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Borderline personality disorder : instilling hope may reduce suicide

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Borderline personality disorder : instilling hope may reduce suicide

Abstract

Borderline Personality Disorder (BPD) is a psychiatric diagnosis associated with extreme behaviors including repeated suicide attempts, emotional instability, distorted thinking, and difficulty controlling impulses (American Psychiatric Association, 1994). In addition, a history of childhood physical and sexual abuse is commonly associated with BPD (Murray, 1993). This history of abuse and rigid thinking are characteristics of this disorder associated with suicide attempts (Brown & Anderson, 1991). As a result, suicidal crises are common with BPD patients. Although traditional treatment methods decrease the number of suicidal attempts, they are moderately effective in decreasing suicidal ideation (McGlashan, 1986). Suicidality is characterized by a sense of hopelessness, that nothing can change (Maris, Berman, & Silverman, 2000). This sense of hopelessness can be modified through spirituality and may decrease the number of suicide attempts. By instilling hope through spirituality, these individuals can modify their behaviors and thoughts that promote suicide (Yahne & Miller, 1999). The purpose of this paper is to introduce spirituality as an adjunct to traditional treatment methods to reduce suicide. BPD characteristics and diagnosis will be described first followed by current treatment options. Spirituality as a means to instilling hope will be recommended as an adjunctive treatment method.

**BORDERLINE PERSONALITY DISORDER:
INSTILLING HOPE MAY REDUCE SUICIDE**

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MAY REDUCE SUICIDE**

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Borderline Personality Disorder (BPD) is a psychiatric diagnosis associated with extreme behaviors including repeated suicide attempts, emotional instability, distorted thinking, and difficulty controlling impulses (American Psychiatric Association, 1994). In addition, a history of childhood physical and sexual abuse is commonly associated with BPD (Murray, 1993). This history of abuse and rigid thinking are characteristics of this disorder associated with suicide attempts (Brown & Anderson, 1991). As a result, suicidal crises are common with BPD patients. Although traditional treatment methods decrease the number of suicidal attempts, they are moderately effective in decreasing suicidal ideation (McGlashan, 1986). Suicidality is characterized by a sense of hopelessness, that nothing can change (Maris, Berman, & Silverman, 2000). This sense of hopelessness can be modified through spirituality and may decrease the number of suicide attempts. By instilling hope through spirituality, these individuals can modify their behaviors and thoughts that promote suicide (Yahne & Miller, 1999).

The purpose of this paper is to introduce spirituality as an adjunct to traditional treatment methods to reduce suicide. BPD characteristics and diagnosis will be described first followed by current treatment options. Spirituality as a means to instilling hope will be recommended as an adjunctive treatment method.

Borderline Personality Disorder Characteristics and Diagnosis

BPD is one of many psychiatric diagnoses delineated on a five-axis system utilized by the American Psychiatric Association. The purpose of this system is to provide clear descriptions of psychiatric disorders so professionals can communicate using the same criteria when diagnosing. An Axis I disorder includes but is not limited to, eating disorders, mood disorders, cognitive disorders, and factitious disorders. Axis II disorders focus on personality disorders and mental retardation. The third axis describes current medical conditions that may be affecting the individual's psychiatric diagnosis. Axis IV, specifies current psychosocial and environmental problems as they relate to the psychiatric diagnosis. Axis V, an assessment of the client's overall level of functioning, ranges from superior functioning to danger to oneself or others (American Psychiatric Association, 1994). When assessing individuals with BPD, Axes I and II are the most important to consider because diagnoses on these axes can greatly affect the course of this disorder (Brown & Anderson, 1991). Specifically, an Axis II diagnosis of BPD must include five or more of the following criteria according to the American Psychiatric Association (1994):

- (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. (p. 654)

Although it may seem these symptoms are apparent in other psychiatric disorders, BPD is distinctive from other disorders for several reasons. These individuals experience a fear of abandonment that is especially intense and will go

to great lengths to avoid being abandoned by another person. They experience extreme emotional swings such as vacillating between anger and love for others. In addition, manipulation is often utilized to gain the attention of a significant other or a caretaker. These individuals may experience short periods of paranoia, however these periods of paranoia are not continuous (American Psychiatric Association, 1994). According to Marziali's study (as cited in Seligman, 1998) a core condition associated with BPD, but not required for diagnosis, is childhood sexual and/or physical abuse.

