may continue to wreak havoc on their personal and professional lives well into their senior years, thus needing ongoing care and support from the therapeutic community (Bockian, Porr & Villagran, 2002).

2.3 Construct of Personality Disorder

In this section the construct of personality and issues of personality disorders will be discussed. The first part looks largely at what is understood by the term personality, and the second part will look at differentiation of Axis I from Axis II disorders and lastly, issues of comorbidity.

2.3.1 Personality

The concept of personality presents many problems when diagnosing psychiatric disorders (NARSAD, 2004), given that the definition of the concept itself is not easy, with Rychlak (1990) suggesting that it is influenced by the different theoretical orientations. Researchers often disagree about the boundaries between personality disorders and even the distinction between healthy and unhealthy personalities. The

NARSAD (2004) research publication states that observing someone's personality on the whole is highly subjective. It implies certain common features in what a person thinks, feels and does over a period of time in changing situations. Different theorists from both the psychodynamic and biological background give some understanding of the concept.

According to psychoanalytic theory, personality can be viewed as the product of a dynamic struggle originating from the clash between our inner drives and the laws, social rules and moral values imposed on us by society. This dynamic struggle is mediated by defence mechanisms, which aim to prevent us from coming into contact with painful realities (Salkind, 1991). Childhood experiences contribute to one's personality, or character, as an adult. According to Freud (1936) traumatic experiences have an especially strong effect on the individual with specific trauma having its own unique impact on a person. Although everyone needs and uses defence mechanisms to some time, the extent to which these defences are used can be indicative of pathology (Brown & Pedder, 1991). Maturity indicates a capacity to acknowledge and tolerate feelings of pain and anxiety without acting on them except when appropriate (Brown & Pedder, 1991). Consequently, excessive defensiveness is seen as a lack of maturity and emotional instability.

Although the issue of biology will be discussed in depth later under the explanatory theories regarding aetiological factors, it is also important to note that there is mounting scientific evidence which attempts to prove that biological factors are crucial in shaping personality (Bockian et al., 2002). According to Bockian and colleagues parents react to children according to their temperaments, as do many others in the individual's environment. Of the portion that cannot be attributed to biology many factors, such as the child's peer interactions, relationships with teachers and clergy, and cultural factors, play a huge role in shaping the ultimate personality of the individual. Silk (2000) states that the belief that biology plays only a minor role is quite mistaken, and strongly supports the biology stance as crucial in shaping the personality.

2.3.2 Personality disorders

A personality disorder is defined in the DSM-IV (APA, 1994) as “an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual’s culture ... has an onset in adolescence or early adulthood, is stable over time and leads to distress or impairment” (p. 629). Personality traits on the other hand are defined as enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts. Personality traits are diagnosed as personality disorders only when they reach a threshold beyond which they are considered to be inflexible, maladaptive, persisting and causing significant social or occupational impairment, and/or subjective distress (APA, 1994; Kaplan & Sadock, 1994).

In the last twenty years the DSM-IV (APA, 1994) groups personality disorders into three clusters, with BPD forming cluster B together with Antisocial, Histrionic and Narcissistic Personality Disorders. The DSM-IV (APA, 1994) notes that individuals may frequently present with co-occurring personality disorders from different clusters as well as other Axis I disorders, as it will be indicated in the issues of comorbidity. This may be part of the reason why personality disorders are more difficult to treat than Axis I disorders, which refer to disturbances in mental states and not disturbances that invoke the entire personality (Kernberg, Selzer, Koenigsberg, Carr & Appelbaum, 1989).

2.3.3 Comorbidity

According to Widiger and Frances (1989), the term comorbid implies two separate disease processes that occur in the same individual. They state that comorbidity may be exaggerated in settings populated by persons with severe mental disorders. A diagnostic system can increase comorbidity by delineating diagnoses, demarcating different categories along a spectrum of disorders, lowering the threshold for diagnosis and including overlapping criteria (Widiger & Frances, 1989, in Tasman, Hales & Frances 1989). Although the DSM-IV (APA, 1994) does acknowledge the fact that BPD often co-occurs with Mood Disorders and that when criteria for both are met, both may be diagnosed, it cautions clinicians to avoid giving an additional diagnosis of BPD based

only on cross-sectional presentation without having documented that the pattern of behaviour has an early onset and a long-standing course.

Although the literature has revealed that there are several studies of comorbidity in patients with BPD, this thesis will focus on those which identify the BPD diagnosis as having a high prevalence co-occurrence rate with either its near-neighbour Axis II disorders (clusters A, B & C) and or Axis I diagnosis/disorder. It is estimated that the overlap of Borderline Personality Disorder with Axis I disorders is between 40% and 60% (Marziali & Monroe-Blum, 1994). Prominent among Axis I / BPD patterns of comorbidity are BPD and Mood Disorders (Skodol, Stout, McGlashan, Grilo, Gunderson, Shea, et al., 1999), Anxiety Disorders (Skodol, Oldham, Hyler, Stein, Hollander, Gallaher, et al., 1995) and Substance Use Disorders (Grant, Stinson, Dawson et al., 2004; Skodol, Oldham, Gallaher, et al., 1999). Other writers like Fava (1998), Goodwin and Jamison (1990), Rosenbluth and Silver (1997) list Depression and Bipolar as being more common thereby overshadowing accurate diagnosis and complicating the patient's treatment response (Skodol, Gunderson, McGlashan et al., 2002). In addition to a potential for being confused with Schizophrenia, Bockian et al. (2002) state that this illness has also been cited by the APA (2002) as co-existing with Mood Disorders, Substance Abuse, Eating Disorders and Post-Traumatic Stress Disorder (PTSD).

Skodol, Oldham and Gallaher, et al. (1999) report that patients diagnosed with BPD have a higher chance of having abused substances other than alcohol and cannabis. They also found that these patients were eight times more likely to have panic disorder and five times more likely to have bulimia than those without the disorder. Similarly, a study by Zimmerman and Mattia (1999) found that almost all their sample of patients with BPD had a concurrent Axis I disorder, with 61% meeting criteria for major depressive disorder, 21% having Panic Disorder with Agoraphobia and 13% having alcohol or other substance abuse. In a literature review on the phenomenological and conceptual interface between BPD and PTSD Gunderson and Sabo (1993) suggest that these seemingly separate disorders are related based on the fact that they are both shaped in part by trauma and that individuals with borderline disorder are therefore vulnerable to developing

PTSD. These authors draw a distinction between the enduring effects that trauma can have on the formation of Axis II personality traits and acute symptomatic reactions to trauma called PTSD, that are accompanied by specific psychophysiological correlates.

In explaining the co-occurrence of BPD with its near-neighbour personality disorders, NARSAD (2004) states that patients with BPD or borderline features do not show a common profile. Instead, the personality traits seem to be a combination of histrionic, narcissistic and antisocial personality characteristics. Their profile was compiled through the administration of a standard test like the Minnesota Multiphase Personality Inventory (MMPI). An American study by Nurnberg, Raslein, Levin, Pollack, Siegel and Prince (1991) also examined issues of comorbidity of BPD and other DSM-III-R Axis II personality disorders. A sample from outpatients participated in the study. Results showed that 20% of patients met criteria for Borderline Personality Disorder and that 82% had at least one additional personality disorder diagnosis. Their conclusion was that BPD appears to constitute a broad, heterogeneous category with unclear boundaries that embrace a general personality disorder concept. They suggested further refinement of the borderline personality disorder construct and investigation into alternative models to the DSM-III-R Axis II classification system.

Although BPD can exist as the sole diagnosis, it is fair to conclude that any patient sample that is limited to such cases cannot be considered representative of BPD as it is diagnosed and treated in either inpatient or outpatient clinical settings. It could be argued that individuals with BPD and no Axis I disorder may be less likely to present for a psychiatric evaluation. Although treatment seeking patterns undoubtedly account for some of the increased comorbidity, symptoms of BPD itself are sufficiently disturbing to the patients and their families that additional diagnoses are hardly a prerequisite for seeking professional help (Skodol, Stout, McGlashan, et al., 1999).

2.4 Borderline Personality Disorder Characteristics

According to the DSM-IV-TR (APA, 2000) a diagnosis of borderline personality disorder requires the presence of five or more of the nine stated criteria (see Appendix A). The

writers state that other Personality Disorders may be confused with Borderline Personality Disorder because they have certain features in common and raise the importance of distinguishing among these disorders based on differences in the characteristic features. This section will try to highlight the core symptoms of the disorder, focussing on those that mimic Axis I illness.

The DSM-IV-TR (APA, 2000), the Diagnostic Interview for Borderline Personality Disorder-Revised (DIB-R) by Gunderson and Kolb (1989) and Skodol, Stout, McGlashan, et al. (1999) all highlight disturbed interpersonal relatedness, impulsivity and affect deregulation as being the essential features of the Borderline Personality Disorder. The DSM-IV-TR highlights problems with self-image as an added core feature and the DIB-R adds cognition problems as part of the main core features.

2.4.1 Unstable / disturbed interpersonal relatedness

This characteristic represents criterion two on the DSM-IV-TR (APA, 2000). It involves idealization of potential caregivers or lovers by these patients at the first or second meeting. They will demand to spend a lot of time together, and share the most intimate details early in a relationship. However, they may switch quickly from idealizing to devaluing these people, feeling that the other person does not care enough, give enough, or is not there enough. In general, these individuals are prone to sudden and dramatic shifts in their view of others, who may alternatively be seen as beneficent supports or as cruelly punitive (Goldstein, 1990). These shifts often reflect disillusionment with a caregiver whose nurturing qualities had been idealized or whose rejection or abandonment is expected.

2.4.2 Problems with self-image

This characteristic represents criterion three in the DSM-IV-TR. It describes an identity disturbance, which is characterized by markedly, and persistently unstable self-image or sense of self. There are sudden and dramatic shifts in self-image, characterized by shifting goals, values and vocational aspirations. There may be sudden changes in opinions and plans about career, sexual identity, values and types of friends. These

individuals may suddenly change from the role of a needy supplicant for help to a righteous avenger of past mistreatment. They show worse performance in unstructured work or school situations (Goldstein, 1990).

2.4.3 Problems in impulse control

This characteristic represents criterion four in the DSM-IV-TR (APA, 2000). Individuals with this disorder display impulsivity in at least two areas that are potentially self-damaging. They may gamble, spend money irresponsibly, binge eat, abuse substances, engage in unsafe sex or drive recklessly. Individuals with BPD also display recurrent suicidal behaviour, gestures or threats or self-mutilating behaviour. Self-mutilation (criterion five) may occur during dissociative experiences and often brings relief by reaffirming the ability to feel or by expiating the individual's sense of being evil (Gunderson & Kolb, 1989).

