# Borderline personality disorder – historical background, clinical issues, epidemiology and etiology

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***Abstract*— In recent years, there has been a growing interest in the topic of personality disorders and the comorbid difficulties in the emotional and social functioning of those affected. This is largely due to the needs of clinicians**

**(including psychologists, psychotherapists, and psychiatrists) monitoring the increasingly isolated occurrence of typically neurotic disorders and the increasing number of individuals with personality difficulties or a nosological, psychiatric diagnosis of personality.**

**It is worth mentioning that the relevant category for personality disorders is "personality disorders**

**and other related features" (Gaebel W., Zielasek J., Reed GM 2017). The term "borderline personality disorder" is often called the personality disorder of our time. However, this definition is often used and misused in everyday language.**

**Borderline personality disorder is associated with significant suffering**

**and, over many years, with difficulties in individual functioning. To date, various approaches have focused on discussing the factors that may have a significant impact on the development of borderline personality disorder, analyzing its course, and examining the effectiveness of existing treatment methods.**

**Below, we present the history of the development of the term borderline personality disorder; a review of various ideas, concepts, and epidemiology (including emotion regulation), as well as its etiology. Thanks to years of collaboration between analysts and analysis of the characteristics of the individuals studied, a definitive definition emerged—one that remains in use today.**

**Keywords— social sciences, security psychology, psychology**

## I. INTRODUCTION

In previous periods, in scientific works, one can find data on syndromes that clinically describe patterns of affective and interpersonal instability, currently defined in the Diagnostic and Statistical Manual of Mental Disorders DSM-V.

As literature demonstrates, even in antiquity, case reports can be found of individuals experiencing intense, divergent moods, manifesting themselves in states of irritation, euphoria, or depression. Homer, Hippocrates, and Aretaeus noted the volatile nature of interconnected episodes of impulsive anger, mania, and melancholy, as well as mood swings.

In the late 19th and early 20th centuries, the classification of borderline personality disorder (BPD) progressed. Initially, BPD was considered in the context of other personality disorders rather than as a distinct disorder. Sigmund Freud (Austrian physician and founder of psychoanalysis) was the first to research personality development and its disorders. He believed that BPD should be viewed within the framework of more serious forms of hysteria. However, he did not use the definition of *" borderline "* (Conti NA, Stagnaro JC 2010).

At that time the term used was: " *borderline" insanity"* , Emil Kraepelin classified such disorders as hysteria, Eugen Bleuler and psychopathology (Conti NA, Stagnaro JC 2007).

The following years saw attempts to group behaviors specific to borderline personality by including them in disease entities:

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schizoid personality structure, pseudoneurotic schizophrenia, latent schizophrenia (Hermann Rorschach, 1921), ambulatory schizophrenia (Gregory Zilboorg , 1941), or "as if" personality (Helene Deutsch, 1942) - in people showing superficial social adaptation and disturbed interpersonal relationships (González Vives S., Diaz -Marsa M., Fuentenebro F. et al. 2006)

## II. Clinical issues

The following are various theoretical perspectives in psychology and psychiatry (according to individual authors) describing borderline personality disorder:

- psychoanalytic approach;
- biological approach;
- biosocial approach;
- descriptive approach.

1) Psychoanalytic Approach

***Borderline personality disorder,*** also known as *borderline personality disorder* or *borderline emotionally unstable personality disorder,* was first introduced to psychiatric and psychoanalytic literature by psychoanalyst Adolf Stern in 1938, as *"borderline,"* characterizing *a "borderline group of neuroses.*" He established the definition of " *borderline disorder* " The researcher described patients whose symptom complexes were characteristic of both neurotic and psychotic states. Due to the difficulty of defining these individuals, he placed them between these two states, i.e., on the borderline between the two diagnoses.

Until the introduction of the term borderline personality disorder into psychopathology, symptoms that were not defined as psychosis were diagnosed as neurosis; whereas symptoms that did not fit the criteria for neurosis were characterized as a psychotic state.

Adolf Stern thus identified 10 characteristics that were responsible for the deterioration of the subjects' condition and their poor response to psychoanalytic treatment and other treatment methods. Among them, the following were predominant:

- narcissism,
- hypersensitivity,
- mental pain,
- stiffness of mind and body,
- lowered self-esteem,
- lack of sense of security,
- masochism,
- projection mechanisms,
- disturbances in the study of reality,
- negative reaction to psychotherapeutic treatment.

