I'm not a bot

Medical conditionBorderline personality disorderOther names Emotionally unstable personality disorder – impulsive or borderline type[1] Emotional intensity disorder[2] Hysteria[3] Hysteric personality – Hysteroid[4] Negative affectivity/neuroticism[5] Idealization by Edvard Munch (1903), who is presumed to have had borderline personality disorder[6]SpecialtyPsychiatry, clinical psychologySymptomsUnstable relationships, distorted sense of self, and intense emotions; impulsivity; recurrent suicidal and self-harming behavior; fear of abandonment; chronic feelings of emptiness; inappropriate anger; dissociation[7][8]ComplicationsSuicide, self-harm[7]Usual onsetEarly adulthood[8]DurationLong term[7]CausesGenetic, neurobiologic, and psychosocial theories proposedDiagnostic methodBased on reported symptoms[7]Differential diagnosisSee § Differential diagnosisTreatmentBehaviour therapy[7]PrognosisImproves over time,[8] remission occurs in 45% of patients over a wide range of follow-up periods[9][10][11][12][13]Frequency5.9% (lifetime prevalence)[7] Personality disorders Cluster A (odd) Paranoid Schizoid Schizotypal Cluster B (dramatic) Antisocial Borderline Histrionic Narcissistic Cluster C (anxious) Avoidant Dependent Obsessive–compulsive Other and unspecified Other specified Unspecified Trait specified Depressive Depressive Cyclothymic Others Passive–aggressive Masochistic Sadistic Psychopathy Haltlose Immature Post-traumatic organic vte Borderline personality disorder (BPD) is a personality disorder characterized by a pervasive, long-term pattern of significant interpersonal relationship instability, an acute fear of abandonment, and intense emotional outbursts.[8][14][15] People diagnosed with BPD frequently exhibit self-harming behaviours and engage in risky activities, primarily due to challenges regulating emotional states to a healthy, stable baseline.[16][17][18] Symptoms such as dissociation (a feeling of detachment from reality), a pervasive sense of emptiness, and distorted sense of self are prevalent among those affected.[14] The onset of BPD symptoms can be triggered by events that others might perceive as normal,[14] with the disorder typically manifesting in early adulthood and persisting across diverse contexts.[8] BPD is often comorbid with substance use disorders,[19][20] depressive disorders, and eating disorders.[14] BPD is associated with a substantial risk of suicide;[8][14] studies estimated that up to 10 percent of people with BPD die by suicide.[21][22] Despite its severity, BPD faces significant stigmatization in both media portrayals and the psychiatric field, potentially leading to underdiagnosis and insufficient treatment.[23][24] The causes of BPD are unclear and complex, implicating genetic, neurological, and psychosocial conditions in its development.[7][25] A genetic predisposition is evident, with the disorder significantly more common in people with a family history of BPD, particularly immediate relatives.[7] Psychosocial factors, particularly adverse childhood experiences, have been proposed.[26] The American Diagnostic and Statistical Manual of Mental Disorders (DSM) classifies BPD in cluster B ("dramatic, emotional, or erratic" PDs) among personality disorders.[8] There is a risk of misdiagnosis, with BPD most commonly confused with a mood disorder, substance use disorder, or other mental health disorders.[8] Therapeutic interventions for BPD predominantly involve psychotherapy, with dialectical behavior therapy (DBT) and schema therapy the most effective modalities.[7][24] Although pharmacotherapy cannot cure BPD, it may be employed to mitigate associated symptoms,[7] with atypical antipsychotics (e.g., Quetiapine) and selective serotonin reuptake inhibitor (SSRI) antidepressants commonly being prescribed, though their efficacy is unclear. A 2020 meta-analysis found the use of medications was still unsupported by evidence.[27] BPD has a point prevalence of 1.6% and a lifetime prevalence of 5.9% of the global population,[8][7][28][29] with a higher incidence rate among women compared to men in the clinical setting of up to three times.[8][28] Despite the high utilization of healthcare resources by people with BPD,[30] up to half may show significant improvement over a ten-year period with appropriate treatment.[8] The name of the disorder, particularly the suitability of the term borderline, is a subject of ongoing debate. Initially, the term reflected historical ideas of borderline insanity and later described patients on the border between neurosis and psychosis. These interpretations are now regarded as outdated and clinically imprecise.[7][31] One of the symptoms of BPD is an intense fear of emotional abandonment. Borderline personality disorder, as outlined in the DSM-5, manifests through nine distinct symptoms, with a diagnosis requiring at least five of the following criteria to be met:[32] Frantic efforts to avoid real or imagined emotional abandonment. Unstable and chaotic interpersonal relationships, often characterized by a pattern of alternating between extremes of idealization and devaluation, also known as 'splitting'.[33] A markedly disturbed sense of identity and distorted self-image.[7] Impulsive or reckless behaviors, including uncontrollable spending, unsafe sexual practices, substance use disorder, reckless driving, and binge eating. Recurrent suicidal ideation or behaviors involving self-harm. Rapidly shifting intense emotional dysregulation. Chronic feelings of emptiness. Inappropriate, intense anger that can be difficult to control. Transient, stress-related paranoid ideation or severe dissociative symptoms. The distinguishing characteristics of BPD include a pervasive pattern of instability in one's interpersonal relationships and in one's self-image, with frequent oscillation between extremes of idealization and devaluation of others, alongside fluctuating moods and difficulty regulating intense emotional reactions. Dangerous or impulsive behaviors are commonly associated with BPD. Additional symptoms may encompass uncertainty about one's identity, values, morals, and beliefs; experiencing paranoid thoughts under stress; episodes of depersonalization; and, in moderate to severe cases, stress-induced breaks with reality or episodes of psychosis. It is also common for individuals with BPD to have comorbid conditions such as depressive or bipolar disorders, substance use disorders, eating disorders, post-traumatic stress disorder (PTSD), and attention deficit hyperactivity disorder (ADHD).[34] Further information: Emotional dysregulation Individuals with BPD exhibit emotional dysregulation. Emotional dysregulation is characterized by an inability to flexibly respond to and manage emotional states, resulting in intense and prolonged emotional reactions that deviate from social norms, given the nature of the environmental stimuli encountered. Such reactions not only deviate from accepted social norms but also surpass what is informally deemed appropriate or proportional to the encountered stimuli.[35][36][37][38] A core characteristic of BPD is affective instability, which manifests as rapid and frequent shifts in mood of high affect intensity and rapid onset of emotions, triggered by environmental stimuli. The return to a stable emotional state is notably delayed, exacerbating the challenge of achieving emotional equilibrium. This instability is further intensified by an acute sensitivity to psychosocial cues, leading to significant challenges in managing emotions effectively.[39][40][41] As the first component of emotional dysregulation, individuals with BPD are shown to have increased emotional sensitivity, especially towards negative mood states such as fear, anger, sadness, rejection, criticism, isolation, and perceived failure.[38][42] This increased sensitivity results in an intensified response to environmental cues, including the emotions of others.[38] Studies have identified a negativity bias in those with BPD, showing a predisposition towards recognizing and reacting more strongly to negative emotions in others, along with an attentional bias towards processing negatively-valenced stimuli.[38] Without effective coping mechanisms, individuals might resort to self-harm, or suicidal behaviors to manage or escape from these intense negative emotions.[43][38] While conscious of the exaggerated nature of their emotional responses, individuals with BPD face challenges in regulating these emotions. To mitigate further distress, there may be an unconscious suppression of emotional awareness, which paradoxically hinders the recognition of situations requiring intervention.[40] A second component of emotional dysregulation in BPD is high levels of negative affectivity, stemming directly from the individual's emotional sensitivity to negative emotions.[24] This negative affectivity causes emotional reactions that diverge from socially accepted norms, in ways that are disproportionate to the environmental stimuli presented.[38] Those with BPD find it difficult to tolerate the distress that is encountered in daily life, and they are prone to engage in maladaptive strategies to try to reduce the distress experienced. Maladaptive coping strategies include rumination, thought suppression, experiential avoidance, emotional isolation, as well as impulsive and self-injurious behaviours.[38] American psychologist Marsha Linehan highlights that while the sensitivity, intensity, and duration of emotional experiences in individuals with BPD can have positive outcomes, such as exceptional enthusiasm, idealism, and capacity for joy and love, it also predisposes them to be overwhelmed by negative emotions.[40][44] This includes experiencing profound grief instead of mere sadness, intense shame instead of mild embarrassment, rage rather than annoyance, and panic over nervousness.[44] Research indicates that individuals with BPD endure chronic and substantial emotional suffering.[34] Emotional dysregulation is a significant feature of BPD, yet Fitzpatrick et al. (2022) suggest that such dysregulation may also be observed in other disorders, like generalized anxiety disorder (GAD). Nonetheless, their findings imply that individuals with BPD particularly struggle with disengaging from negative emotions and achieving emotional equilibrium.[45] Euphoria, or transient intense joy, can occur in those with BPD, but they are more commonly afflicted by dysphoria (a profound state of unease or dissatisfaction), depression, and pervasive distress. Zanarini et al. identified four types of dysphoria characteristic of BPD: intense emotional states, destructiveness or self-destructiveness, feelings of fragmentation or identity loss, and perceptions of victimization.[46] A diagnosis of BPD is closely linked with experiencing feelings of betrayal, lack of control, and self-harm.[46] Moreover, emotional lability, indicating variability or fluctuations in emotional states, is frequent among those with BPD. Although emotional lability may imply rapid alternations between depression and elation, mood swings in BPD are more commonly between anger and anxiety or depression and anxiety.[47] Interpersonal relationships are significantly impacted in individuals with BPD, characterized by a heightened sensitivity to the behavior and actions of others. Individuals with BPD can be very conscious of and susceptible to their perceived or real treatment by others. Individuals may experience profound happiness and gratitude for perceived kindness, yet feel intense sadness or anger[48] towards perceived criticism or harm.[49] A notable feature of BPD is the tendency to engage in idealization and devaluation of others – that is to idealize and subsequently devalue others – oscillating between extreme admiration and profound mistrust or dislike.[50] This pattern, referred to as "splitting", can significantly influence the dynamics of interpersonal relationships.[51][52] In addition to this external "splitting", patients with BPD typically have internal splitting, i.e. vacillation between considering oneself a good person who has been mistreated (in which case anger predominates) and a bad person whose life has no value (in which case self-destructive or even suicidal behavior may occur). This splitting is also evident in black-and-white or all-or-nothing dichotomous thinking.[53] Despite a strong desire for intimacy, individuals with BPD may exhibit insecure, avoidant, ambivalent, or fearfully preoccupied attachment styles in relationships, complicating their interactions and connections with others.[54] Family members, including parents of adults with BPD, may find themselves in a cycle of being overly involved in the individual's life at times and, at other times, significantly detached,[55] contributing to a sense of alienation within the family unit.[53] Anthropologist Rebecca Lester argues that BPD is a disorder of relationships and communication, namely that a person with BPD lacks the communication skills and knowledge to interact effectively with others within their society and culture given their life experience.[56] Personality disorders, including BPD, are associated with an increased incidence of chronic stress and conflict, reduced satisfaction in romantic partnerships, domestic abuse, and unintended pregnancies.[57] Research indicates variability in relationship patterns among individuals with BPD. A portion of these individuals may transition rapidly between relationships, a pattern metaphorically described as "butterfly-like," characterized by fleeting and transient interactions and "fluttering" in and out of relationships.