CONDITION

Borderline personality disorder

Learn about borderline personality disorder, including emotional and relationship symptoms, diagnosis, psychotherapy, crisis care, and long-term recovery.

WHAT IT IS
Mental health condition affecting emotions, relationships, and self-image

BODY SYSTEM
Mental health

MAIN SYMPTOMS
Rapid emotional changes, unstable relationships, impulsive behavior, self-harm

WHAT CAUSES IT
Inherited traits, life experiences, and environment

HOW IT IS DIAGNOSED
Detailed clinical assessment

MAIN TREATMENT
Structured psychotherapy

CAN IT BE CURED?
Sometimes, meaningful recovery occurs over time

IS IT AN EMERGENCY?
Sometimes, when unable to stay safe

LONG-TERM OUTLOOK
Many people experience meaningful recovery over time

Overview

Borderline personality disorder, or BPD, is a mental health condition that affects how a person manages emotions, experiences relationships, and views themselves. It can also involve impulsive behavior, intense fear of rejection or abandonment, self-harm, and suicidal thoughts.

The word "personality" can be misleading. BPD does not mean that someone has a bad or defective personality. It describes a long-standing pattern of emotional and behavioral difficulties that causes distress or disrupts daily life. These patterns often begin by adolescence or early adulthood, although diagnosis requires careful assessment.

Emotions in BPD may feel very strong and may change quickly, especially during conflict, perceived rejection, or uncertainty in a close relationship. A person may shift between idealizing someone and feeling deeply disappointed or angry with them. Their sense of identity,

goals, or values may also feel unstable.

BPD is sometimes confused with bipolar disorder. Both can involve mood changes and impulsivity, but they are not the same. In BPD, emotional shifts are often connected to events and may occur over hours or days. Bipolar disorder involves distinct episodes of mania, hypomania, or depression that follow a different pattern. The conditions can occur together, so a professional evaluation is important.

BPD can seriously affect relationships, education, work, and physical safety. However, it is treatable. Structured psychotherapy can reduce symptoms and improve functioning. Many people experience meaningful recovery over time.

Symptoms

BPD affects people in different ways. Symptoms may also vary in intensity over time. Clinicians look for a persistent pattern across several parts of life rather than one reaction or isolated crisis.

Possible symptoms include:

Feeling detached may include a sense of watching oneself from outside the body or feeling that the world is unreal. This is called dissociation. It may be frightening, but it does not always mean that a person has a psychotic disorder.

Self-harm is not always a suicide attempt. Some people use it to manage overwhelming feelings, punish themselves, or feel something when emotionally numb. It still deserves prompt medical and mental health attention because injuries can be serious and suicide risk can change.

Seek emergency help if you or someone else is in immediate danger, has made a suicide attempt, has taken an overdose, has a plan and access to a lethal method, has a severe self-inflicted injury, or cannot stay safe. In the United States, call or text 988 for the Suicide & Crisis Lifeline, call 911, or go to an emergency department. Elsewhere, use the local emergency number or crisis service.

- Strong fear of being abandoned, rejected, or left alone
- Intense or unstable relationships
- Rapid changes in how a person sees themselves or other people
- An uncertain or shifting sense of identity, values, career plans, or goals

- Impulsive behavior that may cause harm, such as unsafe sex, reckless driving, uncontrolled spending, binge eating, or substance use
- Repeated self-harm, suicidal thoughts, or suicidal behavior
- Strong emotional reactions and difficulty returning to a calmer state
- Ongoing feelings of emptiness
- Intense anger or difficulty controlling anger
- Brief periods of suspicious thinking or feeling detached from oneself or reality during severe stress

Causes and risk factors

There is no single cause of BPD. Research suggests that it develops through a combination of inherited traits, brain and emotional processes, life experiences, and the person's environment.

BPD can run in families, but having an affected relative does not mean that someone will develop the condition. Inherited differences in emotional sensitivity, impulsivity, or stress response may contribute.

Some people with BPD report childhood abuse, neglect, unstable caregiving, loss, or repeated exposure to conflict. These experiences can affect trust, emotional regulation, and the sense of personal safety. However, not everyone with BPD has experienced trauma, and most people who experience trauma do not develop BPD. Trauma should not be assumed.

Other possible contributors include difficulty learning how to recognize and manage emotions, high sensitivity to rejection, and environments in which feelings were dismissed or responded to inconsistently. These factors can interact in complex ways.

BPD often occurs with other mental health conditions, including depression, anxiety disorders, post-traumatic stress disorder, eating disorders, attention-deficit/hyperactivity disorder, substance use disorders, and bipolar disorder. The presence of another condition does not confirm or rule out BPD.

Diagnosis

There is no blood test, brain scan, or questionnaire that can diagnose BPD by itself. Diagnosis is based on a detailed clinical assessment by a qualified mental health professional.

