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AHC Media

The Devalued Body: Symptoms of BPD in Mental Health and Medical Settings

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Borderline personality disorder (BPD) is a complex personality dysfunction that is frequently characterized in sufferers by a history of childhood trauma as well as repetitive self-harm behavior in adulthood. In this edition of *Primary Care Reports*, we will initially review the characteristics of this unique personality disorder. We will then review the few published studies on body image in BPD as well as postulate inter-relationships among childhood trauma, BPD, a devalued body, and subsequent symptom manifestations. Finally, we will close with a description of the potential manifestations of body image-related symptoms in patients with BPD in both mental health settings and medical settings.

An Overview of BPD

Historical Aspects. BPD has probably existed for eons. However, robust descriptions of this psychiatric phenomenon did not emerge until the 20th century. In 1934, Deutsch provided one of the earliest descriptions of BPD in the literature.[1] In portraying this disorder, Deutsch emphasized the intact social veneer of individuals with BPD as well as the presence of underlying aggression. In her own words, Deutsch depicted patients with BPD as having, "…an apparently normal relationship to the world," combined with "…aggressive tendencies … readily convertible to evil."

Stern originally coined the term "borderline" in 1938.[2] This odd moniker emerged from the backdrop of the 1930s psychoanalytic era, during which mental health professionals classified major psychiatric disorders as either neurotic or psychotic in nature. However, Stern encountered a group of patients who seemed to simultaneously exhibit *both* neurotic features and psychotic features — an unexpected deviation from the categorization of psychiatric disorders at that time. From a psychoanalytic perspective, he aptly described these individuals as existing on the border of both neurosis and psychosis — or *borderline* — a term that has persisted for more than 75 years.

EXECUTIVE SUMMARY

Borderline personality disorder (BPD) is a complex personality dysfunction often characterized by a history of childhood trauma as well as repetitive self-harm behavior in adulthood. The prevalence of BPD in the general population is between 2-6%.

- BPD was first described in 1934 emphasizing the intact social veneer of individuals with the presence of underlying aggressive tendencies readily convertible to evil.
- Later, Stern described from a psychoanalytic perspective that these individuals existed on the border of both neurosis and psychosis — or borderline — a term that has persisted for more than 75 years.
- Its etiology is postulated as the indistinct interaction of genetics and the environment.
- Studies has demonstrated significant correlations with lower general body satisfaction, lower self-rated bodily attractiveness, lower self-rated facial attractiveness, and higher social avoidance because of body image concerns.
- Poor body image is often associated with maltreatment in childhood, including sexual abuse, physical abuse, and emotional abuse.
- Recognizing these patients in the office setting is important and should be considered in those patients with poor body image, recurrent suicidal and self-mutilating behavior, increased pain threshold, and multiple somatic complaints.

In 1980, BPD attained legitimate diagnostic status as a personality disorder with the debut of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III).[3] In this edition of the DSM, the criteria for BPD included impulsivity in at least two areas that are potentially self-damaging, a pattern of intense and unstable relationships, inappropriate intense anger, identity disturbance, affective instability, intolerance of being alone, physically self-damaging acts, and chronic feelings of emptiness or boredom. According to the DSM-III, four of the preceding eight criteria were required for the diagnosis of BPD.

As for the contemporary diagnosis of BPD, the eight essential diagnostic themes that were originally described in the DSM-III have been retained in the current diagnostic manual — the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5).[4] However, in the current DSM, there is now a ninth criterion: transient stress-related paranoid ideation or severe dissociative symptoms (*see Table 1*). According to the DSM-5, five of nine criteria are required for diagnosis.

Table 1. The Criteria for Borderline Personality Disorder[4]

- Frantic efforts to avoid real or imagined abandonment
- A pattern of intense and unstable relationships with others
- Marked and persistent identity disturbance
- Impulsivity in at least two areas that are potentially self-damaging, such as spending, sex, substance abuse, reckless driving, or binge eating
- Recurrent suicidal behavior, gestures, or threats; self-mutilating behavior
- Affective instability with marked reactivity of mood
- Chronic feelings of emptiness
- Inappropriate and intense anger, or difficulty controlling anger
- Transient stress-related paranoid ideation or dissociative symptoms

Epidemiology of BPD. According to the DSM-5, the prevalence of BPD in the general population is between 2-6%.[4] However, in contrast to these percentages, Grant and colleagues encountered a community rate of 6%.[5] In outpatient and inpatient mental health settings, prevalence rates of BPD are 10% and 20%, respectively.[4]

