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The relationship between childhood traumatic experience and borderline personality, prognosis and treatment of borderline personality disorder

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Abstract: Borderline Personality Disorder (BPD) is one of the most common personality disorders in society today. In recent decades, the study of BPD has gradually shifted from the initial early adult population to the adolescent population. Previous studies have suggested that borderline personality disorder may be highly correlated with childhood traumatic experiences, and childhood abuse and bullying will seriously affect the formation of individual personality. This paper discusses the characteristics of borderline personality in emotion, behavior, interpersonal relationship, cognition and brain abnormalities. The relationship between the clinical features of BPD and childhood trauma, as well as the treatment and prognosis of borderline personality disorder were expounded, aiming to further explore the occurrence, development and early intervention of borderline personality disorder.

1. Introduction

According to research from the University of Manchester, people with borderline personality disorder are 13 times more likely to report childhood trauma than people without mental health problems. An analysis of data from 42 international studies of more than 5,000 people showed that 71.1% of those diagnosed with a serious health condition reported at least one childhood traumatic experience. The study was carried out by researchers at the University of Manchester in collaboration with Greater Manchester Mental Health NHS Foundation Trust. It was published in the journal Acta Psychiatrica Scandinavia. In the latest in a series of meta-analyses on the effects of childhood trauma on adult mental health, the research team showed a higher likelihood of being associated with BPD compared to mood disorders, psychosis and other personality disorders. The most common form of adverse experience reported by BPD patients was physical neglect (48.9%), followed by emotional abuse (42.5%), physical abuse (36.4%), sexual abuse (32.1%), and emotional neglect (25.3%).

BPD is often a frustrating mental health problem that makes it difficult for someone to control their emotions and impulses. Often associated with self-harm and substance abuse, the disease is difficult to treat and imposes a heavy cost on patients and society as a whole. Certain features of the condition are common, such as experiencing extreme, overwhelming emotions that others may

consider a minor problem, and these features are common but become chronic and exaggerated after suffering trauma in childhood.

Dr Filippo Varese, from the University of Manchester, said: "During childhood and adolescence, our brains are still developing considerably and we are also refining strategies to cope with the challenges of everyday life and the negative emotions that come with it. "In some people who have experienced a prolonged overwhelming chronic disease, these responses may not develop in the same way." People may become more sensitive to 'normal' stress. They are sometimes unable to cope with strong negative thoughts and feelings, and they may resort to dangerous or unhelpful measures to make themselves feel better, such as drug use or self-harm, which can lead to a variety of mental health difficulties, including problems common in people diagnosed with BPD. "We found a strong link between childhood trauma and BPD, and this link was particularly strong when it came to emotional abuse and neglect." He added: "Borderline is a slightly misleading term because it implies that the situation will only have a minor impact. In addition to this, BPD can be very painful and difficult to treat. The term BPD was originally used to mean a mental health problem that wasn't psychosis, anxiety or depression, but something in between. In modern times, another term is' emotionally unstable personality disorder ', which perhaps gives a clearer picture of the situation. "We hope these findings highlight the importance of trauma-informed treatment for the high prevalence of BPD among people accessing mental health services," he said. "But further research is needed to explore the complex factors that may also be involved, such as biology, later life and psychological processes."

2. Characteristics of BPD

2.1. Emotional characteristics

The most striking characteristics of people with BPD are a strong sensitivity to rejection, criticism, and a great fear of abandonment. People with BPD tend to over-idealize the image of others, or to devalue others. As a result, they are constantly alternating between highly positive evaluations of others and huge disappointments.

People with BPD are often enthusiastic, idealistic, joyful, and loving beyond the average person. However, they may be overwhelmed by negative emotions (such as anxiety, depression, guilt, shame, worry, anger, etc.). They are more likely to feel intense grief rather than sadness, shame and humiliation rather than mild embarrassment, anger rather than annoyance, and panic rather than tension. They are especially sensitive to feelings of rejection, criticism, isolation and failure.

Their efforts to escape from their strong negative emotions may lead to self-harm or suicidal behavior until they learn other coping skills. They are able to sense the intensity of their negative emotional reactions, and because they cannot manage them, they turn them off completely. This behavior can be harmful to people with BPD because negative emotions often alert us to a problem situation and cause us to try to deal with it, and people with BPD often perceive these emotions as something that will only cause more trouble and pain.

