Borderline Personality Disorder: Navigating Emotional Storms

Authored by

mohammad looti

June 17, 2026

Borderline personality disorder (BPD) is a personality disorder described as a prolonged disturbance of personality function in a person (generally over the age of eighteen years, although it is also found in adolescents), characterized by depth and variability of moods. The disorder typically involves unusual levels of instability in mood; black and white thinking, or splitting; the disorder often manifests itself in idealization and devaluation episodes, as well as chaotic and unstable interpersonal relationships, self-image, identity, and behavior; as well as a disturbance in the individual's sense of self. In extreme cases, this disturbance in the sense of self can lead to periods of dissociation.

BPD splitting includes a switch between idealizing and demonizing others. This, combined with mood disturbances, can undermine relationships with family, friends, and co-workers. BPD disturbances also may include self-harm. Without treatment, symptoms may worsen, leading (in extreme cases) to suicide attempts.

There is an ongoing debate among clinicians and patients worldwide about terminology and the use of the word borderline, and some have suggested that this disorder should be renamed. The ICD-10 manual has an alternative definition and terminology to this disorder, called Emotionally unstable personality disorder.

There is related concern that the diagnosis of BPD stigmatizes people and supports pejorative and discriminatory practices. It is common for those suffering from borderline personality disorder and their families to feel compounded by a lack of clear diagnoses, effective treatments, and accurate information. This is true especially because of evidence that this disorder originates in the families of those who suffer from it and has a lot to do with psychosocial and environmental factors (Axis IV), rather than belonging strictly in the personality disorders and mental retardation section (Axis II) of the DSM-IV construct. Conceptual, as well as therapeutic, relief may be obtained through evidence that BPD is closely related to traumatic events during childhood and to post-traumatic stress disorder (PTSD), about which much more is known.

Signs and symptoms

Borderline personality disorder is a diagnosis about which many articles and books have been written, yet about which very little is known based on empirical research.

Studies suggest that individuals with BPD tend to experience frequent, strong and long-lasting states of aversive tension, often triggered by perceived rejection, being alone or perceived failure. Individuals with BPD may show lability (changeability) between anger and anxiety or between depression and anxiety and temperamental sensitivity to emotive stimuli.

The negative emotional states specific to BPD may be grouped into four categories: destructive or self-destructive feelings; extreme feelings in general; feelings of fragmentation or lack of identity;

and feelings of victimization.

Individuals with BPD can be very sensitive to the way others treat them, reacting strongly to perceived criticism or hurtfulness. Their feelings about others often shift from positive to negative, generally after a disappointment or perceived threat of losing someone. Self-image can also change rapidly from extremely positive to extremely negative. Impulsive behaviors are common, including alcohol or drug abuse, unsafe sex, gambling and recklessness in general. Attachment studies suggest individuals with BPD, while being high in intimacy- or novelty-seeking, can be hyper-alert to signs of rejection or not being valued and tend toward insecure, avoidant or ambivalent, or fearfully preoccupied patterns in relationships. They tend to view the world generally as dangerous and malevolent, and tend to view themselves as powerless, vulnerable, unacceptable and unsure in self-identity.

Individuals with BPD are often described, including by some mental health professionals (and in the DSM-IV), as deliberately manipulative or difficult, but analysis and findings generally trace behaviors to inner pain and turmoil, powerlessness and defensive reactions, or limited coping and communication skills. There has been limited research on family members' understanding of borderline personality disorder and the extent of burden or negative emotion experienced or expressed by family members. However the effect of expressed emotion by family members may actually be opposite (paradoxical) from the anticipated effect on individuals with such illnesses as depressive disorders and schizophrenia. For BPD such effect may be neutral or positive as opposed to negative, a counter-intuitive result.

Parents of individuals with BPD have been reported to show co-existing extremes of over-involvement and under-involvement. BPD has been linked to increased levels of chronic stress and conflict in romantic relationships, decreased satisfaction of romantic partners, abuse and unwanted pregnancy; these links may be general to personality disorder and subsyndromal problems.

Suicidal or self-harming behavior is one of the core diagnostic criteria in DSM IV-TR, and management of and recovery from this can be complex and challenging. The suicide rate is approximately 8 to 10 percent. Self-injury attempts are highly common among patients and may or may not be carried out with suicidal intent. BPD is often characterized by multiple low-lethality suicide attempts triggered by seemingly minor incidents, and less commonly by high-lethality attempts that are attributed to impulsiveness or comorbid major depression, with interpersonal stressors appearing to be particularly common triggers. Ongoing family interactions and associated vulnerabilities can lead to self-destructive behavior. Stressful life events related to sexual abuse have been found to be a particular trigger for suicide attempts by adolescents with a BPD diagnosis.

Diagnosis

Diagnosis is based on a clinical assessment by a qualified mental health professional. The assessment incorporates the patient's self-reported experiences as well as the clinician's observations. The resulting profile may be supported or corroborated by long-term patterns of behavior as reported by family members, friends or co-workers. The list of criteria that must be met for diagnosis is outlined in the DSM-IV-TR.

