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FEATURE ARTICLE

The emotional pain and distress of borderline personality disorder: A review of the literature

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ABSTRACT: *This paper presents a synthesis of content and assessment of the methodological rigour of published literature related to concepts of emotional pain and distress in women with a diagnosis of borderline personality disorder (BPD). In the past two decades, there has been an increase in research about the prevalence of BPD, interventions, and relative effectiveness of various forms of treatment. However, there are few studies regarding emotional pain and distress in women with BPD. Emotional pain has been reported as an adaptive response to repetitive traumatic experiences in childhood. Searches of the EBSCO host, OVID MEDLINE, CINAHL, and PsycINFO databases were carried out using the following search words: borderline personality disorder, emotional pain, distress, self, suffering, women, for the period 1996–2006. Fifteen papers were assessed for methodological rigour, followed by the analysis of the concepts of emotional pain and distress. Three themes emerged from the literature, the emotionally abused and neglected child; struggling with emotions leading to self-injury; and social problems related to difficulties regulating emotions. A high prevalence of reported childhood abuse was revealed. Emotional pain was described as intense for women suffering from BPD. A further synthesis of research findings is recommended to provide information on the effectiveness of interventions.*

KEY WORDS: *borderline personality disorder, distress, emotional pain, self, suffering.*

INTRODUCTION

The most important determinants of mental health seem to be those pertaining to control over one's own life, identity and dignity, social connectedness, and feelings of cohesion or meaning (WHO 2003). The consequences for mental health of traumatic reactions to violence and humiliation are changes in personality and behavioural patterns that manifest themselves in aggression, risk-taking behaviour, addiction, personality change, and suicide (WHO 2003).

The diagnostic criterion in Diagnostic and Statistical Manual for Mental Disorders (DSM-IV-TR 2000; p. 706) defines borderline personality disorder (BPD) as: 'a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts'. BPD is characterized by psychosocial impairment and high mortality – up to 10% of patients commit suicide, a rate almost 50 times higher compared with the general population (DSM-IV-TR 2000).

The prevalence of BPD ranges from 0.7% in Norway to 1.8% in the USA (Lieb *et al*. 2004). It has been estimated that BPD represents 15–25% of all reported psychiatric illnesses (Kaplan *et al*. 1994). Research has shown that BPD is mainly diagnosed in females (about 75–80%),

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reflecting a gender difference in those who receive treatment (Lieb *et al*. 2004; Skodol & Bender 2003; Widiger l998).

Patients suffering from BPD report distress as a form of intense emotional pain (Lieb *et al*. 2004). This emotional pain has been interpreted as an adaptive response to repetitive traumatic experiences in childhood (with reported prevalence ranging from 40% to 80%) such as the loss of a parent, parental mental illness, witnessed violence, emotional, physical and sexual abuse (Goodwin 2005; Zanarini *et al*. 1997). More than 70% of BPD patients had histories of suicide attempts, where BPD is described as the most lethal of psychiatric disorders, with completed suicide rates of 3.0–9.5% (Soloff *et al*. 2002).

According to Greenberg and Bolger (2001), one important class of primary emotional experience is that of emotional pain and hurt. The experience of emotional pain, precipitated by a trauma or crisis in someone's life, is a higher-level emotional experience than any single emotion alone and signals damage to the self. Thus, pain is both an emotional and physical experience. Distress is defined in the literature as a unique, discomforting, emotional state, experienced by an individual in response to a specific stressor or demand, which results in harm, either temporary or permanent to the person (Ridner 2004).

Previous research describes emotional pain and distress as a chaotic experience of anxiety, feelings of emptiness, hopelessness, meaninglessness, anger, powerlessness, sadness, shame, and guilt with associated difficulty regulating the intense accompanying emotions (Greenberg & Bolger 2001). Emotional pain is also described as the impact of unresolved painful emotional experiences, a sense of personal shattering, and a feeling of disconnection from others (McVea & Gow 2006).

However, few studies have examined the emotional pain of individuals suffering from BPD. The conceptualization of BPD in the DSM-IV-TR (2000) reflects a view of individuals' problems as inherently intrapsychically derived (Becker 2000). Psychiatric research has positivistic traditions, where the testing of hypotheses seems to be most important and the context largely remains unexplored (Benner 1994). This paper presents a synthesis of content and assessment of the methodological rigour of published literature related to concepts of emotional pain and distress in women with a diagnosis of BPD. Our research question was: To what extent do people with the diagnosis of BPD suffer emotional pain and distress?

