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Psychological interventions in borderline personality disorder with self-harm behaviors

Abstract

Borderline Personality Disorder (BPD) is a disorder that is characterized by the delimitation of the limit state, where the patient constantly navigates between the fields of neurosis and psychosis, presenting repetitive manifestations of chronic anxieties, phobias, obsessions, compulsions, symptoms of bizarre conversion, dissociations, hypochondria, perverse sexual tendencies, constant tendencies to impulsivity, abuse of drugs, alcohol and medication, emotional lability, great needs for exhibitionism, chronic feelings of emptiness, difficulties in disengagement, difficulties in sustaining bonds, self-injurious behaviors, among others.[1] It is important to collect data on the patient's life history and current repetitive behaviors that are presented. The first potential symptoms usually emerge in adolescence and early adulthood, thus reverberating throughout life, diagnoses are more common after 17 years of age.[2] Symptoms, among self-injurious behaviors, tend to decrease when appropriate treatment occurs, with continuous medical, psychological and psychiatric/medication monitoring. The importance of psychological assessment and interventions is associated with an in-depth study of the cognitive, emotional and behavioral functions that are presented by these subjects, thus allowing for appropriate treatments and accompaniment. Psychology can make use of several tests, the professional is the one who decides which are the most pertinent and appropriate for each case, however, the evaluation is not based only on tests, it is up to the professional to seek other intervention techniques relevant to the diagnosis.[3] Throughout the process, it is important for the family to be present, along with the development of the work to observe the improvements and persistent behaviors that accompany the patient diagnosed with the disorder. The study looks at the various possibilities of psychological/neuropsychological interventions for harm reduction and subsequent changes in the framework of characterized destructive behaviors.

Keywords: adolescents, adults, disorder, borderline personality, impulsiveness, autolesivo behavior

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Introduction

The English denominationfrom the word "borderline" means the border or line that makes up the margin, tracing the characteristic delimitation of a state considered to be of a limit character (limit state). The borderline designation is associated with the fact that Borderline Personality Disorder is in a constant cross between the fields of neurotic structure and psychotic structure.[4] Some subjective traits of the individual navigate the fragmented seas of hallucination and delirium that are part of the field of psychosis, other times, they navigate lucidity and contact with concrete reality in the field of neurosis, thus, it is evident that the borderline profile oscillates in both psychic structures.

The psychopathology of Borderline Personality Disorder or even the characterization of the well-known limit state crosses in the research a very controversial and diffuse thematic concept, where, it is located basically in an intermediate ground between two theoretical discourses. The term borderline refers to the insertion of the subject between neurotic functioning and also psychotic functioning, with a perspective of continuous alternation, therefore, these patients cannot be classified in a single field, subjectively fluctuating in both throughout the psychic constitution of life, it is important to emphasize that one of the biggest marks of the borderline personality is the absence or the impossibility of building an empathic process towards the other.[5]

The representation of Borderline Personality Disorder is about the dynamic threshold between the sphere of reason and the sphere of complete despair, where there is a constant oscillation between the spread of the process of reason and madness. Thus, these individuals are partly able to control their limits and impulses of hatred and at other times they dwell on the non-containment of the fragmentation drives of madness, in some cases they frequently present themselves, for example, self-injurious behaviors.[5]

Personality disorders are conceptualized as a persistent pattern of experiences, experiences, attitudes and behaviors that are not well accepted by the social context, since it is characterized as a pattern of diffuse order and of inflexible character towards your world outside. The disorder commonly has its initial manifestation of development in the adolescence phase or in the transition to adulthood, thus perpetuating itself throughout life, causing the subject to suffer great burden and difficulties in building emotional bonds, self-mutilation behaviors, strengthening social insertions and sustaining personal relationships.[2]

According to the conceptualizations of the ICD-10, borderline disorder constitutes characteristics related to successive emotional and fragmented instabilities, constant chronic feelings of emptiness and loneliness, great tendencies to get involved in relationships with traits of intensity and affective instability, constant efforts not to come across with the abandonment of the other, repeated suicidal ideas, suicide attempts and self-injurious behaviors.[6]