Here he described, among other things, "psychic bleeding", defining it as:

- paralysis in the face of crises,
- excessive hypersensitivity to criticism, or
- lack of confidence in stressful situations in interpersonal relationships (Stern A, 1993).

In 1942, Helen Deutsch drew attention to individuals experiencing depersonalization who narcissistically identified with other people. These patients had full control over reality but were only capable of establishing superficial relationships and often adopting the characteristics of people with whom they had contact or established interpersonal relationships (Deutsch H, 1942).

Another researcher who characterized borderline in 1947 was Melitta Schmideberg (1947) described borderline personality disorder as *"a stable form of personality disorder characterized by a lack of stability.*" Patients were unable to tolerate order and routine, were late for scheduled appointments, violated social conventions, and so on. They led chaotic lives, engaged in criminal acts, and had a tendency toward addiction. They were also observed to have poor motivation for treatment.

Moreover, in 1953, Robert Knight was the first researcher to attempt to apply findings from *ego psychology to explain borderline personality disorder. He* also used the term *"borderline personality disorder.*" In his work, he highlighted the problem of *ego weakness* in borderline personality and its correlation with psychotic crises. In his opinion, the *ego* fails to function as it should under the pressure of traumatic events. This leads to intermediate states of functioning, between neurotic and psychopathic levels. Characteristic features of borderline personality disorder included:

- lack of concern for one's own situation;
- absence of stress activating the disorder;
- tendency to externalize;
- presence of strange dreams;
- lack of a clear and distinct boundary between waking life and dreams;
- failure (lack of) achievements;
- making unrealistic life plans (Knight RP 1953).

Then, in 1956, Sandor Rado defined borderline personality disorder as *"compulsive disorder.*" Among the patient characteristics, he distinguished: impatience, intolerance to frustration, outbursts of anger, excitability, lack of responsibility, parasitism, hedonism, hunger for affection, and depressive episodes (Rado S 1956).

In turn, Barbara Easser and Stanley Lesser in 1965 used the term " *hysteroid disorders „.* Patients were characterized as irresponsible, their professional careers were irregular, and their interpersonal interactions were chaotic. In their functioning, they revealed emotional problems (early childhood) and disturbed habit patterns (in old age). ( Easser R, & Lesser S, (1965).

Otto Kernberg (1967), however, was the American researcher who contributed most to the description of borderline personality disorder. He pointed out that one of the important indicators of borderline personality disorder is depersonalization of the ego and a depressive-masochistic character trait. He then concluded that borderline personality disorder should not be explained in terms of neurosis or psychosis, nor should it be defined as a form containing features of both neurosis and psychosis. [17]

Kernberg (1967) developed *a psychodynamic model of*

*conflict*, emphasizing that disorders reflect a defensive structure designed to help the child cope with conflict caused by his or her own aggression. The "good self" and object representations are protected by primitive defense mechanisms, shielding them from aggressive tendencies. Conflict is then contained, while the ego is weakened.

Internal conflicts can lead to personality disorders. The goal of therapy is to alleviate this discomfort and help you understand and resolve it.

Additionally, in 1984, the American psychiatrist John Gunderson presented several clinical phenomena characterizing borderline patients:

- people who seemed to function well, at the same time exhibited dysfunctional thinking styles;
- they did poorly during psychoanalysis, therapy often had to be stopped and hospitalization recommended;
- During treatment, the patients' mental state deteriorated in terms of behavior;
- generated anger in the therapist when they entered therapy, their emotional state and the therapist's health seemed to deteriorate (Gunderson JG, Kolb JE, & Austin Y 1981).

It is worth mentioning that for the first time – the definition of borderline pathology and the name of the syndrome currently called " *borderline personality disorder "* were defined in the DSM-III (American Psychiatric Association 1980) by Otto Kernberg and John Gunderson. Term: preschizophrenic personality structure, borderline states, psychotic character, and borderline personality developed from the experience of clinical treatment of severely disturbed and polysymptomatic patients (Kernberg 1975). Psychotherapy focused on transference in the treatment of borderline personality disorders.

