

Signs and Symptoms Of Borderline Personality Disorder

Borderline personality disorder may be characterised by the following signs and symptoms:

- **Markedly disturbed sense of identity**
- **Frantic efforts to avoid real or imagined abandonment**
- **Splitting ("black-and-white" thinking)**
- **Severe impulsivity**

- **Intense or uncontrollable emotional outbursts that often seem disproportionate to the event or situation**

- **Unstable and chaotic interpersonal relationships**

- **Self-damaging behaviour**
- **Distorted self-image**
- **Dissociation**
- **Frequently accompanied by depression, anxiety, anger, substance abuse, or rage**

The most distinguishing symptoms of BPD are marked sensitivity to rejection or criticism, and intense fear of possible abandonment. Overall, the features of BPD include unusually intense sensitivity in relationships with others, difficulty regulating emotions, and impulsivity. Other symptoms may include feeling unsure of one's personal identity, morals, and values; having paranoid thoughts when feeling stressed; dissociation and depersonalization; and, in moderate to severe cases, stress-induced breaks with reality or psychotic episodes.

Emotions

People with BPD feel emotions more easily, more deeply, and longer than others do. In addition, emotions may repeatedly resurge and persist a long time. Consequently, it may take more time for people with BPD than others to return to a stable emotional baseline following an intense emotional experience. People with BPD often engage in idealisation and devaluation of others, alternating between high positive regard and great disappointment.

In Marsha Linehan's view, the sensitivity, intensity, and duration with which people with BPD feel emotions have both positive and negative effects. People with BPD are often exceptionally enthusiastic, idealistic, joyful, and loving. However, they may feel overwhelmed by negative emotions ("anxiety, depression, guilt/shame, worry, anger, etc."), experiencing intense grief instead of sadness, shame and humiliation instead of mild embarrassment, rage instead of annoyance, and panic instead of nervousness.

People with BPD are also especially sensitive to feelings of rejection, criticism, isolation, and perceived failure. Before learning other coping mechanisms, their efforts to manage or escape from their very negative emotions may lead to self-injury or suicidal behaviour. They are often aware of the intensity of their negative emotional reactions and, since they cannot regulate them, they shut them down entirely. This can be harmful to people with BPD, since negative emotions alert people to the presence of a problematic situation and move them to address it which the person with BPD would normally be aware of only to cause further distress.

While people with BPD feel joy intensely, they are especially prone to dysphoria, depression, and/or feelings of mental and emotional distress.

Zanarini et al. recognized four categories of dysphoria that are typical of this condition: extreme emotions, destructiveness or self-destructiveness, feeling fragmented or lacking identity, and feelings of victimisation.

*Within these categories, a BPD diagnosis is strongly associated with a **combination of three specific states:***

***** feeling betrayed, **"feeling like hurting myself", and ** feeling out of control.***

Since there is great variety in the types of dysphoria experienced by people with BPD, the amplitude of the distress is a helpful indicator of borderline personality disorder.

In addition to intense emotions, people with BPD experience emotion lability; or in other words, changeability. Although the term emotional lability suggests rapid changes between depression and elation, the mood swings in people with

this condition actually fluctuate more frequently between anger and anxiety and between depression and anxiety.

Behaviour

Impulsive behaviour is common, including substance or alcohol abuse, eating disorders, unprotected sex or indiscriminate sex with multiple partners, reckless spending, and reckless driving. Impulsive behaviour may also include leaving jobs or relationships, running away, and self-injury.

People with BPD act impulsively because it gives them immediate relief from their emotional pain. However, in the long term, people with BPD suffer increased pain from the shame and guilt that follow such actions. A cycle often begins in which people with BPD feel emotional pain, engage in behaviour to relieve that pain, feel shame and guilt over their actions, feel emotional pain from the shame and guilt, and then experience stronger urges to engage in impulsive behaviour to relieve the new pain. As time goes on, impulsive behaviour may become an automatic response to emotional pain.

Self-harm such as cutting oneself is a common sign in borderline personality disorder.

Self-harming or suicidal behaviour is one of the core diagnostic criteria in the DSM-5. The lifetime risk of suicide among people with BPD is between 3% and 10%. There is evidence that men diagnosed with BPD are approximately twice as likely to complete suicide as women diagnosed with BPD. There is also evidence that a considerable percentage of men who complete suicide may have undiagnosed BPD.

Self-harm, such as cutting, is common and takes place with or without suicidal intent.

The reported reasons for non-suicidal self-injury (NSSI) differ from the reasons for suicide attempts. Nearly 70% of people with BPD self-harm without trying to end their life. Reasons for NSSI include expressing anger, self-punishment, generating normal feelings

(often in response to dissociation), and distracting oneself from emotional pain or difficult circumstances.

In contrast, suicide attempts typically reflect a belief that others will be better off following the suicide. Both suicidal and non-suicidal self-injury are a response to feeling negative emotions.

Sexual abuse can be a particular trigger for suicidal behaviour in adolescents with BPD tendencies.

Interpersonal relationships

People with BPD can be very sensitive to the way others treat them, by feeling intense joy and gratitude at perceived expressions of kindness, and intense sadness or anger at perceived criticism or hurtfulness. Their feelings about others often shift from admiration or love to anger or dislike after a disappointment, a threat of losing someone, or a perceived loss of esteem in the eyes of someone they value. This phenomenon, sometimes called splitting, includes a shift from idealising others to devaluing them. Combined with mood disturbances, idealisation and devaluation can undermine relationships with family, friends, and co-workers.

Self-image can also change rapidly from healthy to unhealthy. While strongly desiring intimacy, people with BPD tend toward insecure, avoidant or ambivalent, or fearfully preoccupied attachment patterns in relationships, and they often view the world as dangerous and malevolent. BPD, like other personality disorders, is linked to increased levels of chronic stress and conflict in romantic relationships, decreased satisfaction on the part of romantic partners, abuse, and unwanted pregnancy.

Sense of self

People with BPD tend to have trouble seeing a clear picture of their identity. In particular, they tend to have difficulty knowing what they value, believe, prefer, and enjoy.

They are often unsure about their long-term goals for relationships and jobs. This difficulty with knowing who they are and what they value can cause people with BPD to experience feeling "empty" and "lost".

Cognitions

The often intense emotions experienced by people with BPD can make it difficult for them to control the focus of their attention—to concentrate. In addition, people with BPD may tend to dissociate, which can be thought of as an intense form of "zoning out".

