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Borderline Personality Disorder and Increased Aggression in Patients

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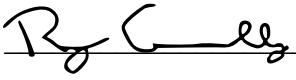
Signature 

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Abstract

The literature review contained in this paper is dedicated towards the understanding of borderline personality disorder (BPD) and its diagnostic effect towards the increases of aggression. Due to a "pervasive pattern of instability of interpersonal relationships, self-image and affects" (American Psychiatric Association, 2013, p.663), BPD patients tend to have higher instances of interpersonal aggression to include; patient/practitioner manipulation, intimate partner violence and problems regulating their moods. This case report reviews a female patient who was in distress about her marriage and the fear of an impending divorce that her husband had initiated. Her tearful affect completely changed when abusive behavior was assessed within their relationship. She was ultimately diagnosed with BPD and was set to continue treatment. Through a literature review, BPD patients display higher instances of various types of aggression, towards themselves and towards other people. Due to their manipulative tendencies and dysregulation of behavior, it has been historically challenging to treat patients who display these diagnoses. Factors that contribute to higher levels of violence and aggression in BPD patients include, structural makeup of the patient's brain, gender, age, and social history of abuse.

Background

The patient of this review presented to the behavioral health clinic in Bagram, Afghanistan, where she spoke with the clinician about her long-standing problems of anxiety and depression. She began the interview tearful and upset about her family situation, being away from her children, and how this has affected her job performance. Her mentation changed, when the subject of the relationship with her husband was brought up. She immediately stopped crying and became extremely agitated in front of the interviewer. She stated that he "needed her" and that "he would not be able to function as a man without her." Additionally, she admitted that her husband was scared of her and had initiated a restraining order through the court system and was taking their children to live with him in Louisiana. When pressed about why he was doing this, she stated, "I may or may not have laid my hands on my husband, even though he deserved it." She declined to answer any further questions about her relationship with her husband.

Borderline personality disorder can be a very challenging disease to diagnose and treat. Many times, the exact etiology of the disease can be a combination of different experiences or biologic factors and it can be difficult for a clinician to pin point how a patient developed the disease. One common development causation of BPD includes psychodynamic theory (object relations theory) where coping skills are not developed during psychosexual development stages (Pine, 2004). Biological theories include; genetic influences, brain structure abnormalities, and neurobiological effects of continued trauma on chemical neurotransmitters (Baumert et al., 2017).

The key to understanding this disease is that there usually is one defining feature that tends to be persistent and consistent. This emotional/behavioral feature is often considered a manifestation of a maladaptive coping mechanisms, leading to personal and interpersonal stressors. Due to these ineffective coping mechanisms, these patients are at a higher risk of aggression and violence towards themselves and others (Barnhill, 2013). It is important for practitioners to be able to assess these traits within patients and determine the extent they engage in aggressive tendencies.

Case Report

Patient is a 40-year-old female Army E6, who has been married for 10 years and has three children. Patient initially presented to the emergency room, with "uncontrollable stress headaches" and requested to see behavioral health services. Upon consult, patient's chief complaint was noted as anxiety/depression, was ruled stable enough for her to keep her firearm, and was requested to see behavioral health the next day. The patient presented to the clinic with a flat affect and limited interaction with support staff.

Upon assessment, patient became hyperverbal, tearful, and emotional, discussing her family situation. The patient stated that she felt she was "losing her family" since her deployment began in March 2020. Her husband has floated the idea of the two of them getting a divorce and he even began to see another woman. He felt that he was in an unsafe relationship and in order to be safe, he needed to take their children and move to a different state. The patient stated she had an "explosive temper" but she had never become physical with her husband, only using emotional and verbal expressions towards him. The patient also felt that he may try and obtain some type of restraining order when she redeployed home but she denied that any action had been taken so far. Patient denies feeling stressed or depressed about her military job. She stated she had worked hard to get to this rank and she did not want to jeopardize it. She said the best thing for her would be to go home and resolve this situation with her husband. She stated her mood as "Sad."