[58] Conversely, a subgroup, referred to as "attached," tends to establish fewer but more intense and dependent relationships. These connections often form rapidly, evolving into deeply intertwined and tumultuous bonds.[58] In certain cases, BPD may be recognized as a disability within the workplace, particularly if the condition's severity results in behaviors that undermine relationships, involve engagement in risky activities, or manifest as intense anger, thereby inhibiting the individual's ability to perform their job role effectively.[59] Individuals with BPD express higher levels of jealousy towards their partners in romantic relations.[60][61] Behavioral patterns associated with BPD frequently involve impulsive actions, which may manifest as substance use disorders, binge eating, unprotected sexual encounters, and self-injury among other self-harming practices.[62] These behaviors are a response to the intense emotional distress experienced by individuals with BPD, serving as an immediate but temporary alleviation of their emotional pain.[62] However, such actions typically result in feelings of shame and guilt, contributing to a recurrent cycle.[62] This cycle typically begins with emotional discomfort, followed by impulsive behavior aimed at mitigating this discomfort, only to lead to shame and guilt, which in turn exacerbates the emotional pain.[62] This escalation of emotional pain then intensifies the compulsion towards impulsive behavior as a form of relief, creating a vicious cycle. Over time, these impulsive responses can become an automatic mechanism for coping with emotional pain.[62] Self-harm and suicidal behaviors are core diagnostic criteria for BPD as outlined in the DSM-5.[8] Between 50% and 80% of individuals diagnosed with BPD engage in self-harm, with cutting being the most common method.[63] Other methods, such as bruising, burning, head banging, or biting, are also prevalent.[63] It is hypothesized that individuals with BPD might experience a sense of emotional relief following acts of self-harm.[64] Estimates of the lifetime risk of death by suicide among individuals with BPD range between 3% and 10%, varying with the method of investigation.[65][53][66] There is evidence that a significant proportion of males who die by suicide may have undiagnosed BPD.[67] The motivations behind self-harm and suicide attempts among individuals with BPD are reported to differ.[43] Nearly 70% of individuals with BPD engage in self-harm without the intention of ending their lives. Motivations for self-harm include expressing anger, self-punishment, inducing normal feelings or feelings of normality in response to dissociative episodes, and distraction from emotional distress or challenging situations.[43][non-primary source needed] Conversely, true suicide attempts by individuals with BPD frequently are motivated by the notion that others will be better off in their absence.[43][non-primary source needed] Individuals diagnosed with BPD frequently experience significant difficulties in maintaining a stable self-concept.[68] This instability manifests as uncertainty in personal values, beliefs, preferences, and interests.[69] They may also express confusion regarding their aspirations and objectives in terms of relationships and career paths. Such indeterminacy leads to feelings of emptiness and a profound sense of disorientation regarding their own identity.[69] Moreover, their self-perception can fluctuate dramatically over short periods, oscillating between positive and negative evaluations. Consequently, individuals with BPD might adopt their sense of self based on their surroundings or the people they interact with, resulting in a chameleon-like adaptation of identity.[70] The heightened emotional states experienced by individuals with BPD can impede their ability to concentrate and cognitively function.[69] Additionally, individuals with BPD may frequently dissociate, which can be regarded as a mild to severe disconnection from physical and emotional experiences.[71] Observers may notice signs of dissociation in individuals with BPD through diminished expressiveness in their face or voice, or an apparent disconnection and insensitivity to emotional cues or stimuli.[71] BPD is predominantly characterized as a disorder involving emotional dysregulation, yet psychotic symptoms frequently occur in individuals with BPD, with about 20–50% of patients reporting psychotic symptoms.[72] These manifestations have historically been labeled as "pseudo-psychotic" or "psychotic-like", implying a differentiation from symptoms observed in primary psychotic disorders. Studies conducted in the 2010s suggest a closer similarity between psychotic symptoms in BPD and those in recognized psychotic disorders than previously understood.[72][73] The distinction of pseudo-psychosis has faced criticism for its weak construct validity and the potential to diminish the perceived severity of these symptoms, potentially hindering accurate diagnosis and effective treatment. Consequently, there are suggestions from some in the research community to categorize these symptoms as genuine psychosis, advocating for the abolishment of the distinction between pseudo-psychosis and true psychosis.[72][74] The DSM-5 identifies transient paranoia, exacerbated by stress, as a symptom of BPD.[8] Research has identified the presence of both hallucinations and delusions in individuals with BPD who do not possess an alternate diagnosis that would better explain these symptoms.[73] Further, phenomenological analysis indicates that auditory verbal hallucinations in BPD patients are indistinguishable from those observed in schizophrenia.[73][74] This has led to suggestions of a potential shared etiological basis for hallucinations across BPD and other disorders, including psychotic and affective disorders.[73] The etiology, or causes, of BPD is multifaceted, with no consensus on a singular cause.[75] BPD may share a connection with post-traumatic stress disorder (PTSD), having both a traumatic substrate.[76] While childhood trauma is a recognized contributing factor, the roles of congenital brain abnormalities, genetics, neurobiology, and non-traumatic environmental factors remain subjects of ongoing investigation.[75][77] Compared to other major psychiatric conditions, the exploration of genetic underpinnings in BPD remains novel.[78] Estimates suggest the heritability of BPD ranges from 37% to 69%,[79] indicating that human genetic variations account for a substantial portion of the risk for BPD within the population. Twin studies, which often form the basis of these estimates, may overestimate the perceived influence of genetics due to the shared environment of twins, potentially skewing results.[80] Certain studies propose that personality disorders are significantly shaped by genetics, more so than many Axis I disorders, such as depression and eating disorders, and even surpassing the genetic impact on broad personality traits.[81] A twin study found that BPD ranks as the third most heritable among ten surveyed personality disorders.[81] Research involving twin and sibling studies has shown a genetic component to traits associated with BPD, such as impulsive aggression; with the genetic contribution to behavior from serotonin-related genes appearing to be modest.[82] A study conducted by Trull et al. in the Netherlands, which included 711 sibling pairs and 561 parents, aimed to identify genetic markers associated with BPD.[83] This research identified a linkage to genetic markers on chromosome 9 as relevant to BPD characteristics,[83] underscoring a significant genetic contribution to the variability observed in BPD features.[83] Prior findings from this group indicated that 42% of BPD feature variability could be attributed to genetics, with the remaining 58% owing to environmental factors.[83] Among specific genetic variants under scrutiny as of 2012[update], the DRD4 7-repeat polymorphism (of the dopamine receptor D4) located on chromosome 11 has been linked to disorganized attachment, and in conjunction with the 10/10-repeat genotype of the dopamine transporter (DAT), it has been associated with issues with inhibitory control, both of which are characteristic of BPD.[84] Additionally, potential links to chromosome 5 are being explored, further emphasizing the complex genetic landscape influencing BPD development and manifestation.[85][86] Empirical studies have established a strong correlation between adverse childhood experiences such as child abuse, particularly child sexual abuse, and the onset of BPD later in life.[87][88][89] Reports from individuals diagnosed with BPD frequently include narratives of extensive abuse and neglect during early childhood, though causality remains a subject of ongoing investigation.[90] These individuals are significantly more prone to recount experiences of verbal, emotional, physical, or sexual abuse by caregivers,[91] alongside a notable frequency of incest and loss of caregivers in early childhood.[92] Moreover, there have been consistent accounts of caregivers invalidating the individuals' emotions and thoughts, neglecting physical care, failing to provide the necessary protection, and exhibiting emotional withdrawal and inconsistency.[92] Specifically, female individuals with BPD reporting past neglect or abuse by caregivers have a heightened likelihood of encountering sexual abuse from individuals outside their immediate family circle.[92] Research also indicates that neurodevelopment variations such as autism spectrum traits, ADHD, or highly sensitive people (HSP) may increase vulnerability to trauma and subsequent borderline personality organization.[93] The enduring impact of chronic maltreatment and difficulties in forming secure attachments during childhood has been hypothesized to potentially contribute to the development of BPD.[94] Marsha Linehan's biosocial developmental theory posits that BPD arises from the interaction between a child's inherent emotional vulnerability and an invalidating environment – an environment characterized by the neglect, ridicule, dismissal, or discouragement of a child's emotions and needs.[95] Research employing structural neuroimaging techniques, such as voxel-based morphometry, has reported variations in individuals diagnosed with BPD in specific brain regions that have been associated with the psychopathology of BPD. Reductions in volume enclosed have been observed in the hippocampus, orbitofrontal cortex, anterior cingulate cortex, and amygdala, among others, which are crucial for emotional self-regulation and stress management.[84] In addition to structural imaging, a subset of studies utilizing magnetic resonance spectroscopy has investigated the neurometabolic profile within these affected regions. These investigations have focused on the concentrations of various neurometabolites, including N-acetylaspartate, creatine, compounds related to glutamate, and compounds containing choline. These studies aim to show the biochemical alterations that may underlie the symptomatology observed in BPD.[84] Research has shown changes in two brain circuits implicated in the emotional dysregulation characteristic of BPD: firstly, an escalation in activity within brain circuits associated with experiencing severe emotional pain, and secondly, a decreased activation within circuits tasked with the regulation or suppression of these intense emotions. These dysfunctional activations predominantly occur within the limbic system, though individual variances necessitate further neuroimaging research to explore these patterns in detail.[96] Contrary to earlier findings, individuals with BPD exhibit decreased amygdala activation in response to heightened negative emotional stimuli compared to control groups. John Krystal, the editor of Biological Psychiatry, commented on these findings, suggesting they contribute to understanding the innate neurological predisposition of individuals with BPD to lead emotionally turbulent lives, which are not inherently negative or unproductive.[96] This emotional volatility is consistently linked to disparities in several brain regions, emphasizing the neurobiological underpinnings of BPD.[97] High sensitivity to social rejection is linked to more severe symptoms of BPD, with executive function playing a mediating role.[98] Executive function—encompassing planning, working memory, attentional control, and problem-solving—moderates how rejection sensitivity influences BPD symptoms. Studies demonstrate that individuals with lower executive function exhibit a stronger correlation between rejection sensitivity and BPD symptoms.[98] Conversely, higher executive function may mitigate the impact of rejection sensitivity, potentially offering protection against BPD symptoms.[98] The clinical diagnosis of BPD can be made through a psychiatric assessment conducted by a mental health professional, ideally a psychiatrist or psychologist. This comprehensive assessment integrates various sources of information to confirm the diagnosis, encompassing the patient's self-reported clinical history, observations made by the clinician during interviews, and corroborative details obtained from family members, friends, and medical records. It is crucial to thoroughly assess patients for co-morbid mental health conditions, substance use disorders, suicidal ideation, and any self-harming behaviors.[99] An effective approach involves presenting the criteria of the disorder to the individual and inquiring if they perceive these criteria as reflective of their experiences. Involving individuals in the diagnostic process may enhance their acceptance of the diagnosis. Despite the stigma associated with BPD and previous notions of its untreatability, disclosing the diagnosis to individuals is generally beneficial. It provides them with validation and directs them to appropriate treatment options.