IOSR Journal of Research & Method in Education (IOSR-JRME)
e-ISSN: 2320–7388, p- ISSN: 2320-737x Volume 16, Issue 3 Ser. 1 (May. – June. 2026) 14-30
www.iosrjournals.org

Histrionic Personality Disorder, A Comparative Study With Bipolar Disorder

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Abstract:
Introduction: *In the modern world, as we move forward; there are various types of advancements that have been taking place in all the different sectors, be it healthcare, research and development or the overall growth of the world. At the same time when there is much growth and success to find new revelations, there are also various types of conditions that sometimes go unnoticed or undiagnosed. Predominantly talking about[1] the neurodegenerative and the psychotic disorders. Histrionic personality disorder is the same one condition that hides the eye of most of us, yet going by the conditioning and symptoms, we can learn that it might be present In a lot of people around us and goes undiagnosed and untreated.*
Objective: *Via this research paper, we will be looking at the extend of the psychotic disorders, predominantly the histrionic Personality disorder, what and how is it causes, what it can lead to and how can one actually prevent it. We will be going through various case studies of the patients around the world to analyse the symptoms and to predict who can and who can not have this disease. Because when we are talking about psychotic disorders, we can never be completely sure about the inference that we draw. The reason to write a review about this disease, is that the symptoms that the person presents with is very commonly present in our surroundings. Histrionic Personality disorder involves people that seek "attention" or in better words it involves people to seek an environment that is completely based on their mood and thoughts, its almost as the person wants others to focus only on them/ their problems even if the present conditions can be detrimental to others. This behaviour if persistent, can lead to various problems in households, friends, colleague and family. We will also be studying it with a comparison with the bipolar disorder, which majorly involves a person showing two personalities, at different times as a reaction to different people or things; in order to validate themselves or their feelings. This can sometimes be confused with histrionic Personality disorder, if we go to the depth of it. Hence, its much important to make a differential Diagnosis between the two and to learn what conditions and circumstances makes them prevalent and how can one understand it.*
Conclusion: *For a better future, we must recognise the conditions that are flicking in our population so that we can work on it to improve the health system of the country. If ignored, these diseases can be fatal to the basic structure of the country and cause harm in many ways.*

Date of Submission: 26-04-2026 Date of Acceptance: 06-05-2026

I. Introduction:

Since time immeoral, neurodegenerative and psychotic disorders have been prevalent in our society. Histrionic personality disorder mental health condition marked by intense, unstable emotions and a distorted self-image. The word "histrionic" literally means "dramatic or theatrical. The word histrionic is derived from hysteria which is a classical term that includes a wide variety of psychopathological states. Ancient Egyptians and Greeks blamed a displaced womb, for many women's afflictions. The word is derived from "hysteria" which means the womb or the uterus, signifying that the particular condition is more present/ prevalent In females than in males. The people with this condition, their self esteem depends on the approval of the others and not on themselves, which not only makes them a people pleaser type of personality but also seeking attention of others for their own validation. Histrionic personality disorder is one of a group of conditions called "Cluster B" personality disorders, which involve dramatic and erratic behavior.

Cluster B personality disorders (PDs) involve impulsive[1,2] and dramatic behavior. There are four types, including borderline PD and antisocial PD. People with these types of personality disorders often don't realize their thoughts and behaviors are problematic. The HPD majorly affects the people in their teens, and majorly the females. There Is also presence in males but some researchers believe that they do go undiagnosed more in males than in females, pointing towards the less focus of males towards their own mental stability and conditions as compared to females.

Some of the symptoms of HPD is, the person may feel depressed when they are not the centre of attention or their effort go useless on anything, having a very rapidly shifting mood, also symptoms such as

being overly expressive and dramatic about your feelings and emotions to the point of much embarrassment In the public of them and the family and friends. Some studies also suggest that in some people with HPD there are symptoms such as using their physical appearance to draw the attention of people by wearing bright coloured clothes, revealing or overly covered cloths; anything that can get people to notice them, acting inappropriately sexual with people they meet even after not being sexually attracted to them, Speak dramatically and express strong opinions but with few facts or details to support their opinions, and the most noticed symptom is constantly seeking validation for their actions. Personality disorders, including histrionic personality disorder, are among the least understood mental health conditions. Studies conducted have found out That there are various factors for HPD. Some suggest that it can be due to a genetic factor, means due to an inherited cause. It can be due to a childhood trauma, such as childhood abuse, sexual abuse or loss of a family member during childhood which later can become problematic in your life and add to your disorder.For people with histrionic personality disorder, their self-esteem depends on the approval of others and doesn't come from a true feeling of self-worth.

Personality disorders, including histrionic personality disorder, are among the least understood mental health conditions. Children may cope with trauma, such as child abuse or the death of a family member, that later as an adult may be disruptive or problematic in their life and become part of a personality disorder. Some studies found that children who experience parenting styles that lack boundaries, are over-indulgent or inconsistent may be more likely to develop HPD, making it one of the most widely accepted cause of HPD. In this paper we shall look forward for the HPD, get in detail about it's causes, symptoms and why it is important To us. Also discuss about the strategies we can use to tackle these conditions.

Gender role in HPD:

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994) describes HPD as marked by a long-standing proclivity towards attention seeking and excessive emotionality, as manifested in seductive and dramatic behavioral patterns. Individuals with HPD are often described as narcissistic, self-indulgent, flirtatious, dramatic, and extroverted.derived from the Greek word "hystera," meaning uterus—as these behaviours were believed to be exclusive to women and were caused by disturbances in the uterus.Diagnostic and Statistical Manual of Mental Disorders, 3rd ed. (DSM-III) included HPD as a diagnosable condition. HPD is regarded as a primarily female disorder (APA, 1994; Hartung & Widiger, 1999), although the evidence for this sex difference is mixed (e.g., Hamburger, Lilienfeld, & Hogben, 1996; Lilienfeld, VanValkenburg, Larntz, & Akiskal, 1986).Histrionic personality disorder has been found to have potential gender differencesin not only genetic level but also social expectation. Women have the familial link and more inheritance than men, which suggests the vulnerability of getting HPD because of gender.

Generally, despite the variability of individuals, patients with HPD tend to have a pattern, intensiveattention-seeking emotions, behaviors, and excessive need for being approved. They appear to the public by making loud and inappropriate actions, pretending to be sexually seductive types, and expressing strong emotions to attract others 'attention. Since the effectiveness of HPD treatment relies heavily on the comorbidity of illnesses and individual differences, sexuality for both the therapist and the patient may be more important than imagination. They need to make a judgment after understanding gender roles and possible biases in facing different patients. Women were assumed to seek more help than men in Phillips and Segal's research in 1969 [17].

However, Clancey and Gove in 1974 showed an opposite point of view, that they found that guys tend to seek more help [18]. It suggested that multiple variables may play parts in diagnosing HPD, such as social norms, gender roles, etc so that these self-reported diagnostic procedures have low reliability as well as validity. Moreover, 90% of HPD female patients met the criteria of hysterical neurosis. This means that the diagnosis of HPD is unspecific and unclear which may be ambiguous with other mental illnesses. Thus, DSM should give specific or exampled HPD behaviors that set a scope for the illness. Many researchers have hypothesized relationships between personality disorders and gender role (i.e., masculinity and femininity). However, research has not addressed if people who are masculine or feminine more often meet the criteria for personality disorders. The present study examined whether college students (N = 665, 60% women) higher in masculinity or femininity more often exhibited features of the 10 DSM-IV personality disorders. Feminine men exhibited more features of all the personality disorders except antisocial. Data were collected from 665 undergraduate students (60% women) at a large public university.
Their ages ranged from 17 to 20 years, with a mean of 18.4 (SD = 0.4). Participants were 83% Caucasian)

Emotional Expression And Attention Seeking Mechanisms:

Impact of cultural norms on Histrionic personality disorder wiith a seemingly endless range of subgroups and individual variations, culture is important because it bears upon what all people bring to the clinical setting. It can account for minor variations in how people communicate their symptoms and which ones

they report. Some aspects of culture may also underlie culture-bound syndromes - sets of symptoms much more common in some societies than in others. More often, culture bears on whether people even seek help in the first place, what types of help they seek, what types of coping styles and social supports they have, and how much stigma they attach to mental illness. Culture also influences the meanings that people impart to their illness.

