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Clinical features, diagnosis, and approaches to the treatment of borderline personality disorder

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Abstract

The aim of the study: To conduct a comprehensive analysis of current scientific data on the clinical picture, diagnostic methods, and therapeutic strategies for BPD to create a holistic view of this pathology and improve approaches to its treatment.

Material and methods: A comprehensive review of peer-reviewed articles, systematic reviews, and meta-analyses from 2019–2024, alongside DSM-5 and ICD-11 criteria, to assess BPD clinical features, diagnostics, and treatments.

Results: The key symptoms of BPD – emotional instability, identity disorders, impulsivity, and instability of interpersonal relationships – form a complex interconnected system that determines the unique clinical profile of each patient. The high level of comorbidity of BPD with other mental disorders, especially depressive and anxiety disorders and post-traumatic stress disorder, has proven to be a key factor in determining the complexity of the clinical picture, prognosis, and treatment approaches. The analysis of modern diagnostic approaches has revealed a significant evolution from the categorical to the dimensional approach, which is most clearly reflected in the criteria of the International Classification of Diseases of the 11th revision (ICD-11). It has been established that structured diagnostic interviews demonstrate high reliability and validity, remaining the "gold standard" for the diagnosis of BPD in clinical trials. Evaluations of the effectiveness of therapeutic approaches have shown that specialized psychotherapies, such as dialectical behavioural therapy (DBT) and schema therapy (ST), are most effective in reducing BPD symptoms and improving psychosocial functioning.

Conclusions: Pharmacological treatment of BPD has shown mixed results, emphasizing the need for an individualized approach to pharmacotherapy.

emotional instability; impulsivity; interpersonal relationships; self-harm; suicidal behaviour; comorbidity

1. INTRODUCTION

Borderline personality disorder (BPD) poses a significant challenge to modern psychiatry and clinical psychology. This complex pathology is characterized by instability in interpersonal relationships, self-perception, emotions, and behaviour, which significantly affects the quality of life of patients and their loved ones. The prevalence of BPD in the general population is estimated at 1.6-5.9%, indicating its significant social significance [1]. A high level of comorbidity with other mental disorders, a tendency to self-harming behaviour, and an increased risk of suicide point out the need for an in-depth study of the clinical

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features, diagnostic methods, and approaches to the treatment of this disorder.

The problematic of the study is the complexity of diagnosis and treatment of BPD due to its heterogeneous nature and frequent comorbidity with other mental illnesses. Despite significant progress in understanding the aetiology and pathogenesis of BPD, there are still significant gaps in knowledge regarding optimal diagnostic criteria and effective therapeutic strategies. This leads to difficulties in the timely detection of the disorder and the provision of adequate care to patients.

The understanding of BPD has evolved considerably in recent years, thanks to intensive research into various aspects of this complex mental condition. Current research covers a wide range of issues, from clinical features to innovative approaches to diagnosis and treatment. Leichsenring et al. [2] presented a comprehensive review that not only systematizes current knowledge about the aetiology and clinical manifestations of BPD, but also outlines current debatable issues. Their work serves as a foundation for further research, identifying gaps in the understanding of this disorder. Chanen et al. [3] focused on the specifics of diagnosis and treatment of BPD in young patients. Their study emphasizes the importance of early detection and intervention, suggesting adapted approaches for adolescents and young adults. This work is logically complemented by the study by Campbell et al. [4], who examine the ethical aspects of diagnosing BPD, stimulating an important discussion about the balance between the potential benefits and risks of diagnosis.

In the context of therapeutic approaches, Bohus et al. [5] conducted a thorough analysis of modern methods of treating BPD. Their work not only evaluates the effectiveness of various forms of psychotherapy and pharmacological treatment, but also offers recommendations for optimizing therapeutic strategies. This analysis is complemented by the study by Del Casale et al. [6], who review in detail current approaches to psychopharmacotherapy for patients with BPD, highlighting both the potential and limitations of different classes of drugs. An important contribution to the understanding of the neurobiological basis of BPD was made by Rodriguez et al. [7]. Their systematic review compares the clinical, neuropsychological, and neuroimaging characteristics of BPD and bipolar disorder, which not only deepens the understanding of neurobiological mechanisms but also highlights the difficulties of differential diagnosis. Sauer-Zavala et al. [8] proposed an innovative modular, person-centred therapy for BPD. This model takes into account the individual characteristics of patients, offering a flexible approach to treatment that can potentially increase the effectiveness of therapeutic interventions. Their work is logically related to the study by Bozzatello et al. [9], who focused on the study of risk factors and early detection of BPD, suggesting strategies that can significantly affect the prognosis and effectiveness of treatment.

Prasad et al. [10] made an important contribution to the understanding of BPD in specific populations by conducting a systematic review and meta-analysis of the prevalence of BPD in the perinatal period. This study not only highlights the characteristics of the manifestation of BPD in women during pregnancy and after childbirth, but also highlights the need to develop specialized approaches to diagnosis and treatment during this critical period. Despite the significant progress reflected in these studies, a number of unresolved issues remain. In particular, there is a need to develop more accurate diagnostic tools, especially for early detection of the disorder. In addition, although the effectiveness of certain psychotherapeutic approaches is well established, there is still a need to optimize and individualize treatment. Future research could focus on the development of personalized therapeutic strategies that take into account individual patient characteristics, including genetic, neurobiological and psychosocial factors. Another important area is the study of long-term treatment outcomes and factors affecting remission and relapse of BPD.

Thus, the review of the current literature on BPD demonstrates significant progress in understanding this complex disorder, but also highlights a number of unresolved issues and promising areas for further research. Integrating existing knowledge and developing new approaches to diagnosis and treatment remain key challenges for the scientific community in psychiatry and clinical psychology.

The aim of this study was to conduct a comprehensive analysis of current scientific data on

clinical features, diagnostic methods and approaches to the treatment of BPD to develop an integrated understanding of this pathology and optimize therapeutic strategies. To achieve this goal, the following objectives were set:

1. The clinical manifestations and features of the course of BPD, including its impact on various areas of patient functioning, are analysed.
2. Modern diagnostic criteria and methods for assessing BPD, their validity and reliability are investigated.
3. The effectiveness of various psychotherapeutic and pharmacological approaches to the treatment of BPD is evaluated on the basis of available empirical data.