Dissociation often occurs in response to experiencing a painful event (or experiencing something that triggers the memory of a painful event). It involves the mind automatically redirecting attention away from that event, presumably to protect against experiencing intense emotion and unwanted behavioural impulses that such emotion might otherwise trigger.

Although the mind's habit of blocking out intense painful emotions may provide temporary relief, it can also have the unwanted side effect of blocking or blunting the experience of ordinary emotions, reducing the access of people with BPD to the information contained in those emotions, which helps guide effective decision-making in daily life. Sometimes, it is possible for another person to tell when someone with BPD is dissociating, because their facial or vocal expressions may become flat or expressionless, or they may appear to be distracted; at other times, dissociation may be barely noticeable.

Disability

BPD is related to lower functioning and disability, even when socioeconomic status, medical conditions, and all psychiatric disorders were controlled. Further, it is more common for females with BPD to experience disabilities than males with BPD. More research is necessary to determine if this is due to a genetic sex difference or social reasons, but more females with BPD are diagnosed than males.

Causes

As is the case with other mental disorders, the causes of BPD are complex and not fully agreed upon. Evidence suggests that BPD and post-traumatic stress disorder (PTSD) may be related in some way. Most researchers agree that a history of childhood trauma can be a contributing factor, but less attention has historically been paid to investigating the causal roles played by congenital

brain abnormalities, genetics, neurobiological factors, and environmental factors other than trauma.

Social factors include how people interact in their early development with their family, friends, and other children. Psychological factors include the individual's personality and temperament, shaped by his or her environment and learned coping skills that deal with stress. These different factors together suggest that there are multiple factors that may contribute to the disorder.

Genetics

The heritability of BPD has been estimated at 40%. That is, 40 percent of the variability in liability underlying BPD in the population can be explained by genetic differences. Twin studies may overestimate the effect of genes on variability in personality disorders due to the complicating factor of a shared family environment. Nonetheless, the researchers of this study concluded that personality disorders "seem to be more strongly influenced by genetic effects than almost any axis I disorder [e.g., bipolar disorder, depression, eating disorders], and more than most broad personality dimensions."

Moreover, the study found that BPD was estimated to be the third most-heritable personality disorder out of the 10 personality disorders reviewed.

Twin, sibling, and other family studies indicate partial heritability for impulsive aggression, but studies of serotonin-related genes have suggested only modest contributions to behaviour.

Families with twins in the Netherlands were participants of an ongoing study by Trull and colleagues, in which 711 pairs of siblings and 561 parents were examined to identify the location of genetic traits that influenced the development of BPD. Research collaborators found that genetic material on chromosome nine was linked to BPD features. The researchers concluded "that genetic factors play a major role in individual differences of borderline personality disorder features."

These same researchers had earlier concluded in a previous study that 42 percent of variation in BPD features was attributable to genetic influences and 58 percent was attributable to environmental influences.

Genes currently under investigation include the 7-repeat polymorphism of the dopamine D4 receptor (DRD4), which has

been linked to disorganized attachment, whilst the combined effect of the 7-repeat polymorphism and the 10/10 dopamine transporter (DAT) genotype has been linked to abnormalities in inhibitory control, both noted features of BPD. There is a possible connection to chromosome 5.

Brain abnormalities

A number of neuroimaging studies in BPD have reported findings of reductions in regions of the brain involved in the regulation of stress responses and emotion, affecting the hippocampus, the orbitofrontal cortex, and the amygdala, amongst other areas. A smaller number of studies have used magnetic resonance spectroscopy to explore changes in the concentrations of neurometabolites in certain brain regions of BPD patients, looking specifically at neurometabolites such as N-acetylaspartate, creatine, glutamate-related compounds, and choline-containing compounds.

Hippocampus

The hippocampus tends to be smaller in people with BPD, as it is in people with post-traumatic stress disorder (PTSD). However, in BPD, unlike PTSD, the amygdala also tends to be smaller.

Amygdala

The amygdalas are smaller and more active in people with BPD. Decreased amygdala volume has also been found in people with obsessive-compulsive disorder. One study has found unusually strong activity in the left amygdalas of people with BPD when they experience and view displays of negative emotions. Since the amygdala generates all emotions (including unpleasant ones), this unusually strong activity may explain the unusual strength and longevity of fear, sadness, anger, and shame experienced by people with BPD, as well as their heightened sensitivity to displays of these emotions in others.

Prefrontal cortex

The prefrontal cortex tends to be less active in people with BPD, especially when recalling memories of abandonment. This relative inactivity occurs in the right anterior cingulate (areas 24 and 32). Given its role in regulating emotional arousal, the relative inactivity of the prefrontal cortex might explain the difficulties people with BPD experience in regulating their emotions and responses to stress.

Hypothalamic-pituitary-adrenal axis

The hypothalamic-pituitary-adrenal axis (HPA axis) regulates cortisol production, which is released in response to stress. Cortisol production tends to be elevated in people with BPD, indicating a hyperactive HPA axis in these individuals. This causes them to experience a greater biological stress response, which might explain their greater vulnerability to irritability. Since traumatic events can increase cortisol production and HPA axis activity, one possibility is that the prevalence of higher than average activity in the HPA axis of people with BPD may simply be a reflection of the higher than average prevalence of traumatic childhood and maturational events among people with BPD. Another possibility is that, by heightening their sensitivity to stressful events, increased cortisol production may predispose those with BPD to experience stressful childhood and maturational events as traumatic.

Increased cortisol production is also associated with an increased risk of suicidal behaviour.

Neurobiological factors

Estrogen

Individual differences in women's estrogen cycles may be related to the expression of BPD symptoms in female patients. A 2003 study found that women's BPD symptoms were predicted by changes in estrogen levels throughout their menstrual cycles, an

effect that remained significant when the results were controlled for a general increase in negative affect.

Developmental factors

Childhood trauma

There is a strong correlation between child abuse, especially child sexual abuse, and development of BPD. Many individuals with BPD report a history of abuse and neglect as young children, but causation is still debated. 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.

*They also report a high incidence of incest and ****loss of caregivers in early childhood.***

Individuals with BPD were also likely to report having caregivers of both sexes deny the validity of their thoughts and feelings. Caregivers were also reported to have failed to provide needed protection and to have 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 significantly more likely to experience sexual abuse by a non-caregiver.

It has been suggested that children who experience chronic early maltreatment and attachment difficulties may go on to develop borderline personality disorder.

Writing in the psychoanalytic tradition, Otto Kernberg argues that a child's failure to achieve the developmental task of psychic clarification of self and other and failure to overcome splitting might increase the risk of developing a borderline personality. A child's inability to tolerate delayed gratification at age 4 does not predict later development of BPD.

