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A General Review of Borderline Personality Disorder

Yangxian Zhong[1, *]

[1]Department of Psychology, Waikato University, Hamilton, New Zealand
*Corresponding author: yz689@students.waikato.ac.nz

Abstract:

Borderline Personality Disorder (BPD) is a pervasive psychological personality disorder that features affective instability, interpersonal dysfunction, and distorted self-concept, often leading to significant psychological distress and impaired functioning. This literature review synthesizes current research on the epidemiology, diagnosis controversies, symptomatology, etiology, and treatment of BPD. Notable findings indicate a high prevalence of BPD, with diagnostic challenges due to symptom overlap with other mental disorders. Etiologically, studies underlined the detrimental impact of childhood trauma and adverse family dynamics. Treatment modalities like Dialectical Behavior Therapy (DBT), Mentalization-Based Treatment (MBT), and Transference-Focused Psychotherapy (TFP) show efficacy in managing symptoms and improving function. This review highlights the complexity of BPD and the need for tailored therapeutic approaches to effectively address the multifaceted nature of the disorder.

Keywords: Personality disorders; Emotion dysregulation; Fear of abandon

1. Introduction

BPD is a complicated mental illness with typical symptoms of constant unstable patterns of affection, self-perception, and social network due to extreme fear of abandonment, which results in intense episodes of sadness, worry, and anger, as well as impulsive, irrational decision-making and self-harm related behaviors [1].

Even though there is already a great number of research on BPD, more attention and scientific evidence regarding this disorder are deserved, just as most research indicated, BPD exerts a debilitating impact on individuals with this mental illness, which manifests as risky, self-harm behaviors, especially suicidal attempts, and completions that mainly on account of uncontrollability of emotion. A comprehensive review of literature in terms of prolonged suicidal attempts in BPD underscores the fact that around one in ten people diagnosed with BPD commit suicide during the latter progression of the BPD course, meanwhile, the long-term pattern of suicidal attempts in BPD also is stressed [2].

When comes to the epidemiology of BPD, it is apparent BPD is a ubiquitous unhealthy mental condition based on vast research evidence. In 2008, Korzekwa et al. conduct a two-phase procedure in the adult outpatient university clinic, in which SCID-II-PQ is employed at the first screening phase of individuals with BPD and then revised diagnostic interview for borderline follows for those classified as positive, however, the research findings reveal that 22.6% of the individuals screened tested positive for BPD according to the DIB-R. This prevalence rate surpasses that observed in semi-structured interview studies [3].

In terms of how BPD would be diagnosed, the DSM-IV outlines specific criteria involving unstable interpersonal relationships, identity disturbance, engaging in highly impulsive activities, reoccurring suicidal threats or gestures, and feelings of emptiness.

Nevertheless, the efficiency of the diagnostic criteria is cast doubt by some researchers due to its comorbidities with other psychological disorders. Some scholars articulates the substantial overlap in symptomatology between BPD and several other psychiatric disorders including bipolar disorder, major depression, and ADHD and this overlap significantly complicates the accurate diagnosis of BPD leading to misdiagnosis [4]. Besides, the validity of BPD as an independent psychological disorder also is questioned, some researchers highlight the instability and inconsistency of BPD symptoms, what's more, propose the heterogeneity within BPD diagnoses, which allows for 151 different symptom combinations to qualify for the diagnosis of BPD [5].

In brief, this review paper aims to explore the etiological model and feasible treatments for BPD based on some essential research findings in this area.

2. BPD Symptomatology

With regard to the symptomatology of BPD, the core

manifestation of BPD could be classified into emotion dysregulation, impulsivity and risk-taking behaviors, unstable social networks, distorted self-image, and suicidal behavior.