METHODS

A search was made of EBSCO host, OVID MEDLINE, CINAHL, and PsycINFO databases for relevant papers for the period 1996–2006 (May). Search words used in combination and separately were: borderline personality disorder, distress, emotional pain, self, suffering, women. In addition, a manual search of relevant papers and significant references, including theoretical papers and books related to the topic, was conducted. The criteria for assessing the quality of the studies were based on established standards for critiquing published empirical work (Høye & Severinsson 2007; NHMRC 2000a,b; Shadish *et al*. 2002; Tobin & Begley 2003; Whittermore & Knafl 2005).

This review has included both quantitative and qualitative data and adapted framework from both research traditions**.** According to Whittermore and Knafl (2005)**,** a review containing varied perspectives on a particular phenomenon is integrative and important to nursing science and practice. This approach allows the inclusion of diverse methodologies and has the potential to play a great role in evidence-based nursing practice (Whittermore & Knafl 2005).

Overview of the approach to analysis

It was not intended to compare studies, but rather to seek associations of emotional pain and distress within the context of BPD. Strategies used to analyse 15 papers included a critical review of methodological procedures. The assessment included issues related to context, sampling, participants, reliability, validity, and generalizations. A content analysis focused on the concepts of emotional pain and distress in relation to BPD followed. Common themes on the conceptual associations of emotional pain and distress that underpin women's experiences of living with BPD emerged.

Search outcome

The search revealed 2072 abstracts and dissertations, non-empirical research, review papers, anecdotal reports, editorials, news, comments, theoretical and empirical research studies that included both women and men. A total of 304 papers were deemed appropriate and 15 met the inclusion criteria: (i) empirical research; (ii) semistructured and qualitative interviews with women with BPD, who expressed emotional pain and distress in the form of trauma, suicidal thoughts, dissociation, eating difficulties, drug abuse; (iii) an exclusively female study population (except one study where gender was treated as an independent variable in the data analysis); and (iv)

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published in English. Exclusion criteria were: (i) laboratory test design; (ii) tests of measures; (iii) family studies; (iv) older adults; (v) economic analyses; (vi) neuropsychiatry; (vii) children/adolescents with BPD; and (viii) borderline patients as mothers with focus on the children; (ix) case studies; and (x) professionals' attitudes and experiences. Of the 15 studies selected 13 were quantitative and two were qualitative.

RESULTS

In regard to *contexts*, the majority of participants were drawn from hospital programme although three studies appeared to have no selection criteria for the inpatient groups (Chapman *et al.* 2005a,b; Yen *et al.* 2002). Four studies (Brown *et al.* 2002; Conklin & Westen 2005; Van Den Bosch *et al.* 2003; Welch & Linehan 2002) were part of randomized controlled clinical trials (Table 1) and generally provided descriptions of method and intervention (NHMRC 2000a,b; Shadish *et al.* 2002). Only four other studies included healthy controls from the community (Bland *et al.* 2004; Bohus *et al.* 2000; Soloff *et al.* 2002; Stiglmayr *et al.* 2001) which tends to decrease sampling bias (NHMRC 2000a).

Sample size increases both internal and external validity (applicability) of quantitative research (NHMRC 2000b; Shadish *et al.* 2002). Most of the quantitative studies (9) critically evaluated their small sample size ($n = 12–75$) (Bland *et al.* 2004; Bohus *et al.* 2000; Brown *et al.* 2002; McKay *et al.* 2004; Soloff *et al.* 2002; Stiglmayr *et al.* 2001; Van Den Bosch *et al.* 2003; Welch & Linehan 2002; Yen *et al.* 2002). Some studies used statistical data analyses (Bland *et al.* 2004; Bohus *et al.* 2000; Conklin & Westen 2005; Stiglmayr *et al.* 2001; Van Den Bosch *et al.* 2003; Zlotnick *et al.* 2003), but only two (Brown *et al.* 2002; Conklin & Westen 2005) undertook assessments of power and statistical validity (Shadish *et al.* 2002).

Few studies reported a demographic profile of *participants*, but available data revealed an age range from 17 to 55 years (average 28–38 years). Many of the women were single/separated/divorced (32.5–57.5%) and majority were Caucasian (68–100%). The proportion of high school graduates was 17–90% and up to 37% had graduated from college. Only four studies reported on employment status and found the majority of participants were unemployed or received a disability pension.