The Mental Health Diagnosis (DSM)-5 reports that borderline disorder is essentially characterized by patterns related to interpersonal instability, instability in the representation of self-image, in affections,

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and a marked impulsiveness associated with self-destructive behaviors. According to the descriptions of the mental health diagnostic manual, personality disorders are included in the name of group B, along with the categorization ofpersonality disorders antisocial, personality disorders histrionic and also narcissistic disorder.[4]

Among all the characteristics presented there are three of them that are more prevalent and common for Borderline disorder, namely the impulsiveness in at least two potentially self-destructive areas (suicide and self-injury), an unstable and intense pattern of interpersonal relationships characterized by alternating between extremes of idealization and devaluation and also affective instability due to marked reactivity and constant change of mood.

It can be seen here that there is a partial consensus on the conceptualization of Borderline Personality Disorder, since there are still some divergences in the basic characterizations of the development, symptoms and / or etiology of the disorder. Throughout the article, we will discuss self-injurious behavior in subjects who have Borderline Personality Disorder and what are the repercussions associated withself-mutilation.

There are some symptoms markedly related to Borderline Personality Disorder, taking into account that, they have patients who have few associated symptoms and others have a large part of the borderline condition, being:

1. Narcissism.
2. Psychic bleeding.
3. Disordered hypersensitivity.
4. Psychic rigidity.
5. Tendency to troubled/negative therapeutic reactions.
6. Feelings and/or inferiority complex.
7. Masochism.
8. "Somatic" insecurity.
9. Constant projection mechanisms.
10. Difficulties to test the reality process.

Risk behaviors are often also present in borderline personality symptoms, which risk may be related to suicidal ideation and attempt behaviors, self-injurious behaviors, sexual behaviors without care and/or preservation and are often placed in risky situations social.[7] Risk behaviors generate, in some situations to borderline patients, feelings of satisfaction and desires that are unconscious, that is, they are faced with a dangerous and negative adverse situation and do not understand that the situation is self-destructive and dangerous.

The self-destructive drive related to self-injurious behaviors is also taken into account in risky behaviors, where the subject traces the injury behavior as an instrument and / or technique to get rid of the tension and anguish experienced. For example, the subject has an existential suffering due to the separation from a marriage, and on a certain day he feels alone and confused, instead of elaborating the feeling of the loss of his partner, he cuts his wrists as a mechanism of compensation and punishment unconscious.

Some authors defend the perspective that the patient with personality disorder has a particularly disturbed and fragmented mind, having linked relationships that are characterized as being very intense, but with markedly unstable links. These patients often have anguish of abandonment, sudden affective variations, such as love/hate, very constant behaviors of aggression and anger, accompanied almost always with the feeling of impulsiveness, fragmentation and rupture.[7]

It is very common to observe that subjects with a borderline personality have a very strong belief that something or someone constantly wants to threaten / harm him or wants to break with his relations with the outside world. For these and other beliefs presented that borderline patients lose the basic borders of relationship with each other, therefore, it is possible to consider that these patients live a constant relationship of proximity versus a relationship of continuous withdrawal.[5] Thus, crossing the perspective of constant and repeated unstable and non-lasting relationships with each other.

The individual who develops personality disorder has a notorious aggressiveness and devastating affective instability, since the trends associated with the order of impulsivity are very present and frequent in his life dynamics. There are some diagnostic patterns that are fundamental to characterize the pathology, since the patient does not necessarily need to present all patterns of behavior in order to have a diagnosis. Some symptoms are important for the clinician to observe, as per Pereira:[1] a repetitive manifestation of chronic anxiety, phobias, obsessions, compulsions, bizarre conversion symptoms, dissociations, hypochondria, perverse sexual tendencies and polymorphic in nature, constant tendencies to impulsivity , drug and alcohol abuse, emotional lability.

In addition to the constant dynamic present of aggression, impulsivity and affective and emotional instability, Borderline Personality Disorder can be accentuated and also bring symptoms of ideation and attempts and drives related to suicide, which further aggravates the treatment and its subsequent prognosis physician.[4] Since, there is no possibility of a modification of the subjective personality structure, however, it is possible that with appropriate treatment and monitoring, the subject will be able to have a better quality of life and more adaptive ways of functioning and social life, without major personal losses. and social.