2.4.4 Affective instability

This characteristic represents criterion six in the DSM-IV-TR. Individuals with BPD may display affective instability that is due to a marked reactivity of mood. (e.g. intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days). The basic dysphoric mood is often disrupted by periods of anger, panic or despair and is rarely relieved by periods of well-being or satisfaction. These episodes may reflect the individual's extreme reactivity to interpersonal stresses. Some researchers have found that as many as 87% of patients with BPD exhibit symptoms of depression (Shea, Widiger & Klein, 1992; Widiger & Frances, 1989), with Bockian et al. (2002) stating that depression and anxiety disorders (including post-traumatic stress disorder) are common in people with BPD. Any increase in stress may be experienced as intolerable and overwhelming. Goldstein (1990) states that anxiety is a marked feature of this disorder and may be experienced as continuous or occurring in recurrent disabling episodes, and is often defended against by impulsive, compulsive or self-destructive behaviour.

2.4.5 Problems with cognition

According to Gunderson and Sabo (1989) these individuals present with distorted thoughts, particularly in terms of relationships and interactions with others. Similarly, Goldstein (1990) states that although individuals with BPD tend to have the above mentioned difficulty, their capacity for reality testing remains intact unless they are in the midst of a psychotic regression. He further states that there is often evidence of paranoid ideation and there may be experiences of depersonalization and derealization which are however, “compartmentalized, and do not reflect pervasive impairments in reality testing” (Goldstein, 1990, p.40). Where psychotic episodes do occur, Goldstein (1990) explains that they tend to be short lived and the individuals appear to recover speedily to previous levels of functioning.

2.5 Diagnostic Processes

The DSM-IV (APA, 1994) and currently the DSM-IV-TR (APA, 2000) is the most widely used form of diagnostic tool in the diagnosis of BPD. It is considered to be the first official manual of mental disorders to focus on clinical utility (Bockian et al., 2002). The explicit definitions serve as means of promoting reliable clinical diagnoses. The development of DSM-IV has benefited from substantial increase in the research on diagnosis that was generated in part by DSM-III and DSM-III-R. Most diagnoses now have an empirical literature or available data sets that are relevant to decisions regarding the revision of the diagnostic manual (APA, 1994).

Although the DSM-IV-TR (APA, 2000) provides the latest and most widely accepted standard for diagnosing disorders, significant criticism of and revision to this categorical assessment model has also been presented (Westen & Shedler, 1999a, 1999b). A categorical approach works well when disorders of a diagnostic class are homogeneous, when there are clear boundaries between classes and different classes are mutually exclusive. The clinician using the DSM-IV should therefore consider that individuals sharing a diagnosis are likely to be heterogeneous even in regard to the defining features of the disorder and that boundary cases will be difficult to diagnose in any but a probabilistic fashion (APA, 1994). Using the DSM requires the use of clinical skills

because there is a recognized and very worrying danger of mistaken diagnosis. Mental health professionals sometimes fall into the trap of applying the BPD diagnosis to people they have difficulties dealing with, perhaps because of a conflict of personalities (Bockian et al., 2002). The specific diagnostic criteria included in DSM-IV are meant to serve as guidelines to be informed by clinical judgement and are not meant to be used in a cookbook fashion. Thus, other tools and skills are required to assist in the diagnosis of BPD.

2.5.1 Structured Interviews

Structured interviews are generally considered the best diagnostic instruments in the field (First, Spitzer, Gibbon & Williams, 1995). These writers state that this form of diagnostic process is substantially better than the one obtained by clinical judgements based on an unstructured clinical interview alone. Among the different types used for personality disorders in general, the Diagnostic Interview for Borderline patients (DIB) has been specifically designed for use in individuals with borderline personality disorder (Gunderson, Kolb & Austin, 1981). The reliabilities obtained for its use in BPD diagnoses is reported to be in the good to excellent range (First et al., 1995). Besides taking only about 45-90 minutes to administer, the DIB has an advantage over unstructured interviews in that it guides the clinician towards asking all the relevant questions without neglecting any important areas. It inquires about historical information, as well as symptom presence. Goldstein (1990) proposes that the two most reliably used assessment instruments are, as previously mentioned, the DIB and a clinical interview developed by Kernberg (1981) (see Appendix B). A study by Moriya, Miyake, Minakawa, Ikuta and Nishizono-Maher (1993) examined diagnosis and clinical features of BPD in the East and West. In the first clinical study of the borderline personality disorder in Asia, the DIB was performed on female outpatients in Japan. The results showed that 38% of these patients were diagnosed with BPD. This study suggests that the instrument can be used reliably.

Similarly, in another study by Atlas and Postelnek (1994), applicability of the Revised DIB to hospitalized adolescents was tested. Results showed that ten out of fourteen

adolescent girls who had chart diagnoses of BPD or such features earned significantly higher scores than the four nonborderline adolescents. Both researchers concluded that although the small sample warrants replication results suggest that the interview seems appropriate in research with adolescent girls.

2.5.2 Neuropsychological testing of patients with BPD

Other instruments, such as psychological tests, have also been used in the diagnosis of BPD. These include an administration of a battery of neuropsychological tests, such as the American study by O'Leary and Cowdry (1994) in which they found that the observed difficulties in separating essential from extraneous visual information and in recalling complex material may be relevant in understanding some of the clinical features of Borderline Personality Disorder. Another study by Leichsenring (1991) used the Holtzman Inkblot Technique (HIT) to discriminate schizophrenics from borderline patients (cited in Long, 1995 – 1996). This test showed that patients with BPD manifested less severe deviant verbalization (DVs) compared to schizophrenics. The latter tended to produce more deviant verbalizations, such as incoherence, neologism and perseveration that were not present with BPD patients.

2.5.3 Millon Clinical Multiaxial Inventory

The Millon Clinical Multiaxial Inventory, Third Edition (MCMI-III), was developed by Theodore Millon (1987). It consists of 175 true-false items and requires about 25 minutes to complete. The MCMI-III gives the clinician information about many subtle variations of borderline personality disorder such as discriminating dependent BPDs from independent BPDs. With regards to dependency Millon (1987) states that although these patients rely on others to make important decisions about their lives, they nonetheless feel helpless and anxious when alone. With the latter, the primary emotion is anger and not helplessness or depression. She further states that they evince a tough exterior and a devil-may-care attitude. Overall, the MCMI-III shows the clinician different possible mixture of personality disorder features such as borderline plus dependence in the former case; and borderline plus antisocial in the latter. Millon (1987) concludes by stating that this diagnostic test can also help the clinician distinguish between disorders in which the

differences are subtle, such as post-traumatic stress disorder versus borderline personality disorder (as cited in Bockian et al., 2002).

To sum up, diagnosing BPD is a complex process that requires both artistic and scientific skills. Arriving at any personality disorder diagnosis, including BPD, requires gaining an understanding of the client. Although the descriptive characteristics of BPD are well presented by the DSM-IV-TR (APA, 2000), other important aspects of BPD psychopathology are not as clearly articulated, such as defense mechanisms, psychological test performance and social functioning. The descriptive criteria have the advantage of increasing the ability of investigators to diagnose BPD as reliably as many more widely studied Axis I disorders (Zanarini, Skodol, Bender, Dolan, Sanislow & Schaefer et al., 2000). Semistructured interviews, according to Skodol and Oldham (1991), are needed for the reliable assessment of BPD and co-occurring Axis I and other Axis II disorders. Because of the absence of evidence of the validity of the diagnostic threshold for a categorical diagnosis of BPD, and because of heterogeneity within the diagnosis, investigators should supplement their DSM-IV diagnoses with assessment tools of underlying personality structure (Skodol, 1989).

2.6 Explanatory theories

There are numerous theories that have attempted to account for the pathogenesis of Borderline Personality Disorder. These clinical theories can be divided into those which are psychodynamic and those which are biogenetic. Paris (1994) states that as in most mental disorders no single factor explains its development. Rather, multiple risk factors, which can be biological, psychological, or social, play a role in its etiology. This approach was first proposed by Engel (1980) then Siever (1997) and currently by Bockian, Porr and Villagran (2002). Engel termed it the “Biopsychosocial model” (as cited in the *American Journal of Psychiatry*, 1994 p. 316). NARSAD (2004) also explains that most of the time, BPD, like schizophrenia and major depression, are caused by a combination of genetic risk and environmental circumstances.

2.6.1 Psychodynamic explanation

From a psychodynamic formulation, borderline patients have a deficit in integrating and maintaining self and object representations (Kernberg, 1967; Kohut, 1977). Kernberg (1967) argues that it is the disturbed infant–parent relationship and the child’s subsequent failure to develop an adequate sense of self that is at the core of the development of borderline personality disorder. Without a soothing parent-child bond, these patients may develop a fragmented self that crumbles easily under pressure (Kernberg, 1972). Their sense of self is weak and the boundary between self and others is highly permeable.

Kernberg (1967) views the borderline personality structure as being formed by the interplay of an excess of aggression, combining with normal developmental tasks which occur between the ages of approximately 6 to 36 months. Whilst the child has successfully developed the ability to differentiate reliably between self representations and other representations (unlike in the psychotic structure), it has not yet developed the capacity to experience either the self or the other in its totality, in other words the infant cannot remember good feelings when frustrated, nor bad feelings when gratified. Good self-and-other– images accrue separately from bad self-and-other– images. The child fears that the bad self-and-other– representations will destroy the good self-and-other– images, and this arouses conflict and anxiety, which the child attempts to ward off by utilising splitting and other primitive defense mechanisms which function to keep good and bad self-and-object– representations from destroying one another. These primitive defenses are utilized because the child, age appropriately, lacks integrative capacities and cognitive maturity. Kernberg (1967) argues that individuals who later present with borderline personality organization experience excess aggression, which heightens their fear of destroying good self-and-object– representations, thus rendering them unable to overcome splitting as a major defence. Kernberg sees this as the cornerstone of borderline personality disorder (Kernberg, 1967, 1984, 1989 cited in Gunderson & Zanarini, 1989).