A wide range of measures was used to assess the various concepts under investigation (see Table 1) and all but one (Bohus *et al.* 2000) reported the *reliability and validity* of instruments used. Stiglmayr *et al.* (2001) examined the content validity of the instruments they used. With one exception (Bland *et al.* 2004), all quantitative studies reported *limitations and biases*, generally related to a reliance upon self-reports which may decrease both reliability and validity (Shadish *et al.* 2002).

Two studies reported their findings as preliminary (Stiglmayr *et al.* 2001; Yen *et al.* 2002). Some studies suggested that *future research* should involve replicating the work in a larger and more diverse group of patients suffering from BPD (Brown *et al.* 2002; McKay *et al.* 2004; Stiglmayr *et al.* 2001; Van den Bosch *et al.* 2003; Welch & Linehan 2002; Yen *et al.* 2002), including both men and women (Conklin & Westen 2005; Yen *et al.* 2002; Zlotnick *et al.* 2003) and thereby increasing transferability and the rigour of the research (NHMRC 2000b; Shadish *et al.* 2002).

Qualitative research on the other hand addresses the issue of 'fit' between participants' views and the researcher's representation of them, which increases procedural rigour (Høye & Severinsson 2007) and credibility (comparable with internal validity) (Tobin & Begley 2003). The two qualitative studies utilized hermeneutic phenomenological designs and evaluated their adequacy on the basis of the data provided (Nehls l999; Perseius *et al.* 2005). The use of relatively small samples decreased the likelihood of generalizability which may decrease the trustworthiness of findings (Tobin & Begley 2003).

Concepts of emotional pain and distress

Three themes emerged in regards to the concepts of emotional pain and distress: the child who is emotionally abused and neglected; struggling with emotions leading to self-injury; and social problems related to difficulties in regulating emotions.

The child who is emotionally abused and neglected

A high prevalence of reported childhood abuse was revealed (as outlined in Table 1). According to Soloff *et al.* (2002), abuse was associated with low self-esteem, feelings of isolation, guilt, shame, anger, hostility and mistrust, confusion about own sexual identity, powerlessness, and distortions in social relationships. In addition, childhood trauma was related to a hopelessness that was associated with suicidal behaviour to achieve emotional relief (Chapman *et al.* 2005b; Soloff *et al.* 2002). Many of these effects are expressions of emotional pain and distress.

Zlotnick *et al.* (2003) examined the differences in clinical features, impairment, and types of childhood traumas between three groups of women with BPD, post-traumatic stress disorder (PTSD), and both BPD and PTSD. They found different characteristics of childhood

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TABLE 1: *Overview of the review papers*

