BORDERLINE PERSONALITY DISORDER: AN INTEGRATIVE BIOPSYCHOSOCIAL PERSPECTIVE ON MENTAL HEALTH

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Abstract: *Borderline personality disorder is a severe and complex mental health condition characterised by emotional instability, impulsivity, identity disturbance, intense interpersonal difficulties, and an increased risk of self-harm and suicidal behaviour. This article examines the disorder from an integrative biopsychosocial perspective, emphasising the interaction between biological vulnerability, temperamental and genetic factors, adverse childhood experiences, attachment disruptions, and invalidating relational environments. Particular attention is given to the construction and perception of the self, the role of abandonment sensitivity, emotional dysregulation, and dichotomous thinking in the development and maintenance of maladaptive relational patterns. The article also analyses the broader psychosocial impact of the disorder, including stigma, social exclusion, occupational difficulties, unstable intimate relationships, and the direct and indirect costs associated with treatment and impaired functioning. In addition, it discusses empirically supported psychotherapeutic approaches, including dialectical behaviour therapy, schema therapy, and mentalization-based treatment. Current evidence suggests that borderline personality disorder should not be regarded as an inevitably chronic or treatment-resistant condition. Structured psychotherapeutic interventions can reduce symptom severity, improve emotional regulation and social functioning, and support the development of a more coherent sense of self. An integrated approach that combines recognition of vulnerability with personal agency and responsibility may therefore provide a more balanced*

and clinically useful framework for understanding and treating the disorder.

Keywords: *borderline personality disorder; biopsychosocial model; emotional dysregulation.*

Introduction

Borderline personality disorder (BPD) is one of the most complex and extensively studied conditions in contemporary mental health. Characterized by marked emotional instability, impulsivity, severe difficulties in interpersonal relationships, and an increased risk of self-harming and suicidal behaviours, the disorder poses significant diagnostic and therapeutic challenges. Beyond its overt symptomatology, BPD reflects a profound imbalance between individual vulnerabilities and the relational context in which these vulnerabilities develop and are expressed.

Over the past decades, research in psychopathology has shown that borderline personality disorder cannot be adequately understood from a unidimensional perspective. Contemporary explanatory models support an integrative biopsychosocial approach, according to which biological and temperamental predispositions interact with early psychological experiences and an invalidating social environment, thereby contributing to the development of emotional dysregulation and maladaptive relational patterns. The aetiology of the disorder therefore involves genetic and neurobiological factors, dysfunctional cognitive and emotional mechanisms, as well as traumatic experiences and disturbed family dynamics.

At the same time, the consequences of the disorder extend beyond the individual level, with significant relational, occupational, and social implications. Stigma, difficulties in social integration, and the associated socioeconomic costs indicate that BPD is not merely a clinical concern, but also an important public mental health issue. Consequently, a comprehensive understanding of the disorder, together with effective intervention, requires an approach that integrates the biological, psychological, and social dimensions of human functioning.

The present paper aims to examine borderline personality disorder from an integrative biopsychosocial perspective by exploring both the aetiological factors involved in its development and empirically supported therapeutic models, such as schema therapy and dialectical behaviour therapy. Through this approach, the paper seeks to highlight how therapeutic interventions may function as corrective relational contexts, facilitating emotional regulation, cognitive restructuring, and the social reintegration of individuals diagnosed with BPD.

Definition and Classification

Borderline personality disorder (BPD) is a major area of interest in contemporary research and is currently regarded as the most extensively studied personality disorder (Skodol, Stein, & Hermann, 2019). Its prevalence is estimated at approximately 1–2% in the general population. The term borderline has historically referred to a heterogeneous constellation of symptoms and patterns of instability. It has frequently been associated with neurosis and psychosis and has, at times, been described as resembling an early or prodromal form of schizophrenia (Welner et al., 1973).

BPD is a severe and pervasive mental disorder that affects multiple areas of an individual's life. Its principal characteristics include instability in interpersonal relationships, limited or severely impaired emotional regulation, disturbances in identity and self-image, suicidal behaviour, and intense anger. Individuals with BPD may experience substantial difficulties in cognitive and psychosocial functioning, poor-quality interpersonal relationships, identity disturbance, and a range of psychiatric comorbidities. The disorder is traditionally classified within Cluster B of the personality disorders, a category associated with dramatic, emotional, and erratic patterns of behaviour. This cluster also includes antisocial, histrionic, and narcissistic personality disorders.