Masterson and Rinsley (1975) (cited in Gunderson & Zanarini, 1989) propose a theory for the formation of borderline pathology that is derived from the stages of appropriate

psychological development as set out by Mahler. They cite the locus of pathology as occurring during the separation – individuation subphase, between 16 and 24 months. During this subphase, the child's attempts to separate from the mother and to become autonomous are responded to by the mother with withdrawal of loving availability. Masterson (1972) suggests that the reason for these mothers' withdrawal in the face of their children's autonomous strivings is a result of the severity of their own abandonment fears. This results not only in the withdrawal of the mother, but in addition arouses active and punitive (albeit unconscious) attempts on the part of the mother to curb the child's distancing behaviour. As a result of the loss of the mother's support for his/her autonomy the child fails to complete differentiation of itself from the mother. According to Masterson and Rinsley:

“ The child then splits the image of the mother into two parts, one is rewarding and gratifying in response to dependency and the other is punitive and withdrawing in response to autonomy. Due to this split, the child sacrifices attention and investment in reality (because it is unpleasurable) in favour of maintaining a positive relationship with the mother” (Masterson & Rinsley, 1975 cited in Gunderson & Zanarini, 1989, p.26).

It is this need to split, along with other primitive defences that the child utilizes in order to deal with its feelings of guilt, rage and fear in relation to the mother's response, that later becomes consolidated into a borderline personality structure. A recurrence of this separation individuation dilemma in adolescence evokes earlier pathological object relations and provides a second distinct, experience of the need to split the perception of the mother unit into two parts, which cannot be perceived simultaneously and thereby solidifies the borderline personality structure. Events that occur later in life that are associated with autonomy and independence may reactivate the separation conflict and its defensive constellation (Masterson & Rinsley, 1975 cited in Gunderson & Zanarini, 1989),

2.6.2 Biological theories

A general convention that has been relatively universally accepted in personality studies is that personality itself involves two components: temperament (largely the genetic / constitutional component) and character (largely the component resulting from the moulding and shaping influences of life events and development) (Oldham, Skodol & Bender, 2005). Due to the extensive heterogeneity within the DSM-IV-TR definition of BPD, there are inevitably multiple combinations of temperamental and environmental factors that lead to its development (Oldham, 2004; Zanarini & Frankenburg, 1997).

According to Siever (1997) the two hallmark psychobiologic vulnerabilities or temperamental predispositions are affective instability and impulse aggression. Siever (1997) states that the individual with BPD is exquisitely sensitive to affective environmental shifts, particularly in their interpersonal sphere, so that they react with feelings of, for example, rage, despair, separation, humiliation and fury at a setback at work. He further explains that it is likely that this highly sensitive affective thermostat is present from a very early age and may apparently have genetic as well as early environmental antecedents. The temper tantrums of childhood may be the antecedents to affective storm that may be seen in the borderline patient during adolescence and adulthood when threatened with a potential loss of a relationship or feelings of abandonment (Siever, 1997).

According to Paris (1994) research studies suggest that the impulsivity that characterizes borderline personality might be associated with decreased serotonin activity in the brain. Siever (1997) further explains that the serotonin system is a behavioural suppressive system that is involved in modulation of mood, appetite, temperature regulation and a variety of vegetative functions. Lesions of serotonergic neurons result in disinhibited aggression. Siever (1997) concludes by stating that neuroendocrine responses to the serotonin releasing agent fenfluramine are blunted, suggesting reduced serotonergic activity in patients with BPD. An American inpatient study by Soloff, Meltzer, Greer et al., (2000) examined the serotonin releasing agent, fenfluramine activity in borderline patients and healthy controls. Results showed that BPD patients had diminished response

to serotonergic stimulation in areas of the prefrontal cortex associated with regulation of impulse behaviour. Similar findings were reported by Goyer, Anderson and Semple (1994) and Leyton (2001). These authors concluded that low serotonin synthesis capacity in the relevant pathways of the brain might promote impulsive behaviour in individuals with borderline personality disorder.

2.6.3 Psychological factors

The psychological factors in this illness vary a great deal. Some borderline patients describe highly traumatic experiences in their childhood, such as physical or sexual abuse, others describe severe emotional neglect (Paris, 1994). Many borderline patients have parents with impulsive or depressive personality traits. However, some patients report a fairly normal childhood. Borderline pathology can arise from many different pathways (Bockian et al., 2002).

The most widely researched or discussed issues according to Bockian et al. (2002) are a history of traumatic abuse, an invalidating environment and cultural factors. It is important to note that not all people who are sexually abused develop borderline symptoms, and that not all people with the disorder have a history of abuse. It is important therefore to caution at this point, that the causal connections remain complex although the history of abuse is common in personality disorder patients, particularly in BPD patients (Siever, 1997).

Zanarini, Marino, Levin, Yong and Frankenburg (1997) conducted a study aimed at describing the severity of sexual abuse reported by a well – defined sample of borderline inpatients. The secondary purpose was to determine the relationship between severity of reported childhood sexual abuse, other forms of childhood abuse, childhood neglect and the severity of borderline symptoms and psychosocial impairment. Results showed that 50% of sexually abused borderline patients reported being abused both in childhood and in adolescence on at least weekly basis, for a minimum of one year, by a parent or other person well known to the patients, and by two or more perpetrators. More than 50% also reported that the abuse involved at least one form of penetration and the use of force or

violence. They reported that the severity of reported childhood sexual abuse was significantly related to the severity of symptoms on four core areas of borderline psychopathology (affect, cognition, impulsivity and disturbed interpersonal relationships), the overall severity of Borderline Personality Disorder, and the overall severity of psychosocial impairment. It was also found that the severity of childhood neglect was significantly related to any five of the 10 factors studied, including the overall severity of borderline pathology, and that the severity of other forms of childhood abuse was significantly related to two of these factors, including the severity of psychosocial impairment. These researchers concluded that, taken together, the results of this study suggest that the majority of sexually abused patients with borderline illness may have been severely abused. They also suggest that the severity of childhood sexual abuse, other forms of childhood abuse, and childhood neglect may all play a role in the symptomatic severity and psychosocial impairment characteristics of borderline personality disorder (Zanarini et al., 1997).

In explaining the invalidating environment Linehan (1993) states that it is one of the most recognized theories of how abuse relates to borderline symptoms as it essentially involves someone telling the individual that his/her feelings, thoughts, and perceptions are not real or do not count. Such invalidation, according to Linehan (1993), can contribute to the development of a personality disorder. She argues that sexual abuse is the ultimate invalidation, especially during childhood, and concludes that when a child reports abuse and is not believed, this invalidation may have the most powerful impact of all. The experience of sexual abuse seems to connect many of the symptoms of BPD into a coherent pattern. For example, Linehan (1993) has noted that children who have experienced incest at the hands of a relative from an early age and into their adolescent years will often use dissociation to mentally escape from a frightening and confusing situation. They are also likely to use splitting in order to continue to have a relationship with the relative. They also experience low self-esteem, which affects their relationships across time, leading to dependency and fear of abandonment, suicidal feelings and depression.

2.6.4 Social factors

According to Paris (1994), the social factors in BPD reflect many of the problems of modern society. He explains that humans live in a fragmented world, in which extended families and communities no longer provide the support they once did. In contemporary urban society, children have more difficulty meeting their needs for attachment and identity. He states that those who are vulnerable to BPD may have a particularly strong need for an environment providing consistent expectations and emotional security. Bockian et al. (2002) and Millon, Davis, Millon, et al. (2000) support Paris (1994) by stating that rapid social change and the loss of social structures represent one of the main problems in creating Borderline Personality Disorder among societies. In their research findings, Bockian et al. (2002) report that there is overwhelming evidence that Borderline Personality Disorder is increasing in frequency. These writers attribute this to both the increase in awareness and diagnosis of BPD by clinicians but also indicate that since our biology has not changed much in the past 50 years, researchers need to look in more depth to social forces as a viable cause.

A prominent factor mentioned by Bockian et al. (2002) is loss through divorce, which they estimated at 50%, with second marriages having even a higher failure rate. Divorce can undermine internalised images that would have helped stabilize the growing individual. Lastly, he suggests that television and other media also have profound impact on personality development. Role models and heroes have become increasingly violent, unstable and overtly sexual. Bockian et al. (2002) report that the vast preponderance of the evidence supports the modelling hypothesis: people who see more violence behave more violently (as cited in Bockian et al., 2002). These writers argue that as children watch television, they learn how to be impulsive, cynical, sexually unrestrained, explosively angry and melodramatic, which they view as borderline.

In summary, the literature has revealed that culture is very diverse. Some of its aspects are healthy. Other aspects are toxic in their encouragement of borderline personality characteristics in our population. Yet, as more people explore values, practices and life styles that enhance inner peace, a sense of maturity and groundedness, a healthy self-

image and a purpose in life, society may begin to enjoy greater psychological health. It also highlights the fact that BPD is a controversial and slippery diagnostic category. It raises certain questions about the utility of the DSM criteria, the existence of the disorder as a discrete entity, or as an ill-defined pathology occupying a somewhat grey area between the neuroses and the psychoses. It points to the differences in theoretical views around not only what constitutes the core features of the disorder, but also whether the disorder exists as fixed pathological condition residing solely in the patient or a condition arising from an intersubjective field of clinician and patient. In reviewing the current literature around BPD, it became more evident that understandings about the diagnoses were dependent both on clinical setting and to a large extent on the theoretical understandings around the nature of the disorder.

CHAPTER 3: METHODOLOGY

3.1 Introduction

This chapter provides information about the aim of the study, the rationale for using qualitative methodology focusing on issues of reliability and validity; sampling techniques are described; the participants involved in the study; the instrument and procedure used to gather data and lastly, it describes the data analysis technique. The most appropriate paradigm for this study, which is qualitative research, is also described and the reason for its selection.

This study was conducted to explore the complex issues experienced by clinicians in the diagnosis of BPD illness. The focus was on different tools utilized other than the DSM and the effects that these have on the management process of patients in a mental health hospital. The study aimed to approach the issue with an open mind and establish if there are any developments with regards to research around new diagnostic approaches and challenges to previous research suggestions that personality disorder is untreatable (Bateman & Fonagy, 2001). Another aim was to get an understanding as to how these clinicians were dealing with the counter-transference issues experienced during the treatment process of these patients.

It was decided to use a qualitative methodology, which would suit the exploratory nature of this research, allow multiple meanings to emerge and foreground the context within which these clinicians grapple with diagnostic issues (Banister, Burman, Parker, Taylor & Tindall, 1994).