Among the symptomatological characteristics presented, narcissism is one of the bases for building the clinical picture of the borderline patient, that is, as a general rule, patients who have a medical diagnosis have narcissistic behaviors. The constitution of narcissism is closely associated with subjects who have experienced very devastating and traumatic situations, such as, for example, very primitive experiences of abandonment, violence, aggression, neglect, brutality, mistreatment and cruelty. It is understood that negative experiences with this dynamic, have repercussions on deep narcissistic injuries related to love, self-concept, security and self-confidence in the face of adverse life situations.[4]

The difficulties associated with pondering with regard to relationships between two have dysfunctional boundaries, due to the fact that they commonly have few mechanisms and resources to deal with the sentimental and emotional issues presented to them.[4] For example, in an adverse situation of disagreement in the relationship, the subject with borderline personality disorder may not be able to elaborate a dialogue in a productive and assertive way, crossing his drives for hostility and aggression.

Self-mutilation behavior is common in personality disorders and the respective is configured as a behavior on the spectrum of impulsive and compulsive representations, where there is a great difficulty to control and / or resist the impulse of the behavior. Self-mutilation

behaviors can be prevalent both in adolescence and in adulthood, it is observed that there is a great predominance for these behaviors to be accompanied with rituals before and after carrying out the harmful act. Impulsivity, as previously portrayed, is a great predictor for understanding the real process of self-mutilation, where there is a very quick response to the aversive stimuli that are presented, thus bringing repercussions to risky behavior.[8]

Some self-mutilation behaviors common to patients with borderline personality can be considered, for example, constant cuts in the skin, poking and/or touching wounds, biting, hitting, poking areas of the body until they bleed, skinning, getting burned, plucking hair from various hemispheres of the body, inserting objects under the nail, self-tattooing, cutting the wrist, among others.[8] The repetition of the behaviors will depend on the impulsivities that are associated with the patient's subjective constitution, thus, the patient may present from the lightest behaviors to the most serious behaviors.

Borderline Personality Disorder is diagnosed in about 75% of cases in females, the diagnosis of the disorder is commonly made between late adolescence and early adulthood, which can be a variable factor.[2]

In self-injurious and/or self-mutilating behaviors, the prevalence between the sexes is related to the higher frequency of females, it is corroborated that the behaviors start in adolescence, in the middle of 17 years of age, and are perpetuated for adulthood, with behaviors that are generally quite similar from one subject to another.[8]

Methodology

In order to carry out the analysis on the psychological / neuropsychological assessment and intervention in patients with Borderline Personality Disorder, bibliographic searches in periodical articles, dissertations and theses were necessary. To search for the study material, the databases of Scielo and Google Scholar were used, where research on the key concepts on "Psychological/ Neuropsychological Assessment of Borderline Disorder", "Symptoms of Borderline Personality Disorder", "Self-Behavior ",“ Borderline Personality Disorder ”and“ Diagnostic and Statistical Manual of Mental Disorders ". The periodicity of bibliographic references was limited between the interval of1993 and 2017,and the languages were Portuguese-PT, Portuguese-BRA and English. After the bibliographic reviews, the articles considered pertinent for the elaboration of the research were selected.

For data analysis, a selectivity of all materials that were found throughout the research on the evaluation will be carried out psychological/neuropsychological character of the borderline personality. Then, a qualitative analysis of the data will be carried out, starting from the secondary objective of psychological/ neuropsychological assessment in subjects who have borderline personality disorder with self-mutilation behaviors.

Etiology

Studies point out that there are many factors etiological factors associated with the constitution of a Borderline Personality Disorder in a subject, factors that can be biological and experiential. As for example, there are markers associated with genetics, heredity, experiences of ruptures and separations in childhood, experiences of loss, child abuse, aggressive and troubled family environment, experiences in chaotic and negligent environments.[3] Thus, it is common to observe that patients who received diagnoses of personality disorder had very persistent and traumatic problems in the children's field, situations that are usually very early and markedly without a process of building resilience. Other authors report that the etiology of borderline disorder is strongly associated with genetic factors, constitutional, family, biochemical, psychodynamic and psychosocial factors.[9] The authors cross-check a lot of information regarding the etiological possibilities of the disorder.