The identification and diagnosis of borderline personality disorder have long presented considerable challenges, and the disorder has undergone numerous conceptual and classificatory changes since the 1950s. Psychotherapists working during that period frequently described BPD as occupying a boundary between psychosis and neurosis, using terms such as preschizophrenia or borderline personality (Perrotta, 2020). Over time, the unstable functioning and so-called borderline personality structure associated with the disorder came to be conceptualised, within the DSM-5 and ICD classification systems, primarily in terms of emotional dysregulation, instability in interpersonal relationships, impulsivity, and self-harming behaviour (Perrotta, 2020).

According to the DSM-5, the diagnostic criteria for borderline personality disorder include frantic efforts to avoid real or imagined abandonment; a pattern of unstable and intense interpersonal relationships characterised by alternating extremes of idealisation and devaluation; identity disturbance; impulsivity, including behaviours such as substance misuse; recurrent suicidal behaviour or self-harm; affective instability; chronic feelings of emptiness; intense or inappropriate anger; and transient paranoid ideation. A diagnosis requires the presence of at least five of these criteria (APA, 2023).

Epidemiological Data

Chronic feelings of emptiness, mistrust, and subjugation may be understood as outcomes of the interaction between biological factors, including temperamental predispositions, and psychosocial influences involved in the development of borderline personality disorder. BPD is strongly associated with traumatic childhood experiences and early adversity, particularly abuse, neglect, and abandonment. In 1993, Marsha Linehan proposed the concept of an invalidating environment as a significant developmental factor in the emergence of the disorder. Such an environment is characterised by intolerance toward the child's emotional expression, thereby limiting the development of the ability to understand, tolerate, regulate, and communicate emotions effectively (Cattane et al., 2017).

Research suggests that the association between childhood abuse and neglect and a diagnosis of BPD is stronger than that identified for any other personality disorder, with histories of childhood adversity being reported by approximately 30% to 90% of patients (Cattane et al., 2017). BPD affects an estimated 1–2% of the general population and is identified in approximately 20–40% of psychiatric patients. The disorder has also traditionally been reported as being approximately three times more prevalent among women than among men.

With regard to psychosocial factors, the development of BPD is strongly associated with childhood trauma, which may take several forms, including sexual abuse, abandonment, exposure to violence, and early parental separation (Kuo et al., 2015). Sexual abuse, which is frequently reported among individuals diagnosed with BPD, often co-occurs with emotional abuse and may contribute to difficulties in trusting close others, alongside a wide range of emotional and interpersonal symptoms. Research indicates that individuals with a history of childhood maltreatment within the family are considerably more likely to experience difficulties in emotional regulation. Moreover, patients with BPD are reportedly 13 times more likely to report adverse childhood experiences than individuals without the disorder (Porter et al., 2019)

BPD appears to develop cumulatively, beginning in childhood and becoming more clearly observable at the symptomatic level during early adolescence (Bozzatello et al., 2019). Its aetiology also includes a genetic component that may contribute to an individual's inherited vulnerability to the disorder (Newton, Howes et al., 2015). Traits such as impulsivity, affective instability, and suicidal behaviour may partly reflect genetically influenced personality dimensions and have been estimated to account for approximately 42% of the variability in borderline personality disorder symptoms (Wilson et al., 2021).

Other biological factors that may contribute to vulnerability include dopaminergic dysfunctions, which have been associated with emotional dysregulation, impulsivity, and cognitive disturbances. Taken together, current findings support the view that the interaction between genetic vulnerability and environmental adversity represents a major contributor to the development of borderline personality pathology (Wilson et al., 2021).

Demographic Data

In recent years, a substantial increase in the number of borderline personality disorder diagnoses has been observed. Researchers have suggested that the prevalence of the disorder may have risen over time, although this apparent increase may also be associated with greater demand for assessment and improved diagnostic recognition. Approximately 75% of diagnosed cases have traditionally been reported among women, resulting in a female-to-male ratio of approximately 3:1. The precise reasons for the higher recorded prevalence among women remain unclear, although both biological and sociocultural factors have been proposed as possible explanations (Reports, 2023).

In 2023, researchers reported that, although the confirmed prevalence of BPD is generally estimated at between 1% and 2%, with an average estimate of approximately 1.4%, some United States statistics suggest that borderline personality features or clinically significant manifestations may affect up to 11% of the general population. This estimate would exceed the reported prevalence of both schizophrenia and bipolar disorder (NMH). BPD is also identified in approximately 20% of psychiatric patients and is frequently associated with comorbid conditions, including mood disorders and suicidal behaviour.