Reference	Country	Outcome measure(s)	Sample	Summary outcome
Bland *et al.* (2004)	USA	PFA, AIM	*n* = 70 *n* = 35, experimental *n* = 35, control	Difficulties in regulating emotions, social relationships and in recognizing facial expressions. 91% reported that they had been sexually abused.
Bohus *et al.* (2000)	Germany	SCID-II, CPT, TPT, SDQ-5, DES	*n* = 31 *n* = 12, experimental *n* = 19, control	Women suffering from BPD who had suffered self-injuries described how emotional distress resulted in strong inner pressure leading to self-injury. 75% of BPD patients reported being sexually abused.
Brown *et al.* (2002)	USA	SCID-II, PHI	*n* = 75, RCT *n* = 46, non-suicidal *n* = 29, suicidal	Motive behind suicidal behaviour was: (i) emotional relief from distressing situations (ii) to help others. These individuals either want to die or manipulate others but not both at the same time.
Chapman *et al.* (2005a)	Canada	SCID-II, LPC-2, AAQ, WBSI, COPE	*n* = 105	Self-injury serves as an escape from unwanted emotions. Unsuccessful thought suppression lead to greater distress and increase the risk of self-injury.
Chapman *et al.* (2005b)	USA	SCID-II, LPC-2, TAAD CTQ, RFL, COPE	*n* = 105	Suicide attempts were associated with hopelessness, depression, childhood physical/emotional abuse.
Conklin and Westen (2005)	USA	SWAP-200,	*n* = 117, RCT *n* = 90, BPD *n* = 27, depressive disorder	The patients reported more distress and emotional dysregulation than that described in DSM-IV.
McKay *et al.* (2004)	USA	PDQ-4, SII, SSI, ACT, BSRI	*n* = 48 *n* = 30, self-mutilating group *n* = 18, non-mutilating group	Self-mutilating behaviour was associated with poor skills in communicating (emotional dysregulation).
Nehls (1999)	USA	Qualitative interviews	*n* = 30	Experience of living with the diagnosis of BPD means: living with a label, with self-destructive behaviour perceived as manipulation, and with limited access to care.
Perseius *et al.* (2005)	Sweden	Qualitative interviews	*n* = 10	Three themes revealed: life on the edge, the struggle for health and dignity, a balancing act on a slack wire over a volcano, and the positive and negative actions of psychiatric care in the drama of suffering.
Soloff *et al.* (2002)	USA	IPDE, DIB, SCID, BIS, BGA, MMPI-Pd	*n* = 61 *n* = 30, experimental *n* = 31, control	Childhood sexual abuse was associated with a 10-time greater risk of self-mutilation, and may contribute to the development of BPD, but cannot explain the whole syndrome.
Stiglmayr *et al.* (2001)	Germany	SCID-I DIB-R DES	*n* = 125 *n* = 24, experimental *n* = 48, experimental *n* = 53, control	Patients with BPD experience aversive tension. Findings of relationship between tension and the experience of dissociation. The role of childhood trauma is mentioned.
Van Den Bosch *et al.* (2003)	Netherlands	SCID-I, II PDQ-4	*n* = 63, RCT *n* = 29, non-addicted *n* = 34, addicted BPD patients	Patients with BPD with and without substance abuse disorder reported an association between trauma and dissociation
Welch and Linehan (2002)	USA	SCID, PDE, SCT	*n* = 122, RCT *n* = 75, parasuicide *n* = 47, drug-dependent	Social problems are an important factor in cases of self-injury, whereas drug use may be influenced by easy access to drugs.
Yen *et al.* (2002)	USA	PDQ-R, AIM, ACS, BDI-II	*n* = 39	Patients with BPD reported intense emotional experiences as a form of emotional dysregulation.
Zlotnick *et al.* (2003)	USA	DIPID-IV, SCID-I, CEQ, SNAP, GAF, LIFE-BASE	*n* = 186 *n* = 71, BPD–PTSD *n* = 86, BPD *n* = 29, PTSD	BPD and PTSD were associated with worse functioning as well as more hospitalization, childhood abuse, eccentric perceptions, and mistrust.

AAQ, Acceptance and Action Questionnaire; ACS, Affect Control Scale; ACT, Affective Communication Test; AIM, Affect Intensity Measure; BDI-II, Beck Depression Inventory – 2nd edition (BDI-II); BGA, Brown-Goodwin Lifetime History of Aggression; BIS, Barratt Impulsiveness Scale; BSRI, Bem Sex Role Inventory; CEQ, Revised Childhood Experiences Questionnaire; CPT, Cold Pressor Test; CTQ, Childhood Trauma Questionnaire; DES, Dissociative Experience Scale; DIB-R, Diagnostic interview of BPD, revised version; DIPD-IV, Diagnostic Interview for DSM-IV Personality Disorders; RCT, randomized controlled trial; RFL, reasons for living; SAS-SR, Social Adjustment Scale – Self-Report; SCID-I, Structured Clinical Interview yielding both assess personality and personality pathology; Axis 1 lifetime diagnosis and Axis I current diagnosis including PTSD; SCID-II, Structured Clinical Interview for DSM-IV Personality Disorders; SCT, Situational Competency Test; SDQ-5, Somatoform Dissociation Questionnaire; EuropASI, A European adaptation of the Addiction Severity Index (ASI); GAF, Global Assessment of Functioning Scale; IPDE, International Personality Disorders Examination; LIFE-BASE, The Longitudinal Interval Follow-Up Evaluation Baseline Version; LPC-2 :Lifetime Parasuicide Count-2; MMPI-Pd, Psychopathic Deviate subscale; PDE, Personality Disorders Examination; PDQ-R, Personality Questionnaire-Revised; PDQ-4, Personality Diagnostic Questionnaire 4; PFA, Pictures of Facial Affect; PHI, Parasuicide History Interview; SII, Self-Injury Interview; SNAP, The Schedule for Adaptive and Non-adaptive Personality; SSI, Social Skills Inventory; STI, The Structured Trauma Interview; SWAP-200, A 200-item Q-sort designed to assess personality and personality pathology; TAAD, The Triage Assessment for Addictive Disorders; The COPE, a 60-item self-report measure of coping strategies; TPT, Tourniquet Pain Test; WBST, The White Bear Suppression Inventory.