Borderline personality disorder was once classified as a subset of schizophrenia (describing patients with borderline schizophrenic tendencies). Today BPD is used more generally to describe individuals who display emotional dysregulation and instability, with paranoid ideation or delusions being only one criterion (criterion #9) of a total of 9 criteria, of which 5, or more, must be present for this diagnosis.

Individuals with BPD are at high risk of developing other psychological disorders such as anxiety and depression. Other symptoms of BPD, such as dissociation, are frequently linked to severely traumatic childhood experiences, which some put forth as one of the many root causes of the borderline personality.

Adolescence

Onset of symptoms typically occurs during adolescence or young adulthood. Symptoms may persist for several years, but the majority of symptoms lessen in severity over time, with some individuals fully recovering. The mainstay of treatment is various forms of psychotherapy, although medication and other approaches may also improve symptoms. While borderline personality disorder can manifest itself in children and teenagers, therapists are discouraged from diagnosing anyone before the age of 18, due to adolescence and a still-developing personality.

There are some instances when BPD can be evident and diagnosed before the age of 18. The DSM-IV states: "To diagnose a personality disorder in an individual under 18 years, the features must have been present for at least 1 year." In other words, it is possible to diagnose the disorder in children and adolescents, but a more conservative approach should be taken.

There is some evidence that BPD diagnosed in adolescence is predictive of the disease continuing into adulthood. It is possible that the diagnosis, if applicable, would be helpful in creating a more effective treatment plan for the child or teen.

Diagnostic and Statistical Manual

The Diagnostic and Statistical Manual of Mental Disorders fourth edition, DSM IV-TR, a widely used manual for diagnosing mental disorders, defines borderline personality disorder (in Axis II Cluster B) as:

A pervasive pattern of instability of interpersonal relationships, self-image and affects, as well as marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
Frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-injuring behavior covered in Criterion 5
A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
Identity disturbance: markedly and persistently unstable self-image or sense of self.
Impulsivity in at least two areas that are potentially self-damaging (e.g., promiscuous sex, eating disorders, binge eating, substance abuse, reckless driving). Note: Do not include suicidal or self-injuring behavior covered in Criterion 5
Recurrent suicidal behavior, gestures, threats or self-injuring behavior such as cutting, interfering with the healing of scars (excoriation) or picking at oneself.
Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability or anxiety usually lasting a few hours and only rarely more than a few days).
Chronic feelings of emptiness
Inappropriate anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
Transient, stress-related paranoid ideation, delusions or severe dissociative symptoms

It is a requirement of DSM-IV that a diagnosis of any specific personality disorder also satisfies a set of general personality disorder criteria.

International Classification of Disease

The World Health Organization's ICD-10 defines a conceptually similar disorder to borderline personality disorder called (F60.3) Emotionally unstable personality disorder. It has two subtypes described below.

F60.30 Impulsive type

At least three of the following must be present, one of which must be (2):

marked tendency to act unexpectedly and without consideration of the consequences;
marked tendency to quarrelsome behaviour and to conflicts with others, especially when impulsive acts are thwarted or criticized;
liability to outbursts of anger or violence, with inability to control the resulting behavioural explosions;
difficulty in maintaining any course of action that offers no immediate reward;
unstable and capricious mood.

It is a requirement of ICD-10 that a diagnosis of any specific personality disorder also satisfies a set of general personality disorder criteria.

F60.31 Borderline type

At least three of the symptoms mentioned in F60.30 Impulsive type must be present , with at least two of the following in addition:

disturbances in and uncertainty about self-image, aims, and internal preferences (including sexual);
liability to become involved in intense and unstable relationships, often leading to emotional crisis;
excessive efforts to avoid abandonment;
recurrent threats or acts of self-harm;
chronic feelings of emptiness.

It is a requirement of ICD-10 that a diagnosis of any specific personality disorder also satisfies a set of general personality disorder criteria.

Chinese Society of Psychiatry

The Chinese Society of Psychiatry's CCMD has a comparable diagnosis of Impulsive Personality Disorder (IPD). A patient diagnosed as having IPD must display "affective outbursts" and "marked impulsive behavior," plus at least three out of eight other symptoms. The construct has been described as a hybrid of the impulsive and borderline subtypes of the ICD-10's Emotionally Unstable Personality Disorder, and also incorporates six of the nine DSM BPD criteria.

Millon's subtypes

Theodore Millon identified four subtypes of borderline. Any individual borderline may exhibit none, or one or more of the following:

Discouraged borderline -- including avoidant, depressive or dependent features
Impulsive borderline -- including histrionic or antisocial features
Petulant borderline -- including negativistic (passive-aggressive) features
Self-destructive borderline -- including depressive or masochistic features

Differential diagnosis

Common comorbid (co-occurring) conditions are mental disorders such as substance abuse, depression and other mood and personality disorders.

Borderline personality disorder and mood disorders often appear concurrently. Some features of borderline personality disorder may overlap with those of mood disorders, complicating the differential diagnostic assessment.

Both diagnoses involve symptoms commonly known as "mood swings." In borderline personality disorder, the term refers to the marked lability and reactivity of mood defined as emotional dysregulation. The behavior is typically in response to external psychosocial and intrapsychic stressors, and may arise or subside, or both, suddenly and dramatically and last for seconds, minutes, hours, days, weeks or months.