Childhood Physical and Sexual Abuse

It is common for BPD individuals to have a history of physical and/or sexual abuse (Herman, Perry, & van der Kolk, 1989; Murray, 1993). In a study of BPD inpatients by Ogata et al (1990) 42% had been physically abused and 71% had been sexually abused. The American Psychiatric Association (1994) found that neglect, hostile conflict, and early parental loss or separation are common in the childhood histories of those diagnosed with this disorder. The long-term effects of child abuse are remarkably consistent with BPD characteristics. These long term effects include difficulty relating to others, utilizing manipulation as a way of gratifying one's needs, using alcohol or drugs to avoid important issues, a propensity for suicidality and self-mutilation, and compulsive sexual behavior (Briere, 1992). Sexually abused BPD patients are more likely to maintain maladaptive behaviors over time such as an inability to regulate emotions,

manage depressive symptomatology, and having little interest in activities outside of oneself (Mitton, Links, & Durocher, 1997).

A history of childhood sexual and/or physical abuse is associated with suicide attempts (Brodsky, Malone, Ellis, Dulit, & Mann, 1997). Those with a history of multiple suicide attempts are likely to be more serious attempters and a high level of lethality characterizes these attempts (Soloff, Lis, Cornelius, & Ulrich, 1994). Suicidal persons are characterized by tunnel vision or an inability to view the world in more than either or categories (Jacobs, Brewer, & Klein-Benheim, 1999). This difficulty in viewing the world in a less rigid way, or dichotomous thinking is another key component of this disorder that contributes to the suicidality of patients.

Dichotomous Thinking

Dichotomous thinking, is a propensity to evaluate experiences in terms of mutually exclusive categories rather than viewing the experience as happening on a continuum. Thus people are either good or bad. These individuals vacillate between idealizing and devaluing others. These thought patterns are manifested in the individual's view of him or herself as being powerless and vulnerable, inherently bad and unacceptable, and seeing the world as frightening (Seligman, 1998). Additionally, Wilkinson-Ryan and Westen (2000) found that BPD individuals are characterized by defining the self in one way such as being a bad person and nothing else. These individuals have difficulty committing to one idea

or thought because they are often irrational and have trouble maintaining consistency between their thoughts, feelings, and behaviors. Although the origins of dysfunctional thought processes are unknown, childhood abuse is correlated with dichotomous thinking in regard to how the victim views the perpetrator (Veen & Arntz, 2000). In addition, Chiles and Strosahl (1995) found these thought processes are characterized by the belief that killing oneself is the easiest way out.

Suicidal hopelessness is characterized by rigid thinking in which there appear to be no other alternative besides suicide (Maris, Berman, & Silverman, 2000). Individuals contemplating suicide can become hopeless because it does not seem he or she will get better or life will ever improve. This can be especially dangerous because dichotomous thinking is exacerbated by suicidality. However, in study by Beck, Brown, and Berchik (as cited in Maris, Berman, & Silverman, 2000) suicidal hopelessness can be modified by clinical intervention.

Suicidality

Childhood abuse and dichotomous thinking, core elements of BPD are characteristics that greatly increase the incidence of suicide. Suicidality is suicidal ideation, a recent suicidal gesture, or attempt to commit suicide (Brown & Anderson, 1991). Managing suicidality with BPD patients is an ongoing process often characterized by numerous suicidal crises (Davis, Gunderson, & Myers, 1999). It is important to note that 1 in 10 borderline clients will complete

suicide (Seligman, 1998). It is imperative that suicidality be closely monitored as the risk of completed suicide increases with additional psychiatric diagnoses.

According to Soloff, Lis, Cornelius, and Ulrich (1994), a high number of past suicide attempts increased the probability that the seriousness of each attempt will increase in degree of lethality. It is necessary to differentiate between lethal intent and suicidal acts without lethal intent, or parasuicide.