As for gender distribution, 75% of those afflicted with BPD in clinical samples are purportedly female.[4] However, Grant and colleagues reported equal prevalence rates between men and women in epidemiological samples.[5]

As for other demographic characteristics, in terms of U.S. ethnic groups, BPD may be more common among Hispanics, compared with whites or blacks.[6] Although rates may be higher in westernized countries,[7] the disorder has been identified worldwide (i.e., among individuals from different countries).[4] According to the DSM-5, the symptoms of BPD begin to emerge in early adolescence.[4]

Etiology of BPD. Like all psychiatric disorders, the postulated etiology of BPD is the indistinct interaction of genetics and the environment.[4] While genetics have been reported to account for a substantial contribution to the development of BPD,[4] the phenomenon of epigenetics (i.e., altered gene expression due to environmental stimuli, such as trauma) is rarely credited and factored into this conclusion.

As for environmental factors, a common theme in the childhood histories of individuals with BPD is repetitive trauma (e.g., physical, sexual, emotional abuses; witnessing violence).[4,8] This aspect of the etiology of BPD will become highly relevant to our unfolding discussion

of body image.

Symptom Differences in the Clinical Presentation of BPD in Mental Health vs Medical Settings. While the core psychological features of BPD are similar across affected individuals, there appear to be distinct differences in the symptom presentations of patients with BPD in mental health settings vs medical settings.[8] To clarify these differences, patients with BPD in psychiatric settings tend to verbalize concerns about relationship difficulties, report mood instability/lability and dysphoria, and exhibit graphic and dramatic forms of self-harm behavior (e.g., cutting, scratching, burning oneself), including suicide attempts. In contrast to mental health settings, patients with BPD in medical settings tend to describe unsubstantiated physical symptoms within three distinctive contexts: 1) medically self-sabotaging behavior, 2) pain sensitivity, and 3) multiple somatic complaints. Use of the term "unsubstantiated" is not meant to imply the complete absence of genuine pathology or dysfunction but to underscore the psychological magnification or intentional exacerbation of such symptoms.

Outcome in BPD. Individuals with BPD appear to have three distinct long-term outcomes: 1) greater stability with maturity (i.e., symptom remission),[4] which appears to be the most frequent outcome; 2) completed suicide, with a rate of approximately 10%;[4] and 3) no significant change in symptoms throughout the majority of the lifespan.[9] As for the most frequent outcome, while a number of investigators have reported meaningful symptom reductions over time in long-term follow-up studies,[10-12] a review of the literature indicates continuing functional impairment with regard to employment.[13] Combined together, these findings suggest that over time, there may be less robust expression of BPD symptoms but perhaps not significant functional improvement in some key life areas, such as employment.

Studies of Body Image Among Individuals with BPD

Several studies have been undertaken in the area of body image and BPD (*see Table 2*). In a U.S. study, we examined women outpatients who were being treated in a university psychiatric clinic where care is provided by resident physicians.[14] Using simple correlations, we found that higher scores on a self-report measure for BPD demonstrated statistically significant correlations with lower general body satisfaction, lower self-rated bodily attractiveness, lower self-rated facial attractiveness, and higher social avoidance because of body image concerns (i.e., avoidance of social activities in which body and appearance might be a focus). These correlations were at the

Table 2. Summary of Studies on Borderline Personality Disorder and Body Image

First Author	Year Published	Sample Types	Sample Size	Findings
Sansone[14]	2001	Women psychiatric outpatients	48	Participants with BPD features evidenced ↓ general body satisfaction, ↓ self-rated attractiveness, ↓ facial attractiveness, and ↑ social avoidance due to body image concerns
Haaf[15]	2001	Women with BPD, with bulimia nervosa, and controls	47 (BPD)	Participants with BPD had more negative concepts about their bodies
Sansone[16]	2010	Women psychiatric inpatients	126	Participants with BPD features evidenced greater body self-consciousness and negative perceptions of appearance, ↓ comfort/trust with their bodies
Dyer[17]	2013	Women with BPD and controls	89 (BPD), 41 (controls)	Participants with BPD evidenced greater body image difficulties
Muehlenkamp[18]	2013	Male/female undergraduate students	398	Participants with BPD features evidenced ↓ body regard
Dyer[19]	2013	Women with scars from burns	125	Participants with self-inflicted burns and resulting scars demonstrated ↑ rates of BPD and greater negative body image than women with accidental burns
Witthoft[20]	2014	Psychiatric inpatients with PTSD/CSA and controls	91	Participants with PTSD, CSA, and BPD evidenced greater attentional bias toward body-related stimuli than those with PTSD, CSA, but no BPD

Note: PTSD = post-traumatic stress disorder; CSA = childhood sexual abuse

P = 0.05-0.01 levels. To summarize, compared with non-BPD peers, participants with BPD symptoms in this study reported less satisfaction on all of the body-image assessments administered.