Bipolar depression is generally more pervasive with sleep and appetite disturbances, as well as a marked nonreactivity of mood, whereas mood with respect to borderline personality and co-occurring dysthymia remains markedly reactive and sleep disturbance not acute.

The relationship between bipolar disorder and borderline personality disorder has been debated. Some hold that the latter represents a subthreshold form of affective disorder, while others maintain the distinctness between the disorders, noting they often co-occur.

Some findings suggest that BPD may lie on a bipolar spectrum, with a number of points of phenomenological and biological overlap between the affective lability criterion of borderline personality disorder and the extremely rapid cycling bipolar disorders. Some findings suggest that the DSM-IV BPD diagnosis mixes up two sets of unrelated items--an affective instability dimension related to Bipolar-II, and an impulsivity dimension not related to Bipolar-II.

It is important to emphasize that medical conditions which cause organic behavioral function may result in a clinical picture that mimics to some degree BPD. Hormonal dysfunction over a long period, or brain dysfunction (e.g. the encephalopathy caused by lyme disease) can result in identity disturbance and mood lability, as can many other chronic medical conditions such as lupus. These conditions may isolate the patient socially and emotionally, and/or cause limbic damage to the brain. However, this is not borderline personality disorder which results, but rather a reaction to the isolating circumstances caused by a medical condition and the possibly coincident struggles of the patient to control his or her mood given damage to the brain's limbic system. Heavy alcohol usage over a long period itself can cause an encephalopathy which may cause limbic damage. Various frontal lobe syndromes can result in disinhibition and impulsive behavior.

Comorbid (co-occurring) conditions in BPD are common. When comparing individuals diagnosed with BPD to those diagnosed with other personality disorders, the former showed a higher rate of also meeting criteria for

anxiety disorders
mood disorders (including clinical depression and bipolar disorder)

eating disorders (including anorexia nervosa and bulimia)
and, to a lesser extent, somatoform or factitious disorders
dissociative disorders
Substance abuse is a common problem in BPD, whether due to impulsivity or as a coping mechanism, and 50 percent to 70 percent of psychiatric inpatients with BPD have been found to meet criteria for a substance use disorder, especially alcohol dependence or abuse which is often combined with the abuse of other drugs.

Causes

As with other mental disorders, the causes of BPD are complex and not fully understood. One finding is a history of childhood trauma, abuse or neglect, although researchers have suggested diverse possible causes, such as a genetic predisposition, neurobiological factors, environmental factors, or brain abnormalities.

There is evidence that suggests that BPD and post-traumatic stress disorder (PTSD) are closely related. Evidence further suggests that BPD might result from a combination that can involve a traumatic childhood, a vulnerable temperament and stressful maturational events during adolescence or adulthood.

Childhood abuse

Numerous studies have shown a strong correlation between child abuse, especially child sexual abuse, and development of BPD. Many individuals with BPD report to have had a history of abuse and neglect as young children. Patients with BPD have been found to be significantly more likely to report having been verbally, emotionally, physically or sexually abused by caregivers of either gender. There has also been a high incidence of incest and loss of caregivers in early childhood for people with borderline personality disorder. They were also much more likely to report having caregivers (of both genders) deny the validity of their thoughts and feelings. They were also reported to have failed to provide needed protection, and neglected their child's physical care. Parents (of both sexes) were typically reported to have withdrawn from the child emotionally, and to have treated the child inconsistently. Additionally, women with BPD who reported a previous history of neglect by a female caregiver and abuse by a male caregiver were consequently at significantly higher risk for being sexually abused by a noncaregiver (not a parent). It has been suggested that children who experience chronic early maltreatment and attachment difficulties may go on to develop borderline personality disorder.

Other developmental factors

Some studies suggest that BPD may not necessarily be a trauma-spectrum disorder and that it is

biologically distinct from the post-traumatic stress disorder that could be a precursor. The personality symptom clusters seem to be related to specific abuses, but they may be related to more persistent aspects of interpersonal and family environments in childhood.

Otto Kernberg formulated a theory of borderline personality based on a premise of failure to develop in childhood. Writing in the psychoanalytic tradition, Kernberg argued that failure to achieve the developmental task of psychic clarification of self and other can result in an increased risk to develop varieties of psychosis, while failure to overcome splitting results in an increased risk to develop a borderline personality.

Genetics

An overview of the existing literature suggested that traits related to BPD are influenced by genes. A major twin study found that if one identical twin met criteria for BPD, the other also met criteria in 35 percent of cases. People that have BPD influenced by genes usually have a close relative with the disorder.

Twin, sibling and other family studies indicate a partially heritable basis for impulsive aggression, but studies of serotonin-related genes to date have suggested only modest contributions to behavior.

Mediators and moderators

While research has examined variables that predict the development of borderline personality disorder (BPD), researchers have only recently begun to examine the variables that mediate and moderate the relationships between these variables and the development of the disorder. A mediator is a variable that affects how the relationship occurs. Mediation is said to be present when both the predictor variable and the mediating variable are significantly correlated with the dependent variable, and when the relationship between the predictor variable and the outcome variable is significantly reduced when controlling for the mediating variable. A moderating variable by contrast specifies the conditions under which a given outcome will occur. Moderation is said to occur when there is an interaction effect between the predicting variable and the moderating variable on the dependent variable. More specifically, the effect of the predicting variable is different depending on the level of the moderating variable.