[53] The psychological evaluation for BPD typically explores the onset and intensity of symptoms and their impact on the individual's quality of life. Critical areas of focus include suicidal thoughts, self-harm behaviors, and any thoughts of harming others.[100] The diagnosis relies on both the individual's self-reported symptoms and the clinician's observations.[100] To exclude other potential causes of the symptoms, additional assessments may include a physical examination and blood tests, to exclude thyroid disorders or substance use disorders.[100] The International Classification of Diseases (ICD-10) categorizes the condition as emotionally unstable personality disorder, with diagnostic criteria similar to those in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), where the disorder's name remains unchanged from previous editions.[8] Further information: Personality disorder § DSM-5, and Alternative DSM-5 model for personality disorders The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) has eliminated the multiaxial diagnostic system, integrating all disorders, including personality disorders, into Section II of the manual. For a diagnosis of BPD, an individual must meet five out of nine specified diagnostic criteria.[101] The DSM-5 characterizes BPD as a pervasive pattern of instability in interpersonal relationships, self-image, affect, and a significant propensity towards impulsive behavior.[101] Moreover, the DSM-5 introduces alternative diagnostic criteria for BPD in Section III, titled Alternative DSM-5 Model for Personality Disorders (AMPD). These criteria are rooted in trait research and necessitate the identification of at least four out of seven maladaptive traits.[102] Marsha Linehan highlights the diagnostic challenges faced by mental health professionals in using the DSM criteria due to the broad range of behaviors they encompass.[103] To mitigate these challenges, Linehan categorizes BPD symptoms into five principal areas of dysregulation: emotions, behavior, interpersonal relationships, sense of self, and cognition.[103] See also: ICD-11 § Personality disorder The World Health Organization's ICD-11 completely restructured its personality disorder section. It classifies BPD as Personality disorder, (6D10) Borderline pattern, (6D11.5).[104][failed verification] Previously, the ICD-10 (version 2019) had identified a condition akin to BPD, termed Emotionally unstable personality disorder (EUPD) (F60.3).[105] The borderline pattern specifier is defined as a personality disturbance marked by instability in interpersonal relationships, self-image, and emotions, as well as impulsivity. The Borderline pattern specifier may be applied to individuals whose pattern of personality disturbance is characterized by a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, as indicated by five (or more) of the following: Frantic efforts to avoid real or imagined abandonment. A pattern of unstable and intense interpersonal relationships, which may be characterized by vacillations between idealization and devaluation, typically associated with both a strong desire for and fear of closeness and intimacy. Identity disturbance, manifested in markedly and persistently unstable self-image or sense of self. A tendency to act rashly in states of high negative affect, leading to potentially self-damaging behaviours (e.g., risky sexual behaviour, reckless driving, excessive alcohol or substance use, binge eating). Recurrent episodes of self-harm (e.g., suicide attempts or gestures, self-mutilation). Emotional instability due to marked reactivity of mood. Fluctuations of mood may be triggered either internally (e.g., by one's own thoughts) or by external events. As a consequence, the individual experiences intense dysphoric mood states, which typically last for a few hours but may last for up to several days. Chronic feelings of emptiness. Inappropriate intense anger or difficulty controlling anger manifested in frequent displays of temper (e.g., yelling or screaming, throwing or breaking things, getting into physical fights). Transient dissociative symptoms or psychotic-like features (e.g., brief hallucinations, paranoia) in situations of high affective arousal. Other manifestations of Borderline pattern, not all of which may be present in a given individual at a given time, include the following: A view of the self as inadequate, bad, guilty, disgusting, and contemptible. An experience of the self as profoundly different and isolated from other people; a painful sense of alienation and pervasive loneliness. Proneness to rejection hypersensitivity; problems in establishing and maintaining consistent and appropriate levels of trust in interpersonal relationships; frequent misinterpretation of social signals.—6D11.5 Borderline pattern in ICD-11 Psychologist Theodore Millon proposed four subtypes of BPD, where individuals with BPD would exhibit none, one, or multiple subtypes.[106] Subtype Features Personality Traits Discouraged borderline Including avoidant, depressive, and dependant features Pliant, submissive, loyal, humble; feels vulnerable and in constant jeopardy; feels hopeless, depressed, helpless, and powerless. Impulsive borderline Including histrionic or antisocial features Capricious, superficial, flighty, distractible, frenetic, and seductive; fearing loss, becomes agitated, and gloomy and irritable; potentially suicidal. Petulant borderline Including negativistic features Negativistic, impatient, restless, as well as stubborn defiant, sullen, pessimistic, and resentful; easily slighted and quickly disillusioned. Self-destructive borderline Including depressive or masochistic features Inward-turning, intropunitively angry; conforming, deferential, and ingratiating behaviors have deteriorated; increasingly high-strung and moody; possible suicide Main article: Misdiagnosis of borderline personality disorder Individuals with BPD are subject to misdiagnosis due to various factors, such as the overlap (comorbidity) of BPD symptoms with those of other disorders such as depression, PTSD, and bipolar disorder.[107][108] Misdiagnosis of BPD can lead to a range of adverse consequences. Diagnosis plays a crucial role in informing healthcare professionals about the patient's mental health status, guiding treatment strategies, and facilitating accurate reporting of successful interventions.[109] Consequently, misdiagnosis may deprive individuals of access to suitable psychiatric medications or evidence-based psychological interventions tailored to their specific disorders.[110] Critics of the BPD diagnosis contend that it is indistinguishable from negative affectivity upon undergoing regression and factor analyses. They maintain that the diagnosis of BPD does not provide additional insight beyond what is captured by other diagnoses, positing that it may be redundant or potentially misleading.[111] The onset of BPD symptoms typically occurs during adolescence or early adulthood, with possible early signs in childhood.[112] Predictive symptoms in adolescents include body image issues, extreme sensitivity to rejection, behavioral challenges, non-suicidal self-injury, seeking exclusive relationships, and profound shame.[53] Although many adolescents exhibit these symptoms without developing BPD, those who do are significantly more likely to develop the disorder and potentially face long-term social challenges.[53] BPD is recognized as a stable and valid diagnosis during adolescence, supported by the DSM-5 and ICD-11.[113][114][115][116] Early detection and treatment of BPD in young individuals are emphasized in national guidelines across various countries, including the US, Australia, the UK, Spain, and Switzerland, highlighting the importance of early intervention.[115][117][118] Historically, diagnosing BPD during adolescence was met with caution,[115][119][120] due to concerns about the accuracy of diagnosing young individuals,[121][122] the potential misinterpretation of normal adolescent behaviors, stigma, and the stability of personality during this developmental stage.[115] Despite these challenges, research has confirmed the validity and clinical utility of the BPD diagnosis in adolescents,[113][114][115][116] though misconceptions persist among mental health care professionals,[123][124][125] contributing to clinical reluctance in diagnosing and a key barrier to the provision of effective treatment BPD in this population.[123][126][127] A diagnosis of BPD in adolescence can indicate the persistence of the disorder into adulthood,[128][129] with outcomes varying among individuals. Some maintain a stable diagnosis over time, while others may not consistently meet the diagnostic criteria.[130] Early diagnosis facilitates the development of effective treatment plans,[128][129] including family therapy, to support adolescents with BPD.[131] Lifetime co-occurring (comorbid) conditions are prevalent among individuals diagnosed with BPD. Individuals with BPD exhibit higher rates of comorbidity compared to those diagnosed with other personality disorders. These comorbidities include mood disorders (such as major depressive disorder and bipolar disorder), anxiety disorders (including panic disorder, social anxiety disorder, and post-traumatic stress disorder (PTSD)), other personality disorders (notably schizotypal, antisocial, and dependent personality disorder), substance use disorder, eating disorders (anorexia nervosa and bulimia nervosa), attention deficit hyperactivity disorder (ADHD),[132] somatic symptom disorder, and the dissociative disorders.[133] It is advised that a personality disorder diagnosis should be made cautiously during untreated mood episodes or disorders unless a comprehensive lifetime history supports the existence of a personality disorder.[134] Gender variations in lifetime prevalence of comorbid Axis I disorders among individuals diagnosed with BPD: A comparative study between 2008[135] and 1998[136] Axis I diagnosis Overall (%) Male (%) Female (%) Mood disorders 75.0 68.7 80.2 Major depressive disorder 32.1 27.2 36.1 Dysthymia 09.7 07.1 11.9 Bipolar I disorder 31.8 30.6 32.7 Bipolar II disorder 07.7 06.7 08.5 Anxiety disorders 74.2 66.1 81.1 Panic disorder with agoraphobia 11.5 07.7 14.6 Panic disorder without agoraphobia 18.8 16.2 20.9 Social phobia 29.3 25.2 32.7 Specific phobia 37.5 26.6 46.6 PTSD 39.2 29.5 47.2 Generalized anxiety disorder 35.1 27.3 41.6 Obsessive–compulsive disorder** 15.6 – – Substance use disorders 72.9 80.9 66.2 Any alcohol use disorder 57.3 71.2 45.6 Any non-alcohol substance use disorder 36.2 44.0 29.8 Eating disorders** 53.0 20.5 62.2 Anorexia nervosa** 20.8 07 * 25 * Bulimia nervosa** 25.6 10 * 30 * Eating disorder not otherwise specified** 26.1 10.8 30.4 Somatoform disorders** 10.3 10 * 10 * Somatization disorder** 04.2 – – Hypochondriasis** 04.7 – – Somatoform pain disorder** 04.2 – – Psychotic disorders** 01.3 01 * 01 * * Approximate values ** Values from 1998 study[133]– Value not provided by from both studies A 2008 study stated that 75% of individuals with BPD at some point meet criteria for mood disorders, notably major depression and bipolar I, with a similar percentage for anxiety disorders.[135][non-primary source needed] They found that 73% of individuals with BPD meet criteria for substance use disorders, and about 40% for PTSD.[135] A higher proportion of males meet criteria for substance use disorders, whereas females are more likely to have PTSD and eating disorders.[135] 38% of individuals with BPD were found to meet criteria for ADHD,[132] and 15% for autism spectrum disorder (ASD) in separate studies.[137][non-primary source needed] Seventy-five percent (75%) of individuals with BPD concurrently experience mood disorders, notably major depressive disorder (MDD) or bipolar disorder (BD),[52] complicating diagnostic clarity due to overlapping symptoms.[138][139][140] Distinguishing BPD from BD is particularly challenging, as behaviors part of diagnostic criteria for both BPD and BD may emerge during depressive or manic episodes in BD. However, these behaviours are likely to subside as mood normalises in BD to euthymia, but typically are pervasive in BPD.[141] Differences between BPD and BD mood swings include their duration, with BD episodes typically lasting for at least two weeks at a time,[a] in contrast to the rapid and transient mood shifts seen in BPD.[141][144][143] Additionally, BD mood changes are generally unresponsive to environmental stimuli, whereas BPD moods are. For example, a positive event might alleviate a depressive mood in BPD, responsiveness not observed in BD.[144] Furthermore, the euphoria in BPD lacks the racing thoughts and reduced need for sleep characteristic of BD,[144] though sleep disturbances have been noted in BPD.[145] Historically, BPD was considered a milder form of BD,[146][147] or part of the bipolar spectrum. However, distinctions in phenomenology, family history, disease progression, and treatment responses refute a singular underlying mechanism for both conditions.[148] Research indicates only a modest association between BD and BPD, challenging the notion of a close spectrum relationship.[149][150] BPD is a psychiatric condition distinguishable from premenstrual dysphoric disorder (PMDD), despite some symptom overlap. BPD affects individuals persistently across all stages of the menstrual cycle, unlike PMDD, which is confined to the luteal phase and ends with menstruation.