3.2 Motivation for choosing a qualitative approach

According to Ely, Anzul, Friedman and Garner (1991) qualitative methodology is not the methodology of choice for those who wish their research to be cut-and-dried or devoid of emotional intensity. Nor is it for those who do not want to become intimately involved with people throughout the course of the research. These researchers cite five characteristics that the researcher needs to possess when doing a qualitative research

study. These are: intellectual flexibility, which is seen as the most crucial characteristic as it helps one to be responsive to new unexpected and unwelcome data or new information emerging in the process, humour which entails the ability to listen to what one has said, to laugh at it, and then seek ways to improve rather than being overly concerned, accepting ambiguity as researchers do not know what they will uncover as the data comes to light, empathy which is the ability to empathize, to look at and understand the world from another person's point of view; lastly, accepting one's emotions, and being able to view this characteristic as a source of strength and to be open to mining one's emotions for their intellectual lessons are an advantage. These researchers describe qualitative research as involving a process of interplay between affect and cognition, which the researcher engages in as he or she goes about the very messy but exhilarating business of gathering and analysing knowledge about phenomena that is not reduced to numbers as happens with quantitative research.

Qualitative research, emerging largely as a reaction against the domination of positivism in the social sciences, adopted philosophical positions that provided the basis for qualitative methods in the social and behavioural sciences (Mouton, 1990; Patton, 1990). The strongest emerging breed of social science researchers came from phenomenology, which provides the theoretical basis for this study.

Qualitative research designs are viewed as increasingly important alternative approaches of inquiry for social sciences because they emphasise the role of meaning and purpose that individuals attach to their experiences in the understanding of human behaviour (Bickman & Rog, 1998; Creswell, 1994; Silverman, 1993). Furthermore, it creates an opportunity for researchers to approach and examine the context of their study more holistically and with less rigidity (Banister, Burman, Parker, Taylor, & Tindall, 1994). Banister et al. (1994) define qualitative research as the interpretative study of a specified issue or problem in which the researcher is central to the sense that is made. Similarly, Denzin and Lincoln (1994) describe qualitative research as multi-method in focus, involving an interpretative and naturalistic approach to its subject matter. This means

that qualitative researchers study things in their natural settings, attempting to make sense of and interpret phenomena in terms of the meanings people bring to them.

Bogdan and Biklen (1982), Lincoln and Guba (1985) and Lofland and Lofland (1984) all suggest that it is difficult to come up with a universal definition of qualitative research since “the matter is so involved that it is not possible to provide a simple definition” (as cited in Ely et al., 1999, p.4). According to these writers there are five characteristics of qualitative research. Firstly, that events can be understood adequately only if they are seen in context, hence the qualitative researcher immerses her/himself in the setting. Secondly, that the context of inquiry is not contrived but natural, thus nothing is predefined or taken for granted. Thirdly, qualitative researchers want those who are studied to speak for themselves, to provide their perspective in words and other actions. Therefore, qualitative research is an interactive process in which the persons studied teach the researcher about their lives. The fourth characteristic is that qualitative researchers attend to the experiences as whole, not as separate variables. Lastly, for many qualitative researchers, the process entails appraisal about what was studied.

Miles and Huberman (1984) argue that a major characteristic of most qualitative research is that information, events and experiences are shared and lived in a natural setting with openness and sensitivity, thus creating an environment that is relevant for locating and appreciating the meanings people attach to their lives. Reflexivity, is probably the most distinctive feature in qualitative research as it strengthens this process by encouraging the researcher to be continuously self reflective of the dynamics of the research design, process, evaluation and in his/her integral involvement in the aims, outcomes, knowledge construction and dissemination of information (Banister et al., 1994).

Qualitative research has been criticized on the grounds that it is subjective and not scientifically credible (Banister et al., 1994; Denzin & Lincoln, 1994). However, these criticisms have been viewed mainly as politics within the field of research and not enough has been put forward to dismiss it as a credible source of knowledge (Charmaz, 1995; Ragin, 1994 in Denzin & Lincoln, 1994). The question of scientific objectivity has

not only been challenged by qualitative researchers, but the question of how objectivity is defined has also been referred to as an illusion since there is nothing from which one can be distant (Ragin, 1994).

The issues of reliability and validity have always been a contested and controversial area of research. Qualitative research surpasses the rigid formality and objectivity of quantitative research by introducing transparency in the process without compromising it, thus creating opportunities for addressing reliability and validity. As such, it is possible to overcome and address the proposed shortcomings through linking results to other work of similar genre as well as by checking theoretical assumptions (Corradi, 1991; Strebel, 1993). An additional and useful technique to enhance reliability and validity is triangulation, which involves studying phenomenon in a minimum of two ways (Smaling, 1992). According to Banister et al. (1994) another alternative is to keep a reflexive journal where the experiences of both researcher and participants are acknowledged and validated. By doing so, the researcher develops a source for crosschecking, data gathering and a means of reflecting on his/her interpretations and/or behaviour while conducting the study.

Banister et al. (1994) state that achieving an absolutely valid research that represents a definitive truth is not possible within a qualitative paradigm, which holds that all knowledge is socially constructed. Hence, qualitative research recognizes a complex, dynamic social world, with the active involvement of researcher and participants acknowledging that understanding is constructed socially and multiple realities exist.

3.3 Participants

For this study convenience sampling, which is referred to by Black and Champion (1976) as a sampling procedure in which the researcher obtains a desired number of participants by selecting those most accessible to him or her and those that possess certain characteristics of interest to the researcher, was used. In this case, the sample was limited to the Western Cape, and specifically to the Valkenberg Psychiatric Hospital, Groote Schuur Hospital and William Slater adolescent unit.

Initially four psychiatrists, two psychiatric registrars and four psychologists were selected and approached for participation in the study but eventually seven participants comprised the final sample because of the difficulty in finding suitable time for the interview. The subjects were all known to the interviewer and were not chosen for any specific reason other than that they had some kind of experience in working with psychiatric patients either in private practice or in the hospital system or both.

3.3.1 Bibliographical data of participants

The race, gender, qualifications, length of experience and work placement is presented below:

Clinicians A, F & B are white male consultant psychiatrists who have ± 14 years of experience in the field. They are placed at psychotherapeutic, acute admission and forensic units respectively.

Clinicians C, D & E are one white male and two female clinical psychologists who have experience which ranges from four to eighteen years. They are placed at forensic, psychotherapeutic and out-patients admission units respectively. Clinician D also has four years of experience in private practice.

Clinician G is a white male registrar with a four year experience in the field of psychiatry. He is currently placed at ward 1 psychotherapeutic unit. He also does neurology sessions at Groote Schuur neurology clinic.

3.4 Interviewing guide

The data was collected by means of semi-structured interview conducted in the language of the interviewee. The schedule used was developed through the review of the literature in this area generally (see Appendix D). Once the items were compiled, they were grouped in terms of the topics they seemed to cover on the interview schedules. To

reduce errors and ensure uniformity in data collection, the researcher personally conducted all the interviews.

Brenner, Brown and Canter (1985) and Newell (1993) cite six advantages of interviews. Firstly, they permit the collection of the most extensive data on each person interviewed whereas a questionnaire would have missed the opportunity to explore intimate details of, for example, counter-transference feelings experienced by the clinicians. Secondly, they allow both parties to explore central themes in the life world of the interviewee, which in this case was the difficulty that these clinicians experienced in working with BPD patients. Thirdly, they are neither strictly structured nor entirely nondirective, hence latitude was given for clinicians to talk about personal experiences regarding their work with BPD patients. Any misunderstandings from any of the participants can be dealt with immediately such as that the resultant data is unequivocally understood. Lastly, they allow opportunity for expatiation.

Breakwell, Hamond and Fife-Schaw (2000) add that the interview method maximizes the chances of maintaining objectivity and achieving valid and reliable data. Newell (1993) supports this view by saying that the interview maintains the focus of the interaction between the interviewer and the interviewee without being overly directive. Consequently, the interviewee can determine the course of the interview without major concerns on the part of the interviewer that the data collected will be completely useless. All of these advantages of an interview are especially important considering that this was an exploratory study in which the researcher had to follow some of the information as it was raised. Lack of an opportunity to ask for clarity of what was brought up as well as the opportunity to hear this within its proper context would have rendered the responses discussed in the next session less valuable.

3.5 Procedure

King (1994) suggests that the best recruitment strategy is for one to send a letter containing basic information about the study and what will be expected of the prospective participants as an initial contact. To avoid both the postal delays and the probability that

prospective participants might not respond for reasons other than refusal to participate in the study, the researcher delivered letters personally, and questions about the study were answered. Breakwell et al. (2000) suggest that taking time to meet prospective participants personally tends to promote rapport between the researcher and the prospective participants. King (1994) indicates that the relationship that develops following the personal contact between the researcher and the participant should be viewed as part of the research and not a distraction from it. The initial contact allowed the participant an opportunity to see and talk to the researcher. On the whole, by the time the interviews were conducted, the participants were at ease with the researcher. It is hypothesized that these circumstances contributed to the facilitation of more in-depth responses that participants offered. With those who refused, the advantage of personal contact as the initial means of contact was that it allowed the researcher an opportunity to at least ask a few questions regarding their refusal to be interviewed on this subject.

The tape recorder was used to avoid any distortions that the interviewer might encounter in transcribing or interpreting the data collected. One interview was conducted with each participant taking approximately 45 minutes to one hour at the clinicians' offices.

3.6 Data Analysis

This study used thematic qualitative analysis to analyse the data. According to Hayes (2000) this approach is still the most popular among researchers. It involves identifying particular themes, which occur in the material, which is being studied. Those themes may emerge from the data as they are analysed, taking the form of recurrent statements, attributions or assumptions which people make. Marshall and Rossman's (1995) non-linear model for analysing qualitative material was used. According to this model, themes are not predetermined but rather they emerge from the material being analysed. This model identifies five procedural steps, namely: organisation of data; formulation of categories; emergence of themes and patterns; testing the emergent categories; themes and patterns; search for alternative explanations and writing the report.

3.6.1 Organizing the data

During this stage, the researcher should already have a preliminary understanding of the meaning of the data. This is the stage where she takes all her material and immerses herself in it again. The recorded interviews were carefully listened to, then numbered, transcribed verbatim and typed onto the computer in preparation for data analysis. Silverman (1993) points out that transcribing and repeated reading of the material often leads to insights which in turn shape the analysis. Miller and Crabtree (1999) state that by the time one has finished this task, he or she should know the data well enough to know more or less what kind of things can be found where, as well as what sorts of interpretations are likely to be supported or not by the data.

3.6.2 Generating categories, themes and patterns

This stage, according to Ragin (1994) involves sorting out the various bits of data, and it is here that identification of prominent themes occurs. Recurring patterns and items, which appear to be dealing with similar topics, are placed together. Thereafter, the texts were then re-examined for omissions. Themes identified by the researcher were also influenced by the research questions and the literature on the said topic. The coded section of texts, which included sentences and paragraphs were grouped together into themes. Through repeated reading of the coded texts similarities, differences and contradictions emerged and resulted in the production of further sub-themes. Subsequent to having selected the final themes and having ascertained their possible relationships, quotes were selected.