Research has found statistically significant relationships between BPD symptoms and both sexual and physical abuse. Other factors including family environment variables also contribute to the development of the disorder. Bradley et al. found that both child sexual abuse (CSA) and childhood physical abuse and BPD symptoms were significantly related, and both CSA and childhood physical abuse were significantly related to family environment. When family environment and

childhood physical abuse were entered simultaneously into a regression equation, family environment was related to BPD symptoms and childhood physical abuse was related to BPD symptoms, although the relationship between BPD symptoms and childhood physical abuse was reduced. Therefore, CSA and childhood physical abuse both directly influence the development of BPD symptoms directly and are mediated by family environment.

Other research has examined the relationship between negative affectivity, thought suppression and BPD symptoms. The results of the mediational models in this study found that thought suppression mediated the relationship between negative affectivity and BPD symptoms. While negative affectivity significantly predicted BPD symptoms after controlling for CSA, this relationship was greatly reduced when thought suppression was introduced into the model. Thus, the relationship of negative affectivity to BPD symptoms is mediated by thought suppression.

Ayduk et al. (2008) found an interaction between rejection sensitivity and executive control in the prediction of BPD symptoms. This study found that BPD features were positively associated with rejection sensitivity (RS) and neuroticism and negatively associated with emotional control (EC). Their statistical analysis indicated that among those low in EC, RS was positively related to BPD features and among those high in RS, EC was negatively associated with BPD. By contrast, among those high in EC, RS was not significantly related to BP features, and among those low in RS, EC was not related to BPD features. In Study 2, BPD features were positively correlated to RS and negatively correlated with executive control. Additionally, the authors found that delay gratification times at age 4 had no significant relationship with BPD features at the time of the current study. Again, as in Study 1, the RS x EC interaction was significant. Among those low in EC, RS was positively related to BPD features, while among those high in EC, the effect of RS was reduced to marginal significance. Moreover, among those high in RS, EC was negatively associated with BPD features, but among those low in RS, EC was unrelated to BPD features.

Parker, Boldero and Bell (2006) indicated that both AI and AO self-discrepancy magnitudes were strongly correlated to each other and to BPD features. Self-complexity was not significantly related to any of the other factors. Among those high in self-complexity, the relationship between AI self-discrepancy magnitudes and BPD features was lower than among those with less self-complexity. Actual-ought self-discrepancy relationship with BPD features was not significantly moderated by self-complexity.

BPD is complex, and several factors have an impact on whether clinical features of BPD are present. None of the prediction factors above are sufficient to be the key factor in the development of BPD features. Increased knowledge of the development of the disorder may help prevent symptom aggravation and identify new treatment strategies. Future research should integrate the knowledge gained from these areas and study these variables simultaneously. Studies in which these variables are simultaneously examined would provide greater specificity in the relationships

between the variables. These articles taken together not only increase our knowledge of what factors and variables lead to the development of BPD features and BPD itself but also, when taken together, indicate future lines of research yet to be studied.

Management

Psychotherapy forms the foundation of treatment for borderline personality disorder with medications playing a lesser role. Treatments should be based on individual case presentation, rather than upon the diagnosis of BPD with co-morbid conditions determining medications use, if any. Hospitalization has not been found to improve outcomes or prevent suicide over community care in those with BPD.

Psychotherapy

A number of techniques have been studied for borderline personality disorder including cognitive behavioral therapy, interpersonal therapy, dialectical behavior therapy, and psychodynamic therapy among others. A special problem of psychotherapy with borderline patients is intense projection. It requires the psychotherapist to be flexible in considering negative attributions by the patient rather than quickly interpreting the projection.

Medications

The evidence of benefit for antipsychotics, mood stabilizers, and omega-3 fatty acids is weak. Antidepressants, antipsychotics and mood stabilisers (such as lithium) are regularly used however to treat co-morbid symptoms such as depression.

Services

Individuals with BPD sometimes use mental health services extensively. They accounted for about 20 percent of psychiatric hospitalizations in one survey. The majority of BPD patients continue to use outpatient treatment in a sustained manner for several years, but the number using the more restrictive and costly forms of treatment, such as inpatient admission, declines with time. Experience of services varies. Assessing suicide risk can be a challenge for mental health services (and patients themselves tend to underestimate the lethality of self-injurious behaviours) with typically a chronically elevated risk of suicide much above that of the general population and a history of multiple attempts when in crisis.

Prognosis

The American Psychiatric Association states that recent advancements have led to treatments reaching an 86% remission rate 10 years after treatment.

Particular difficulties have been observed in the relationship between care providers and individuals diagnosed with BPD. A majority of psychiatric staff report finding individuals with BPD moderately to extremely difficult to work with, and more difficult than other client groups. Some clients feel a diagnosis is helpful, allowing them to understand they are not alone, and to connect with others who have BPD and who have developed helpful coping mechanisms. On the other hand, some with the diagnosis of BPD have reported that the term "BPD" felt like a pejorative label rather than a helpful diagnosis, that self-destructive behaviour was incorrectly perceived as manipulative, and that they had limited access to care. Attempts are made to improve public and staff attitudes.