Consumers of mental health services, whose cultures vary both between and within groups, naturally carry this diversity directly to the service setting. For an example, in india; there is a lot of stigma that is related to mental health issues, due to which the person suffering often ends up getting no proper treatment or keeping medical attention. Due to which there is an under representation of these cases nationwide. Psychiatric categories in general, and the personality disorders in particular, remain problematic and contested. This is no where more clearly evident than in the case of the 'antisocial' and 'histrionic' personality disorders. In part, the problem is related to the observation of differences in gender distribution. Men are more likely to be diagnosed 'antisocial' than women, and women are more likely to be diagnosed 'histrionic' than men. Confusion results partly from the suspicion that these categories may be culturally conditioned and therefore spurious as medical labels true in some 'absolute' sense. It becomes very important that there is a change of mindset in the people that can provide a safe space for the people who have these problems for them to come forward and get a treatment that helps them over come these problems, rather than make them feel as an outlander and make them keep included rather than excluded.

Adaptive and maladaptive behaviour in HPD:

Adaptive behavior allows individuals to adapt in a positive manner to various situations. It is a functional adjustment to a particular behavior. Adaptive behavior creates a condition where the individual can truly develop and grow. In our day to day life, if a particular behavior is constructive and productive it can be considered as adaptive behavior.For example, when an individual faces a problem in life, he uses various techniques to find solutions by coming to terms with the condition. This is a form of adaptive behavior. Unlike in the case of maladaptive behavior, the individual does not run away from the situation, or avoid it, but faces the situation. This is usually considered as healthy behavior. Maladaptive behavior can be viewed as the direct opposite of adaptive behavior. It is a negative form of behavior which harms the individual. In abnormal psychology, this term is used extensively to refer to conditions which detriment the well-being of an individual. When the anxiety that an individual feels is not lessened through individual behavior and is only dysfunctional to the individual, these types of behaviors are considered maladaptive. In this sense, maladaptive behavior is coping mechanisms that are not productive. Instead of relieving the anxiety and tension that the individual feels, it leads to the creation of further health problems.

For example, substance abuse is a maladaptive behavior that harms the individual even though it provides a momentary relief. In the long run, this is dysfunctional to the individual. Maladaptive behavior does not lead to personal growth and development of the individual but causes the downfall of a human being. On one level, it hinders the development of the individual where he or she feels unable to find a solution to the anxiety experienced. This inability to accept one's condition leads to disruptions in person life as well as professional life. Such an individual may encounter difficulties not only in day to day chores but also in handling relationships.as it can lead to severe health conditions. In relation to HPD, some individuals show maladaptive behavior changes in the patient. We need to understand that HPD is not a disease which shows the same symptoms in all patients. Some try to cope up with their distress by the maladaptive behaviour because they find it very hard to express themselves openly or in the way that could help them.

Role Of Dramatic Emotional Displays In Interpersonal Relationships:

Dramatic emotional displays play a nuanced role in interpersonal relationships,acting both as communicative signals that facilitate understanding and potential sources of conflict when intensity is misaligned with relational expectations. Emotional expression helps partners interpret internal states and needs, which can strengthen mutual understanding and emotional intimacy when calibrated appropriately. Studies have shown that individuals' tendencies to express emotions vary systematically with their attachment orientations for example, those with secure attachment report higher emotional expressivity and positive affect, while anxiously attached individuals show more intense negative emotional experience and expression compared to avoidant individuals, who tend toward emotional suppression.

The intensity of emotional displays also affects physiological and psychological responses within close dyads.

In experimental research on romantic couples, partners who express emotions intensely during stressful tasks exhibited stronger physiological stress responses unless those expressions were met with supportive responsiveness from the other partner, suggesting that partner support can buffer the potentially disruptive effects of high-arousal emotional displays. Further, emotional communication patterns influence interaction outcomes: couples are more attuned to negative emotional displays than positive ones, often reciprocating

negativity more readily, which can escalate conflicts if negative displays are dramatic or prolonged. Attachment theory underscores these dynamics. Emotional expression and regulation processes are linked with relational satisfaction, with secure attachment associated with more effective emotional communication and higher satisfaction, and insecure patterns often leading to less congruent maladaptive displays that undermine relationship quality. Intensity and authenticity matter: when high-intensity displays reflect genuine states and are embedded in a context of mutual responsiveness, they can enhance empathy and relational closeness. However, disproportionate, ambiguous, or instrumentally used dramatic expressions may create misunderstanding, foster conflict escalation, and reduce trust, particularly in stressed relationships. In sum, dramatic emotional displays are neither inherently positive nor negative their impact depends on attachment dynamics, partner responsiveness, and the relational context, shaping whether such displays facilitate connection or contribute to conflict.

Effectiveness Of Psychotherapeutic Modalities:

Cognitive Behavioral Therapy (CBT) is considered an effective, evidence-based modality for treating Histrionic Personality Disorder (HPD) by focusing on modifying maladaptive, attention-seeking and dramatic behaviors. It helps patients identify distorted thought patterns, such as "I must be the center of attention to be worthy" and replaces them with healthier cognitive process.

Key Components And Effectiveness Of CBT For HPD

Behavioral modifi cations: CBT helps patients understands triggers for emotional outbursts and reduces reliance on dramatic behaviors to gain approval; another component is Cognitive restructuring: in which the therapist challenge deeply held , distorted beliefs , enabling more realistic self-concepts and reduced emotional volatility , Skill building: techniques like mindfulness ,emotional volatility, Sometimes Combined approaches like CBT with other modalities, such as Schema Therapy or Acceptance and Commitment Therapy(ACT) can be effective in reducing overcompensation coping strategies.

Efectiveness Of CBT In Histrionic Personality Disorder

CBT shows moderate effectiveness in managing symptomatic aspects of HPD, particularly maladaptive beliefs related to approval seeking, emotional exaggeration and interpersonal validation. CBT helps patient identify distorted cognitions such as overestimation of intimacy, dependency of external affirmation, and catastrophization of rejection, while simultaneously encouraging more adaptive responses. Outcomes are generally favorable in reducing emotional dysregulation, interpersonal conflicts, and co morbid anxiety or depressive symptoms. Comparative studies suggest that CBT is useful for improving day to day functioning but is less effective in producing deep personality change in HPD. Its structured and problem focused approach may also be limited by patients tendency.

Effectiveness Of Ischema Therapy In Histrionic Personality Disorder:

Ischema therapy has emerged as a promising integrative approach for personality disorders characterized by early maladaptive ischemia and emotional dysregulation, in HPD, schema therapy targets schemes such as emotional deprivation, approval seeking, abandonment, and defectiveness, which often originate from inconsistent or emotionally invalidating childhood environments. By [28] combining cognitive restructuring, experiential techniques and elements of psychodynamic therapy, ischemia therapy allows patients to process unmet emotional needs while maintaining a structured [30] therapeutic framework.

Emerging evidence suggests the schema therapy may lead to more durable personality change than standard CBT, particularly in patients with treatment resistant or severe personality pathology. Although direct research on HPD remains limited compared to borderline personality. disorder, available data indicate meaningful improvements inemotional regular part.

