PERSONALITY DISORDERS

Borderline Personality Disorder

BPD

DSM-5-TR 301.83 | ICD-10-CM F60.3

Pervasive instability of affect, identity and relationships with marked impulsivity and recurrent self-harm, beginning by early adulthood.

PREVALENCE	TYPICAL ONSET	SEX RATIO	COURSE
~1.6% point, ~5.9% lifetime	Adolescence to early 20s	1:1 community, 3:1 F clinic	~85% remit by 10 years

CLINICAL PICTURE

- Frantic efforts to avoid real or imagined abandonment dominate, so a cancelled appointment can precipitate crisis, rage or self-injury.
- Relationships oscillate between idealization and devaluation, and clinicians typically notice strong countertransference pulls in both directions.
- Affective instability shifts within hours rather than days, most often among dysphoria, irritability and anxiety rather than toward euphoria.
- Non-suicidal self-injury such as cutting or burning relieves numbness or tension; roughly 75% attempt suicide and 8-10% eventually die by suicide.
- Chronic emptiness, unstable self-image, and transient stress-related paranoia or dissociation lasting minutes to hours are characteristic.
- Impulsivity spans spending, sex, substance use, reckless driving and binge eating, and is scored separately from self-harming behavior.

DIAGNOSTIC CRITERIA AT A GLANCE

- Requires five or more of nine criteria spanning affective, interpersonal, behavioral and identity domains, present since early adulthood.
- The pattern must be pervasive across contexts and stable over time rather than episodic, which separates it from mood-episode phenomena.
- Recurrent suicidal or self-mutilating behavior is a distinct criterion from impulsivity, and both may be counted toward the threshold.
- Diagnosis before age 18 is explicitly permitted when the features have been present for at least one year and are unlikely to be developmental.
- The Section III alternative model rates self and interpersonal dysfunction plus traits such as emotional lability, anxiousness and impulsivity.

NEUROBIOLOGY & PHYSIOLOGY

- Heritability runs 40-60%, with amygdala hyperreactivity and reduced prefrontal and anterior cingulate top-down control driving affective storms.
- Reduced hippocampal and amygdala volumes with altered frontolimbic functional connectivity are the most replicated structural imaging findings.
- Blunted endogenous opioid tone may explain chronic emptiness and the analgesic quality of self-injury, alongside reduced pain sensitivity under stress.
- HPA axis dysregulation with abnormal dexamethasone suppression follows the early-life adversity reported by a majority of patients.
- Serotonergic hypofunction tracks impulsive aggression, while dopaminergic dysregulation is linked to transient psychotic-like and dissociative symptoms.
- Oxytocin effects are paradoxical, since intranasal oxytocin can reduce rather than increase trust in patients with high rejection sensitivity.

PSYCHOLOGICAL MECHANISMS

- Linehan's biosocial theory holds that an emotionally vulnerable temperament transacting with an invalidating environment yields pervasive dysregulation.
- Disorganized attachment and unresolved trauma generate hyperactivated attachment strategies, so closeness and abandonment both register as threats.
- Mentalization failure under attachment stress collapses the distinction between internal states and external reality, driving misreading of intent.
- Splitting and projective identification defend against intolerable ambivalence and account for staff splitting on inpatient units.
- Self-injury and impulsive acts are negatively reinforced by immediate affect relief, which makes them highly resistant to insight alone.

DIFFERENTIAL & COMORBIDITY

- Bipolar II is distinguished by sustained episodes lasting days to weeks with sleep and energy change, versus reactive shifts lasting hours in BPD.
- Complex PTSD, ADHD, substance use disorders and antisocial personality disorder overlap heavily and are usually better formulated as comorbid.
- Comorbidity rates are high: major depression near 80%, PTSD 30-50%, substance use near 50%, eating disorders near 30%, and other personality disorders.
- Risk management requires separating chronic suicide risk from acute-on-chronic escalation, since repeated brief hospitalization can be iatrogenic.
- Screen for trauma history, intimate partner violence, and prescribing hazards including opioid and benzodiazepine dependence or stockpiling.

Treatment EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- No medication is FDA-approved for BPD, and guidelines place psychotherapy first with pharmacotherapy reserved for comorbidity or acute crisis.
- Mood stabilizers such as **lamotrigine** and **topiramate** showed early signal for anger and impulsivity, but the largest lamotrigine trial was negative.
- Second-generation antipsychotics such as **aripiprazole 5-15 mg/day** or quetiapine reduce anger and cognitive-perceptual symptoms short-term.
- SSRIs treat comorbid depression and anxiety but do not address core BPD features, so avoid reflexive polypharmacy and long-term sedative prescribing.
- Benzodiazepines can disinhibit and increase self-harm, so limit quantities dispensed and review overdose risk for every agent prescribed.

PSYCHOTHERAPY

- **DBT** over 12 months with weekly individual therapy, skills group, phone coaching and a consultation team has the strongest randomized trial evidence.
- **MBT** and **transference-focused psychotherapy** produce comparable gains, supporting a structured, well-boundaried frame over any single brand.
- **Good psychiatric management** is a generalist model teachable in a day and shown non-inferior to DBT in a Canadian randomized trial.
- **Schema therapy** and STEPPS add further options, and all effective models share a clear frame, explicit crisis planning and therapist consultation.
- Expect one to two years of treatment, with early gains in self-harm and hospitalization preceding improvement in identity and functioning.

ADJUNCT & SUPPORTIVE

- Favor brief crisis stabilization over extended inpatient stays, which can reinforce regression and interrupt outpatient skills learning.
- Written crisis and safety plans, means restriction and explicit between-session contact rules measurably reduce emergency presentations.
- Family psychoeducation such as Family Connections lowers caregiver burden and criticism, improving the patient's interpersonal environment.
- Track outcome with the **BSL-23**, DERS or the Zanarini rating scale, and monitor self-harm frequency rather than subjective distress alone.
- Address vocational rehabilitation and social role functioning, which lag behind symptom remission by years in longitudinal follow-up data.

CLINICAL PEARLS

- Mood shifts in hours, not weeks; that timing separates BPD instability from bipolar II.
- Most patients remit: roughly 85% no longer meet criteria at 10 years of follow-up.
- Prescribe less and structure more; polypharmacy is the commonest iatrogenic harm here.

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NOTE

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