The clinical picture is very complex and has many distinct components. Otto Kernberg points out that the analysis of borderline personality organization is based on three structural criteria:

a. blurring of identity,
b. the level of defensive actions (splitting, primitive idealization, projective identification, denial, sense of omnipotence and devaluation) and
c. the ability to examine reality.

- Identity blurring – observed in a feeling of emptiness that is chronic and subjective, inconsistent self-perception, contradictory behaviors, as well as an impoverished and inconsistent vision of other people.
- Defensive Action Level - Primitive defenses dominate here, centered around the mechanism of splitting. These mechanisms protect the ego from conflict by separating conflicting experiences of the self and significant others.
- The ability to examine reality (is retained), or in other words, the ability to distinguish the "I" from the "non-I," or what is intrapsychic and what constitutes external stimuli. (Kernberg O,.Seler M., Koeningsberg , Carr A., Appelbaum A 2007).

2) Biological Approach

The biological model, however, emphasizes that borderline personality disorders are based on mood disorders with a biological basis.

In 1921, the German psychiatrist Emil Kraepelin was the first among many researchers to characterize the excitable personality as *"emotionally unstable",* and in 1950 Kurt Schneider described *the labile personality* (sudden mood changes and excessive reaction to a weak stimulus), which, according to him, had a constitutional basis (Schneider K 1923).

In the following years - in 1980, Alan Stone distinguished three subtypes of borderline disorders:

a) associated with schizophrenia, b) associated with affective disorder and c) associated with organic damage to the central nervous system (CNS) (Stone MH 1980).

In 1981, an American psychiatrist, Hagop Akiskal explored the relationship between borderline personality disorder and affective disorders. He believed that emotionally unstable individuals and their family systems were characterized by a cyclical temperament. They experienced cyclical mood swings that resembled bipolar disorder (Akiskal HS 1981).

3) Biosocial Approach

Theodore Millon (1981), whose work played a significant role in the psychological concept of personality disorders, coined the term *"cycloid personality"* —alternating periods of low and high mood. These changes stem from biological traits and temperament. Cycloid personality is considered one of the varieties of personality disorders that undoubtedly lead to significant emotional and behavioral problems (Linehan MM 2010).

In her work, created by Marsha Linehan " *Biosocial theory "* presents an analysis of how interactions between biological and social determinants influence the development of borderline personality. In terms of etiology, borderline personality is primarily a dysfunction of the emotion regulation system, stemming from biological factors combined with certain environmental dysfunctions. The emotional sensitivity of patients diagnosed with borderline personality disorder stems from their biological predispositions. Adults internalize the characteristics of their invalidating environment (e.g., they invalidate their own emotional experiences and seek reassurance from others and overestimate the ease of solving life's problems). This leads to setting unrealistic goals, inappropriately using punishment instead of rewards, self-hatred when they fail, and intense self-criticism. Their behavioral responses are extremely intense. Anxiety can reach panic levels, while irritability easily escalates into rage (Linehan MM 2010).

In recent years, especially in the United States, many researchers have become intrigued by the issue of borderline personality disorder, which is why the main positions listed below have emerged:

- *conflict model* (presenting borderline pathology as a type of intrapsychic defensive structure, relating to the abnormal integration of affects, drives and object relations;
- *deficit model* (reflecting developmental disorders that

result in deficits in the " self " or "ego");
- *descriptive research model* (a set of characteristics for a large number of patients);
- *DSM-III model* (clinically observed symptoms);
- *biological model* (including borderline pathology in terms of affective disorders) (Ogłodek E., Araszkiewicz A, 2011)

4) Descriptive Approach

The criteria included in the 11th edition of the International Classification of Diseases and Related Health Problems ( ICDs ) Health Problems , 11th Revision , ICD-11), published by the World Health Organization (WHO) and in force from January 1, 2022, can serve as a certain outline of the description of borderline pathologies (World Health Organization, 2020). They correlate with the approach presented in the current Diagnostic and Statistical Manual of Mental Disorders Disorders , Fifth Edition, DSM-5), published by the APA (American Psychiatric Association, 2013). [29]. Diagnostic criteria for borderline personality disorder according to the International Classification of Diseases ICD-10. In the diagnostic criteria for borderline personality disorder, ICD-10 uses the term *"emotionally unstable personality disorder"* (F60.3); it distinguishes two subtypes: impulsive (F60.31) and borderline (F60.32).