2. MATERIALS AND METHODS

The study of the clinical features, diagnosis, and treatment approaches for BPD was conducted through a comprehensive analysis of current scientific literature and clinical data. The source base was based on peer-reviewed scientific articles, systematic reviews and meta-analysis results published in leading international medical journals over the past five years (2019-2024). To ensure comprehensive coverage of the topic, we analysed the diagnostic criteria for BPD presented in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) [11] and the International Classification of Diseases of the 11th revision (ICD-11) [12]. This made it possible to compare categorical and dimensional approaches to the diagnosis of BPD and assess their clinical validity.

The study of the clinical features of BPD was based on the analysis of epidemiological data and the results of clinical trials. In particular, the data on the prevalence of BPD in the general population and among patients of psychiatric institutions presented in the works of Bohus et al. [5] and Leichsenring et al. [2]. Particular attention was paid to the study of the comorbidity of BPD with other mental disorders, which allowed us to identify complex relationships between the symptoms of different disorders and their impact on the clinical picture. To evaluate the diagnostic methods for BPD, the validity and reliability of structured diagnostic interviews were analysed: Structured Clinical Interview for DSM-5 [11], Diagnostic Interview for Borderlines, Revised (DIB-R) [13]; and self-report questionnaires: Borderline Personality Questionnaire (BPQ) [14], McLean Screening Instrument for Borderline Personality Disorder (MSI-BPD) [15]. This made it possible to compare their effectiveness and determine optimal approaches to diagnosis in different clinical contexts. Particular attention was paid to the study of the specifics of the diagnosis of BPD in adolescents and young adults, using the data presented in the work of Bozzatello et al. [9].

The analysis of the effectiveness of therapeutic approaches was based on the results of randomized controlled trials and meta-analyses. In particular, the meta-analysis by Setkowski et al. [16], which allowed comparing the effectiveness of different psychotherapeutic methods in the treatment of BPD. The assessment of the impact of psychotherapy on the psychosocial functioning of patients with BPD was based on the meta-analysis of Zahediabghari et al. [17]. To study the effectiveness of pharmacological treatment of BPD, a large-scale study by Lieslehto et al. [18] was analysed, which covered 22,601 patients with BPD in Sweden over 16 years. This made it possible to assess the impact of different classes of psychotropic drugs on the risk of suicidal behaviour among patients with BPD.

Particular attention was paid to the study of innovative and integrated approaches to the treatment of BPD. In particular, the conceptual framework of modular, personality-oriented treatment of BPD presented in the work by Sauer-Zavala et al. [8]. The effectiveness of integrated approaches to the treatment of comorbid BPD and post-traumatic stress disorder (PTSD) was also considered based on a systematic review by Zeifman et al. [19]. To ensure the objectivity and comprehensiveness of the analysis, a critical comparison of the results of various studies was conducted, identifying common trends and discrepancies in the findings. This made it possible to form a comprehensive understanding of the current state of the problem of diagnosis and treatment of BPD, as well as to identify promising areas for further research.

The study highlighted the methodological limitations of existing research, including the

lack of direct comparison of the effectiveness of different therapeutic approaches within a single study and the limited number of long-term studies of treatment effectiveness. This allowed us to critically assess the existing evidence base and formulate recommendations for further research. To summarize and systematize the data obtained, comparative tables were created that reflect the key aspects of clinical manifestations, diagnostic methods and therapeutic approaches in BPD.

3. RESULTS

3.1. Clinical manifestations and features of the course of BPD

Among the complex mental disorders, a special place is occupied by BPD. This pathology is characterized by a persistent pattern of imbalance in several key areas of mental functioning. In particular, individuals with BPD demonstrate significant difficulties in managing their emotions, restraining impulsive reactions, building stable relationships with others, and forming a holistic and consistent self-image. This multifaceted instability significantly affects the overall functioning of an individual, creating numerous challenges for both the individual and mental health professionals [20]. BPD significantly reduces the quality of life of those who suffer from it, creating serious obstacles in their social adaptation and interaction with others. According to epidemiological studies, the prevalence of BPD in the general population is about 1.6% [5]. However, among patients seeking psychiatric care, this figure is much higher – up to 20% of inpatients and 10% of outpatients meet the diagnostic criteria for BPD [21]. The clinical picture of BPD is characterized by a wide range of symptoms covering emotional, cognitive, behavioural and interpersonal areas of functioning. According to the DSM-5 [11] diagnostic criteria, at least 5 of the 9 key features are required to establish the diagnosis of BPD.

One of the central symptoms is emotional instability, which manifests itself in sharp mood swings, irritability, and intense affective reactions to external stimuli [5]. Patients with BPD often describe their emotional state as an "emotional rollercoaster", experiencing rapid changes from euphoria to deep despair within a short period of time. This emotional volatility can last from a few hours to several days, which significantly distinguishes BPD from other mood disorders with longer episodes of mood changes [20]. Another key feature is a chronic sense of inner emptiness and loneliness. Patients often report a lack of a clear sense of identity, which can manifest itself in dramatic changes in life goals, values, and career plans [7]. This diffusion of identity is closely linked to problems in self-perception and self-esteem. The self-image of patients with BPD is often unstable and contradictory, oscillating between the extremes of idealization and devaluation of their own personality [5]. Impulsivity is another characteristic feature of BPD, which manifests itself in a wide range of potentially self-destructive behavioural patterns. This may include risky sexual behaviour, substance abuse, overeating, reckless financial spending, etc. [18]. A particularly dangerous manifestation of impulsivity is a tendency to self-harming behaviour and suicide attempts. According to studies, up to 75% of patients with BPD have a history of at least one suicide attempt, and about 10% commit suicide [20].

It should be emphasized that the clinical picture of BPD is characterized by considerable variability. Symptoms can vary significantly not only from patient to patient, but also over time in the same individual. This variability complicates the process of establishing a diagnosis and choosing the optimal therapeutic strategy. An additional challenge is the frequent coexistence of BPD with other mental disorders, which can obscure or modify its manifestations. This problem of comorbidity will be discussed in more detail in the following parts of the paper.