In a study from Germany, Haaf and colleagues compared *body concept* among women with BPD, women with bulimia nervosa, and women without psychiatric disturbances (i.e., the control group).[15] In this study, the researchers found highly significant differences between the cohort with BPD and the other two cohorts, with the BPD cohort reporting more negative concepts about their bodies.

In a second U.S. study, we examined body image among a sample of women psychiatric inpatients.[16] In this study, we found that higher scores on one of two measures of BPD were associated with being more self-conscious in general about body issues. In addition, participants with higher BPD scores on either measure evaluated their own appearances more negatively and indicated less comfort and trust in their bodies.

In another study from Germany, Dyer and colleagues compared several aspects of body image between women with BPD and healthy controls.[17] As expected, compared to healthy controls, participants with BPD evidenced significantly more negative scores on the two body-image measures used in this study.

In a study of U.S. undergraduate students, Muehlenkamp and colleagues examined *body regard* — a concept that refers to how one perceives, experiences, and/or cares for one's body.[18] In this study, researchers found that higher scores on the assessment for BPD were associated with lower scores on the assessment for body regard. On a side note, lower body regard in this study was also associated with a higher frequency of non-suicidal self-harm behavior.

In another study from Germany, Dyer and colleagues examined women with scars due to burns.[19] Participants were recruited through the Internet and public flyers. In this sample, slightly more than half of the participants reported that their scars were due to intentional self-inflicted burning. These individuals were compared to the remainder of the sample, who incurred their burn scars from accidents (i.e., not intentional, not self-induced). As expected, participants with self-inflicted burns and resulting scars demonstrated statistically significantly higher scores on the measure of BPD used in this study. These individuals also exhibited generally more negative responses on body-image assessments than participants with burn scars due to accidents.

In a final study from Germany, Witthoft and colleagues examined psychiatric inpatients with post-traumatic stress disorder and childhood sexual abuse in comparison to healthy controls.[20] The clinical sample was subsequently divided according to BPD status. Researchers found that those participants with both psychiatric phenomena and BPD had a stronger attentional bias toward body-related stimuli compared to participants with both psychiatric diagnoses and no BPD or healthy controls.

In summarizing these studies, there appear to be reliable relationships between BPD and poor body image as well as between nonsuicidal self-harm behavior and poor body image. Importantly, not a single study reported a contradictory finding. Thus, according to the extant literature consisting of multiple measures and facets, individuals with BPD appear to demonstrate varying degrees of body image difficulties.

Explanations for Poor Body Image in BPD

Why might there be an association between poor body image and BPD? Poor body image is oftentimes associated with various forms of maltreatment in childhood, including sexual abuse, physical abuse, and emotional abuse.[21] Indeed, it is likely that any form of repetitive maltreatment in childhood (e.g., bullying, witnessing violence) contributes to body-image difficulties.

Why might this be? For young children, the social environment functions somewhat as a mirror. A childhood environment that is brimming with negativity (particularly when directed toward the child) will likely influence the way that the child perceives him/herself. Stated another way, how children are viewed and treated by others affects, to some degree, how they envision and treat themselves. Therefore, early relationships with caretakers play a fundamental role in shaping concepts of self, esteem toward self, and perception of body value or worth. If a child is valued by caretakers, he/she is likely to express positive attitudes toward self. If a child is devalued by caretakers, he/she is likely to express negative attitudes toward self.

In examining these negative environmental influences, sexual and physical abuses may be particularly disastrous in terms of their effects on body image. These types of abuses may be more likely to promote a sense of dissociation — a process that allows the victim to vacate the present moment in order to momentarily transcend the shock of violation. While perhaps helpful in the moment (vacating the traumatizing situation), dissociation unfortunately fosters an unintended division of self —"me vs my body." If persistent, this division of self may set the stage for the ongoing and unconscious perception that body self is to some degree separate from psychological self — i.e., that body self is not genuinely "me." As a result, the body may be more at risk for developing into the *non*-self field for acting out negative emotions and behaviors.

