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Case Report

A Case of Borderline Personality Disorder: Psychological Interventions by Dialectical Behaviour Therapy Lens

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ABSTRACT

Borderline Personality Disorder (BPD) is a severe and intricate psychiatric condition characterized by widespread emotional instability, impulsive behaviours, disturbances in identity, and impaired interpersonal relationships. This paper offers a comprehensive overview of BPD by integrating key psychological interventions for a case of Borderline Personality Disorder, to explore its definition, etiology, evolution, assessment tools, evidence-based management strategies, premorbid personality traits, and clinical significance. A biopsychosocial framework is utilized to explain how genetic vulnerabilities, neurobiological factors, and environmental stressors contribute to the disorder's emergence and progression. Effective psychotherapies, such as Dialectical Behaviour Therapy and Mentalization-Based Treatment, are highlighted as successful interventions. The discussion also covers the impact of personality development, early diagnosis, and supportive care on prognosis. This review aims to enhance understanding and improve treatment approaches for individuals affected by BPD.

KEYWORDS: Borderline personality disorder, Emotional regulation, Assessment tools, Psychotherapy, Genetics, Premorbid traits, Evidence-based treatment, prognosis

INTRODUCTION

Borderline Personality Disorder is recognized as one of the most challenging psychiatric disorders, affecting approximately 1–2% of the general population and a considerably higher percentage within clinical settings[1]. It is typified by emotional dysregulation, unstable interpersonal relationships, impulsivity, and a distorted self-image, which lead to substantial functional impairments, suicidal tendencies, and psychological distress[2]. The course of BPD is varied; some individuals experience a reduction in symptoms over time, while others continue to struggle with chronic symptoms and difficulties in relationships.

The origins of BPD are multifactorial, involving a combination of genetic, neurobiological, and environmental influences[3]. Childhood trauma, neglect, and adverse relationship experiences interact with a biological susceptibility, resulting in maladaptive coping strategies and issues in personality development. Understanding the significance of premorbid

personality traits, such as heightened emotional sensitivity or impulsivity, is crucial for identifying individuals at risk and implementing early interventions[4].

The progression of BPD indicates that while some patients achieve symptom remission, others face persistent impairment. Assessment methods, including structured clinical interviews and validated self-report measures, are essential for accurate diagnosis and for differentiating BPD from other psychiatric disorders[5]. Management strategies are primarily based on psychotherapy, with strong evidence supporting treatments such as Dialectical Behaviour Therapy[6], Cognitive Behavioural Therapy[7], and Mentalization-Based Treatment (Bateman & Fonagy, 2008). While pharmacological interventions are used adjunctively, their evidence base is less robust (Leichsenring et al., 2011). According to the American Psychiatric Association (2013), Borderline Personality Disorder is recognized by a pervasive pattern that includes emotional dysregulation, an unstable self-image, impulsivity, and highly intense but unstable interpersonal relationships, usually appearing by early adulthood. Common signs of BPD include impulsive actions, an intense fear of being left alone, significant shifts in mood, and repeated suicidal thoughts or gestures.

Diagnostic Classification

ICD -11: Personality Disorders (6D10 – 6D11)

In ICD -11, specific personality disorder types (like BPD) are not separate categories. Instead:

- There is a single diagnosis: Personality Disorder (6D10) Specified by severity: mild, moderate, severe.
- Trait domain qualifiers are added to describe the style (e.g., negative affectivity, disinhibition, detachment, anankastia, dissociality).
- A separate category exists for Borderline Pattern (6D11) to retain continuity with DSM and ICD-10.

ICD -11: Borderline Pattern Qualifier (6D11)

Diagnosis requires that the general criteria for PD (6D10) are met plus at least 4 of the following features:

1. Marked impulsivity: acting rashly without considering consequences.
2. Instability in relationships: intense, alternating between idealization and devaluation, with fear of abandonment.
3. Markedly unstable self-image: disturbance in identity, goals, values, or career plans.
4. Chronic feelings of emptiness.
5. Emotional instability: intense, rapidly fluctuating moods.
6. Recurrent self-harm or suicidal behaviour, threats, or gestures.
7. Transient stress-related paranoid ideation, dissociation, or severe cognitive distortions.