The BPD has a comprehensive impact on the lives of patients, affecting virtually all areas of their functioning. Let's have a closer look at the main aspects of this impact. The interpersonal sphere is one of the most affected in the case of BPD. Patients demonstrate marked instability in relationships, characterized by alternating extremes of idealization and devaluation of partners [5]. This phenomenon, known as "splitting", leads to frequent and intense conflicts in romantic, friendship, and professional relationships. Fear of abandonment is another key as-

pect of interpersonal difficulties in BPD. Patients often demonstrate excessive sensitivity to the real or imagined threat of rejection, which can provoke intense emotional reactions and manipulative behaviour [20].

In the professional sphere, patients with BPD often face significant difficulties. The emotional fluctuations, lack of self-control and communication difficulties that are characteristic of BPD, often have a negative impact on the professional life of patients. This can be reflected in the inability to stay at the same job for a long time, tense relationships in the team and with management, and obstacles to the implementation of long-term professional plans. These difficulties make it very difficult for people with BPD to build a stable career [21]. According to studies, up to 50% of patients with BPD have problems finding or keeping a job for a long time [5]. Cognitive functioning in BPD also undergoes certain changes. Patients may demonstrate temporary thinking disorders, especially in stressful situations. This can manifest in the form of paranoid ideation, dissociative symptoms, or short-term psychotic episodes [20]. In addition, patients with BPD often have difficulty regulating attention and concentration, which can negatively affect their academic and professional activities. The physical health of patients with BPD can also suffer as a result of the disorder. Chronic stress associated with emotional instability can lead to a variety of psychosomatic symptoms, including headaches, sleep disturbances, gastrointestinal disorders, and more [5]. The tendency to engage in dangerous behaviour and self-harm inherent in people with BPD increases the likelihood of injury and other harmful consequences for their physical condition. It should be noted that the degree of impact of BPD on the overall functioning of an individual is not the same in all cases and may vary depending on the intensity of the disorder and the presence of comorbid mental illnesses. Some patients may demonstrate a relatively high level of social and occupational functioning, especially during periods of symptom remission. However, even in such cases, internal emotional distress and instability may remain significant [20].

BPD is characterized by a high incidence of co-occurring mental illness. Epidemiological studies show that about 85% of people diagnosed with BPD have at least one other psychiatric disorder. This significant comorbidity emphasizes the complexity of the clinical picture of BPD and the need for a comprehensive approach to its diagnosis and treatment [5]. The high frequency of comorbid disorders complicates the process of diagnosing and treating BPD. This is because symptoms of different pathologies can overlap and mutually reinforce each other, creating a complex clinical picture. Depressive disorders are particularly common among comorbid conditions in BPD, which requires special attention when assessing a patient's condition and planning treatment. According to various estimates, from 40% to 70% of patients with BPD meet the criteria for major depressive disorder throughout their lives [20]. It is important to note that depressive symptoms in BPD may have certain features, such as greater mood lability and sensitivity to interpersonal stressors, compared to "pure" depression [21]. BPD is often accompanied by various forms of anxiety disorders. It is especially common to see it combined with generalized anxiety disorder, panic attacks, and social phobia. This high incidence of simultaneous diagnosis of anxiety and BPD indicates a complex relationship between these pathologies and the need for their comprehensive consideration when assessing a patient's condition [5]. Interestingly, some researchers consider increased anxiety to be one of the underlying mechanisms of emotional dysregulation in BPD [20].

PTSD is another important comorbid condition, especially given the high prevalence of traumatic experiences in the history of patients with BPD. According to some estimates, up to 30% of patients with BPD meet the criteria for PTSD [5]. There is a complex two-way relationship between PTSD and BPD. On the one hand, trauma can be a catalyst for the onset of PTSD symptoms. On the other hand, the heightened emotional sensitivity inherent in individuals with PTSD makes them more vulnerable to developing PTSD after stressful situations. This interaction underscores the importance of taking traumatic experiences into account when working with patients with BPD and vice versa. Substance use disorders also often coexist with BPD. According to studies, up to 50% of patients with BPD have problems with alcohol or drug abuse [20]. This comorbidity poses additional challeng-

es for treatment, as substance use can exacerbate the impulsivity and emotional instability characteristic of BPD. Eating disorders, such as bulimia and compulsive overeating, often coexist with Binge Eating Disorder. This high frequency of concurrent diagnosis indicates a possible link between the mechanisms of development of these disorders and requires special attention in the examination and treatment of patients with BPD. This may be due to the common mechanisms of emotional dysregulation and impulsivity that are characteristic of both types of disorders [21]. It is important to note that BPD also often coexists with other personality disorders. The highest rates of comorbidity are observed for avoidant, dependent, and paranoid personality disorders [5]. This high comorbidity emphasizes the complexity and heterogeneity of personality pathology and raises questions about the validity of clear categorical boundaries between different personality disorders.

The interaction between BPD and comorbid disorders is multifaceted and ambiguous. The presence of additional mental pathologies can exacerbate the manifestations of BPD and negatively affect the course of the disease. At the same time, effective treatment of BPD can have a positive effect on the symptoms of comorbid disorders, which points out the importance of an integrated approach to treatment [20]. This emphasizes the importance of an integrated approach to diagnosis and treatment that takes into account the totality of psychopathological manifestations in each individual patient.

Summarizing the main aspects of the clinical manifestations and features of the course of BPD, we can identify the key characteristics that determine the specifics of this disorder and its impact on various areas of patients' lives. To visualize this information, we propose to consider a comparative table of the main symptoms of BPD and their impact on patient functioning (Table 1).

Table 1. Comparative characteristics of the main symptoms of BPD and their impact on patient functioning.

Symptom	Prevalence	Manifestations	Impact on operations	Relationship to comorbidities
Emotional instability	>90%	Sharp mood swings, intense affective reactions	Significantly affects interpersonal relationships and professional performance	Often increases in MD and AD
Violation of identity	70-80%	Unstable self-image, diffusion of identity	Affects self-esteem, life goals and values	Complicates the differential diagnosis with other PD
Impulsiveness	75-80%	Risky behaviour, self-harm	Increases the risk of injury and negative health effects	It is aggravated by comorbid SUD
Fear of abandonment	>80%	Excessive rejection sensitivity, manipulative behaviour	Creates difficulties in forming stable relationships	May increase with AD
Chronic feeling of emptiness	60-70%	Lack of meaning in life, boredom	Affects overall life satisfaction and motivation	Often associated with depressive symptoms

Note: Note: Mood disorders (MD); anxiety disorders (AD); personality disorders (PD); substance use disorders (SUD). The prevalence of symptoms is based on studies of patients with diagnosed BPD.