In addition, in the aftermath of having been abused by others, the victim may be more likely to act out

on his/her own body. This complex response by the victim is probably attributable to a number of psychological processes, including imitation, repetition/compulsion, and/or attempts to master the trauma. To state this process in a simpler manner, a devalued body is far easier to act out upon than a valued body. Therefore, the presence of poor body image is likely to be a fertile ingredient or active mediator in the process of self-harm behavior.

Given the preceding relationships among childhood maltreatment, poor body image and acting out on self, one would suspect that the threshold for self-harm behavior among these individuals would be lower in comparison with others, particularly with regard to self-mutilation.[21] Therefore, it is plausible that BPD would be diagnostically and clinically characterized by self-directed self-harm behavior.

Negative Body Image and BPD in Psychiatric Settings: Self-Harm Behavior

One of the criterion for BPD in the DSM-5 that is likely influenced to some degree by poor body image is, "recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior."[4] In clinical support of the association between self-harm behavior and BPD, as early as 1975, Mack described self-harm behavior as the "behavioral specialty" of individuals with BPD.[22] Other authors have empirically confirmed this. For example, in a review of the literature, Oumaya and colleagues found that up to 80% of individuals with BPD engage in self-mutilation, with more than 41% reporting 50 or more incidents.[23] Cerrutti and colleagues examined a nonclinical sample of 365 young adults and reported distinct associations between self-harm behavior and BPD.[24]

As for more dramatic forms of self-harm behavior, Black and colleagues found that at least three-quarters of patients with BPD have attempted suicide.[25] In addition, Zanarini and colleagues reported that 60% of inpatients with BPD evidenced two or more past suicide attempts.[26]

It is important to keep in mind that the preceding empirical findings likely represent the proverbial tip of the iceberg, as most assessments of self-harm behavior in studies of individuals with BPD have been limited to cutting and burning oneself and/or suicide attempts. Realistically, there are innumerable forms of self-harm behavior. Some self-harm behaviors are fairly obvious and graphic, such as scratching, biting, bruising, or picking at oneself. Other self-harm behaviors are more covert, such as distancing oneself from God,[27] inciting partner violence, sabotaging a job, or sabotaging a relationship. Moreover, some self-harm behaviors are cloaked in the medically exotic behaviors of interfering with wound healing and exercising an injury on purpose.[27] To summarize, findings suggest that one of the clinical outcomes of body image problems in individuals with BPD in mental health settings is self-harm behavior.

Negative Body Image and BPD in Medical Settings: Somatic Symptoms

Body image difficulties in BPD may also contribute to the expression of various somatic syndromes in medical settings. Like the clinical manifestations of body-image problems in mental health settings, the clinical manifestations of body-image problems in medical settings can be traced back, in part, to maltreatment in childhood.

Maltreatment by others in childhood communicates to the child the message that, "You are bad." These cumulative negative messages may culminate in negative cognitive schemas around the body ("I am bad, my body is bad").[28] These negative cognitive schemas around the body may ultimately conclude in the general impression of a faulty, inadequate, or "bad body" — i.e., that one's body is dysfunctional or "not right." The perception of a faulty body may then subsequently encourage body violation by oneself (i.e., medically self-harming behaviors) and/or the misperception of body dysfunction (i.e., unsubstantiated pain sensitivity, multiple somatic complaints). Body image issues in patients with BPD in medical settings may manifest in three general types of somatic syndromes: 1) medically self-harming behavior, 2) pain sensitivity, and 3) multiple somatic complaints.

Medically Self-Harming Behaviors. Medically self-harming behaviors (i.e., self-destructive behaviors that are undertaken in a medical context) are basically self-harm equivalents that manifest in medicalized forms. These behaviors are explicitly self-harming in that they: 1) suggest medical dysfunction and invite unnecessary tests and treatments, and/or 2) surreptitiously disrupt the integrity of one's body. Perhaps the most infamous syndrome in this regard is factitious disorder or Munchausen's syndrome (i.e., the deceptive falsification of physical signs and symptoms or the surreptitious induction of injury or disease), which oftentimes entails actual physical injury to oneself to produce misleading symptoms.