Parasuicide can be distinguished from suicide as repetitious suicide attempts that appear to be for the purpose of being rescued by another person (Gunderson, Kolb, & Austin, 1981). It is a fascination with self-destructive behaviors without having lethal intent and is a way to manage distress because the client is unable to regulate emotions (Chiles & Strosahl, 1995; Davis, Gunderson, & Myers 1999). However, parasuicide can be fatal, regardless of the intent of the individual. Therefore seriousness of attempt can not be gauged solely on level of intent of the suicidal person (Chiles & Strosahl, 1995). Thus, each suicide attempt must be treated as though the patient is fully intent on killing him or herself.

Current Treatment Options

Treatment options specifically for BPD are somewhat effective in the management and treatment of the maladaptive behaviors that characterize this disorder. In a study by Marziali (as cited in Seligman, 1998) current treatment methods need to better address the needs of this population over time as 50% drop

out of treatment prematurely, leaving approximately 10% completing treatment with a “successful outcome.” According to Gunderson’s study (as cited in Seligman, 1998) the duration of treatment with BPD individuals could last up to five years, however these individuals are still at risk of reverting to maladaptive behavior. For example, Dialectical Behavior Therapy treatment outcomes are diminished one year following treatment (Linehan & Heard, 1992). In a study of 94 inpatients conducted by McGlashan (1986) the average inpatient stay is 2.5 years with one half of the patients requesting or requiring further therapeutic support after his or her inpatient stay is completed. Therefore, these patients need long term therapy, yet so many are dropping out of treatment prematurely. Clearly, current methods are not sufficient in treating this disorder effectively.

Three current treatment strategies, Dialectical Behavior Therapy, Supportive Psychotherapy, and Group Therapy are utilized most often in the treatment of this disorder. Dialectical Behavior Therapy is the only treatment modality that has been empirically tested (Linehan & Heard, 1992). However, each treatment modality has shown some success in treating specific aspects of this disorder (Seligman, 1998).

Dialectical Behavior Therapy

Dialectical Behavior Therapy is a cognitive behavioral approach that is specifically designed to treat chronically suicidal people. Treatment goals are hierarchically ordered by importance: (1) reduction of parasuicide and life

threatening behaviors, (2) reduction of behaviors that interfere with the process of therapy, and (3) reduction of the behaviors that interfere with the quality of life (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991). Salient aspects of this mode of treatment are teaching the client skills to moderate behavior, change thought processes, plan for success and failure, solving problems, and utilizing the client and therapist relationship as a model in which the client can learn new ways of relating to others (Koerner & Linehan, 2000). In addition, this approach attempts to reduce client behaviors that interfere with the therapeutic process (Seligman, 1998). This approach is more effective than any type of treatment available in decreasing the number of parasuicidal acts, staying in therapy longer, and having fewer inpatient admissions (Linehan, Kanter & Comtois, 1999).

Supportive Psychotherapy

This mode of treatment focuses on utilizing the therapist/client relationship as a way to model appropriate behavior for the client (Clarkin, Yeomans, & Kernberg, 1999). There are five overall goals to this type of therapy: (1) establishing boundaries, (2) developing new interests and social skills, (3) separation and individuation, (4) developing social skills, interests, and feelings, and (5) carefully planning termination (Seligman, 1988). The last goal, termination requires thoughtful consideration. The termination phase of treatment begins with setting a date for the client and therapist's last meeting. It is important to successfully terminate by informing the client far ahead of time that

therapy will end so the client does not feel abandoned by the therapist. The main goals of this phase are dealing with client's perception of impending termination and issues that come up as a result of the impending termination of therapy (Rockland, 1992). According to Sabo, Gunderson, Najavits, Chauncey, and Kiesel (1995) this therapy was effective in decreasing suicidal behavior, but did not change suicidal ideation or acts of self-harm.

Group Therapy

Group therapy is useful in decreasing the client's dependency on the therapist, as there are other people for the client to focus on in a group situation. The client receives feedback from other group members not just one source, the therapist; so the client's feelings are not associated with one person, giving the feedback more importance. The group can influence individual members to change behavior by holding the individual responsible to the group. For example, the group may focus on one individual reducing the number of acting out behaviors. Then the individual is held accountable to the group for his or her behavior. Thus, group members can learn from each other's experiences (Munroe-Blum, 1992). In a study by Nehls (2000) group members reported decreased hostility and depression through understanding from other members.