[151][152] While PMDD, affecting 3–8% of women,[153] includes mood swings, irritability, and anxiety tied to the menstrual cycle, BPD presents a broader, constant emotional and behavioral challenge irrespective of hormonal changes. Approximately 74% of individuals with BPD also fulfill criteria for another Axis II personality disorder during their lifetime, according to research conducted in 2008.[135] The most prevalent co-occurring disorders are from Cluster A (paranoid, schizoid, and schizotypal personality disorders), affecting about half of those with BPD, with schizotypal personality disorder alone impacting one-third of individuals. Being part of Cluster B, BPD patients also commonly share characteristics with other Cluster B disorders (antisocial, histrionic, and narcissistic personality disorders), with nearly half of individuals with BPD showing signs of these conditions, and narcissistic personality disorder affecting roughly one-third.[135] Cluster C disorders (avoidant, dependent, and obsessive-compulsive personality disorders) have the least comorbidity with BPD, with just under a third of individuals with BPD meeting the criteria for a Cluster C disorder.[135] Main article: Management of borderline personality disorder The main approach to managing BPD is through psychotherapy, tailored to the individual's specific needs rather than applying a one-size-fits-all model based on the diagnosis alone.[26] While medications do not directly treat BPD, they are beneficial in managing comorbid conditions like depression and anxiety.[154] Evidence states short-term hospitalization does not offer advantages over community care in terms of enhancing outcomes or in the long-term prevention of suicidal behavior among individuals with BPD.[155] The stages used in dialectical behavior therapyLong-term, consistent psychotherapy stands as the preferred method for treating BPD and engagement in any therapeutic approach tends to surpass the absence of treatment, particularly in diminishing self-harm impulses.[156] Among the effective psychotherapeutic approaches, dialectical behavior therapy (DBT), schema therapy, and psychodynamic therapies have shown efficacy, although improvements may require extensive time, often years of dedicated effort.[157] Available treatments for BPD include dynamic deconstructive psychotherapy (DDP),[158] mentalization-based treatment (MBT), schema therapy, transference-focused psychotherapy, dialectical behavior therapy (DBT), and general psychiatric management.[53][159] The effectiveness of these therapies does not significantly vary between more intensive and less intensive approaches.[160] Transference-focused psychotherapy is designed to mitigate absolutist thinking by encouraging individuals to express their interpretations of social interactions and their emotions, thereby fostering more nuanced and flexible categorizations.[161] Dialectical behavior therapy (DBT), on the other hand, focuses on developing skills in four main areas: interpersonal communication, distress tolerance, emotional regulation, and mindfulness, aiming to equip individuals with BPD with tools to manage intense emotions and improve interpersonal relationships.[161][162][159] Cognitive behavioral therapy (CBT) targets the modification of behaviors and beliefs through problem identification related to BPD, showing efficacy in reducing anxiety, mood symptoms, suicidal ideation, and self-harming actions.[7] Mentalization-based therapy and transference-focused psychotherapy draw from psychodynamic principles, while DBT is rooted in cognitive-behavioral principles and mindfulness.[156] General psychiatric management integrates key aspects from these treatments and is seen as more accessible and less resource-intensive.[53] Studies suggest DBT and MBT may be particularly effective, with ongoing research into developing abbreviated forms of these therapies to enhance accessibility and reduce both financial and resource burdens on patients and providers.[163][164][156] Schema therapy considers early maladaptive schemas, conceptualized as organized patterns that recur throughout life in response to memories, emotions, bodily sensations, and cognitions associated with unmet childhood needs.[165] Additionally, mindfulness meditation has been associated with positive structural changes in the brain and improvements in BPD symptoms, with some participants in mindfulness-based interventions no longer meeting the diagnostic criteria for BPD after treatment.[166][167][168][169] A 2010 Cochrane review found that no medications were effective for the core symptoms of BPD, such as chronic feelings of emptiness, identity disturbances, and fears of abandonment. Some medications might impact isolated symptoms of BPD or those of comorbid conditions.[170] A 2017 systematic review[171] and a 2020 Cochrane review[172] confirmed these findings.[171][172] This 2020 Cochrane review found that while some medications, like mood stabilizers and second-generation antipsychotics, showed some benefits, SSRIs and SNRIs lacked high-level evidence of effectiveness.[172] The review concluded that stabilizers and second-generation antipsychotics may effectively treat some symptoms and associated psychopathology of BPD, but these drugs are not effective for the overall severity of BPD; as such, pharmacotherapy should target specific symptoms.[172] Specific medications have shown varied effectiveness on BPD symptoms: haloperidol and flupenthixol for anger and suicidal behavior reduction; aripiprazole for decreased impulsivity and interpersonal problems;[170] and olanzapine and quetiapine for reducing affective instability, anger, and anxiety, though olanzapine showed less benefit for suicidal ideation than a placebo.[170][171] Mood stabilizers like valproate and topiramate showed some improvements in depression, impulsivity, and anger, but the effect of carbamazepine was not significant. Of the antidepressants, amitriptyline may reduce depression, but mianserin, fluoxetine, fluvoxamine, and phenelzine sulfate showed no effect. Omega-3 fatty acid may ameliorate suicidality and improve depression. As of 2017[update], trials with these medications had not been replicated and the effect of long-term use had not been assessed.[170][171] Lamotrigine[27] and other medications like IV ketamine[173][174] for unresponsive depression require further research for their effects on BPD. Quetiapine showed some benefits for BPD severity, psychosocial impairment, aggression, and manic symptoms at doses of 150 mg/day to 300 mg/day,[27] but the evidence is mixed.[172] Despite the lack of solid evidence, SSRIs and SNRIs are prescribed off-label for BPD[27][175] and are typically considered adjunctive to psychotherapy.[175] Given the weak evidence and potential for serious side effects, the UK National Institute for Health and Clinical Excellence (NICE) recommends against using drugs specifically for BPD or its associated behaviors and symptoms. Medications may be considered for treating comorbid conditions within a broader treatment plan.[176] Reviews suggest minimizing the use of medications for BPD to very low doses and short durations, emphasizing the need for careful evaluation and management of drug treatment in BPD.[177][178] The disparity between those benefiting from treatment and those receiving it, known as the "treatment gap," arises from several factors. These include reluctance to seek treatment, healthcare providers' underdiagnosis, and limited availability and accessibility to advanced treatments.[179] Furthermore, establishing clear pathways to services and medical care remains a challenge, complicating access to treatment for individuals with BPD. Despite efforts, many healthcare providers lack the training or resources to address severe BPD effectively, an issue acknowledged by both affected individuals and medical professionals.[180] In the context of psychiatric hospitalizations, individuals with BPD constitute approximately 20% of admissions.[181] While many engage in outpatient treatment consistently over several years, reliance on more restrictive and expensive treatment options, such as inpatient admission, tends to decrease over time.[182] Service experiences vary among individuals with BPD.[183] Assessing suicide risk poses a challenge for clinicians, with patients underestimating the lethality of self-harm behaviors. The suicide risk among people with BPD is significantly higher than that of the general population, characterized by a history of multiple suicide attempts during crises.[184] About half of all individuals who commit suicide are diagnosed with a personality disorder, with BPD being the most common association.[185] With treatment, the majority of people with BPD can find relief from distressing symptoms and achieve remission, defined as a consistent relief from symptoms for at least two years.[186][187] Remission rates are about 50 to 70% over the course of five years.[188] The remission rate is estimated to be around 50% at 10 years, with 93% of people being able to achieve a 2-year remission and 86% achieving at least a 4-year remission, with a 30% risk of relapse over 10 years.[189] Patient personality can play an important role during the therapeutic process, leading to better clinical outcomes. Recent research has shown that BPD patients undergoing dialectical behavior therapy (DBT) exhibit better clinical outcomes correlated with higher levels of the trait of agreeableness in the patient, compared to patients either low in agreeableness or not being treated with DBT. This association was mediated through the strength of a working alliance between patient and therapist; that is, more agreeable patients developed stronger working alliances with their therapists, which in turn, led to better clinical outcomes.[190] In addition to recovering from distressing symptoms, people with BPD can also achieve high levels of psychosocial functioning. A longitudinal study tracking the social and work abilities of participants with BPD found that six years after diagnosis, 56% of participants had good function in work and social environments, compared to 26% of participants when they were first diagnosed. Vocational achievement was generally more limited, even compared to those with other personality disorders. However, those whose symptoms had remitted were significantly more likely to have good relationships with a romantic partner and at least one parent, good performance at work and school, a sustained work and school history, and good psychosocial functioning overall.[191] BPD has a point prevalence of 1.6%[187] and a lifetime prevalence of 5.9% of the global population.[135][8][7][28][29] Within clinical settings, the occurrence of BPD is 6.4% among urban primary care patients,[192] 9.3% among psychiatric outpatients,[193] and approximately 20% among psychiatric inpatients.[194] Utilization of healthcare resources by individuals with BPD is high.[30] Up to half may show significant improvement in their condition, resulting in ineligibility for diagnosis of BPD, following a ten-year period with appropriate treatment.[8] Regarding gender distribution, women are diagnosed with BPD three times more frequently than men in clinical environments.[8][28] Nonetheless, epidemiological research in the United States indicates no significant gender difference in the lifetime prevalence of BPD within the general population.[195][135] The relationship between BPD and ethnicity continues to be ambiguous, with divergent findings reported in the United States.[28] The overall prevalence of BPD in the U.S. prison population is thought to be 17%.[196] Devaluation in Edvard Munch's Salome (1903). Idealization and devaluation of others in personal relations are common traits of BPD. The painter Edvard Munch depicted his new friend, the violinist Eva Mudocci, in both ways within days. First as "a woman seen by a man in love", then as "a bloodthirsty and cannibalistic Salome".[197] In modern times, Munch has been diagnosed as having had BPD.[198][199] The coexistence of intense, divergent moods within an individual was recognized by Homer, Hippocrates, and Aretaeus, the latter describing the vacillating presence of impulsive anger, melancholia, and mania within a single person. The concept was revived by Swiss physician Théophile Bonet in 1684 who, using the term folie maniaco-mélancolique,[200] described the phenomenon of unstable moods that followed an unpredictable course. Other writers noted the same pattern, including the American psychiatrist Charles H. Hughes in 1884 and J. C. Rosse in 1890, who called the disorder "borderline insanity".[201] In 1921, Emil Kraepelin identified an "excitable personality" that closely parallels the borderline features outlined in the current concept of BPD.[202] The idea that there were forms of disorder that were neither psychotic nor simply neurotic began to be discussed in psychoanalytic circles in the 1930s.[203] The first formal definition of borderline disorder is widely acknowledged to have been written by Adolph Stern in 1938.[204][205] He described a group of patients who he felt to be on the borderline between neurosis and psychosis, who very often came from family backgrounds marked by trauma. He argued that such patients would often need more active support than that provided by classical psychoanalytic techniques. The 1960s and 1970s saw a shift from thinking of the condition as borderline schizophrenia to thinking of it as a borderline affective disorder (mood disorder), on the fringes of bipolar disorder, cyclothymia, and dysthymia. In the DSM-II, stressing the intensity and variability of moods, it was called cyclothymic personality (affective personality).