There is no determinant factor for the realization of the disorder in human life, however, attention is drawn to the fact that the experiences related to the loss process in childhood are potentializing events for the emergenceand / or subjective construction of the disorder. This does not mean that all children who experience loss processes will develop the condition, but the authors emphasize that studies show that 20% to 40% of diagnoses experienced traumatic situations of loss of mother or loss of father and/or figure of caregiver.[3]

Another markedly potentiating factor is the traumatic experience of child sexual abuse, some studies show that 80% of individuals who have been diagnosed with the disorder, portray sexual abuse in their life experiences, commonly linked to the family environment.[3] However, it was possibly children who suffer from abuse, but who do not receive any social and family support to address the early traumatic situation.

In other studies, patients with a borderline medical diagnosis, portray a continuous history that emotional distress since early childhood, namely, the absence of affection, love and maternal affection, aggressive conflicts with the father figure, outbursts of anger directed at the child on the part of the child. from the father, separation or abandonment at a very early age, cruelty, hostility, aggression and mistreatment, neglect, constant absences of the maternal figure, prolonged brutality on the part of the parental figures.[10] It is important to note that the etiology and the origin of the borderline disorder, tend to be very related to the experiences of trauma due to mistreatment in early childhood, where traumas are presented by parental figures and/ or figures of security and support.

The etiology of behaviors self-injurious is very complex and still without a concrete definition, since the self-mutilation behavior is characterized as being a strategy that the subject finds to deal with the sensations of emptiness and non-reality outside. Self-mutilation behaviors can be related to a defense mechanism used by the subject, or even a very primitive strategy, which does not have a healthy and/ or positive development.[8]

Psychological/neuropsychological intervention

Borderline Personality Disorder is still subject to many doubts and research related to the field, and it is of great interest both to the subject's family members who live with the disease, as well as to the neuro scientific community (psychology), since it is necessary that there is a psychological/neuropsychological assessment of personality disorders in order to have a better understanding and deepening about the subject's behaviors.

The psychological/neuropsychological assessment seeks the use of behavioral studies to investigate how to process the subject's brain functioning, thus making subsequent differential diagnoses and determining the possible changes and / or dysfunctions that are presented in the patient's clinical condition and the forms of intervention.[11] In the case of patients who suffer from Borderline Personality Disorder and self-mutilation, psychological / neuropsychological assessment is important to understand the spheres that are compromised and the most appropriate forms of intervention by the professional to prevent further damage.

The focus ofNeuropsychology is to investigate studies on possible compromising areas of the subject's cognitive, emotional and behavioral structures. She can use instruments such as tests, observation, anamnesis, evaluation, interview, among others, to assess psychological aspects related to concentration, attention, memory and executive functions of the subject. Thus allowing the professional to diagnose the professional to trace the most appropriate treatment and the subsequent indication and referrals.[11]

It is seen in studies on the cognitive structure of patients with Borderline Personality Disorder that there are some neurological changes that can explain / justify some behaviors that are presented, such as:

1. Clear changes in the process of functioning of the serotonergic activity receptors that are totally linked to the repercussion of impulsive/compulsive behaviors.[5]
2. Dysfunction in cholinergic activity, which is linked to the affective instability that the subject presents.[5]
3. The activation in constant excess of the surveillance systems, linked to the process of the functioning of the adrenal glands, which are very linked to stimulation and/or exposure even in childhood to episodes of a traumatic order, thus showing considerable organic dysfunctions.[5]
4. Existing biological vulnerabilities can contribute to hyperactivation of the amygdala, affecting individuals who are more sensitive to external stimuli that are relational.[5]

That is, there are very powerful dysfunctions in the spheres of impulsivity and affective instability, where self-mutilation behaviors will be more evident in the patient's clinical history.

