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ANXIETY-DEPRESSIVE DISORDER IN PATIENTS WITH BORDERLINE PERSONALITY DISORDER: CLINICAL MANIFESTATIONS, TRIGGERS, AND EASING FACTORS

Bondarenko Yaroslav¹

Scientific Adviser: Mozgova Tetiana²

1. Student of the Third Faculty of Medicine

Kharkiv National Medical University, UKRAINE

2. Professor of the Department of Psychiatry, Addiction Studies,
Medical Psychology, and Social Work

Kharkiv National Medical University, UKRAINE

Relevance: Anxiety-depressive disorder in patients with borderline personality disorder (BPD) is a common and complex consequence that affects daily life, especially in individuals aged 16-25. This period is often marked by identity crises, social and personal conflicts, and the emotional burden can lead to severe outcomes, such as prolonged depression, suicidal thoughts, and neurotic states. Investigating the clinical manifestations of this disorder, the triggers of exacerbations, and factors that alleviate the condition is crucial for developing effective approaches to managing, curating, and treating such patients.

Aim of the Study: The study aims to analyze the genesis and symptomatology of anxiety-depressive disorder in patients with BPD, identify key triggers and exacerbation triggers, and examine factors that may potentially alleviate the condition.

Materials and Methods: The study was conducted based on interviews with respondents aged 16-25 who have been diagnosed with borderline personality disorder and concurrent anxiety-depressive disorder. Participants were asked about the onset, course, and exacerbations of the disorder, as well as factors that contribute to the alleviation of their condition.

Research results:

Genesis. Most respondents noted that the first symptoms of anxiety and depression appeared in adolescence, usually after traumatic events or conflicts in

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the family. One respondent shared: *"I was 15 years old and there were constant fights at home. It made me feel anxious and unwanted."*

One of the participants in the interview recalls the traumatic experience of sexual violence, which became a turning point for the development of her mental state: *"In 2019, I was at home when a friend of an acquaintance called me with questions about what happened when I was raped. That was someone who knew about this incident and was asking me about it. It triggered such an emotional storm in me that I couldn't handle it. Somehow, the whole neighborhood started talking about it. Why did he tell people about it? Why didn't he tell the truth? That same evening, I cut my wrists."*

Respondents recalled that after such events, their emotional state deteriorated quickly, and they lost control over their lives and emotions. Here, we can trace the triggering mechanism for the development of borderline personality disorder, where emotional strain under the influence of external factors becomes a trigger for symptom onset. In response to her experience, the respondent couldn't cope with feelings of alienation, social rejection, and pressure from those around her. This significantly impacted her cognitive perception of herself and the world, leading to the formation of destructive thoughts.

The respondent described her emotional state as chaotic, noting that she didn't know how to proceed or handle the situation. She felt deep resentment toward herself, the person who had called, the perpetrator, and society in general. The sense of alienation and isolation from society intensified her emotional burden, while stereotypical views from others further destabilized her mental state. Social condemnation and negative stereotypes fueled the formation of a primary thought she expressed as: *"I am alone; everyone I know considers me a girl of loose morals."* This became a primary factor in the development of an "avalanche-like disorder," where one traumatic event triggers a series of negative cognitions and intensifies destructive reactions.

Patients with borderline personality disorder generally exhibit heightened emotional vulnerability and a tendency toward hyperarousal, particularly in response to social and interpersonal stressors [1].

Causes and Triggers: Interpersonal conflicts and feelings of rejection often serve as triggers for exacerbations. Patients try to manage their emotions, but with each attempt, they lose not only control over what they feel but also over their thoughts. It becomes difficult to listen, challenging to understand the reality around them. Emotions—such as regret, anger, sadness, and confusion—seem to cloud their surroundings like a veil. Respondents noted that parental criticism or a partner's indifference led to serious emotional breakdowns. One participant shared, *"My father often says something hurtful, like that I'm not capable of anything. I*

can't handle it; it drives me to a state where I just don't want to talk to anyone. Or when I didn't complete some household chores because of my health, but I'm still forced to do them."

Another respondent shared, *"My boyfriend, being in the military, is often away from home. And when he comes back but doesn't give me attention, it raises doubts. It makes me think that he doesn't need me anymore, and I start to panic. Then this anxiety turns into depression, and I can't live normally. It all escalates into neurosis."*

Problems in relationships with parents also often became triggers for worsening symptoms. One respondent recalled, *"We argued because I didn't set up my phone the way my mom wanted. She called me not only sick but also stupid. Or when my father, seeing that I was struggling with something, criticizes me in such a way that it drives me into depression"*. Such negative influences from close surroundings foster thoughts of personal inadequacy. When parents set excessively high expectations for a child during upbringing and disregard their wishes, they, perhaps unconsciously, not only take away the child's interests but also their belief in themselves.

High grades in school, victories in competitions, constant expectations of success become a barrier that the child cannot overcome. They begin to think that something is wrong with them, that they do not meet their parents' standards. Children try to do everything to attract attention. Often, parents impose the belief on their child that emotions should be suppressed. The phrase *"Don't cry, you're a boy, why are you acting like a girl?"* has become a symbol of a generation of people who suppress their feelings and suffer silently, unable to express even love or pain. These children grow up to be adults who are still waiting for words of love from their parents, trying to meet their standards. In adulthood, they often distance themselves from their parents, unwilling to maintain contact, not bringing their children over—their need for parental love remains unfulfilled.

It is hard to imagine what people with borderline personality disorders feel in such situations. Their emotions, which they can barely control, reach a critical point in these circumstances. Patients with borderline personality disorder suffer especially deeply in such situations.

