Erich Schlesinger
email: erich.schlesinger@euba.sk
ORCID: 0000-0002-7587-9369
Ekonomická Univerzita v Bratislave

György Pál Pápay
email: ceo@eucult.eu
ORCID: 0009-0009-1866-6357
Wyższa Szkoła Biznesu – National Louis University

Krzysztof Brocławik
email: kbroclawik@wsb-nlu.edu.pl
ORCID: 0000-0002-0049-8481
Wyższa Szkoła Biznesu – National Louis University

Borderline Personality Disorder

Zaburzenia osobowości typu borderline

DOI: 10.66935/978-83-65926-16-6.07

Cytuj jako: Schlesinger, E., Pál Pápay, G., Brocławik, K. (2025). Borderline Personality Disorder. In J. Felczak (ed.), *Przekraczanie granic między sferami egzystencji* (T. 1) (pp. 1-16). Wydawnictwo WSB-NLU.

Abstract: Borderline personality disorder is a complex and often severe personality disorder characterized by instability in emotional experience, interpersonal relationships, self-esteem, and behavior. In this article, we discuss the diagnostic criteria according to the International Classification of Diseases (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), as well as the clinical manifestations that allow for accurate diagnosis and differentiation from other mental disorders. Furthermore, we explore various therapeutic approaches that have proven effective in the treatment of the presented personality disorder. In the conclusion of the article, we present a case study illustrating the practical application of the diagnosis and treatment of borderline personality disorder in a clinical setting. This article provides a comprehensive overview of borderline personality disorder,

its therapeutic options, and the importance of a multidisciplinary approach in the treatment of this challenging disorder.

Streszczenie: Osobowość chwiejna emocjonalnie typu borderline (Borderline Personality Disorder – BPD) to złożone i często poważne zaburzenie osobowości, które charakteryzuje się niestabilnością w sferze emocjonalnej, relacjach interpersonalnych, samoocenie oraz zachowaniu. W niniejszym artykule omawiamy kryteria diagnostyczne według Międzynarodowej Klasyfikacji Chorób (ICD-10) oraz Diagnostycznego i Statystycznego Podręcznika Zaburzeń Psychicznych (DSM-5), a także objawy kliniczne, które pozwalają na precyzyjną diagnozę i różnicowanie od innych zaburzeń psychicznych. W dalszej części analizujemy różne podejścia terapeutyczne, które okazały się skuteczne w leczeniu tego typu zaburzeń osobowości. W zakończeniu artykułu przedstawiamy studium przypadku, które ilustruje praktyczne zastosowanie diagnostyki i leczenia osobowości borderline w środowisku klinicznym. Niniejszy artykuł stanowi kompleksowy przegląd zaburzenia osobowości typu borderline, dostępnych opcji terapeutycznych oraz podkreśla znaczenie podejścia multidyscyplinarnego w leczeniu tego wymagającego zaburzenia.

Keywords: borderline personality disorder, diagnostic criteria, psychotherapy, dialectical behavior therapy, case study, multidisciplinary approach

Słowa kluczowe: osobowość borderline, kryteria diagnostyczne, psychoterapia, terapia dialektyczno-behawioralna, studium przypadku, podejście multidyscyplinarne

Introduction

Borderline personality disorder, abbreviated as BPD, also known as emotionally unstable personality disorder, belongs to the three most frequently diagnosed personality disorders in the outpatient clinics of clinical psychologists and psychiatrists. This psychopathological condition occurs in different cultural and geographical areas, including the Slovak Republic, where it is increasingly becoming the subject of diagnosis. Although this disorder is relatively frequent in specialist outpatient clinics, it often remains unknown or insufficiently understood by the lay public.