CASE HISTORY

Ms. KL, a 28-year-old unmarried female, is currently pursuing the first year of her MD in dermatology, belonging to the Upper-Middle Socio-Economic status, Hindu religion, and hailing from Udaipur. The information provided was only provided by her, and was adequate and reliable.

Since adolescence, she reported being emotionally sensitive and easily hurt in relationships. She described longstanding difficulties in managing emotions, setting boundaries, and trusting others. These patterns appeared to have gradually intensified over time, particularly during her NEET preparation period and following a breakup, leading to increased emotional instability and self-harming behaviors She reported frequent crying spells, anger outbursts, low self-worth, difficulty in concentrating, and repeated episodes of interpersonal conflict. She also described a pattern of pushing people away during emotional discomfort and then urgently seeking closeness. She expressed confusion about her identity and shared distressing inner thoughts related to being unloved or unwanted. There was no history of previous psychiatric treatment. Mental status examination revealed labile affect, preoccupation with themes of abandonment and worthlessness, and a tendency toward emotional dysregulation. Intellectual Insight was present, and judgment was Intact.

DIAGNOSIS

Emotionally Unstable Personality Disorder, Borderline Type (F60.31)

TEST FINDINGS

1. Structured Clinical Interview for DSM-IV Axis II Disorders (SCID-II): The SCID-II was administered to assess the presence of personality disorder traits. The patient fulfilled the diagnostic criteria for

Borderline Personality Disorder, with the presence of symptoms such as affective instability, fear of abandonment, unstable interpersonal relationships, identity disturbance, impulsivity (including self-harm), chronic feelings of emptiness, and inappropriate anger. Sub-threshold traits of dependent personality were also observed, particularly in her difficulty making decisions and fear of losing support from close others.

2. Beck Depression Inventory-II (BDI-II): The BDI-II was used to evaluate the presence and severity of depressive symptoms. The patient obtained a total score of 21, which falls in the moderate range of depression. Higher scores were noted in items related to sadness, feelings of failure, self-dislike, and crying. There were also mild elevations in loss of interest, fatigue, and self-critical thoughts. No active suicidal ideation was reported at the time of assessment.
3. Difficulties in Emotion Regulation Scale (DERS):The DERS was administered to assess the patient's ability to regulate emotions across multiple domains. She obtained a total score of 119/180, indicating moderate to high levels of emotional dysregulation. Subscale scores were: Non-acceptance = 16/30, Goals = 17/25, Impulse = 15/25, Awareness = 19/25, Strategies = 34/50, and Clarity = 18/25. The profile reflected difficulty in managing emotions during distress, limited access to coping strategies, and occasional confusion regarding emotional states. The results were in line with the patient's clinical presentation of emotional vulnerability, affective lability, and poor impulse control.
4. Sentence Completion Test (SSCT): The patient's responses on the SSCT revealed underlying conflicts in areas of self-concept, familial relationships, and interpersonal functioning. Attitudes toward parents reflected emotional distance, unresolved hurt, and feelings of being emotionally neglected, particularly in relation to the mother. Responses suggested the presence of trust issues and dependency in peer relationships, along with fear of being judged or abandoned. Attitudes toward self showed high levels of self-criticism, confusion, and emotional vulnerability, with recurrent themes of not being good enough and uncertainty about identity. Conflicts were seen around emotional expression and fear of closeness. Fears centered on rejection and not being understood, while future aspirations appeared present but clouded by self-doubt. Overall, responses reflected significant emotional insecurity, interpersonal dependency, and difficulties with boundary formation, consistent with borderline personality features.
5. Rorschach Inkblot Test: The patient gave 24 responses. The protocol reflected signs of emotional reactivity and poor modulation of affect. X-% was 0.42, indicating some distortion in perception under emotional stress, while X+% was 0.68, showing generally conventional thinking with occasional lapses. The affect ratio (CF+C>FC) suggested impulsive emotional expression. D score was -1, reflecting limited coping under stress. Sum Y was 3, indicating situational anxiety and difficulty tolerating emotional pressure. Thematic content included feelings of betrayal, confusion about self, and interpersonal mistrust. Overall, the protocol suggested affective instability, disturbed interpersonal schemas, and fragile self-image, consistent with borderline personality dynamics.

