

# BORDERLINE PERSONALITY DISORDER IN 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..

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

## 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: 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)

## Clinical issues

The following are various theoretical perspectives in psychology and psychiatry (according to individual authors)

57 describing borderline personality disorder :

- 58 • psychoanalytic approach;
- 59 • biological approach;
- 60 • biosocial approach ;
- 61 • descriptive approach.

#### 62 I. Psychoanalytic Approach

63 Borderline personality disorder , also known as *borderline*  
64 *personality disorder* or *borderline emotionally unstable*  
65 *personality disorder* , was first introduced to psychiatric and  
66 psychoanalytic literature by psychoanalyst Adolf Stern in 1938,  
67 as "borderline ,"characterizing a "borderline group of neuroses"  
68 ." He established the definition of " *borderline disorder*." The  
69 researcher described patients whose symptom complexes were  
70 characteristic of both neurotic and psychotic states. Due to the  
71 difficulty  
72 of defining these individuals, he placed them between these two  
73 states, i.e., on the borderline between the two diagnoses. Until  
74 the introduction of the term borderline personality disorder into  
75 psychopathology , symptoms that were not defined  
76 as psychosis were diagnosed as neurosis; whereas symptoms  
77 that did not fit the criteria for neurosis were characterized as  
78 psychotic state.

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

- 84 • narcissism,
- 85 • hypersensitivity,
- 86 • mental pain,
- 87 • stiffness of mind and body,
- 88 • lowered self-esteem,
- 89 • lack of sense of security,
- 90 • masochism,
- 91 • projection mechanisms,
- 92 • disturbances in the study of reality,
- 93 • negative reaction to psychotherapeutic treatment.
- 94 • Here he described, among other things, "psychic bleeding"  
95 defining it as:  
96 • paralysis in the face of crises,  
97 • excessive hypersensitivity to criticism, or  
98 • lack of confidence in stressful situations in interpersonal  
99 relationships (Stern A, 1993).

100 In 1942, Helen Deutsch drew attention to individuals  
101 experiencing depersonalization who narcissistically identified  
102 with other people. These patients had full control over reality  
103 but were only capable of establishing superficial relationships  
104 and often adopting the characteristics of people with whom they  
105 had contact or established interpersonal relationships ( Deutsch  
106 H, 1942). Another researcher who characterized borderline  
107 1947 was Melitta Schmideberg (1947) described borderline  
108 personality disorder as "a stable form of personality disorder  
109 characterized by a lack of stability ." Patients were unable  
110 tolerate order and routine, were late for scheduled  
111 appointments, violated social conventions, and so on. They  
112 chaotic lives, engaged in criminal acts, and had a tendency  
113 toward addiction. They were also observed to have poor

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

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

133 Then, in 1956, Sandor Rado defined borderline personality  
134 disorder as "*compulsive disorder* ." Among the patient  
135 characteristics, he distinguished: impatience, intolerance to  
136 frustration, outbursts of anger, excitability, lack of  
137 responsibility, parasitism, hedonism, hunger for affection, and  
138 depressive episodes (Rado S 1956). In turn, Barbara Easser and  
139 Stanley Lesser in 1965 used the term " *hysteroid disorders* " .  
140 Patients were characterized as irresponsible, their professional  
141 careers were  
142 irregular, and their interpersonal interactions were chaotic. In  
143 their functioning, they revealed emotional problems (early  
144 childhood) and disturbed habit patterns (in old age). ( Easser R,  
145 & Lesser S, (1965).

146 Otto Kernberg (1967), however, was the American  
147 researcher who contributed most to the description of  
148 borderline personality disorder. He pointed out that one of the  
149 important indicators of borderline personality disorder is  
150 depersonalization of the ego and a depressive-masochistic  
151 character trait. He then concluded that borderline personality  
152 disorder should not be explained in terms of neurosis or  
153 psychosis, nor should it be defined as a form containing features  
154 of both neurosis and psychosis. Kernberg (1967) developed a  
155 *psychodynamic model of conflict* , emphasizing that disorders  
156 reflect a defensive structure designed to help the child cope with  
157 conflict caused by his or her own aggression. The "good self"  
158 and object representations are protected by primitive defense  
159 mechanisms, shielding them from aggressive tendencies.  
160 Conflict is then contained, while the ego is weakened. Internal  
161 conflicts can lead to personality disorders. The goal of therapy  
162 is to alleviate this discomfort and help you understand and  
163 resolve it. Additionally, in 1984, the American psychiatrist John  
164 Gunderson presented several clinical phenomena  
165 characterizing borderline patients:

- 166 • people who seemed to function well, at the same time  
167 exhibited dysfunctional thinking styles;
- 168 • they did poorly during psychoanalysis, therapy often had to  
169 be stopped and hospitalization recommended;
- 170 • During treatment, the patients' mental state deteriorated in

171	terms of behavior;	226	temperament. They experienced cyclical mood swings that
172	• generated anger in the therapist when they entered therapy	227	resembled bipolar disorder ( Akiskal HS 1981).
173	their emotional state and the therapist's health seemed	228	Theodore Millon (1981), whose work played a significant
174	deteriorate ( Gunderson JG, Kolb JE, & Austin Y 1981).	229	role in the psychological concept of personality disorders,
175	It is worth mentioning that for the first time – the definition	230	coined the term " <i>cycloid personality</i> " —alternating periods of
176	of borderline pathology and the name of the syndrome currently	231	low and high mood. These changes stem from biological traits
177	called " <i>borderline personality disorder</i> " were defined in the	232	and temperament. Cycloid personality is considered one of the
178	DSM-III (American Psychiatric Association 1980) by Otto	233	varieties of personality disorders that undoubtedly lead to
179	Kernberg and John Gunderson . The terms pre-schizophrenic	234	significant emotional and behavioral problems ( Linehan MM
180	personality structure, borderline states , psychotic character	235	2010). In her work, created by Marsha Linehan " <i>Biosocial</i>
181	and borderline personality developed from the experience	236	<i>theory</i> " presents an analysis of how interactions between
182	clinical treatment of severely disturbed and polysymptomatic	237	biological and social determinants influence the development
183	patients ( Kernberg 1975). Psychotherapy focused on	238	of borderline personality . In terms of etiology, borderline
184	transference in the treatment of borderline personality disorder	239	personality is primarily a dysfunction of the emotion regulation
185	The clinical picture is very complex and has many distinctive	240	system, stemming from biological factors combined with
186	components. Otto Kernberg points out that the analysis of	241	certain environmental dysfunctions. The emotional sensitivity
187	borderline personality organization is based on three structural	242	of patients diagnosed with borderline personality disorder stems
188	criteria:	243	from their biological predispositions. Adults internalize the
189	• blurring of identity,	244	characteristics of their invalidating environment (e.g., they
190	• the level of defensive actions (splitting, primitive	245	invalidate their own emotional experiences and seek
191	idealization, projective identification, denial, sense	246	reassurance from others, and overestimate the ease of solving
192	omnipotence and devaluation) and	247	life's problems). This leads to setting unrealistic goals,
193	• the ability to examine reality.	248	inappropriately using punishment instead of rewards, self-
194	Identity blurring – observed in a feeling of emptiness that	249	hated when they fail, and intense self-criticism. Their
195	chronic and subjective, inconsistent self-perception of	250	behavioral responses are extremely intense. Anxiety can reach
196	contradictory behaviors , as well as an impoverished and	251	panic levels, while irritability easily escalates into rage
197	inconsistent vision of other people. Defensive Action Level	252	(Linehan MM 2010). In recent years, especially in the United
198	Primitive defenses dominate here, centered around the	253	States, many researchers have become intrigued by the issue of
199	mechanism of splitting. These mechanisms protect the ego from	254	borderline personality disorder, which is why the main
200	conflict by separating conflicting experiences of the self and	255	positions listed below have emerged:
201	significant others. The ability to examine reality (is retained	256	• <i>conflict model</i> (presenting borderline pathology as a type of
202	or in other words, the ability to distinguish the "non-I,"	257	intrapsychic defensive structure, relating to the abnormal
203	from the "non-I," or what is intrapsychic and what constitutes	258	integration of affects, drives and
204	external stimuli. ( Kernberg O., Seler M., Koenigsberg , Campbell	259	object relations;
205	A., Appelbaum A 2007).	260	• <i>deficit model</i> (reflecting developmental disorders that
		261	result in deficits in the " self "
		262	or "ego");
206	MAIN PART	263	• <i>descriptive research model</i> (a set of characteristics for a
207	The biological model, however, emphasizes that borderline	264	large number of patients);
208	personality disorders are based on mood disorders with a	265	• <i>DSM-III model</i> (clinically observed symptoms);
209	biological basis.	266	• <i>biological model</i> (including borderline pathology in terms
210	In 1921, the German psychiatrist Emil Kraepelin was the first	267	of affective disorders) (Ogłodek E., Araszkievicz A, 2011)
211	among many researchers to characterize the excitable	268	The criteria included in the 11th edition of the International
212	personality as " <i>emotionally unstable</i> " , and in 1950 Kurt	269	Classification of Diseases and Related Health Problems ( ICDs
213	Schneider described <i>the labile personality</i> (sudden mood	270	) Health Problems , 11th Revision , ICD-11), published by the
214	changes and excessive reaction to a weak stimulus), which,	271	World Health Organization (WHO) and in force from January
215	according to him, had a constitutional basis (Schneider K 1923).	272	1, 2022, can serve as a certain outline of the description of
216	In the following years - in 1980, Alan Stone distinguished	273	borderline pathologies (World Health Organization, 2020).
217	three subtypes of borderline disorders:	274	They correlate with the approach presented in the current
218	a) associated with schizophrenia, b) associated with affective	275	Diagnostic and Statistical Manual of Mental Disorders
219	disorder and c) associated with organic damage to the central	276	Disorders , Fifth Edition, DSM-5), published by the APA
220	nervous system (CNS) ( Stone MH 1980).	277	(American Psychiatric Association , 2013). [29] Diagnostic
221	In 1981, an American psychiatrist, Hagop Akiskal explored	278	criteria for borderline personality disorder according to the
222	the relationship between borderline personality disorder and	279	International Classification of Diseases ICD-10 In the
223	affective disorders. He believed that emotionally unstable	280	diagnostic criteria for borderline personality disorder , ICD-10
224	individuals	281	uses the term " <i>emotionally unstable personality disorder</i> "
225	and their family systems were characterized by a cyclical	282	(F60.3); it distinguishes two subtypes: impulsive (F60.31) and