[128] While the term "borderline" was evolving to refer to a distinct category of disorder, psychoanalysts such as Otto Kernberg were using it to refer to a broad spectrum of issues, describing an intermediate level of personality organization[202] between neurosis and psychosis.[206] After standardized criteria were developed by John Gunderson[207] to distinguish it from mood disorders and other Axis I disorders, BPD became a personality disorder diagnosis in 1980 with the publication of the DSM-III.[187] The diagnosis was distinguished from sub-syndromal schizophrenia, which was termed "schizotypal personality disorder".[206] The DSM-IV Axis II Work Group of the American Psychiatric Association finally decided on the name "borderline personality disorder", which is still in use by the DSM-5.[8] However, the term "borderline" has been described as uniquely inadequate for describing the symptoms characteristic of this disorder.[208] Psychodynamic theorists have historically offered the most comprehensive theoretical models of BPD. Gunderson stressed the patient's fundamental interpersonal hypersensitivity, which he viewed as partially genetic.[209] Kernberg sees the disorder as one involving disturbed object relations, marked by an excess of aggression and use of primitive defenses, such as splitting, projection, and projective identification.[210] Gerald Adler, writing from a self psychology perspective, viewed the disorder as resulting from the failure of evocative memory and characterized by an intolerance of aloneness.[211] Masterson hypothesized that the disorder resulted from core developmental problems with separation-individuation.[212] More recently, Mark L. Ruffalo has advanced the hypothesis that BPD is fundamentally a disorder of paradox or self-contradiction.[213] Earlier versions of the DSM—before the multiaxial diagnosis system—classified most people with mental health problems into two categories: the psychotics and the neurotics. Clinicians noted a certain class of neurotics who, when in crisis, appeared to straddle the borderline into psychosis.[214] The term "borderline personality disorder" was coined in American psychiatry in the 1960s. It became the preferred term over a number of competing names, such as "emotionally unstable character disorder" and "borderline schizophrenia" during the 1970s.[215][216] Borderline personality disorder was included in DSM-III (1980) despite not being universally recognized as a valid diagnosis.[217] The credibility of individuals with personality disorders has been questioned at least since the 1960s.[218]:2 Two concerns are the incidence of dissociation episodes among people with BPD and the belief that lying is not uncommon in those diagnosed with the condition.[219] Researchers disagree about whether dissociation or a sense of emotional detachment and physical experiences, impact the ability of people with BPD to recall the specifics of past events. A 1999 study reported that the specificity of autobiographical memory was decreased in BPD patients.[220] The researchers found that decreased ability to recall specifics was correlated with patients' levels of dissociation, which 'may help them to avoid episodic information that would evoke acutely negative affect'.[220][221] See also: Gender differences in suicide In a clinic, up to 80% of patients are women, but this might not necessarily reflect the gender distribution in the entire population.[222] According to Joel Paris, the primary reason for gender disparities in clinical settings is that women are more likely to develop symptoms that prompt them to seek help. Statistics indicate that twice as many women as men in the community experience depression. Conversely, men more frequently meet criteria for substance use disorder and psychopathy, but tend not to seek treatment as often. Additionally, men and women with similar symptoms may manifest them differently. Men often exhibit behaviors such as increased alcohol consumption and criminal activity, while women may internalize anger, leading to conditions like depression and self-harm, such as cutting or overdosing. Hence, the gender gap observed in antisocial personality disorder and borderline personality disorder, which may share similar underlying pathologies but present different symptoms influenced by gender. In a study examining completed suicides among individuals aged 18 to 35, 30% of the suicides were attributed to people with BPD, with a majority being men and almost none receiving treatment. Similar

findings were reported in another study.[67] Among men diagnosed with BPD there is also evidence of a higher suicide rate: "men are more than twice as likely as women—18 percent versus 8 percent"—to die by suicide.[223] There are also sex differences in personality traits and Axis I and II comorbidity.[224] Men with BPD are more likely to recreationally use substances, have explosive temper, high levels of novelty seeking and have (especially) antisocial, narcissistic, passive-aggressive or sadistic personality traits (male BPD being characterised by antisocial overtones[224]). Women with BPD are more likely to have eating, mood, anxiety, and post-traumatic stress disorders.[224] Manipulative behavior to obtain nurturance is considered by the DSM-IV-TR and many mental health professionals to be a defining characteristic of borderline personality disorder.[225] In one research study, 88% of therapists reported that they have experienced manipulation attempts from patient(s).[226] Marsha Linehan has argued that doing so relies upon the assumption that people with BPD who communicate intense pain, or who engage in self-harm and suicidal behavior, do so with the intention of influencing the behavior of others.[227] The impact of such behavior on others—often an intense emotional reaction in concerned friends, family members, and therapists—is thus assumed to have been the person's intention.[227] According to Linehan, their frequent expressions of intense pain, self-harming, or suicidal behavior may instead represent a method of mood regulation or an escape mechanism from situations that feel unbearable, however, making their assumed manipulative behavior an involuntary and unintentional response.[228] See also: Social stigma The features of BPD include emotional instability, intense and unstable interpersonal relationships, a need for intimacy, and a fear of rejection. As a result, people with BPD often evoke intense emotions in those around them. Pejorative terms to describe people with BPD, such as "difficult", "treatment resistant", "manipulative", "demanding", and "attention seeking", are often used and may become a self-fulfilling prophecy, as the negative treatment of these individuals may trigger further self-destructive behavior.[23] Since BPD can be a stigmatizing diagnosis even within the mental health community, some survivors of childhood abuse who are diagnosed with BPD are re-traumatized by the negative responses they receive from healthcare providers.[229] One camp[who?] argues that it would be better to diagnose these people with post-traumatic stress disorder (PTSD), as this would acknowledge the impact of abuse on their behavior.[citation needed] Critics of the PTSD diagnosis argue that it medicalizes abuse rather than addressing the root causes in society.[230] Regardless, a diagnosis of PTSD does not encompass all aspects of the disorder (see brain abnormalities and terminology). The stigma surrounding borderline personality disorder includes the belief that people with BPD are prone to violence toward others.[231] While movies and visual media often sensationalize people with BPD by portraying them as violent, the majority of researchers agree that people with BPD are unlikely to physically harm others.[231] Although people with BPD often struggle with experiences of intense anger, a defining characteristic of BPD is that they direct it inward toward themselves.[232] One 2020 study found that BPD is individually associated with psychological, physical, and sexual forms of intimate partner violence (IPV), especially amongst men.[233][non-primary source needed] In terms of the AMPD trait facets, hostility (negative affectivity), suspiciousness (negative affectivity) and risk-taking (disinhibition) were most strongly associated with IPV perpetration for the total sample.[233] In addition, adults with BPD have often experienced abuse in childhood, so many people with BPD adopt a "no-tolerance" policy toward expressions of anger of any kind.[232] Their extreme aversion to violence can cause many people with BPD to overcompensate and experience difficulties being assertive and expressing their needs.[232] This is one reason why people with BPD often choose to harm themselves over potentially causing harm to others.[232][43][231] People with BPD are considered to be among the most challenging groups of patients to work with in therapy, requiring a high level of skill and training for the psychiatrists, therapists, and nurses involved in their treatment.[234] A majority of psychiatric staff report finding individuals with BPD moderately to extremely difficult to work with and more difficult than other client groups.[235][non-primary source needed] This largely negative view of BPD can result in people with BPD being terminated from treatment early, being provided harmful treatment, not being informed of their diagnosis of BPD, or being misdiagnosed.[236] With healthcare providers contributing to the stigma of a BPD diagnosis, seeking treatment can often result in the perpetuation of BPD features.[236] Efforts are ongoing to improve public and staff attitudes toward people with BPD.[237][238] Some clients feel the diagnosis is helpful, allowing them to understand that they are not alone and to connect with others with BPD who have developed helpful coping mechanisms. However, others experience the term "borderline personality disorder" as a pejorative label rather than an informative diagnosis. They report concerns that their self-destructive behavior is incorrectly perceived as manipulative and that the stigma surrounding this disorder limits their access to health care.[239] Indeed, mental health professionals frequently refuse to provide services to those who have received a BPD diagnosis.[240] Because of concerns around stigma, and because of a move away from the original theoretical basis for the term (see history), there is ongoing debate about renaming borderline personality disorder. While some clinicians agree with the current name, others argue that it should be changed,[241] since many who are labelled with borderline personality disorder find the name unhelpful, stigmatizing, or inaccurate.[241][242] Alternative suggestions for names include emotional regulation disorder or emotional dysregulation disorder. Impulse disorder and interpersonal regulatory disorder are other valid alternatives, according to John G. Gunderson of McLean Hospital in the United States.[243] Another term suggested by psychiatrist Carolyn Quadrio is post-traumatic personality disorganization (PTPD), reflecting the condition's status as (often) both a form of chronic post-traumatic stress disorder (PTSD) as well as a personality disorder.[89] However, although many with BPD do have traumatic histories, some do not report any kind of traumatic event, which suggests that BPD is not necessarily a trauma spectrum disorder.[244] The Treatment and Research Advancements National Association for Personality Disorders (TARA-APD) campaigned unsuccessfully to change the name and designation of BPD in DSM-5, published in May 2013, in which the name "borderline personality disorder" remains unchanged and it is not considered a trauma- and stressor-related disorder.[245] In literature, characters believed to exhibit signs of BPD include Catherine in Wuthering Heights (1847), Smerdyakov in The Brothers Karamazov (1880), and Harry Haller in Steppenwolf (1927).[246][247][248] Films have also attempted to portray BPD, with characters in Margot at the Wedding (2007), Mr. Nobody (2009), Cracks (2009),[249] Truth (2013), Wounded (2013), Welcome to Me (2014),[250][251] and Tamasha (2015)[252] all suggested to show traits of the disorder. The behavior of Theresa Dunn in Looking for Mr. Goodbar (1975) is consistent with BPD, as suggested by Robert O. Friedel.[253] Films like Play Misty for Me (1971)[254] and Girl, Interrupted (1999, based on the memoir of the same name) suggest emotional instability characteristic of BPD,[255] while Single White Female (1992) highlights aspects such as identity disturbance and fear of abandonment.[254]:235 Clementine in Eternal Sunshine of the Spotless Mind (2004) is noted to show classic BPD behavior,[256][257] and Carey Mulligan's portrayal in Shame (2011) is praised for its accuracy regarding BPD characteristics by psychiatrists.[258] Television series like Crazy Ex-Girlfriend (2015) and the miniseries Maniac (2018) depict characters with BPD.[259] Traits of BPD and narcissistic personality disorders are observed in characters like Cersei and Jaime Lannister from A Song of Ice and Fire (1996) and its TV adaptation Game of Thrones (2011).[260] In The Sopranos (1999), Livia Soprano is diagnosed with BPD,[261] and even the portrayal of Bruce Wayne/Batman in the show Titans (2018) is said to include aspects of the disorder.[262] The animated series BoJack Horseman (2014) also features a main character with symptoms of BPD.[263] Awareness of BPD has been growing, with the U.S. House of Representatives declaring May as Borderline Personality Disorder Awareness Month in 2008.[264] People with BPD will share their personal experiences of living with the disorder on social media to raise awareness of the condition.[265] Public figures like South Korean singer-songwriter Lee Sun-mi have opened up about their personal experiences with the disorder, bringing further attention to its impact on individuals' lives.[266] Psychology portal Affective empathy Obsessive love disorder Pseudohallucination