DBT Formulation Based on Biosocial Model (Marsha Linehan, 1993)

The patient's emotional and interpersonal difficulties were understood through the biosocial framework, which sees borderline traits as arising from a lifelong interaction between biological vulnerability and a dismissive environment. From early adolescence, she reported heightened emotional sensitivity, experiencing emotions more intensely and struggling to return to baseline once triggered. Minor events caused deep hurt, crying, or anger, which she could not always explain or manage. This pattern indicated a biological vulnerability to emotional dysregulation, a core biosocial feature. She described growing up in an environment where her emotional expressions were often dismissed. For example, her concerns about bullying due to her voice were ignored by her family until diagnosed with a vocal cord issue years later. Surgery eased physical issues but worsened her feelings of being unheard and invalidated, shaping her internal narrative that her emotional needs were unimportant or unbelievable.

Further invalidation occurred through caregivers' inconsistent or emotionally distant responses. Her mother's long-standing psychiatric illness and patterns of emotional unavailability were experienced by the patient as neglectful. She often

perceived her mother as more affectionate toward outsiders or house help than toward her. These repeated invalidating experiences over time appear to have significantly shaped the patient's core beliefs about relationships — particularly regarding trust, closeness, and worthiness of care.

The patient's biological sensitivity and invalidation history likely caused emotional dysregulation, unstable relationships, identity confusion, and impulsive coping. She struggles with boundaries and understanding her needs, depending on others for reassurance but pushing them away when overwhelmed, creating a cycle of closeness and withdrawal. When unmet, she feels abandoned or rejected, even if unintentional, reflecting a fear of abandonment and black-and-white thinking. Self-harming behaviors like cutting and punching her hand appeared to release emotional tension, shift focus from psychological pain, or signal distress when words aren't enough. These acts temporarily eased her chaos, reinforcing them despite long-term harm.

The biosocial model explains this pattern as the outcome of a system in which emotional pain was never reliably acknowledged or regulated through healthy external responses. Over time, the patient developed her own, often harmful, strategies to cope with these emotional storms. In the context of this case, the biosocial framework helped explain how early and ongoing invalidation of emotional experience, paired with a biologically sensitive temperament, contributed to the emergence and persistence of borderline features — including affective instability, unstable self-image, intense fear of abandonment, chronic emptiness, and impulsive behaviors.

This formulation guided the selection of Dialectical Behavior Therapy (DBT) as the treatment approach, focusing on helping the patient develop skills in emotion regulation, distress tolerance, interpersonal effectiveness, and mindfulness, while gradually working toward a more stable sense of self and relational security.