In terms of affective instability, which is a hallmark characteristic of BPD, followed by rapid mood changes, intense emotional responses to environmental stressors, and slow return to emotional baseline. People with BPD have very intense emotions that last for a very long time, and it takes people quite long to return to a baseline emotional state, which markedly interferes with the ability to function in daily settings. Such a symptom relates to particular troubles that individuals show in managing their responses either to daily stresses and slights or to problems that are either real or imagined, with others. Anger, sadness, and anxiety are frequently experienced and at high intensities that disturb their relations with people and affect their work and social environment [6].

Also, BPD carries an extremely high prevalence of suicidal attempts, commitments, or threats, which are both reoccurring and self-harm behavior, such as cutting or burning. Most of the time, the behavior is likely said to be reactive to interpersonal stressors. It, therefore, may serve as a coping action in expressing pain or emotional distress. Instead, relevant measures predict a substantial risk of complete suicide among these people. Most suicidal attempts behaviors are seen as a way to express deep mental pain or suffering, or battle against feelings of numbness or emptiness. The frequency of such behaviors exposes the intensity of emotional storms among persons with BPD and thus concludes, without wasting time, that effective therapeutic interventions are absolutely necessary [6].

In addition, most individuals with BPD manifest impulsiveness in behaviors that include taking great risks with recklessness: driving at very high speeds, overeating, engaging in binge eating, substance abuse, and engaging in unplanned sexual encounters. Attempts to either tolerate or avoid the behavior often are a way of managing or escaping painful emotions or dysphoria. Unfortunately, such acts are a clear giveaway to self-destruction and tend to be linked more with self-destruction, contributing to the feelings of chronic guilt and shame that characterize such a disorder. Financial troubles, health problems, and troubles in relations with family, spouses, and friends—all add to the turbulence in feelings, which results in the havoc created by this impulsiveness [6].

And when comes to the instability of interpersonal relations, the interpersonal relations of persons with BPD are unstable and intense—usually, they oscillate between extreme idealization and devaluation (such as splitting). The instability is what can cause very stormy interpersonal relations due to a multiplicity of emotional struggles, misunderstandings, and, in severe cases, even social isolation. This fear of abandonment may bring forth frantic efforts to avoid being left alone, and in most cases, paradoxically, this might be what drives others away. These relational difficulties are at the heart of the disorder, with cascading impacts that adversely affect many destabilizing life events within the lives of affected persons [7].

Another basic symptom of BPD is to have a noticeably and constantly pendulous self-concept. Elements of self-identity have been reported to change from time to time to the extent that the person's values, aspirations, and even professional goals, including self-worth, may end up being changed. These changes make it hard to keep a continuous eyes on personal goals and also the career path, leading to feelings of emptiness and boredom. An individual with a distorted self-perception may suddenly alter their decisions or attitudes, such as career, sexual identity, and types of friends, depending on the people they stay with [7].

3. Etiology of BPD

It is well-recognized that the etiology of BPD is complicated and multifaceted, which means that there is an interplay between environmental and psychosocial elements facilitating the development of BPD. Moreover, the following part will particularly focus on how the external environmental and psychosocial factors could be considered as risky factors or predictors of BPD to some extent.

3.1 Early Adverse Experience and BPD

In a review paper discussing the causal association between early adverse experience and BPD, a systematic analysis of a wide range of formal articles in the period from 1995 and 2007 through Hill's criteria, emphasizes strength, consistency, specificity, temporality, and biological gradient. The authors first discuss the strength of the correlation between early traumatic history and BPD by reviewing multiple studies indicating a disproportionately high prevalence of TE in childhood among those diagnosed with BPD compared to individuals with other personality disorders. What's more, longitudinal studies also are discussed to support the premise that traumatic events in childhood precede the onset of BPD symptoms, like a research conducted at four sites across the northeastern United States and designed to investigate the interaction mechanism between distinct traumatic exposure and various personality disorders out of naturalistic approach, in which researchers observe that there is especially significant correlation between BPD and TE, especially sexual abuse. Moreover, the researchers also find that the first traumatic exposure of BPD patients generally occurs at a younger age when compared with other personality dis-