The extant literature contains a number of case reports that indicate associations between factitious disorder and BPD.[29-37] In the majority of these reports, the diagnosis of BPD was well established before the clinical presentation of factitious symptoms.

In addition to case reports, Sutherland and Rodin reported the prevalence rate of BPD among individuals with factitious disorder, which is by nature difficult to study.[38] These investigators examined 10 individuals with factitious disorder and reported that 30% had BPD. In this study, the diagnosis of

BPD was retrospectively assessed according to available data in existing medical records. Note that while this approach undoubtedly incurred problems with missing information and diagnoses, it still yielded a substantial rate of this personality dysfunction.

A second form of medically self-harming behavior is purposefully making medical situations worse (i.e., hurting oneself through a medical context). We have examined this behavior (i.e., "Have you ever intentionally, or on purpose, made medical situations worse on purpose [e.g., skipped medication]?") and its association with BPD in both psychiatric and internal medicine samples.[39] In the psychiatric sample, which consisted of 441 patients, the subsample with substantial BPD symptoms was significantly more likely to endorse having made medical situations worse. Likewise, in the internal medicine sample, which consisted of 332 patients, the subsample with substantial BPD symptoms was significantly more likely to endorse having made medical situations worse.

A third form of medically self-harming behavior is preventing wounds from healing (i.e., a direct violation of the body). We have examined and confirmed the relationship between preventing wounds from healing (i.e., "Have you ever intentionally, or on purpose, prevented wounds from healing?") and BPD in several studies with different types of populations: 1) internal medicine outpatients,[40] 2) obstetrics/gynecology outpatients,[41] and 3) psychiatric and internal medicine patients in a compiled database of multiple studies.[42]

To summarize, while not traditionally envisioned as overt self-harm behavior from a psychiatric perspective, the behaviors culminating in factitious disorder, making medical situations worse, and preventing wounds from healing all share two things in common: 1) they disrupt body functioning and body integrity (i.e., they are self-injury equivalents) and 2) they are often related to BPD.

Pain Sensitivity. Studies examining pain sensitivity in BPD initially emerged in the early 1990s. At the outset, investigators were intrigued by the ability of patients with BPD to engage in graphic forms of self-harm, such as cutting and burning themselves, seemingly without experiencing pain. Researchers then began to systematically examine pain tolerance among patients with BPD using exposure to physically noxious stimuli. These stimuli included hot and cold probes, tourniquet pressure, mechanical pressure, capsaicin, laser radiant-heat impulses, and electrical stimuli.[43] Overall, findings from these investigations confirmed that a substantial number of participants with BPD experience attenuated responses to pain. As a result of these findings, investigators estimated that an attenuated pain response occurs in up 80% of individuals with BPD.[43]

Following the confirmation of high pain tolerance among many individuals with BPD, a number of investigators proposed possible explanations.[43] These included stress-induced analgesia; the psychological re-interpretation of pain, mediated by dissociation; inherent neurosensory abnormalities; underlying attitudinal and/or psychological abnormalities; and/or the release of endogenous opioids. In addition, Niedtfeld and colleagues discussed the role of pain processing in the central nervous system.[44] Whatever the explanation(s), the presence of pain tolerance among individuals with BPD was a noteworthy conclusion.

Around the time of these very investigations, clinicians in medical settings were noting an opposite finding — that patients with BPD appeared to demonstrate a *poor* tolerance or an intolerance to pain. In 2004, Harper affirmed this impression by stating that, "it [is] particularly difficult for… [the borderline patient]…to endure prolonged acute pain" (p. 196); "the borderline patient's tolerance of discomfort will typically be of shorter duration than other individuals" (p. 197).[45] Clinical impressions were soon followed by research endeavors into this area.

Clinical impressions of pain sensitivity among patients with BPD culminated in two veins of research: 1) studies examining the relationship between pain intolerance and BPD, and 2) studies examining the explicit prevalence of BPD among various cohorts of pain patients. With regard to the first vein of studies, Merceron and colleagues reported an association between chronic pain and BPD through the use of projective psychological testing (e.g., the Rorschach and the Thematic Apperception Test).[46] Tragesser and colleagues examined participants who were in rehabilitation for pain and found that the cohort with BPD reported higher levels of minimum and maximum pain during the past month in comparison with their non-BPD peers.[47] Frankenburg and Zanarini compared individuals with BPD who were in symptom remission to individuals with BPD who were still evidencing active symptoms and reported that the former cohort endorsed significantly fewer pain-related conditions, such as fibromyalgia, temporal-mandibular joint syndrome, and back pain.[48] McWilliams and Higgins examined data from the National Comorbidity Survey Replication Study and found that individuals with any of four types of pain syndromes (i.e., arthritis, severe/frequent headaches, chronic spinal pain, other chronic pain) reported higher levels of BPD symptoms than participants without these pain syndromes.[49]