283	borderline (F60.32).	340	Bomba and his colleagues) regarding the psychological picture
284	1) <i>Impulsive type</i>	341	that allows for the diagnosis of a given patient as a borderline
285	A. The general criteria for personality disorder (F60) are met	342	case. Patients are characterized as autistic and bizarre, yet they
286	B. At least three of the following symptoms are present:	343	retain a sense of reality and exhibit no other psychotic
287	• a noticeable tendency to act impulsively with	344	symptoms. Occasional delusions and psychomotor agitation are
288	considering the consequences,	345	fleeting and resolve quickly without treatment during the
289	• a predisposition to argumentative behavior and conflict	346	observation period. Generally, researchers consider borderline
290	interactions, with attention drawn	347	states to include all mental disorders with "psychological value"
291	to when impulsive actions are thwarted or criticized,	348	but, thanks to the patient's retained sense of reality, not
292	• easily expressing anger or observing violent behavior , with	349	psychosis ( Bomba J, Mamrot E, Orwid M. 1981). Masiak
293	an	350	(1992) emphasizes that individuals with borderline personality
294	to control violent behavior ,	351	traits exhibit hostility and anger in their attitudes toward the
295	• difficulty sustaining activities that do not involve	352	world. They blame other people and the outside world for their
296	immediate gratification.	353	problems. The predominant feelings are boredom,
297	2) <i>Borderline type</i>	354	dissatisfaction, and a sense of loneliness and emptiness. Their
298	At least three of the symptoms listed below from criteria	355	histories include episodes of theft, sexual excesses, self-harm,
299	"B" for the impulsive type are present , and, in addition, at least	356	and suicide attempts . Sokolik, in turn, emphasizes that the
300	two of the following symptoms are present:	357	partially preserved ability to distinguish oneself from the
301	• unclear or disorganized self-image, own goals and interests	358	external environment allows them to remain in touch with
302	preferences	359	reality. Neurotic symptoms may be observed in patients, but
303	(including sexual ones),	360	they are highly variable. They often cannot identify what ails
304	• tendency to engage in intense and unstable relationships	361	them (compared to individuals with neurotic traits).
305	often	362	Descriptions typically include a lack of joy in life, persistently
306	to consequences in the form of emotional crises,	363	low mood, difficulties in interpersonal relationships, feelings of
307	• striving to avoid the experience of abandonment,	364	emptiness, low self-esteem, a lack of emotional experience, the
308	• periodic threats or self-harming actions ,	365	presence of nonspecific anxiety, and volatility. The author also
309	• constant feeling of inner emptiness	366	emphasizes a higher incidence of criminal behavior ,
310	Diagnostic criteria for borderline personality disorder	367	alcoholism, and drug addiction ( Sokolik Z 2000). Jakubik,
311	according to the next edition of the American Psychiatric	368	however, points out that using the terminology of borderline
312	Association's classification of mental disorders: DSM	369	depression, borderline schizophrenia, borderline syndrome, or
313	(301.83). To diagnose borderline personality disorder , at least	370	borderline state may be justified in cases of psychoses with
314	5 of the 9 criteria listed below must be met:	371	atypical clinical presentation and course. He believes that
315	• A desperate effort to avoid imagined rejection by others	372	borderline personality disorder encompasses one of the various
316	• Unstable and turbulent interpersonal relationships	373	myths present in the classification of mental disorders (Jakubik
317	characterized by fluctuations between extreme states	374	A 1996).
318	idealization or devaluation.	375	3) <i>Prevalence of personality disorders</i>
319	• Disorganization of the sense of self-identity - a distinct and	376	Borderline personality disorder is one of the most
320	persistently unstable image of oneself	377	challenging to treat and is also the most commonly diagnosed
321	or "I",	378	personality disorder in psychiatric patients. Data collected from
322	• Impulsivity manifesting itself in at least two categories	379	an epidemiological study (the largest to date) indicate a slight,
323	e.g., spending, sexual intercourse, substance abuse	380	yet statistically significant, variation in the prevalence of
324	reckless driving, or binge eating.	381	borderline personality disorders among 3.02% of women and
325	• Chronic suicidal and/or self-harm behaviors, gestures,	382	2.44% of men in the American population (Grant BF, Chou SP,
326	threats.	383	Goldstein RB, Huang B, Stinson FS, Saha TD, et al. 2008). The
327	• The instability of emotional reactions is caused by mood	384	prevalence of borderline personality disorder is approximately
328	swings	385	6% in primary care patients and the general population, and 15-
329	on the occurring conditions (e.g. severe episodes	386	20% in outpatient clinics and psychiatric hospitals. Hospital
330	dysphoria, irritability or anxiety lasting from several hours	387	statistics for borderline personality disorder indicate that
331	to even several days).	388	approximately 75% of individuals
332	• Experiencing a chronic feeling of emptiness.	389	are women, while a lower percentage is observed in the general
333	• Inappropriate behavior, experiencing anger and difficulty	390	population ( Gunderson JG, Links PS 2008). Researchers,
334	controlling it (e.g. frequent outbursts of anger, repeated	391	however, differ in their opinions regarding the prevalence of
335	involvement in fights).	392	borderline personality disorder by gender - most articles report
336	• Stress-related paranoid ideas (of a transient nature)	393	that it is diagnosed more often in women
337	or very severe dissociative symptoms	394	than men. Other scientific publications do not indicate a gender
338	In the Polish literature, it is also important to refer to clinical	395	difference. However, borderline personality traits are more
339	experience with adolescents (presented by psychiatrist Jacubik	396	frequently observed among young adults.