Therapeutic Alliance In HPD:

Therapeutic Alliance as a Predictor of outcome.The therapeutic alliance is defined as the collaborative and affective bond between therapist and patient, consisting of agreement on goals, agreement on tasks, and development ofa personal

bond.Meta-analytic evidence demonstrates that therapeutic alliance is a robust, consistent, and moderate predictor of psychotherapy outcomes across treatment modalities The strength of the alliance accounts for outcome variance independently of the type of psychotherapy used, indicating that alliance is not merely a by-product of symptom improvement. Alliance quality shows a significant[29] association with treatment adherence, session attendance, and continuation of therapy, (for example: a weak or unstable therapeutic alliance isconsistently associated with poorer treatment outcomes and higher rates of premature termination).Difficulties in Forming a stable therapeutic alliance patients with personality disorders, including

HPD, demonstrate greater difficulty in forming and maintaining a stable therapeutic alliance compared to patients with axis-I disorders. Alliance formation is often rapid but superficial, characterized by early idealization of the therapist followed by sudden devaluation or disengagement. Emotional expressiveness, attention-seeking behavior, and suggestibility may mask limited emotional insight, leading to pseudo-engagement rather than genuine collaboration. Interpersonal sensitivity and heightened need for validation can result in boundary testing, dependency, and inconsistent commitment to therapeutic tasks. Transference and countertransference reactions are more intense and fluctuating, increasing the risk of alliance ruptures if not actively addressed. Therapeutic Alliance in Histrionic Personality Disorder Psychotherapy with HPD patients is characterized by marked fluctuations in therapeutic engagement and often demonstrate high emotional involvement early in treatment. Alliance instability in HPD is linked to excessive emotional dramatization, externalization of responsibility, difficulty tolerating frustration or delayed gratification. Therapeutic alliance ruptures are common and often occur when therapy shifts from supportive validation to interpretive or insight-oriented interventions. Successful therapeutic engagement in HPD requires consistent structure, clear boundaries, gradual pacing of interpretive work, emphasis on emotional regulation before insight and active repair of alliance disruptions. Clarification-oriented psychotherapy is effective in reducing the general and disorder-specific symptoms of patients with histrionic personality disorder.

Treatment Barriers And Engagement:

The very traits that define HPD often serve as the primary barriers to establishing a functional therapeutic alliance. Superficial Engagement: Patients often enter therapy with a "performance"mindset, seeking[,24,25] validation or admiration from the therapist rather than genuine change. Boundary Testing: Due to a need for constant attention, patients may engage in seductive or provocative behaviour, challenging the professional boundaries essential for effective treatment.[26,27] Crisis-Oriented Presentation: Treatment is often interrupted by "manufactured" crises designed to recapture the therapist's focus, stalling progress on long-term behavioral goals. 2. High Attrition and Dropout Rates: HPD is associated with some of the highest dropout rates among Cluster B personality disorders. This instability is usually driven by: (1) Novelty Effect: Patients may be highly motivated during the initial "honeymoon" phase of therapy.

Once the novelty wears off and the hard work of introspection begins, interest rapidly wanes. (2) Perceived Rejection: If a therapist redirects a patient or sets a firm boundary, the patient may interpret this as a profound personal rejection, leading them to prematurely terminate therapy to "protect" their ego.

Resistance to Insight and Emotional Confrontation: A core defense mechanism in HPD is global, impressionistic thinking. Patients focus on vivid emotions rather than factual details or logical sequences. Cognitive Avoidance: When asked to analyze the "why" behind their actions, patients often respond with vague descriptions (e.g., "I just felt overwhelmed!") to avoid the pain of deep self-reflection. Resistance to Confrontation: Direct confrontation regarding maladaptive patterns is often met with dramatic emotional outbursts or "theatrical" displays of distress, which serve to divert the conversation away from uncomfortable truths.

Poor Adherence and Inconsistent Motivation: Motivation in HPD is frequently extrinsic—driven by the desire for praise—rather than intrinsic.A patient's commitment to homework or behavioural changes often fluctuates based on their current mood or the level of positive reinforcement they receive from their social circle. Patients may suddenly claim they are "cured" after a single breakthrough or a positive social interaction, leading to non-adherence to long-term medication or therapy schedules.

Role Of Group Therapy And Social-Skills Interventions:

Effectiveness of Group Psychotherapy Group psychotherapy is an evidence-based treatment modality demonstrating significant symptom reduction and functional improvement across a range of psychiatric conditions. Meta-analytic studies demonstrate that group therapy produces significant improvements in symptom severity, interpersonal functioning, and overall psychological distress.(effect sizes comparable to individual psychotherapy, particularly for anxiety and mood disorders.) The therapeutic effects of group therapy are attributed to shared experiences, interpersonal learning, normalization of distress, and peer feedback. Outcomes are influenced by group cohesion, structure, and consistency of participation. Group formats provide opportunities for real-time observation and modification of maladaptive interpersonal behaviors.

Therapeutic Alliance And Engagement In Group Therapy:

The therapeutic alliance in group therapy extends beyond the therapist–patient relationship to include member-to-member alliances and overall group cohesion, making alliance formation a multidimensional process. Strong group alliance is associated with greater attendance (sustained participation), lower dropout rates, greater emotional disclosure and improved clinical outcomes. Poor alliance or low group cohesion predicts early attrition (higher dropout rates) and reduced therapeutic gains.

Alliance development in group therapy requires clear structure, defined roles, and consistent facilitation.The quality of the therapeutic alliance within group therapy is a significant predictor of treatment engagement and outcome, similar to individual therapy. Social-Skills Training and Structured Group Interventions. Structured group-based social-skills interventions improve interpersonal functioning, social competence, communication skills, adaptive behavior and are particularly useful for individuals with, impulsivity, and maladaptive attention-seeking behaviors.

Cognitive Behavioral Social Skills Training (CBSST) integrates cognitive restructuring, behavioral rehearsal, and social problem-solving within a group format. Randomized controlled trials demonstrate that participants receiving structured social-skills training show significant improvements in assertiveness, emotional regulation, social functioning and quality of life compared to control conditions. Limitations and Risks of Group Therapy in Personality Disorders (Including HPD) Despite potential benefits, group therapy in HPD presents unique challenges related to emotional dysregulation, interpersonal sensitivity, and maladaptive attention-seeking behaviors. In HPD, group settings can reinforce dramatization or excessive external validation-seeking ,or experience interpersonal conflicts that disrupt group cohesion,if not adequately structured. Poorly moderated groups increase the risk of boundary violations, alliance ruptures, and symptom reinforcement.Research emphasizes the importance of highly structured, therapist-led groups with clear boundariesto prevent maladaptive interpersonal dynamics or destabilization of the group process.Group therapy is most effective in HPD when used as an adjunct to individual psychotherapy ratherthan a standalon intervention.Careful patient selection and ongoing monitoring are essential tomaximize benefits and minimize.

Cognitive Distortions And Self Image Instability:

External validation as the basis of self worth

Individuals with Histrionic Personality Disorder (HPD) characteristically exhibit a strong desire to be noticed, admired, and validated by others. To attract attention, they may engage in exaggerated, dramatic, or theatrical behaviors and often use their physical appearance—such as clothing, makeup, or expressive body language—as a means of gaining attention. Their self-esteem is frequently dependent on external approval, and they may feel deeply abandoned or rejected when they do not receive the attention they seek. This pattern of behavior is often linked to underlying identity instability. For example,

adolescents struggling with an unclear sense of self may adopt histrionic behaviors, such as exaggerating achievements or forming overly intense relationships, as a way to compensate for feelings of insecurity or inner emptiness. Although these individuals may appear confident and expressive, their strong need for validation often masks deeper emotional vulnerabilities. A core feature of HPD is emotional instability.

Individuals may present as charismatic, energetic, and engaging, but their emotions tend to be unpredictable and rapidly shifting. Their mood is heavily influenced by the reactions of others: admiration and praise can lead to feelings of excitement and validation, whereas criticism or perceived neglect may result in distress, anxiety, anger, or dramatic emotional reactions. This reliance on external feedback contributes to frequent mood swings and emotional volatility. The development of Histrionic Personality Disorder is often associated with early childhood experiences. Growing up in environments where emotional needs were either excessively indulged or consistently neglected may foster a pattern of seeking attention through exaggerated emotional expression. Over time, this learned behavior becomes a primary strategy for securing reassurance, connection, and a sense of self-worth.

Role of suggestibility and impressionistic speech in HPD:-

Behavioral and Affective Patterns Individuals with Histrionic Personality Disorder exhibit a pervasive pattern of excessive emotionality characterized by self-dramatization, theatricality,and coquetry. This profile is often defined by affective instability, where emotions are superficial and shift rapidly. Consequently, these individuals frequently demonstrate a lack of constancy,particularly within their interpersonal relationships.

