Borderline personality disorder can be a difficult diagnosis because of similarities to other conditions, particularly mood disorders. It is a common presentation in both psychiatric and general practice, with accurately diagnosed cases seen in 10% of psychiatric outpatients, 20% of psychiatric inpatients and 6% of family medicine patients. These values are higher than would be expected given a prevalence of about 1% in the general population. Women account for 70% of patients with this disorder in clinical settings, and the most common age at first presentation is in late adolescence. Unfortunately, a large proportion of patients with the disorder are not identified in practice.

Patients with borderline personality disorder are frequently encountered in the emergency department, where they present following threatened suicide or a suicide attempt. More than 500,000 such visits to emergency departments occur each year in the United States. The incidence of suicide attempts among patients with borderline personality disorder is highest among those in their twenties, but mortality peaks in the thirties, with a 10% lifetime rate of completed suicide.

Retrospective studies have shown that symptoms resolve over time, with 75% of patients at 15-year follow-up and 92% of patients at 27-year follow-up no longer having the disorder. One large, well-conducted 10-year prospective study found that 93% of those with borderline personality disorder had at least a 2-year period of remission, but only 50% also attained good psychosocial functioning.

In this article, we focus on the current diagnostic criteria for borderline personality disorder, as presented in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM-IV-TR), and how these criteria can be used to differentiate it from other disorders that may share symptoms. A summary of the evidence used in this review is found in Box 1. We based our review primarily on findings from a relatively small body of experimental studies that used the very similar DSM-III and DSM-IV definitions of borderline personality disorder and its symptoms. Recent research, which was the focus of our review, was generally of high quality and used sophisticated assessment and measurement strategies to differentiate the disorder from other psychiatric disorders.

What is the origin of the term “borderline personality disorder”? The term “borderline” was first described by the psychoanalyst Adolf Stern in 1938. He used it to refer to a group of patients whose conditions worsened during therapy and who showed masochistic behaviour and psychic rigidity, indicating a protective mechanism against any perceived changes in the environment or within the individual. The term was later expanded in the late 1960s and 1970s by Otto Kernberg; this diagnosis was used in empirical studies conducted by Grinker and Werble. Gunderson and Singer reviewed the literature and listed several features that identify borderline personality disorder, and a diagnostic interview based on these features was later developed by Gunderson and colleagues. The diagnosis was included in the DSM-III and was slightly revised in the DSM-IV, with the addition of a ninth criterion for cognitive symptoms, but both sets of criteria were based primarily on clinical experience and the work of Gunderson and Singer. The definition in the DSM-IV-TR is unchanged, although important modifications have been proposed for DSM-5. In particular, the diagnostic system for personality disorders will become a hybrid model, with both categorical diagnoses, includ-
How is borderline personality disorder diagnosed?

The diagnosis is based on symptoms that have been present since adolescence or early adulthood and appear in multiple contexts. There are no laboratory or imaging tests that can help with the diagnosis. A number of structured and semistructured interviews can assist in making the diagnosis, although they often require specialized training to administer. The Diagnostic Interview for Borderlines – Revised is a validated and frequently used tool that is generally considered the “gold standard”; however, it can take 30–60 minutes to administer. Several self-report measures have been developed within the past decade but are rarely used in routine clinical practice. One commonly used self-report questionnaire for mood disorders — the Mood Disorder Questionnaire — frequently misdiagnoses borderline personality disorder as bipolar disorder.