It has been estimated that approximately 30% of deaths by suicide may involve individuals who meet the diagnostic criteria for BPD, while between 8% and 10% of individuals diagnosed with the disorder eventually die by suicide (Milosevic, 2023). Individuals with first-degree relatives diagnosed with borderline personality disorder may be four to twenty times more likely to develop BPD themselves. They may also have an increased vulnerability to related conditions and behaviours, including substance misuse, depression, and self-harm.

A South Korean study published in 2019 reported a BPD prevalence of 1.06 cases per 1,000 inhabitants, with a male-to-female ratio of 1:1.65. The average age at diagnosis was approximately 20 years, while symptoms were reported to emerge at a mean age of around 14.6 years. The highest prevalence was identified in Seoul, where 8.71 individuals per 1,000 inhabitants were reported to have BPD.

According to a study conducted in 2018, the most common age range for receiving a BPD diagnosis was between 20 and 29 years, with 8,503 patients identified within the population examined, in contrast to considerably lower rates among older age groups (Yonsei, 2023). The statistics presented above are derived primarily from recent studies conducted in the United States and Asia. At present, there appear to be no published epidemiological studies specifically examining the prevalence of borderline personality disorder in Romania.

Associated Factors

With regard to the aetiology of borderline personality disorder, research classifies the associated factors into several broad categories. These include biological and genetic vulnerabilities, psychological factors such as abuse, neglect, and abandonment, as well as adverse experiences within the family environment during childhood (Kjennerud & Neale, 2013).

From a biological perspective, certain innate characteristics may increase vulnerability to the development of the disorder. These include temperamental dimensions such as heightened emotional intensity, low levels of sociability, and increased negative affectivity (Skabeikyte & Barkauskiene, 2021). Moreover, brain regions such as the hippocampus and amygdala, which are involved in emotional regulation, cognitive control, and the stress response, appear to show structural or functional alterations in individuals with BPD (Cattane, Rossi, & Cattaneo, 2017).

In terms of personality factors, BPD symptomatology is frequently associated with high levels of neuroticism. This personality dimension, characterised by a heightened tendency to experience negative emotions, is related to the affective instability typical of BPD, as well as dysphoria, poorly controlled anger, and chronic feelings of emptiness (Zanarini et al., 2020). By contrast, personality traits commonly associated with positive interpersonal and adaptive functioning, including extraversion, agreeableness, and conscientiousness, tend to be expressed at considerably lower levels among individuals diagnosed with BPD (Morey et al., 2002; Zanarini et al., 2020).

Another relevant factor associated with genetic vulnerability is parental psychopathology, particularly maternal psychopathology. Maternal BPD symptoms, severe depression, antisocial personality disorder, and substance use disorders have been identified as relevant risk factors in the aetiology of borderline personality disorder (Fatimah et al., 2019). Research suggests that genetic factors may account for approximately 40% of the variation in vulnerability to the disorder.

Parental psychopathology may increase risk through both the genetic transmission of susceptibility to mental disorders and passive gene–environment correlation, whereby parental genetic characteristics are associated with the environment in which the child is raised. Mental health difficulties experienced by parents, particularly mothers, may influence parenting practices and alter family dynamics. Research indicates that parental behavioural disorders, antisocial personality disorder, and the use of nicotine, alcohol, and other substances may increase the child's subsequent vulnerability to BPD. Mothers presenting with BPD symptoms may also be more likely to adopt maladaptive, inconsistent, or emotionally dysregulated parenting practices.

To examine the combined relevance of biological and environmental factors, Fatimah and colleagues (2019) compared BPD symptomatology among individuals raised by their biological parents with that observed among individuals raised by adoptive parents, in contexts in which parental psychopathology was present. The findings indicated a stronger association between parental psychopathology and BPD symptoms among children raised in biological families, suggesting a possible interaction between genetic vulnerability and the family environment.

In interaction with genetic predispositions, adverse childhood experiences constitute another major category of factors associated with the development of BPD. Compared with other personality disorders, the adversities most frequently identified in BPD include emotional, physical, and sexual abuse, as well as neglect and abandonment (Zanarini, 2020). Approximately 91% of patients have been reported to describe a history of abuse, while 92% report experiences of physical or emotional neglect before the age of 18 (Zanarini, 2020).