Cognitive and Speech Characteristics The characteristic style of speech ispredominantly impressionistic and notably lacking in detail. Verbal communication tends to be vague, generalized, and hyperbolic, often marked by the expression of black-and-white opinions that lack substantive supporting evidence. Suggestibility and External Orientation Most patients are highly suggestible and easily influenced by others. This trait often manifests as a rapid tendency to trust others and a reliance on authority figures to resolve personal problems. Furthermore, this suggestibility contributes to an inability to maintain a steadfast pursuit of long-term goals or a consistent value orientation.

Identity diffusion in HPD compared to other cluster B disorders:-

Before diving into identity diffusion, it is important for us to understand cluster B disorders at its core. Cluster B disorders are a collection of personality disorders that affect how people behave. There are four cluster B disorders: antisocial, borderline, histrionic, and narcissistic personality disorders. People with cluster

B personality disorders are more likely to behave dramatically and erratically. Patients with Cluster B,personality disorders experience[5,] no time, memory, continuity, self, or core identity. It is also important to understand identity diffusion. Identity diffusion refers to a state where individuals lack a clear sense of self and have not made[10] commitments to any particular identity or life direction. Individuals experiencing identity diffusion may feel lost or confused about their personal identity and future paths, making it difficult for them to navigate crucial decisions related to education and career choices. Let us dive into each of these disorders and how identity diffusion is shaped into each of it.Idealisation—paired with a lack of self-awareness and identity instability—is often seen in histrionic personality disorder (HPD), in[6]which the individual yearns not just to be admired, but to become someone else entirely. They may struggle to define their own dreams or values, instead fixating on polished images of success borrowed from others. They often describe outcomes e.g., status — without acknowledging the effort such traits require. Envy is often under-recognised in HPD, but it can surface intensely when someone else's presence threatens the individual's place at the emotional centre of a room, a relationship, or a story. However, unlike envy in narcissistic presentations, which often revolves around status or control, envy in HPD tends to be more emotionally reactive and tied to intimacy and identity. It often emerges when another person is admired, competent, or emotionally self-sufficient — qualities that destabilise the HPD individual's sense of being special, desired, or indispensable. When discussing identity diffusion in narcissistic personality disorders, it becomes imperative to [7]acknowledge that lack of authenticity is one of the primary traits of narcissistic identity disorders. Narcissists' distorted self-image makes it challenging for them to know themselves completely. Criticism jeopardises the high image narcissists have of themselves, therefore any reprehension is frequently optically discerned as an assault on their inflated sense of self, which causes them to react defensively by becoming manipulative, irate, or withdrawing. Their underlying worries about their identity and worth are the cause of their hypersensitivity to reprehension. Several clinical theorists have attempted to describe the nature of identity disturbance in borderline personality disorder. According to Kernberg, identity diffusion in patients with borderline personality disorder reflects an inability to integrate positive and negative representations of the self, much as the patient has difficulty integrating positive and negative representations of others. The result is a shifting view of the self, with sharp discontinuities, rapidly shifting roles (e.g., victim and victimizer, dominant and submissive), and a sense of inner emptiness. A central issue in understanding identity disturbance in patients with borderline personality disorder is the relationship between identity disturbance and a history of sexual abuse. Research suggests that 30%–75% of adult and adolescent patients with borderline personality disorder have reported histories of sexual abuse (15–17). Not only this, it has been suggested that often identity diffusion in different types of personality disorders stems from a traumatic childhood and/or sexual abuse. However, when researching antisocial personality disorders, variables like substance abuse, family background and traumatic life events did not show significant effect on identity diffusion. It has been concluded that there is a negative relationship between antisocial personality traits and healthy identity development (commitment making, identification with commitment, exploration in breadth, and exploration in depth), and a positive relationship between antisocial personality traits and ruminative identity exploration. Ruminative exploration closely resembles identity diffusion, as both describe the difficulties individuals have in establishing a stable identity. In line with these findings, Kalemi, Tzinakou, Kouroupaki, and Douzenis (2016) and Morsunbul (2015) found that adolescents who show more ruminative exploration also behave more aggressively than adolescents who score lower on ruminative exploration, and Adams et al. (2001) suggest that identity diffusion is more likely to lead to conduct disorder in adolescents. Thus we can conclude that people who suffer from a personality disorder seem to have more problems with identity diffusion than people who do not have a personality disorder.

Overestimation of intimacy in relationships in HPD:-

Research on intimacy has demonstrated that people have an emotional need to feel close to others, "the belongingness hypothesis is that human beings have a pervasive drive to form and maintain at least a minimum quantity of lasting, positive, and significant interpersonal relationships. "Feeling that one does not belong has been linked to poorer health, adjustment, and well-being. Intimacy, regarded as a factor of sexual satisfaction, is strongly related to passion, as it describes the feeling of closeness in romantic and sexual context.On the other hand, intimacy as an independent concept is conceptualized more broadly and refers to the feeling of closeness and bond in regard to the relationship as a whole, not only the sexual aspect (as described below). Intimacy is usually understood as positive feelings and accompanying actions that produce attachment, closeness, and partners' mutual dependence on each other. Some individuals have difficulty developing intimate relationships. When people fail to develop and maintain intimacy in a relationship, they tend to feel lonely and depressed. Sternberg's research indicates that intimacy understood this way consists of such components as,among others, the desire to care about the welfare of the partner, experiencing happiness in the presence of and because of the partner, respect for the partner, the belief that one can count on the partner in times of need, mutual understanding, mutual sharing of experiences and goods, giving and receiving emotional support, exchange of

intimate information or mutual understanding and a sense of community—both material and spiritual.

Information that is exchanged between relationship partners is critical to relationship development. Exchanging information is a necessary step towards uncertainty reduction, which incorporates one's ability to predict and explain other people's actions.Women were believed to be more expressive than were males. Their traditional social role was defined as disclosing feelings and attitudes, and they were responsible for establishing intimacy in the relationship. Modern couples tend to exhibit patterns of full and equal self-disclosure. In the past, couples may have reserved more of their thoughts and feelings while they were dating and even after marriage. In contrast, the current generation seems to view reciprocal intimate disclosure as an integral part of a close, opposite-sex relationship. In general, romantic relationships that contain a high level of self-disclosure have been found to be both more intimate and more satisfying for both partners. After revealing personal or private information, people with higher levels of risk in intimacy are less likely to feel positively about their partners and about their interaction. Thus, if at least one partner is high in risk in intimacy, then the likelihood for the two partners to increase understanding for one another is likely to be diminished.Premature perception of relationships as intimate presumably reflects the difficulty that HPD individuals have in achieving emotional intimacy in romantic or sexual relationships, and their tendency to consider relationships to be more intimate than they actually are. Thus,some of the difficulties in HPD revolve around the increasing and deepening of intimacy in close relationships. These difficulties are speculated to originate from problematic relationships. For women, interpersonal closeness was additionally important, with a sense of closeness found to be even more important than sexual satisfaction for women cohabiting with their partners. Women place a higher value on experienced closeness. Higher levels of closeness, applied caresses, and overall relationship satisfaction can be observed in the cohabiting couple. When sexual arousal begins to gradually diminish with increasing levels of stability, the relationship begins to lose its heat and becomes more of a friendship, which for many people is associated with a sense of burnout in the relationship. Regardless of gender and cohabitation, for all subgroups analysed, sexual satisfaction was an important factor in relationshipsatisfaction. Emotionally manipulative and intolerant of delayed gratification,women with HPD demand confirmation and attention from intimate partners. A study that compared women with HPD to a matched control group without personality disorders found they were more likely to have been sexually unfaithful and report greater sexual preoccupation and sexual boredom with lower levels of sexual assertiveness and relationship satisfaction.

Now we will be looking at BPD and it's sub topics to see how it is different from HPD.