Source: compiled by the author based on Bohus et al. [5], Rodriguez [7], Leichsenring et al. [20], Mendez-Miller et al. [21].

The analysis of the table highlights the multifaceted nature of BPD, focusing on the diversity of its manifestations and their profound impact on various aspects of patients' lives. It should be noted that despite the widespread prevalence of certain symptoms, their intensity, and form of manifestation can vary significantly from case to case. This emphasizes the need for a personalized approach to the diagnosis and treatment of BPD, which would take into account the specific combination of symptoms and their impact on the life of a particular person. Moreover, the frequent combination of BPD with other mental disorders indicates the need for a comprehen-

sive assessment of the patient's condition and the application of a comprehensive therapeutic strategy that would cover the entire spectrum of psychopathological manifestations in individuals with BPD.

3.2. Modern methods of diagnosing BPD

The diagnosis of BPD remains a challenge, especially in the early stages of the disorder. The current diagnosis of BPD is based on two key classification systems: DSM-5 [11] and ICD-11 [12]. The DSM-5 [11], published in 2018, defines BPD as a persistent pattern of instability in interpersonal relationships, self-perception, and affect, as well as marked impulsivity. DSM-5 diagnosis of BPD requires the identification of at least five of the nine key features that cover various aspects of an individual's psychological functioning. These features include a deep fear of loneliness and unstable interpersonal relationships that reflect difficulties in social interaction. The person's inner world is characterized by an unstable self-perception and a constant feeling of inner emptiness. Behavioural manifestations of the disorder are expressed in a tendency to risky behaviour and self-harm, which is often a consequence of emotional instability and difficulties in regulating anger. The cognitive sphere may undergo short-term changes in the form of paranoid thoughts or dissociative states, especially under the influence of stress. These various symptoms form a complex clinical picture that reflects profound impairments in emotional regulation, interpersonal relationships, and self-identity, which are key aspects of personality functioning in BPD.

Despite the widespread use of these criteria in clinical and research work, they have certain disadvantages and limitations. In particular, Zimmerman et al. [22] found that the correlation between the number of criteria and the severity of BPD was observed only up to a certain limit of five criteria. This fact calls into question the feasibility of using a threshold approach in the diagnosis of BPD, indicating the need to revise existing diagnostic methods.

ICD-11 [12] offers an alternative approach to the diagnosis of BPD. Instead of a categorical system, ICD-11 introduces a dimensional approach, where BPD is considered as one of the possible manifestations of a general personality disorder. According to the ICD-11, a combined approach is used to diagnose BPD. It includes determining the level of impairment of personal functioning (from mild to severe) and identifying a characteristic "borderline pattern" of behaviour. This method allows for a more flexible assessment of the manifestations of the disorder in each case [23]. This approach is designed to overcome the limitations of categorical diagnosis and better reflect the continuum of severity of the disorder.

The application of these diagnostic criteria in practice requires the clinician to take a thorough history, observe the patient's behaviour, and assess their functioning in various areas of life. It is important to note that the diagnosis of BPD is often complicated by the presence of comorbid mental disorders and the need for differential diagnosis. For example, Campbell et al. [4] emphasize that the symptoms of BPD may overlap with those of mood disorders, anxiety disorders, and post-traumatic stress disorder.

The diagnosis of BPD in adolescents and young adults deserves special attention. Although it was traditionally believed that the diagnosis of personality disorders in persons under the age of 18 was problematic due to the incomplete formation of personality, modern research confirms the possibility and importance of early diagnosis of BPD. Bozzatello et al. [9] emphasize that early diagnosis of BPD is key to timely treatment and improved prognosis. However, the use of diagnostic criteria in adolescents requires special care and consideration of age-related peculiarities of personality development.

Various psychometric methods are widely used to increase objectivity and unify the diagnosis of BPD. They can be divided into two main groups: structured diagnostic interviews and self-assessment questionnaires. In clinical trials, structured diagnostic interviews are considered the gold standard for diagnosing BPD. The most common is the SCID-5-PD, an interview that contains a set of standardized questions that allow for a methodical assessment of the presence of each diagnostic criterion of BPD. The SCID-5-PD requires the participation of a qualified professional and usually lasts from one to two hours. Another commonly used in-

strument is the DIB-R, which assesses four main domains of functioning: affective, cognitive, impulsive, and interpersonal. This instrument has high reliability and validity, but requires a significant time commitment (about 3-4 hours).

The Zanarini Rating Scale for Borderline Personality Disorder (ZAN-BPD) is often used to determine the intensity of BPD symptoms. It contains 9 items that meet the DSM-5 criteria and allows quantifying the severity of the disorder. Self-assessment questionnaires are more efficient in terms of time and resources, which makes them convenient for screening and monitoring the dynamics of BPD symptoms. Among the most reliable is the BPQ, with 80 items assessing 9 aspects of BPD. The shorter 10-item MSI-BPD demonstrates high accuracy in detecting BPD and is especially useful for primary screening. For adolescents, special instruments have been developed – the Borderline Personality Features Scale for Children (BPFSC) and the Short Version of the Borderline Personality Features Scale for Children (BPFSC-11) – that take into account the age-specific characteristics of BPD. It should be emphasized that none of these instruments can completely replace the expert assessment of an experienced clinician. Vanwoerden and Stepp [24] highlight that the optimal approach is a combination of structured interviews, self-report questionnaires, and clinical assessment.

The accuracy of the diagnosis and evaluation of the effectiveness of treatment for BPD depends to a large extent on the validity and reliability of diagnostic methods. Validity refers to the ability of a method to measure exactly what it is intended to measure, and reliability refers to the stability of the results over repeated measurements.

The DSM-5 criteria for BPD showed good internal consistency (Cronbach's α= 0.84) and inter-rater reliability (κ=0.71) according to the study by Zimmerman et al. [22]. However, the feasibility of a categorical approach to the diagnosis of BPD remains controversial. Some scientists, in particular Ivchenko [23], believe that the ICD-11 measurement approach can more accurately reflect the clinical realities of BPD [12].