The relationship between childhood adversity and later psychopathology is nevertheless influenced by resilience and by the broader developmental context. A child who experiences a single adverse event is not necessarily likely to develop a mental disorder. By contrast, repeated exposure to an unhealthy, inconsistent, or invalidating environment may interfere with the development of adaptive coping capacities and psychological resilience, thereby increasing vulnerability to psychopathology (Paris, 2018).

Adverse experiences such as abuse and neglect frequently occur within the family and are influenced by their frequency, severity, duration, and intensity. The connection between biological vulnerability and the psychosocial environment can also be observed in individual differences in the perception and impact of maltreatment. Children

with greater needs for emotional support, for example, may experience parental neglect as more threatening or damaging than children with different temperamental characteristics (Zanarini, 2020).

Although emotional and physical abuse, together with emotional and physical neglect, represent highly relevant factors in the development of BPD, the role of sexual abuse may depend on the context in which it occurs. Its impact may be particularly pronounced when the abuse takes place within the family and is accompanied by emotional abuse, physical violence, betrayal, or the loss of a secure attachment relationship. Individuals with BPD have been reported to be approximately 13 times more likely to describe childhood adversity than members of other clinical populations (Herzog, 2022).

Repeated abandonment, abuse, and neglect by primary caregivers or attachment figures may contribute to the development of mistrust, an intense fear of abandonment, and difficulties in understanding, expressing, and regulating emotions. Childhood maltreatment may also influence impulsivity and anger regulation. From an emotional-developmental perspective, some individuals with BPD may continue to experience interpersonal situations through patterns of fear, vulnerability, and helplessness that originated in childhood, particularly when present-day experiences activate earlier attachment-related threats (Herzog, 2022).

The Construction and Perception of the Self in Borderline Personality Disorder

Within contemporary approaches to mental health, borderline personality disorder requires a complex framework that extends beyond symptomatic description and addresses the deeper dynamics of psychological and relational functioning. In addition to the emotional instability and impulsivity frequently discussed in the literature, identity diffusion represents a central feature of the disorder. This refers to the difficulty of maintaining a coherent and stable sense of self over time. Chronic feelings of emptiness, fluctuations in personal values, and excessive adaptation to the identities or expectations of others in relational contexts suggest a fragile sense of identity, often rooted in early experiences of insecure or invalidating attachment.

The intense fear of abandonment may be understood not merely as an isolated symptom, but as an organising principle of psychological functioning in BPD. A range of behaviours commonly described as maladaptive, including the rapid idealisation and devaluation of others, disproportionate emotional reactions, self-harming behaviours, and relational testing, may be conceptualised as attempts to prevent the loss of an emotional bond. From this perspective, borderline personality

disorder may be interpreted, at least partly, as an adaptation to a relational environment experienced as unpredictable or invalidating. Although such strategies may initially serve a protective function, they may subsequently become rigid and dysfunctional.

At the interpersonal level, individuals with BPD often display heightened sensitivity to social cues and may remain hypervigilant to subtle signs of rejection, withdrawal, or emotional distance. This relational hyperreactivity does not necessarily indicate an absence of empathy. On the contrary, it may reflect an intensified form of emotional processing that increases the likelihood of catastrophic interpretations of interpersonal ambiguity. The resulting emotional reactions may provoke defensive or distancing responses from others, thereby reinforcing fears of abandonment and maintaining dysfunctional relational cycles.

Although biological vulnerabilities and early traumatic experiences are not chosen by the individual, taking responsibility for present behaviour remains a central component of the therapeutic process. A balanced approach to mental health avoids both stigmatisation and excessive victimisation, seeking instead to integrate an understanding of causal factors with personal responsibility for change. Within this framework, the therapeutic relationship becomes a central space for intervention, offering opportunities to repair attachment-related experiences and develop more adaptive emotional regulation strategies.

Contrary to earlier perspectives that regarded borderline personality disorder as a chronic condition largely resistant to treatment, more recent research indicates a considerably more favourable prognosis, particularly when structured and empirically supported psychotherapeutic interventions are available. This change in perspective reinforces the need for an integrated approach that acknowledges both the complexity of the vulnerabilities involved and the genuine potential for recovery and psychological restructuring.