Emotional Dysregulation And Impulsivity Pathways:-

To study about the pathways, we will he furthur dividing it into subtopics-

Neural circuitry behind rapid emotional shifts:- Borderline Personality Disorder (BPD) is marked by emotional dysregulation, instability in self-image and relationships, and high impulsivity. While functional magnetic resonance imaging (fMRI) studies have provided valuable insights into the disorder's neural [4]correlates, electroencephalography (EEG) may capture real-time brain activity changes relevant to BPD's rapid emotional shifts. This review summarizes findings from studies investigating resting state and task-based EEG in individuals with BPD, highlighting common neurophysiological markers and their clinical implications. A targeted literature search (1980–2025) was conducted across databases, including PubMed, Google Scholar, and Cochrane. The search terms combined "EEG" or "electroencephalography" with "borderline personality disorder" or "BPD". Clinical trials and case reports published in English were included if they recorded and analyzed EEG activity in BPD.Findings indicate that individuals with BPD often show patterns consistent with chronic hyperarousal (e.g., reduced alpha power and increased slow-wave activity) and difficulties shifting between vigilance states.Borderline Personality Disorder (BPD) is marked by emotional dysregulation, instability in self-image and relationships, and high impulsivity. While functional magnetic resonance imaging (fMRI) studies have provided valuable insights into the disorder's neural correlates, electroencephalography (EEG) may capture real-time brain activity changes relevant to BPD's rapid emotional shifts.

This review summarizes findings from studies investigating resting state and task-based EEG in individuals with BPD, highlighting common neurophysiological markers and their clinical implications. A targeted literature search (1980–2025) was conducted across databases, including PubMed, Google Scholar, and Cochrane. The search terms combined "EEG" or "electroencephalography" with "borderline personality disorder" or "BPD". Clinical trials and case reports published in English were included if they recorded and analyzed EEG activity in BPD. A total of 24 studies met the inclusion criteria. Findings indicate that individuals with BPD often show patterns consistent with chronic hyperarousal (e.g., reduced alpha power and increased slow-wave activity) and difficulties shifting between vigilance states. Studies examining frontal EEG asymmetry reported varyingresults—some linked left-frontal activity to heightened hostility, while others found correlations between right-frontal shifts and dissociation. Childhood trauma, mentalization deficits, and dissociative symptoms were frequently predicted or correlated with EEG anomalies, underscoring the impact of adverse experiences,neuralregulation—however, substantial heterogeneity in methods, small sample sizes, and

comorbid conditions limited study comparability. Overall, EEG research supports the notion of altered arousal and emotion regulation circuits in BPD. While no single EEG marker uniformly defines the disorder, patterns such as reduced alpha power, increased theta/delta activity, and shifting frontal asymmetries converge with core BPD features of emotional lability and interpersonal hypersensitivity. More extensive, standardized, and multimodal investigations are needed to establish more reliable EEG biomarkers and elucidate how early trauma and dissociation shape BPD's neurophysiological profile.BPD has its roots in a confluence of environmental variables and genetic vulnerability. Adverse early experiences, such as inconsistent caring, neglect, or abuse, may have a particularly negative impact on children who are genetically predisposed to heightened emotional sensitivity. These encounters have the potential to alter brain development in ways that raise the likelihood of developing BPD. Particularly in the areas of impulse control and mood regulation, neurobiological research has shed important light on the disorder's underlying causes. Structural and functional brain imaging studies have identified anomalies in several essential brain areas. For instance, people with BPD often have hyperactive amygdalae, which are involved in processing emotions. This increased activity may explain the extreme emotional reactions and trouble settling down after being agitated.Pharmacologically, several classes can dampen amygdala responses on fMRI, but this has not translated into disorder-specific benefit. In humans, benzodiazepines acutely attenuate amygdala BOLD activity (dose-dependent lorazepam effects) and modulate central-amygdala microcircuits , yet in BPD they are generally discouraged (except for very brief crisis use) because of disinhibition and dependence risk. SSRIs tend to reduce amygdala reactivity to negative stimuli after 6–12 weeks (shown across multiple fMRI studies in depression/healthy samples) . Still, they do not improve the core pathology of BPD and are used adjunctively for comorbid depression/anxiety . Some second-generation antipsychotics can alter amygdala–prefrontal connectivity, but high-quality evidence shows little to no effect on overall BPD severity.

Functional magnetic resonance imaging shows altered brain activity and structure in BPD. However, the oldest and first neuroimaging technique is electroencephalography (EEG). In EEG, electrodes are applied to the scalp to measure the electrical activity produced by neurons in the brain's cortex. Waveforms of this activity are usually recorded using frequency bands (e.g., alpha, beta, theta, and delta), which might represent various physiological or cognitive states. The signals acquired from post-synaptic potentials in cortical neurons are amplified and recorded for additional analysis, and standardized electrode placement techniques, like the 10–20 system, ensure uniform alignment with anatomical landmarks. Because of its great temporal precision (in the range of milliseconds), EEG is a perfect tool for researching brain dynamics in real-time, including the exact timing of neural responses to certain stimuli, which are frequently investigated using event-related potentials (ERPs) .

Hormonal effect on the symptoms of BPD:

Stress and stress hormones influence a wide range of (social) cognitive functions, including empathy. Alterations in stress hormone secretion have been reported for several mental disorders, including borderline personality disorder (BPD). Many of the symptoms seen in BPD occur within social contexts. Accordingly, alterations in social cognition tasks have been described for BPD patients in some but not all studies. In this talk, we will present studies that examined the [4] association between stress and empathy in BPD patients.First, we investigated the effects of mineralocorticoid receptor (MR) stimulation with fludrocortisone on empathy. Furthermore, we studied the influence of psychosocial stress exposure on empathy by using two different stressors: 1) the TSST, which is accompanied by a pronounced cortisol response and 2) the Cyberball task, which induces social exclusion but no cortisol increase.Pharmacological MR stimulation with fludrocortisone resulted in higher emotional empathy in BPD patients and controls. When exposed to the TSST, BPD patients showed lower emotional empathy scores compared to healthy controls. There were no group differences after a control condition and concerning cognitive empathy and after the Cyberball task.The results showed a complex interplay between stress (hormones) and empathy in BPD patients and healthy individuals. Emotional empathy seems to be more sensitive to the effects of stress hormones compared to cognitive empathy.

Impulsitivity:-

Impulsivity has been described as a critical risk factor of self-injurious behaviour (i.e., nonsuicidal self-harm and suicide attempts), that are frequently present in BPD. Nonsuicidal self-harm (NSSH) refers to self-injurious[9] behaviours (self-poisoning, stabbing, etc.) without suicide intent . Specifically, in BPD, NSSH has been reported in 90% of cases, and suicide attempts in 75% .One of the most relevant models to explain and predict suicidal behaviour is the Interpersonal Theory of Suicide (14). According to this model, interpersonal variables associated with the perception of interpersonal rejection, and the history of poor and traumatic interpersonal relationships would be relevant predictors of NSSH, suicidal ideation and suicide attempts (15). At the same time, studies show that sensitivity to rejectionhas been frequently associated with borderline symptomatology.There is mounting evidence that highlights the importance of adolescent borderline personality

pathology in the development of adolescent self-harm and suicidal behavior. Adolescent self-harm has been associated with BPD traits including affective lability, identify problems, insecure attachment,oppositional behavior, and cognitive disorganization (Adrian, Zeman, Erdley, Lisa, & Lim, 2011; Franklin, Aaron, Arthur, Shorkey, & Prinstein, 2012).

Morerecently, Nakar and colleagues (2016) studied two-year trajectories of self-harm, suicide attempts, and substance misuse in a community sample of 513 adolescents and found all three self-destructive behaviors were highly overlapping and significantly associated with BPD symptomatology. In a sample of adolescent inpatients across Germany, 35% had a history of a suicide attempt, and dimensional BPD psychopathology conferred additional relative risk for a lifetime suicide attempt In a studycomparing suicidal adolescents with and without BPD, those with BPD exhibited more suicide attempts, aggression, and psychiatric co-morbidity. For adult BPD, the presence of suicide attempts or selfinjurious behavior is one of the diagnostic criteria (APA, 2013) and a defining feature of thedisorder.Cross-sectional rates of self-mutilation in adults with BPD have ranged from 17% to 80% (median = 53%) and suicide attempts have ranged from 46% to 92% (median = 76%) (reviewed in Zanarini, Frankenburg, Reich, Fitzmaurice, Weinberg, & Gunderson, 2008)

Role of invalidating environments in emotional dysregulation

An invalidating environment refers to contexts—often within families—where an individual's emotional experiences are dismissed, punished, trivialized, or inconsistently responded to. Such environments teach individuals to distrust their internal emotional states and fail to develop adaptive emotion regulation strategies. A 2025 study by Wang et al. found that perceived parental invalidation significantly predicts the severity of borderline personality features in adolescents, especially when combined with heightened biological sensitivity. Empirical work since 2020 further demonstrates that invalidation disrupts emotional learning processes. When emotions are repeatedly ignored or criticized, individuals may oscillate between emotional suppression and heightened emotional reactivity—key features of dysregulation. Experimental research shows that invalidating responses increase distress and impair emotional processing, particularly in individuals already prone to dysregulation. Moreover, a 2022 meta-analysis confirmed a robust association between parental invalidation and borderline symptoms, reinforcing thelong-term impact of such environments on emotional functioning.In conclusion, contemporary research strongly supports the view that invalidating environments undermine the development of healthy emotion regulation. By distorting emotional awareness and reinforcing maladaptive responses, 6such environments significantly contribute to persistent emotional dysregulation across the lifespan.