- **Impulsive type**

a. The general criteria for personality disorder (F60) are met.
b. At least three of the following symptoms are present:

– a noticeable tendency to act impulsively without considering the consequences,
– a predisposition to argumentative behavior and conflict in interactions, with attention drawn to when impulsive actions are thwarted or criticized,
– easily expressing anger or observing violent behavior, with an inability to control violent behavior,
– difficulty sustaining activities that do not involve immediate gratification.

- **Borderline type**

At least three of the symptoms listed below from criterion "B" for the impulsive type are present, and, in addition, at least two of the following symptoms are present:

- unclear or disorganized self-image, own goals and internal preferences (including sexual ones),
- tendency to engage in intense and unstable relationships, often leading to consequences in the form of emotional crises,
- striving to avoid the experience of abandonment,
- periodic threats or self-harming actions,
- constant feeling of inner emptiness

Diagnostic criteria for borderline personality disorder according to the next edition of the American Psychiatric Association's classification of mental disorders: DSM-V (301.83).

To diagnose borderline personality disorder, at least 5 of the 9 criteria listed below must be met:

- A desperate effort to avoid imagined rejection by others.
- Unstable and turbulent interpersonal relationships, characterized by fluctuations between extreme states – idealization or devaluation.
- Disorganization of the sense of self-identity - a distinct and persistently unstable image of oneself or "I",
- Impulsivity manifests itself in at least two categories, e.g., spending, sexual intercourse, substance abuse, reckless driving, or binge eating.
- Chronic suicidal and/or self-harm behaviors, gestures, or threats.
- The instability of emotional reactions is caused by mood swings depending on the occurring conditions (e.g. severe episodes of dysphoria, irritability or anxiety lasting from several hours to even several days).
- Experiencing a chronic feeling of emptiness.
- Inappropriate behavior, experiencing anger and difficulty controlling it (e.g. frequent outbursts of anger, repeated involvement in fights).
- Stress-related paranoid ideas (of a transient nature) or very severe dissociative symptoms

In the Polish literature, it is also important to refer to clinical experience with adolescents (presented by psychiatrist Jacek Bomba and his colleagues) regarding the psychological picture that allows for the diagnosis of a given patient as a borderline case. Patients are characterized as autistic and bizarre, yet they retain a sense of reality and exhibit no other psychotic symptoms. Occasional delusions and psychomotor agitation are fleeting and resolve quickly without treatment during the observation period. Generally, researchers consider borderline states to include all mental disorders with "psychological value" but, thanks to the patient's retained sense of reality, not psychosis (Bomba J, Mamrot E, Orwid M. 1981).

Marek Masiak (1992) emphasizes that individuals with borderline personality traits exhibit hostility and anger in their attitudes toward the world. They blame other people and the outside world for their problems. The predominant feelings are boredom, dissatisfaction, and a sense of loneliness and emptiness. Their histories include episodes of theft, sexual excesses, self-harm, and suicide attempts. Zbigniew Sokolik, in turn, emphasizes that the partially preserved ability to distinguish oneself from the external environment allows them to remain in touch with reality. Neurotic symptoms may be observed in patients, but they are highly variable. They often cannot identify what ails them (compared to individuals with neurotic traits). Descriptions typically include a lack of joy in life, persistently low mood, difficulties in interpersonal relationships, feelings of emptiness, low self-esteem, a lack of emotional experience, the presence of nonspecific anxiety, and volatility. The author also emphasizes a higher incidence of criminal behavior, alcoholism, and drug addiction (Sokolik Z 2000).

Andrzej Jakubik, however, points out that using the terminology of borderline depression, borderline schizophrenia, borderline syndrome, or borderline state may be

justified in cases of psychoses with atypical clinical presentation and course. He believes that borderline personality disorder encompasses one of the various myths present in the classification of mental disorders (Jakubik A 1996).

## III. Prevalence of personality disorders

Borderline personality disorder is one of the most challenging to treat and is also the most commonly diagnosed personality disorder in psychiatric patients.[36] Data collected from an epidemiological study (the largest to date) indicate a slight, yet statistically significant, variation in the prevalence of borderline personality disorders among 3.02% of women and 2.44% of men in the American population (Grant BF, Chou SP, Goldstein RB, Huang B, Stinson FS, Saha TD, et al. 2008).

