Borderline Personality Disorder, Alcohol Abuse, and Compulsive Self Harm Behaviors

Research suggests that addiction is often the consequence of inadequate caregiving during critical periods of childhood development. While may causal affects may lead to substance abuse, one contributing factor is thought to be a result of insecure bonding between primary caregiver and child. Often, alcohol being the most prominently used to manage emotional dysregulation that results from adverse childhood experiences (Choca, 2011). However, substance abuse alone is not the only result of attachment related injuries. One hallmark psychiatric disorder that is known to be a direct result of trauma, neglect, and abuse in early development is Borderline Personality Disorder (BPD). BPD is developed due to early attachment injuries that result in neurological changes and perceptions which alter the formation of one's personality. A multitude of self-harm and addictive behaviors are often found in individuals with this diagnosis, thus prompting research to help understand and alleviate the damaging effects that BPD inflicts both interpersonally and on society at large.

Through historic and current evidenced based research, the field of psychology understands that individual personality is developed from intrinsic and extrinsic factors, with both social and environmental components influencing development. The underpinnings have been set for how one views themselves and others in the context of relationships during critical periods of development. As such, inadequate caregiving during these periods influence one's ability to create healthy attachments and bonding to others, as well as poor self-image and emotional regulation. of relationships (Corey, 2005). Louis Cozolino, the author of Neuroscience of Human Relationships, writes how neuropathways within the brain develop one's ability to interact socially and how neurological changes due to maltreatment in early childhood reduce a person's ability to function as a member of a larger social group. (Cozolino, 2006). Cozolino's works highlights how emotional dysregulation, ego, and personality development are affected due to attachment injury and trauma (Cozolino, 2006).

Daniel Siegel, author of The Developing Mind, attempts to tackle the age-old question of nature versus nurture from a medical standpoint and through volumes of neurological research on human attachment. Siegel's writings draw clear lines between neurobiology, interpersonal experience, and personality development beginning at birth, with significance being placed on the role of the primary caregiver (Siegel, 1999). Siegel's work investigated the caregiving aspects of human development, in particulate personality traits, management of anxiety, attachment capabilities of young children which ultimately validated previous research which indicates that early interactions with one's primary caregiver are vital to self-image, ego, and personality development. Furthermore, a recent 50-year longitudinal twin study found that "49% of personality coming from hereditary factors and 51% coming from environmental influences" (Polderman, Benyamin, Leeuw, et.al. 2015). This illustrates how nurturing influences over half of a person's functionality within a social context.

From the current body of knowledge on attachment, while "perfect" parenting is not necessary to secure attachments to develop; however, there does need to be enough attunement to a child's needs to create bonding. This attunement with patients is achieved through right hemisphere orientation with is believed to contain our relational circuitry (Van Nuys, 2014). The

importance of such knowledge indicates the value of inter-personal connections and its effect on our ability to regulate emotion and overall functionality within one's daily life. Siegal expands upon his views of attachment and indicates that when inadequate caregiving is experienced, one is not able to uphold personal identity which leaves one sensitive to extrinsic relationship stimuli (Siegal, 2012).

Attunement, as discussed by Dr. Alan Schore, is the article "Relational Trauma and the Developing Right Brain (2009), is best understood by the function of the right brain and how it relates to attachment, attachment injury, trauma, and psychopathy. Further, when appropriate attunement is had within relationships and when breaks in attunement occur, they are adequately repaired which leads to a secure attachment to others. These concepts tie into emotional stability and cognitive processing, as early life experiences are a time when people learn to get their needs met, what successful and negative consequences are to behavior, and how to manipulate one's world. The result of these experiences may lead to the development of personality disorders.

Borderline Personality Disorder: Disorders of the personality are a separate category within the DSM 5 and are described as "…long-term patterns of thoughts and behaviors that are unhealthy and inflexible. The behaviors cause serious problems with relationships and work. People with personality disorders have trouble dealing with everyday stresses and problems" (Medline Plus, 2017). There are currently 10 identified personality disorders in the DSM-5 with BPD being grouped as a cluster B disorder. Cluster B disorders are considered to include behaviors that are erratic, dramatic, and unpredictable (Harvard Health Education, 2000). Symptoms of BPD also include intense mood swings, anger, irritability, fear of abandonment, compromised emotional regulation, poor ego strength, intense feelings of loneliness, susceptibility to suicidal ideation, self-harm behaviors, and instability in most relationships (Harvard Health Education, 2000).