Emotional instability is the core symptom of BPD patients, and its recognition, understanding and processing of emotions as well as language expression are significantly weakened, resulting in long-term emotional fluctuations and interpersonal instability, and significant impairment of social function. BPD patients who experienced childhood trauma often indulge in rumination when faced with negative or stressful events, constantly blaming themselves and others, and even amplifying negative emotions and adverse consequences, eventually leading to extreme emotional outbursts[1]. If you suffer from emotional abuse and physical abuse for a long time, the difficulty of emotional regulation will be more obvious. Recurrent, planned and socially unacceptable self-injury in BPD patients without suicidal intent is called non-suicidal self-injury (NSSI). A study showed that more

than 90% of BPD had NSSI behavior, and the common ways of self-injury were cutting, scratching and hitting, followed by burns, biting, head banging, hair grabbing, nail biting and other ways, and most patients used more than one way of self-injury[2].

2.2. Behavior characteristics

Impulsive behavior is common in people with borderline personality disorder, which can include drug or alcohol abuse, eating disorders, unsafe or promiscuous sex, impulse spending, and reckless driving. Impulsive behaviors may also include running away from work and relationships, running away from home, and self-harm.

The reason people with BPD act impulsively is that it gives them an immediate sense of relief from their immediate emotional pain. In the long run, however, the shame and guilt associated with such behavior can cause people with BPD to suffer more. A common cycle goes like this: the person with BPD feels emotional pain, then he uses impulsive behavior to relieve that pain, he feels shame and guilt for his impulsive behavior, and from that shame and guilt he feels new emotional pain, and there is a stronger push to use impulsive behavior to relieve the new pain. Over time, impulsive behavior may become an automatic response to emotional distress.

The lifetime risk of suicide for people with BPD is between 3% and 10%. There is evidence that men diagnosed with BPD have about twice the risk of suicide compared to women. There is also evidence that a significant proportion of all men who commit suicide may have undiagnosed BPD. Reasons for non-suicidal self-harm include releasing anger, self-punishment, stimulating oneself to feel normal (often used to cope with dissociation), and distracting oneself from emotionally painful or difficult situations. Instead, suicide attempts often reflect the belief that "someone else will be better off after I kill myself." Self-harm and suicidal behavior are both responses to negative emotions.

2.3. Interpersonal relationship

People with BPD can be very sensitive to the way others treat them, feeling intense pleasure and gratitude when they perceive kindness expressed by others, and intense sadness or anger when they perceive criticism and hurt. After negative events such as disappointment, the potential threat of losing someone, or the perception that they have lost respect in the eyes of someone they value, their feelings toward others often shift from admiration and love to anger and disgust. This idealization and devaluing of others, combined with emotional distress, can take a toll on people with BPD's relationships with family, friends, and co-workers. The self-image of a person with BPD can also quickly shift from a healthy image to an unhealthy one.

People with BPD have a strong desire for intimacy, but they tend to have insecure, avoidant, conflicted attachment patterns filled with fear and anxiety in their relationships, and they often see the world as dangerous and malicious. Like other personality disorders, BPD is associated with increased levels of chronic stress and conflict in romantic relationships, decreased partner satisfaction, abuse, and unwanted pregnancies.

2.4. Cognize

Often intense emotions cause people with BPD to have problems controlling their attention. In addition, people with BPD may try to visualize dissociation, which can be thought of as a stronger form of "emptying yourself." Dissociation usually occurs in response to experiencing a painful event, or experiencing something that evokes the memory of a painful event. It usually involves the conscious mind automatically turning its attention away from events, presumably in order to protect itself from experiencing strong emotions and the unwanted impulses these emotions may trigger.

While the habit of consciously blocking intensely painful emotions can provide temporary relief, it can also have the unwanted side effect of blocking or dulling the experience of normal emotions. This allows people with BPD to reduce their intake of the information contained in these emotions, which can effectively guide us in making decisions in our daily lives. Sometimes, it is possible for others to tell when a person with BPD is in a dissociative state, because the person's facial expressions and voice become hollow and emotionless, or they appear to be distracted; At other times, dissociation may go unnoticed.

2.5. Cerebral abnormality

The hippocampus is part of the limbic system and is responsible for short-term memory, long-term memory and spatial orientation. Scholars generally agree that the hippocampus plays an important role in forming new memories of experienced events. People with BPD tend to have smaller hippocampal areas than people without BPD. People with BPD have a smaller and more active amygdala. Reduced amygdala volume has also been seen in people with OCD. One study showed that when BPD experiences a negative event, or displays negative emotions, the left amygdala is highly active. Because the amygdala is responsible for all emotions, including unpleasant ones, this unusually intense activity may explain the unusual intensity and duration of emotions such as fear, sadness, anger, and shame that people with BPD experience, as well as their heightened sensitivity to such emotions displayed by others.