We have also examined the relationship between pain and BPD in several studies. In an initial investigation of internal medicine

outpatients, we encountered statistically significant correlations in five of the six statistical analyses (2 × 3) between self-rated pain scores at present and over the past 12 months, as well as scores on three self-report measures for BPD.[50] In a second larger study, we examined a sample of internal medicine outpatients who were being seen in a resident-physician clinic and found that participants who evidenced BPD symptomatology on either of two measures reported statistically significantly higher levels of pain at the time of assessment, during the past week, and during the past year at the $P < 0.001$ level.[51] In this latter study, we also examined pain catastrophizing (i.e., catastrophic thoughts and feelings about pain), and, as anticipated, found that participants with higher BPD scores demonstrated statistically significantly higher scores on the measure of pain catastrophizing. (In this study, we did not examine possible adjunctive contributors such as anxiety.)

Collectively, the preceding studies indicate that individuals with BPD generally report higher levels of pain in comparison to individuals without BPD. In addition, pain catastrophizing may be one of several factors that explains higher ratings of pain in patients with BPD.

Researchers have also examined the explicit prevalence of BPD among pain patients — the second vein of research. For example, Gatchel and colleagues examined tertiary care patients with chronic low back pain and reported that 26.9% met the criteria for BPD.[52] Manchikanti and colleagues examined tertiary care patients with chronic back pain (two separate groups) and reported that 10% and 12%, respectively, met the criteria for BPD.[53] Workman and colleagues examined patients referred to a physical therapy pain management program and found that 31% met the criteria for BPD.[54] Dersh and colleagues examined patients with occupational spine disorders and reported that 27.9% met the criteria for BPD.[55] Braden and Sullivan examined individuals with pain from a community sample and found that 27.4% met the criteria for BPD.[56] Fischer-Kern and colleagues examined patients with various types of chronic pain symptoms and reported that 58% met the criteria for BPD.[57] We examined family practice outpatients with chronic pain and found that 47.1%, 29.4%, and 47.1% evidenced BPD symptoms according to three different assessments.[58] We also examined the prevalence rate of BPD symptoms among a consecutive sample of chronic pain patients who were being seen by a pain management specialist in a private practice setting and determined that 9.4% and 14.5% evidenced BPD on two study measures.[59] All of the preceding studies illustrate the same general finding — that prevalence rates for BPD are higher among pain patients than the prevalence rate of BPD in the community (when averaged, the prevalence rate of BPD in the preceding eight studies is 30.0% or nearly one-third).

To conclude, both veins of research indicate that there are associations between pain and BPD. Given relationships between the "faulty body" (i.e., body image difficulties) and BPD, these findings reinforce the potential expression of that "faultiness" through the syndrome of pain.