397 4) *Emotion regulation in the context of destructive* 454  
 398 *behavior* 455  
 399 The results of the research by Zanarini et al . confirmed that 456  
 400 70-75% of patients with borderline disorder present at least one 457  
 401 self-harming act , including: substance abuse, eating disorders, 458  
 402 transverse skin incisions on the forearms, burning the body 459  
 403 cutting veins, and suicidal thoughts and tendencies (Ogłodek E 460  
 404 Araszkiwicz A 2011). Holm and Severinsson's research 461  
 405 explored the determinants of destructive behaviors in borderline 462  
 406 personality disorder and primarily analyzed their causes 463  
 407 Women described their condition as highly intense emotional 464  
 408 pain, employing self-destructive strategies to survive. These 465  
 409 results underscored the thesis that self-harm is a way to obtain 466  
 410 emotional relief and escape from difficult/unwanted thoughts 467  
 411 and feelings. The goal is to survive the emotional pain (Holm 468  
 412 AL, Severinsson E 2010). Numerous studies confirm the link 469  
 413 between self-aggressive behavior and borderline personality 470  
 414 disorder. James and Taylor, analyzing their research results 471  
 415 found a significant correlation between borderline personality 472  
 416 disorder symptoms and the occurrence of suicide attempts in 473  
 417 women. In men, borderline personality disorder symptoms 474  
 418 correlated with behaviors According to the authors , the 475  
 419 presence of borderline personality disorder symptoms can 476  
 420 predict the risk of self-destructive behavior ( suicidal and auto 477  
 421 aggressive) ( James LM, Taylor J. 2008). As publications 478  
 422 indicate, these individuals struggle to cope with stress and 479  
 423 problems, simultaneously experiencing a high fear of 480  
 424 abandonment and preventing others from being close to them 481  
 425 thus fearing intimacy. They typically oscillate between 482  
 426 euphoria and rage. Individuals with borderline personality 483  
 427 disorder are typically admitted to hospital after self-harm or a 484  
 428 suicide attempt. Due to underlying psychological difficulties 485  
 429 approximately 3-10% of individuals with this disorder commit 486  
 430 suicide, usually after the age of 30 and after numerous 487  
 431 unsuccessful attempts at specialist treatment. It is also worth 488  
 432 mentioning here that there is still a lack of data on the 489  
 433 epidemiology of borderline personality disorders in the Polish 490  
 434 population. The latest version of the World Health Organization 491  
 435 (WHO) classification emphasizes the internalized and 492  
 436 externalized nature of the problems experienced by people with 493  
 437 personality disorders. The former emphasizes the individual's 494  
 438 internal experiences, encompassing various aspects of the " self 495  
 439 ." The latter, however, emphasizes difficulties in interpersonal 496  
 440 relationships, which can be analyzed within the framework of 497  
 441 object relations theory (which emphasizes the importance of a 498  
 442 person's first relationships throughout life). Borderline 499  
 443 personality disorder is a hereditary disorder, with an estimated 500  
 444 42-68% of the variance attributed to genetic factors ( Distel 501  
 445 MA, Willemsen G, Ligthart L, et al. 2010). The core symptoms 502  
 446 that meet the criteria (including emotional lability, impulsivity 503  
 447 and hypersensitivity in interpersonal relationships) are often 504  
 448 observed in other family members. The importance of the 505  
 449 environment is also worth emphasizing. Attachment disorders 506  
 450 neglect, childhood trauma, relationship problems between 507  
 451 parents, or mental disorders within the family system are factors 508  
 452 that increase the risk of the disorder ( Gunderson JG, Links 509  
 453 2008). 510