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trauma such as severity, but the majority of participants across all three groups reported childhood neglect and this, as opposed to other forms of abuse, seemed to be a salient factor for personality disorder in general. Suicide proneness and impulsiveness was higher in the group with the dual diagnoses (Zlotnick *et al*. 2003). The authors suggest that early traumas might play more of a role in the development of PTSD than BPD and this could be an important divergence for individuals with BPD.

Although participants reported childhood abuse and/or trauma as part of their demographic profile, several studies did not include measurements of these experiences (Bland *et al*. 2004; Bohus *et al*. 2000; Chapman *et al*. 2005b; Conklin & Westen 2005; Welch & Linehan 2002). Half the studies examined participants' emotions and suffering, describing them variously as emotional dysregulation, aversive tension, dissociation, self-injury, parasuicide, but did not relate childhood trauma to their emotional problems (Bland *et al*. 2004; Bohus *et al*. 2000; Brown *et al*. 2002; Chapman *et al*. 2005a; McKay *et al.* 2004; Stiglmayr *et al*. 2001; Yen *et al*. 2002).

One study reported a relationship between trauma and dissociation, but neglected discussion of emotional experiences (Van Den Bosch *et al*. 2003). Perseius *et al*. (2005; p. 166), on the other hand, discussed dissociation as a common effect of trauma in childhood and the struggle for health and dignity, as well as the tenuous emotional dramas analogous to 'balancing on a slack wire over a volcano'. Interestingly, the qualitative study by Nehls (l999) lacks discussion of childhood trauma in her exploration of the experience of living with BPD.

She did report, however, that nurses had been unwilling to explore the histories of these women, because they were afraid of exacerbating their distress and frustration. Notwithstanding, it would seem that there is a consistent relationship between childhood abuse and/or trauma and the concepts of emotional pain and distress.

Struggling with emotions leading to self-injury

Most studies ($n = 10$) including the two qualitative reports associated self-injury to participants' emotions and behaviour (Table 1). Women suffering from BPD reported feeling unhappy, depressed, or despondent and sometimes these emotions tended to spiral out of control (Conklin & Westen 2005). Likewise, high levels of emotional distress was described as sadness, anxiety, shame, guilt, and anger by Bland *et al*. (2004) and Yen *et al*. (2002). Brown *et al*. (2002) suggested that self-injury was a way to obtain emotional relief and, similarly, others saw it as an escape from unwanted emotions, thoughts, or distressing situations, and as a way of achieving emotional relief (Bohus *et al*. 2000; Stiglmayr *et al*. 2001). As mentioned earlier, several studies revealed that women suffering from BPD had difficulties regulating their emotions (e.g. emotional dysregulation) and Chapman *et al*. (2005a) in particular, reported difficulties regulating intense emotions that were accompanied by distress. Ultimately, as evidenced by more than half of the studies, this condition seems to be almost unbearable leading to self-injury (Bohus *et al*. 2000; Brown *et al*. 2002; Chapman *et al*. 2005a,b; Conklin & Westen 2005; McKay *et al*. 2004; Welch & Linehan 2002; Zlotnick *et al*. 2003). The experience of physical pain when self-mutilating may not be a deterrent to repeating parasuicide attempts given the significantly increased threshold for pain perception in women with BPD, in both periods of calmness and intense distress (Bohus *et al*. 2000).

Welch and Linehan (2002) suggested that in cases of self-injury, an important factor in different situations could be the influence of access to prescription drugs. Perseius *et al*. (2005) found that interviewees reported enormous emotional pain and distress. Self-injury was grounded in the experience of living with emotional pain, culminating in the desire to be dead (Nehls 1999). Women suffering from BPD seemed desperate, using self-injury, dissociation, impulsivity, and inappropriate anger to escape their negative emotional states. According to Perseius *et al*. (2005), outbursts of anxiety and emotional pain by these women reflect their despair, hopelessness, and self-loathing. Perseius *et al*. (2005) reported ambivalence between the women's wish for love and their self-hate, which meant they felt unworthy of love. The fear of being rejected compels them to continually test their relationship with another person to determine if they really can be trusted.