Further, individuals who are diagnosed with BPD are known to struggle with impulsivity, abuse substances more frequently, and are found to engage self-mutilating practices. Harvard Health reports that in severe cases one will experience panic, distorted thinking, and psychotic episodes (Harvard Health Education, 2000). In a 2009 study, reported by Current Psychiatry, indicated the suicide rate amongst BPD individuals as 3.8% and earlier studies reported 8%-10% suicide rates, which is approximately 50 times that of the average population (Berk, Grosjean, Warnick, and et.al. 2016).

Individuals with BPD are highly in-tune with mood changes of those around them and are quick to feel rejection, real or fictious. Due to the fear of abandonment, interpersonal relationships for a BPD individual are often fraught with arguments, threats, manipulation and other destructive behaviors (Harvard Health Education, 2000). With BPD individuals, their very existence depends on the approval of those within close relations, with their primary motivation to obtain and secure attachment; however, their volatile and inconsistent emotional lability is counterproductive to obtaining said goal, thus generating a cycle of abandonment and interpersonal upheaval.

A greater prevalence of depression and anxiety has been found in individuals with BPD as studies have shown that a diagnosis of depression, as defined by the DSM-IV-TR, are at 22.4% and anxiety rates at 15.2% (Kraus, Schafer, Csef, et al., 2000)., whereas in the general population positive depression scores normally run around 6.7% (NIMH, 2010). In addition to

depression and anxiety, patients who have been diagnosed with BPD also show higher incidence of alcohol, opioid, and cocaine related abuse (Salters-Pedneault, 2018).

As with many types of psychiatric disorders, substance abuse is often co-occurring and is thought to be used as a means of self-medication to alleviate psychiatric symptoms. BPD is often, if not always, accompanied by anxiety and difficulties with emotional regulation (Chocha, 2011). Dr. Pedro Chocha PhD of Arizona State University reports that alcohol is seen with individuals who have anxiety, due to its depressant qualities. Alcohol acts as a means of lowering anxiety, has calming properties, and with its ease of accessibility makes it readily available for use. Alcohol abuse is the number one substance of choice with 63% of BPD individuals having been diagnosed with alcohol dependence disorder (Salters-Pedneault, 2018).

In a recent study conducted by Dr. Kristalyn Salters-Pedneault PhD of Boston University reports:

There is a remarkable overlap between substance abuse disorders and borderline personality disorder. One recent study found that about 78% of adults who have been diagnosed with BPD will also have a co-occurring substance use disorder at some time in their lives, meaning the symptoms and course of BPD and the substance use disorder occur at the same time (Salters-Pedneault, 2018).

While BPD is widely considered a trauma related disorder, there is some evidence of a genetic component. Salters-Pednault PhD, reports findings that indicate BPD and alcoholism may share common genetic pathways. This may indicate that genes that put people at higher risk for BPD may also create higher risk for alcoholism (Salters-Pednault, 2018). As previously stated, the next contributing factor is environmental as the maltreatment experienced in childhood leads to susceptibility to alcohol abuse and later dependence. The combination of these two factors both increase the likelihood of the development of both conditions. Finally, a third potential reason for the link between alcohol abuse and BPD is that alcohol decreases the intense emotional feelings that BPD individuals struggle to regulate

In a recent article published in Psychology Today, explains that three-quarters of those with BPD engage in self-harm behaviors; however, a study in 2008, indicated numbers as high as 90% (Sack, 2015). Self-harm behaviors are self-destructive actions that include: cutting, burning, hitting, hair-pulling, head-banging, and skin picking (Sack, 2015). These behaviors are non-suicidal gestures, instead are employed to shift mental pain to physical pain, express anger, frustration, stress, to self-punish, and are a cry for attention (Sack, 2015).

The combination of alcohol consumption and poor impulse control, place BPD individuals at high risk of self-harm behaviors. In a study published by the National Institute of Health states: a number of risk factors were found to be associated with self-mutilation, including borderline personality disorder, alcohol dependence, childhood sexual abuse, and multiple suicide attempts. Not only is self-mutilation a clinically significant problem, but when combined with a history of attempted suicide, the psychological dysfunction observed is markedly high” (NIH, 2011).