Patient endorsed an increasing level of depression since her arrival at Bagram Air Base. Currently she rated her depression level at a 10/10 and it had "plateaued" at this level. She stated

she had been crying, feeling guilty, and sad. When asked to describe her sleep pattern, she stated she had problems falling asleep and staying asleep. Sometimes only getting around one to two hours of sleep per night. She also reported feeling tired throughout the day. She endorsed nightmares, describing her experiences as "feeling lost." The patient states she has had a loss in appetite. She stated, "I do not feel hungry at all" even when applied to eating some of her favorite foods. Patient endorses a high level of anxiety but was unable to apply a numerical level. She did state she had a stress headache at a 4/10 pain level. She noted that she took 325mg tablet of Acetaminophen with relief. Rated her current anxiety level at a 10/10, which her baseline level around a 7/10. Activities that helped to decrease her anxiety included exercise. Things that made her anxiety worse included; speaking with friends who did not understand her situation and formal interactions with work leadership. Patient denies suicidal ideation and self-injurious behavior and noted that she did not have previous attempts. She reported that her children are her main priority and they keep her going. Denies a past medical history of mental health issues. Denies hallucinations, skin abrasions/cuts. Denies tobacco use but does endorse 1-2 caffeinated beverages per day.

Education and coping strategies were reviewed with the patient. Patient was educated on effective journaling and how to use this skill to organize her emotion and to channel this to have a concise conversation with her husband. Provider presented the idea that he would contact her command and recommend that she is placed first on the list for troop draw down during the retrograde. Patient endorsed the use of medications to help with her depression and anxiety. Provider conveyed to the patient that he wanted her to try journaling for the next week and that during their next scheduled appointment, they would speak about the inclusion of medications.

Patient verbalized understanding of education, coping strategies, and future plans. Another appointment was made roughly a week from the initial patient intake date.

Literature Review

The DSM-5 has borderline personality disorder is diagnosable by the existence of five of nine symptomatic conditions. These symptoms include "fears of abandonment, unstable interpersonal relationships, unstable sense of self, self-damaging impulsivity, parasuicidal behavior or self-mutilation, affective instability, chronic feelings of emptiness, inappropriate anger, and transient paranoid ideation or dissociative symptoms." (American Psychiatric Association, 2013, p. 665)

The precise etiology of this disease is unknown but researchers believe it is multifactorial in nature and are a combination of environmental and genetic processes. Chanen et al (2011) stated that environmental factors of this disease are only partly known and researchers are still weary of how much these factors contribute towards disease formation. This is due to the fact that it is challenging to be able to track certain environmental factors for the development of this disease. Some of the environmental factors considered for the development of borderline personality include extensive sexual abuse as a child, an unstable family environment, and a family history of borderline personality disorder. The researcher listed genetic factors that predispose a patient's sensitivity to borderline personality disorder include, misfunctioning serotonergic systems, a carrier of the 5-HTTLPR gene, polymorphism in the dopamine transporter (DAT1). Brain abnormities also play a major part of this disease. Even if researchers are fully unable to understand if these abnormalities cause borderline personality disorder or it is merely a symptom of the disease. Neurological findings that have occurred in these patients

include, abnormalities in the frontolimbic networks, reduced orbitofrontal cortex volumes, decreased anterior cingulate cortex volumes, and damage to the midline structures of the brain.

Tusaie & Fitzpatrick (2017) describe borderline personality disorder is a mental health condition that emphasizes extreme mood dysregulation that harbors the facets of emotional regulation and how people respond to situational factors. BPD affects people's emotions and the way they process thoughts. These functionality problems can lead a person to maintain insecure relationships, negative self-image perceptions and have problems with dysregulation of behaviors and emotions. A concern of these patients includes being alone or abandoned by people who are close to them. This causes many of them to engage in manipulative behaviors, become agitated towards loved ones, and experience extreme mood dysregulation in order to have a semblance of control towards others.

Borderline personality disorder is the second most prevalent personality disorder, next to obsessive compulsive personality disorder. Kulacaoglu & Kose (2018) have found that the prevalence of this disease is generally found in anywhere from 1.6% to 5.9% of the United Stated population. This number increases when looking at the diagnostics of the inpatient psychotic population, which has been calculated to be up towards 20% of this group. Within the general population, there is no discernable difference between the rates of the disease between men and women. However, women tend to have a higher hospitalization rates, with an almost 3:1 ratio when it comes to inpatient hospitalization. Even though some rates of borderline personality disorder have been shown to be higher in women, men tend to be the gender that perpetrates the higher levels of violence

Robitaille et al. (2017) Men with borderline personality disorder have been shown to have higher levels of aggressive behavior and violence towards others. The process by which

men with borderline personality engage in violence is still somewhat unknown and is viewed as a subject that could be multifactorial in origin. Most people believe that the borderline feature of emotional dysregulation is most at fault on why men commit acts of violence. This dysregulation is specifically detailed towards the emotion of anger and how men are biologically/socially more predisposed towards this behavior. Beaudette & Stewart (2016) conducted a study within the Canadian prison system to determine how many incoming violent inmates suffered from mood disorders, substance abuse problems, and overall psychiatric conditions. Out of 1110 men assessed from the ages of 18 to 70, 15.9% of the violent criminal offenders qualified for the diagnosis of borderline personality disorder. In addition, 44.9% of the men assessed in the research study were also diagnosed with anti-social personality disorder or another underlined diagnoseable mood disorder. This obvious trend leads towards higher rates of intimate partner violence.