Self-Harm, Suicidality & Crisis Behavior:

Emergency psychiatric interventions and outcomes. Emergency departments ensure the safety of patients with mental health disorders and[15] initiate psychiatric treatment.

However, emergency workers experience several challenges in approaching patients with mental health disorders Acute psychiatric conditions that impact an individual's thought processes and behaviors and impact their functionality are among the reasons for attending the ED. Individuals may experience a crisis when their coping mechanisms are inadequate and their perceived conditions are unrealistic; thus, they attend the ED All interventions that are implemented in the ED are conducted in a limited time, with effective measures and rapid, correct guidance. Therefore, such interventions allow individuals to quickly resolve their issues and return to their lives without loss

In an emergency situation, the physician must establish conversational contact with the patient and take the history more rapidly and in more structured fashion than in a non-emergency psychiatric or medical interview, both because of the intensity of the patient's disease state and because of the possible danger to the patient or others.

The examiner must observe the patient's behavior closely while examining him or her, paying attention to spontaneous movements and any signs of psychomotor agitation, tension, or impulsiveness.

The setting for the initial examination should be chosen to maximize the safety of the patient and the examiner (10– 12). Laying down clear structures, including telling the patient what type of behavior is expected of him or her, is a more sensible and probably more successful approach than simply applying restrictive measures without any critical thought behind them.

Pharmacotherapy should be begun only if situational calming and confidence-building measures have been tried without success. The choice of medication and of its route of administration depends on the patient's diagnosis and on the particular disease manifestations that are to be treated.

NSSI (Non Suicidal Self Injury)

Non-suicidal self-injury (NSSI), defined as the deliberate destruction or alteration of body tissue without conscious suicidal intent, is increasingly recognized as a major public health concern. DSM-5 defines

non-suicidal self-injury (NSSI) as socially unaccepted, direct, repeated and deliberate harm done to one's own body. NSSI happens in many ways, such as cutting, scratching the skin, burning, hitting, and interfering with wound healing.

Emotional dysregulation is the core characteristic of NSSI manifesting by self-harm behaviors, impulsiveness, lack of emotional awareness and experiencing high intensity of negative emotion. Emotional dysregulation is a pivotal characteristic of NSSI. This NSSI behavior most often occurs during adolescence and has a high prevalence rate in both clinical and epidemiological samples. NSSI is a risk factor for both suicide and mental health problems such as depression and anxiety in the short-term and a longer-term risk factor for more severe mental illness and suicide. Adolescents exhibiting NSSI have stronger emotional affect, poorer emotional regulation, and a greater propensity for avoidance behaviors, particularly avoidance behaviors that are intended to relieve or distract from emotional pain (including the physical pain generated by NSSI.

Borderline personality disorder (BPD) is a severe mental disorder characterized by emotional instability, intense and volatile relationships, impulsivity, distorted or fragile self-image, paranoia, and frequent suicidal ideation. The biosocial theory of BPD proposes that emotional deficits, such as hypersensitivity, overreactivity, a tendency for slow recovery from the physiological responses associated with emotions, and defects of emotional regulation represent core disease characteristics. While BPD is usually diagnosed in young adults, some adolescents exhibit relatively stable cognitive, emotional, and behavioral characteristics similar to those of adult BPD patients, and coined the term adolescent borderline personality features (BPFs).

Adolescent BPF found a higher risk of suicide, NSSI, and substance abuse as well as frequent risk-taking behaviors, seriously impaired social function, and poor overall mental health. Studies have examined the associations between NSSI with BPFs and emotional regulation. However, NSSI is also frequently observed in depression, which is the most prevalent psychiatric disorder among adolescents.

Depression and BPD can often co-occur.

Current study examined the associations between BPF symptoms (emotional instability, identity disorder, poor family relations, negative emotional regulation, cognitive reappraisal, and expression suppression) and NSSI in adolescent patients with depression, and explored whether emotional regulation plays a mediating rolebetween borderline personality traits and NSSI. Existing literature showed that individuals with BPD are more likely than others to develop mood disorders.

Individuals prone to mood disorders are more likely to develop NSSI.

Predictors of suicidal ideation and attempts.It is clinically important to understand the factors that increase the likelihood of the frequent and recurrent suicide attempts seen in those with borderline personality disorder (BPD). Borderline patients at greatest risk for suicidal behavior include those with prior attempts, comorbid major depressive disorder, or a substance use disorder. Comorbidity with major depression serves to increase both thenumber and seriousness of the suicide attempts. Hopelessness and impulsivity independently increase the risk of suicidal behavior, as does a turbulent early life and the presence of antisocial traits.

Kernberg (1984, 2004, 2018) asserts that a main manifestation of BPD is identity disturbance. Identity is defined as a set of representations or concepts of self and significant others, which may achieve different levels of integration and plays a key role in regulating one's functioning and determining the quality and consistency of one's self-definition, self-direction, and interpersonal relationships. People with BPD are characterized by severe identity disturbance, conceptualized as identity diffusion syndrome, which manifests as an incoherent sense of self and others that results in disruptions in self-regulation. In addition, adolescence is the developmental period when suicidal behavior can reach its greatest severity over the lifetime of individuals with BPD In a 6 year follow-up study, which aimed at understanding the prospective predictors of suicide in patients with BPD they noticed that among 90 subjects, 25 (27.8%) made at least one suicide attempt in the interval, most occurring in the first two years. The risk of an attempt was increased by: a.) low socioeconomic status, b.) poor psychosocial adjustment, c.) a family history of suicide d.) prior psychiatric hospitalization; e.) absence of any outpatient treatment prior to the attempt.In the six year interval, 25 subjects (27.8%) reported medically significant suicide attempts. Interval attempters differed from non-attempters in having significantly ower SES, less education, and poorer social adjustment (SAS-sr). Interval attempters were more likely to report a history of medication use and psychiatric hospitalization prior to the interval attempt. They were also more likely to report a family history of suicide. Among interval attempters, 92% had baseline histories of prior attempts, compared to 81.3% of interval non-attempters. Risk factors predictive of suicide attempts change over time. Acute stressors such as MDD were predictive only in the short term (12 mos.), while poor psychosocial functioning had persistent and long term effects on suicide risk. Half of BPD patients have poor psychosocial outcomes despite symptomatic improvement. A social and vocational rehabilitation model of treatment is needed to decrease suicide risk and optimize long term outcomes in BPD. At 6 year follow-up, variables best predictive of increased risk of suicide attempt in the interval included: a.) a family history of suicide, b.) no outpatient

treatment (prior to the attempt), c.) low baseline SES, and d.) poor baseline psychosocial functioning (SAS-sr). A high GAS score at baseline was the only variable which diminished risk. It is noteworthy that any OPD treatment in the 12 month interval diminished the suicide risk, and suggests this is due to successful treatment of MDD or decreased illness severity. Importantly, absence of OPD treatment remained a predictor of suicide risk to the 6 year follow-up.

In summary, because BPD is frequently complicated by suicidal behavior, clinicians must avoid the mistake of thinking that a pattern of repeated attempts indicates little desire to die. Clinicians have an important role in preventing suicide attempts and completed suicides by understanding the risk factors.