As such, with the co-occurrence of alcohol abuse and BPD, the incident of self-harm behavior greatly increases. Due to BPD individual’s propensity towards poor impulse control, when

combined with alcohol which acts to further reduce one's ability to control impulses, thus elevating the risk self-harm. The combination of these three elements contribute greatly the severity and distress of BPD individuals, which consequently adds another element to the difficulty in treating the disorder.

Well known throughout psychiatric communities is that the need for improved treatment protocols for those diagnosed with BPD. The Harvard Review of Psychiatry claims that "Borderline Personality Disorder accounts for nearly 20% of all psychiatric hospitalizations and outpatient clinic admissions, but only three percent of the research budget of the National Institute of Mental Health" (Harvard Review of Psychiatry, 2016). The same articles report that BPD patients experience more psychosocial stressors than those diagnosed with Bipolar disorder (Harvard Review of Psychiatry, 2016). Furthermore, BPD is one of the expensive conditions to treat, as BPD individuals can exhaust the mental health system, social support systems, as well as medical and emergency rooms due to their demanding and erratic behavior. (Cummings and Cummings, 2012). These facts and more should be given a great deal of attention as BPD presents not only a large of a public health concern, but personal anguish.

Currently, a few treatment options are used BPD which include are dialectical behavior therapy (DBT) and was created by Marcia Linehan. DBT utilizes mindfulness techniques, grounding techniques, medication, and hospitalization when necessary. Additional treatment modalities include, psychotherapy, insight-based treatments and cognitive behavioral therapy. BPD patients are likely to see a reduction in symptoms when they are able to stay in treatment for extended periods of time. Also, when a BPD patient begins to age, one begins to see a reduction in self-harm behaviors and labile responses. When medication is necessary, best practices includes, SSRI's, Tricyclics, and MAOI. The purpose of these medications is to reduce the symptoms of "…affective dysregulation and impulsive-behavioral dyscontrol, particularly depressed mood, anger, and impulsive aggression, including self-mutilation" (Oldham, et.al. 2010). Interestingly enough, while these medications were found to reduce aggression and impulsivity, there did not appear to be a reduction in anxiety and depression, which implies that these behaviors act independently from one another. (Oldham, et.al. 2010).

The significance to this understanding the correlation between BPD, alcohol abuse/dependence, and self-harm behaviors provides better treatment options that will assist BPD patients towards better psychiatric health. It is through the mastering, via understanding one's emotions and increasing awareness and attention to the nature of one's mind that individuals can begin to reshape the way the brain functions. By doing so, people can begin to experience a more harmonious existence due to the reduction of opposing structures playing against one another. The end result includes healthier relationships, a cultivation of positive emotions, and the ability to master our lives. This is in stark contrast to a life of one being held hostage emotions that can be overwhelming when left unmanaged. The ability to rewire and change one's thought patterns is the key to compassion, empathy, and understanding other's internal world as well.

The interest in this topic stems from this writer's early experience with Borderline Personality Disorder and the lack of skill possessed to treat these patients. My first place of employment after graduate school was within a county jail facility that housed 700 inmates. Of those 700, there were 550 males and 150 females. The majority of the females and to a lesser degree, many males, carried the BPD diagnosis. I was new in the field and did not have the skill necessary to treat these individuals. Most were enraged, inflamed, and manipulated staff as well

as each other. For a long time after having left the position, I did not want to work with BPD patients. My own anxiety increased, I felt inept, and was just waiting for the escalation of behaviors to begin.

After starting this degree, I decided to move towards, instead of away from my vulnerabilities and focus on where I needed the most work. Therefore, whenever there is an assignment or research article, I try to further my knowledge and understanding of BPD, so that I can be a better clinician to this population. My knowledge has grown exponentially. I continue to learn about the causes, treatments, and protocols for BPD patients. While I cannot say that I enjoy the work any more or that my treatment outcomes are any better, I can say that I do understand it more thoroughly. This has provided me with more empathy and understanding with those individuals inflicted, as truly it is typically horrific life circumstances that have created this disorder, which is no fault of the individual who carries the diagnoses.

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