Epidemiology

The prevalence of BPD in the general population ranges from 1 to 2 percent. The diagnosis appears to be several times more common in (especially young) women than in men, by as much as 3:1, according to the DSM-IV-TR, although the reasons for this are not clear.

The prevalence of BPD in the United States has been calculated as 1 percent to 3 percent of the adult population, with approximately 75 percent of those diagnosed being female. It has been found to account for 20 percent of psychiatric hospitalizations.

History

Since the earliest record of medical history, the coexistence of intense, divergent moods within an individual has been recognized by such writers as Homer, Hippocrates and Aretaeus, the last describing the vacillating presence of impulsive anger, melancholia and mania within a single person. After medieval suppression of the concept, it was revived by Swiss physician Théophile Bonet in 1684, who, using the term folie maniaco-mélancolique, noted the erratic and unstable moods with periodic highs and lows that rarely followed a regular course. His observations were followed by those of other writers who noted the same pattern, including writers such as the American psychiatrist C. Hughes in 1884 and J.C. Rosse in 1890, who described "borderline insanity". Kraepelin, in 1921, identified an "excitable personality" that closely parallels the borderline features outlined in the current concept of borderline.

Adolf Stern wrote the first significant psychoanalytic work to use the term "borderline" in 1938, referring to a group of patients with what was thought to be a mild form of schizophrenia, on the borderline between neurosis and psychosis. For the next decade the term was in popular and colloquial use, a loosely conceived designation mostly used by theorists of the psychoanalytic and

biological schools of thought. Increasingly, theorists who focused on the operation of social forces were recognized as well.

The 1960s and 1970s saw a shift from thinking of the borderline syndrome as borderline schizophrenia to thinking of it as a borderline affective disorder (mood disorder), on the fringes of manic depression, cyclothymia and dysthymia. In DSM-II, stressing the affective components, it was called cyclothymic personality (affective personality). In parallel to this evolution of the term "borderline" to refer to a distinct category of disorder, psychoanalysts such as Otto Kernberg were using it to refer to a broad spectrum of issues, describing an intermediate level of personality organization between neurotic and psychotic processes.

Standardized criteria were developed to distinguish BPD from affective disorders and other Axis I disorders, and BPD became a personality disorder diagnosis in 1980 with the publication of DSM-III. The diagnosis was formulated predominantly in terms of mood and behavior, distinguished from sub-syndromal schizophrenia which was termed "Schizotypal personality disorder". The final terminology in use by the DSM today was decided by the DSM-IV Axis II Work Group of the American Psychiatric Association.

Society and culture

Film and television

Several films portraying characters either explicitly diagnosed or with traits strongly suggestive of mental illness have been the subject of discussion by certain psychiatrists and film experts. The films Play Misty for Me and Fatal Attraction are two examples, as is the memoir Girl, Interrupted by Susanna Kaysen (and the movie based on it, with Winona Ryder as Kaysen). Each of these films suggests the emotional instability of the disorder; however, the first two cases show a person more aggressive to others than to herself, which in fact is less typical. The 1992 film Single White Female suggests different aspects of the disorder: the character Hedy suffers from a markedly disturbed sense of identity and, as with the last two films, abandonment leads to drastic measures.

The character of Anakin Skywalker/Darth Vader in the Star Wars films has been "diagnosed" as having BPD. Psychiatrists Eric Bui and Rachel Rodgers have argued that the character meets six of the nine diagnostic criteria; Bui also found Anakin a useful example to explain BPD to medical students. In particular, Bui points to the character's abandonment issues, uncertainty over his identity and violent dissociative episodes. Other films attempting to depict characters with the disorder include The Crush, Malicious, Interiors, Notes On a Scandal, The Cable Guy and Cracks. The film Borderline, based on the book of the same name by Marie-Sissi Labrèche, attempts to explore BPD through its main character, Kiki.

Literature

The memoir Songs of Three Islands by Millicent Monks is a meditation on how BPD affects several generations of the wealthy Carnegie family.

In Lois McMaster Bujold's science fiction novel Komarr, Tien Vorsoisson has BPD; her disorder drives a large part of the story.

Awareness

In early 2008, the United States House of Representatives declared the month of May as Borderline Personality Disorder Awareness Month.

Controversies

Gender

The diagnosis of BPD has been criticized from a feminist perspective. This is because some of the diagnostic criteria/symptoms of the disorder uphold common gender stereotypes about women. For example, the criteria of "a pattern of unstable personal relationships, unstable self-image, and instability of mood," can all be linked to the stereotype that women are "neither decisive nor constant". The question has also been raised of why women are three times more likely to be diagnosed with BPD than men. Some think that people with BPD commonly have a history of sexual abuse in childhood. One feminist critique suggests that BPD is a stigmatizing diagnosis that can sometimes evoke negative responses from health care providers, and additionally, that women who have survived sexual abuse in childhood are therefore sometimes re-traumatized by any such abusive mental health service.