When interviewing patients, different domains of symptoms must be explored. Symptoms in borderline personality disorder occur in 4 domains: affectivity, interpersonal functioning, impulse control and cognitive. The diagnosis requires that at least 5 of 9 specific criteria be met (Box 1). Affective symptoms

The first affective criterion is the presence of “affective instability due to a marked reactivity of mood … that lasts hours to rarely more than a few days.” These frequent mood changes may appear to overlap with bipolar disorder, but there are several clear distinctions. First, the duration of the fluctuations is shorter than in bipolar disorder. In bipolar disorder, mood changes must remain consistent and persist for at least 4 days to meet criteria for a hypomanic episode and 7 days for a manic episode. A second difference is the persistence of affective lability throughout life, rather than during a discrete mood episode. Moreover, symptoms of borderline personality disorder gradually improve with time. In contrast, bipolar disorder has discrete periods (lasting on average 3 months) for both mania and depression that cause patients to present and function distinctly differently from their baseline, and these episodes can occur at any point during a patient’s life.

The third difference is reactivity of mood. The mood symptoms of patients with borderline personality disorder are triggered by external events and are particularly sensitive to perceived rejection, failure and abandonment. Moods usually shift between depression and anger, and euphoria is transient. Shifts between depression and euphoria are more frequently seen in bipolar disorder. Most of the data on affective lability are derived from ecological momentary assessment studies, in which patients are asked to record mood fluctuations and psychosocial stressors several times each day. This technique provides results that are consistent, different and more valid than when patients are asked at a later point to recall their experiences.

Several characteristics may help distinguish mood fluctuations in patients with borderline personality disorder from those in healthy controls. Several studies suggest that negative emotions may persist for longer and be more intense in patients with the disorder than in healthy controls, although this is not true for positive emotions. A second discriminating characteristic is the quality of mood reported by patients with the disorder. Several high-quality observational studies that used ecological momentary assessment found that patients with borderline personality disorder described continuous dysphoria, high emotional variability and increased hostility compared with healthy controls.
Inappropriate and intense anger is the next affective symptom of borderline personality disorder and is related to affective instability, as described earlier. The final affective symptom is a chronic feeling of emptiness. This experience is hard to define and lacks specificity for the diagnosis compared with other diagnostic criteria. However, patients with the disorder have described it as feeling as if “something is missing,” and it overlaps with hopelessness, isolation and loneliness, as well as some symptoms of depression. One small study found that symptoms of emptiness, along with self-condemnation, hopelessness and other symptoms of the disorder, including fear of abandonment and self-destructiveness, help distinguish the disorder from major depression.

**Impulsive symptoms**
The impulsive symptoms of borderline personality disorder may be more recognizable to clinicians, but they can still pose diagnostic challenges. Patients with recurrent suicide attempts or threats or episodes of self-harm are commonly seen in the emergency department and in psychiatric assessments. Between 60% and 78% of patients with the disorder have shown suicidal behaviours, with more than 90% engaging in self-harm. Persistent cutting as a way of regulating emotions is a characteristic feature of the disorder, as are recurrent overdoses related to stressful events. Recurrent presentation to the emergency department because of suicidality is suggestive of the diagnosis, with almost half of such patients meeting the diagnostic criteria for borderline personality disorder.

Impulsivity and self-destructiveness in borderline personality disorder encompass many other behaviours, including gambling, spending, binge eating and sexual promiscuity. Substance abuse is also frequent: alcohol and substance abuse or dependence are seen in more than 50% of patients with the disorder. The combination of substance use and borderline personality disorder is associated with an increased risk of completed suicide.

**Interpersonal symptoms**
A pattern of unstable relationships, marked by extremes of idealization and devaluation, is one of the most important symptoms in making an accurate diagnosis of borderline personality disorder, with studies reporting a sensitivity of 74% and a specificity of 87%. Because of this interpersonal instability, less than half of women with the disorder marry, and even less have children. Patients with the disorder also make frantic efforts to avoid abandonment. Clinical experience suggests that, over time, some patients react to this fear by becoming socially isolated to protect themselves from potential abandonment.