Structured diagnostic interviews, such as the SCID-5-PD and DIB-R, have high inter-rater reliability (κ= 0.85 and 0.80, respectively) and good convergent validity with other measures of BPD [22]. However, these instruments require significant time and interviewer training, which limits their use in routine clinical practice. Self-assessment questionnaires, in particular the BPQ and MSI-BPD, have shown high internal consistency (Cronbach's α exceeds 0.80) and stability of results across repeated tests (correlation coefficient r exceeds 0.70). These indicators indicate the reliability of these tools in the diagnosis of BPD [25]. These instruments have also shown good convergent validity with clinical diagnoses of BPD. However, self-report methods can be vulnerable to response bias and limited patient insight. It is important to note that the validity and reliability of diagnostic methods may vary depending on the context of use. For example, Bozzatello et al. [9] note that diagnostic accuracy may be lower in the assessment of BPD in adolescents due to the instability of symptoms and the influence of normative developmental processes. The issue of cross-cultural validity of diagnostic methods for BPD deserves special attention.

Research shows that the manifestations of BPD can vary in different cultural contexts, which highlights the need for cultural adaptation of diagnostic tools [26]. To increase the reliability and validity of the diagnosis of BPD, it is recommended to use a multimodal approach that includes structured interviews, self-report questionnaires, and clinical assessment. Campbell et al. [4] emphasize the importance of considering not only symptoms, but also the functional impact of the disorder when making a diagnosis.

To summarize, it is worth saying that modern methods of diagnosing BPD demonstrate satisfactory validity and reliability, especially when various instruments are used in combination. However, issues remain unresolved, including the optimal balance between categorical and dimensional approaches to diagnosis, as well as the specifics of diagnosing BPD in adolescents and young adults.

In order to better understand and compare different methods of diagnosing BPD, it is useful to consider their main characteristics systematically. Below is a comparative table that summarizes the key aspects of the most commonly used diagnostic tools, including their format, timing, validity, reliability, as well as their main advantages and limitations (Table 2).

Table 2. Comparative characteristics of the main methods of diagnosing BPD.

Method	Format	Time of the event	Validity	Reliability	Advantages	Restrictions
DSM-5	Clinical assessment	Varies	Good	Good inter-examiner reliability (κ=0.71)	Widely used, standardized	The categorical approach may not reflect a continuum of severity
ICD-11	Clinical assessment	Varies	Needs further research	Needs further research	Measurable approach, assessment of severity	New system, limited application experience
SCID-5-PD	Structured interview	12 hours	High	High inter-examiner reliability (κ=0.85)	The gold standard for research	Requires training, significant time investment
DIB-R	Structured interview	3-4 hours	High	High inter-examiner reliability (κ=0.80)	Detailed assessment of four areas of operation	Long holding time
ZAN-BPD	Clinical scale	10-15 minutes	Good	Good inter-examiner reliability	Quick assessment of symptom severity	Limited information on personal functioning
BPQ	Self-reported questionnaire	20-30 minutes	Good	High internal consistency (α>0.80)	A detailed assessment of 9 characteristics of an MSO	Possible bias in responses
MSI-BPD	Self-reported questionnaire	5-10 minutes	Good	Good test-retest reliability (r>0.70)	Fast screening, high sensitivity	Possible false positive results

Notes: DSM-5 – Diagnostic and Statistical Manual of Mental Disorders, 5th Edition; ICD-11 – International Classification of Diseases of the 11th revision; SCID-5-PD – Structured Clinical Interview for DSM-5 Personality Disorders; DIB-R – Diagnostic Interview for Borderlines, Revised; ZAN-BPD – Zanarini Rating Scale for Borderline Personality Disorder; BPQ – Borderline Personality Questionnaire; MSI-BPD – McLean Screening Instrument for Borderline Personality Disorder; BPD – borderline personality disorder; κ – kappa coefficient; α – Cronbach's alpha coefficient; r – correlation coefficient.

Source: compiled by the author based on Campbell et al. [4]; Bozzatello et al. [9]; Vanwoerden and Stepp [24].

Each diagnostic method has its own strengths and limitations. The choice of the most appropriate tool is determined by the specifics of the clinical case, available resources and the objectives of the examination. It is worth noting that an integrated approach that uses a combination of different diagnostic methods usually provides the most comprehensive and reliable assessment of the BPD. Further research is needed to improve the accuracy of diagnosis and improve treatment outcomes for patients with BPD, with the aim of improving existing and developing new diagnostic tools.

3.3. Effectiveness of therapeutic approaches in the treatment of BPD

Therapeutic methods of treating BPD have undergone significant changes due to the development and implementation of specialized psychotherapeutic techniques. One of the key areas was the dialectical behavioural therapy (DBT) developed by Linehan [27]. She became a pioneer in this field by combining cognitive behavioural therapy techniques with mindfulness and dialectical thinking practices. The effectiveness of DBT was confirmed by a meta-analysis by Setkowski et al. [16], who demonstrated a significant reduction in the symptoms of BPD com-

pared to usual care therapy (g=0.42; 95% CI, 0.11-0.73, where g is the Hedges effect size, CI is the confidence interval), especially in terms of reducing suicidal behaviour and self-harm. An effect size of 0.42 means a moderate positive effect. The 95% confidence interval of 0.11 to 0.73 indicates the statistical significance of the result, as it is entirely in the positive range, not including zero. This means that we can say with 95% confidence that the true effect in the population is positive.

The success of DBT has stimulated the development of other specialized approaches, such as mentalization therapy (MT), developed by Bateman and Fonagy [28], which focuses on improving patients' understanding of mental states. Although MT showed a slightly smaller effect compared to DBT (g=0.54; 95% CI, – 0.02-1.10), it still demonstrated a significant improvement in the symptoms of BPD. In parallel, schema therapy (ST), developed by Young et al. [29], which integrates elements of different therapeutic approaches, has shown the greatest effect in reducing symptoms of BPD (g=1.14; 95% CI, 0.48-1.80), although these results are based on a smaller number of studies. Transfer-focused psychotherapy (TFP), developed by Yeomans et al. [30], is a psychodynamic approach aimed at integrating fragmented representations of self and others, but a meta-analysis by Setkowski et al. [16] did not reveal its statistically significant superiority over Treatment as Usual (TAU). Despite the variety of approaches and some differences in their effectiveness, Ellison [31] notes that different specialized psychotherapeutic approaches to the treatment of BPD often produce similar results. This may indicate the existence of common therapeutic mechanisms that contribute to the improvement of patients' condition, regardless of the specific theoretical basis of the method. This similarity in the effectiveness of different approaches emphasizes the need for further research to identify the key factors that lead to positive changes in the treatment of BPD. This, in turn, may contribute to the development of more comprehensive and individualized therapeutic strategies.

