Borderline Personality Disorder: An Analysis of Development, Prevention, and Intervention

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Abstract

This review discusses the development of BPD (Borderline Personality Disorder) and its impact on the prevention and intervention of the disorder. With new research, our understanding of BPD is growing. This paper aims to summarize the current research on the disorder and to make recommendations for treatment, prevention, and early intervention based on research findings. The present literature review synthesizes findings from current research papers and studies on the development and treatment of BPD. The literature was organized by topics of development, intervention, and prevention, and brought together when finding the role of development in treatment. The review revealed that BPD is highly treatable, but also highly misdiagnosed or not diagnosed, leading to a worsening of the disorder. Individuals with BPD will develop the disorder from a combination of genetics, adverse experiences, and transactions in the environment. The disorder is primarily treated through means of psychotherapy. Psychopharmacology is typically only used in treating comorbid disorders. These findings are important in developing proper treatment and diagnosis of BPD, and suggest that interventions done earlier through psychotherapy have a high success rate in the remission of the disorder.

Introduction

Borderline personality disorder (BPD) is a psychological disorder characterized by a pervasive pattern of instability in affect regulation, impulse control, interpersonal relationships, and self-image [17]. It is one of the most complex and misunderstood psychiatric conditions that is highly stigmatized and largely neglected. Patients with this disorder pose a significant danger to themselves and others due to a major reluctance to diagnose the condition[13]. Not diagnosing BPD in individuals who demonstrate symptoms leads to a lack of treatment for a highly treatable condition[5]. Additionally, BPD is associated with intensive therapy, and with societal costs exceeding those of anxiety, depression, diabetes, and Parkinson's disease. BPD constitutes a significant public health concern that must be caught early to prevent such consequences and guarantee increased quality of life for those who exhibit symptoms of BPD[15]. Understanding the pathways to the disorder's development is critical for informing prevention and intervention.

The DSM V has established nine criteria associated with a diagnosis of BPD. Individuals must meet a minimum of 5 criteria to acquire a diagnosis[1].

i	Frantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
ii	A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
iii	Identity disturbance: markedly and persistently unstable self-image or sense of self.

iv	Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.)
v	Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
vi	Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
vii	Chronic feelings of emptiness.
viii	Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
ix	Transient, stress-related paranoid ideation or severe dissociative symptoms.

BPD was first introduced in the DSM-III in 1980[2(pp. 285-288)]. It was characterized as the "borderline" between the psychotic personality and the neurotic personality. These patients were said to

have a "stable instability"[21, pp 398-416]. As a result, individuals with BPD express a desperate need to attach to others as transitional objects, have a distorted sense of self and others, a reliance on idealization and devaluation, and a fear of abandonment[13,18]. BPD is characterized by heightened emotional sensitivity, inability to regulate intense emotional responses, and a slow return to emotional baseline[10]. Individuals with BPD experience instability of interpersonal relationships, negative and shifting self-image, marked impulsivity, especially in expressing emotions, controlling moods, and exhibiting chronic suicidal tendencies[13]. Ninety-two to ninety-six percent of individuals with BPD have an observed insecure attachment style, characterized by a lack of trust and a secure base[20]. The condition also presents as vague somatic complaints, high-risk sexual behaviors, disordered eating, or chronic pain[17]. According to neuropsychological studies, cognitive flexibility, set shifting, attentional shifting, decision-making, sustained attention, problem-solving, inhibition, planning, strategy, and working memory are among the cognitive functions impaired in individuals with BPD. In the general adult population, the lifetime prevalence of BPD has been reported to be from 0.7 to 2.7%, while its prevalence is about 12% in outpatient and 22% in inpatient psychiatric services[15].

BPD has severe and pervasive consequences that continue to cause problems throughout an individual's life. There is an established correlation between increased suicide risk and a diagnosis of BPD[17]. It has been shown that 40-90% of individuals with BPD either engage in nonsuicidal self-injury or make a suicide attempt[1,10]. The diagnostic continuity of BPD in adolescence is similar to that in adulthood, and the symptoms continue to be seen in a significant portion of adolescents even after 20 years[23]. Despite this evidence, there is still a significant reluctance to diagnose BPD, although there is increasing evidence to do so for the role of prevention and early intervention. Often, a misdiagnosis leads to missed early intervention opportunities and later development of BPD[20]. Additionally, the current data used to inform specific, universal, or selective prevention programs for BPD is inadequate[8].