The prevalence of borderline personality disorder is approximately 6% in primary care patients and the general population, and 15-20% in outpatient clinics and psychiatric hospitals. Hospital statistics for borderline personality disorder indicate that approximately 75% of individuals are women, while a lower percentage is observed in the general population (Gunderson JG, Links PS 2008). Researchers, however, differ in their opinions regarding the prevalence of borderline personality disorder by gender – most articles report that it is diagnosed more often in women than men. Other scientific publications do not indicate a gender difference. However, borderline personality traits are more frequently observed among young adults.

## IV. Emotion regulation in the context of destructive behavior

The results of the research by Zanarini et al. confirmed that 70-75% of patients with borderline disorder present at least one self-harming act, including: substance abuse, eating disorders, transverse skin incisions on the forearms, burning the body, cutting veins, and suicidal thoughts and tendencies (Ogłodek E, Araszkiewicz A 2011). Holm and Severinsson's research explored the determinants of destructive behaviors in borderline personality disorder and primarily analyzed their causes. Women described their condition as highly intense emotional pain, employing self-destructive strategies to survive. These results underscored the thesis that self-harm is a way to obtain emotional relief and escape from difficult/unwanted thoughts and feelings. The goal is to survive the emotional pain (Holm AL, Severinsson E 2010). Numerous studies confirm the link between self-aggressive behavior and borderline personality disorder. James and Taylor, analyzing their research results, found a significant correlation between borderline personality disorder symptoms and the occurrence of suicide attempts in women. In men, borderline personality disorder symptoms correlated with behaviors According to the authors, the presence of borderline personality disorder symptoms can predict the risk of self-destructive behavior (suicidal and auto aggressive) (James LM, Taylor J. 2008).

As publications indicate, these individuals struggle to cope with stress and problems, simultaneously experiencing a high fear of abandonment and preventing others from being close to them, thus fearing intimacy. They typically oscillate between euphoria and rage. Individuals with borderline personality disorder are typically admitted to hospital after self-harm or a suicide attempt. Due to underlying psychological difficulties, approximately 3-10% of individuals with this disorder commit suicide, usually after the age of 30 and after numerous unsuccessful attempts at specialist treatment. It is also worth mentioning here that there is still a lack of data on the epidemiology of borderline personality disorders in the Polish population.

The latest version of the World Health Organization (WHO) classification emphasizes the internalized and externalized nature of the problems experienced by people with personality disorders. The former emphasizes the individual's internal experiences, encompassing various aspects of the " self." The latter, however, emphasizes difficulties in interpersonal relationships, which can be analyzed within the framework of object relations theory (which emphasizes the importance of a person's first relationships throughout life). Borderline personality disorder is a hereditary disorder, with an estimated 42-68% of the variance attributed to genetic factors (Distel MA, Willemsen G, Ligthart L, et al. 2010). The core symptoms that meet the criteria (including emotional lability, impulsivity, and hypersensitivity in interpersonal relationships) are often observed in other family members. The importance of the environment is also worth emphasizing. Attachment disorders, neglect, childhood trauma, relationship problems between parents, or mental disorders within the family system are factors that increase the risk of the disorder (Gunderson JG, Links PS 2008).

## V. Etiology

The development of borderline personality disorder is influenced by many different etiological factors: genetic predisposition, neurotransmitter imbalance, brain structure disorders, early childhood trauma and the nature of the relationship with parents (Popiel A 2011).

1) Genetic determinants: studies conducted in the family system emphasize the importance of an increased incidence of mental disorders in first-degree relatives; in the case of borderline personality, this circumstance concerns certain traits (e.g. impulsivity) or mood fluctuations (e.g. depressiveness) ( Emmelkamp PMG, Kamphuis JH 2011).
2) Brain structure and function, neurotransmitters