Neurological patterns

*The intensity and reactivity of a person's negative affectivity, or tendency to feel negative emotions, predicts BPD symptoms more strongly than does childhood sexual abuse. This finding, differences in brain structure and the fact that some patients with BPD do not report a traumatic history, suggest that BPD is distinct from the post-traumatic stress disorder which frequently accompanies it. **Thus, researchers examine developmental causes in addition to childhood trauma.***

Research published in January 2013 by Dr. Anthony Ruocco at the University of Toronto has highlighted two patterns of brain activity that may underlie the dysregulation of emotion indicated in this disorder: (1) increased activity in the brain circuits responsible for the experience of heightened emotional pain, coupled with (2) reduced activation of the brain circuits that normally regulate or suppress these generated painful emotions.

These two neural networks are seen to be dysfunctionally operative in the frontolimbic regions, but the specific regions vary widely in individuals, which calls for the analysis of more neuroimaging studies.

*Also (contrary to the results of earlier studies) sufferers of BPD showed less activation in the amygdala in situations of increased negative emotionality than the control group. Dr. John Krystal, editor of the journal *Biological Psychiatry*, wrote that these results "[added] to the impression that people with borderline personality disorder are 'set-up' by their brains to have stormy emotional lives, although not necessarily unhappy or unproductive lives". Their emotional instability has been found to correlate with differences in several brain regions.*

Mediating and moderating factors

Executive function

While high rejection sensitivity is associated with stronger symptoms of borderline personality disorder, executive function appears to mediate the relationship between rejection sensitivity and BPD symptoms. That is, a group of cognitive processes that include planning, working memory, attention, and

problem-solving might be the mechanism through which rejection sensitivity impacts BPD symptoms.

A 2008 study found that the relationship between a person's rejection sensitivity and BPD symptoms was stronger when executive function was lower and that the relationship was weaker when executive function was higher. This suggests that high executive function might help protect people with high rejection sensitivity against symptoms of BPD.

A 2012 study found that problems in working memory might contribute to greater impulsivity in people with BPD.

Family environment

Family environment mediates the effect of child sexual abuse on the development of BPD. An unstable family environment predicts the development of the disorder, while a stable family environment predicts a lower risk. One possible explanation is that a stable environment buffers against its development.

Self-complexity

Self-complexity, or considering one's self to have many different characteristics, appears to moderate the relationship between Actual-Ideal self-discrepancy and the development of BPD symptoms. That is, for individuals who believe that their actual characteristics do not match the characteristics that they hope to acquire, high self-complexity reduces the impact of their conflicted self-image on BPD symptoms.

However, self-complexity does not moderate the relationship between Actual-Ought self-discrepancy and the development of BPD symptoms. That is, for individuals who believe that their actual characteristics do not match the characteristics that they should already have, high self-complexity does not reduce the impact of their conflicted self-image on BPD symptoms. The protective role of self-complexity in Actual-Ideal self-discrepancy, but not in Actual-Ought self-discrepancy, suggests that the impact of conflicted or unstable self-image in BPD depends on whether the individual views self in terms of characteristics

that they hope to acquire, or in terms of characteristics that they should already have acquired.

Thought suppression

A 2005 study found that thought suppression, or conscious attempts to avoid thinking certain thoughts, mediates the relationship between emotional vulnerability and BPD symptoms. A later study found that the relationship between emotional vulnerability and BPD symptoms is not necessarily mediated by thought suppression. However, this study did find that thought suppression mediates the relationship between an invalidating environment and BPD symptoms.

Diagnosis

Diagnosis of borderline personality disorder is based on a clinical assessment by a mental health professional. The best method is to present the criteria of the disorder to a person and to ask them if they feel that these characteristics accurately describe them.

Actively involving people with BPD in determining their diagnosis can help them become more willing to accept it. Although some clinicians prefer not to tell people with BPD what their diagnosis is, either from concern about the stigma attached to this condition or because BPD used to be considered untreatable, it is usually helpful for the person with BPD to know their diagnosis. This helps them know that others have had similar experiences and can point them toward effective treatments.

In general, the psychological evaluation includes asking the patient about the beginning and severity of symptoms, as well as other questions about how symptoms impact the patient's quality of life. Issues of particular note are suicidal ideations, experiences with self-harm, and thoughts about harming others. Diagnosis is based both on the person's report of their symptoms and on the clinician's own observations. Additional tests for BPD can include a physical exam and laboratory tests to rule out other possible triggers for symptoms, such as thyroid conditions or substance abuse.

The ICD-10 manual refers to the disorder as emotionally unstable personality disorder and has similar diagnostic criteria.

In the DSM-5, the name of the disorder remains the same as in the previous editions.

Diagnostic and Statistical Manual

The Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM-5) has removed the multiaxial system. Consequently, all disorders, including personality disorders, are listed in Section II of the manual. A person must meet 5 of 9 criteria to receive a diagnosis of borderline personality disorder.

*The DSM-5 defines **the main features of BPD as a pervasive pattern of instability in interpersonal relationships, self image, and affect, as well as markedly impulsive behaviour.** In addition, the DSM-5 proposes alternative diagnostic criteria for Borderline personality disorder in section III, "Alternative DSM-5 Model for Personality Disorders."*

These alternative criteria are based on trait research and include specifying at least four of seven maladaptive traits.

According to Marsha Linehan, many mental health professionals find it challenging to diagnose BPD using the DSM criteria, since these criteria describe such a wide variety of behaviours.

To address this issue, Linehan has grouped the symptoms of BPD under five main areas of dysregulation: emotions, behaviour, interpersonal relationships, sense of self, and cognition.

International Classification of Disease

*The World Health Organization's ICD-10 defines a disorder that is conceptually similar to borderline personality disorder, called (F60.3) Emotionally **unstable personality disorder.** Its two subtypes are described below.*

F60.30 Impulsive type

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

- 1. marked tendency to act unexpectedly and without consideration of the consequences;*

2. *marked tendency to engage in quarrelsome behaviour and to have conflicts with others, especially when impulsive acts are thwarted or criticised;*
3. *liability to outbursts of anger or violence, with inability to control the resulting behavioural explosions;*
4. *difficulty in maintaining any course of action that offers no immediate reward;*
5. *unstable and capricious (impulsive, whimsical) mood.*

F60.31 Borderline type

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

1. *disturbances in and uncertainty about self-image, aims, and internal preferences;*
2. *liability to become involved in intense and unstable relationships, often leading to emotional crisis;*
3. *excessive efforts to avoid abandonment;*
4. *recurrent threats or acts of self-harm;*
5. *chronic feelings of emptiness.*
6. *demonstrates impulsive behaviour, e.g., speeding, substance abuse*

The ICD-10 also describes some general criteria that define what is considered a Personality disorder.