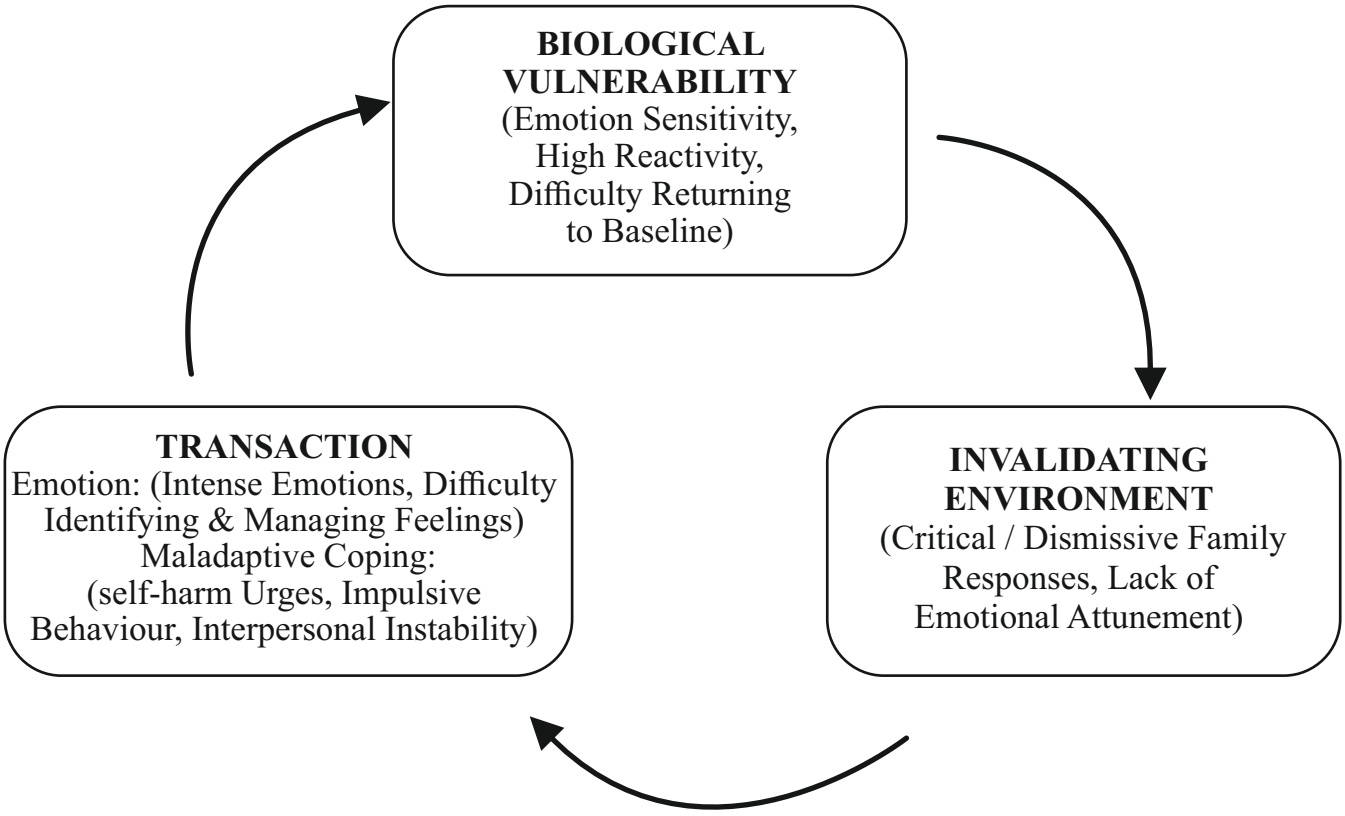

Figure 1: Biosocial Model (Marsha Linehan, 1993)

Focus of Therapy and Psychotherapeutic Strategy Planned

Based on the clinical presentation and formulation, the focus of therapy was to address persistent emotional dysregulation, unstable interpersonal relationships, low self-worth, and impulsive behaviors such as self-harm. The therapy aimed to help the patient build greater awareness of her emotional states, learn healthier ways of managing distress, and improve her functioning in close relationships.

A structured Dialectical Behavior Therapy (DBT) approach was planned to address the core difficulties identified through the biosocial model. The treatment was tailored to target skill deficits in the following areas:

- Mindfulness – to increase awareness of present-moment experiences and reduce reactivity to automatic emotional triggers.
- Distress Tolerance – to build the patient's ability to manage emotional crises without engaging in self-harming behaviors or interpersonal withdrawal.
- Regulation of Emotions – to help her identify and name emotions, reduce vulnerability to mood swings, and increase emotional stability over time.
- Interpersonal Effectiveness – to improve assertiveness, boundary-setting, and the ability to express needs in relationships without escalating conflict.

The therapy also aimed to help the patient develop a more stable sense of identity, reduce black-and-white thinking patterns, and tolerate emotional discomfort without resorting to avoidance or impulsive actions. Psycho-education was included to normalize her emotional experiences and enhance her understanding of how invalidating experiences in the past may have shaped her current difficulties.

The therapeutic strategy was planned as long-term and structured, with an emphasis on collaborative goal-setting, consistent skill-building, and the gradual application of DBT techniques in real-life situations. Family involvement was considered at later stages if appropriate, with the aim of supporting the patient's emotional growth and boundary development.