Some feminist writers have suggested it would be better to give these women the diagnosis of a post-traumatic disorder as this would acknowledge their abuse, but others have argued that the use of the PTSD diagnosis merely medicalizes abuse rather than addressing the root causes in society. Women may be more likely to receive a personality disorder diagnosis if they reject the female role by being hostile, successful or sexually active; alternatively if a woman presents with psychiatric symptoms but does not conform to a traditional passive sick role, she may be labelled as a "difficult" patient and given the stigmatizing diagnosis of BPD.

Stigma

The features of BPD include emotional instability, intense unstable interpersonal relationships, a need for relatedness and a fear of rejection. As a result, people with BPD often evoke intense

emotions in those around them. Pejorative terms to describe persons with BPD such as "difficult," "treatment resistant," "manipulative," "demanding" and "attention seeking" are often used, and may become a self-fulfilling prophecy as the clinician's negative response triggers further self-destructive behaviour. In psychoanalytic theory, this stigmatization may be thought to reflect countertransference (when a therapist projects their own feelings on to a client), as people with BPD are prone to use defense mechanisms such as splitting and projective identification. Thus the diagnosis "often says more about the clinician's negative reaction to the patient than it does about the patient ... as an expression of counter transference hate, borderline explains away the breakdown in empathy between the therapist and the patient and becomes an institutional epithet in the guise of pseudoscientific jargon" (Aronson, p 217).

This inadvertent counter transference can give rise to inappropriate clinical responses including excessive use of medication, inappropriate mothering and punitive use of limit setting and interpretation. People with BPD are seen as among the most challenging groups of patients, requiring a high degree of skill and training in the psychiatrists, therapists and nurses involved in their treatment. While some clinicians agree with the diagnosis under the name "borderline personality disorder", some would like the name to be changed. One critique says that some who are labeled "Borderline Personality Disorder" feel this name is unhelpful, stigmatizing, and/or inaccurate.

The Treatment and Research Advancements National Association for Personality Disorders (TARA-APD) campaigns to change the name and designation of BPD in DSM-5. The paper How Advocacy is Bringing BPD into the Light reports that "the name BPD is confusing, imparts no relevant or descriptive information, and reinforces existing stigma...".

Terminology

Because of the above concerns, and because of a move away from the original theoretical basis for the term (see history), there is ongoing debate about renaming BPD. Alternative suggestions for names include emotional regulation disorder or emotional dysregulation disorder. Impulse disorder and interpersonal regulatory disorder are other valid alternatives, according to John Gunderson of McLean Hospital in the United States. Another term (for example, by psychiatrist Carolyn Quadrio) is post traumatic personality disorganization (PTPD), reflecting the condition's status as (often) both a form of chronic post traumatic stress disorder (PTSD) and a personality disorder in the belief that it is a common outcome of developmental or attachment trauma. Some people do not report any kind of traumatic event.

Borderline Personality Disorder: Summarized

The main feature of borderline personality disorder (BPD) is a pervasive pattern of instability in

interpersonal relationships, self-image and emotions. People with borderline personality disorder are also usually very impulsive.

This disorder occurs in most by early adulthood. The unstable pattern of interacting with others has persisted for years and is usually closely related to the person's self-image and early social interactions. The pattern is present in a variety of settings (e.g., not just at work or home) and often is accompanied by a similar lability (fluctuating back and forth, sometimes in a quick manner) in a person's emotions and feelings. Relationships and the person's emotion may often be characterized as being shallow.

A person with this disorder will also often exhibit impulsive behaviors and have a majority of the following symptoms:

Frantic efforts to avoid real or imagined abandonment
A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
Identity disturbance, such as a significant and persistent unstable self-image or sense of self
Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating)
Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
Emotional instability due to significant reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
Chronic feelings of emptiness
Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
Transient, stress-related paranoid thoughts or severe dissociative symptoms

As with all personality disorders, the person must be at least 18 years old before they can be diagnosed with it.

Borderline personality disorder is more prevalent in females (75 percent of diagnoses made are in females). It is thought that borderline personality disorder affects approximately 2 percent of the general population.

Like most personality disorders, borderline personality disorder typically will decrease in intensity with age, with many people experiencing few of the most extreme symptoms by the time they are in the 40s or 50s.

Details about Borderline Personality Disorder Symptoms

Frantic efforts to avoid real or imagined abandonment.

The perception of impending separation or rejection, or the loss of external structure, can lead to profound changes in self-image, emotion, thinking and behavior. Someone with borderline personality disorder will be very sensitive to things happening around them in their environment. They experience intense abandonment fears and inappropriate anger, even when faced with a realistic separation or when there are unavoidable changes in plans. For instance, becoming very angry with someone for being a few minutes late or having to cancel a lunch date. People with borderline personality disorder may believe that this abandonment implies that they are "bad." These abandonment fears are related to an intolerance of being alone and a need to have other people with them. Their frantic efforts to avoid abandonment may include impulsive actions such as self-mutilating or suicidal behaviors.

Unstable and intense relationships.