The World Health Organization (2013) estimates that one in three partnered women worldwide are in some type of an abusive relationship. 42% of these women have sustained immediate physical injuries, while 13% have received wounds that were considered life threatening, and could have led towards a fatality. Women, who are partners with men who have a diagnosis of borderline personality disorder, are at a higher risk of more severe and more frequent incidents of intimate partner violence. A study by Jackson et al. (2015) the researchers found potential emotional mechanisms that men could display, which could place a female in a higher danger of violence. These additional factors or how Jackson et al. (2015) labels them as, "mechanisms of intimate partner violence" are additional influences that increase the risk of violence of men who have BPD. The study notes emotional perception of relationship stimuli, anxious adult attachments towards women, alcohol and substance abuse, and increased instances

of impulsivity as additional risk factors. Even though men tend to be more outward directed in their aggressive behavior, women diagnosed with BPD tend to engage in self injurious behaviors. Men tend to under report their self-harm.

Northey et al. (2016) noted that there was no definitive proof that women engage in self harm more than men do. There is a perception that women tend to engage in higher rates of self-harm but the researchers were unable to find any definitive statistics to corroborate this. Men with BPD tend to under report this type of violence and they usually engage in self harm in a different way than women. When they get angry, men tend to hit inanimate objects in fits of rage. Women tend to be much more subtle and much more private with their actions.

Northly et al. (2016) also found this behavior has been shown to be apparent in around 4% of the female population with 14% being college students. This study labeled the three most common forms of self-mutilation as, skin cutting, banging or hitting their heads, and the last subset of the population includes intentional burning. The most common form of self-harm is cutting, with around 70% of the women who responded to the study. The second most popular form of self-harm included banging their head or punching through walls, which included between 21% to 44%. Skin burning is the third lowest of the group, with 15% to 35% responding applicants. It was also reported that patients tending to engage in more than one form of self-harm and age of onset is right around the ages of 14 to 24 years old. Additionally, Northly et al. (2016) also found women who engaged in these types of behavior usually had a corresponding psychiatric diagnosis in relation to BPD. Common secondary diagnoses included post-traumatic stress disorders, generalized anxiety disorder, major depression, and schizophrenia. For females and males, many of these behaviors have been shown to be in direct correlation with a past history of abusive behavior.

In a study conducted by McFetridge et al. (2015) the researchers found that 75% of the participants who have BPD also have an instance of some type of abuse or a post-traumatic stress diagnosis. In order to better cope with some of these past experiences, many of them will resorted to some type of suicide or self-injurious behavior. Within the adolescent community, McFetridge et al. (2015) found that 90% of patients with borderline personality reported self-harm behavior, while it was reported that 75% of these participants had considered or attempted suicide. In relation, adults reported a lower rate of self-harm (75%) and a first-time single suicide attempt 50%. Within the realm of self-harm actions, skin cutting appeared to be the most popular technique, with around 70% of those interviewed stating that they partook in it. Other popular self-harm methods included, hitting oneself which accounted for 21% to 44% of the responding population. 15% to 35% also responded to burning themselves and responded with attempting more than one type of style. A wide array of abuse can contribute to the progression of this disease and added one as a symptom.

Most manifestations of aggression in patients with borderline personality disorder include verbal or emotional outbursts towards either family members or other people. In a disease where one of the hallmarks of diagnosis is emotional dysregulation, many of these patients tend to strike out verbally against others usually in situations where they are unable to obtain a suitable solution to their wants and or needs. This being the most common trait of this disease and the variability in diagnosis, specific verbal aggression patterns can be a challenging trait to track in this patient population. Scott et al. (2017) believe one of the physiological processes which causes borderline personality patients to become aggressive includes the interaction between the affective and the interpersonal hypersensitivity of this disease process. One pathway that leads towards aggression in this patient population is negative emotional reactivity that seems to be

applied to most if not all situations. Because of this baseline emotional instability, many of these patients might take a minor negative interaction and overreact to the situation. This instability with a BPD person's personality can lead towards violence in many different scenarios. Downey & Feldman's (1996) study hypothesized that verbal aggression from borderline personality patients can be determined by what they called the "Rejection Sensitivity Model." In it the researcher's hypothesis that people with borderline personality disorder are more sensitive towards rejection and facing it in the future. This can lead towards higher levels of emotional verbal outbursts when trying to utilize an incomplete set of coping skills.