Due to the potentially fatal consequences of untreated BPD with confirmed suicidal correlation, there is a need to understand the development of BPD to inform prevention and intervention efforts to maintain safety within these individuals and improve quality of life. Along with suicidal ideation and impulsive action, those with BPD suffer from severe functional impairment, affecting their ability to manage their lives safely. There is also a lack of approved, effective medication for the treatment of BPD. When the disorder goes untreated, it places a massive burden on families and diagnosed individuals, causing chronic suffering due to the unstable and dangerous nature of the condition. The present paper explores how BPD develops within an individual and how we can use this to inform prevention and intervention. First, we will compare and analyze different perspectives on the disorder's development. Next, we will discuss the current prevention and intervention efforts. Finally, we will offer suggestions for improving these efforts based on developmental perspectives.

Methods

This literature review explored the development of BPD within individuals. Then, it explored how we have used this information to inform methods for early intervention and prevention. Criteria for inclusion in this review included: peer-reviewed, published in English, and explored etiology, prevention, and intervention of borderline personality disorder.

For this paper, researchers conducted database searches using PubMed and Google Scholar during June and July 2025. Keywords included: “Borderline personality disorder” and “causes”. Text screening and data extraction were completed by the first author (SS).

Results

Development of BPD

A diagnosis of BPD in young people has similar reliability, validity, and prevalence to BPD in adults[8]. However, the causes of BPD in individuals have only been theorized, as it is a complex condition. The most established theory of BPD development is the Biosocial Theory, formulated by Marsha Linehan in 1993. According to Linehan, BPD is primarily a disorder of emotion dysregulation and emerges from transactions between individuals with biological vulnerabilities and specific environmental influences[10].

The theory argues that an invalidating developmental context intermittently reinforces extreme emotional expressions. They simultaneously communicate to the child that such emotional displays are unwarranted and that emotions should be managed internally, without parental support. As a result, the child does not learn how to understand, label, regulate, or tolerate emotional responses and instead learns to oscillate between emotional inhibition and extreme emotional lability[10]. The child also fails to learn how to solve the problems contributing to these emotional reactions. Reciprocal transactions between biological vulnerability and environmental risk potentiate emotion dysregulation and lead to more extreme behavioral dyscontrol[10].

Additional vulnerabilities that contribute to the development of BPD are impulsivity, being bullied, sexual abuse, and neglect[10]. Trauma and neglect may exacerbate biologic predisposition and behavioral tendencies already present in those with borderline personality disorder[17]. Disrupted interpersonal relationships have long been described as a risk factor for the development of borderline pathology. For example, parental underinvolvement impairs a child's ability to socialize effectively[10]. The first years of life, when rapid and significant changes in brain development occur, are considered a sensitive period. The caregiver-child interaction in this sensitive early childhood period is significant for the development of BPD. One study found that up to 84% of individuals with BPD were exposed to neglect and emotional abuse by their parents before the age of 18[24]. It has also been shown that childhood trauma is a significant factor for the initiation of "self-destructive" behavior[10]. Borderline personality traits were associated with prior significant negative experiences in 12-year-old children. This effect was more pronounced when families had psychiatric histories. However, some individuals experience the same borderline traits but do not have any trauma[6].

Neuropsychologically, deficits in serotonin functioning are associated with BPD-related conditions and behaviors. Volume reductions in the hippocampus and amygdala, both brain regions mainly involved in stress responses and cognition[6]. In another study with 2282 children and adolescents, it was found that high levels of negative affect, shyness, and impulsivity, which are temperament traits,

predicted the development of BPD[22].

In conclusion, BPD is determined by a combination of genetic and environmental factors. BPD traits recognized in childhood often continue into adulthood. The biosocial theory by Marsha Linehan is the most reliable and widely recognized. Other lines of thought have branched off from this, like the Halo Effect, a cognitive bias where one positive trait of a person, product, or company influences our overall perception of it[11]. A history of trauma and abuse is also thought to be a cause of the disorder. Individuals with BPD also have impaired stress response and cognition, as well as deficits in 5-HT (serotonin) functioning. Genetically, a family history of BPD and impulsivity can contribute to the development of the disorder.

Current Prevention and Treatment for BPD

Based on current knowledge of the development of BPD, treatments have aimed at reducing symptoms caused by these factors. First, there is evidence that BPD can be reliably diagnosed and differentiated from other mental disorders by semi‐structured interviews[15]. This allows us to distinguish who should receive treatment for BPD and who would benefit from another treatment. Despite this, some research suggests that interventions targeting related mental health issues and negative social outcomes could potentially include BPD prevention as a beneficial side effect due to symptom overlap[8]. The strongest data support early intervention for the emerging BPD phenotype. The treatment should be realistic in aims, require change in the attitudes of clinicians and service systems, and be mindful of the risk of iatrogenic harm[8].