Individuals with borderline personality disorder therefore occupy a complex position at the intersection of profound vulnerability and responsibility for their own behaviour. Their vulnerability is not a matter of choice, but rather the result of interactions between biological predispositions and early traumatic experiences (Linehan, 1993; Fonagy & Bateman, 2008). This heightened emotional sensitivity may lead to intense affective responses that are difficult to regulate. At the same time, contemporary therapeutic approaches emphasise that individuals remain responsible for how they manage their emotions and actions in the present.

Maintaining a balance between acknowledging vulnerability and encouraging responsibility helps avoid both the demonisation of

individuals with BPD and their excessive portrayal as passive victims. It also provides an integrative framework for intervention and theoretical understanding. Dialectical behaviour therapy and schema therapy explicitly draw on this tension by helping patients regulate intense emotions, recognise maladaptive patterns, and develop more functional coping strategies.

The vulnerability–responsibility dialectic may therefore be regarded as a central principle in both the study and practice of mental health. It combines compassion for the individual's developmental history with a clear recognition of personal agency and the capacity for change.

The Impact of the Disorder on Psychosocial Functioning

At the social level, individuals diagnosed with borderline personality disorder are often perceived primarily through their visible behavioural manifestations, such as emotional instability, impulsivity, and relational difficulties, while the profound affective vulnerability underlying these reactions is frequently overlooked. The intensity of emotional experiences and fluctuations in interpersonal relationships may be interpreted by others as dramatisation, manipulation, or lack of self-control. Such interpretations often lead to social distancing, labelling, and stigma.

Within interpersonal contexts, these perceptions may generate defensive reactions, emotional withdrawal, or rejection. In professional and even clinical settings, individuals with this diagnosis may be regarded as "difficult" or "resistant to treatment." A problematic relational cycle may consequently emerge, in which fear of abandonment and the intense need for validation are amplified by negative social responses, thereby contributing to the persistence and reinforcement of symptoms. Social perceptions of BPD therefore represent more than an external reaction to observable behaviour. They may become active factors in the dynamics and course of the disorder.

Given the severe and pervasive nature of BPD, the disorder may involve substantial direct and indirect costs. Direct costs include the medical and therapeutic expenses associated with treatment, whereas indirect costs arise from the social, psychological, and occupational consequences of the disorder and its numerous comorbidities (Wagner, 2022). These indirect consequences are largely related to the social and emotional dysfunction experienced by individuals with BPD. Their lives may be marked by recurrent emotional crises followed by harmful coping behaviours, including substance use and self-harm, which may significantly affect multiple areas of functioning.

The direct consequences of the disorder include the financial costs of both pharmacological treatment and psychotherapy. Wagner (2022) divides these expenses into direct medical costs, including hospital services, psychiatric inpatient care, emergency department use, and prescribed medication, and therapeutic costs, including individual therapy, group therapy, counselling, and crisis intervention. Linehan (1993) further reported that approximately 55% of individuals with BPD experience at least one hospitalisation within a year, frequently in relation to suicidal behaviour.

Wagner also discusses costs associated with delinquent or aggressive behaviour that may occur in some cases, including expenses related to property damage and physical injury. Findings from a German study conducted by Wagner and colleagues in 2015 indicated that direct medical costs accounted for 49.2% of the total economic burden associated with the disorder, while indirect costs represented 45.3%.

Dysfunctional interpersonal relationships are among the central features of borderline personality disorder. Relationships involving individuals with BPD are frequently characterised by high levels of conflict, intense fear of abandonment, and alternating patterns of idealisation and devaluation (Stepp et al., 2009; Beeney et al., 2018). Consequently, heightened emotional instability and impaired mental health may significantly affect romantic, familial, social, and professional relationships (Beckes & Coan, 2011; Beeney et al., 2018).

BPD is associated with instability, identity disturbance, psychological disorganisation, pronounced interpersonal difficulties, and insecure attachment. According to Lavner and colleagues (2016), these characteristics may increase the likelihood of unsuccessful or unstable relationships. Individuals diagnosed with BPD have been reported to face a higher risk of distressed romantic relationships, early marriage, and divorce (Disney et al., 2012; Smith & South, 2020). More recent research also associates borderline pathology with shorter relationship duration and suggests that individuals presenting with BPD traits may be more likely to select partners with similar psychological characteristics (Lavner et al., 2015).