In another study Arola et al. (2016) looked at the demographics of the adolescent female population within small community hospitals in the Northern part of Finland. They studied the cases of 508 adolescents between the ages of 13-17 and they focused their efforts on the female patients who had personality type disorders. They found that of the female adolescents between these ages, 39% of the respondents had committed some type of criminal offense. When it came to violent crimes however, young adolescent females who particularly had borderline personality disorder, were at a much more prevalent rate. The researchers found that 38% of the crimes that were committed were considered violent in nature. This was also in line with another Finnish study that was conducted by Weizmann-Henelius et al. In their study, they found that 82.6% of imprisoned borderline personality inmates had committed a violent crime. These statistics are also eerily similar to some of the more notional relationships that female adolescents have during their early stages of development.

It would appear that borderline personality traits have a major impact on adolescent females, between the ages of 15-19 and their long-term development of close romantic relationships. Lazarus et al. (2019) found this within their study. The researchers looked at a

sample size of 2,310 school aged girl within an inner-city Pittsburgh, Pennsylvania school district and looked for two distinct things. The first concept the researchers were trying to analyze was borderline personality symptoms and how they coalesce with common vulnerabilities of different relationship types. The second point the researchers were trying to understand was the relation of borderline personality symptoms and how they interact with four relationship characteristics of support, antagonism, verbal aggression, and physical violence. Information gathered on the first point, the researchers found that many of the relationship traits females had as an adolescent, tended to present themselves as the woman became an adult. This was statistically formulated by the reporting of adolescents having increased numbers of romantic partners and a much higher importance placed on the closeness of the relationship. In relation to the second point, the researchers found three key points on adolescent development. First, they found a correlation between higher borderline symptoms associating themselves with the grouping of poor romantic traits, rather than the positive one. They grouped with antagonism, verbal and physical aggression, rather than seeking out relationships that are built upon a strong support structure. They also found the earlier the presentation of antagonism and aggression type symptoms, the higher the instance of these symptoms when the participant became an adult. This was also true in relation towards verbal aggression but did not correlate with relationship traits that foster support. Antisocial personality disorder also appeared to be an increasing factor in wither a person is at risk for displaying violent behaviors.

Gonzalez et al. (2016) looked at borderline personality disorder as an instigator for violence or if there are other comorbidities that are associated with this. Upon a review of 14,000 men and women utilizing the Structure Clinical Interview II – Questionnaire, they looked at self-reported instances of violence and how these instances were directed towards others.

From their statistical analysis, they were able to formulate that the level of violence a person with borderline personality demonstrated was greater when associated with another comorbid disorder. For example, levels and the amount of violence for these patients were much higher when they were associated with antisocial personality disorder. Yet, borderline personality disorder led towards higher levels of anxiety, avoidance of abandonment and impulsivity which the researchers felt could be underlying issues towards the buildup of violent behavior. Behaviors from the study that were not associated with suicidal behaviors and affective instability were not associate with violence. Another area the researchers investigated was what they saw were the different pathways of violence both men and women tend to show it in different ways. For instance, in this study the researchers found that men tend to have a four times higher rate of what they titled "paranoid ideation" under stress that can lead them into engaging in a violent act. For females, the they engage in much smaller acts of self directed violence and can be formulated in many different ways such as hitting, slapping, and more injurious behaviors. There is also a linear increase in borderline symptoms when it comes to the correlation of symptoms between men and women. The linear increase is more profound in women, than it is in men. Indicating that women tend to become more violent when they show more traits of borderline personality disorder. Borderline personality traits can be seen more specifically through biological processes and brain structure function. Some researchers believe that these traits lead towards higher instances of borderline personality and violence towards others.

Mancke et al. (2015) looked at particular brain functions and the effects they have towards more aggressive behavior. The support that structural neuroimaging, functional neuroimaging, and neurochemistry have specific markers within them, that can be accountable