Family members

People with BPD are prone to feeling angry at members of their family and alienated from them. On their part, family members

often feel angry and helpless at how their BPD family members relate to them.

A study in 2003 found that family members' experiences of burden, emotional distress, and hostility toward people with BPD were actually worse when they had greater knowledge about BPD.

These findings may indicate a need to investigate the quality and accuracy of the information received by family members. Parents of adults with BPD are often both over-involved and under-involved in family interactions. In romantic relationships, BPD is linked to increased levels of chronic stress and conflict, decreased satisfaction of romantic partners, abuse, and unwanted pregnancy. However, these links may apply to personality disorders in general

Adolescence

On set of symptoms typically occurs during adolescence or young adulthood, although symptoms suggestive of this disorder can sometimes be observed in children.

Symptoms among adolescents that predict the development of BPD in adulthood may include problems with body-image, extreme sensitivity to rejection, behavioural problems, non-suicidal self-injury, attempts to find exclusive relationships, and severe shame. Many adolescents experience these symptoms without going on to develop BPD, but those who experience them are 9 times as likely as their peers to develop BPD. They are also more likely to develop other forms of long-term social disabilities.

Clinicians are discouraged from diagnosing anyone with BPD before the age of 18, due to the normal ups and downs of adolescence and a still-developing personality. However, BPD can sometimes be diagnosed before age 18, in which case the features must have been present and consistent for at least 1 year.

A BPD diagnosis in adolescence might predict that the disorder will continue into adulthood.

Among adolescents who warrant a BPD diagnosis, there appears to be one group in which the disorder remains stable over time and

another group in which the individuals move in and out of the diagnosis.

Earlier diagnoses may be helpful in creating a more effective treatment plan for the adolescent.

Family therapy is considered a helpful component of treatment for adolescents with BPD.

Differential diagnosis and comorbidity

Lifetime comorbid (co-occurring) conditions are common in BPD. Compared to those diagnosed with other personality disorders, people with BPD showed a higher rate of also meeting criteria for

- *mood disorders, including major depression and bipolar disorder*
- *anxiety disorders, including panic disorder, social anxiety disorder, and post-traumatic stress disorder (PTSD)*
- *other personality disorders*
- *substance abuse*
- *eating disorders, including anorexia nervosa and bulimia*
- *attention deficit hyperactivity disorder.*
- *somatoform disorders*
- *dissociative disorders*

A diagnosis of a personality disorder should not be made during an untreated mood episode/disorder, unless the lifetime history supports the presence of a personality disorder.

Comorbid Axis I disorders

Gender differences in Axis I lifetime comorbid diagnosis, 2008 and 1998

Axis I diagnosis	Overall (%)	Male (%)	Female (%)
Mood disorders	75.0	68.7	80.2
<i>Major depressive disorder</i>	32.1	27.2	36.1
<i>Dysthymia</i>	9.7	7.1	11.9
<i>Bipolar I disorder</i>	31.8	30.6	32.7
<i>Bipolar II disorder</i>	7.7	6.7	8.5
Anxiety disorders	74.2	66.1	81.1
<i>Panic disorder with agoraphobia</i>	11.5	7.7	14.6
<i>Panic disorder without agoraphobia</i>	18.8	16.2	20.9
<i>Social phobia</i>	29.3	25.2	32.7
<i>Specific phobia</i>	37.5	26.6	46.6
<i>PTSD</i>	39.2	29.5	47.2
<i>Generalised anxiety disorder</i>	35.1	27.3	41.6
<i>Obsessive-compulsive disorder**</i>	15.6	---	---
Substance use disorders	72.9	80.9	66.2
<i>Any alcohol use disorder</i>	57.3	71.2	45.6
<i>Any drug use disorder</i>	36.2	44.0	29.8
Eating disorders**	53.0	20.5	62.2
<i>Anorexia nervosa**</i>	20.8	7 *	25 *
<i>Bulimia nervosa**</i>	25.6	10 *	30 *

<i>Eating disorder not otherwise specified**</i>	26.1	10.8	30.4
Somatoform disorders**	10.3	10 *	10 *
<i>Somatisation disorder**</i>	4.2	---	---
<i>Hypochondriasis**</i>	4.7	---	---
<i>Somatoform pain disorder**</i>	4.2	---	---
Psychotic disorders**	1.3	1 *	1 *
<p>* Approximate values ** Values from 1998 study --- Value not provided by study</p>			

A 2008 study found that at some point in their lives, 75 percent of people with BPD meet criteria for mood disorders, especially major depression and Bipolar I, and nearly 75 percent meet criteria for an anxiety disorder.

Nearly 73 percent meet criteria for substance abuse or dependency, and about 40 percent for PTSD. It is noteworthy that less than half of the participants with BPD in this study presented with PTSD, a prevalence similar to that reported in an earlier study. The finding that less than half of patients with BPD experience PTSD during their lives challenges the theory that BPD and PTSD are the same disorder.

There are marked gender differences in the types of comorbid conditions a person with BPD is likely to have— a higher percentage of males with BPD meet criteria for substance-use disorders, while a higher percentage of females with BPD meet criteria for PTSD and eating disorders.

In one study, 38% of participants with BPD met the criteria for a diagnosis of ADHD.

In another study, 6 of 41 participants (15%) met the criteria for an autism spectrum disorder (a subgroup that had significantly more frequent suicide attempts).

Regardless that it is an infradiagnosed disorder, a few studies have shown that the "lower expressions" of it might lead to wrong diagnoses. The many and shifting Axis I disorders in people with BPD can sometimes cause clinicians to miss the presence of the underlying personality disorder. However, since a complex pattern of Axis I diagnoses has been found to strongly predict the presence of BPD, clinicians can use the feature of a complex pattern of comorbidity as a clue that BPD might be present.

Mood Disorders

Many people with borderline personality disorder also have mood disorders, such as major depressive disorder or a bipolar disorder. Some characteristics of BPD are similar to those of mood disorders, which can complicate the diagnosis.

It is especially common for people to be misdiagnosed with bipolar disorder when they have borderline personality disorder or vice versa. For someone with bipolar disorder, behaviour suggestive of BPD might appear while the client is experiencing an episode of major depression or mania, only to disappear once the client's mood has stabilised. For this reason, it is ideal to wait until the client's mood has stabilised before attempting to make a diagnosis.