^ An exception is rapid-cycling BD, which can be challenging to differentiate from the affective lability found in BPD.[142][143][141] ^ Cloninger RC (2005). "Antisocial Personality Disorder: A Review". In Maj M, Akiskal HS, Mezzich JE (eds.). Personality disorders. New York City: John Wiley & Sons. p. 126. ISBN 978-0-470-09036-7. Archived from the original on 4 December 2020. Retrieved 5 June 2020. ^ Blom JD (2010). A Dictionary of Hallucinations (1st ed.). New York: Springer. p. 74. ISBN 978-1-4419-1223-7. Archived from the original on 4 December 2020. Retrieved 5 June 2020. ^ Bollas C, et al. (American Psychological Association) (2000). Hysteria (1st ed.). Taylor & Francis. Archived from the original on 15 December 2022. Retrieved 14 December 2022. ^ Novais F, Araújo A, Godinho P (25 September 2015). "Historical roots of histrionic personality disorder". Frontiers in Psychology. 6 (1463): 1463. doi:10.3389/fpsyg.2015.01463. PMC 4585318. 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People diagnosed with borderline personality disorder (BPD) are at high risk of dying by suicide: almost all report chronic suicidal ideation, 84% of patients with BPD engage in suicidal behavior, 70% attempt suicide, with a mean of 3.4 lifetime attempts per individual, and 5–10% die by suicide (Black et al., 2004; McGirr et al., 2007; Soloff et al., 1994). ^ a b Aviram RB, Brodsky BS, Stanley B (2006). "Borderline personality disorder, stigma, and treatment implications" (PDF). Harvard Review of Psychiatry. 14 (5): 249–256. doi:10.1080/10673220600975121. PMID 16990170. S2CID 23923078. Retrieved 24 December 2024. The stigmatization of BPD is likely to be a result of several characteristics of the BPD syndrome. [... Pejorative] terms such as "difficult," "treatment resistant," "manipulative," "demanding," and "attention seeking" [are used to describe such individuals. This] can have an impact upon the treater's a priori expectations. [... Such] stigmatization is likely to be a result of several characteristics of the BPD syndrome [... and the fact that] psychotherapy with [them] may involve disturbing and frightening behavior, including intense anger, chronic suicidal ideation, self-injury, and suicide attempts. [...Clinicians, under the stigma, may] see lower levels of [their patient's] functioning as deliberate and within [ones] control, or as manipulation, or as a rejection of help, [...and may therefore respond] in unintentionally damaging ways, [...possibly by withdrawing] physically and emotionally. [...] It has been found that when one person has negative expectations of another, the former changes his or her behavior toward the latter. These interpersonal situations have been described as self-fulfilling prophecies. ^ a b c Dixon-Gordon KL, Peters JR, Fertuck EA, Yen S (2017). "Emotional Processes in Borderline Personality Disorder: An Update for Clinical Practice". Journal of Psychotherapy Integration. 27 (4): 425–438. doi:10.1037/int0000044. PMC 5842953. PMID 29527105. [Clinicians] may hesitate to [provide treatment to BPD patients] due to discomfort working with the high-risk behaviours and intense interpersonal and emotional dysregulation typical of [the disorder... Treatments supported by empirical evidences include Dialectical behavior therapy, Mentalization-based treatment, Transference-focused psychotherapy, Schema-focused therapy, and General Psychiatric Magement... On the psychopathology side, it's possible that] emotional reactivity may be [more] pronounced [...] in response to social stressors and in interpersonal and self-conscious emotions (e.g., anger, shame) [...] Emotional vulnerability in BPD may also vary across specific emotions, [particularly for] sadness, hostility, and fear. ^ Clinical Practice Guideline for the Management of Borderline Personality Disorder. Melbourne: National Health and Medical Research Council. 2013. pp. 40–41. ISBN 978-1-86496-564-3. In addition to the evidence identified by the systematic review, the Committee also considered a recent narrative review of studies that have evaluated biological and environmental factors as potential risk factors for BPD (including prospective studies of children and adolescents, and studies of young people with BPD) ^ a b Leichsenring F, Leibing E, Kruse J, New AS, Leweke F (January 2011). "Borderline personality disorder". Lancet. 377 (9759): 74–84. doi:10.1016/s0140-6736(10)61422-5. PMID 21195251. S2CID 17051114. ^ a b c d Stoffers-Winterling J, Storebø OJ, Lieb K (2020). "Pharmacotherapy for Borderline Personality Disorder: an Update of Published, Unpublished and Ongoing Studies" (PDF). Current Psychiatry Reports. 22 (37): 37. doi:10.1007/s11920-020-01164-1. PMC 7275094. PMID 32504127. Archived (PDF) from the original on 4 May 2022. 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Retrieved 23 March 2019. A pervasive pattern of instability of interpersonal relationships, self-image, and affects [...] indicated by five (or more) of the following: [...] ^ Fertuck EA, Fischer S, Beeney J (December 2018). "Social Cognition and Borderline Personality Disorder: Splitting and Trust Impairment Findings". The Psychiatric Clinics of North America. 41 (4): 613–632. doi:10.1016/j.psc.2018.07.003. PMID 30447728. S2CID 53948600 – via Elsevier Science Direct. BPO [Borderline Personality Organization] is rooted in psychoanalytic object relations theory (ORT) which conceptualizes BPD and BPO to exhibit a propensity to view significant others as either idealized or persecutory (splitting) and a trait-like paranoid view of interpersonal relations. From the ORT model, those with BPD think that they will ultimately be betrayed, abandoned, or neglected by significant others, despite periodic idealizations. ^ a b DSM-5 Task Force (2013). 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[We] assessed the relations between momentary negative affect (hostility, sadness, fear) and interpersonal problems (rejection, disagreement) in a sample of 80 BPD and 51 depressed outpatients at 6 time-points over 28 days [...] Results revealed a mutually reinforcing relationship between disagreement and hostility, rejection and hostility, and between rejection and sadness in both groups, at the momentary and day level. The mutual reinforcement between hostility and rejection/disagreement was significantly stronger in the BPD group. ^ Arntz A (September 2005). "Introduction to special issue: cognition and emotion in borderline personality disorder". Journal of Behavior Therapy and Experimental Psychiatry. 36 (3): 167–72. doi:10.1016/j.jbtep.2005.06.001. PMID 16018875. ^ Linehan 1993, p. 146 ^ "What Is BPD: Symptoms". National Education Alliance for Borderline Personality Disorder. Archived from the original on 10 February 2013. Retrieved 31 January 2013. ^ a b Robinson DJ (2005). 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Relationships(Outline) Types Genetic or adoptive Kinship Family Stepfamily Parent Father Mother Son Daughter Grandparent Sibling Brother Sister Cousin Aunt Uncle Niece and nephew By marriage Spouse Husband Wife Open marriage Polygamy Polyandry Polygyny Group marriage Mixed-orientation Partner(s) Significant other Boyfriend Girlfriend Cohabitation Long-distance Online Same-sex Queerplatonic Intimate and sexual Casual Monogamy Non-monogamy Mutual monogamy Polyamory Polyfidelity Affair Cicisbeo Concubinage Courtesan Mistress Activities Bonding Courtship Dating Engagement Bachelor's Day Mating Meet market Romance Singles event Wedding Endings Breakup Legal/marital separation Annulment Divorce Widowhood Emotions and feelings Affinity Attachment Intimacy Jealousy Limerence Love Friend zone Platonic Romantic friendship Unconditional Passion Sexuality Non-romantic friendship Alliance Cross-sex Female Male Practices Bride price dower dowry service Homogamy Hypergamy Infidelity Sexual activity Transgression Repression Abuse Child Dating Domestic Elderly Narcissistic parent Controlling behavior Stalking vte Part of a series onLoveRed-outline heart icon Types of love Affection Bonding Broken heart Compassionate love Conjugal love Courtly love courtship troubadours Falling in love Friendship cross-sex romantic zone Interpersonal attraction Interpersonal relationship Intimacy Limerence Love addiction Love at first sight Love triangle Lovesickness Lovestruck Passion Passionate and companionate love Platonic love Puppy love Queerplatonic relationship Romance Self-love Amour de soi Unconditional love Unrequited love Social views Anarchist Free love Patriotism Chinese Ren Yuanfen French Amour-propre Greek words for love Agape Eros Ludus Mania Philautia Philia Pistis Pragma Storgē Xenia Indian Kama Bhakti Maitrī Islamic Ishq Jewish Chesed Latin Amor Caritas Portuguese Saudade Yaghan Mamihlapinatapai Concepts Color wheel theory of love Bhakti yoga Biology of romantic love Love letter Love of Christ Love of God in Christianity Love magic Valentine's Day Philosophy Religious views love deities Sacred Heart Similarity Physical attractiveness Triangular theory of love vte Part of a series onPsychology Outline History Subfields Basic psychology Abnormal Affective neuroscience Affective science Behavioral genetics Behavioral neuroscience Behaviorism Cognitive/Cognitivism Cognitive neuroscience Social Comparative Cross-cultural Cultural Developmental Differential Ecological Evolutionary Experimental Gestalt Intelligence Mathematical Moral Neuropsychology Perception Personality Psycholinguistics Psychophysiology Quantitative Social Theoretical Applied psychology Anomalistic Applied behavior analysis Art Assessment Aviation Biography of famous people Clinical Coaching Color Community Consumer Counseling Critical Educational Ergonomics Fashion Feminist Food Forensic Health History Humanistic Industrial and organizational Legal Media Medical Military Music Occupational health Pastoral Peace and war Political Positive Photography Psychometrics Psychotherapy Religion School Sex differences Sport and exercise Suicidology Systems Trading Traffic Concepts Behavior Behavioral engineering Behavioral genetics Behavioral neuroscience Cognition Competence Consciousness Consumer behavior Emotions Feelings Human factors and ergonomics Intelligence Maslow's hierarchy of needs Mental state Mind Psychology of religion Psychometrics Sex differences Terror management theory Lists Counseling topics Disciplines Organizations Outline Psychologists Psychotherapies Research methods Schools of thought Timeline Topics Psychology portalvte In social psychology, an interpersonal relation (or interpersonal relationship) describes a social association, connection, or affiliation between two or more people. It overlaps significantly with the concept of social relations, which are the fundamental unit of analysis within the social sciences. Relations vary in degrees of intimacy, self-disclosure, duration, reciprocity, and power distribution. The main themes or trends of the interpersonal relations are: family, kinship, friendship, love, marriage, business, employment, clubs, neighborhoods, ethical values, support and solidarity. Interpersonal relations may be regulated by law, custom, or mutual agreement, and form the basis of social groups and societies. They appear when people communicate or act with each other within specific social contexts,[1] and they thrive on equitable and reciprocal compromises.[2] Interdisciplinary analysis of relationships draws heavily upon the other social sciences, including, but not limited to: anthropology, communication, cultural studies, economics, linguistics, mathematics, political science, social work, and sociology. This scientific analysis had evolved during the 1990s and has become "relationship science",[3] through the research done by Ellen Berscheid and Elaine Hatfield. This interdisciplinary science attempts to provide evidence-based conclusions through the use of data analysis. Friendships are non-sexual, non-romantic interpersonal relationships.[4] Social relations can be homosocial such as female bonding and male bonding or heterosocial such as cross-sex friendship. In some countries a reduction of friendships is observed, also called friendship recession or loneliness epidemic. Main article: Intimate relationship Romantic relationships have been defined in countless ways, by writers, philosophers, religions, scientists, and in the modern day, relationship counselors. Two popular definitions of love are Sternberg's Triangular Theory of Love and Fisher's theory of love.[5][6][7][additional citation(s) needed] Sternberg defines love in terms of intimacy, passion, and commitment, which he claims exist in varying levels in different romantic relationships. Fisher defines love as composed of three stages: attraction, romantic love, and attachment. Romantic relationships can have great social and cultural variability,[8] and may for example exist without any sexual intimacy, between people of any gender, or among a group of people, as in polyamory or open relationships. Main article: Romance (love) While many individuals recognize the single defining quality of a romantic relationship as the presence of love, it is impossible for romantic relationships to survive without the component of interpersonal communication. Within romantic relationships, love is therefore equally difficult to define. Hazan and Shaver[9] define love, using Ainsworth's attachment theory, as comprising proximity, emotional support, self-exploration, and separation distress when parted from the loved one. Other components commonly agreed to be necessary for love are physical attraction, similarity,[10] reciprocity,[6] and self-disclosure.