for many of the traits of a person with multidimensional model of aggression in borderline personality disorder. They mark some of the hall mark signs of the disease by listing and explaining some of the key symptoms of emotional dysregulation, empathic functioning, and hypersensitivity. From there, the authors sought to explain the correlation of these behaviors with the biological make up of a person's brain. For instance, one of the most consistent findings the researchers were able to formulate included that patients with smaller amygdala's and hippocampal volumes were some of the most common structures found in the brains of patients with borderline personality disorder. They noted that the decreasing amount of grey matter in these patients is one of the key structural features of aggression and can be an indicator for patient violence. Functional neuroimaging has shown prolonged amygdala activity in relation towards a negative event. This can lead a patient to not be able to process the stressful situation and is one of the main causes of affective dysregulation, a key component to borderline personality disorder. Finally, neuro chemistry markers including prefrontal serotonergic activity can lead towards the borderline trait of impulsivity and the ability for people to act before they think. Another neurochemical that the authors found of note was that of decreased levels of oxytocin and how it has an effect on threat hypersensitivity. This neurochemical aides in the formation of social behavior and positive attachment patterns. Patient's environmental influences have also been important in the development of borderline personality disorder, especially with the development and utilization of certain coping mechanisms.

Some researchers believe the lack of maladaptive coping strategies can preclude people to become at a higher risk of aggression. Gardner et al. (2012) sought out to study the links between maladaptive coping strategies and how they influence or limit different types of aggression. The types of aggression the researchers focused on included reactive aggression,

which included behaviors that are committed during times of duress. This is different than proactive aggression, which is a type of behavior that is planned and is formulated to achieve some form of objective or purpose. What the researchers found during their study of adults and adolescents was four different hypotheses. They found that borderline personality disorder is associated with both reactive and proactive aggression, and the findings indicated it had a greater impact on the reactive patterns. A second finding of the study found that borderline personality traits responded ineffectively towards emotional coping skills. This was also supported by the analysis of their third point, which was the correlation between reactive aggression, their newly found emotional coping skills, and how borderline patients would react when faced in a stressful situation. The researchers found there was a decrease in reactive aggression after the implementation of positive emotional coping skills. The final point the authors tested included the relationship between emotional coping acting as a mediator between borderline personality patients and their thoughts of reactive aggression. They were only able to find this correlation in adults and not in adolescents. They feel emotional coping is key contributor to adult ways to process aggression, while it is not yet fully developed in the adolescent population. The experiences that children have growing up in a household with parents who are diagnosed with BPD greatly affect the future outcomes of these kids.

There is only a minor amount of studies that have been able to provide clear clinical information about the prevalence of BPD in adolescence. According to Borkum et al. (2017) it can be challenging to diagnosis children with this disease because of the patient's maturity level and often associated diagnosis of other childhood mental health disorders such as a mood disorder or ADHD. In their study, they interviewed 104 adolescent patients between the ages of 13 to 17 who met the DSM-5 criteria for BPD. The researchers then interviewed them as adults.

From these interviews, the researchers were able to correlate chronic abuse, perpetrated by multiple family members, and different forms of violent exposures, became better predictors of violent BPD tendencies when the patient became an adult. For example, adolescents who were exposed to minimal incidents of verbal abuse, tend to have much lower rates of BPD. On the contrary, patients who experienced violent physical harm, at a chronic level, tended to display a higher propensity for BPD as an adult and the aggressive dysregulation associated with the disease.

Being able to assess and understand violence within a BPD patient is important to keeping others safe. BPD is a disease characterized by emotional dysregulation and utilization of ineffective coping skills. Because of these traits, patients can react to stressors by engaging in violent or aggressive behavior. The way in which people act out in a violent matter can vary from depending on biological and structural makeup of a person's brain. If a person is male or female can change the presentation of self-harm our outward aggression towards others. Younger people tend to develop BPD traits while in their social and developmental stages of maturity and often will carry this on with them when they get older.

Implications

Implications for practice include focused assessment procedures to specifically diagnose BPD and credible threats of violence. Using specific assessment tools can aide a practitioner in determining a patient's level of emotional dysregulation and what they could be doing to cope with these instances. Assessment questions should include detailed and through implications about suicide, self-harm, and aggression towards others. BPD screeners that can be included in the patient interview include; the McLean Screening Instrument for BPD, Personality and Diagnostic Questionnaire-BPD Scale, and the Structured Clinical Interview for DSM-V Axis II Personality Disorder – Patient Questionnaire. If the practitioner has gathered clear data on the patient concerning their BPD diagnosis, an assessment about self-harm and aggression needs to be accomplished. Simple screeners to better assess patient violence or self-harm include; Ask Suicide-Screening Questions, Behavioral Health Screening-Emergency Department, and the Suicide Potential Scale. Once a diagnosis of BPD has been made and the practitioner feels that there could be a credible threat of violence. There needs to be a more proactive approach to placing the patient into an inpatient setting or even getting the police involved. The development of these skills can be fostered through hospital site education, based upon geographical location and the specific patient population the practitioner is treating.

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