At face value, the affective lability of BPD and the rapid mood cycling of bipolar disorders can seem very similar. It can be difficult even for experienced clinicians, if they are unfamiliar with BPD, to differentiate between the mood swings of these two conditions.

However, there are some clear differences.

First, the mood swings of BPD and bipolar disorder tend to have different durations. In some people with bipolar disorder, episodes of depression or mania last for at least two weeks at a time, which is much longer than moods last in people with BPD. Even among those who experience bipolar disorder with more rapid mood shifts, their moods usually last for days, while the moods of people with BPD can change in minutes or hours. So while euphoria and impulsivity in someone with BPD might resemble a manic episode, the experience would be too brief to qualify as a manic episode.

Second, the moods of bipolar disorder do not respond to changes in the environment, while the moods of BPD do respond to changes in the environment.

That is, a positive event would not lift the depressed mood caused by bipolar disorder, but a positive event would potentially lift the depressed mood of someone with BPD. Similarly, an undesirable event would not dampen the euphoria caused by bipolar disorder, but an undesirable event would dampen the euphoria of someone with borderline personality disorder.

Third, when people with BPD experience euphoria, it is usually without the racing thoughts and decreased need for sleep that are typical of hypomania. And severe, high levels of sleep disturbance are rarely a symptom of BPD, whereas they are a common symptom of bipolar disorders (along with appetite disturbance). Because the two conditions have a number of similar symptoms, BPD was once considered to be a mild form of bipolar disorder or to exist on the bipolar spectrum.

However, this would require that the underlying mechanism causing these symptoms be the same for both conditions.

Differences in phenomenology, family history, longitudinal course, and responses to treatment indicate that this is not the case.

Researchers have found "only a modest association" between bipolar disorder and borderline personality disorder, with "a strong spectrum relationship with [BPD and] bipolar disorder extremely unlikely. Benazzi et al. suggest that the DSM-IV BPD diagnosis combines two unrelated characteristics: an affective instability dimension related to Bipolar II and an impulsivity dimension not related to Bipolar II.

Premenstrual Dysphoric Disorder

Premenstrual dysphoric disorder (PMDD) occurs in 3–8 percent of women.

Symptoms begin 5–11 days before menstruation and cease a few days after it begins.

Symptoms may include marked mood swings, irritability, depressed mood, feeling hopeless or suicidal, a subjective sense of being overwhelmed or out of control, anxiety, binge eating,

difficulty concentrating, and substantial impairment of interpersonal relationships.

People with PMDD typically begin to experience symptoms in their early twenties, although many do not seek treatment until their early thirties.

Although some of the symptoms of PMDD and BPD are similar, they are different disorders. They are distinguishable by the timing and duration of symptoms, which are markedly different: the symptoms of PMDD occur only during the luteal phase of the menstrual cycle, whereas BPD symptoms occur persistently at all stages of the menstrual cycle. In addition, the symptoms of PMDD do not include impulsivity.

Comorbid Axis II Disorders

Percentage of people with BPD and a lifetime comorbid Axis II diagnosis, 2008

Axis II diagnosis	Overall (%)	Male (%)	Female (%)
Any Cluster A	50.4	49.5	51.1
<i>Paranoid</i>	21.3	16.5	25.4
<i>Schizoid</i>	12.4	11.1	13.5
<i>Schizotypal</i>	36.7	38.9	34.9
Any Other Cluster B	49.2	57.8	42.1
<i>Antisocial</i>	13.7	19.4	_9.0
<i>Histrionic</i>	10.3	10.3	10.3
<i>Narcissistic</i>	38.9	47.0	32.2
Any Cluster C	29.9	27.0	32.3
<i>Avoidant</i>	13.4	10.8	15.6

<i>Dependent</i>	<i>_3.1</i>	<i>_2.6</i>	<i>_3.5</i>
<i>Obsessive-compulsive</i>	<i>22.7</i>	<i>21.7</i>	<i>23.6</i>

More than two-thirds of people diagnosed with BPD also meet the criteria for another Axis II personality disorder at some point in their lives. (In a 2008 study, the rate was 73.9 percent.)

Cluster A disorders, which include paranoid, schizoid, and schizotypal, are the most common, with a prevalence of 50.4 percent in people with BPD.

The second most common is another Cluster B disorder, which includes antisocial, histrionic, and narcissistic. These have an overall prevalence of 49.2 percent in people with BPD, with narcissistic being the most common, at 38.9 percent; antisocial the second most common, at 13.7 percent; and histrionic the least common, at 10.3 percent.

The least common are Cluster C disorders, which include avoidant, dependent, and obsessive-compulsive, and have a prevalence of 29.9 percent in people with BPD.

The percentages for specific comorbid Axis II disorders can be found in the table to the right.

Management

Psychotherapy is the primary treatment for borderline personality disorder.

Treatments should be based on the needs of the individual, rather than upon the general diagnosis of BPD. Medications are useful for treating comorbid disorders, such as depression and anxiety.

Short-term hospitalisation has not been found to be more effective than community care for improving outcomes or long-term prevention of suicidal behaviour in those with BPD.

Psychotherapy

Long-term psychotherapy is currently the treatment of choice for BPD.

There are six such treatments available: dynamic deconstructive psychotherapy (DDP), metallisation-based treatment (MBT), transference-focused psychotherapy, dialectical behaviour

therapy (DBT), general psychiatric management, and schema-focused therapy.

While DBT is the therapy that has been studied the most, empirical research and case studies have shown that all of these treatments are effective for treating BPD, except for schema-focused therapy. Long-term therapy of any kind, including schema-focused therapy, is better than no treatment, especially in reducing urges to self-injure.

Cognitive behavioural therapy (CBT) is also a type of psychotherapy used for treatment of BPD. This type of therapy relies on changing people's behaviours and beliefs by identifying problems from the disorder. CBT is known to reduce some anxiety and mood symptoms as well as reduce suicidal thoughts and self-harming behaviours.

Metallisation-based therapy and transference-focused psychotherapy are based on psychodynamic principles, and dialectical behaviour therapy is based on cognitive-behavioural principles and mindfulness. General psychiatric management combines the core principles from each of these treatments, and it is considered easier to learn and less intensive. Randomised controlled trials have shown that DBT and MBT may be the most effective, and the two share many similarities.

However, a naturalistic study indicated that DDP may be more effective than DBT.