Guidelines for treatment include: scheduling regular visits; providing clear explanations of diagnosis, testing, and clinical management; tolerating angry outbursts while still setting limits; maintaining awareness of personal feelings; and enlisting the help of a psychiatrist when needed. No medications have been approved by the U.S. Food and Drug Administration specifically for the treatment of BPD, although there are medications that treat certain symptoms that may overlap with other disorders (e.g., feelings of worthlessness and depressed mood can be treated by antidepressants)[12]. Clinicians

should prioritize medication safety by avoiding polypharmacology and limiting the use of controlled substances when treating BPD. If medications are prescribed, treatment should be augmented by psychological therapy[17]. Psychotherapy is a crucial component of treatment as the benefits of medications are uncertain[9].

The first evidence-based psychotherapy for BPD was Dialectical Behavioural Therapy (DBT), which has been empirically tested many times[9]. The individual therapy is focused on a hierarchy of targets, with life-threatening behaviours at the top of the list, and employs a dialectic, or synthesis, between the conflicting ideas of validation and change. Group skill sessions focus on teaching a variety of skills to help patients with mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness. Telephone consultation is available at all times for patients who are in crisis and provides brief support and guidance on which skills to use and how to use them in their everyday lives. Finally, consultation team meetings serve to help maintain treatment fidelity and support therapists[9]. This treatment was seen to reduce self-harm and suicidality, as well as rates of hospitalization, with moderate effect sizes [9]. At this time, BPD is the only major psychiatric disorder for which psychosocial interventions remain the primary treatment[13].

In summary, BPD can be differentiated and diagnosed through a series of interviews. Clinicians are recommended to set boundaries while still being informative and validating towards patients. Currently, DBT is the prevailing treatment method, which consists of different forms of therapy and the practice of dialectical thinking. The effects of medication are still inconclusive, and no approved medications exist specifically for the treatment of BPD. It is recommended to refrain from polypharmacology and focus treatment on psychotherapy.

How Development of BPD Influences Prevention and Treatment

Taken altogether, the development of BPD plays a crucial role in determining prevention and intervention. For example, the age of onset of BPD varies, but symptoms usually manifest in early adulthood[15]. Treating BPD at the critical time period of adolescence may significantly improve the

long-term functioning of these patients[9]. Although longstanding beliefs suggest borderline personality disorder has a chronic, unchanging course over a patient's lifespan, most patients will experience remission.

Focusing on intervention during childhood may aid in the prevention of BPD symptoms. A study published by the team of Muratori and colleagues (2022) found that mindful parenting interventions could help reduce the additional risk factors needed to develop future BPD in children already presenting behavioral disturbances[19]. Since adolescent-onset BPD is recognized as a valid and reliable clinical entity, the diagnosis should be provided by the clinicians and explained to both the patient and the family. When sub-threshold BPD is present, terms such as “BPD features” should be preferred. Multidisciplinary and collaborative networks, including family, social workers, and school environments, provide greater leverage than individual psychotherapy alone. The combination of different settings for sessions (e.g., individual, group, telephone calls) showed a positive effect on care continuity and positively impacted the adolescent’s feeling of safety[4]. Early intervention is likely to be effective if it includes a service culture that is nonstigmatizing toward BPD, youth-friendly, and oriented to early detection and treatment for BPD. Essential elements of care appear to include a model for understanding BPD, clinical case management, and treatment of co-occurring functional, physical, and psychopathological difficulties[7].

In terms of prevention, safety planning is a brief, effective intervention to help individuals survive suicidal crises by teaching them a set of steps they can take to reduce the likelihood of engaging in suicidal behavior[17]. Additionally, when considering decreasing risk by targeting comorbid disorders, life‐threatening behaviors (e.g., suicidal, self‐mutilating or high‐risk behaviors, attacks against others) must be given priority, and then be explored whether there is a major depressive disorder requiring pharmacotherapy or inpatient treatment[15]. Due to the high comorbidity of BPD with addictive disorders, the use of substances with dependence potential should be avoided as far as possible.

Psychotherapy should be utilized to address trauma, reducing symptoms as treatment continues. A study conducted proved that trauma-focused therapy strongly benefited BPD patients and decreased their symptoms drastically while posing no significant risks[14]. However, genetics account for 40-60% of variation in BPD, so treatment methods may vary depending on the individual, as these factors potentially influence outcomes[3].

All in all, early intervention when possible assists in preventing the disorder from worsening further. In treatment, professionals should be clear with the patient while maintaining proper boundaries. Outside of treatment, it is recommended to create a more accommodating environment as well. Understanding the nature of BPD is crucial in the prescription and treatment of comorbid disorders. Psychotherapy is a form of treatment that has been proven effective in individuals with BPD.