Long term risk trajectories Suicidal behavior refers to any act with the intent to end one's own life, such as attempting suicide, making a suicide plan, or expressing suicidal thoughts or feelings. Suicide is a cause of premature death and is highly associated with mental distress . The most well-documented risk factor for suicide is a history of attempted suicide. The incidence of suicide is highest within the first years of the attempt but the risk of suicide seems to persist for many years after a suicide attempt.

Although less is known , both children and adolescents share similar risk factors, including impulsivity, irritability, depression, exposure to violence, emotional dysregulation, family conflict, and maltreatment. Some risk factors such as impulsivity and temperament traits are largely heritable,show some stability, and can often be measured at younger ages. Traits such asnegative urgency—tendencies to act impulsively when experiencing strong negative affect—have been associated with high risk . On the other hand, self-harm behaviors, also known as non-suicidal self-injuries (NSSIs), refer to any deliberate act of self-injury or self-harm without the intent to die. This can include cutting, burning, hitting oneself, or any other behavior that results in physical harm

NSSIs [15]are often used as a coping mechanism to deal with emotional pain, stress, or trauma and are more frequent than suicide attempts, In patients with borderline personality disorder, it is important to pay particular attention to these factors. Among these risk factors, available evidence shows how precocious environmental factors (family-related and trauma-related) interact withtemperamental and personality factors—associated with genetic andneurobiological correlates—in the pathogenesis of this personality disorder.

As we have observed again and again, the diagnosis of BPD remains essentially based on clinical assessment, implemented with structured diagnostic interviews and self-report questionnaires. Laboratory and instrumental assessment can prove to be useful tools to rule out the presence of medical comorbidities, the symptomatology of which can be mistaken for a psychiatric disorder like BPD. Finally, differential diagnosis with other psychiatric conditions, like mood disorders, must always be considered

Comparative Efficacy of Evidence-Based Psychotherapies and the Role of Pharmacotherapy in Borderline Personality Disorder:-

Borderline Personality Disorder is characterized by emotional dysregulation, identity disturbance, and interpersonal hypersensitivity. For the MBBS student, understanding that BPD is a "psychotherapy-first" diagnosis is critical. Unlike Major Depressive

Disorder or Schizophrenia, where primary biological interventions are curative, BPD requires neurocognitive restructuring through specialized therapy.

II. Analysis Of Psychotherapeutic Modalities

Dialectical Behavior Therapy (DBT)

Developed by Marsha Linehan, DBT is the gold standard for reducing parasuicidal behavior. It operates on a biosocial theory, suggesting that emotional dysregulation stems from biological vulnerability met with an invalidating environment.

Key Mechanism: The"Dialectic"—balancing acceptance of the patient as they are with the necessity of change.Clinical Utility: Highly effective in reducing emergency room visits and self-harm.

Mentalization-Based Treatment (MBT)

MBT focuses on the capacity to"mentalize"—understanding one's own mental state and that of others. In BPD, stress often causes a collapse in mentalization, leading to "psychic equivalence" (where internal feelings are perceived as external reality).

Key Mechanism: Enhancing the patient's ability to reflect on intentions before reacting.Clinical Utility: Improves interpersonal functioning and reduces long-term hospitalization.

Transference-Focused Psychotherapy (TFP).Based on object-relations theory, TFP utilizes the patient-therapist relationship to observe "split" representations (e.g., viewing the self as "all bad" and the therapist as "all good").
Key Mechanism: Interpretation of the transference in the "here-and-now."
Clinical Utility: Targets identity diffusion and personality structure more aggressively than DBT.

Acceptance and Commitment Therapy (ACT).ACT is a "third-wave" CBT that moves away from changing thought content to changing the relationship with thoughts. Key Mechanism: Psychological flexibility through mindfulness and value-based action.Clinical Utility: Effective for comorbid anxiety and experiential avoidance.

III. The Role Of Medication Vs. Psychotherapy

In clinical psychiatry, the "Medication vs. Psychotherapy" debate for BPD is often a false dichotomy; however, the hierarchy of evidence is clear.

The Primacy of Psychotherapy

Current NICE and APA guidelines state that psychotherapy is the primary treatment. There is noFDA-approved medication specifically for BPD. Psychotherapy[11] addresses the core pathology: identity disturbance and interpersonal dysfunction.

Targeted Pharmacotherapy (Adjuvant Role).Medications are used "off-label" to manage specific symptom clusters (Symptom-Targeted Pharmacotherapy): Research, including the Cochrane Reviews, suggests that while DBT has the most robust evidence for self-harm reduction, TFP and MBT show comparable, and sometimes superior, results for improving social functioning and reducing "borderline" traits over 24-month periods.

Long Term Recovery and Functional Outcomes(10 -20years)

Long term follow up studies conducted over the past two decades have significantly reshaped the understanding of prognosis in borderline personality disorder(BPD) and related personality pathologies. Historically, personally [13,14]disorders were considered chronic and largely resistant to treatment . However, longitudinal research now demonstrates that many patients achieve symptomatic remission over time, especially when they receive structured psychotherapy and adequate psychological support.

Longitudinal Studies on Recovery :

One of the most influential investigations into the long term course of BPD is the Mc Lean Study of Adult Development, a large prospective cohort study conducted by researches at McLean hospital affiliated with Harvard Medical School. The findings revealed that symptomatic remission is common, even among patients who initially present with severe pathology. Approximately 85-90 percent of patients experienced remission of diagnostic criteria within 10 years , and maintained this remission over subsequent follow ups . Remission in this context typically refers to the absence of sufficient symptoms to meet diagnostic criteria for BPD for at least two consecutive years.

Importantly , the study also showed that the frequency of self harm and suicide attempts and psychiatric hospitalizations declines substantially over time. This trend reflects both the natural course of the disorder and the cumulative effects of psychotherapy and psychosocial adaptation, over a 10 year period , the majority of patients with BPD showed significant reductions in impulsivity , emotional instability, and interpersonal dysfunction. Symptomatic Remission vs Functional Recovery Although symptomatic remission is relatively common , functional recovery tends to occur more slowly.

Functional recovery refers to improvements in broader aspects of life functioning , including employment , education , relationships and overall social integration.Longitudinal research indicates that while many patients no longer need meet diagnostic criteria for BPD after several yeas, a significant proportion continue to experience challenges in domain such as.

IV. Maintianing Stable Employment Forming And Sustaining Long Term Relationships Achieving Financial Independence Coping With Stress And Interpersonal Conflict:

For example , data from the Mclean study showed that although most participants achieved symptom remission , only about one third achieved sustained functional recovery, defined as stable employment or education and at least one meaningful interpersonal relationship is maintained[13] over several years.Reduction in Self Harm and Suicidality. One of the most clinically important findings from long term studies is the substantial reduction in self injurious behaviors and suicidal ideation over time.

During early adulthood individuals with BPD frequently exhibit high rates of self harm and suicide attempts . However, longitudinal data show that these behaviors typically decline with age and with therapeutic engagement. Several factors contribute to this decline:improved emotional regulation skills developed through psychotherapy, Neurobiological maturation , particularly within prefrontal regulatory circuits, Greater life stability including employment and supportive relationships, reduced impulsivity as individuals progress through adulthood. Nevertheless , individuals with BPD remain at higher lifetime risk of suicide compared with the general population. Estimates suggest that approximately 8-10% of individuals with bpd die by suicide, underscoring the importance of sustained treatment and monitoring evenafter symptomatic improvement.

Influence Of Psychotherapy On Long Term Outcome

Structured psychotherapies such as a Dialectical Behavior Therapy(DBT), Mentalization Basedtreatment(MBT), Transfernce-Focused[12]Psychotherapy(TFP), and scheme-focused therapies play acentral role in improving long term outcomes. Evidence suggests that these interventions help patients develop:

More stable self identity, improved emotional regulation, greater interpersonal awareness, healthier coping mechanisms Patients who remain engaged in therapy for extended periods tend to show greater reduction in symptom severity and better functional outcomes compared with those receiving non specialized treatment or brief interventions. Psychotherapy may also promote neurocognitive changes , including improvements in mentalization, executive functioning and emotional processing, these changes contribute to more adaptive Interpersonal behaviours and improved quality of life Quality of life and social integration.Despite persistent challenges, many individuals with BPD eventually achieve meaningful improvements in quality of life . Long term studies indicate that patients may gradually develop :stable employment, long term partnerships , improved social networks, greater self - efficacy and autonomy .These improvements are often gradual and may[14]occur over many years . for this reason , clinicians emphasize long term therapeutic engagement realistic expectations for recovery.