Researchers are interested in developing shorter versions of these therapies to increase accessibility, to relieve the financial burden on patients, and to relieve the resource burden on treatment providers.

From a psychodynamic perspective, a special problem of psychotherapy with people with BPD is intense projection. It requires the psychotherapist to be flexible in considering negative attributions by the patient rather than quickly interpreting the projection.

Some research indicates that mindfulness meditation may bring about favourable structural changes in the brain, including changes in brain structures that are associated with BPD.

Mindfulness-based interventions also appear to bring about an improvement in symptoms characteristic of BPD, and some clients who underwent mindfulness-based treatment no longer met a minimum of five of the DSM-IV-TR diagnostic criteria for BPD.

Medications

A 2010 review by the Cochrane collaboration found that no medications show promise for "the core BPD symptoms of chronic feelings of emptiness, identity disturbance and abandonment." However, the authors found that some medications may impact isolated symptoms associated with BPD or the symptoms of comorbid conditions.

*Of the typical **antipsychotics** studied in relation to BPD, haloperidol may reduce anger and flupenthixol may reduce the likelihood of suicidal behaviour. Among the atypical antipsychotics, one trial found that aripiprazole may reduce interpersonal problems and impulsivity. Olanzapine may decrease affective instability, anger, psychotic paranoid symptoms, and anxiety, but a placebo had a greater ameliorative impact on suicidal ideation than olanzapine did. The effect of ziprasidone was not significant.*

*Of the **mood stabiliser's** studied, valproate semisodium may ameliorate depression, interpersonal problems, and anger. Lamotrigine may reduce impulsivity and anger; topiramate may ameliorate interpersonal problems, impulsivity, anxiety, anger, and general psychiatric pathology. The effect of carbamazepine was not significant.*

*Of the **antidepressants**, amitriptyline may reduce depression, but , fluoxetine, fluvoxamine, and phenelzine sulfate showed no effect. Omega-3 fatty acid may ameliorate suicidality and improve depression.*

As of 2010, trials with these medications had not been replicated and the effect of long-term use had not been assessed.

Because of weak evidence and the potential for serious side effects from some of these medications, the UK National Institute for Health and Clinical Excellence (NICE) 2009 clinical guideline for the treatment and management of BPD recommends, "Drug treatment should not be used specifically for borderline personality

disorder or for the individual symptoms or behaviour associated with the disorder."

However, "drug treatment may be considered in the overall treatment of comorbid conditions." They suggest a "review of the treatment of people with borderline personality disorder who do not have a diagnosed comorbid mental or physical illness and who are currently being prescribed drugs, with the aim of reducing and stopping unnecessary drug treatment."

Services

There is a significant difference between the number of those who would benefit from treatment and the number of those who are treated. The so-called "treatment gap" is a function of the disinclination of the afflicted to submit for treatment, an underdiagnosing of the disorder by healthcare providers, and the limited availability and access to state-of-the-art treatments. Nonetheless, individuals with BPD accounted for about 20 percent of psychiatric hospitalizations in one survey.

The majority of individuals with BPD who are in treatment 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 clinicians, and patients themselves tend to underestimate the lethality of self-injurious behaviours. **People with BPD typically have a chronically elevated risk of suicide much above that of the general population and a history of multiple attempts when in crisis.***

Approximately half the individuals who commit suicide meet criteria for a personality disorder.

Borderline personality disorder remains the most commonly associated personality disorder with suicide.

Prognosis

With treatment, the majority of people with BPD can find relief from distressing symptoms and achieve remission, defined as a consistent relief from symptoms for at least two years.

This longitudinal study tracking the symptoms of people with BPD found that 34.5% achieved remission within two years from the beginning of the study. Within four years, 49.4% had achieved remission, and within six years, 68.6% had achieved remission. By the end of the study, 73.5% of participants were found to be in remission.

Moreover, of those who achieved recovery from symptoms, only 5.9% experienced recurrences. A later study found that ten years from baseline (during a hospitalisation), 86% of patients had sustained a stable recovery from symptoms.

Patient personality can play an important role during the therapeutic process, leading to better clinical outcomes. Recent research has shown that BPD patients undergoing Dialectical Behaviour Therapy (DBT) exhibit better clinical outcomes correlated with higher levels of the trait of agreeableness in the patient, compared to patients either low in agreeableness or not being treated with DBT. This association was mediated through the strength of a working alliance between patient and therapist; that is, more agreeable patients developed stronger working alliances with their therapists, which in turn, led to better clinical outcomes.

In addition to recovering from distressing symptoms, people with BPD also achieve high levels of psychosocial functioning. A longitudinal study tracking the social and work abilities of participants with BPD found that six years after diagnosis, 56% of participants had good function in work and social environments, compared to 26% of participants when they were first diagnosed. Vocational achievement was generally more limited, even compared to those with other personality disorders. However, those whose symptoms had remitted were significantly more likely to have good relationships with a romantic partner and at least one parent, good performance at work and school, a sustained work and school history, and good psychosocial functioning overall.

Epidemiology

The prevalence of BPD was initially estimated to be 1 to 2 percent of the general population and to occur three times more often in women than in men.

However, the lifetime prevalence of BPD in a 2008 study was found to be 5.9% of the general population, occurring in 5.6% of men and 6.2% of women. The difference in rates between men and women in this study was not found to be statistically significant.

History



“Idealization in Edvard Munch’s The Brooch. Eva Mudocci (1903)”



Devaluation in Edvard Munch’s Salome (1903). Idealization and devaluation of others in personal relations is a highly specific trait in BPD (introduction and main text). The painter

Edvard Munch depicted his new friend, the violinist Eva Mudocci, in both ways within days. First as “a woman seen by a man in love”, then as “a bloodthirsty and cannibalistic Salome. In modern times, Munch has been diagnosed by psychiatrists as having had BPD, including by an authority in the field, James F. Masterson.

The coexistence of intense, divergent moods within an individual was recognised by Homer, Hippocrates, and Aretaeus, the latter describing the vacillating presence of impulsive anger, melancholia, and mania within a single person. The concept was revived by Swiss physician Théophile Bonet in 1684 who, using the term folie maniaco-mélancolique Hippocrate described the phenomenon of unstable moods that followed an unpredictable course. Other writers noted the same pattern, including the American psychiatrist C. Hughes in 1884 and J.C. Rosse in 1890, who called the disorder "borderline insanity, In 1921, Kraepelin identified an "excitable personality" that closely parallels the borderline features outlined in the current concept of BPD.