The clinician will ask about emotional patterns, relationships, identity, impulsive behavior,

self-harm, suicidal thoughts, and how symptoms affect daily life. They may ask when the difficulties began and whether they occur across different situations. With permission, information from a family member or another clinician may sometimes help clarify the history.

The assessment should also consider physical health, current medicines, alcohol or drug use, trauma, and other mental health conditions. Depression, bipolar disorder, post-traumatic stress disorder, substance use, and attention-deficit/hyperactivity disorder can share some features with BPD. More than one diagnosis may be appropriate.

A diagnosis should not be made from one symptom, a single conflict, or a short period of distress. Adolescents can have BPD when the pattern is persistent and clinically significant, but assessment should account for normal development and changing circumstances.

Some people worry that the diagnosis will define them or affect how clinicians treat them. It is reasonable to ask how the diagnosis was reached, what alternatives were considered, and how it will guide care. A diagnosis should help create a useful treatment plan, not become a judgment about the person.

Treatment and management

Psychotherapy, also called talk therapy, is the main treatment for BPD. Effective care is usually structured, has clear goals, and includes a plan for managing crises. Treatment may continue for months or longer, depending on the person's needs and progress.

Dialectical behavior therapy, or DBT, was developed specifically for people with chronic self-harm and BPD. It teaches skills for managing intense emotions, tolerating distress, staying aware of the present moment, and communicating more effectively. Treatment may include individual therapy, group-based skills training, and coaching on how to use skills during difficult situations.

Mentalization-based therapy helps people become more accurate and flexible when thinking about their own mental state and the thoughts or intentions of others. Other structured approaches include schema-focused therapy and transference-focused psychotherapy. Availability varies, and no single approach is best for everyone.

A stable working relationship with the treatment team is important. The person and clinician may agree on goals such as reducing self-harm, improving relationships, returning to work or education, or managing substance use. Treatment can be difficult at times, especially when trust and abandonment are major concerns. Discussing missed appointments, urges to leave treatment, or conflict with a therapist can itself be part of therapy.

Medicines do not treat the full pattern of BPD, and no medicine is approved by the U.S. Food

and Drug Administration specifically for BPD. A clinician may sometimes prescribe medicine for a coexisting condition, such as major depression, or use a time-limited medicine strategy for a specific symptom. Benefits, side effects, overdose risk, and interactions should be reviewed carefully. Taking several psychiatric medicines without clear targets can add risk without improving core symptoms.

Crisis care should focus on immediate safety, calming the situation, identifying what triggered the crisis, and deciding what support is needed next. Hospital care may be appropriate when there is serious and immediate danger or another condition requires inpatient treatment. Routine hospital admission is not automatically needed for every increase in distress.

A written safety plan can list warning signs, coping steps, supportive people, professional contacts, and ways to reduce access to lethal means. It should be developed with a clinician rather than relying only on a promise not to self-harm.

Sleep, regular meals, physical activity, and avoiding alcohol or non-prescribed drugs can support treatment. These steps do not replace psychotherapy, but they may reduce factors that make emotional control harder. Family education or therapy may also help relatives respond consistently while maintaining appropriate boundaries.

Complications

Without effective support, BPD can disrupt close relationships, employment, education, finances, and housing. Impulsive behavior may lead to injuries, infections, legal problems, unwanted pregnancy, or harmful substance use.

Repeated self-harm can cause scarring, nerve damage, blood loss, or infection. BPD is also associated with an increased risk of suicide. Any new or worsening suicidal thinking should be taken seriously, especially when it involves a plan, preparation, access to lethal means, intoxication, or a recent major loss.

Other mental health conditions may make treatment more complex. For example, substance use can increase impulsivity, while an eating disorder can create urgent physical health risks. Coordinated care helps prevent one condition from being overlooked.

Complications are not inevitable. Symptoms often become less severe with treatment and time. Improvement may include fewer crises, safer coping, steadier relationships, and a stronger sense of identity, even if emotional sensitivity remains.

Follow up

Routine follow-up allows the person and clinician to review symptoms, safety, relationships, daily functioning, and progress toward treatment goals. Visits may also address physical health, substance use, sleep, and any medicine side effects.

A treatment plan should explain who to contact during office hours, what to do outside those hours, and when emergency services are needed. After a crisis or emergency visit, timely follow-up can help review the trigger, update the safety plan, and reconnect the person with ongoing treatment.

If therapy does not feel helpful, discuss the reasons before stopping when possible. The approach may need to change, goals may need to become clearer, or a different therapist may be a better fit. Medicines should not be stopped suddenly without speaking to the prescriber, because some can cause withdrawal symptoms or a return of the condition they were treating.

Routine concerns to raise at an appointment include increasing emotional instability, more frequent self-harm urges, medication problems, substance use, worsening relationships, or difficulty attending therapy. Immediate danger, a suicide attempt, a severe injury, or an inability to stay safe requires urgent or emergency help rather than waiting for a routine visit.

Sources

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