[11] Early adolescent relationships are characterized by companionship, reciprocity, and sexual experiences. As emerging adults mature, they begin to develop attachment and caring qualities in their relationships, including love, bonding, security, and support for partners. Earlier relationships also tend to be shorter and exhibit greater involvement with social networks.[12] Later relationships are often marked by shrinking social networks, as the couple dedicates more time to each other than to associates.[13] Later relationships also tend to exhibit higher levels of commitment.[12] Most psychologists and relationship counselors predict a decline of intimacy and passion over time, replaced by a greater emphasis on companionate love (differing from adolescent companionate love in the caring, committed, and partner-focused qualities). However, couple studies have found no decline in intimacy nor in the importance of sex, intimacy, and passionate love to those in longer or later-life relationships.[14] Older people tend to be more satisfied in their relationships, but face greater barriers to entering new relationships than do younger or middle-aged people.[15] Older women in particular face social, demographic, and personal barriers; men aged 65 and older are nearly twice as likely as women to be married, and widowers are nearly three times as likely to be dating 18 months following their partner's loss compared to widows. The term significant other gained popularity during the 1990s, reflecting the growing acceptance of 'non-heteronormative' relationships. It can be used to avoid making an assumption about the gender or relational status (e.g. married, cohabitating, civil union) of a person's intimate partner. Cohabiting relationships continue to rise, with many partners considering cohabitation to be nearly as serious as, or a substitute for, marriage.[15] In particular, LGBTQ+ people often face unique challenges in establishing and maintaining intimate relationships. The strain of internalized discrimination, socially ingrained or homophobia, transphobia and other forms of discrimination against LGBTQ+ people, and social pressure of presenting themselves in line with socially acceptable gender norms can affect their health, quality of life, satisfaction, emotions etc. inside and outside their relationships.[16][17][18] LGBTQ+ youth also lack the social support and peer connections enjoyed by hetero-normative young people.[19] Nonetheless, comparative studies of homosexual and heterosexual couples have found few differences in relationship intensity, quality, satisfaction, or commitment.[20] Although nontraditional relationships continue to rise, marriage still makes up the majority of relationships except among emerging adults.[21] It is also still considered by many to occupy a place of greater importance among family and social structures. In ancient times, parent–child relationships were often marked by fear, either of rebellion or abandonment, resulting in the strict filial roles in, for example, ancient Rome and China.[22][23] Freud conceived of the Oedipal complex, the supposed obsession that young boys have towards their mothers and the accompanying fear and rivalry with their fathers, and the Electra complex, in which the young girl feels that her mother has castrated her and therefore becomes obsessed with her father. Freud's ideas influenced thought on parent–child relationships for decades.[24] Another early conception of parent–child relationships was that love only existed as a biological drive for survival and comfort on the child's part.[25] In 1958, however, Harry Harlow's study " The Hot Wire Mother'' comparing rhesus' reactions to wire surrogate "mothers" and cloth "mothers" demonstrated that affection was wanted by any caregiver and not only the surrogate mothers.[26] The study laid the groundwork for Mary Ainsworth's attachment theory, showing how the infants used their cloth "mothers" as a secure base from which to explore.[27][28] In a series of studies using the strange situation, a scenario in which an infant is separated from then reunited with the parent, Ainsworth defined three styles of parent-child relationship. Securely attached infants miss the parent, greet them happily upon return, and show normal exploration and lack of fear when the parent is present. Insecure avoidant infants show little distress upon separation and ignore the caregiver when they return. They explore little when the parent is present. Infants also tend to be emotionally unavailable.[29] Insecure ambivalent infants are highly distressed by separation, but continue to be distressed upon the parent's return; these infants also explore little and display fear even when the parent is present. Some psychologists have suggested a fourth attachment style, disorganized, so called because the infants' behavior appeared disorganized or disoriented.[30] Secure attachments are linked to better social and academic outcomes and greater moral internalization as research proposes the idea that parent-child relationships play a key role in the developing morality of young children. Secure attachments are also linked to less delinquency for children, and have been found to predict later relationship success.[31][32][6] For most of the late nineteenth through the twentieth century, the perception of adolescent-parent relationships was that of a time of upheaval. G. Stanley Hall popularized the "Sturm und drang", or storm and stress, model of adolescence.[33] Psychological research has painted a much tamer picture. Although adolescents are more risk-seeking and emerging adults have higher suicide rates, they are largely less volatile and have much better relationships with their parents than the storm and stress model would suggest[34] Early adolescence often marks a decline in parent-child relationship quality, which then re-stabilizes through adolescence, and relationships are sometimes better in late adolescence than prior to its onset.[35] With the increasing average age at marriage and more youths attending college and living with parents past their teens, the concept of a new period called emerging adulthood gained popularity. This is considered a period of uncertainty and experimentation between adolescence and adulthood. During this stage, interpersonal relationships are considered to be more self-focused, and relationships with parents may still be influential.[36] Sibling relationships have a profound effect on social, psychological, emotional, and academic outcomes. Although proximity and contact usually decreases over time, sibling bonds continue to have effect throughout their lives. Sibling bonds are one of few enduring relationships humans may experience. Sibling relationships are affected by parent-child relationships, such that sibling relationships in childhood often reflect the positive or negative aspects of children's relationships with their parents.[37] Business is generally held to be distinct from personal relations, a contrasting mode which other than excursions from the norm is based on non-personal interest and rational rather than emotional concerns. Business relationships Partnership Employer and employee Contractor Customer Landlord and tenant Co-worker Alliance Enemy Frenemy — a person with whom an individual maintains a friendly interaction despite underlying conflict, possibly encompassing rivalry, mistrust, jealousy or competition[38] Neighbor Familiar stranger Official Proximity: Proximity increases the chance of repeated exposure to the same person. Long-term exposure that can develop familiarity is more likely to trigger like or hate.[39] Technological advance: The Internet removes the problem of lack of communication due to long distance. People can communicate with others who live far away from them through video calls or text. Internet is a medium for people to be close to others who are not physically near them.[39] Similarity: People prefer to make friends with others who are similar to them because their thoughts and feelings are more likely to be understood.[39] Interpersonal relationships are dynamic systems that change continuously during their existence. Like living organisms, relationships have a beginning, a lifespan, and an end. They tend to grow and improve gradually, as people get to know each other and become closer emotionally, or they gradually deteriorate as people drift apart, move on with their lives and form new relationships with others. One of the most influential models of relationship development was proposed by psychologist George Levinger.[40] This model was formulated to describe heterosexual, adult romantic relationships, but it has been applied to other kinds of interpersonal relations as well. According to the model, the natural development of a relationship follows five stages: Acquaintance and acquaintanceship – Becoming acquainted depends on previous relationships, physical proximity, first impressions, and a variety of other factors. If two people begin to like each other, continued interactions may lead to the next stage, but acquaintance can continue indefinitely. Another example is the association. Buildup – During this stage, people begin to trust and care about each other. The need for intimacy, compatibility and such filtering agents as common background and goals will influence whether or not interaction continues. Continuation – This stage follows a mutual commitment to quite a strong and close long-term friendship, romantic relationship, or even marriage. It is generally a long, relatively stable period. Nevertheless, continued growth and development will occur during this time. Mutual trust is important for sustaining the relationship. Deterioration – Not all relationships deteriorate, but those that do tend to show signs of trouble. Boredom, resentment, and dissatisfaction may occur, and individuals may communicate less and avoid self-disclosure. Loss of trust and betrayals may take place as the downward spiral continues, eventually ending the relationship. (Alternately, the participants may find some way to resolve the problems and reestablish trust and belief in others.) Ending – The final stage marks the end of the relationship, either by breakups, death or by spatial separation for quite some time and severing all existing ties of either friendship or romantic love. According to the latest Systematic Review of the Economic Literature on the Factors associated with Life Satisfaction (dating from 2007), stable and secure relationships are beneficial, and correspondingly, relationship dissolution is harmful.[41] The American Psychological Association has summarized the evidence on breakups. Breaking up can actually be a positive experience when the relationship did not expand the self and when the breakup leads to personal growth. They also recommend some ways to cope with the experience: Purposefully focusing on the positive aspects of the breakup ("factors leading up to the break-up, the actual break-up, and the time right after the break-up") Minimizing the negative emotions Journaling the positive aspects of the breakup (e.g. "comfort, confidence, empowerment, energy, happiness, optimism, relief, satisfaction, thankfulness, and wisdom"). This exercise works best, although not exclusively, when the breakup is mutual.[42] Less time between a breakup and a subsequent relationship predicts higher self-esteem, attachment security, emotional stability, respect for your new partner, and greater well-being. Furthermore, rebound relationships do not last any shorter than regular relationships.[43][44] 60% of people are friends with one or more ex.[45] 60% of people have had an off-and-on relationship. 37% of cohabiting couples, and 23% of the married, have broken up and gotten back together with their existing partner.[46] Terminating a marital relationship implies divorce or annulment. One reason cited for divorce is infidelity. The determinants of unfaithfulness are debated by dating service providers, feminists, academics, and science communicators.[47][48][49][50] According to Psychology Today, women's, rather than men's, level of commitment more strongly determines if a relationship will continue.[51] Research conducted in Iran and other countries has shown that conflicts are common between couples, and, in Iran, 92% of the respondents reported that they had conflicts in their marriages.[52] These conflicts can cause major problems for couples and they are caused due to multiple reasons. Abusive relationships involve either maltreatment or violence such as physical abuse, physical neglect, sexual abuse, and emotional maltreatment.[53] Abusive relationships within the family are very prevalent in the United States and usually involve women or children as victims.[54] Common individual factors for abusers include low self-esteem, poor impulse control, external locus of control, drug use, alcohol abuse, and negative affectivity.[55] There are also external factors such as stress, poverty, and loss which contribute to likelihood of abuse.[56] Codependency initially focused on a codependent partner enabling substance abuse, but it has become more broadly defined to describe a dysfunctional relationship with one or both partners having extreme dependence on or preoccupation with the relationship. For example, a narcissist and a sycophant with abandonment issues may create codependency as the narcissist values the flattery from the sycophant and the sycophant values the narcissist's approval.