Studies of brain structure and function (fMRI ) support the notion of increased activity in the amygdala, which is responsible for the emergence of fearful emotions. Furthermore, abnormalities in the functioning of areas of the orbitofrontal cortex, which control planning functions, have been indicated. As further research results indicate, disturbances in the regulation of emotional states (emotions can be easily aroused but are not subject to our control) are

associated with a reduction in the volume of the limbic system structures (hippocampus and amygdala) (Siever LJ, Davis KL 1991). Studies have also shown that the greatest anomalies in serotonergic conduction are found in people with high levels of autoaggression. In addition, there is a decreased level of endogenous opioids (also known as beta-endorphins). It is worth noting that the occurrence of depersonalization may be related to excessive activation of opioid receptors. Beta-endorphins play an important role in shaping interpersonal bonds (which is related to their decreased levels in borderline personality disorder). During the intense phase of infatuation/falling in love, activation of the ventral tegmentum increases, which is associated with the release of endorphins. When this state of intense emotion resolves, activation of the cortex leads to conflicting feelings. Simultaneously, two areas of the central nervous system are not effectively cooperating, so the patient experiences emotional experiences of love and hatred at times. Risky sexual behavior or the pursuit of attention from others, expressed through outbursts of anger, are closely related to the activation of the dopaminergic and mesolimbic systems and the release of opioids, as well as dopamine and oxytocin. The occurrence of dysfunction of endorphin secretion controls mood changes: a sense of emptiness, depressive states and euphoric states (Bartel A, Zeki S 2004).

3) Trauma, Environment, and Upbringing

In a normally developing child, during the first years of life, a gradual integration of extremely positive and negative representations of self and others occurs, resulting in internal representations of self and objects. These representations are more authentic and complex when they recognize that each individual is a blend of both positive and negative traits, and as a result, contact with them sometimes brings satisfaction or frustration. In patients with advanced borderline pathology, this mechanism does not occur. The permanent, pathological, and intrapsychic structure is the constant demarcation between the idealized and persecutory parts of emotionally intense experiences. There is a lot of information in the literature about patients with borderline personality disorder who describe traumatic experiences in childhood. The development of disorders is influenced not only by the experience of trauma, but also by the type of trauma, its duration and implications (including, colloquially speaking, a "slap" or blows with physical injuries; sexual abuse by a person outside the family, or a relative repeatedly forcing the child to have sexual intercourse). Research conducted by Lobbestal et al., examining the relationship between adverse childhood experiences and personality disorders, revealed the emergence of certain patterns. The analysis showed that sexual abuse experience was significantly associated with avoidant, borderline, paranoid, and schizoid personality disorders; while physical abuse experience correlated with antisocial personality disorder (Lobbestael J., Arntz A., Bernstein Dv 2010). In another study, Judith Herman, exploring the topic of borderline personality disorder, showed that as many as 81% of patients with this diagnosis experienced trauma in childhood, including 71% of physical abuse, 68% of sexual abuse, and 62% of witnesses of domestic violence (Herman JL, Perry JC, van der Kolk BA 1989). According to Gunderson et al., parental neglect, in the form of actual abandonment and rejection or perceived "rejection", also plays a significant role (Gunderson JG, Lyons-Ruth K 2008). Thomas and Chess, on the other hand, emphasize that the good or poor fit of the child to the environment is fundamental to understanding later behavioral functioning (Thomas A. & Chess S 1977). Young, on the other hand, refers to traumatic experiences in childhood when basic needs essential for a child's proper development were not met. Kernberg refers to *"frustration of emotional needs*, " Bateman and Fonagy to an inadequate *"reflection of emotional experience*. " Linehan refers to the importance of *an "invalidating environment*. " It is worth noting here that the authors are consistent in concluding that this is only important when a child with a temperament - biologically determined sensitivity - finds itself in unfavorable environmental conditions (Paris J 2008) It is worth emphasizing here that the above-mentioned circumstances cannot be unequivocally considered as the cause of borderline personality disorder.

## VI. Conclusions

The level of knowledge describing the determinants and pathomechanisms of borderline personality disorder is currently more pluralistic and more structured. Despite this, a lack of theoretical and practical certainty can still be observed among clinicians and psychotherapists (Cierpiałkowska L. and Soroko E. 2017).

Successful treatment of borderline patients is demanding and, in fact, more complex than the literature presents. The increasing number of research studies and scientific publications in the context of borderline personality disorder provides an opportunity for further development of knowledge, appropriate and effective therapeutic interventions for patients, in order to ensure appropriate support and adequate specialist assistance.

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