Manifestations of BPD, such as emotional lability, disorders of self-acceptance and instability of interpersonal relationships, are very noticeable and have a fundamental influence on the quality of life of individuals who suffer from it. Persons with this personality disorder show a tendency to unclear ideas about themselves and their life goals. They experience chronic feelings of emptiness or depression and often find themselves in dependent or self-

destructive patterns of behaviour. Other characteristic signs may be eating disorders, impulsivity, a tendency to substance addictions and persistent problems in interpersonal relationships. These problems worsen the ability to create and maintain stable and healthy bonds.

BPD has a marked impact on different aspects of the individual's life. This is reflected in his professional, personal and social functioning. In addition, the disorder also has an important influence on family and close relationships, where the diagnosed person may cause feelings of tension, frustration and emotional exhaustion among the closest people.

Characteristics of Borderline Personality Disorder

Persons with personality disorders, regardless of the level of their intelligence or social status, often experience chronic psychological discomfort and repeatedly get into conflicts that are typical for a concrete personality disorder. A common feature of all personality disorders is long-term, rigid behaviour that leads to personal or social problems and failures. The presence of a personality disorder represents an important risk factor for repeated problematic experience of interpersonal relationships, which are often characterized by dissatisfaction and stress on both sides (Heretik & Heretik, 2007).

Borderline personality disorder is one of the most frequently diagnosed personality disorders. According to available research, approximately 2 to 3% of the population suffer from this disorder. This disorder is more frequent in women, with the ratio between women and men being 2:1, and it occurs more often in families with a higher prevalence of mood disorders, dissocial disorders and addictions (Praško, 2003).

Epidemiological data on the prevalence of borderline personality disorder, however, differ. Vágnerová (2004) states that borderline personality disorder affects a maximum of 1 to 2% of the population.

In patients with this personality disorder, an unclear and disturbed image of their own identity is a frequent accompanying phenomenon. It is manifested not only in the area of personal goals and preferences, but also in the evaluation of their own abilities and roles in life. These persons may have problems with clearly determining their long-term goals. This leads to constant changes in their interests and desires. This disturbed image of the self may also concern sexual preferences, where confusion or conflicts within one's own sexual identity are often present. This may lead to difficulties in creating stable relationships and satisfying interactions (Bohus, 2005).

Persons suffering from borderline personality disorder often feel a deep inner feeling of emptiness. This may lead to their tendency to search for external sources that would fill this feeling. In this way, they may become intensely attached to other people, while focusing on their presence as a means of filling this emptiness. This process may result in a disturbance of their ability to perceive relationships adequately. This is often manifested by incorrect evaluation of the motives and actions of other persons. These errors in perception may lead to irrational expressions, such as contempt or unfair condemnation of others (Nolen-Hoeksema et al., 2012).

The presented maladaptive mechanisms of perception and behaviour become part of the clinical picture of this disorder and importantly influence interpersonal relationships and the quality of life of affected individuals.

Clinical manifestations of BPD may be systematically divided into five main areas:

1. **Affect regulation** – persons with BPD often experience intense and inadequate emotional fluctuations, which may be difficult to control. These affective manifestations may appear as rapid changes of mood, extreme impulsivity or sudden attacks of anger or sadness.

2. **Self-image** – people with this disorder often have an unstable and unclear image of their own identity. Their self-esteem may be very variable, which leads to difficulties in setting and maintaining life goals and patterns of behaviour.

3. **Psychosocial integration** – this type of personality disorder is characterized by difficulties in interpersonal relationships, which are often intense but unstable. Persons suffering from BPD have a tendency to create relationships that are excessively dependent or, on the contrary, excessively emotionally distant.

4. **Cognitive abilities** – in this area, disorders of perception and interpretation of reality appear. Patients may have a tendency to disintegration of thoughts, distortions in self-evaluation or impulsive and often irrational decision-making.

5. **Problematic behaviour** – the behaviour of these persons is often impulsive, without regard to consequences. This may include risky behaviour, such as self-harm, inappropriate sexual behaviour or disorders in the area of substances. These impulsive tendencies result in frequent problems in everyday life and interpersonal relationships.