Identity disturbance is the second interpersonal symptom. This symptom has not been clearly defined, but it generally refers to frequent and suddenly changing goals, beliefs, vocational aspirations and sexual identity, as well as a painful sense of incoherence. Patients may also feel as if they are assuming the identity of other people to whom they are close. The identity disturbance seen in this disorder should be differentiated from the normal identity issues one sees in adolescents. Being unable to define an identity on one’s own and instead being dependent on interpersonal relationships to define one’s identity, as well as frequent fluctuations or a sense of incoherence in one’s identity, are more strongly associated with borderline personality disorder than with typical adolescent identity issues.

**Cognitive symptoms**
Few studies of cognitive symptoms in borderline personality disorder have been conducted. What is known is that about 40%–50% of patients with the disorder have brief periods of psychotic symptoms or dissociation. Typical symptoms include paranoid thoughts and auditory hallucinations, but their course is much shorter than in schizophrenia, often lasting only hours to days, and the presence of symptoms is related to stres-

---

**Box 2: Diagnostic criteria of borderline personality disorder**

A pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by 5 (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behaviour covered in criterion 5.
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least 2 areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). Note: Do not include suicidal or self-mutilating behaviour covered in criterion 5.
5. Recurrent suicidal behaviour, gestures or threats, or self-mutilating behaviour.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

*Reprinted with permission from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Copyright © 2000 American Psychiatric Association.*
Box 3: Resources for patients and clinicians

For patients
- National Institute of Mental Health: [www.nimh.nih.gov/health/topics/borderline-personality-disorder/index.shtml](http://www.nimh.nih.gov/health/topics/borderline-personality-disorder/index.shtml)
- Borderline Personality Disorder Resource Center: [http://bpdresourcecenter.org/](http://bpdresourcecenter.org/)
- National Education Alliance for Borderline Personality Disorder: [www.borderlinepersonalitydisorder.com/index.html](http://www.borderlinepersonalitydisorder.com/index.html)
- Chapman AL, Gratz KL. The borderline personality disorder survival guide: everything you need to know about living with BPD. Oakland (CA): New Harbinger Publications; 2007.

For clinicians
- National Education Alliance for Borderline Personality Disorder: [www.borderlinepersonalitydisorder.com/index.html](http://www.borderlinepersonalitydisorder.com/index.html)
- Behavioural Tech, LLC (for clinicians interested in dialectical behaviour therapy): [www.behavioraltech.org/index.cfm](http://www.behavioraltech.org/index.cfm)
- Paris J. Treatment of borderline personality disorder: a guide to evidence-based practice. New York (NY): Guilford Press; 2008.
- Gunderson JG, Links PS. Borderline personality disorder: a clinical guide. Washington (DC): American Psychiatric Publishing; 2008.

Box 4: Applying the results of this review in clinical practice (fictional case)

A 39-year-old woman with a long psychiatric history presented for assessment in a specialized personality disorder clinic. She was first seen at age 19 with depression in the context of an abusive relationship. At the time, she was prescribed an antidepressant and gradually felt somewhat better, but she continued to have problems with mood fluctuations. The patient was seen again at age 25 for elevated mood accompanied by decreased sleep and increased energy in the context of an exciting new relationship. Although she reported that these symptoms were present “all the time,” her diagnosis was changed to bipolar disorder and the antidepressant switched to lithium. Her mood quickly became depressed, coinciding with the breakup of the relationship. Three months later, the patient became increasingly isolated with anxiety about further “emotional trauma” induced by her last breakup. After a particularly stressful day at work, she threatened to overdose on medications, because “the voice of my dead grandmother told me to.” These symptoms were new, and the patient also reported feeling as if she was not real and that she was in a television program. The diagnosis was revised to schizoaffective disorder, and the patient was admitted to hospital and given antipsychotic drug treatment. The psychotic symptoms resolved in a matter of days, but the patient remained suicidal with depression that fluctuated with episodes of anger. A pattern of impulsive suicide attempts, psychotic symptoms and psychiatric admissions persisted for the next 10 years, despite numerous medications. Throughout this period, the patient continued to attend school and began a job as a child care worker in a special education environment.