The first significant psychoanalytic work to use the term "borderline" was written by Adolf Stern in 1938. It described a group of patients suffering from what he thought to be a mild form of schizophrenia, on the borderline between neurosis and psychosis. The 1960s and 1970s saw a shift from thinking of the condition as borderline schizophrenia to thinking of it as a borderline affective disorder (mood disorder), on the fringes of bipolar disorder, cyclothymia, and dysthymia. In the DSM-II, stressing the intensity and variability of moods, it was called cyclothymic personality (affective personality). While the term "borderline" was evolving 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 organisation between neurosis and psychosis. After standardised criteria were developed to distinguish it from mood disorders and other Axis I disorders, BPD became a personality disorder diagnosis in 1980 with the publication of the DSM-III, psychosis The diagnosis was distinguished from sub-syndromal schizophrenia, which was termed "Schizotypal personality disorder".

The DSM-IV Axis II Work Group of the American Psychiatric Association finally decided on the name "borderline personality disorder," which is still in use by the DSM-5 today.

However, the term "borderline" has been described as uniquely inadequate for describing the symptoms characteristic of this disorder.

Controversies

Credibility and validity of testimony

The credibility of individuals with personality disorders has been questioned at least since the 1960s.

Two concerns are the incidence of dissociation episodes among people with BPD and the belief that lying is a key component of this condition.

Dissociation

Researchers disagree about whether dissociation, or a sense of detachment from emotions and physical experiences, impacts the ability of people with BPD to recall the specifics of past events. A 1999 study reported that the specificity of autobiographical memory was decreased in BPD patients. The researchers found that decreased ability to recall specifics was correlated with patients' levels of dissociation.

Lying as a feature

Some theorists argue that patients with BPD often lie. However, others write that they have rarely seen lying among patients with BPD in clinical practice. Regardless, lying is not one of the diagnostic criteria for BPD.

The belief that lying is a distinguishing characteristic of BPD can impact the quality of care that people with this diagnosis receive in the legal and healthcare systems. For instance, Jean Goodwin relates an anecdote of a patient with multiple personality disorder,

now called dissociative identity disorder, who suffered from pelvic pain due to traumatic events in her childhood.

Due to their disbelief in her accounts of these events, physicians diagnosed her with borderline personality disorder, reflecting a belief that lying is a key feature of BPD. Based upon her BPD diagnosis, the physicians then disregarded the patient's assertion that she was allergic to adhesive tape. The patient was in fact allergic to adhesive tape, which later caused complications in the surgery to relieve her pelvic pain.

Gender

Since BPD can be a stigmatising diagnosis even within the mental health community, some survivors of childhood abuse who are diagnosed with BPD are re-traumatised by the negative responses they receive from healthcare providers.

One camp argues that it would be better to diagnose these men or women with post-traumatic stress disorder, as this would acknowledge the impact of a abuse on their behaviour. Critics of the PTSD diagnosis argue that it medicalises a abuse rather than addressing the root causes in society.

Regardless, a diagnosis of PTSD does not encompass all aspects of the disorder

Joel Paris states that "In the clinic ... Up to 80% of patients are women. That may not be true in the community" He offers the following explanations regarding these gender discrepancies: "The most probable explanation for gender differences in clinical samples is that women are more likely to develop the kind of symptoms that bring patients in for treatment. Twice as many women as men in the community suffer from depression (Weissman & Klerman, 1985). In contrast, there is a preponderance of men meeting criteria for substance abuse and psychopathy (Robins & Regier, 1991), and males with these disorders do not necessarily present in the mental health system. Men and women with similar psychological problems may express distress differently. Men tend to drink more and carry out more crimes. Women tend to turn their anger on themselves, leading to depression as well as the cutting and overdosing that characterise BPD. Thus, anti-social personality disorder (ASPD) and borderline

personality disorders might derive from similar underlying pathology but present with symptoms strongly influenced by gender (Paris, 1997a; Looper & Paris, 2000).

We have even more specific evidence that men with BPD may not seek help. In a study of completed suicides among people aged 18 to 35 years (Lesage et al., 1994), 30% of the suicides involved individuals with BPD (as confirmed by psychological autopsy, in which symptoms were assessed by interviews with family members). Most of the suicide completers were men, and very few were in treatment. Similar findings emerged from a later study conducted by our own research group (McGirr, Paris, Lesage, Renaud, & Turecki, 2007)."

In short, men are less likely to seek or accept appropriate treatment, more likely to be treated for symptoms of BPD such as substance abuse rather than BPD itself (furthermore, the symptoms of BPD and ASPD may derive from a similar underlying aetiology) and possibly men are simply more likely to commit suicide prior to diagnosis.

Among men diagnosed with BPD there is also evidence of a higher suicide rate: "men are more than twice as likely as women—18 percent versus 8 percent"—to die by suicide.

There are also sex differences in borderline personality disorders. Men with BPD are more likely to abuse substances, have explosive temper, high levels of novelty seeking and have anti-social, narcissistic, passive-aggressive or sadistic personality traits.

Women with BPD are more likely to have eating disorders, mood disorders, anxiety and post-traumatic stress.

Manipulative behaviour

Manipulative behaviour to obtain nurturance is considered by the DSM-IV-TR and many mental health professionals to be a defining characteristic of borderline personality disorder. However, Marsha Linehan notes that doing so relies upon the assumption that people with BPD who communicate

intense pain, or who engage in self-harm and suicidal behaviour, do so with the intention of influencing the behaviour of others. The impact of such behaviour on others—often an intense emotional reaction in concerned friends, family members, and therapists—is thus assumed to have been the person's intention.

However, since people with BPD lack the ability to successfully manage painful emotions and interpersonal challenges, their frequent expressions of intense pain, self-harming, or suicidal behaviour may instead represent a method of mood regulation or an escape mechanism from situations that feel unbearable. Linehan notes that if, for example, one were to withhold pain medication from burn victims and cancer patients, leaving them unable to regulate their severe pain, they would also exhibit "attention-seeking" and self-destructive behaviour in order to cope

Stigma

The features of BPD include emotional instability; intense, unstable interpersonal relationships; a need for intimacy; and a fear of rejection. As a result, people with BPD often evoke intense emotions in those around them. Pejorative terms to describe people with BPD, such as "difficult", "treatment resistant", "manipulative", "demanding", and "attention seeking", are often used and may become a self-fulfilling prophecy, as the negative treatment of these individuals triggers further self-destructive behaviour.

Physical violence

The stigma surrounding borderline personality disorder includes the belief that people with BPD are prone to violence toward others.