Therapeutic Strategies Planned

- Psycho-education: To help the patient understand the nature of Emotionally Unstable Personality Disorder and how her emotional sensitivity and past invalidation contributed to her current difficulties. Psycho-education also focused on the biosocial model, helping her recognize patterns in her emotional responses and relationships.
- Mindfulness Training: Introduced to build present-moment awareness, reduce emotional reactivity, and increase attention to thoughts, feelings, and urges without immediate judgment or action. Basic mindfulness skills (observe, describe, participate) were taught and practiced through short daily exercises.
- Distress Tolerance Skills: To help the patient manage high emotional arousal without engaging in self-harm or impulsive actions. Skills such as distraction (ACCEPTS), self-soothing, and grounding techniques were introduced and rehearsed in sessions for use during emotional crises.
- Emotion Regulation Techniques: Focused on helping the patient understand, name, and manage her emotional experiences. Work included identifying vulnerability factors, using the ABC skill (Accumulate positives, Build mastery, Cope ahead), and practicing opposite action to manage urges triggered by intense emotions.
- Interpersonal Effectiveness Skills: Aimed at improving her ability to communicate assertively, maintain self-respect, and build healthier boundaries. Skills such as DEAR MAN, GIVE, and FAST were introduced for situations involving unmet emotional needs or perceived rejection.
- Diary Card and Behavioral Chain Analysis: Used regularly to track urges, emotional states, and behaviors such as self-harm or anger outbursts. These tools were also used to identify triggers and apply learned skills in real-life contexts.
- Validation and Therapeutic Engagement: Efforts were made to validate the patient's emotional experiences while also encouraging responsibility and change. The therapist maintained a balance of acceptance and change-oriented work to strengthen alliance and motivation.

Motivation for Therapy and Prognostic Indicators

The patient appeared motivated for therapy and expressed a desire to understand her emotional difficulties and improve her relationships. She was cooperative during sessions and showed willingness to participate in therapeutic tasks. She acknowledged the impact of her emotions on her academic and social functioning and showed psychological awareness regarding her struggles.

Good prognostic factors included her psychological mindedness, readiness to engage in therapy, and strong academic background. She was able to reflect on her thoughts and emotions and was open to learning new coping strategies. Her ability to form a therapeutic alliance and her consistent attendance further supported a positive outlook.

However, certain factors were noted as potential challenges, such as long-standing emotional dysregulation, low tolerance for distress, and difficulties in maintaining stable interpersonal boundaries. The presence of self-harming behavior was also considered a clinical risk and required careful monitoring throughout therapy. These factors were considered in planning structured, skill-based DBT sessions over a longer duration.

CLINICAL OBSERVATIONS AND DISCUSSION

Working with Ms. K.L. presented important clinical insights into managing cases of Emotionally Unstable Personality Disorder using a DBT framework. In the early phase, the patient appeared emotionally overwhelmed and uncertain about the therapy process. Her narratives were often filled with emotional intensity, and she expressed difficulty in identifying and explaining her own needs. The therapist maintained a validating and non-judgmental stance, which gradually allowed the patient to build trust and open up more freely. One of the initial challenges was her limited tolerance for distress, which often led to impulsive reactions such as self-harm. Therapy sessions had to be paced carefully, with early emphasis on stabilization, safety planning, and teaching distress tolerance techniques. The use of diary cards and chain analysis helped structure her reflection and identify repeated triggers. Emotional validation played a key role in reducing defensiveness and supporting engagement.

The patient found mindfulness exercises difficult at first, often stating that her mind “couldn't stop running.” With consistent practice and gentle repetition, she began to describe moments of pause and space between feelings and reactions. This progress was slow but steady, and reinforced during sessions with praise and structured feedback. Emotion regulation work was a core focus, as the patient struggled with intense mood swings and difficulty labeling emotions. She was taught to track vulnerabilities and apply opposite action when urges became strong. As she learned to name her feelings and connect them to past invalidating experiences, she reported a sense of emotional clarity. Interpersonal work required careful preparation. The patient initially feared that being assertive would lead to abandonment or rejection. Role plays and stepwise introduction of 'DEAR MAN' helped her rehearse conversations in safer ways. She began to report small successes in boundary-setting and found it empowering to express her needs clearly.

One therapeutic difficulty was the tendency to idealize and devalue the therapist in early stages. The therapist-maintained consistency and neutrality while gently addressing these shifts when they emerged. This helped the patient recognize her interpersonal patterns and begin working through them with greater awareness. Termination work involved addressing the patient's fears of losing emotional support and building confidence in her internal coping system. Gradual spacing of sessions was used to support autonomy. Although the patient acknowledged ongoing challenges, she also expressed a sense of pride and readiness to move forward independently. Overall, therapy with Ms. K.L. highlighted the importance of structure, validation, skill-building, and consistent therapeutic presence in working with emotionally vulnerable clients. The DBT framework provided both containment and direction, allowing the patient to make meaningful changes in her emotional, behavioral, and relational world.

CONFLICT OF INTEREST: None

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