During the current assessment at the clinic, the patient reported that her elevated mood was present only for several hours at a time. During these periods, she experienced symptoms of irritability and affective lability that remained unchanged from baseline, which indicated that she did not experience discrete hypomanic episodes. The patient reported that, even during periods of elevated mood, she was able to attend work and concentrate. These mood fluctuations were usually brought on by conflicts with partners or family. When at work or in low stress situations, she would feel euthymic. Her psychotic symptoms would also occur during episodes of high stress and persisted only for several hours. At times, symptoms would resolve within days, even without seeking medical treatment. With a revised diagnosis of borderline personality disorder, the patient began a long-term program of specialized individual and group psychotherapy, during which most of her medications were gradually removed. This focused approach to treatment led to a decrease in symptoms and improvements in her interpersonal relationships.

What are the challenges in making the diagnosis?

The current diagnostic criteria for borderline personality disorder allow for 256 different combinations of symptoms that could lead to a diagnosis. Clinicians thus may find it challenging to make a diagnosis of borderline personality disorder. Because of their limited time to spend with patients, clinicians can look for several key factors to help them decide whether further assessment for the disorder is necessary.

The most important factor is whether the difficulties have been long standing or, for adolescents, present for at least 1 year. If there is a sudden change in functioning or new symptoms, a diagnosis of borderline personality disorder is less likely according to the DSM-IV-TR definition.

Having difficulties in multiple areas is another important factor. For example, suicidality or self-harm without problems with mood or relationships is less likely to be borderline personality disorder, whereas a history of suicide attempts along with impulsive substance use and problems with chronic feelings of emptiness and anger is more suggestive of a diagnosis.

If the diagnosis of borderline personality disorder is not made, an affected person may end up...
with several diagnoses of comorbid disorders, none of which responds to common treatments. For example, patients who have major depressive disorder and comorbid borderline personality disorder generally do not respond as well to antidepressant medications as patients who have major depressive disorder alone.53

How should patients be informed of their diagnosis?

Once a diagnosis of borderline personality disorder has been established, it is important to inform the patient of the diagnosis and discuss the implications for treatment options and outcomes. There is no evidence to indicate that informing patients of the diagnosis causes problems, so it is unfortunate that this important step is often omitted.56

When informing a patient about a suspected diagnosis of borderline personality disorder, clinical experience suggests that it is helpful to show the patient the list of diagnostic criteria and explain why the diagnosis is being considered. Educating patients about the increasing number of specific treatments and the good prognosis with gradually resolving symptoms can also help reduce their anxiety about a diagnosis that is highly stigmatized in the medical system and the general population. Even a single psychoeducation session could help to reduce symptoms, as was found in a randomized trial in which 30 of 50 late adolescent women found to have borderline personality disorder were randomly assigned to attend such a session within a week after being told about their diagnosis.57 Patients can also be directed to specific resources that can provide more information (Box 3).

Beyond the ethical implications of informing patients of their diagnosis, patients benefit from improved understanding about their disorder and often feel as if the clinical picture “finally makes sense.”20,38 Informing patients may also help to prevent misunderstandings about the diagnosis and to avoid improper treatments in the future.

Overlap of symptoms with those of other psychiatric disorders makes diagnosis of borderline personality disorder a challenge. Careful evaluation can usually clarify the clinical picture. Box 4 gives an example of how the diagnostic criteria can be applied in practice.

Gaps in knowledge

Accurate diagnosis of borderline personality disorder remains challenging. It is easy to miss the forest for the trees by identifying a single symptom and making an incorrect diagnosis based on that symptom alone. Borderline personality disorder is a clinical diagnosis, with no supporting laboratory or imaging tests. Even the core pathological features remain in debate,46,50 but there is a broad consensus supporting the current criteria.

One area that is receiving increasing attention is the presentation, course and treatment of the disorder in adolescents.40–42 Research in this area will allow for earlier diagnosis and treatment, which may lead to improved long-term outcomes.