While movies and visual media often sensationalise people with BPD by portraying them as violent, the majority of researchers agree that people with BPD are unlikely to physically harm others. Although people with BPD often struggle with experiences of intense anger, a defining characteristic of BPD is that they direct it inward toward themselves.

One of the key differences between BPD and antisocial personality disorder (ASPD) is that people with BPD tend to internalise anger by hurting themselves, while people with ASPD tend to externalize it by hurting others.

In addition, adults with BPD have often experienced abuse in childhood, so many people with BPD adopt a "no-tolerance" policy toward expressions of anger of any kind to others. Their extreme aversion to violence can cause many people with BPD to overcompensate and experience difficulties being assertive and expressing their needs. This is one way in which people with BPD choose to harm themselves over potentially causing harm to others.

Another way in which people with BPD avoid expressing their anger through violence is by causing physical damage to themselves, such as engaging in non-suicidal self-injury.

Mental healthcare providers

People with BPD are considered to be among the most challenging groups of patients to work with in therapy, requiring a high level of skill and training in the psychiatrists, therapists and nurses involved in their treatment.

A majority of psychiatric staff report finding individuals with BPD moderately to extremely difficult to work with and more difficult than other client groups.

Efforts are ongoing to improve public and staff attitudes toward people with BPD.

In psychoanalytic theory, the stigmatisation among mental healthcare providers may be thought to reflect countertransference (when a therapist projects his or her own feelings on to a client).

Thus, a diagnosis of BPD "often says more about the clinician's negative reaction to the patient than it does about the patient" and "explains away the breakdown in empathy between the therapist and the patient and becomes an institutional epithet in the guise of pseudoscientific jargon." This inadvertent countertransference can give rise to inappropriate clinical responses, including

excessive use of medication, inappropriate mothering, and punitive use of limit setting and interpretation.

*Some clients feel the diagnosis is helpful, allowing them to understand that they are not alone and to connect with others with BPD who have developed helpful coping mechanisms. However, others experience the term "**borderline personality disorder**" as a pejorative label rather than an informative diagnosis. They report concerns that their self-destructive behaviour is incorrectly perceived as manipulative and that the stigma surrounding this disorder limits their access to healthcare. Indeed, mental health professionals frequently refuse to provide services to those who have received a BPD diagnosis.*

Terminology

Because of the above concerns, and because of a move away from the original theoretical basis for the term, there is ongoing debate about renaming borderline personality disorder. While some clinicians agree with the current name, others argue that it should be changed, since many who are labelled with borderline personality disorder find the name unhelpful, stigmatising, or inaccurate.

Valerie Porr, president of Treatment and Research Advancement Association for Personality Disorders states that "the name BPD is confusing, imparts no relevant or descriptive information, and reinforces existing stigma"

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 suggested 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) as well as a personality disorder.

However, although many with BPD do have traumatic histories, some do not report any kind of traumatic event, which suggests that BPD is not necessarily a trauma spectrum disorder.

The Treatment and Research Advancements National Association for Personality Disorders (TARA-APD) campaigned unsuccessfully to change the name and designation of BPD in DSM-5, published in May 2013, in which the name "borderline personality disorder" remains unchanged and it is not considered a trauma- and stressor-related disorder.

Society and Culture

Film and television

There are several films and television shows that portray characters either explicitly diagnosed or with traits suggestive of BPD. These may be misleading if they are thought to depict this disorder accurately. Unfortunately, dramatic portrayals of people with BPD in movies and other forms of visual media contribute to the stigma surrounding borderline personality disorder, especially the myth that people with BPD are violent toward others. The majority of researchers agree that in reality, people with BPD are very unlikely to harm others.

*The films *Play Misty for Me* and *Girl, Interrupted* (based on the memoir of the same name) both suggest the emotional instability of the disorder; however, the first case shows a person more aggressive to others than to herself, which is not characteristic of the disorder.*

*The 1992 film *Single White Female*, like the first example, also suggests characteristics, some of which are actually atypical of the disorder: the character Hedy had a markedly disturbed sense of identity and reacts drastically to abandonment.*

*Films attempting to depict characters with the disorder include **A Thin Line Between Love and Hate, Filth, Fatal Attraction, The Crush, Mad Love, Malicious, Interiors, The Cable Guy, Mr. Nobody, Cracks, and Welcome to Me.***

*Psychiatrists Eric Bui and Rachel Rodgers argue that the character of Anakin Skywalker/Darth Vader in the *Star Wars* films 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 dissociative episodes

Awareness

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

References

- *Chapman, Alexander L.; Gratz, Kim L. (2007). The Borderline Personality Disorder Survival Guide: Everything You Need to Know About Living with BPD. Oakland, CA: New Harbinger Publications. ISBN 978-1-57224-507-5.*
- *Linehan, Marsha M.; Comtois, Katherine Anne; Murray, Angela M.; Brown, Milton Z.; Gallop, Robert J.; Heard, Heidi L.; Korslund, Kathryn E.; Tutek, Darren A.; et al. (2006). "Two-Year Randomized Controlled Trial and Follow-up of Dialectical Behaviour Therapy vs Therapy by Experts for Suicidal Behaviours and Borderline Personality Disorder". Archives of General Psychiatry. 63 (7): 757–66. doi:10.1001/archpsyc.63.7.757. PMID 16818865.*
- *Linehan, Marsha (1993). Cognitive-behavioural treatment of borderline personality disorder. New York: Guilford Press. ISBN 0-89862-183-6.*

- *Manning, Shari (2011). Loving Someone with Borderline Personality Disorder. The Guilford Press. ISBN 978-1-59385-607-6.*
- *Millon, Theodore (1996). Disorders of Personality: DSM-IV-TM and Beyond. New York: John Wiley & Sons. ISBN 0-471-01186-X.*
- *Millon, Theodore (2004). Personality Disorders in Modern Life. ISBN 0-471-32355-1.*
- *Millon, Theodore; Grossman, Seth; Meagher, Sarah E. (2004). Masters of the mind: exploring the story of mental illness from ancient times to the new millennium. John Wiley & Sons. ISBN 978-0-471-46985-8.*
- *Millon, Theodore (2006). "Personality Subtypes". Institute for Advanced Studies in Personology and Psychopathology. Dicandrien, Inc. Retrieved 1 November 2010.*
American Psychiatric Association (2000). Diagnostic and Statistical Manual of Mental Disorders (4th ed.). American Psychiatric Association. ISBN 978-0-89042-025-6.
- *American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed.). American Psychiatric Publishing. ISBN 978-0-89042-555-8.*