[57] There are some who even refer to codependency as an addiction to the relationship.[58] The focus of codependents tends to be on the emotional state, behavioral choices, thoughts, and beliefs of another person.[59] Often those who are codependent neglect themselves in favor of taking care of others and have difficulty fully developing an identity of their own.[60] Narcissists focus on themselves and often distance themselves from intimate relationships; the focus of narcissistic interpersonal relationships is to promote one's self-concept.[61] Generally, narcissists show less empathy in relationships and view love pragmatically or as a game involving others' emotions.[62][61] Narcissists are usually part of the personality disorder, narcissistic personality disorder (NPD). In relationships, they tend to affect the other person as they attempt to use them to enhance their self-esteem.[63] Specific types of NPD make a person incapable of having an interpersonal relationship due to their being cunning, envious, and contemptuous.[63] Human beings are innately social and are shaped by their experiences with others. There are multiple perspectives to understand this inherent motivation to interact with others. According to Maslow's hierarchy of needs, humans need to feel love (sexual/nonsexual) and acceptance from social groups (family, peer groups). In fact, the need to belong is so innately ingrained that it may be strong enough to overcome physiological and safety needs, such as children's attachment to abusive parents or staying in abusive romantic relationships. Such examples illustrate the extent to which the psychobiological drive to belong is entrenched. Another way to appreciate the importance of relationships is in terms of a reward framework. This perspective suggests that individuals engage in relations that are rewarding in both tangible and intangible ways. The concept fits into a larger theory of social exchange. This theory is based on the idea that relationships develop as a result of cost–benefit analysis. Individuals seek out rewards in interactions with others and are willing to pay a cost for said rewards. In the best-case scenario, rewards will exceed costs, producing a net gain. This can lead to "shopping around" or constantly comparing alternatives to maximize the benefits or rewards while minimizing costs. Relationships are also important for their ability to help individuals develop a sense of self. The relational self is the part of an individual's self-concept that consists of the feelings and beliefs that one has regarding oneself that develops based on interactions with others.[64] In other words, one's emotions and behaviors are shaped by prior relationships. Relational self theory posits that prior and existing relationships influence one's emotions and behaviors in interactions with new individuals, particularly those individuals that remind them of others in their life. Studies have shown that exposure to someone who resembles a significant other activates specific self-beliefs, changing how one thinks about oneself in the moment more so than exposure to someone who does not resemble one's significant other.[65] This section does not cite any sources. Please help improve this section by adding citations to reliable sources. Unsourced material may be challenged and removed. (May 2016) (Learn how and when to remove this message) Power is the ability to influence the behavior of other people.[66] When two parties have or assert unequal levels of power, one is termed "dominant" and the other "submissive". Expressions of dominance can communicate an intention to assert or maintain dominance in a relationship. Being submissive can be beneficial because it saves time, limits emotional stress, and may avoid hostile actions such as withholding of resources, cessation of cooperation, termination of the relationship, maintaining a grudge, or even physical violence. Submission occurs in different degrees; for example, some employees may follow orders without question, whereas others might express disagreement but concede when pressed.[67] Groups of people can form a dominance hierarchy.[68] For example, a hierarchical organization uses a command hierarchy for top-down management. This can reduce time wasted in conflict over unimportant decisions, prevents inconsistent decisions from harming the operations of the organization, maintain alignment of a large population of workers with the goals of the owners (which the workers might not personally share) and, if promotion is based on merit, help ensure that the people with the best expertise make important decisions. This contrasts with group decision-making and systems which encourage decision-making and self-organization by front-line employees, who in some cases may have better information about customer needs or how to work efficiently. Dominance is only one aspect of organizational structure. A power structure describes power and dominance relationships in a larger society. For example, a feudal society under a monarchy exhibits a strong dominance hierarchy in both economics and physical power, whereas dominance relationships in a society with democracy and capitalism are more complicated. In business relationships, dominance is often associated with economic power. For example, a business may adopt a submissive attitude to customer preferences (stocking what customers want to buy) and complaints ("the customer is always right") in order to earn more money. A firm with monopoly power may be less responsive to customer complaints because it can afford to adopt a dominant position. In a business partnership a "silent partner" is one who adopts a submissive position in all aspects, but retains financial ownership and a share of the profits.[69] Two parties can be dominant in different areas. For example, in a friendship or romantic relationship, one person may have strong opinions about where to eat dinner, whereas the other has strong opinions about how to decorate a shared space. It could be beneficial for the party with weak preferences to be submissive in that area because it will not make them unhappy and avoids conflict with the party that would be unhappy. The breadwinner model is associated with gender role assignments where the male in a heterosexual marriage would be dominant as they are responsible for economic provision.[70] It has been suggested that Relationship quality be merged into this section. (Discuss) Proposed since January 2025. Social exchange theory and Rusbult's investment model show that relationship satisfaction is based on three factors: rewards, costs, and comparison levels (Miller, 2012).[71] Rewards refer to any aspects of the partner or relationship that are positive. Conversely, costs are the negative or unpleasant aspects of the partner or their relationship. The comparison level includes what each partner expects of the relationship. The comparison level is influenced by past relationships, and general relationship expectations they are taught by family and friends. Individuals in long-distance relationships, LDRs, rated their relationships as more satisfying than individuals in proximal relationship, PRs.[72][73] Alternatively, Holt and Stone (1988) found that long-distance couples who were able to meet with their partner at least once a month had similar satisfaction levels to unmarried couples who cohabitated.[74] Also, the relationship satisfaction was lower for members of LDRs who saw their partner less frequently than once a month. LDR couples reported the same level of relationship satisfaction as couples in PRs, despite only seeing each other on average once every 23 days.[75] Social exchange theory and the am investment model both theorize that relationships that are high in cost would be less satisfying than relationships that are low in cost. LDRs have a higher level of costs than PRs, therefore, one would assume that LDRs are less satisfying than PRs. Individuals in LDRs are more satisfied with their relationships compared to individuals in PRs.[73] This can be explained by unique aspects of the LDRs, how the individuals use relationship maintenance behaviors, and the attachment styles of the individuals in the relationships. Therefore, the costs and benefits of the relationship are subjective to the individual, and people in LDRs tend to report lower costs and higher rewards in their relationship compared to PRs.[73] Confucianism is a study and theory of relationships, especially within hierarchies.[76] Social harmony—the central goal of Confucianism—results in part from every individual knowing their place in the social order and playing their part well. Particular duties arise from each person's particular situation in relation to others. The individual stands simultaneously in several different relationships with different people: as a junior in relation to parents and elders; and as a senior in relation to younger siblings, students, and others. Juniors are considered in Confucianism to owe their seniors reverence and seniors have duties of benevolence and concern toward juniors. A focus on mutuality is prevalent in East Asian cultures to this day. The mindfulness theory of relationships shows how closeness in relationships may be enhanced. Minding is the "reciprocal knowing process involving the nonstop, interrelated thoughts, feelings, and behaviors of persons in a relationship."[77] Five components of "minding" include:[78] Knowing and being known: seeking to understand the partner Making relationship-enhancing attributions for behaviors: giving the benefit of the doubt Accepting and respecting: empathy and social skills Maintaining reciprocity: active participation in relationship enhancement Continuity in minding: persisting in mindfulness Popular perceptions of intimate relationships are strongly influenced by movies and television. Common messages are that love is predestined, love at first sight is possible, and that love with the right person always succeeds. Those who consume the most romance-related media tend to believe in predestined romance and that those who are destined to be together implicitly understand each other. These beliefs, however, can lead to less communication and problem-solving as well as giving up on relationships more easily when conflict is encountered.[79] Social media has changed the face of interpersonal relationships. Romantic interpersonal relationships are no less impacted. For example, in the United States, Facebook has become an integral part of the dating process for emerging adults.[80] Social media can have both positive and negative impacts on romantic relationships. For example, supportive social networks have been linked to more stable relationships.[81] However, social media usage can also facilitate conflict, jealousy, and passive-aggressive behaviors such as spying on a partner.[82] Aside from direct effects on the development, maintenance, and perception of romantic relationships, excessive social network usage is linked to jealousy and dissatisfaction in relationships.[83] Another common behavior in online communities, including dating, is lurking. Lurking means watching communities without posting or replying. Some say it means never posting, while others say even small posts count (Neelen & Fetter, 2010; Golder & Donath, 2004). Lurking is often seen negatively, tied to "freeloading" (Preece, Nonnecke, & Andrews, 2004), but others see it as valid participation. Lurking depends on personal goals, personality, and group dynamics. For example, introverts tend to lurk more, and people with higher tech confidence participate more (Ross et al., 2009; Sun, Rau, & Ma, 2014). Studies show up to 90% of users may lurk at some point (Muller, 2012). Lurking can help gather info or support without interacting, but it can make a community seem less active, Lurking can make online relationships feel one-sided because it reduces interaction. When someone just watches without joining in, it can create distance and make it harder to build trust. This can slow down the growth of a real connection.. Understanding lurking can help encourage more participation (Yeow, Johnson, & Faraj, 2006). [84] A growing segment of the population is engaging in purely online dating, sometimes but not always moving towards traditional face-to-face interactions. These online relationships differ from face-to-face relationships; for example, self-disclosure may be of primary importance in developing an online relationship. Conflict management differs, since avoidance is easier and conflict resolution skills may not develop in the same way. Additionally, the definition of infidelity is both broadened and narrowed, since physical infidelity becomes easier to conceal but emotional infidelity (e.g. chatting with more than one online partner) becomes a more serious offense.[81] I and Thou Interactionism Interpersonal attraction Interpersonal tie Loneliness Outline of relationships Queerplatonic relationship Relational mobility Relational models theory Relationship status Relationship forming Social connection Socionics Relationship science ^ Ye, Jinhui; Ye, Xiaoting (4 November 2020). "Adolescents' interpersonal relationships, self-consistency, and congruence: Life meaning as a mediator". Social Behavior and Personality. 48 (11): 1–11. doi:10.2224/sbp.9428. S2CID 226526839. ^ Molm, Linda D.; Schaefer, David R.; Collett, Jessica L. (2007). "The Value of Reciprocity". Social Psychology Quarterly. 70 (2): 199–217. doi:10.1177/019027250707000208. JSTOR 20141780. S2CID 146252068. ^ Berscheid, Ellen (1999). 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