The effectiveness of psychotherapy is not limited to reducing the symptoms of BPD. Zahediabghari et al. [17] conducted a meta-analysis of the impact of psychotherapy on the psychosocial functioning of patients with BPD. The results showed that specialized psychotherapies significantly improve psychosocial functioning compared to non-specific approaches (g=0.41; 95% CI, 0.09-0.73). This underscores the importance of assessing not only symptomatic improvement, but also the overall functioning of patients in various domains of life. Although psychotherapy is considered the first line of treatment for BPD, pharmacological interventions are often used as an adjunctive method or in cases where psychotherapy is not available. However, the efficacy of pharmacotherapy for BPD remains a matter of debate. A recent large-scale study conducted by Lieslehto et al. [18], which included more than 22,000 patients with BPD over 16 years, revealed interesting patterns in the effect of different medications on the risk of suicidal behaviour. In particular, medications for the treatment of attention deficit hyperactivity disorder (ADHD) showed a reduction in the risk of suicide attempts and completed suicides (Hazard Ratio (HR) 0.83; 95% CI, 0.73-0.95). Methylphenidate (HR 0.84; 95% CI, 0.72-0.97) and lisdexamfetamine (HR 0.78; 95% CI, 0.63-0.97) were particularly effective.

In contrast, antidepressants (HR 1.38; 95% CI, 1.25-1.53) and antipsychotics (HR 1.18; 95% CI, 1.07-1.30) were associated with an increased risk of suicidal behaviour. The highest risk was observed with benzodiazepines (HR 1.61; 95% CI, 1.45-1.78). These results remained stable even after accounting for potential protopathic bias. These findings raise serious questions about the common practice of prescribing antidepressants and antipsychotics to patients with BPD. They also highlight the potential benefit of treating ADHD symptoms in patients with BPD, especially given the high comorbidity of these disorders. Medication therapy for BPD is primarily aimed at reducing individual symptoms, rather than treating the disorder as a whole. No medication is officially approved for the specific treatment of BPD. The prescription of pharmacotherapy should be based on an individual approach, taking into account the specific symptoms, the presence of comorbidities, as well as the potential risks and benefits for a particular patient.

A deeper understanding of the complex nature of BPD and an awareness of the limitations of traditional treatments have stimulated the de-

velopment of new, integrated therapeutic strategies. A particularly promising area has been the development of modular, individualized approaches to the treatment of BPD. These methods allow treatment to be tailored to the specific needs of each patient, taking into account the unique combination of symptoms and features of the disorder. Sauer-Zavala et al. [8] presented a conceptual framework and clinical data for modular, person-centred treatment of BPD. This approach allows therapy to be tailored to the individual needs of the patient, focusing on specific problem areas and using the most appropriate therapeutic techniques.

The integration of different therapeutic approaches also shows promising results. For example, combining elements of DBT and cognitive behavioural therapy for PTSD has been shown to be effective in treating patients with comorbid BPD and PTSD. A meta-analysis conducted by Slotema et al. [32] showed that integrated approaches can be effective in reducing the symptoms of both disorders. Zeifman et al. [19] conducted a systematic review of approaches to the treatment of comorbid BPD and PTSD. They found that integrated treatment protocols that simultaneously address the symptoms of both disorders may be more effective than sequential treatment of each disorder separately.

Innovative technological solutions are also finding their way into the treatment of BPD. The use of mobile apps to monitor symptoms, teach emotion regulation skills, and provide support between sessions shows promise. However, these approaches require further research to determine their long-term effectiveness and safety. It is important to note that, regardless of the specific therapeutic approach, the key to successful treatment of BPD is the formation of a stable therapeutic alliance. Clarkin et al. [33] emphasize that the therapist's ability to form and maintain a strong therapeutic alliance with patients suffering from BPD may have a greater impact on treatment outcomes than the specific techniques of a particular psychotherapeutic method.

For a comprehensive analysis and comparison of the effectiveness of different approaches to the treatment of BPD, it is advisable to systematize their key characteristics and research findings. Below is a comparative table that highlights the main aspects of the most studied therapies for BPD, including their impact on symptoms, suicidal behaviour, and social functioning (Table 3).

Table 3. Comparative characteristics of the effectiveness of therapeutic approaches in the treatment of BPD.

Method of treatment	Effectiveness in reducing the symptoms of BPD	Impact on suicidal behaviour	Impact on psychosocial functioning	Notes
Dialectical behavioural therapy (DBT)	g=0.42 (95% CI, 0.11-0.73)	Significant reduction	Positive impact	The most studied method
Mentalization therapy (MT)	g=0.54 (95% CI, 0.02-1.10)	Moderate decline	Positive impact	Effective for improving interpersonal relationships
Scheme therapy (ST)	g=1.14 (95% CI, 0.48-1.80)	Insufficient data	Positive impact	The biggest effect, but less research
Transfer-focused psychotherapy (TFP)	No statistically significant advantage over TAU was found	Insufficient data	Moderate positive impact	Needs more research
Medications for ADHD	Not applicable	HR=0.83 (95% CI, 0.73-0.95)	Insufficient data	The most effective in reducing suicide risk
Antidepressants	Not applicable	HR=1.38 (95% CI, 1.25-1.53)	Insufficient data	Associated with an increased risk of suicidal behaviour

Antipsychotics	Not applicable	HR=1.18 (95% CI, 1.07-1.30)	Insufficient data	Associated with an increased risk of suicidal behaviour
Benzodiazepines	Not applicable	HR=1.61 (95% CI, 1.45-1.78)	Insufficient data	The highest risk of suicidal behaviour
Integrated approaches	Varies depending on the combination	Potentially effective	Potentially effective	A promising area that requires further research

Note: BPD – borderline personality disorder; ADHD – attention deficit hyperactivity disorder; TAU – treatment as usual; g – Hedges effect size; HR – hazard ratio; CI – confidence interval. The effectiveness of psychotherapeutic methods was assessed in comparison with TAU. For pharmacological approaches, data on the impact on suicidal behaviour compared to periods of non-use of medications are presented.