order groups [8]. Besides this longitudinal study, another longitudinal study aimed to examine whether there is a strong association between childhood adverse experiences and the development of various personality disorders in early adulthood, which highlights that physical abuse and neglect also serve as a strong predictor of BPD except for sexual abuse [9]. In terms of specificity, the review recognizes the complex nature of BPD etiology, indicating that while a significant correlation between childhood trauma and BPD exists, trauma is not an absolute determinant of BPD, accordingly, the authors propose that a multifactorial etiological model could be taken into account, which suggests that while childhood trauma is a significant factor, it interacts with genetic, biological, and other external circumstantial elements. Concerning the discussion of consistency across research, it turns out that research consistently demonstrates higher rates of early adverse experiences among BPD patients across different populations and research methodologies. In terms of the study sample, most research mentioned in this review mainly focuses on comparing individuals diagnosed with BPD with patients who struggled with other personality disorders, but there is also research taking account of demographic variables, which involves the inner-city, primarily African American population from an inpatient substance abuse treatment center. Besides, various research methods are employed in most studies such as retrospective analysis, clinical case, and longitudinal studies. Moreover, this review not only advances the understanding of BPD's complex origins but also guides future research and clinical practice in developing more effective interventions for this challenging and often misunderstood disorder as it emphasizes the significance of the multifaced etiology of BPD which interplay of early adversities and other external environmental influences serves as possible predictors of BPD, and in turn the mental health clinician could be more susceptible to adopt an idiosyncratic approach in the interventions and treatments like integrated treatment [10].

3.2 Relationship between Family Interaction and Development of BPD

There are also other researchers dedicated to exploring the relationship between family interaction and the development of BPD, several scholars design a transactional mode in their study which stresses invalidating family environments—where individual feelings, thoughts, and behaviors are routinely dismissed or met with inappropriate responses—serve to aggravate the emotional and behavioral dysfunction, which is the representative manifestation of BPD. The authors also illustrate how negative family interactions, particularly those characterized as invalidating or conflict-laden, and the absence of validating, supportive, and empathetic interactions, significantly contribute to the onset and progression of BPD [11].

Besides, there is one research that explores the influence of childhood trauma, parental bonding, and family functioning in female teenagers with BPD. The sample of this research primarily consists of adolescent inpatients, comparing those diagnosed with BPD to a clinical control group with different combinations of psychological disorders. Through structured clinical interviews and self-reported measures in which the childhood traumatic history, family dysfunction, and quality of bonding with parents are assessed, the research identifies remarkable distinctions regarding the prevalence and typology of childhood adversities between the two groups. The findings of this research reveal an obviously higher prevalence of childhood adversity in the BPD group, accompanied by adversities such as sexual abuse, inadequate maternal protection, and family disorganization emerging as prominent, independent predictors of BPD in adolescents. This study underscores the complex interplay of various forms of childhood adversity during the course of BPD, highlighting the critical effect of familial relationships and environment [12].

In addition, there is also research designed to explore the intricate association between childhood family models, TE, and the development of BPD, but the impact of sexual abuse would be especially elaborated, moreover, a mixed sample of depressed female inpatients is employed.

Weaver and Clum in their study meticulously assess childhood adversities such as sexual assault, physical maltreatment, witnessed violence, and early separation, alongside various dimensions of family environment like cohesiveness, expressiveness, conflict, and control, through structured questionnaires administered to a cohort of depressed female inpatients. A significant finding of this study is the pronounced prevalence of TE in individuals diagnosed with BPD, which contrasted sharply with individuals immune to BPD. Particularly, sexual assault appeared to be predictive of BPD, indeed when physiological maltreatment and family interaction patterns factors are managed. Furthermore, the study illustrates that BPD individuals report distinctively less cohesive, expressive, and more conflict-laden family environments. The implication of these findings is profound, suggesting that both individual TE and broader family dynamics exert essential influence in the development of BPD [13].