Another major issue is how the change to a trait-based diagnostic system in the upcoming DSM-5 will affect the diagnosis of borderline personality disorder, with debate over how clinically useful such a system will be.60,64

Management

Once a diagnosis is made and the patient informed, a discussion about treatment can follow. In the past, treatment of borderline personality disorder was considered challenging, but some interventions have been developed over the past 2 decades that have dramatically changed the lives of patients with this disorder. In a forthcoming article in CMAJ,65 we will review the literature on the treatment of borderline personality disorder and provide some general suggestions on how to manage patients with the disorder.

References

1. Widiger TA, Weissman MM. Epidemiology of borderline personality disorder. Hosp Community Psychiatry 1991;42:1015-21.
2. Zimmerman M, Rothschild L, Chelminski I. The prevalence of DSM-IV personality disorders in psychiatric outpatients. Am J Psychiatry 2005;162:1911-8.
3. Gross R, Olsson M, Gamberoff M, et al. Borderline personality disorder in primary care. Arch Intern Med 2002;162:53-60.
4. Leinenweber MF, Lane MC, Loranger AW, Kessler RC. DSM-IV personality disorders in the National Comorbidity Survey Replication. Biol Psychiatry 2007;62:553-64.
5. Gunderson JG, Links PS. Borderline personality disorder: a clinical guide. 2nd ed. Washington (DC): American Psychiatric Publishing; 2008. p. 350.
6. Zanarini MC, Frankenburg FR, Khera GS, et al. Treatment histories of borderline inpatients. Compr Psychiatry 2001;42:144-50.
7. The Surgeon General’s call to action to prevent suicide. Washington (DC): United States Public Health Service; 1999.
8. Paris J, Zweig-Frank H. A 27-year follow-up of patients with borderline personality disorder. Compr Psychiatry 2001;42:482-7.
9. Paris J, Brown R, Nowlis D. Long-term follow-up of borderline patients in a general hospital. Compr Psychiatry 1987;28:530-5.
10. Zanarini MC, Frankenburg FR, Reich DB, et al. Time to attainment of recovery from borderline personality disorder and stability of recovery: A 10-year prospective follow-up study. Am J Psychiatry 2010;167:663-7.
11. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. Fourth edition. Text revision. Washington (DC): The Association; 2000. p. 943.
12. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 3rd ed. Washington (DC): The Association; 1980. p. 494.
13. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 4th ed. Washington (DC): The Association; 1994. p. 886.
14. Stern A. Psychoanalytic Investigation of and therapy in the borderline group of neuroses. Psychoanal Q 1938;7:467-89.
15. Kernberg OF. A psychoanalytic classification of character pathology. J Am Psychoanal Assoc 1970;18:800-22.
6. Grinker RR, Werble B. The borderline patient. New York (NY): Jason Aronson Inc.; 1977. p. 226.
7. Gunderson JG, Singer MT. Defining borderline patients: an overview. Am J Psychiatry 1975;132:1-10.
8. Gunderson JG, Kolb JE, Austin V. The diagnostic interview for borderline patients. Am J Psychiatry 1981;138:986-903.
9. Skodol AE, Bender DS, Morey LC, et al. Personality disorder types proposed for DSM-5. J Pers Disord 2011;25:156-69.
10. Paris J. Treatment of borderline personality disorder: a guide to evidence-based practice. New York (NY): Guilford Press; 2008. p. 260.
11. Zanarini MC, Gunderson JG, Frankenburg FR, et al. Discriminat-
12. Ing BPDD from other axis II disorders. J Pers Disord 1989;3:10-8.
13. First MB. User’s guide for the structured clinical interview for DSM-IV axis II personality disorders: SCID-II. Washington (DC): American Psychiatric Press; 1997. p. 91.