Moreover, self-harm became a means by which respondents tried to cope with emotional pain. Self-harm is a common issue among people with mental disorders, especially those with borderline personality disorder (BPD). It is a behavior often used to regulate emotions or reduce dissociation. Patients with BPD often report dissociative episodes during which they lose the sense of control over their bodies and the reality around them. This feeling is partly based on the fact that the person feels they have no control over their body or actions [2].

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One respondent noted, *"When I feel hopeless, I often cut myself. Unfortunately, it becomes the only way to distract myself from emotional pain."* Another respondent, recalling a suicide attempt, shared, *"When everything happened, I tried to hang myself. I felt like I could no longer bear this pain"*.

Patients themselves note that the pain becomes so overwhelming that they lose the sense of reality: they don't understand where they are, who they are, or what their life is for. They can't find answers and want nothing except to stop this pain. Self-aggression becomes the only way out in the eyes of the patient – physical pain helps relieve the mental burden, as described by the sufferers. In moments of deep depression, when the person is unable to cope with emotional pain, physical aggression toward themselves becomes a way to manage suffering – as described by the respondents.

Course of the condition. Respondents described frequent mood swings and the inability to control their emotions. One of the interview participants shared: *"My emotions can change very quickly. One day I feel fine, but the next day everything can go wrong. If something happens, I easily lose control over my mood."*

During depressive episodes, patients often experienced deep apathy and a loss of interest in any activity: *"When depression starts, I just want to lie down and do nothing. I try to distract myself, watch TV shows, but even that doesn't help."*

Exacerbation. Exacerbations of anxiety-depressive states were often accompanied by self-aggression. One respondent noted: *"When I can't control my emotions, I start hurting myself. It seems like the only way to stop the pain in my head."* Another respondent recalled that the last serious episode of exacerbation was triggered by a conflict with a friend and partner: *"I couldn't sleep properly for several nights because of the argument with my friend. Then my boyfriend didn't pay attention to me. It all piled up, and I just couldn't take it anymore."*

During acute episodes, many patients felt the urge to self-harm as a way to reduce emotional pain. One respondent shared: *"I cut myself when I couldn't stand the emotions anymore. It was the only thing that helped a little."* These pain-altering methods often end in suicide. Among respondents, suicide attempts were common. Borderline personality disorder (BPD) is associated with suicidal behavior and self-harm. Up to 10% of patients with BPD will die by suicide. However, no research data supports the effectiveness of suicide prevention for this disorder, and hospitalization is not beneficial. The most evidence-based treatment for BPD is specially developed psychotherapy [3]. Cognitive psychotherapy even showed effectiveness among respondents. Many patients with this disorder have treatment courses marked by several unsuccessful suicide attempts. These treatment methods are linked to multiple psychotherapy trials, numerous prescriptions, repeated visits to the emergency department, and hospitalization due to suicide

attempts and threats. Nevertheless, research literature on treating suicidality in BPD lacks evidence-based recommendations for preventing death by suicide [3].

It is also worth noting that when a patient enters an episode of self-aggression, it does not always manifest as cutting. Respondents noted that they could hit themselves, for example, in the face. As one respondent pointed out, "*I would sometimes hit myself in the face until bruises appeared.*" Additionally, this is not always a way to feel something other than "emotional pain," as one respondent shared: "*I hit myself not only because I wanted to numb the pain, but just to feel something during periods of apathy and depression.*" They associate the aggression toward themselves with self-punishment when interacting with a trigger.

Factors That Ease the Condition. Despite the difficulty of controlling emotions, many respondents noted that support from close people, especially partners or family members, helps them cope with anxiety and depression. One of the participants shared: "*My husband is very supportive of me. He is always there when I'm struggling. His support gives me a sense that I'm not alone in my fight.*" Some respondents emphasized that during active phases of the illness, shopping and spending time with friends become important means of easing their condition. One respondent noted: "*When I feel bad, I go shopping or meet with friends. It helps me distract myself, change my environment, and ease the tension a little.*" Such activities create a sense of normalcy and provide a temporary respite from anxious thoughts. Creative activities also became an important way of expressing emotions. One respondent said: "*I write poetry when I feel bad. It gives me the opportunity to express my emotions and ease the burden.*" She added that she often writes poetry after using cannabis: "*When I smoke, it's easier for me to express my feelings through poetry. It helps me distract myself.*" Several respondents also mentioned the positive impact of psychotherapy. One of the participants shared her experience: "*I go to therapy, and I feel it helps me better control my emotions. Medication helps, but I take it rarely.*" Among the medications mentioned by respondents, Carbamazepine and Neuleptil were the most commonly reported.

Attitude Toward Their Condition. Patients often feel helpless in the struggle with their emotions. One interview participant described this: "*I can't always control my emotions. They just seem to get out of control, and I can't do anything about it.*" At the same time, some patients express hope that they will learn to better control their emotions over time. One respondent noted: "*I hope I'll be able to learn to handle these emotions better. I believe I'll be able to live normally.*" Among the respondents, there were those who viewed their personality disorder as a personal trait.

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Conclusions. Anxiety-depressive disorder in patients with borderline personality disorder often worsens under the influence of traumatic events such as sexual violence and emotional instability in relationships. Emotional fluctuations, anxiety, and depression are typical for these patients, and many resort to self-harm as a way to cope with emotional pain. At the same time, support from close ones, psychotherapy, physical activity, and creativity are important factors that ease the patients' condition.

To achieve lasting improvements in mental health, it is necessary to take into account the individual needs of patients and create comprehensive therapeutic programs that include both medication and psychosocial support.

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