3.6.3 Testing the emergent categories and patterns

According to Marshall and Rosman (1995) a process involving the critique of categories during which the researcher seeks for alternative patterns and linkages in the material should be used. During this phase the researcher gets a fresh view on the data, which allows her to carefully take each pile separately and examine it to see exactly what this theme is. The theme is then given a provisional name, and at this point the researcher may also attempt the first draft of a written definition.

Once this has taken place, the researcher then needs to further examine each emerging theme, consistently going back to each transcript and carefully re-reading to see if it contains more information, which is relevant to the theme. According to Hayes (2000) this is an important part of the analytical process because it is easy to overlook information if one is not actually looking for it. In explaining this process Hayes (2000) states that if for example the data have thrown up ten themes, each interview transcript will be systematically examined at least eleven times – once for the first analysis, and then separately for each of the ten themes. When this second stage has been completed, the researcher is in a position to take each theme and construct its final analytical form.

3.6.4 Searching for alternative explanations

The emphasis in this phase is to find alternative, plausible explanations for the data and the connections between them. Examples from the literature were used to support the findings.

3.7 Ethical considerations

Due to the nature of this study, a letter requesting permission to participate in the study was delivered individually to the prospective interviewees (Appendix C). Permission was granted by the head of ethics committee who also participated in the study. No access to personal records was needed. Prior to the interviews, participants were informed about rationale and aims of the study. All interviewees participated with informed consent. Confidentiality of interviews, transcripts and participants personal details were ensured and participants were given the choice to read the transcripts and change or add any information if they wished to do so. Participants were referred to as A, B, C, D, E, F, and G.

CHAPTER 4

RESULTS AND DISCUSSION

4.1 Introduction

The main themes, similarities and contradictions emerging from the interviews are outlined in this chapter in order to gain an understanding of participants' experiences of both diagnosis and management of the borderline illness. It needs to be kept in mind that this list of themes is not exhaustive instead the main themes have been mentioned. In addition, both categories that emerged are not always discrete. The themes outline both similarities as well as contradictions between and within participants' responses.

4.2 Diagnostic challenges

The majority of participants indicated that they did not have a problem in using the term BPD when diagnosing their patients because it makes one aware of what he/she is dealing with. However one participant indicated that he hardly uses the term due to the stigma that the illness carries both socially and also within other medical disciplines.

“Diagnosis carries a stigma with it and people have a tendency of being biased ...”

(D)

There is an implication in this statement that the stigma is seen as having negative impact for patients, influencing the type of treatment/management they are likely to receive.

4.2.1 Problems with recording diagnosis on patient's file

While participants reported not being reticent in making this diagnosis, most indicated that they tended to be cautious about recording the diagnosis in the patient's file. They preferred to use the term traits rather than recording the full diagnosis. This again is related to concerns about stigmatization, which they said the diagnosis carries. They also

suggested that using the term trait helps in keeping one open to other possibilities, like comorbidity before the final diagnosis can be made.

“I would like to record it as traits as opposed to the full diagnosis because when you refer patients for further management to other disciplines ... this may impact negatively on the way other people respond to them ...” (E)

One participant indicated that he experienced some difficulties about when to apply the term traits or personality disorder especially around cluster B personality disorders, stating that:

“There’s an overlap as to where the one belongs in that cluster ... so quite often when I’m getting to know somebody, I might say cluster B traits ... meaning that it’s covering all these possibilities ... and then later, history might make it easy to find it to be specifically borderline ...” (G)

Another participant preferred to describe the problems the patient was presenting with rather than a diagnosis, suggesting that this may give a better indication of what he/she may need as intervention.

“Perhaps referring to affective instability, behavioural problems ... describing specifically what one was referring to as a problem ...” (A)

These findings suggest that clinicians are aware of the potential difficulties that making and recording BPD diagnosis has, particularly the negative implications for the patient. Certain stereotypes have developed around the disorder such as the pejorative connotations that this diagnosis has come to assume. For example, Kernberg (1989), in describing these patients, states that they represent a great portion of the most difficult to treat clients in psychiatry. This has therefore meant that some clinicians are reluctant to utilize this diagnostic category because they are aware of the negative impacts, especially on how the patients are received and managed in psychiatric hospitals. Despite the

difficulties, the results of this study indicate that there are also benefits to both patients and clinicians. In relation to the latter, a diagnosis assists the clinicians to understand certain behaviours seen in patients that they may otherwise be unable to make sense of, particularly their responses to these patients. The intense and inappropriate anger which constitutes the disorders of affect DSM-IV-TR (APA, 2000) was perceived by some participants in this study as tending to predominate the range of negative emotions experienced by borderline individuals. It may seem that these negative emotions are due to the fact that borderline patients have difficulties with self-soothing. This is understood in terms of their inability to evoke the image of a sustaining, holding and soothing caretaker in times of emotional stress and distress as noted by Masterson and Rinsley (1975), resulting in the individual becoming flooded by feelings of loneliness, panic and rage. These account for the stormy nature of many borderline individuals' interpersonal relationships, hence the negative attitude towards them. The application of theoretical knowledge on these unusual presentations indicate a way in which such responses can be used in a therapeutic way to understand the internal psychic world of the patient, thus allowing one to know how to intervene and what would not be useful with a particular patient.

The suggestion by some participants that this seems to be a catch all kind of diagnosis might influence one to conclude that the label borderline states as indicated by Knight (1953), could be conveying information about the uncertainty and indecision of the clinician than it does about the condition of the patient. The fact that issues of comorbidity were also reported by some participants as complicating accurate diagnosis makes one wonders whether this diagnosis is perceived as being the negative determination after other possibilities have been exhausted. If that may be the case, it would seem that it is therefore not possible to tell the effects of comorbidity on borderline pathology and the serious implications these have on the treatment process. Similarly, the suggestion by theorists such as Zilboorg (1941), Deutch (1942) and Schmideberg (1947) that this illness is a variant of schizophrenia that did not require hospitalization with others saying these patients fall in the border between neurosis and psychosis, makes one not believe that borderline psychopathology is an entity, but rather a vast

developmental territory, indeed between psychosis and neurosis, resulting upon failures of development in a number of seriously psychopathological disturbances of personality.

4.2.2 Commonly identified features of BPD

The majority of participants cited interpersonal problems, repetitive suicidal attempts and affective instability as the common features that help them in identifying and diagnosing BPD.

“Affective instability, behavioural problems and a range of interpersonal problems ...” (A)

“To me I’m more interested into looking at their interpersonal relationships ... that for me makes a cut-off ...” (C)

“A sense of identity diffusion, primitive defenses, and a history of interpersonal difficulties, impulsivity and anger ... I think all the above ...” (D)

“Yho! Core features ... it’s such a broad question ... I think the thing that stands out for me is from long standing history of self-harming ... particularly self-mutilation ...” (G)

All the features mentioned constitute features identified in the DSM-IV as diagnostic criteria, but other features not in the DSM were also included, with one participant saying...

“For me dependency would be the deciding factor ... and also, when I’m being mobilized to do more than what I would normally do for them ...” (E)

Although all features highlighted in the DSM-IV-TR (APA, 2000) were mentioned, there were also others reported such as dependency and primitive defenses which are not described in detail in the DSM. Dependency for example was suggested as a strong

indicator for borderline characteristic by one of the participants. This view could have been influenced by the fact that borderline patients suffer from fears of abandonment DSM-IV-TR (APA, 2000) and these manifest in various ways. For example, borderline patients feel both dependent and hostile. These fears may emerge as attempts to merge with others in an effort to ward off their aloneness and to reassure themselves that they will not be abandoned. The fact that they seem to have the need to monitor the amount of intimacy they allow in any particular relationship and withdraw from significant others when the abandonment fears become too great could have been influenced by the fact that early trust may have been shattered by people who were close to them as mentioned by Masterson and Rinsely (1975). This therefore, sets up a cycle of dependency on those to whom they are close and when frustrated can express enormous anger toward their intimate friends and in this case, their therapist.

With regards to primitive defenses, Kernberg (1967) cautions that therapists should be aware of this process so that they can act neutrally towards these patients rather than be defensive. Because individuals with BPD show problems in self-cohesion and some are vulnerable to psychotic decompensation under stress as indicated in the literature reviewed, the primitive defenses therefore are used as defence mechanisms in order to protect themselves from experiences that will heighten their feelings of fragmentation.

4.2.3 Axis I and Axis II conditions which co-exist with BPD

All participants indicated that borderline personality disorder frequently co-exist with many Axis I disorders. The most commonly cited Axis I disorders were Mood, Anxiety, substance-related and impulse-control disorders.

There was a general feeling of concern when participants responded to this particular question, with some verbalizing that because BPD is a grey area and as such has a tendency of mimicking other psychiatric disorders, it makes it difficult to diagnose and manage. Others felt that the illness presents with chaotic disorganized emotionally very highly charged sort of picture ... it is important to be able to discriminate it from other mental disorders ... BPD diagnosis takes precedence...

These were some of the responses:

“Anxiety Disorder, PTSD and Substance-Related Disorder... but when you sit down with them, you will see the borderline dynamic...” (A)

“Impulse Control Disorder, Mood Disorder, Substance Related Disorder ... I would also look at psychotic episodes ... assess whether it is paranoia or is directly linked to the borderline illness or other personality disorders ...” (E)

“Mood Disorders ... Bipolar II disorders often come into the differential and occasionally when a person describes strong dissociative symptoms ... also, Impulse Control Disorder ...” (A)

“Bipolar... particularly depressive type ... where they present with self-harming behaviour The other thing I might think about is Dissociative Identity Disorder, mh... ja...” (G)

It was also interesting to note that clinicians B, C and F who work in forensic and acute admission units respectively reported that Substance-related disorders were a problem not only in patients with borderline illness but across the board. This disorder was also coupled with Impulse-control disorder, Mood and Anxiety Disorders by these clinicians.

With regards to Axis II, the most commonly cited personality disorders were Narcissistic, Antisocial and Histrionic Personality Disorders, all of which form the cluster B of DSM-IV-TR diagnostic criteria. Interestingly disorders from other clusters were also mentioned namely, Dependent and Schizotypal Personality Disorders.

Clinicians A, D, E & F indicated that there is an overlap of BPD with some of Axis II disorders such as Dependent and Schizotypal Personality Disorders.