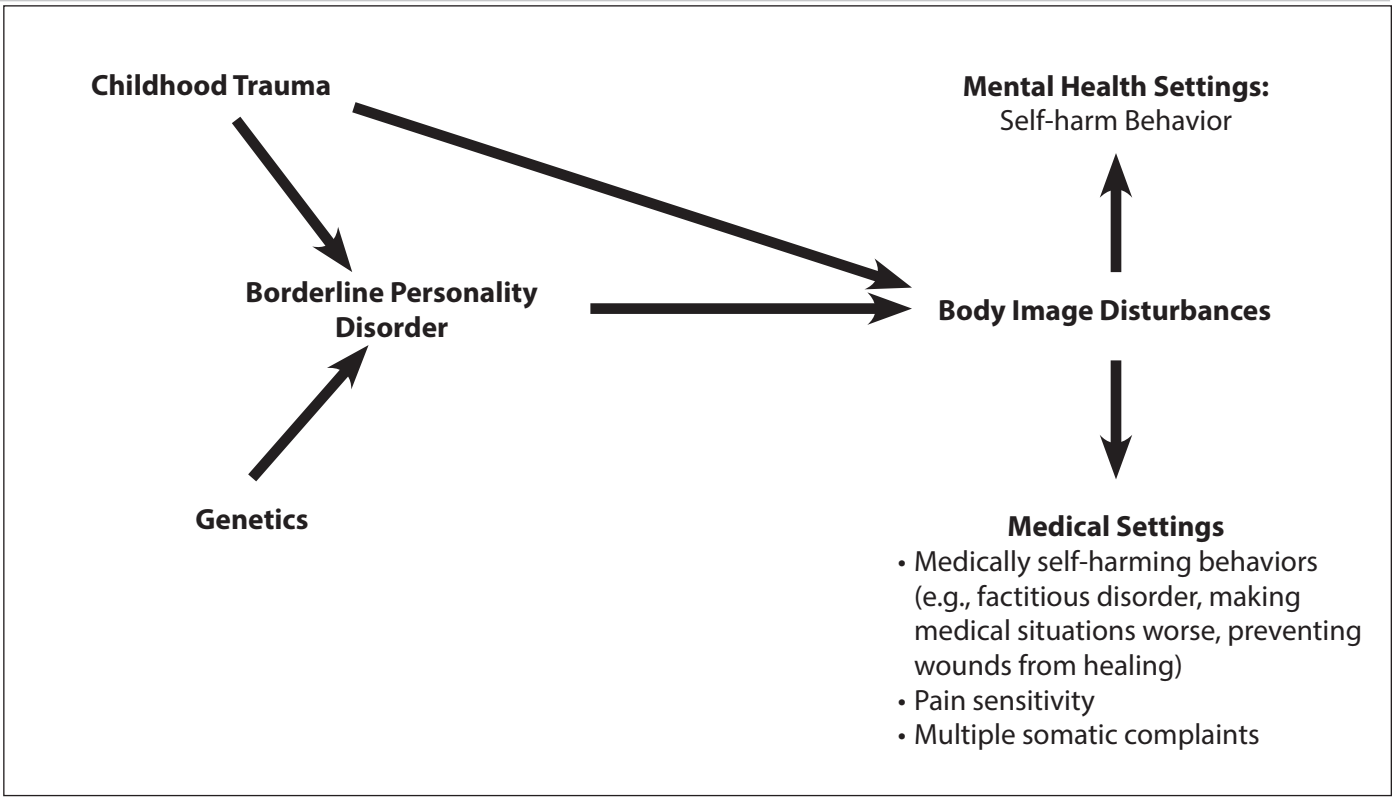
Multiple Somatic Complaints. The third and final area of the expression of negative body image in BPD in the medical setting is that of multiple somatic complaints. A number of authors have observed and clinically described multiple somatic symptoms among patients with BPD.[60-65] These historical descriptions foreshadowed the need for systematic research into the relationship between multiple somatic complaints and BPD, which initially unfolded with somatization disorder.

Somatization disorder is a diagnostic concept that existed in previous versions of the *Diagnostic and Statistical Manual of Mental Disorders*, but not in the current DSM-5.[4] Somatization disorder is characterized by multiple somatic symptoms (at least eight) in four distinct symptom categories (pain, sexual, gastrointestinal, and pseudoneurological areas). As for the findings of these studies, Prasad and colleagues,[66] Hudziak and colleagues,[67] and Spitzer and Barnow[68] all confirmed distinct relationships between somatoform disorders and BPD. However, given the clinically restrictive nature of the diagnosis of somatization disorder, there was a genuine need to examine somatic characteristics from a broader and more clinically relevant perspective — i.e., that of somatic preoccupation. In the DSM-5, this phenomenon would fall under the diagnosis of *somatic symptom disorder*.[4]

In an early investigation of somatic preoccupation, Lloyd and colleagues reported a relationship between a proneness to reporting somatic complaints and BPD.[69] We examined relationships between somatic preoccupation and BPD among four different samples of internal medicine outpatients being seen in a resident-physician clinic. In three of our studies, we used the same measure for the assessment of somatic preoccupation,[70-72] while in a fourth study, we used a different measure for the assessment of somatic preoccupation.[73] In all four studies, findings were consistent: participants with BPD features demonstrated significantly higher levels of somatic preoccupation than participants without these features. In this final study, we also examined whether there were any particular symptom patterns associated with BPD.[73] However, no individual symptom or symptom pattern emerged; somatic symptoms were diverse and panoramic.