In personality disorders there are some neuropsychological factors that are intrinsically associated, such as, great attentional vigilance, a dysfunction in affective modulation, deficits in inhibitory control, deficits in cognitive flexibility, deficits in the planning process, in the adequate inhibition of responses and in decision making.[8]

The representations of the impulses in self-mutilation behaviors are linked to deficits in the process of the attentional sphere, with losses very associated with the structure of the frontal lobe, where the manifestations of executive functions are allowed. Executive functions are responsible for organizing the links of social relationships.[8]

There are no psychological tests that are properly said to identify psychological/neuropsychological changes in the functions of a subject with Borderline Personality Disorders who have a demand for self-harm / self-mutilation. There are some tests that help and direct the professional to identify potentialities related to impulsivity, anger, aggression, the empathic process, persistent patterns of emotional instability, self-image, Paranoid ideation, suicidal thinking, affective instability, among others research points.

The psychological/neuropsychological assessment will be supported in view of what the professional seeks to investigate and analyze in the face of the patient's pathological condition, that is, the professional is responsible for all stages of the evaluation development process. It is important that all steps are completed successfully and that both the professional/patient are in constant integration.

In this direction, the literature on neuropsychology in Borderline Disorders suggests the use of some techniques and instruments for an evaluation in patients with personality disorders and self-injurious behaviors, it is always important that the professional master the application of the evaluations to obtain a satisfactory result. To assess the Borderline personality we will use: Open interview; Rorschach; Thematic Apperception Test (TAT), the Wechsler Intelligence Scale for Adults (WAIS-III), Self-mutilation Behavior Scale, Barrat Impulsivity Scale, Rey Complex Figure and the Problem-Solving Inventory (PSI).

The interviewopen and/or anamnesis are about understanding content associated with the patient's life dynamics, how they do their routine, data on family and social trajectory, use of medication, emergency conflicts, among others. The neuropsychologist can observe and evaluate the entire life story that the patient reports, being always aware of the bodily and verbal expressions that are presented throughout the interview.[4]

The Rorschach plank assessment method presupposes the analysis of the way the subject observes and perceives the stimuli that are presented to them, thus tracing the way the subject deals with adverse situations in a concrete context, perceiving their sensory expressions and the their used compensation mechanisms. Thus, this assessment allows the neuropsychologist to obtain the perception of the cognitive process of the experiences of contact with the real that the subject has and its subsequent elements of contradiction and challenging opposition. The projective test of Rorschach refers the subject to content related to fantasy (unreality), where projections can occur under the real needs and impulsive processes that the subject has.[12]

The Thematic Apperception Test (TAT) is also a projective test that aims to understand how people observe and project different personal and social situations. The way the subject elaborates his experience in face of a certain print, clearly denotes the structure of the subject in relation to his real context, that is, the professional has access to the latent contents of the subject's personality because the respective exposes his feelings from the confrontations presented.[12] Contents related to loneliness, aggression, neglect, helplessness, rupture processes, among others, may arise in the evaluation.

The Wechsler Intelligence Scale for Adults (WAIS-III) is aimed at assessing/analyzing the intelligence and/or intellectual aspects of both adults and adolescents. The assessment reports the process of cognitive skills that were developed by the subject and their respective psychiatric, neurological and emotional problems presented.[12] Content related to psychological pain, feelings of anguish/anxiety, the capacity for intellectual performance, among others, may arise in the development of the evaluation.

The Self-mutilation Behavior Scaleit provides indications of possible frequencies and / or reasons why self-mutilation behaviors occur, existing motivations, the use of drugs and psychoactive substances, the intensity of the pain process, among others. The instrument basically assesses 11 subtypes of self-mutilation during the last 12 months, and is usually targeted at patients with moderate and severe mutilation.[8]

The Barrat Impulsivity Scale is an instrument used to assess the repercussions related to motor impulsivity, the attention process and the existing failures in the field of procedural planning.[8] It is a scale widely used to identify impulsivities that the subject cannot control, such as self-injury.