“Rapid cycling of emotions with dependency, which I think the borderline almost, always presents with...” (E)

“Axis II ... with BPD there is usually a lack of clarity, it might come out as Dependant PD, and also one has to distinguish between Narcissistic PD or Antisocial PD...” (D)

The results reported by these participants seem to once again indicate the complexities characterizing the process of both diagnosing and managing the borderline illness. From these responses, it would seem that long-term treatment is required as previously mentioned by Kernberg et al. (1989) and Stolorow and Brandschaft (1994). Also, hospital readmission should be viewed as a predictable part of the course of treatment. For many clinicians, a history of self-harming behaviour is the defining feature of BPD illness yet only one participant raised concerns around this issue. This diverges from The Work Group on Borderline Personality Disorder view that the illness’s mortality rate by suicide is rated as very high. This, however does not indicate that this lethal form of self-harming behaviour should be ignored. It is therefore very important to discuss the frame with these patients as part of their management plan. This would help clinicians to develop a more positive attitude towards these patients. Important issues would be to develop consistent appointment of fees, discussing consequences of missed appointments, connections made between the patient’s actions and feelings, identification of self-destructive behaviours and active monitoring of the therapist’s counter-transference issues.

In general, based on the above-mentioned issues of comorbidity, it would seem important for the therapist to collaborate with the patient throughout the therapy process. It would also be helpful at this stage for the therapists to be sensitive to their own need to seek consultation.

4.2.4 Processes that assist one at arriving at the BPD diagnosis

Participants indicated that many processes need to happen in order to ensure correct diagnosis. An in-patient setting was highlighted as playing a central role in helping one to arrive at the diagnosis. All participants agreed that observing the patients over a period of time helps in gathering and properly documenting important information. They all felt that without a thorough history taking interview and good source of collateral information from a parent, close relative or a close friend, one cannot be certain that they have delineated the core features which define BPD because, for example a person can sound appropriate and in two, three weeks later, it can be at that point that the extent of the problem starts to emerge. It was thus felt that sufficient time to observe the patient's behaviour across different situations was needed:

“You must have seen them for a period of time before you can arrive at the diagnosis ... (F)

“I think the more I spend time with the patient, the more confident I'd be in giving the diagnosis ...” (G)

Some of the participants indicated that they also rely on less easily defined understandings, deriving from psychodynamic theories to help them in the diagnostic process. The most useful tool reported by participants was the feelings evoked in them by the patients, namely counter-transference:

“Through history taking and also through your own counter-transference feelings you can actually sense it in that first history taking interview ... some during that first session ... and others on the third session ...” (A)

“Largely my counter-transference feelings ... but I would say basically the history ... for instance if there are problems in them holding down a job ... also, I would look at their sexual relationships ... whether they are homosexual or bisexual. Basically my work is based on Object Relations ... and therefore, how they

respond and how they make me feel would guide me and serve as a guide to making my diagnosis ...” (E)

Another participant reported that although she seldom utilizes Kernberg’s theoretical views in trying to understand the borderline illness, she finds them informative in that they focus on how the borderline organization manifests, she explained that the primitive defenses which according to her include projective identification, denial, idealization etc. are utilized because the person lacks integrative capacities and cognitive maturity.

In addition to guidance provided by DSM and theory based clinical judgment in reaching diagnosis, it emerged that the MCMI-III (Millon, 1987) was another useful tool for diagnosing BPD. Interestingly, none of the participants used the DIB-R (Gunderson & Kolb, 1989) which, according to First et al. (1995) and Goldstein (1990), is one of the most reliable diagnostic tool in the field when used with the clinical interview. Concerns were raised by some of the participants with regard to not using other diagnostic tools as indicated by the following:

“I probably should refer to them more frequently. I think one’s concept of borderline goes beyond the operational criteria embedded in the DSM... one often encounters the lack of boundaries in one’s clinical work.... This group of patients has an inclination to regress ... those might be the clues.... I think one uses one’s own counter-transference feelings and intuitive approach sometimes ... and you know I suppose not specifically looking at operational criteria but having a sense that a person is quite changeable in presentation ... they shift dramatically from a position of accepting, very appreciative of one’s intervention, to being angry with a sense of substantial basis to that change ... I suppose moving between states of lines might all be clues which are not described in those terms in the DSM ... I guess they are guided by the operational criteria ...” (A)

There seem to be a number of issues suggested by participants in relation to the processes utilized in assisting one to arrive at the BPD diagnosis. An in-patient clinical setting was

most definitely reported to have a profound impact on the diagnosing of BPD. The findings suggested may be due to the fact that patients with this disorder present differently in different settings, with certain features of the disorder, such as suicidality and substance abuse, being foregrounded in the hospital setting. This may account for the reasons that hospital clinicians are more able to accurately use this diagnosis. They have more time, which helps them gain a clear understanding of the patient, using both the descriptive characteristic type of diagnostic criteria and supplementing these with assessment tools of underlying personality structure as indicated by Skodol (1989). Similarly, Widiger and Frances (1989) also support the opinion that the DSM-IV diagnostic criteria should be weighted with respect to its relative efficiency within and across particular settings. From these findings, one can see the utility of this approach. Another reason for highlighting in-patient settings as helping in facilitating accurate diagnosis may be that clinicians are located within a medical model which forces the diagnostic aspect of intervention and seeks to isolate pathological manifestations into discrete 'disease entities'.

Other processes reported, such as collateral information from close relatives or friends, are also very important in that they give a true reflection of how the patient has been functioning over the years. These are carried out through interaction with family, friends, during individual and/or group therapy sessions and during ward round presentations. These findings reinforce the statement as laid out in the DSM-IV-TR (APA, 2000) with regards to paying attention to the pattern of behaviour and the duration of illness before the BPD diagnosis can be made.

In general diagnosis of psychological conditions, similar to the diagnosis of medical conditions, is both an art and science. In some cases the diagnosis is clear and simple. In other cases, diagnosis can be tricky, and draws on the skill, experience, and intuition of the diagnostician. This process engages both the mind and the heart of the clinician.

4.3 Demographic patterns in BPD diagnosis

4.3.1 Proportion of patients in which the diagnosis applies

There was no consensus of approximated rates of BPD. The variations appeared to vary according to the types of wards and settings participants worked in.

“It’s a tricky question ... mh ... what proportion ... I think I see it across the board in different areas of work ... in-patient, out-patient neuro-clinic ... you see it at every psychotic population ... but I would say ... to maybe even as high as ... ja let’s just say 10% ...” (G)

One participant however indicated that her approximation of an 80% incidence rate was based on her previous experience in working with these patients both in private and public sectors.

“I have worked in private practice for a couple of years and most of my clients exhibited borderline symptoms ... I am also involved with teaching in the psychology department ... I feel most comfortable when teaching about the borderline illness ... I am currently involved with screening of patients for admission both in Valkenberg OPD and GSH neuro-clinic ... and I must say that 80% of the patients that I have seen exhibited borderline symptoms ...” (D)

4.3.2 Age issues

The majority of the participants reported that they are cautious around diagnosing the illness in early adulthood, citing different reasons. Contrary to the DSM-IV-TR (APA, 2000), stipulation that diagnosis can be made on persons older than 18 years, most of participants cited age 20 years as the ideal age to make the diagnosis. The concerns raised were that diagnosing the illness around the age of 18 years is tricky as teenagers are at a developmental stage in which their behaviour mimics some of the borderline symptoms.

“One shouldn’t ideally diagnose the illness before late adolescence ... but I suppose if one is seeing a pattern of behaviour that resembles BPD in younger adolescence ... and if in its psychological formulation relating to that patient incorporated ideas that come from object relations etc. ..., then I see no harm in utilizing those models in my diagnosis ...” (A)

“I know I have diagnosed patients at age 17 years, but I shouldn’t call it borderline at that age ... but the features will be overwhelmingly pointing at that direction ... and I think one could say that if it continues like that ... it could lead to borderline ... (G)

“DSM says 18 ... but I would be very cautious in making the diagnosis stick that early ...” (C)

With patients aged 50 years and above, most participants indicated that they would first look at organic factors before diagnosing the borderline illness. The majority of the participants felt that patients seemed to do better once they reached their forties. This notion was attributed to a number of reasons, such as the fact that they could either be burned-out or that the depression has either lessened or eliminated at that age. Other factors highlighted were that they could have either stopped abusing substances especially continued alcohol abuse coupled with the willingness to work through their inner pain instead of deflecting it onto other people.

Some participants also reported that commitment to continued therapy with a clinician who did not take their actions personally and was willing to stick with them in the long term also helps in facilitating early recovery.

However, there were also voices indicating that BPD can still manifest around age 50 years, although the presentation of the disorder might be redialed by various social and personal factors.

“Age 50 years ... yes I would ... firstly I would look at the background history ... for instance the relationships and how these have manifested over the years ... work history and check whether there’s been any kind of disruptive behaviour noted over the years One finds that if there is some kind of holding environment ... this usually sustains them and one finds that when they experience distress, then this is when they start breaking down ..” (E)

4.3.3 Gender Issues

Although the majority of participants indicated that a large proportion of the patients they see at in-patient and out-patient settings are predominantly female, this does not suggest that it is an exclusively female illness. The views expressed attempted to account for why the disorder came to be seen as female or why the rate is higher in females. Included in the reasons for this gender difference was that clinicians are not alert to the diagnosis in males. The “high prevalence – female stereotypes” were further contradicted by reports from one participant, who worked in a male unit, that a majority of patients that he sees show either borderline traits or meet the DSM-IV BPD criteria. According to some participants, the disparities in assigning the diagnosis to men may be due to differences on how the illness is expressed, with a particular focus on anger:

“Gender ... I think in terms of gender I don’t think that the illness occurs more in women than in men ... but I think the presentation comes out differently Men express anger in different ways to women.... For instance, somebody who’s been rejected, women might make a huge scene and embarrass or shame the person in some way ... whereas men might abuse substances, be aggressive or extremely violent in their response ...” (C)

Socialization was also seen to play a role with certain behaviours, particularly female ones, lending themselves more easily to an expression of borderline pathology than others:

“I think it’s such a complicated issue ... perhaps it’s because men are socialized to be more independent whereas women are socialized to be more dependent e.g. get married to somebody and have a happy family ...” (C)

However, participants reported that these stereotypes are gradually changing:

“That has definitely changed with time and women are becoming more and more predominant in the work environment ... they have different vehicles to keep their sense of self intact ...” (C)

“It is also interesting to note that modern society no longer sanctions patriarchy ... and that more and more men are also assuming supportive roles in the management of their families / homes ...” (D)

4.3.4 Race Issues

All the participants reported that the issue of race was not a determining factor in terms of the prevalence rate. They all agreed that the illness affects everyone across the board. However, some of them also added cultural and psycho-social issues as having an impact in determining how a person’s personality is shaped / evolves. The general feelings expressed were the lack of formerly stable institutions, such as marriage. Also, the absence of grandparents nearby or in the home was another lost support system. Other institutions that may have corrected instabilities in family life, such as strong neighbour and community ties were also perceived to be in decline. All these societal and family dynamic issues according to participants make it more difficult for the developing child to internalize stable role models.