Effectiveness of DBT, MBT, ACT, and Transference-Focused Therapy

Dialectical Behaviour Therapy (DBT)

DBT is the best known and most available Evidence-based therapies for BPD.

It has been initially developed by Marsha Linehan for highly suicidal patients who did not respond to[19]standard[18]cognitive-behavioral interventions. DBT significantly reduces suicidal behaviour and self-harm in patients with BPD and produces improvement in general psychopathology and depressive symptoms.Patients receiving DBT show reduced [20]hospitalization rates with improved treatment compliance[19] and therapy adherence. DBT improves impulsivity and mood instability in BPD patients and focuses on emotion regulation,distress tolerance, interpersonal effectiveness, and mindfulness skills.

Mentalization-Based Therapy (MBT)

MBT is a dynamic approach developed by Bateman and Fonagy that aims to stabilize a person's“mentalization” skills in stressful situations to understand interpersonal interactions.MBT is based on improving the patient's ability to understand mental states of self and others. It improves interpersonal functioning and emotional regulation. It is derived from attachment theory and psychodynamic principles and has demonstrated effectiveness in reducing BPD symptom severity and improving social functioning.

Transference-Focused Psychotherapy (TFP)

TFP is a manualized psychodynamic therapy developed by Otto Kernberg , which focuses on analysis of the patient-therapist[20]relationship(transference).TFP helps integrate split internal representations of self and others.

Evidence shows TFP can reduce BPD symptoms and improve personality organization and has been shown to be useful in reducing aggression and improving mentalization.Randomized trials show TFP and DBT are both effective treatments for BPD.

Acceptance and Commitment Therapy (ACT)

ACT is a third-wave cognitive behavioural therapy focusing on psychological flexibility .It is based on functional contextualism and relational frame theory and helps patients accept distressing thoughts rather than avoid them. It holds that psychopathological processes like cognitive fusion; avoidance of experience; attachment to a verbally conceptualized self and a verbally conceptualized past; confusion between goals andvalues; and absence of committed behavior are central to mental disorders.Treatment involves psychoeducation on key mechanisms, mindfulness exercises and cognitive defusion. ACT promotes value-based behaviour and commitment to meaningful goals and can be used as an adjunct therapy with DBT for emotional dysregulation in BPD.

Factors effecting the treatment in BPD:

Therapeutic alliance

Strong therapeutic alliance between patient and therapist predicts better treatment outcome.Alliance quality predicts symptom improvement[20] even in disorder-specific therapies.

Early symptom change

Early improvement in symptoms during therapy predicts better long-term outcomes.Monitoring early treatment progress helps identify patients who may not benefit from therapy.

Psychosocial and demographic factors
Predictors of treatment outcome include psychosocial, clinical, treatment-related, and demographic factors.

Approximately 28 different predictors of outcome have been identified in research. Among those, 18 factors were examined in three or more studies, of which 15 were significant predictors of treatment outcomes.

Treatment adherence
Homework completion and active participation in therapy predict positive outcomes.

Attachment style
Patients with preoccupied attachment patterns may respond less effectively to treatment.

Social cognition and mentalization ability

Patients with better social cognitive capacity show better treatment outcomes. Poor mentalization ability may be associated with poorer treatment response.

Baseline severity

Some studies show more severely ill patients may have greater potential to achieve change during therapy, and should remain a focus for psychotherapy services.

Identity distortion:

The aim of this topic is to examine the phenomenological nature of the concept of identity disturbance andfeelings of emptiness and to clarify their diagnostic significance for BPD. The concept of identity and self faces a peculiar distinction between "core" and "narrative" selfhood that may be useful for diagnosis. Identity disturbance is described in terms of uncertainty concerning career choices, values, goals, and friendship patterns. In the DSM-IV, the concept of "a sense of self" appears for the first time but is undefined.Identity distortion is rarely influenced by single factor, rather are cumulative consequence of a disfigured conscience.

Origin: -

Notable contributions came from psychoanalysts, describing identity disturbance and feelings of emptiness as reflecting disturbances at a structural level of the psyche. In their terminology, "structure" may refer both to the overall psychic structures in Freud's model of the id, ego, and superego but also to single mental structures or processes such as defensive or cognitive functions.Deutsch described a group of patients with what she termed "as if" personalities, referring to the patient's readiness to mold oneself according to the surroundings defines the term "identity" as expressing "a mutual relation in that it connotes both a persistent sameness within oneself [21](self-sameness) and a persistent sharing of some kind of essential character with others" Most importantly, descriptions of the experiential (phenomenal) level of psychopathology are often conflated withcomplex meta-psychological constructs,which concern a sub-personal(unconscious) level of pathology.This is evident in Erikson's view on identity as referring to (1) "a conscious sense of individual identity," (2) "an unconscious striving for a continuity of personal character," (3) "a criterion for the silent doings of ego synthesis," and(4) "an inner solidarity with a group's ideals and identity"Growing evidence shows that diagnosing and treating borderline personality disorder (BPD) is of high relevance for affected youths. Although identity crisis is part of thenormative developmental process, identity diffusion is a potential candidate for being an appropriate concept in further developing screening tools and interventions for BPD treatment in adolescence.The importance of[22] emphasizing and promoting the BDP diagnosis for adolescents is twofold. First, BPD is highly prevalent and highly dysfunctional (high comorbidity, increased risk for incarceration) mental disorder.

Second, interventions in adolescence are or should be of high priority because of the malleability and flexibility of this developmental period. Successful interventions—even in case of subsyndromal BPD features—can serve as indicated prevention for adult BPD.

Identity—a key process in normative adolescent development—plays an important role in the development and organization of BPD symptoms. The Alternative Model for Personality Disorders (Section III of DSM-5) sees identity disturbance as a central construct in diagnosing personality disorders in general, and especially BPD. Moreover, impairments of identity affect other domains related to personality pathology. Identity diffusion interferes with pursuinggoals(self-directedness), understanding others perspectives, and establishing close relationships. In a recent review, Kaufmanand Meddaoui called for a deeperempirical understanding of identity pathology. Identity diffusion could play a central role in building a unifying theory of BPD, because it is associated with constructs that form the core of BPD in different etiological modelsErikson (1968) summarizes with the following statement:I shall present human growth from the point of view of the conflicts, inner and outer, which the vital personality weathers, reemerging from each crisis with increased

sense of inner unity, with an increase of good judgment, and an increase in the capacity 'to do well' according to his own standards and to the standards of those who are significant to him.Erikson goes on to say "The use of the words 'to do well' of course points the whole question of cultural relativity"Identity Development in Adulthood (Ages 25 and Beyond) Erikson held that identity development does not end with its formation (Hoare, 2002). He viewed it as an ongoing process that captures one's invest ments throughout the long years of adulthood. Thus, identity development is both a normative period of adolescence and an evolving aspect of adulth ood. In contrast to Erikson's extensive writings on the adolescent identity formation process, he did not offer detailed comments regarding identity'sevolution throughout the adult life (Kroger, 2007). As a result, he has been criticized for extending his theory beyond adolescenc e without providing much detail.

In summary, Erikson's psychosocial theory is composed of eight developme ntal stages which span throughout the course of life. Each stage presents th e individual with an inherent task or conflict that they must successfully re solve to proceed with development. Erikson placed a great deal of emphasi s on sociocultural factors because he believed these strongly influence deve lopment. Such factors are especially relevant in the process of identity form ation. Erikson believed that childhood identifications lay the groundwork f or identity formation in adolescence. The process of forming an identity in volves creating a coherent sense of self and who one is in relation to the wo rld. Adolescence represents an optimal time for identity development due t o a variety of physical, cognitive, and social factors. Although Erikson believ ed identity was largely "fixed" by the end of adolescence, he did suggest tha t identity continues to evolve throughout adulthood

Acknowledgement:

The paper was done by the students of SGT medical college for batch 2023 and 2024 combined. In order to learn and make a systematic review of histrionic personality disorder and bipolar disorder.

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