## 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

511 a lot of information in the literature about patients with  
 512 borderline personality disorder who describe traumatic  
 513 experiences in childhood. The development of disorders is  
 514 influenced not only by the experience of trauma, but also by the  
 515 type of trauma, its duration and implications (including,  
 516 colloquially speaking, a "slap" or blows with physical injuries  
 517 sexual abuse by a person outside the family, or a relative  
 518 repeatedly forcing the child to have sexual intercourse)  
 519 Research conducted by Lobbetal et al ., examining the  
 520 relationship between adverse childhood experiences and  
 521 personality disorders, revealed the emergence of certain  
 522 patterns. The analysis showed that sexual abuse experience was  
 523 significantly associated with avoidant, borderline , paranoid  
 524 and schizoid personality disorders ; while physical abuse  
 525 experience correlated with antisocial personality disorder  
 526 Lobbetael J., Arntz A., Bernstein Dv 2010).

527 In another study, Judith Herman, exploring the topic of  
 528 borderline personality disorder , showed that as many as 81%  
 529 of patients with this diagnosis experienced trauma in childhood,  
 530 including 71% of physical abuse, 68% of sexual abuse, and  
 531 62% of witnesses of domestic violence ( Herman JL, Perry J  
 532 van der Kolk BA 1989). According to Gunderson et al., parental  
 533 neglect, in the form of actual abandonment and rejection  
 534 perceived "rejection", also plays a significant role ( Gundersen  
 535 JG, Lyons-Ruth K 2008). Thomas and Chess , on the other  
 536 hand, emphasize that the good or poor fit of the child to the  
 537 environment is fundamental to understanding later behavioral  
 538 functioning ( Thomas A. & Chess S 1977). Young, on the other  
 539 hand, refers to traumatic experiences in childhood when basic  
 540 needs essential for a child's proper development were not met  
 541 Kernberg refers to "frustration of emotional needs , " Bateman  
 542 and Fonagy to an inadequate "reflection of emotional  
 543 experience . " Linehan refers to the importance of  
 544 "invalidating environment . " It is worth noting here that the  
 545 authors are consistent in concluding that this is only important  
 546 when a child with a temperament - biologically determined  
 547 sensitivity - finds itself in unfavorable environmental  
 548 conditions ( Paris J 2008) It is worth emphasizing here that the  
 549 above-mentioned circumstances cannot be unequivocally  
 550 considered as the cause of borderline personality disorder.

## 551 CONCLUSION

552 The level of knowledge describing the determinants and  
 553 pathomechanisms of borderline personality disorder is  
 554 currently more pluralistic and more structured. Despite this  
 555 lack of theoretical and practical certainty can still be observed  
 556 among clinicians and psychotherapists ( Cierpiakowska Ł  
 557 and Soroko E. 2017).

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

assistance.

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