Also, there is research conducted in Hungary to examine the potential correlation between childhood adversities and the development of BPD in Hungary inpatients, which provides valuable insights into the risky factors most strongly associated with BPD. The study assesses the traumatic history of 80 borderline inpatients compared to 73

depressed inpatients and 51 healthy controls, focusing on abuse, neglect, and family dysfunction. The results reveal a higher prevalence of all forms of childhood trauma—especially serious sexual assault (40% to 86%), marked by incest, penetration, and repetitive abuse—among BPD patients than in the control groups. This study highlights the significant role of intrafamilial physical abuse, sexual abuse, and neglect by caretakers as the strongest predictors of a BPD diagnosis, indicating a pattern where BPD patients often emerge from highly disturbed family environments [14].

In addition, there is also one research designed to demonstrate how childhood emotional neglect and overprotection affect the development of BPD. Zweig-Frank and Paris meticulously evaluate the recollections of 62 borderline patients compared to 99 non-borderline controls whose age is between 18 and 50 and whose intellectual functioning reaches at least an average level, recruited from a general hospital psychiatric clinic and a university student mental health clinic. Utilizing the Parental Bonding Instrument, the study assesses patients' memories of parenting on dimensions of care and protection. The study's findings reveal that both male and female BPD patients, regardless of the treatment setting, recall significantly less parental care and greater overprotection compared to controls. These findings are consistent across genders and the two different clinical settings, strengthening the generalizability of the results. Specifically, BPD patients hold the belief that both parents are emotionally unavailable and adopt an authoritarian parenting style when required to recall their interaction with primary caregivers in childhood, which supports psychodynamic theories positing biparental failures in the developmental histories of individuals with BPD. This research is highly insightful as not only highlights the critical role of childhood experiences in the etiology of BPD but also suggests a complex interplay between lack of parental care and excessive control in shaping the emotional world of those who develop this disorder [15].

4. Treatment of BPD

It is well-known, that there are various treatments for BPD, mainly classified as psychotherapy, pharmacotherapy, and sometimes combined therapies to ameliorate or improve the overall functioning or specific dysfunction issues in patients with BPD. Currently, several mainstream psychotherapies are the focus of this review, which refer to dialectical behavioral therapy, cognitive behavioral therapy, mentalization-based therapy, and transference-focused psychotherapy.

4.1 Dialectical behavioral therapy (DBT)

Dialectical behavioral therapy is a subtype of CBT designed to help people to better identify and cope with emotion dysregulation, which involves several crucial skills referring to mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance respectively. It is targeted at individuals with BPD in the first place, even though it has been applied in distinctive treatment approaches to other mental disorders [16].

Moreover, there is a comprehensive meta-analysis conducted to examine the effectiveness of DBT by Kliem, Kröger, and Kosfelder by employing mixed-effects modeling. This study selectively screens the relevant research out of a single diagnosis of BPD, specific treatment related to formal or suggested DBT guidelines, and a number of intervention groups, afterward, drawing from 16 primary studies including eight randomized controlled trials (RCTs) and eight non-randomized or controlled trials (nRCTs), which focuses particularly on influence on suicidal and self-injurious behaviors. The results revealed moderate global effect sizes post-intervention, indicating DBT's effectiveness in reducing these critical behaviors among BPD patients, like suicidal gestures, self-harm, and some general psychopathology symptoms like depression. What's more, it is also verified that DBT's efficacy in significantly decreasing self-rated psychopathology, such as depression, anxiety, dissociation, and self-mutilating behavior, both immediately following treatment and at follow-up periods. The evidence from research results likewise supports DBT's structured approach, which prioritizes the reduction of life-threatening behaviors and enhances skills for dealing with distress, emotional regulation, and interpersonal effectiveness [17].