Social difficulties related to regulating emotions

Several studies addressed social aspects of living with BPD and the burden of emotional pain and distress (Bland *et al*. 2004; Brown *et al*. 2002; McKay *et al.* 2004; Soloff *et al*. 2002; Welch & Linehan 2002). For example, McKay *et al.* (2004) found that women with BPD scored low in emotional expression, sensitivity, and social control. They exhibited interests and talents that were generally culturally valued in men and not in women. This has been speculated to form a conflict in role identity that is accentuated by other specific social difficulties evident in BPD (McKay *et al.* 2004).

Bland *et al*. (2004) found that women with BPD were significantly less able to recognize facial emotions than their control counterparts, especially sadness, anger, and disgust. They also demonstrated significantly higher

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intensity of emotion. It follows that difficulties with intensity and regulation of emotions have a negative impact on interpersonal relationships and social behaviour. Some studies used Linehan's (l993) emotional regulation model, but did not include social aspects of the model (Bland *et al*. 2004; Chapman *et al*. 2005a,b; Yen *et al*. 2002).

Exploring the experiences of living with BPD (Nehls 1999) and the accompanying suffering (Perseius *et al*. 2005) allowed both studies to identify participants' contextual and social identities through narrative. Some women believed that their tendency towards self-destructive behaviour was seen by professionals and others as manipulative (Nehls 1999), while others described feelings of being manipulated, and of prejudice among professionals (Perseius *et al*. 2005). They felt disadvantaged in the care system and socially destitute, not wanting to share their feelings with, or to burden others. The emotional pain and distress associated with BPD had a negative impact on socialization and social well-being.

INTERPRETATION AND REFLECTIONS

This paper presents a synthesis of content as well as assessing the methodological rigour of the published literature related to emotional pain and distress in women with a diagnosis of BPD. While few studies in the review referred to these concepts specifically, they did identify many elements that constitute emotional pain and distress as described by other authors (Greenberg & Bolger 2001; McVea & Gow 2006; Ridner 2004). The assessment of methodological rigour enabled a determination of research quality. The thematic review identified three areas: the child who is emotionally abused and neglected, struggling with emotions leading to self-injury, and social difficulties related to regulating emotions, and each will be discussed in turn.

Up to 80% of individuals experience emotional pain that is an adaptive response to repetitive traumatic experiences in childhood (Zanarini *et al*. 1997). The effects of verbal abuse, physical neglect, witnessed violence, or inconsistent treatment by caretakers are more common among individuals suffering from BPD. The review revealed the importance of childhood sexual, physical, and emotional abuse as determinants of the emotional pain and distress experienced by women with this diagnosis.

However, public perceptions differ and could impact on behaviour. For example, Becker (2000) suggests that to be seen as an individual with a traumatic experience is to engender support and empathy because it is easy to understand another's suffering and pain. The woman with a diagnosis of PTSD becomes the 'good girl', while the woman suffering from BPD may be seen as manipulative, splitting, and difficult, becoming the 'bad girl'.

Notwithstanding diagnostic dilemmas, it is clear that early traumas can impact on emotions and behaviour in adult life. But several studies did not utilize self-reports of childhood abuse as a variable to explain some findings. For example, Bland *et al*. (2004) found that women with BPD had greater difficulty recognizing facial emotions and demonstrated greater emotional intensity than their control counterparts. Lack of reporting about sexual abuse was described as a study limitation rather than a possible explanation. They suggested that difficulty with negative emotions accounted for most of the emotion-laden problems that are described in individuals with BPD.

A high rate of childhood abuse was revealed by Bohus *et al*. (2000), but again the notion of dissociative experiences as a defence mechanism to cope with traumatic experiences was not discussed. They found that individuals suffering from BPD did not experience any more dissociative features than controls, but did reveal an increased pain threshold. Conklin and Westen (2005) suggested that individuals whose emotions tend to spiral out of control and have difficulty self-soothing may become overly dependent on others to help regulate emotion. The incidence of sexual assault in relation to the women's emotional painful experiences was also not discussed. It may be that some authors are wary of using findings of childhood abuse and trauma derived from self-reports.

The qualitative studies explored women's experiences living with BPD (Nehls l999), and attempted to understand their emotional pain and suffering (Perseius *et al*. 2005). Neither fully explored childhood experiences. It could be that participants may have hidden, or suppressed the emotional pain and distress from their early years. Perseius *et al*. (2005) did, however, refer to dissociation as a common effect of childhood trauma.

