An Overview of Borderline Personality Disorder, ICD10 (F60.3), DSM5 301.83

- Borderline Personality Disorder (BPD) is an established mental health disorder recognised by all major diagnostic systems.
- It has very clearly defined diagnostic inclusion criteria which need to be established for the diagnosis to be reached.
- It is not a diagnosis of exclusion or a 'dustbin' diagnosis, assigned when 'nothing else fits'

- Like any other illness, BPD is a biological condition, with established physical correlates – certain parts of the brain (amygdala) are overactive and others (prefrontal cortex) are underactive (1)
- There is also evidence that neurohormones, such as oxytocin and opioids, mediate the exaggerated fears of rejection and abandonment that are characteristic of BPD (2).

- Every effective therapy modality enhances prefrontal cortex activity
- Doing this helps a patient build an ability to gain control over behaviours and feelings, and make more accurate interpretations of the world and people around them.
- Like a lot of medical conditions, BPD is significantly heritable (42-68% of the variance is associated with genetic factors) (3,4).

- Early life trauma can play a generative role in a lot of BPD patients, but the presence or absence of trauma does not exclude the possibility of the disorder (5).
- It is entirely possible to develop BPD without any history of abuse.
- It is established that a sizable percentage of patients who experience early childhood trauma do not develop BPD (6).

- BPD is a disorder with major deficits in the brain's emotion regulation system.
- This leaves a patient very sensitive to environmental stress. In particular, patients struggle with interpersonal stressors (anger, rejection) and circumstances lacking structure (inconsistency, ambiguity, unpredictability).
- Patients benefit from stable and predictability reliable environments, across domains like housing, relationships, sobriety and support networks.
- Much of the process of 'recovery' is building such an environment around oneself.

- Symptom improvement and symptom remission does happen for most BPD patients (50% by 2 years, 85% by 10 years).
- Unlike most other psychiatric disorders, a significant majority of those reaching remission usually do not relapse (7).
- However, alongside the aim of symptom improvement a life must also be lived.

- While symptom severity and life-satisfaction in BPD do show improvements, it is a challenge for BPD patients to improve long-term social functioning outcomes (e.g. only one-third patients achieve stable marriages or full-time employment by 10 years) (7).
- Therefore deciding upon and working towards such 'life outcomes' should also form a focus of the our therapeutic 'task' of building a "life worth living"

- Numerous proven psychological treatments exist for patients with BPD. These include therapy techniques like MBT, DBT and CBT – all require a considerable commitment of time (1-3 hours per week for a year or more) working with a trained therapist.
- The majority of BPD patients show substantial symptom improvement without receiving any of these therapies.
- Managing BPD like other SMIs using sound medical principles is usually sufficient to generate stabilisation and social adaptation, and reduce distress (8–10).
- Intensive psychological treatments can be considered for patients who do not respond.

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