Discussion

The development of BPD within an individual, and how this knowledge can be used to inform the prevention and intervention of the disorder. BPD develops as a result of multiple factors, including genetic components like family history and brain functioning, as well as adverse experiences like abuse and neglect. The most developed theory is the biosocial theory, which is a transaction of environmental and internal factors. Current prevention and treatment includes first diagnosing the disorder through interviews and then aiming to treat it through means of therapy, with DBT regarded as the most effective treatment. DBT was created with BPD in mind and teaches patients to handle situations that typically trigger BPD symptoms. There is extensive research proving the effectiveness of DBT as well as associating it with improved emotional stability and functioning. The development of BPD influences treatment by providing guidelines for health professionals as well as methods of treatment (e.g, psychotherapy over polypharmacology). It also creates an emphasis on emotional regulation and the importance of validating the patient. There is a focus on relationships, addressing issues like relationship patterns, attachment issues, and communication strategies, as BPD patients typically struggle to maintain

them. However, not all treatments will prove the same in individuals, as the condition has a vast genetic variation.

Early intervention is crucial, as the diagnosis has a similar validity to that of adults and is extremely heritable. As there is a reluctance to diagnose BPD due to the complexity of the disorder, many individuals go untreated and go on to develop worse symptoms. It is crucial to recognize symptoms of the disorder in adolescence and address them, because it is a period where emotional and interpersonal patterns are still developing. Even in younger individuals, it is recommended to diagnose "BPD traits" to properly treat the patient. If BPD is caught in adolescence, proper treatment will prevent the disorder from worsening in adulthood and significantly improve the quality of life for the individual by regulating relationships, emotions, and habits. Individuals can learn skills and healthy coping mechanisms to learn how to manage the condition. This suggestion is highly feasible if the professional is willing to make the diagnosis. It also has a long-lasting impact and is crucial to early intervention and prevention.

During treatment, conditions like major depressive disorder and anorexia nervosa may make the condition worse, so prioritizing and treating these conditions early on is critical. Comorbid disorders increase clinical complexity and intensify emotional instability, making treatment more challenging to address. These disorders may require an integrated approach to treatment. Due to the instability of the condition and the developed correlation to suicide, there are safety concerns with leaving such disorders untreated. If suicidal ideation or thought is present, it must be prioritized. Due to impulsivity in individuals with BPD, neglecting primary comorbid disorders can significantly decrease quality of life by adding additional emotional distress and worsening the underlying BPD. This proposal is of vital importance in treatment.

In interacting with the patient, mental health professionals need to understand the nature of the disorder in treatment. They should be open while setting boundaries to maintain a professional relationship. Treatment should aim to maintain "neutral" as individuals with BPD gravitate towards idealizing or devaluing relationships. Professionals should help patients view experiences and people

dialectically and work through past adverse experiences. Without education on BPD, treatment will be made highly challenging for the patient and for the specialist. Strategies provided are not only effective but also feasible. BPD may be heavily influenced by the relationships in individuals' lives, so professionals should aim to also discuss them and view them dialectically. In the future, treatment should work towards a more personalized approach due to the variability of how symptoms are represented and comorbid disorders that may be present. Therapy should be adapted to the individual, considering the intensity of certain symptoms. Age, trauma, and social support should also be considered to further address the condition. Adjunct therapies may be integrated in the case that a comorbid disorder is present and requires such. This treatment aims to adapt therapy to the individual rather than following the same framework for each individual.

The limitations of the literature include the scarcity of information on BPD, development, and treatment, as the review was made more difficult. Due to the lack of extensive research on the disorder, it is increasingly difficult to propose one framework for treatment. Therefore, further research should be completed on the different ways the disorder can present and determine how each symptom can be addressed in treatment. However, the literature review defined recommendations for future treatment, elucidating directions for further research. It also urges the importance of treatment and prevention by looking into the detrimental intimate struggles that individuals with BPD may face. It looked into multiple studies, taking a wide range of information into account when examining the complex condition. Sources defined guidelines for professionals, understanding the nature of BPD and applying it to treatment.

Conclusion

This literature review explored the question of how BPD develops, and how that information can be used to inform treatment and prevention. The literature was a comprehensive review of the condition, explaining origins, symptoms, treatment, and prevention of BPD. Although the development of the disorder varies, prevention and treatment are still crucial for an individual with BPD. Due to a reluctance to diagnose the disorder, it becomes increasingly worse throughout the individual’s life and has severe

financial and mental implications that become harder to treat with time. Future directions should include an openness to diagnose the condition in adolescents, as “traits of BPD” or “BPD”, for treatment and clarity in the individual. Treatment should align with the individual and the nature of the condition. Clinicians should aim to develop early interventions and treatments based on personal profiles. The role of pharmacology should be further studied, but not used as the primary treatment for BPD.

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