Rey's Complex Figure is based on a complex figure with many stimuli and geometric shapes that are illustrated to the patient. After presenting the figure, the patient is asked to draw everything he remembers that is related to the figure he just saw. The test assesses the potentialities related to visuospatial organization skills, the

development of strategies, the delimitation of plans and the process of sustaining memory.[8]

Finally, we have the Problem-Solving Inventory (PSI), which is an inventory characterized by investigating the subject's problem-solving ability. The inventory consists of three scales, the scale of confidence in solving/solving problems, the scale of the approach / avoidance style and the scale of personal subjective control. The subject evaluates cognitive abilities related to self-confidence, problem solving, resilience and control in situations of great adversity.[8]

However, despite the many testing possibilities that assess borderline disorder and self-mutilation it is important that the neuropsychologist knows the best application methods/techniques, based on the eventual demand that is being presented by the patient. Since neuropsychology does not only use tests to understand a disorder, it may have come to use the process of observation, clinical interview, clinical listening, among others.

Treatment

Continuous treatment of patients with Borderline Personality Disorder and injury behaviors is associated with many specific factors and areas, where psychiatry, psychology and neuropsychology work together to provide the best treatment possibilities and strategies depending on idiosyncrasy displayed. The intersection between psychotherapeutic processes and drugs brings great potential to these patients, subsequently bringing emotional balance, impulse control, improvements in communication, less marked and self-destructive stress levels. However, the psychotherapeutic process is fundamental concomitant with any other treatments in which the subject is willing to participate.

The literature refers to some drugs/psychotropics that are commonly used intreatment of Borderline Personality Disorders with self-injurious characteristics, always depending on the symptoms and the severity of the clinical case that is presented. Carvalho[13] report the use of typical Antipsychotics, atypical Antipsychotics, mood stabilizers, Selective Serotonin Reuptake Inhibitors, Monoaminooxidase Inhibitors, Venlafaxine, Anxiolytics and Naltrexone and their subsequent positive repercussions in the treatment of borderline patients.

Typical antipsychotics are important because borderline patients commonly present episodes of severe psychotic order, which are usually triggered by environmental stressors. Some antipsychotics such as thiotixene, trifluoperazine, haloperidol, phenelzine, have shown improvements in reducing the severity of depressive symptoms, the process of paranoid ideation, psychotic functioning, interpersonal sensitivity, psychotic, obsessive-compulsive and phobic-anxious symptoms, and a considerable improvement in symptoms related to hostility and anger.[13]

The atypical antipsychotics are sometimes considered better than the typical ones, as they have a lower rate of extrapyramidal symptoms during the pharmacological treatment. The most common atypical antipsychotics used in this patient population are clozapine, olanzapine, risperidone, with positive repercussions in improving the impulses of aggression and improving the balance of affective symptoms.[13]

Mood stabilizers can be very effective in treating patients considered to be borderline, especially those who have severe lack of control of mood swings. The most widely used stabilizers are Amitriptyline, tricyclic antidepressants, carbamazepine, lithium, desipramine, divalproate and lamotrigine. Medications can have repercussions on global symptomatic improvements with regard to irritability, anger, suicidal symptoms, hostility and interpersonal sensitivity.[13]

The selective inhibitors of serotonin reuptake can bring improvements in relation to impulsivity and the improvement of mood swings symptoms of patients with borderline disorder, selective inhibitors such as Fenfluramine and fluoxetine, bring improvements in the symptoms of depression and aggression. Monoaminooxidase inhibitors, on the other hand, show great improvements in affective symptoms, impulsive and aggressive symptoms, tranylcypromine and phenelzine suggest effectiveness in the treatment of atypical depressive symptoms, such as anger and hostility.[13]

Venlafaxine is a well-known antidepressant used in clinical cases of borderline personality diagnosis, with the competence of inhibiting, reuptake and rescue of norepinephrine and serotonin, that is, it rescues the stability and balance of patients who have constant depressive processes.[13]

Anxiolytic agents such as alprazolam, Clonazepam, Buspirone, bring antimanic effects that increase serotonergic neurotransmission to the brain, can be an excellent agent for the treatment of severe anxiety attacks in patients with personality disorders.[13]

Finally, we have Naltrexone which is very indicated in cases that affect the process of self-mutilation, where the demand for self-mutilation is very common in borderline patients who often have obsessive-compulsive thoughts. Naltrexone is very potent to annihilate behaviors of possible insensitivity to pain due to an excessive activity that is presented by the brain, thus making the subject to obtain risk behaviors less frequently, namely self-injury/self-mutilation.[13]

Medication is not excessively excluded from the process by the psychological/neuropsychological clinic, however, it is understood that psychotherapy is fundamental for improving the quality of life of patients with Borderline Personality Disorder concomitant with self-mutilation behaviors. That is, the correct and adequate medication is also essential for the crossing of treatments and subsequent desired success.