“I treat each patient exclusively ... and that cultural issues and how these have impacted on the person’s symptomatology and behaviour are all taken into consideration before a patient can be labeled as BPD ...” (B)

“if you look at the psycho-social background of these patients you find that it usually consists of poverty and high rate of substance abuse ... and these affect us all across the board Race is no issue because the illness is brought about by trauma ... if people would just be aware of this, they would be able to seek help ...” (D)

These findings suggest that most participants seem not to be in agreement with some of the issues raised in the literature with regards to prevalence rates. Diagnostic biases were reported, which, according to most participants, were influenced by societal stereotypes. The general feeling communicated by most participants was that more research needs to be done around demographic issues, more specifically on age and gender disproportions. It became apparent that, despite the devastating nature of this disorder as indicated by the Work Group on Borderline Personality Disorder (2000), it has not received the scientific and clinical attention that other health and psychiatric problems of equal, or even lesser level of disability, have received.

With regards to participants' evaluation of the proportion of patients in which the diagnosis applies, the responses were not conclusive. Although they evaluated the prevalence rate according to the types of wards they worked in, they were aware of the fact that it would be difficult to come up with definitive prevalence studies because these are unavailable (Kaplan & Saddock, 1994). What the literature reveals are estimated rates. What both the literature and the participants agree upon is that there are enough people among the general population for the illness to be called a common disorder. What became an area of controversy was the perception that the illness has gender and racial disparities attached to it, with the DSM-IV-TR (APA, 2000) stating that the illness is diagnosed predominantly in females. The majority of the participants disputed these stereotypes stating that the illness is seen across the board. Similarly, Skodol and Bender (2003) seem to be in agreement with these views, stating that these stereotypes are due to problems in the diagnostic processes and procedures and that socio-cultural factors, as mentioned by most participants, are also instrumental in the manifestation of the borderline illness. Another important finding, which could have accounted for gender

stereotypes, was the fact that certain behaviours were labeled as pathological only when they occurred in women (Henry & Cohen, 1983). One participant explained the above-mentioned statement in depth by detailing exactly how these behaviours were played out. One issue which came out more strongly from him was that women tend to suppress their anger hence this emotion usually manifests in a mental illness, whereas men tend to act out their anger by becoming extremely violent or sometimes abuse substances. This could be the reason why men make up a large percentage of the prison. Also, how a child or adult is socialized was seen as shaping one's personality. The fact that girls are socialized to assume submissive roles as opposed to boys seems to have also contributed to these gender stereotypes. Interestingly, this particular participant concluded by reporting that these stereotypes are currently fading and that women seem to have adopted different vehicles to keep their sense of self-intact. One might also attribute these positive changes to ongoing research studies done and also to the different awareness programmes that are featured on TV, radio, community clinics, schools etc. With regards to race issues, the general feeling from the researchers' point of view was that this area needs further investigation as suggested by Akhtar, Byrnè and Doghramji (1986). Though this area appears to be controversial and still needs more clarification and understanding, participants were able to integrate the good and the bad experiences of these patients and make sense of it.

Participants' understanding with regards to age issues differed compared to the literature reviewed (DSM-IV-TR, 2000). These were influenced by their different experiences with some of BPD patients. Most participants felt that maturity as in age 20 years played a major role in terms of helping them to confidently diagnose the BPD illness. Similarly, these responses seem to be in agreement with Bockian et al. (2002) who also state that BPD is indeed a difficult illness to diagnose given the fact that many of its symptoms, which are experienced in early adulthood, echo the turmoil of adolescence. In trying to give an overview of how the adolescence stage manifests, it is important to note that borderline illness, similar to the adolescence stage, has been described by different theorists as being one of the most difficult and troubling problems in all of psychiatry and that every domain of function including cognition, mood and behaviour is affected

(Benjamin, 1993). Similarly, adolescence is also characterized by profound biological, psychological and social developmental changes. The biological onset is signaled by the rapid acceleration of skeletal growth and the beginnings of physical sexual development. On the other hand, psychological onset is characterized by an acceleration of cognitive development and consolidation of personality formation. Socially this is a period of intensified preparation for the coming role of young adulthood. For some teenagers, these changes could be emotionally overwhelming, hence some participants feel that it would be wise to defer making a final BPD diagnosis until this stage is completed. Runeson and Beskow (1991) are also noted to have examined the rate of suicide in adolescents and young adults, their results concluded that the majority of these youngsters also exhibit BPD illness. It may thus seem appropriate to defer the diagnosis until the patient is mature enough to have overcome the adolescence stage. Some of the participants' responses were also contradictory in nature, with some stating that although they diagnose the illness at age 18 as stipulated by the DSM-IV-TR (APA, 2000) they did not feel comfortable in doing so.

With regards to diagnosing the illness at age 50 years, only one participant suggested that she would definitely diagnose the disorder at such a late stage. She reported that her main focus would be looking at relationship issues coupled with work history. This would help in that it would inform her as to how these have manifested over the years. Her explanation was that if there was a lack of holding environment the ego may decompensate and if that status quo was maintained over time the person may start exhibiting borderline symptoms. These views are in agreement with Kernberg (1967) who states that without a soothing parent-child bond, these patients may develop a fragmented self that crumbles easily under pressure. In this case, one would look at husband/wife relationships, or boyfriend/girlfriend or companionship relationships at large. The literature disputes these statements with Bockian et al. (2000) stating that the illness tends to have run its course by middle age. Similarly, Stone (1986) is also in support of this view.

4.4 Management issues

All participants said that they experienced difficulties during their involvement with patients who have had borderline illness. They reported that the treatment process was very lengthy and that it required a lot of commitment from both the clinician and the client. There was a feeling of hopelessness and helplessness when these issues were reported. Overall there seemed to be ambivalent feelings which were expressed around engaging with these patients at all levels.

4.4.1 The impact of clinician's reactions on management

Participants indicated that these patients evoke intense adverse reactions in them which makes it difficult for them to engage or form an alliance, a part of the process that is perceived as a necessary tool in a therapeutic relationship. There was an overwhelming negative response in all of them when asked about their counter-transference feelings towards these patients.

“One's counter-transference feelings play an important role in terms of facilitating treatment process.... These patients bring out the worst in people ... you almost want to strangle them... and that sometimes becomes a problem because it makes one feel biased in terms of looking at other options ...” (B)

“I think often I feel a large sense of engagement on both sides ... I think often when somebody is in despair ... in crisis and distress and presenting a threat to take an overdose ... I always feel a sense of irritation or frustration which is out of context with the situation ... You sort of feel like there's some manipulation going on here ...” (G)

However it was indicated that the feelings evoked can be used therapeutically, if understood theoretically.

“Yes counter-transference is a very important tool in treating the borderline and therefore you have to use it in that way ... use it positively ... yes I do agree that

you feel pushed to do something that's uncharacteristic ... for example, in that initial interview you have a sense of disengagement and manipulation from the patient which results to your negative counter-transference reactions ...” (D)

4.4.2 The impact of diagnosis on management decision

There was a clear indication from all the participants that the BPD diagnosis does inform their intervention in that it alerts them to the kinds of dynamics that they may experience during therapy sessions. The severity of the patient's symptoms, for example self-harming behaviour especially self-mutilation, mean that the patient might have to receive compulsory treatment in secure settings i.e. in a partial-hospitalization program. It was felt that besides engaging in long-term individual psychotherapy, the patient might also benefit from group therapy. Use of psychotropic medication, and self-report measures of depression, anxiety, general symptom distress, interpersonal function and social adjustment were all monitored during the patient's stay in hospital. A multidisciplinary team approach was thus emphasized by all the participants in order to deal with all the above mentioned aspects. However, in terms of offering individual psychotherapy, most of the participants reported that they would rather refer to colleagues. They perceived these patients as difficult to treat and manage. But, it was also made clear that if therapy was offered, certain conditions informed by theory, need to exist:

“Careful assessment which would be looking at how high or low functioning the person is would help in determining the type of therapy I would offer... also, whether I would offer it myself or refer ...” (E)

“One should be very much aware of setting limits and boundaries because these patients can be very manipulative and tend to sometimes take over the therapy space ...” (E)

An interesting finding of this study relates to the impact of clinicians' emotional reactions towards the BPD patient and how these affect treatment process. The findings suggest that these patients elicit such powerful and often uncomfortable counter-transference

responses which add to the difficulties encountered in the diagnosis and management of these patients. It would seem that the responses elicited or created in clinicians in this sample are specific to each clinician and therefore once again support the hypothesis set out by Stolorow and Brandchaft (1994) around the intersubjective nature of this disorder. It would seem that the most commonly agreed upon single feature of these patients is that therapists find them difficult to manage. The debates around projective identification which creates powerful countertransference responses in therapists and responses which arise out of the therapist's own pathology is the site of current theoretical debate. The idea of projective identification renders the therapist helpless to the patient's projected feelings. The therapist simply becomes a container for the evacuated contents of the patient's internal world. This debate is beyond the scope of this paper but is central to any real understandings of the nature of borderline pathology.

If the therapist is merely a passive player in the therapeutic dyad, the case for a fixed and existent borderline pathology becomes stronger. However, Fromm (1995) and Stolorow and Brandchaft (1994) suggest that if the therapist is an active player in what can be seen as a borderline dyad then the possibility exists for this disorder to be seen as arising out of an intersubjective field of patient, clinician context. Stolorow and Brandchaft (1994) explain that the borderline patient places the therapist in a dilemma which often results in a diagnostic act which is more a reflection of the therapist's internal dynamics than of the patient's pathology.

Other aetiological factors such as the biological constructs which are perceived to be instrumental in the development of the Borderline Personality Disorder illness as noted by Siever (1997) Soloff et al. (2000), Goyer (1994) and Leyton, (2001), would also be seen as contributory in terms of compounding the nature of the disorder itself thereby maintaining the difficulties experienced by the participants when dealing with these patients. Additional issues such as sexual abuse and poverty, as reported by Zanarini, Marino, Levin, Yong and Frankenburg (1997) and Paris (1994) respectively would seem to be rendering participants incapacitated emotionally thereby perpetuating these feelings of hopelessness and helplessness exhibited by them when responding to these patients.