At times women may hide the emotional pain and distress of their early years, but self-injury is often seen as a consequence of being emotionally abused and neglected as a child, and in the desire to be dead. The most common reason given for suicide attempts was to escape or get relief from situations causing extreme distress. In order to understand the reasons for suicide attempts, it is necessary to explore personal experiences. Knowing the reasons behind parasuicide attempts could help to clarify its purpose and enable ways of changing behaviour.

The behaviour of women who injure themselves has been interpreted as a way to obtain attention and care

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from other people (Perseius *et al*. 2005). Some women reported that self-injury was not an attempt to manipulate others, but rather because they felt misunderstood and mistrusted (Nehls l999). Other findings revealed that these women wish to obtain emotional relief through self-injury and sometimes manipulate others. Brown *et al*. (2002) assert this is unlikely to occur at the same time. This seems to be contrary to the notion that these women use 'splitting' to attract attention and care from other people (McKay *et al.* 2004). The motives behind their self-injury seem to be complex (cf. Perseius *et al*. 2005), and the 'splitting' and contradictory behaviours associated with BPD could be a form of survival manifested by women coping with conflicting social expectations.

Difficulties processing intense emotions and distress lead to a social ineptness that can be destructive. Much of the literature refers to the emotional turbulence that accompanies BPD and a lack of perception of self and others. Interpersonal relationships often fail which lead to further pain and distress. BPD is characterized by difficulties in emotional regulation and interpersonal relationships and therefore complicate social interactions. The literature revealed several social situations where feelings of abandonment might occur and lead to intense emotional distress. According to McKay *et al.* (2004), some women may be aware of their irrationality but are unable to express their feelings and frustrations by means of language and may speak impulsively without adequately evaluating content. Participants in Bland *et al.* (2004) study had problems understanding non-verbal language, recognizing facial expressions and had high levels of emotional intensity.

It seems that women who self-injure are deficient in social skills and experience distress because of these deficiencies. Self-injury could be linked to social difficulties and not simply driven by diagnosis (cf. Welch & Linehan 2002). Parasuicide behaviour serves to communicate distress (Linehan l993). Women with BPD struggle to control their daily lives and try to avoid situations that contribute to feelings of helplessness and powerlessness.

Living with a diagnosis of BPD was expressed as living with a label and having limited access to care (Nehls l999). The women did not deny their diagnosis but deplored the stereotypes and stigma attached to this particular diagnostic category. While they expressed the need for care and treatment, they disliked professionals who disempowered them (Nehls l999).

There is evidence of the emotional pain and distress associated with a diagnosis of BPD in the published research literature. The present review enabled a closer examination of the inner turmoil that such women deal with, such as abuse and neglect as a child, emotionally painful situations that lead to self-injury, and their inability to function appropriately in social contexts.

Implications for research and practice

Several factors seem to be important for increasing methodological rigour and the quality of future research (NHMRC 2000a,b; Shadish *et al*. 2002). The majority of quantitative studies in this review had not been evaluated in terms of statistical or content validity. The failure to examine important aspects of models and concepts as revealed in the four studies employing the emotional regulation model presented by Linehan (l993) limit the generalizability of results. Similarly, the use of self-report measures in quantitative research increases the likelihood of response bias (Shadish *et al*. 2002). Other types of measurement such as in-depth interviews could allow for more detailed investigation. Most (84%) studies did not report their findings as preliminary, even when small sample size (n = 12–75) were used. A larger and more diverse group of patients suffering from BPD would increase rigour (NHMRC 2000b; Shadish *et al*. 2002).

The synthesizing of concepts related to emotional pain and distress revealed important implications for practice. The emotionally abused and neglected child struggles with emotional pain and distress as an adult woman, expressing this distress through self-injury. These women have a need to be confirmed and accepted by health-care professionals. They are hesitant to share their emotional pain and distress; they deny injuring themselves in order to manipulate others, but feel that nobody understands their suffering. Social problems can be related to difficulties regulating emotions and controlling behaviour. Self-injury could be their way of communicating with others and enduring the emotional pain related to social expectations and demands. They struggle to empower themselves and try to find meaning in their suffering. They need professionals who can collaborate in an emotional and therapeutic way, thus making it safe for them to tell their story.

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