4.2 Mentalization-based Therapy

In terms of mentalization-based therapies targeted at BPD, its focus on promoting the development of mentalization if emotion stability has been achieved, and being more attentive to individuals' own mental states and internal representation which could be regarded as a distinction from DBT.

In one research conducted by Fonagy and Luyten, it has been testified that some specific impairment of mentalization is closely associated with some primary symptoms of BPD, like emotion dysregulation, interpersonal instability, and impulsiveness. The authors posit a connection between BPD and a diminished threshold for initiating the attachment system, subsequently resulting in swift impairment of regulated mentalization. This correlation is associated with deficiencies in discerning between personal and external mental states, culminating in increased responsiveness to social cues and inadequate fusion of

cognitive and affective elements within mental states. These dysfunctions foster the propensity of individuals with BPD to enter into intense, unstable interpersonal cycles and experience significant affect dysregulation and impulsivity. What's more, Fonagy and Luyten discuss the therapeutic implications of this expanded mentalization-based model. They advocate for interventions that enhance mentalization capacities within the context of attachment relationships. The goal is to improve both the behavioral and affective symptoms of BPD by restoring the ability to mentalize, particularly in the context of emotionally charged interpersonal interactions. The authors suggest that effective treatment must focus on stabilizing mentalization during times of emotional stress, thereby addressing the core psychopathological features of BPD [18].

4.3 Evaluation of Different Treatments for BPD

Furthermore, some researchers implement an in-depth study evaluating three distinct treatments for BPD: Dialectical Behavior Therapy (DBT), Transference-Focused Psychotherapy (TFP), and Supportive Treatment, which aims to investigate the yearlong efficacy of these outpatient treatments, with a cohort of ninety patients diagnosed with BPD. The assessments are conducted at four-month intervals, monitoring various domains including suicidality, aggression, impulsivity, anxiety, depression, and social adjustment. However, their findings reveal significant improvements across all three treatment modalities in terms of depression, anxiety, global functioning, and social adjustment. Notably, both DBT and TFP demonstrate significant associations with reductions in suicidality, while TFP and Supportive Treatment are linked to improvements in anger management. Additionally, TFP uniquely facilitates substantial progress in impulsivity, irritability, and aggressive behaviors, showcasing its broader impact across multiple behavioral and emotional domains [19].

5. Discussion

Diagnosis and treatment of BPD are considerably complicated due to the disorder's intricate nature. Despite the progress made in comprehending the fundamental symptoms of BPD through current research, the clinical management of this condition remains complicated due to the considerable overlap with other psychiatric disorders and the considerable variability in symptom presentation. As a consequence, there has been a demand for more refined diagnostic standards that more precisely capture the diversity of the disorder.

Furthermore, despite the demonstrated effectiveness of treatments such as Dialectical Behavior Therapy (DBT), the multifaceted presentation of symptoms associated with BPD implies that a universal strategy may prove insufficient. There is a notable research void concerning the necessity for individualized treatment approaches that take into account the variations in symptoms and underlying psychopathology among each patient.

Furthermore, further longitudinal investigations are required to monitor the evolution of symptoms associated with BPD. Such research would shed light on the developmental trajectories of BPD, aid in the identification of critical early intervention moments, and offer insights into the chronic and variable nature of symptoms. Such knowledge would contribute to the development of more dynamic therapeutic and diagnostic models.

6. Conclusion

To summarize, the examination of the existing literature on BPD demonstrates the intricate nature of identifying and treating this formidable condition. The interplay of environmental circumstances and psychological effects contributes to the varied manifestations of BPD, requiring a comprehensive approach to its treatment. Further investigation should focus on examining the subtle details of diagnostic criteria to improve precision and specificity, hence minimizing the risk of incorrect diagnoses. In summary, the continuous investigation into BPD is vital for progressing treatment methods, enhancing patient results, and eventually, improving the quality of life for persons affected by this condition.

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