The literature commonly associates BPD with disorganised attachment, which may involve oscillation between anxious and avoidant attachment patterns. Anxious attachment is characterised by jealousy, dependency, and fear of abandonment, whereas avoidant attachment involves discomfort with intimacy, reduced emotional disclosure, and avoidance of closeness with a partner (Beeney et al., 2017; Smith & South, 2020). The emotional manifestations of BPD cannot always be adequately situated within a single attachment category. Individuals may fluctuate between dysphoria and euphoria, closeness and

withdrawal, or idealisation and devaluation, patterns that may contribute to maladaptive interpersonal behaviour (Beeney et al., 2017).

Attachment style provides a foundation for relational functioning by shaping how individuals perceive, approach, and maintain close relationships. In people with BPD, attachment patterns may be strongly influenced by early traumatic experiences. Disorganised attachment can contribute to chaotic and unstable romantic relationships marked by repeated shifts between extreme closeness and extreme distance (Holmes, 2004). Although the symptomatology of BPD helps explain difficulties in adaptive functioning, attachment theory offers an additional framework for understanding the apparently chaotic and maladaptive relational behaviour associated with the disorder (Smith & South, 2020).

From the perspective of social networks, individuals with BPD may experience social exclusion, reduced empathic responses from others, and stigmatisation (Bodner & Cohen, 2011; Beeney, 2018). These experiences may be related to temperamental characteristics, intense interpersonal reactions, and difficulties integrating into groups. Social exclusion may also occur within healthcare settings. Research suggests that some mental health professionals may maintain greater emotional distance from patients with BPD and respond with less empathy than they do toward other clinical populations (Markham, 2009; Beeney, 2018).

Another factor contributing to reduced social integration is the broader mental health burden experienced by these individuals. Research indicates that people with high levels of depression and anxiety tend to occupy less central positions within social networks and may have fewer stable or reciprocal connections (Rosenquist, Fowler, & Christakis, 2010; Beeney, 2018).

Another characteristic of borderline pathology with psychological and social consequences is dichotomous thinking, expressed through idealisation and devaluation and often referred to as splitting (Story et al., 2023). This involves evaluating experiences through mutually exclusive categories, typically in all-or-nothing or “black-and-white” terms (Veen & Arntz, 2000; Story et al., 2023). In relational contexts, splitting may involve perceiving a partner, another significant person, or the self as entirely good or entirely bad.

Splitting is commonly conceptualised as a defensive mechanism that may develop in childhood when the child lacks the psychological resources required to integrate painful, contradictory, or emotionally overwhelming experiences. As a result, experiences may be organised around extremes of gratification and frustration rather than understood

in a more complex and integrated manner (Hinshelwood, 1989). In romantic or otherwise close relationships, individuals with BPD may experience instability in their representations of both themselves and others. Fear of abandonment may be expressed through emotional crises, interpersonal testing, or sudden negative evaluations of a partner following perceived rejection or disappointment. Such patterns may make stable affective relationships difficult to maintain, particularly when they remain unrecognised and untreated (Story et al., 2023).

From an occupational perspective, research indicates that BPD symptoms may negatively affect both hiring decisions and workplace performance. During recruitment processes, disclosure or knowledge of a BPD diagnosis may influence employment decisions, with the individual sometimes being viewed as unsuitable because of presumed low frustration tolerance or anticipated difficulties in relationships with employers and colleagues (Juurlink et al., 2018). Such assumptions may also reflect diagnostic stigma rather than the individual's actual level of functioning.

In relation to workplace performance, BPD has been associated with absenteeism resulting from hospitalisation, psychiatric treatment, and difficulties functioning under pressure. Additional challenges may include impaired planning, decision-making difficulties, and reduced impulse control. Consequently, the occupational lives of individuals with BPD may involve an increased risk of job loss, voluntary resignation, uncertainty regarding professional responsibilities, and limited support from colleagues (Juurlink et al., 2018).

Conclusions

Individuals with borderline personality disorder experience profound emotional vulnerabilities and considerable interpersonal difficulties. Nevertheless, recent research indicates that these difficulties are not necessarily permanent or irreversible. Empirically supported psychotherapeutic interventions, including dialectical behaviour therapy (Linehan, 1993; Linehan et al., 2006), schema therapy (Giesen-Bloo et al., 2006), and mentalization-based treatment (Bateman & Fonagy, 2008), can lead to significant reductions in symptom severity, improvements in social functioning, and the development of more effective self-regulation capacities.

From a mental health perspective, these findings highlight the value of an integrated approach to personality disorders, in which recognition of biological and psychosocial vulnerability is combined with support for personal responsibility, agency, and the individual's capacity for change. Longitudinal research further suggests that a substantial proportion of patients no longer meet the diagnostic criteria for BPD

over time and may achieve stable and adaptive functioning (Zanarini, 2015; Paris, 2008).