Case Example. Bethany was a well-dressed, 28-year-old, unmarried

Figure 1. Inter-relationships Among Childhood Trauma, Borderline Personality, Body Image, and Symptom Manifestations



outpatient who presented to her internal medicine physician for the evaluation of relentless headaches. In reviewing the medical record, the physician noted that Bethany had had multiple appointments during her brief time at the clinic (e.g., one approximately every 3 weeks), with visits characterized by numerous physical complaints highlighted by fatigue and/or pain. There were numerous medical diagnoses, including tension-vascular headaches, irritable bowel syndrome, fibromyalgia, multiple chemical sensitivities, various allergies, and chronic back pain — to name a few. Bethany had undergone various courses of drug treatment for these complaints, often with very modest responses. The medical record also indicated a past request for a handicap parking decal as well as the patient's recent submission of disability forms for completion. Upon physical examination, while describing intense pain across her forehead (a pain rating of "10"), Bethany would occasionally break into a casual mode of conversation, with no overt discomfort or unease. In discussing her past history, Bethany briefly disclosed a distressed relationship with her mother, who was cryptically described as demanding, inconsistent, constantly critical, and, at times, physically abusive. Bethany also indicated that she had always been overweight, even as a child, and dated very little due to her lack of self-confidence. "Who would want me, looking like this?" Bethany had been seen once by a psychologist in early adolescence for suicidal ideation, but could not remember any specific mental health diagnosis. When she left home for college, Bethany began to experience the onslaught of multiple physical difficulties. She completed college with marginal grades and had ongoing difficulties maintaining a job, ostensibly due to her many physical ailments and excessive sick days. Bethany described herself as barely functional.

The possible inter-relationships between childhood trauma, genetics, BPD, body-image difficulties, and symptom manifestations in mental health and medical settings are diagrammed in Figure 1.

Conclusions

BPD is a complex personality dysfunction that has its roots in genetics and the environment. One of the key postulated environmental factors for this disorder is repetitive trauma in childhood. Repetitive trauma in childhood, while of diverse origins, is likely to culminate in a number of negative manifestations in childhood, including poor body image. Poor body image likely sets the stage for a number of acting out behaviors on the body or the sense of a faulty body. In mental health settings, acting out on the body is frequently manifested as self-harm behavior. In medical settings, acting out on the body may manifest as medically self-harming behavior (e.g., factitious disorder, making medical situations worse, preventing wounds from healing). In medical settings, the concept of a faulty body likely explains the presentations of pain sensitivity and somatic preoccupation. Overall, repetitive trauma in childhood and

the resulting effects on body image appears to have diverse effects in adulthood. Addressing these effects in patients with BPD remains a significant clinical challenge, particularly among those individuals in medical settings. More research is needed to determine ways to alleviate this traumatic vestige from childhood.

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CME Questions

1. According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), borderline personality is characterized by all of the following *except*:
   a. prevalence rate in community samples between 2-6%.
   b. equal rates in men and women.
   c. higher rates in westernized countries.
   d. emergence during adolescence.
2. In terms of the etiology of borderline personality, there appears to be a strong genetic contribution. However, according to the authors, this contribution does not adequately account for:
   a. the phenomenon of epigenetics.
   b. the role of cultural influences.
   c. the role of the mother/child relationship.
   d. the role of trans-generational trauma.
3. With regard to the various studies of body image in borderline personality disorder:
   a. studies indicate that borderline personality is associated with a positive body image.
   b. studies indicate that borderline personality is associated with both a positive body image and a negative body image.
   c. studies indicate that borderline personality is more often than not associated with a negative body image.
   d. studies indicate that borderline personality is consistently associated with a negative body image.
4. Body image difficulties may partially explain the various types of symptoms that manifest among patients with borderline personality in medical settings. These symptoms include all of the following *except*:
   a. medicalized forms of self-harm behavior (e.g., factitious |disorder).
   b. multiple somatic complaints.
   c. various pain syndromes.
   d. All of the above
5. According to pain studies in individuals suffering from borderline personality:
   a. with self-inflicted injuries, patients with borderline personality in mental health settings tend to be pain tolerant.
   b. patients with borderline personality in medical settings tend to be pain intolerant.
   c. Both A and B
   d. Neither A nor B
6. The increased level of pain experienced by patients with borderline personality in medical settings may be partially explained by:
   a. repressed childhood memories of trauma.
   b. pain catastrophizing.
   c. splitting.
   d. projective identification.

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