Source: compiled by the authors based on Sauer-Zavala et al. [8], Setkowski et al. [16], S. Zahediabghari et al. [17], Ellison [31], Slotema et al. [32].

The analysis of the data presented in the table demonstrates the complexity and diversity of approaches to the treatment of BPD. It is evident that psychotherapeutic methods, especially those specialized for BPD, show significant effectiveness in reducing symptoms and improving psychosocial functioning. However, pharmacological treatments remain controversial, especially in terms of their impact on suicidal behaviour. Integrated and innovative approaches that combine different treatments show promise, but require further research. It is important to emphasize the importance of a personalized approach to therapy that takes into account the specific needs and individual characteristics of each person diagnosed with BPD. This approach allows for the development of the most effective treatment strategy adapted to a particular case.

4. DISCUSSION

The study reveals the multifaceted nature of BPD, highlighting its clinical aspects, diagnostic methods and various therapeutic approaches. The results indicate a significant diversity of symptoms of BPD, which complicates the diagnostic process and leads to variability in treatment outcomes. This heterogeneity of the clinical picture emphasizes the complexity of the disorder and the need for a comprehensive approach to its study and treatment.

In the context of the clinical manifestations of BPD, this study highlights the central role of emotional instability, identity disturbances, and interpersonal difficulties. The results are consistent with the findings of the meta-analytical study by McLaren et al. [34], who investigated the phenomenon of hypermentalisation in BPD. The authors found that patients with BPD demonstrate an increased tendency to overinterpret the mental states of others, which correlates with difficulties in interpersonal relationships and emotional instability. However, in contrast to the present study, McLaren et al. focused exclusively on the cognitive aspect of BPD, without considering the full range of symptoms. This limitation emphasizes the need for an integrative approach to the study of BPD that would encompass all aspects of the disorder.

The study revealed a significant evolution of diagnostic approaches to BPD, reflecting a growing understanding of the complexity and multidimensionality of this disorder. In particular, the analysis showed that the introduction of ICD-11 criteria marks an important transition from a categorical to a dimensional approach to the diagnosis of BPD. This new approach allows assessing the severity of impairment along a continuum (mild, moderate, or severe) and taking into account a specific "borderline pattern", which can potentially provide a more accurate and individualized diagnosis. The identified trend towards a measurable approach in the diagnosis of BPD is confirmed and further developed in the work of Masland et al. [35]. The authors expand on the discussion by emphasizing the importance of destigmatizing BPD through the introduction of a more nuanced understanding of the disorder. They argue that a measurable approach not only improves diagnostic accuracy, but can also help reduce stigma and, as a result, improve clinical outcomes. These observations support the findings of this study on

the benefits of a measured approach. In particular, they highlight its ability to more accurately reflect the spectrum of severity of the disorder and to take into account the individual characteristics of each patient.

In the field of treatment of BPD, this study revealed the effectiveness of specialized psychotherapeutic approaches, in particular, dialectical behavioural therapy (DBT) and schema therapy. These results correlate with the findings of a systematic review and meta-analysis by Stoffers-Winterling et al. [36]. However, in contrast to the present study, Stoffers-Winterling et al. [37] found greater efficacy of DBT compared to other approaches, while in the present study, ST showed the greatest effect. This discrepancy can be explained by differences in methodology and sample of studies, which emphasizes the need for further comparative studies of the effectiveness of different psychotherapeutic approaches in the treatment of BPD.

The present study revealed an unexpected effect of some medications in the treatment of BPD, in particular, an increased risk of suicidal behaviour with antidepressants and antipsychotics. These findings partially contradict the conclusions of Stoffers-Winterling et al. [36], who in their review of pharmacotherapy for BPD noted the potential benefit of antipsychotics in reducing cognitive and perceptual symptoms. However, Stoffers-Winterling et al. [37] also point out the limited evidence base for the effectiveness of pharmacotherapy in BPD, which is consistent with the findings of the present study. The identified discrepancies in the results of the studies emphasize the complexity of pharmacotherapy for BPD. They also highlight the need for a personalized approach to treatment, with close monitoring of possible side effects of medications in each individual patient.

The study revealed a significant incidence of comorbid mental disorders in patients with BPD. According to the data obtained, about 85% of people with BPD have at least one other psychiatric diagnosis. Most often, there is a combination of BPD with depressive disorders (in 40-70% of cases), anxiety disorders and PTSD (up to 30% of cases). This high comorbidity emphasizes the complexity of the clinical picture of BPD and the need for a comprehensive approach to its diagnosis and treatment. This high comorbidity creates significant difficulties for diagnosis and treatment, as the symptoms of different disorders can overlap and mutually reinforce each other. The identified patterns of comorbidity of BPD are confirmed and studied in depth in the work of Ford and Courtois [38], who focused on the relationship between complex PTSD and BPD. The authors expand the understanding of this problem by arguing that these disorders share common aetiological factors, in particular, the experience of chronic interpersonal trauma. They emphasize that BPD and complex PTSD often coexist, which not only complicates the diagnostic process but also requires a comprehensive approach to treatment. However, in contrast to the present study, which considers BPD and PTSD as separate, though often comorbid, disorders, Ford and Courtois propose a more radical approach. They put forward the concept of treating BPD and complex PTSD as a single spectrum of disorders. This concept is based on the identification of a significant overlap in symptoms and similar mechanisms of these disorders. This approach may have a significant impact on the revision of methods of diagnosis and therapy for BPD.

However, it is worth noting that this concept needs further empirical validation. Although it offers an interesting theoretical framework, its practical application may face some difficulties, especially given the already established diagnostic categories and treatment approaches.