People with borderline personality disorder may idealize potential caregivers or lovers at the first or second meeting, demand to spend a lot of time together, and share the most intimate details early in a relationship. However, they may switch quickly from idealizing other people to devaluing them, feeling that the other person does not care enough, does not give enough, is not "there" enough. These individuals can empathize with and nurture other people, but only with the expectation that the other person will "be there" in return to meet their own needs on demand. These individuals are prone to sudden and dramatic shifts in their view of others, who may alternately be seen as beneficient supports or as cruelly punitive. Such shifts other reflect disillusionment with a caregiver whose nurturing qualities had been idealized or whose rejection or abandonment is expected.

Identity disturbance.

There are sudden and dramatic shifts in self-image, characterized by shifting goals, values and vocational aspirations. There may be sudden changes in opinions and plans about career, sexual identity, values and types of friends. These individuals may suddenly change from the role of a needy supplicant for help to a righteous avenger of past mistreatment. Although they usually have a self-image that is based on being bad or evil, individuals with borderline personality disorder may at times have feelings that they do not exist at all. Such experiences usually occur in situations in which the individual feels a lack of a meaningful relationship, nurturing and support. These individuals may show worse performance in unstructured work or school situations.

How is Borderline Personality Disorder Diagnosed?

Personality disorders such as borderline personality disorder are typically diagnosed by a trained mental health professional, such as a psychologist or psychiatrist. Family physicians and general practitioners are generally not trained or well-equipped to make this type of psychological

diagnosis. So while you can initially consult a family physician about this problem, they should refer you to a mental health professional for diagnosis and treatment. There are no laboratory, blood or genetic tests that are used to diagnose borderline personality disorder.

Many people with borderline personality disorder don't seek out treatment. People with personality disorders, in general, do not often seek out treatment until the disorder starts to significantly interfere or otherwise impact a person's life. This most often happens when a person's coping resources are stretched too thin to deal with stress or other life events.

A diagnosis for borderline personality disorder is made by a mental health professional comparing your symptoms and life history with those listed here. They will make a determination whether your symptoms meet the criteria necessary for a personality disorder diagnosis.

Causes of Borderline Personality Disorder

Researchers today don't know what causes borderline personality disorder. There are many theories, however, about the possible causes of borderline personality disorder. Most professionals subscribe to a biopsychosocial model of causation -- that is, the causes of are likely due to biological and genetic factors, social factors (such as how a person interacts in their early development with their family and friends and other children), and psychological factors (the individual's personality and temperament, shaped by their environment and learned coping skills to deal with stress). This suggests that no single factor is responsible -- rather, it is the complex and likely intertwined nature of all three factors that are important. If a person has this personality disorder, research suggests that there is a slightly increased risk for this disorder to be "passed down" to their children.

Borderline Personality Disorder Treatment

Introduction

Borderline Personality Disorder is experienced in individuals in many different ways. Often, people with this disorder will find it more difficult to distinguish between reality from their own misperceptions of the world and their surrounding environment. While this may seem like a type of delusion disorder to some, it is actually related to their emotions overwhelming regular cognitive functioning.

People with this disorder often see others in "black-and-white" terms. Depending upon the circumstances and situation, for instance, a therapist can be seen as being very helpful and caring toward the client. But if some sort of difficulty arises in the therapy, or in the patient's life, the person might then begin characterizing the therapist as "bad" and not caring about the client at all.

Clinicians should always be aware of this "all-or-nothing" lability most often found in individuals with this disorder and be careful not to validate it.

Therapists and doctors should learn to be like a rock when dealing with a person who has this disorder. That is, the doctor should offer his or her stability to contrast the client's lability of emotion and thinking. Many professionals are turned-off by working with people with this disorder, because it draws on many negative feelings from the clinician. These occur because of the client's constant demands on a clinician, the constant suicidal gestures, thoughts, and behaviors, and the possibility of self-mutiliating behavior. These are sometimes very difficult items for a therapist to understand and work with.

Psychotherapy is nearly always the treatment of choice for this disorder; medications may be used to help stabilize mood swings. Controversy surrounds overmedicating people with this disorder.

Psychotherapy

Like with all personality disorders, psychotherapy is the treatment of choice in helping people overcome this problem. While medications can usually help some symptoms of the disorder, they cannot help the patient learn new coping skills, emotion regulation, or any of the other important changes in a person's life.

An initially important aspect of psychotherapy is usually contracting with the person to ensure that they do not commit suicide. Suicidality should be carefully assessed and monitored throughout the entire course of treatment. If suicidal feelings are severe, medication and hospitalization should be seriously considered.

The most successful and effective psychotherapeutic approach to date has been Marsha Linehan's Dialectical Behavior Therapy. Research conducted on this treatment have shown it to be more effective than most other psychotherapeutic and medical approaches to helping a person to better cope with this disorder. It seeks to teach the client how to learn to better take control of their lives, their emotions, and themselves through self-knowledge, emotion regulation, and cognitive restructuring. It is a comprehensive approach that is most often conducted within a group setting. Because the skill set learned is new and complex, it is not an appropriate therapy for those who may have difficulty learning new concepts.

Like all personality disorders, borderline personality disorder is intrinsically difficult to treat. Personality disorders, by definition, are long-standing ways of coping with the world, social and personal relationships, handling stress and emotions, etc. that often do not work, especially when a person is under increased stress or performance demands in their lives. Treatment, therefore, is also likely to be somewhat lengthy in duration, typically lasting at least a year for most.