The prefrontal lobes of people with BPD tend to be less active than the general population, especially when the brain evokes abandoned memories. Since the prefrontal lobe has a role in regulating emotional arousal, its relative inactivity may explain the difficulty people with BPD have in managing their emotions and coping with stress.

The hypothalamic-pituitary-adrenal axis (HPA axis) is responsible for regulating the secretion of cortisol, which is released in response to stress. People with BPD tend to produce more cortisol than the general population, which means that these people have an overactive HPA axis. This causes them to experience a deeper biological stress response, which may explain their greater susceptibility to irritability. Since traumatic events can increase cortisol secretion and HPA axis activity, one possible explanation for the high HPA activity prevalent in people with BPD is that people with BPD generally experience more traumatic events than the average person; Another possible explanation: increased cortisol production may make people with BPD more likely to experience stressful events as traumatic. In addition, increased cortisol production has been linked to a higher risk of suicidal behavior.

3. Association between clinical features of BPD and childhood trauma

3.1. Severe sexual abuse in childhood is associated with severe self-harm and self-injurious behavior

Levey et al. 's[3] case study on childhood abuse around the world found that abuse events often repeated in two-generation families, and parents who had experienced childhood abuse often doubted their ability to be parents and could not properly educate their children. After childhood trauma, such as rape, parental beatings or school bullying, children may internalize or separate their pain. One reason for separation is to remove yourself from the source of the trauma, or to avoid associating with painful memories, which makes it easier to hide hostile feelings. When encountering aversive events again, BPD patients show increased alertness and re-experience, and may also have dissociative symptoms and hyperexcitability[4]. People with BPD also have a core characteristic of difficulty maintaining stable relationships, which may be related to adverse childhood experiences. Their

parents' emotional control ability is poor, and they only adopt simple and rude parenting methods, such as opposition, scolding and punishment[5]. Reasonable attachment relationships may increase BPD's sense of security, from which support can be obtained and distress alleviated. However, individuals exposed to childhood trauma are often unable to form secure attachments, and their fear of interpersonal rejection or abandonment manifests as a persistent fear. As a result, people with BPD have emotional outbursts when someone close to them leaves, in order to avoid being abandoned or separated. Loneliness is also an inner experience of people with BPD, and emotional abuse and emotional neglect are associated with feelings of loneliness[6].

3.2. Improper family education in childhood.

Parenting style is a relatively stable behavior pattern that parents show in the process of raising and educating their children. It is a behavior tendency that parents show in the daily life of educating and raising children; It is a summary of the characteristics of various parenting behaviors of parents. Parenting style reflects the nature of parent-child interaction and has stability across situations. Different parenting styles have different effects on children's psychology, especially personality characteristics. The parenting style of parents will subtly affect the personality characteristics of their children. It is mainly reflected in two aspects. On the one hand, it is positive, including parents' positive parenting style and parental care; The other side is negative, including rejection, denial, harsh punishment, excessive interference or overprotection, and inconsistent attitudes from both parents[7]. Many studies have found that the positive parenting style score of BPD adolescent families is significantly lower than that of non-BPD adolescent families, and BPD subjects report more negative parenting styles in their families. Stepp and Whalen et al. found that low levels of parental warmth and severe punishment during adolescence predicted subsequent increases in BPD symptoms; Conversely, BPD symptoms predicted an increase in severe parental punishment later in life. This suggests that there is a vicious cycle between negative parenting and increased BPD symptoms that continues to progress toward negative outcomes. Why is parenting style such an important factor in the development of BPD symptoms in adolescents? Deci and Ryan proposed the Self-determination theory (SDT). This theory points out that individuals have three basic psychological needs: ability needs, relationship needs and autonomy needs. Ability need refers to the individual needs to be able to do a certain behavior; Relational need refers to an individual's desire to feel connected to others, including caring for, caring for, and being cared for and cared for by others. Autonomous need refers to the desire of an individual to organize and complete certain activities or behaviors, and the experience of self-determination in the process of organizing behaviors. However, the negative parenting style of parents in BPD families neglects these psychological needs in the development of adolescents. For example, the over-protection and severe punishment of parents limit the satisfaction of individual ability needs and autonomy needs of adolescents. Parental rejection, low levels of warmth and inconsistent attitudes result in adolescents feeling less love and care from their parents, which hinders the satisfaction of their relationship needs.

3.3. Parents with poor emotional control (disapproval, scolding, and punishment) are associated with difficulty maintaining stable relationships.