These findings suggest that mental health should not be understood solely in terms of prevention or symptom reduction. It also involves the development of functional capacities, psychological resilience, relational stability, and a more coherent sense of self. Borderline personality disorder should therefore be approached not as an inevitably chronic and unchangeable condition, but as a complex form of psychological suffering for which meaningful recovery remains possible.

References

Arntz, A., & Jacob, G. (2017). Schema therapy in practice: An introductory guide to the schema mode approach. John Wiley & Sons.

Beeney, J. E., Hallquist, M. N., Clifton, A. D., Lazarus, S. A., & Pilkonis, P. A. (2018). Social disadvantage and borderline personality disorder: A study of social networks. Personality Disorders: Theory, Research, and Treatment, 9(1), 62.

Bozzatello, P., Bellino, S., Bosia, M., & Rocca, P. (2019). Early detection and outcome in borderline personality disorder. Frontiers in psychiatry, 10, 710.

Bozzatello, P., Garbarini, C., Rocca, P., & Bellino, S. (2021). Borderline personality disorder: Risk factors and early detection. Diagnostics, 11(11), 2142.

Caballero, F. F., Miret, M., Power, M., Chatterji, S., Tobiasz-Adamczyk, B., Koskinen, S., ... & Ayuso-Mateos, J. L. (2013). Validation of an instrument to evaluate quality of life in the aging population: WHOQOL-AGE. Health and quality of life outcomes, 11, 1-12.

Cattane, N., Rossi, R., Lanfredi, M., & Cattaneo, A. (2017). Borderline personality disorder and childhood trauma: exploring the affected biological systems and mechanisms. BMC psychiatry, 17, 1-14.

Dobson, K. S., & Dozois, D. J. (Eds.). (2021). Handbook of cognitive-behavioral therapies. Guilford Publications.

Farrell, J. M., Shaw, I. A., & Shaw, I. (2012). Group schema therapy for borderline personality disorder: A step-by-step treatment manual with patient workbook. John Wiley & Sons.

Fatimah, H, Wiernik, B., Gorey, c., McGue, M., Iacono, W., & Bornovalova, M. (2020). Familial Factors and the risk of Borderline personality pathology: Genetic and environmental transmission. Psychological Medicine, 50(8), 1327-1337.

Gardner, K., & Qualter, P. (2009). Reliability and validity of three screening measures of borderline personality disorder in a nonclinical population. Personality and Individual Differences, 46(5-6), 636-641.

Hallion, L. S., Steinman, S. A., Tolin, D. F., & Diefenbach, G. J. (2018). Psychometric properties of the Difficulties in Emotion Regulation Scale (DERS) and its short forms in adults with emotional disorders. Frontiers in psychology, 9, 539.

Hamid, N., Molajegh, R. R., Bashlideh, K., & SHEHNIYAILAGH, M. (2020). The Comparison of Effectiveness of Dialectical Behavioral Therapy (DBT) and Schema Therapy (ST) in Reducing the Severity of Clinical Symptoms (Disruptive Communication, Emotional Deregulation and Behavioral Deregulation) of Borderline PersonalityDisorder in Iran. Pakistan Journal of Medical and Health Sciences, 14(2), 1354-1362.

Jackson, K. M., & Trull, T. J. (2001). The factor structure of the Personality Assessment Inventory-Borderline Features (PAI-BOR) Scale in a nonclinical sample. Journal of Personality Disorders, 15(6), 536-545.

Joseph, S., & Maltby, J. (2014). Positive functioning inventory: initial validation of a 12-item self-report measure of well-being. Psychology of Well-Being, 4, 1-13.

Juurlink, T. T., Ten Have, M., Lamers, F., van Marle, H. J., Anema, J. R., de Graaf, R., & Beekman, A. T. (2018). Borderline personality symptoms and work performance: a population-based survey. BMC

Kaufman, E. A., Xia, M., Fosco, G., Yaptangco, M., Skidmore, C. R., & Crowell, S. E. (2016). The Difficulties in Emotion Regulation Scale Short Form (DERS-SF): Validation and replication in adolescent and adult samples. Journal of psychopathology and behavioral assessment, 38, 443-455.