14. Poreh AM, Rawlings D, Claridge G, et al. The BPQ: a scale for the assessment of borderline personality based on DSM-IV cri-
teria. J Pers Disord 2006;20:247-60.
15. Arnts A, van den Hooorn M, Cornelis J, et al. Reliability and validity of the Borderline Personality Disorder Severity Index. J Pers Disord 2003;17:45-59.
16. Zanarini MC, Vujanovic AA, Parachini EA, et al. A screening mea-
sure for BPDD: the McLean Screening Instrument for Borderline Personality Disorder (MSI-BPDD). J Pers Disord 2003;17:568-73.
17. Zanarini MC, Vujanovic A-A, Parachini EA, et al. Zanarini Rat-
ing Scale for Borderline Personality Disorder (ZAN-BPD): a continuous measure of DSM-IV borderline psychopathology [published eratum in J Pers Disord 2003;17:370]. J Pers Disord 2003;17:233-42.
18. Zimmerman M, Galione JN, Ruggero CJ, et al. Screening for bipolar disorder and finding borderline personality disorder. J Clin Psychiatry 2010;71:1212-7.
19. Grilo CM, McGlashan TH, Skodol AE. Stability and course of personality disorder diagnosis: the need to consider comorbidities and continuities between axis I psychiatric disorders and axis II per-
sonality disorders. Psychiatr Q 2000;71:291-307.
20. Paris J. Personality disorders over time: precursors, course and outcome. J Pers Disord 2003;17:479-86.
21. Tracic Shea M, Edelen MO, Pinto A, et al. Improvement in border-
line personality disorder in relationship to age. Acta Psychiatr
22. Scand 2009;119:143-8.
23. Zanarini MC, Frankenburg FR, Reich DB, et al. The subsyndromal phenomenology of borderline personality disorder: a 10-year follow-up study. Am J Psychiatry 2007;164:929-35.
24. Goodwin FK, Jamison KR, Ghaemi SN. Manic–depressive illness: bipolar disorders and recurrent depression. 2nd ed. New York (NY): Oxford University Press; 2007. p. 1262.
25. Nica EI, Links PS. Affective instability in borderline personality disorder: experience sampling findings. Curr Psychiatr Rep 2009;11:74-81.
26. Stiglmayr CE, Shapiro DA, Stieglitz RD, et al. Experience of aversive tension and dissociation in female patients with border-
line personality disorder: a controlled study. J Psychiatr Res 2001;35:307-12.
27. Solhan MB, Trull TJ, Jahng S, et al. Clinical assessment of affective instability: comparing EMA indices, questionnaire reports, and retrospective recall. Psychiatr Assess 2009;21:425-36.
28. Stiglmayr CE, Gratthoff T, Limnell MM, et al. Aversive tension in patients with borderline personality disorder: a computer-based controlled field study. Acta Psychiatr Scand 2005;111:372-9.
29. Zeigler-Hill V, Abraham J. Borderline personality features: instabil-
ity of self-esteem and affect. J Soc Clin Psychiatr 2006;25:668-87.
30. Russell JJ, Moskowitz DS, Zuroff DC, et al. Stability and vari-
ability of affective experience and interpersonal behavior in bor-
derline personality disorder. J Abnorm Psychol 2007;116:578-88.
31. Trull TJ, Solhan MB, Tragerger SL, et al. Affective instability: meas-
uring a core feature of borderline personality disorder with ecologi-
cal momentary assessment. J Abnorm Psychol 2008;117:647-61.
32. Johansen M, Karterud S, Pedersen G, et al. An investigation of the prototype validity of the borderline DSM-IV construct. Acta Psychiatr Scand 2004;109:289-98.
33. Klonsky ED. What is emptiness? Clarifying the 7th criterion for borderline personality disorder. J Pers Disord 2008;22:418-26.
34. Rogers JH, Widiger TA, Krupp A. Aspects of depression associ-
ated with borderline personality disorder. Am J Psychiatry 1995;152:268-70.