Interestingly, one participant who seemed to show much commitment in treating BPD patients was very verbal about how people should be informed about these issues so that they can take action.

With regards to other management strategies, it was clear from all the participants that self-harming behaviours particularly self-mutilation coupled with the micro-psychotic episodes exhibited by the patients were a major concern and that these would definitely inform their treatment and management strategies. This response was in agreement with the Work Group on Borderline Personality Disorder (2001) which rated the illness's death by suicide at massive percentages and that these were higher than the rate in the general population. Participants reported different treatment strategies other than psychotherapy alone in their management plan. They reported engaging in a multidisciplinary team approach, which would involve pharmacotherapy, social work intervention, occupational therapy and family sessions. However, it was discouraging to note that most participants reported that they were reluctant to engage in therapy with these patients, with one participant verbalizing that he would avoid working with them if possible.

5. Conclusion

In summary, a large variety of themes have emerged from interviewing participants. The content of themes raised before were explored further and some new themes emerged. Many of the issues raised previously are pertinent to the literature reviewed. These issues relate not only to the processes used in making the diagnosis, but also to the interpersonal nuances between participants and their patients and how these according to them lead to difficulties in the treatment and management of patients with BPD.

The fact that participants brought in their unique backgrounds and broad psychological and psychiatric knowledge into their responses helped in terms of putting the diagnostic issues into perspective. This again appears to lie in their interpersonal relationship with their patients who according to them adopted particular roles or a hidden agenda, which they found manipulative and inappropriate.

CHAPTER 5

CONCLUSION AND RECOMMENDATIONS FOR THE FUTURE

5.1 Introduction

This was a study set out to explore the experiences of clinicians in the diagnosis of BPD patients admitted to either male or female wards at Valkenberg hospital in the Western Cape region. The aims of the study were as follows: to consider how a sample of local clinicians view this disorder i.e. to identify common themes as well as contradictions, omissions and ambiguities in their stories; to explore their different methods of assessment used in the formulation of the BPD diagnosis; the impact of the clinical setting on their diagnosis; and management; to explore their views on the usefulness of the diagnosis and their counter-transference responses to their patients with borderline.

The study was conducted using a qualitative methodology as well as interviews with seven clinicians. The results of this study suggest that controversy which exists in the literature is well supported. The findings illustrate that the clinical setting, theoretical orientation and personality of the therapist all seem to play a role in the clinician's use and management of the diagnosis and that the clinical setting and the act of diagnosing is a complex one. These findings have reinforced the controversies around both constitutions of the disorder as well as its existence as a discrete pathological entity. It would appear that more research into the relationship between context, personality of the clinician and the diagnosis needs to be done to arrive at any certainty about this diagnostic category.

These results seem to have also made it clear that working with patients suffering from borderline personality disorder begins with an acceptance that they live in an immature psychological world, fueled by certain constitutional vulnerabilities, where they attempt to shield themselves from conflict and anxiety by splitting the world into all good and all bad. Although this produces an illusory sense of psychological safety, in fact, it renders relationships fragile and chaotic and drives away the very people who are so badly

needed to stabilize the patient. From the interviews, it was made clear by some participants that the challenge to therapists is not to be driven away physically or emotionally, but rather to engage with the patient in a consistent and constructive exploration of their affects and behaviour, no matter how intense the explosion of feeling or how lacerating their attack on our self-esteem and professionalism. Only when patients are able to recognize what they are feeling, and how this relates to what they are doing, will they begin to develop more mature psychological structures. Exploration and insight into the developmental and genetic roots can often facilitate this process, leading to a world less split in dichotomous good and bad.

5.2 Limitations of the study

The literature has revealed that BPD is the most difficult to manage of the Axis II mental disorders and that its prevalence rate could be higher than the statistics given. These patients have also been identified as being the highest treatment consumers in mental health services. Sexual abuse, which the literature has identified as one of the most common factor in the manifestation of the BPD illness has been on the rise since South Africa became a democratic country in 1994. It may seem as though societal values and norms have been aggravated since both capital and corporal punishment were abolished. The pace also in terms of social integration has increased resulting in cultural clashes. Political differences and poor socio-economic development have also caused an added stress to societies. Peer pressure to conform among the youth is also rife.

Given all the above-mentioned factors it would seem that the sample needed to be larger than the one used. It would be interesting to get views from a larger group of clinicians both from public and private sectors in the Western Cape region. Also, it would have been interesting to explore what their role is in the new South Africa in trying to curb these diverse issues (especially childhood sexual abuse), which have impacted negatively in the formation of personality structure. The study also failed to look at current S.A. statistics with regards to BPD prevalence rate and their perspective on the illness in general. Current management approaches and their success rate could have been explored. But, it should also be noted that this was a mini study, which was supposed to

be limited to the issues of diagnostic phenomenon. Motivation for a more in-depth kind of approach, which is comprehensive in nature, would be ideal.

5.3 Recommendations for future research

The findings that emerged from this study brought to the surface not only difficulties encountered in the diagnosis of BPD but also opened up an opportunity to explore other avenues for future research which might also help with effective management of the illness. Such avenues include clinician's motivation to take on more patients with borderline illness. For example, most clinicians responded negatively when asked whether they were willing to work with these kinds of patients. Other areas of importance include the additional use of diagnostic processes such as the DIB-R and further research on neurobiological studies. These would help in terms of augmenting the DSM diagnostic process which the participants reported to be mostly utilizing. More than 25 years ago, treatment was considered nearly hopeless. Today, specialized treatments offer new hope. These may empower the clinicians working with these patients with skills, which focus exclusively on the borderline illness.

Areas of future research may include looking at gauging the effects of childhood abuse and other stress in BPD on brain activity. This will reveal how treatment affects the course of illness. Other areas may include the meanings that this diagnostic category has come to assume for clinicians, the reasons for the pejorative connotations of this diagnostic category and an attempt to locate more clearly the positioning of this disorder within the spectrum of psychopathology.

In conclusion, further enquiry is needed in terms of aetiological understandings and critique; clearly in the area of gender as a social construct and the impact that this has on the aetiological and diagnostic considerations attached to this disorder. In the future, we might probably have methods of pharmacotherapy and psychotherapy designed for this challenging patient population.

In the meantime, the best hope for most patients consists of linking up with a good therapist.

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APPENDIX A DSM-IV-TR DIAGNOSTIC CRITERIA

□ Diagnostic criteria for 301.83 Borderline Personality Disorder

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- (1) Frantic efforts to avoid real or imagined abandonment. **Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.
- (2) A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
- (3) Identity disturbance: markedly and persistently unstable self-image or sense of self.
- (4) Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). **Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5.
- (5) Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
- (6) Affective instability, due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
- (7) Chronic feelings of emptiness.
- (8) Inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper; constant anger, recurrent physical fights).
- (9) Transient, stress-related paranoid ideation or severe dissociative symptoms.

APPENDIX B

THE DIAGNOSTIC INTERVIEW FOR BORDERLINES, REVISED

The DIB was revised in 1989 to sharpen its ability to differentiate between BPD and other personality disorders. It considers symptoms that fall under four main headings:

1. **Affect**

- Chronic/major depression
- Helplessness
- Hopelessness
- Worthlessness
- Guilt
- Anger (including frequent expressions of anger)
- Anxiety
- Loneliness
- Boredom
- Emptiness

2. **Cognition**

- Odd thinking
- Unusual perceptions
- Nondelusional paranoia
- Quasipsychosis

3. **Impulse action patterns**

- Substance abuse/dependence
- Sexual deviance
- Manipulative suicide gestures
- Other impulsive behaviours

4. **Interpersonal relationships**

- Intolerance of aloneness
- Abandonment, engulfment, annihilation fears
- Counterdependency
- Stormy relationships
- Manipulativeness
- Dependency
- Devaluation
- Masochism/sadism
- Demandingness
- Entitlement

The DIB-R is the most influential and best-known “test” for diagnosing BPD. Use of it has led researchers to identify four behaviour patterns they consider peculiar to BPD: abandonment, engulfment, annihilation fears; demandingness and entitlement; treatment regressions; and ability to arouse inappropriately close or hostile treatment relationships. (<http://www.palace.net/~l1ama/psych/bpd.html> 6/20/02)

APPENDIX C

UCT
Child Guidance Clinic
Rondebosch
c/o 440 3100/7 (VBH)
558-7121 (H)

1-08-2002

Dear Sir/Madam

RE: PARTICIPATION IN A BORDERLINE PD STUDY

I hereby wish to ask your permission for participation in my M3 CLINICAL PSYCHOLOGY thesis study for the year 2002.

The aim of the study is not to prove any particular hypothesis but rather to consider how some local clinicians are viewing this disorder. I wish to explore how the clinical setting affects the diagnosis of BPD and the clinicians counter-transference response to their borderline patients among other things.

Please find questionnaire herewith attached.

Yours sincerely

NOBUNTU GQIBA
Intern Psychologist

APPENDIX D SEMI-STRUCTURED INTERVIEW GUIDE

1. In your clinical practice do you make the diagnosis of Borderline Personality Disorder?
2. In what proportion of patients roughly do you think the diagnosis applies?
3. If you believe the diagnosis applies do you record it in the case notes? (What proportion)?
4. Which of these factors assist you in arriving at the diagnosis of BPD?
 - Inpatient...outpatient setting
 - Length of contact (how long...range of time required)
 - Self report...informant i.e. symptoms? Collateral?

Are there restraints on applying the diagnosis in certain settings? ...in private practice?

5. In your clinical experience what other conditions do you most commonly consider in the differential diagnosis of BPD?
 - Axis I...axis II disorders...other disorders
 - Do you apply the term borderline traits in your clinical work? ...is it helpful?

In your practice, when you make a diagnosis of BPD how often do you make additional diagnoses?

- Axis I ... axis II

6. Do you ever refer to diagnostic schedules when making the diagnosis? ..e.g. DI B-R.
Which? ...do you utilize another approach to making the diagnosis?

7. Which aspects of a patient's presentation do you find most helpful in alerting you to the possibility of BPD?
8. What do you see as the core features of the syndrome?
9. Do your own emotional reactions ever help in diagnosing or treating such patients/clients? ...how?
10. What is the earliest age you would diagnose the illness...how often do you make the diagnosis in a patient/client over the age of 50 years?
11. What proportion of the patients that you diagnose as having BPD is female?
12. How does race impact on the diagnosis of BPD? ...do you think BPD varies across race groups with regard to prevalence? ...presentation?
13. How does a diagnosis of BPD inform your intervention? ...would you offer psychotherapy? (Offer it yourself...refer...?) Would you offer pharmacotherapy? ..any other ways...when other diagnoses have been made?