Krägeloh, C. U., Henning, M. A., Hawken, S. J., Zhao, Y., Shepherd, D., & Billington, R. (2011). Validation of the WHOQOL-BREF quality of life questionnaire for use with medical students. Education for health, 24(2), 545.

Kuo, J. R., Khoury, J. E., Metcalfe, R., Fitzpatrick, S., & Goodwill, A. (2015). An examination of the relationship between childhood emotional abuse and borderline personality disorder features: The role of difficulties with emotion regulation. Child abuse & neglect, 39, 147-155.

Linehan, M. M., & Kehrer, C. A. (1993). Borderline personality disorder. Clinical handbook of psychological disorders, 2.

Lobbestael, J. (2012). Validation of the schema mode inventory. The Wiley-Blackwell handbook of schema therapy: Theory, research, and practice, 541-551.

Lobbestael, J., van Vreeswijk, M., Spinhoven, P., Schouten, E., & Arntz, A. (2010). Reliability and validity of the short Schema Mode Inventory (SMI). Behavioural and cognitive psychotherapy, 38(4), 437-458.

Mehlum, L. (2021). Mechanisms of change in dialectical behaviour therapy for people with borderline personality disorder. Current opinion in psychology, 37, 89-93.

Melartin, T., Häkkinen, M., Koivisto, M., Suominen, K., & Isometsä, E. (2009). Screening of psychiatric outpatients for borderline personality disorder with the McLean Screening Instrument for Borderline Personality Disorder (MSI-BPD). Nordic Journal of Psychiatry, 63(6), 475-479.

Narud, K., Mykletun, A., & Dahl, A. A. (2005). Quality of life in patients with personality disorders seen at an ordinary psychiatric outpatient clinic. BMC psychiatry, 5, 1-12.

Noblin, J. L., Venta, A., & Sharp, C. (2014). The validity of the MSI-BPD among inpatient adolescents. Assessment, 21(2), 210-217.

Paris, J. (2018). The Relationship Between Childhood Adversity and Borderline Personality Disorder". Borderline Personality Disorder, 71-82.

Perrotta, G. (2020). Borderline Personality Disorder: definition, differential diagnosis, clinical contexts and therapeutic approaches. Ann Psychiatry Treatm, 4(1), 043-056.

Reeves, A. J., Baker, R. T., Casanova, M. P., Cheatham, S. W., & Pickering, M. A. (2020). Examining the factorial validity of the Quality of Life Scale. Health and Quality of Life Outcomes, 18, 1-17.

Reeves, M. D. (2007). The effect of invalidation on emotion regulation: An empirical investigation of Linehan's biosocial theory. The Florida State University.

Skabeikyte, G., & Barkauskiene, R. (2021). A systematic review of the factors associated with the course of borderline personality disorder symptoms in adolescence. Borderline personality disorder and emotion dysregulation, 8(1), 1-11.

Skodol, A., Stein, M., & Hermann, R. (2019). Borderline personality disorder: Epidemiology, pathogenesis, clinical features, course, assessment, and diagnosis. UpToDate. Waltham, MA: UpToDate.

Smith, M., & South, S. (2020). Romantic attachment style and borderline personality pathology: A meta-analysis. Clinical psychology review, 75, 101781.

Stein, M. B., Pinsker-Aspen, J. H., & Hilsenroth, M. J. (2007). Borderline pathology and the Personality Assessment Inventory (PAI): An evaluation of criterion and concurrent validity. Journal of personality assessment, 88(1), 81-89.

Story, G. W., Smith, R., Moutoussis, M., Berwian, I. M., Nolte, T., Bilek, E., ... & Dolan, R. J. (2023). A social inference model of idealization and devaluation. Psychological Review.

Van Dijk, S. (2013). DBT made simple: A step-by-step guide to Dialectical Behavior Therapy. New Harbinger Publications.

Van Wijk-Herbrink, M. F., Roelofs, J., Broers, N. J., Rijkeboer, M. M., Arntz, A., & Bernstein, D. P. (2018). Validation of schema coping inventory and schema mode inventory in adolescents. Journal of Personality Disorders, 32(2), 220-241.

Wilson, N., Robb, E., Gajwani, R., & Minnis, H. (2021). Nature and nurture? A review of the literature on childhood maltreatment and genetic factors in the pathogenesis of borderline personality disorder. Journal of psychiatric research, 137, 131-146.

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.

Fonagy, P., & Bateman, A. (2008). *The development of borderline personality disorder—a mentalizing model*. Journal of Personality Disorders, 22(1), 4–21.