35. Zanarini MC, Frankenburg FR, et al. Reported childhood onset of self-mutilation among borderline patients. J Pers Disord 2006;20:9-15.
36. Linehan M. Cognitive-behavioral treatment of borderline per-
sonality disorder. New York (NY): Guilford Press; 1993. p. 558.
37. Bongar B, Peterson LG, Golann S, et al. Self-mutilation and the chronically suicidal patient: an examination of the frequent visi-
tor to the psychiatric emergency room. Ann Clin Psychiatry 2004;16:437-43.
38. McGlashan TH, Grillo CM, Skodol AE, et al. The Collaborative Longitudinal Personality Disorders Study: baseline axis I and II diagnostic co-occurrence. Acta Psychiatr Scand 2000;102:256-64.
39. McGirr A, Paris J, Lesage A, et al. Risk factors for suicide com-
pleation in borderline personality disorder: a case-control study of cluster B comorbidity and impulsive aggression. J Clin Psychiatry 2007;68:721-9.
40. Fossati A, Maffei C, Bagnato M, et al. Latent structure analysis of DSM-IV personality disorder criteria. Compr Psychiatry 1999;40:72-9.
41. Westen D, Betan E, Delfie JA. Identity disturbance in adoles-
cence: associations with borderline personality disorder. Dev Psychopathol 2011;23:305-13.
42. Zanarini MC, Gunderson JG, Frankenburg FR. Cognitive fea-
tures of borderline personality disorder. Am J Psychiatry 1990;147:57-63.
43. Zlotnick C, Johnson DM, Yen S, et al. Clinical features and im-
pairment in women with borderline personality disorder (BPDD) with posttraumatic stress disorder (PTSD), BPDD without PTSD, and other personality disorders with PTSD. J Nerv Ment Dis 1995;2:217-61.
44. Newton-Howes G, Tynyr P, Johnson T. Personality disorder and the outcome of depression: meta-analysis of published studies. Br J Psychiatry 2006;188:13-20.
45. McDonald-Scott P, Machizawa S, Sato S. Diagnostic disclo-
sure: a tale in two cultures. Psychiat Med 1992;2:147-57.
46. Zanarini MC, Frankenburg FR. A preliminary, randomized trial of psychoeducation for women with borderline personality dis-
order. J Pers Disord 2008;22:284-90.
47. Lequesne ER, Hersh RG. Disclosure of a diagnosis of borderline personality disorder. J Psychiatr Pract 2004;10:170-6.
48. Bateman A, Fonagy P. Psychotherapy for borderline personality disorder: mentalization-based treatment. Oxford (UK): Oxford University Press; 2004. p. 381.
49. Biskin RS, Paris J, Renaud J, et al. Outcomes in women diag-
nosed with borderline personality disorder in adolescence. J Can Acad Child Adolesc Psychiatry 2011;20:168-74.
50. Stepp SD, Pikonis PA, Hipwell AE, et al. Stability of borderline personality disorder features in girls. J Pers Disord 2010;24:460-72.
51. Chanen AM, McCutcheon LK, Germain, D, et al. The HYPE Clinic: an early intervention service for borderline personality disorder. J Psychiatr Pract 2009;15:163-72.
52. Gunderson JG. Revising the borderline diagnosis for DSM-V: an alternative proposal. J Pers Disord 2010;24:694-708.
53. Hopwood CJ, Malone JC, Ansell EB, et al. Personality assess-
ment in DSM-5: empirical support for rating severity, style, and traits. J Pers Disord. 2011;25:305-20.
54. Biskin RS, Paris J. Management of borderline personality disor-
der. CMAJ. In press.

Affiliations: From the Department of Psychiatry (Biskin, Paris), Institute of Community and Family Psychiatry, Sir Mortimer B. Davis Jewish General Hospital, Montréal, Que.

Contributors: Robert Biskin drafted the manuscript and conducted the literature review. Joel Paris supervised the process and rewrote and edited sections of the manuscript. Both authors approved the final version submitted for publication.