Intergenerational transmission refers to the phenomenon that parents' abilities, characteristics, behaviors or ideas are passed on to their children. In the field of emotions, researchers have long found that parents' emotional development has a significant impact on their children's emotional lives. Parents' good emotion expression and emotion regulation can promote children's understanding and management of emotions. The difficulty of emotional regulation when parents face conflict situation is an important cause of children's emotional disorder. For example, Che Hanbo et al. found that

cognitive emotion regulation strategies such as father and mother's catastrophization, blaming others, and rumination can effectively predict children's negative emotion regulation strategies[8]. Limited by the developmental stage, children's emotional regulation mainly adopts passive coping, emotional venting, aggressive behavior, etc. These strategies do not play a role through the cognitive components of emotional regulation, and more affect emotional responses and emotional behaviors, which is not a direct study on children's cognitive emotional regulation strategies. Due to the poor emotional control ability of parents, they will only take simple and rude parenting methods for educating children, such as opposition, reprimand and punishment, which will eventually lead to BPD patients difficult to maintain stable interpersonal relationships.

4. Treatment and future direction of BPD

4.1. Means of treatment

4.1.1. Cognitive behavioral therapy

Patients with borderline personality disorder often have some inappropriate and non-positive ideas, such as others are unfriendly to them and they are the most unsuccessful people, etc. These improper ideas and ideas easily lead to difficulties and obstacles in the process of maintaining interpersonal relationships and intimate relationships, and even thoughts and behaviors of self-harm and suicide due to frequent self-denial[9]. Cognitive behavioral therapy can help patients gradually realize the mistakes in their thoughts and ideas, help them better digest emotions and establish correct thoughts and ideas[10]. The most typical treatment method of cognitive behavioral therapy is dialectical behavioral therapy, which is used to treat chronic suicidal psychology. Later, through practical research, it gradually evolved into a method to treat borderline personality disorder. Dialectical behavior therapy can deeply explore the main causes of borderline personality disorder, take biological sociology as the basis, reasonably control patients' bad emotions, and help patients master correct interpersonal skills[11]. Linehan believes that emotional dysregulation is a central feature of BPD, and suggests that it may be caused by congenital biological defects and adverse childhood experiences. DBT aims to change behavior and manage emotions through a "balanced and integrated approach of acceptance and change." There are four main treatment modes of DBT: individual psychotherapy, group skill training, telephone guidance and therapist team consultation. At present, DBT is not only used in outpatient treatment of borderline personality disorder, but also can be effectively used in inpatient treatment.

4.1.2. Mentalization-BasedTher apy (MBT)

At present, the mentalization based therapy (MBT) founded and developed by Fonagy and Bateman has become the mainstream of short-term psychotherapy for BPD in Europe and the United States. MBT originates from psychoanalytic object relations theory and integrates attachment theory and many psychoanalytic concepts and principles. With the efforts of Fonag and others, MBT has a specific operational process and has become a popular treatment model for contemporary psychoanalysis. Bateman et al. believe that the essential problem of borderline personality disorder is the loss of mental function. They have not developed the ability to explain their own emotions and others' emotions by relying on internal and external cues, and lose their mental ability in interpersonal communication, thus affecting the process of regulating emotions and behaviors[12]. The core of MBT treatment is to improve the mental ability of patients, that is, the ability to understand and identify the mental state of self and others, through the mental response of self and others' thoughts, emotions, motives, intentions, to achieve the purpose of regulating and controlling emotions and behaviors.

MBT mainly plays three roles: (1) Clarifying and transforming the unscientific relationship model, especially the attachment relationship model, mainly improving the psychological problems of patients who are afraid of being rejected and abandoned. (2) Make patients correctly understand the relationship between themselves and others. (3) Clear and reasonable ways to change patients' negative emotions[13].

At present, MBT is mainly carried OUT in partial hospitalization (MBT-PH) and outpatient diagnosis (MBT-OUT), and the effect has been confirmed by clinical experiments. A randomized controlled trial of psychodynamic therapy based on the principle of MBT and standardized psychiatric nursing methods found that patients in the MBT group had better efficacy in reducing self-injury-suicidal behavior, hospital stay, drug use, improving anxiety symptoms and restoring mental function. The patients were followed up in two stages. In the 18-month follow-up study, patients who initially received MBT-based psychodynamic therapy received group psychotherapy twice a week, while the standard care group received conventional therapy (TAU). It is found that the former has better curative effect in the treatment of BPD.