The study revealed the possible effectiveness of medications used to treat ADHD in reducing the risk of suicidal behaviour in patients with BPD and comorbid disorders. These findings partially support the conclusions of Pascual et al. [39], who, in their review of the pharmacological treatment of BPD and comorbid conditions, also noted the potential benefit of stimulants in the treatment of comorbid ADHD. However, Pascual et al. emphasize the need for careful use of these drugs due to the risk of abuse, which was not sufficiently covered in the present study. This discrepancy highlights the importance of balancing potential benefits and risks in the pharmacological treatment of BPD and comorbid conditions.

The study found that dissociative symptoms play a significant role in the clinical picture of BPD. In particular, the results showed that pa-

tients with BPD often demonstrate temporary thought disorders, especially in stressful situations, which can manifest as paranoid ideas or short-term psychotic episodes. These dissociative manifestations have been identified as one of the diagnostic criteria for BPD, which underscores their clinical significance. In addition, the study found a strong association between dissociative symptoms and a history of traumatic experiences in patients with BPD, indicating a potential aetiological role for trauma in the development of this disorder. These findings are confirmed and studied in depth in the work of Krause-Utz [40], who studied in detail the relationship between dissociation, trauma, and BPD. The author extends the understanding of this problem by proposing the conceptualization of dissociation as a potentially adaptive coping mechanism in response to traumatic experiences. According to this concept, dissociation may initially arise as a defensive response to an unbearable emotional experience, allowing the individual to temporarily "disconnect" from the traumatic reality. However, Krause-Utz goes further, arguing that in BPD, this initially adaptive mechanism becomes maladaptive and begins to maintain and exacerbate the symptoms of the disorder. This is because chronic dissociation can interfere with the integration of traumatic experiences, emotional regulation, and the formation of a stable sense of self, which are key issues in BPD.

In contrast to the present study, which focused mainly on the clinical manifestations of dissociation in BPD, Krause-Utz [40] offers a more detailed neurobiological model of this phenomenon. The author considers dissociation as a result of disorders in neural networks responsible for the integration of sensory information, emotional regulation, and self-awareness. In this model, special attention is paid to changes in the functioning of the limbic system, the prefrontal cortex, and the relationships between them. Such a neurobiological concept is essential for a deeper understanding of the mechanisms of BPD formation and the development of targeted therapies. It may justify the use of techniques that aim to increase awareness and integrate emotional experience, such as mindfulness practices or specialized cognitive behavioural techniques.

This study also highlighted the role of chronic feelings of emptiness as one of the key symptoms of BPD. These results correlate with the findings of a systematic review by Miller et al. [41], who investigated the phenomenon of chronic emptiness in BPD. The authors found that the feeling of emptiness is a central symptom of BPD, which is associated with an increased risk of suicidal behaviour and general deterioration in functioning. However, in contrast to the present study, Miller et al. propose to conceptualize chronic emptiness as a separate construct that requires specific therapeutic interventions.

The study presents a comprehensive analysis of clinical aspects, diagnostic methods, and therapeutic approaches to BPD, which is generally consistent with the results of other contemporary research in this area. However, the differences identified in some aspects, especially regarding the effectiveness of different psychotherapeutic techniques and the role of medication, highlight the complexity and multidimensionality of BPD as a clinical phenomenon. These discrepancies also point to the need for further research to better understand the mechanisms of BPD, improve diagnostic criteria, and create more effective and individualized treatment strategies.

5. CONCLUSIONS

The study found that the key symptoms of BPD – emotional instability, identity disorders, impulsivity, and instability of interpersonal relationships – form a complex interconnected system that determines the unique clinical profile of each patient. This complex of symptoms is not limited to affecting the person's psychological state, but also significantly complicates their social and professional adaptation. As a result, patients with BPD face serious obstacles in establishing long-term relationships and implementing their life plans. The high level of comorbidity of BPD with other mental disorders, especially depression, anxiety disorders and PTSD, has proven to be not just a concomitant phenomenon, but a key factor determining the complexity of the clinical picture, prognosis, and treatment approaches. This underscores the need for

a comprehensive, multidisciplinary approach to assessment and therapy that takes into account not only the symptoms of BPD, but also the full range of psychopathological manifestations and their interaction.

An analysis of current diagnostic approaches has revealed a significant evolution from a categorical to a dimensional approach, which is most clearly reflected in the ICD-11 criteria. This transition reflects a fundamental shift in the understanding of the nature of personality disorders, allowing for a more accurate assessment of the severity of the disorder and individual patient characteristics. Structured diagnostic interviews, such as the SCID-5-PD and DIB-R, have been shown to demonstrate high reliability and validity, remaining the "gold standard" for diagnosing BPD in clinical trials. However, their use in routine practice is limited due to the considerable time required and the need for special training of interviewers. Self-report questionnaires, such as the BPQ and MSI-BPD, have shown good validity and reliability in screening and monitoring symptoms, making them valuable tools for initial assessment and monitoring of patients' progress.

Evaluation of the effectiveness of therapeutic approaches revealed that specialized psychotherapeutic methods, in particular DBT and ST, demonstrate the greatest effectiveness in reducing symptoms of BPD and improving psychosocial functioning. These approaches not only reduce the severity of symptoms, but also contribute to the development of adaptive emotion regulation skills, interpersonal effectiveness, and stabilization of self-perception. Pharmacological treatment of BPD has shown mixed results, emphasizing the need for an individualized approach to pharmacotherapy with careful weighing of potential risks and benefits for each patient.

The results obtained have significant practical implications for improving the diagnosis and treatment of BPD. Based on the study, it is recommended to implement a comprehensive, multicomponent approach that takes into account individual patient characteristics, comorbidities, and specific needs at different stages of therapy. It is especially important to ensure the integration of psychotherapeutic and pharmacological methods, focusing on the development of adaptive skills and improving the overall functioning of patients. Limitations of the study include the lack of direct comparison of the effectiveness of different therapeutic methods within a single study, the lack of long-term studies of treatment effectiveness, and the incomplete study of the influence of cultural factors on the manifestations and treatment of BPD. These limitations point to areas for future research.

Further research should focus on a deeper understanding of BPD at the neurobiological level, including genetic factors and brain function. The development of more accurate diagnostic methods remains a priority, especially for early detection of the disorder in younger age groups. It is crucial to assess the long-term effectiveness of various therapeutic strategies and their impact on patients' quality of life to optimize treatment. Studying the mechanisms of action of successful therapeutic interventions can help to develop innovative, more targeted treatments for BPD.

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