Treatment Considerations

BPD is one of the more difficult psychiatric diagnoses to effectively treat because the core of borderline behavior is characterized by impulsivity and

affective instability (Paris, 1994). As a result, individuals have difficulty resisting impulses and regulating emotions and vacillate between suppression of feelings to avoid abandonment or expressing those feelings in a self-destructive way (Seligman, 1998). Consequently, individuals are prone to experience more chaotic and unstable relationships because of this inability to regulate emotions or behavior effectively. An important facet of therapy is preventing the therapist from becoming the client's rescuer as that will only reinforce the idea that the client is not responsible for his or her behavior (Seligman, 1998). Another factor complicating effective treatment of the borderline individual, are additional psychiatric diagnoses. BPD is often comorbid with other Axes I and II disorders (Brown & Anderson, 1991). The incidence of suicide increases if a patient is diagnosed with BPD and one or more of the following disorders: (1) major depression, (2) alcohol abuse, and (3) antisocial traits (Jonas & Pope, 1992). In addition, these levels of impulsivity and affective instability are associated with more suicide attempts (Brodsky, Malone, Ellis, Dulit, & Mann, 1997). Noncompliance with treatment is very common and can lead therapists to abandon treating these individuals, which is the very thing they fear. Therefore, therapists must plan for noncompliance as a part of treatment (Seligman, 1998).

Suicidal ideation generally does not decrease for years even if the individual has been in treatment. In a study of psychiatric inpatients diagnosed with BPD, clients were tested each year for five years after discharge from a

treatment facility. Suicidal behavior declined after six months of discharge, however, self-harm, suicidal ideation, and self-harm ideation changed very little (Sabo, Gunderson, Najavits, Chauncey, & Kiesel, 1995). The risk of suicide and the level of impairment is highest in the young adult years and decreases in the patient's thirties and forties (American Psychiatric Association, 1994). An adjunct to existing treatment methods, spirituality may decrease the number of suicidal incidents (Miller & Thoresen, 1999). In a study by Beck, Brown, Berchik, et al., (as cited in Jacobs, Brewer, Klein-Benheim, 1999) suicidal intent was strongly correlated with hopelessness. Thus, the level of hopelessness is a better predictor of suicide than is depression. Hopelessness can be modified by clinical intervention (Maris, Berman, & Silverman, 2000). This can be done through instilling hope in the chronically suicidal individual thereby giving the patient and the therapist time to focus on other facets of this disorder (Miller & Thoresen, 1999). Thus, spirituality as a life long adjunctive treatment for these individuals is imperative to hopefully decrease the number of suicide attempts. Spirituality may be an effective way of instilling hope in these individuals (Jacobs, Brewer, & Klein-Benheim, 1999).

Spirituality

According to the Zinnbauer et al. study (as cited in Miller & Thoresen, 1999), spirituality was "concerned more with individual subjective experiences, sometimes shared with others" (p.6). A spiritual person believes in a transcendent

dimension to life that surpasses the universe and material existence. Thus, what we can see visually, is not all there is to life, there is a dimension that each person can draw strength and power from through a belief system or through specific practices. Some examples of this include a spiritual belief in God, a Higher Power, or the meaning of good and evil (Elkins, Hedstrom, Hughes, Leaf, & Saunders, 1988). It is important to note that spirituality does not necessarily involve religion (Miller & Thoresen, 1999). Spiritual individuals understand there is meaning to life and recognize a personal mission in life. They understand that all people are connected to each other, therefore the suffering of another requires some action. In addition, an awareness of the frailty of human life is essential to appreciate life (Elkins, Hedstrom, Hughes, Leaf, & Saunders, 1988).

Spirituality is correlated with more positive overall health and can be taught, however it must be done in a way that is respectful to the client. Spirituality can be helpful for the client to comprehend his or her problems through understanding and experiencing meaning in one's life. The client chooses how he or she would like to express spirituality through religious practices or non-religious means. Thus developing a belief in multidimensional power of spirituality can engender hope, which may moderate suicidality (Jacobs, Brewer, & Klein-Benheim, 1999; Yahne & Miller, 1999).