Discussion

It is evident that Borderline Personality Disorder has multifactorial associations and it is necessary that the professional is attentive to the whole body of the psychopathological symptoms that are presented, mainly with the symptoms related to the initial manifestations, to the cognitive aspects, the impulsivities, the drives and the constant risks of suicide and/or self-mutilation.[4] The clinician needs to be attentive throughout the evaluations on aspects related to the way the subject perceives and interprets internal and external events, since a subject with a borderline diagnosis has greater diffusions about existing and / or even denying his problems.[3]

Some authors report that after the neuropsychological diagnosis there are identifications of serious cognitive flaws in subjects who have a diagnosis of borderline personality. Failures are closely associated with impairments in the domains of the cognitive sphere, for example, in processes related to attention, malleability, flexibility, working memory and cognitive abilities to plan and perform a certain activity.[3]

In addition to the diagnosis of neuropsychology, a specific physical examination at the neurological level is also necessary, as very clear evidence of interruptions and failures in brain circuits is presented in

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the studies. In the borderline diagnosis, so-called brain disruptions are closely related to flaws in intellectual mechanisms, flaws in the impulsiveness of aggression, flaws in the mechanisms of affective regulation, flaws in the ability to make decisions, cognitive rigidity, wrong attitudes and distorted interpretations.[3]

With regard to thes suicidal thoughts and self-mutilation behaviors, it is observed that cognitive deficiencies are largely compromised in borderline disorder, thus causing failures in the executive function process. Therefore, the executive functions that are also responsible for emotional aspects, become unstable, making the subject have commitments to control their subsequent behavioral impulses.[3]

It is necessary that the clinicianneuropsychologist obtain skills and aptitudes to understand the results of the projective and quantifiable tests, joints and interpretations of the information collection of the open interview, always outlining new diagnostic hypotheses, when necessary.[11] It is also useful for the clinician to responsibly decide the selection of tests and the methods and techniques that will be performed throughout the diagnostic evaluation process.

It is important that if possible, the family is somewhat integrated into the process of neuropsychological monitoring and treatment, since it is necessary for the patient and family to understand what is happening in the diagnosis, how the associated symptoms arise, the process of psychoeducation , the use of necessary medications, among other demands that may arise during the process of diagnosis and treatment.

Conclusion

Borderline Personality Disorder is a psychic pathology that has a very wide variety of symptoms that are presented during development, the symptoms are very invasive, devastating and annihilating, where monitoring is necessary for the subject to obtain a better quality of life. In clinical cases of borderline diagnoses, neuropsychology works in conjunction with neurology and psychiatry, in order to neutralize the negative and self-destructive repercussions of the disorder.

It is necessary to identify, throughout the process, whether the patient and / or the familyin the diagnosis, which symptoms and comorbidities are associated with the disorder, and their subsequent forms of treatment. The neuropsychologist clinician, necessarily, needs to have mastery and aptitude about the tests and techniques that he intends to apply during the process.

Projective techniques are very important for the evaluation psychological/neuropsychological study of borderline patients, since they allow in-depth access to the patient's external and internal contexts, thus understanding desires, fears, conflicts, drives, plans, ideas, ruptures, idiosyncrasy, defense mechanisms and their subjective structure.

The evaluation psychological/neuropsychological in patients with borderline disorder are very valid because they understand the diagnosis in a qualitative perspective, where various cognitive and emotional spheres of the patient's subjective structure are investigated. However, the choice of diagnostic mechanisms is the professional's complete competence, a quality clinical management and with competence has repercussions on further improvements in the life of the patient who suffers from the disorder.[14]

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Conflicts of interest

The authors declare that there is no conflict of interest to declare.

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