4.1.3. SchemaTherapy (ST)

After more than 20 years of exploration, JeffreyYoung et al. created schema therapy (ST) on the basis of traditional cognitive behavior, combining object relations theory, psychodynamic theory, gestalt theory and constructivism. This new type of cognitive behavioral therapy was initially used for complex personality disorders and has gradually become an effective treatment for BPD. ST has four main concepts: early maladaptive schema, coping style, schema scope and schema model, of which early maladaptive schema (EMS) is the core concept. Young et al. believe that early maladaptive schema may be an important cause of personality disorder, including cognition, emotion and feeling. It is formed under the influence of unsatisfied early core emotions and adverse early life experiences (abuse, hostility, etc.), and individuals establish self-defeating adverse schema to react negatively to the environment at that time. This kind of negative schema appears repeatedly in the later life of the individual and eventually leads to many psychological problems[14]. The goal of ST is to help borderline patients identify maladjustment in adulthood as a result of unmet emotional needs in childhood. Schema therapy is mainly divided into two stages: schema assessment and schema change. In the assessment phase, the therapist identifies the patient's suitability for schema therapy, identifies their schema, understands the early causes of the schema, and relates them to the current problem. In the stage of change, therapists flexibly combine adversarial empathy, cognitive, interpersonal and behavioral strategies, replace maladaptive coping styles with positive and healthy behaviors, and promote the change of patients' schemas.

4.1.4. BPD exclusive interpersonal therapy (Interpersonal Psychotherapy For Borderline Personality Disorder, IPT BPD)

In 1984, Klerman et al. created interpersonal therapy (IPT) for the treatment of depression patients, which initially achieved promising results in the treatment of unipolar depression, and after decades of development, has been successful in the treatment of a variety of personality disorders[15]. Interpersonal Psychotherapy (IPT) is a concise approach to psychotherapy with a highly structured operating manual and a diagnostic orientation. In recent years, IPT has been used to treat patients with borderline personality disorder. The core symptoms of mood disorders and relationship problems in BPD patients are the main reasons why IPT can treat BPD. The traditional model of IPT is not fully adapted to the complexity of BPD pathology, and Markowitz and colleagues have adapted interpersonal therapy for BPD and proposed BPD-Specific Interpersonal therapy (IPT-BPD)[16]. The adjusted features mainly include a different understanding of the disorder concept, a longer treatment

time, and more flexibility in the setting. The IPT treatment setup is 36 50-minute sessions over 32 weeks, divided into two sessions. The first stage, the establishment of effective treatment relationship, so that the symptoms get initial relief. If patients successfully complete this phase, they can move on to a second phase of therapy, where therapeutic relationships are strengthened and help develop more adaptive interpersonal mechanisms. SilvioBellino et al. designed a modified protocol (IPT-PBD-R) to overcome Markowitz's limitations in clinical operation.

In fact, the research on IPT-BPD still has some limitations: there are few individual empirical studies on the efficacy of IPT; The sample size is limited; Reliable assessment of the combined effects of IPT requires more specialized instruments. More research may be needed in these areas in the future.

4.2. Future directions of BPD treatment research

The available evidence supports that psychotherapy for BPD is more effective than pharmacological interventions, but psychotherapy is expensive and not widely used in the mental health system. According to the results of the recent meta-analysis, there are several forms of treatment (not just one) that are effective for BPD. However, long-term tracking data is lacking. Joel Pari s (2005) proposed the direction of further research on the treatment of BPD in the future.

First of all, since BPD is regarded as a chronic disease, future studies should go beyond the short-term efficacy and investigate the long-term effects of various therapies. However, at present, there is a lack of data on long-term treatment, whether it is psychotherapy or drug therapy. At the same time, studies are needed to prove that treatment works better than natural rehabilitation. Because BPD tends to improve gradually over time, future research is needed to understand whether long-term treatment speeds up the recovery process.

Secondly, many studies have pointed out that different approaches under different theoretical bases can improve the symptoms of BPD, so there may be some common factors that contribute to all treatments, such as general factors such as solid treatment alliances and problem-solving approaches often mentioned in the psychotherapy literature, which are more effective than some specific techniques. Future research could target more of these common factors rather than just specific therapies. Also, the newly proposed integrated treatment model needs to be tested.

Finally, although the current drug treatment of BPD is not ideal, but these drugs were invented to treat other mental disorders, if the development of new drugs to specifically target the core symptoms of BPD (instability and impulsivity), drugs may play a more important role in BPD treatment in the future.

5. Conclusions

BPD is a kind of psychological disease with high incidence in today's society. Therefore, the relevant clinical medical research needs to conduct continuous and in-depth exploration on the treatment means of borderline personality disorder, clarify the core concepts of borderline personality disorder, and use more scientific and reasonable treatment methods to improve the treatment level and promote the early recovery of patients.

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