Hope as A Psychotherapeutic Strategy

Hope is a vital element in healing as it focuses on reality based thoughts, not maladaptive thinking. By focusing on the positive, hope can increase a sense of well being or emotional health (Yahne & Miller, 1999). Instilling hope through spirituality decreases dichotomous thinking by acknowledging the present difficulties while the future is a focus for change (Jacobs, Brewer, & Klein-Benheim, 1999). Thus, the future is a place to develop positive thoughts and behaviors. It is important to educate the client that hopelessness is not permanent. In addition, it is beneficial when clients know that hopelessness does not have to affect all areas of one's life. To instill hope, the therapist can assist the client in discovering what he or she cares about. Yahne & Miller (1999) stated this can be done in two ways: hope as willpower and hope as a way to be. Hope as willpower is the desire to endure and learn new ways of living. Hope as a way to be is utilizing oneself or another as a reason to live. Hope placed in oneself is recognizing one's own abilities and resources with the assistance of a therapist. The therapist is emphasizing skills and qualities the client already possesses, but may have not recognized or known how to develop. For example, a client who is knowledgeable in literature may volunteer to teach children or adults about this subject. Through this volunteering, the client may place hope in his or her abilities to assist others and also place hope in appreciation of one's unique

qualities. It is most important to tailor developing a sense of hope to fit the client's abilities so he or she may take responsibility for changing oneself.

Introducing rituals into the counseling relationship helps strengthen the process of instilling hope (Yahne & Miller, 1999). The client and therapist can work together to discover what rituals are meaningful for the client. For example, the client may choose to meditate, pray, or study specific aspects of spirituality. Moore (1992) believed rituals reinforce a spiritual connection to oneself and a power higher than oneself. Focusing primarily on the negative breaks the spiritual connection because it does not reinforce what can be changed.

Spirituality can help one sustain hope and give reason and purpose for reducing suicidal attempts (Jacobs, Brewer, & Klein-Benheim, 1999; Yahne & Miller, 1999). Spirituality can assist an individual to perceive events in a more positive way through instilling hope, purpose, and a more positive outlook for the future (Chopra, 1991).

Assessing Client's Spirituality

Determining the client's level of involvement in spirituality is important so the therapist can choose interventions to match client needs. Three dimensions of spirituality need to be assessed: (1) practice, (2) beliefs, and (3) experience (Miller & Thoresen, 1999). The practice of spirituality involves mostly observable action such as meditation or contemplation. The practice of spirituality affirms the second dimension, personal beliefs about the importance of

spirituality. These beliefs include aspects such as personal values, morality, or beliefs about transcendence. The third dimension, spiritual experiences assess the role that daily spiritual events play in the individual's life (Miller & Thoresen, 1999). Through assessment, the therapist can determine the client's consistency between thoughts and behaviors and gain knowledge regarding how the client views the world (Jacobs, Brewer, & Klein-Benheim, 1999; Miller & Thoresen, 1999). Spirituality can help clients develop behaviors that bring thoughts and behaviors closer together. Working on those thoughts and behaviors that are inconsistent and reconciling incompatible thoughts and behaviors promotes a more fully integrated sense of self. As a result, individuals are able to move forward towards spiritual development (Becvar, 1997).

Conclusion

Borderline Personality Disorder is difficult to treat because of the nature of its symptomatology as it is characterized by impulsivity, suicidality, and emotional instability. Many individuals who have developed this disorder have been sexually or physically abused. A key component in working with those who have been abused is reducing the number of suicide attempts, which can be difficult and require long term treatment as most patients need treatment for up to five years. Current treatment methods have not been effective in reducing suicidal ideation in the long term (McGlashan 1986). In addition, there is a high drop out rate that may be prevented by developing alternative treatment methods.

Instilling hope through the development of spirituality may reduce the incidence of suicidal and parasuicidal ideation, and consequently, the number of suicide attempts (Jacobs, Brewer, & Klein-Benheim, 1999; Yahne & Miller, 1999). This method of treatment may provide stability in other areas of the client's life. However, further research is needed to support the potential of spirituality to instill hope.

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