Other psychological treatments which have been used, to lesser effectiveness, to treat this disorder include those which focus on social learning theory and conflict resolution. These types of solution-focused therapies, though, often neglect the core problem of people who suffer from this disorder -- difficulty in expressing appropriate emotions (and emotional attachments) to significant people in their lives due to faulty cognitions.

Providing a structured therapeutic setting is important no matter which therapy type is undertaken. Because people with this disorder often try and "test the limits" of the therapist or professional when in treatment, proper and well-defined boundaries of your relationship with the client need to be carefully explained at the onset of therapy. Clinicians need to be especially aware of their own feelings toward the patient, when the client may display behavior which is deemed "inappropriate." Individuals with borderline personality disorder are often unfairly discriminated against within the broad range of mental health professionals because they are seen as "trouble-makers." While they may indeed need more care than many other patients, their behavior is caused by their disorder. Phillip W. Long, M.D. also notes that:

"The therapeutic alliance should form within the patient's real experiences with the therapist and with the treatment. The therapist must be able to tolerate repeated episodes of primitive rage, distrust, and fear. Uncovering is to be avoided in favor of bolstering of ego defenses, in order to eventually allow the patient to be less anxious about potential fragmentation and loss. The goals of therapy should be in terms of life gains toward independent functioning, and not complete restructuring of the personality."

Hospitalization

Hospitalization is often a concern with people who suffer from borderline personality disorder because they so often visit hospital emergency rooms and are sometimes seen on inpatient units because of severe depression.

People with this disorder often present in crisis at their local community mental health center, to their therapist, or at the hospital emergency room. While an emergency room is an immediate source of crisis intervention for the patient, it is a costly treatment and regular visits to the E.R. should be discouraged. Instead, patients should be encouraged to find additional social support within their community (including self-help support groups), contact a crisis hotline, or contact their therapist or treating physician directly. Emergency room personnel should be careful not to treat the person with borderline personality disorder in blind conjunction with another set of therapists or doctors who are treating the patient for the same problem at another facility. Every attempt should be made to contact the client's attending physician or primary therapist as soon as possible, even before the administration of medication which may be contraindicated by the primary treatment provider. Crisis management of the immediate problem is usually the key component to effective

treatment of this disorder when it presents in a hospital emergency room, with discharge to the patient's usual care provider.

Inpatient treatment often takes the form of medication in conjunction with psychotherapy sessions in groups or individually. This is an appropriate treatment option if the person is experiencing extreme difficulties in living and daily functioning. It is, however, relatively rare to be hospitalized in the U.S. for this disorder. Long-term care of the person suffering from borderline personality disorder within a hospital setting is nearly never appropriate. The typical inpatient stay for someone with borderline personality disorder in the U.S. is about 3 to 4 weeks, depending upon the person's insurance. Since this treatment is so expensive, it is getting more difficult to obtain. Results of such treatment are also mixed. While it is an excellent way of helping stabilize the client, it is usually too short a time to attain significant changes within the individual's personality makeup.

Good inpatient care facilities for this disorder should be highly structured environments which seek to expand the individual's independence. Phillip W. Long, M.D., adds that the goals of such a treatment modality, "include decreasing acting out, clearly identifying and working with inappropriate behaviors and feelings, accepting with the patient the magnitude of the therapeutic task, fostering more effective interpersonal relationships, and working with both real and transference relationships within the hospital."

Partial hospitalization or a day treatment program is often all that's needed for people who suffer from borderline personality disorder. This allows the individual to gain support and structure from a safe environment for a short time, or during the day, and returning home in the evening. In times of increased stress or difficulty coping with specific situations, this type of treatment is more appropriate and more healthy for most people than full inpatient hospitalization.

Medications

Phillip W. Long, M.D. has noted:

"During brief reactive psychoses, low doses of antipsychotic drugs may be useful, but they are usually not essential adjuncts to the treatment regimen, since such episodes are most often self-limiting and of short duration.

It is, however, clear that low doses of high potency neuroleptics (e.g., haloperidol) may be helpful for disorganized thinking and some psychotic symptoms. Depression in some cases is amenable to neuroleptics. Neuroleptics are particularly recommended for the psychotic symptoms mentioned above, and for patients who show anger which must be controlled. Dosages should generally be low and the medication should never be given without adequate psychosocial intervention."

Antidepressant and anti-anxiety agents may be appropriate during particular times in the patient's

treatment, as appropriate. For example, if a client presents with severe suicidal ideation and intent, the clinician may want to seriously consider the prescription of an appropriate antidepressant medication to help combat the ideation. Medication of this type should be avoided for long-term use, though, since most anxiety and depression is directly related to short-term, situational factors that will quickly come and go in the individual's life.

Self-Help

Self-help methods for the treatment of this disorder are often overlooked by the medical profession because very few professionals are involved in them. Encouraging the individual with borderline personality disorder to gain additional social support, however, is an important aspect of treatment. Many support groups exist within communities throughout the world which are devoted to helping individuals with this disorder share their commons experiences and feelings.

Patients can be encouraged to try out new coping skills and emotion regulation with people they meet within support groups. They can be an important part of expanding the individual's skill set and develop new, healthier social relationships.