Diagnostic Criteria for Borderline Personality Disorder

At present, the tenth revision of the International Classification of Diseases, ICD-10, is mainly used in Europe for the classification of mental disorders. In the United States of America, the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders, DSM-5, is used for this purpose (DSM-5, 2015).

Emotionally unstable personality disorder (F60.3) is included in the ICD-10 classification (1996) among specific personality disorders (F60). It distinguishes two subtypes of emotionally unstable personality: the impulsive type (F60.30) and the borderline type (F60.31).

Diagnostic Criteria for Borderline Personality Disorder according to ICD-10

Impulsive type: for the diagnosis of the impulsive type, the general criteria for personality disorder must be met. It is necessary that the patient shows at least three of the following characteristics, while one of them must be a tendency to impulsive behaviour, criterion 2:

1. A marked tendency to sudden and unconsidered action, which does not take consequences into account.
2. A tendency to intolerance and frequent conflicts with others, especially if impulsive behaviour is disturbed or criticized.
3. A tendency to outbursts of anger or rage, accompanied by inability to control the following explosive behaviour.
4. Difficulties in remaining with activities that do not bring immediate gain or satisfaction.
5. Unstable and unpredictable mood.

Borderline type: for the borderline type of personality disorder, at least three symptoms from the criteria of the impulsive type must be met. It is also necessary that the patient shows at least two of the following characteristics:

1. Uncertainty and disturbed self-image, including unclear goals, values and preferences, including sexual ones.
2. A tendency to create intense and unstable relationships, which often lead to emotional crises.
3. Excessive effort to avoid rejection and abandonment.

4. Repeated self-harm or dangerous behaviour that threatens health.
5. Chronic feelings of emptiness and inner despair.

Diagnostic Criteria for Borderline Personality Disorder according to DSM-5

The disorder is determined by the presence of five or more signs from the following characteristics:

1. Strong effort of the individual to avoid real or perceived abandonment.
2. A pattern of unstable and intense interpersonal relationships, which is characterized by alternating between extreme idealization and devaluation.
3. Identity disorder: marked and permanent instability in self-image and perception of one's own person.
4. Impulsive behaviour in at least two areas that carry the risk of self-harm, for example excessive spending, sex, abuse of addictive substances, dangerous driving or binge eating.
5. Repeated suicidal tendencies, threats or self-harming behaviour.
6. Affective instability caused by a marked reaction of mood to external stimuli.
7. Chronic feelings of emptiness.
8. Inappropriate and intense anger or problems with its control.
9. Transient paranoid ideas or severe dissociative states, which are caused by stress.

Supplementary Note on ICD-11

As an additional update to the original text, it is possible to mention the ICD-11 classification. In ICD-11, personality disorders are not divided mainly into separate categorical subtypes, such as the impulsive type or the borderline type. The classification is more focused on the severity of personality dysfunction and on trait domains, for example negative affectivity, disinhibition or detachment (Reed et al., 2019).

The borderline pattern may still be used as a qualifier. It is, however, used as part of a broader clinical description of the patient, and not as a separate categorical diagnosis in the same way as in ICD-10. This allows the clinician to describe the individual profile of personality pathology more specifically, while the connection with the concept of borderline personality disorder remains preserved (World Health Organization, 2022).

Treatment of Borderline Personality Disorder

Treatment of borderline personality disorder is a complex and time-consuming process. It is focused on reducing acute symptoms, such as affective dysregulation, depressive symptoms, anxiety, emotional lability and anger, impulsive behaviour, abuse of psychoactive substances, eating disorders, impulsive sexual behaviour, excessive spending, cognitive and perceptual symptoms, hypersensitivity in relationships, illusions, derealization and depersonalization (Heretiková Marsálová, 2016).

Many research studies on the treatment of borderline personality disorder indicate that pharmacotherapy should not be considered the primary and only method of treatment of this disorder. Despite this, in some specialists this form of treatment is often primarily used. In clinical practice, the following are most often used: antidepressants – they help to improve mood, reduce depressive symptoms, feelings of emptiness, anxiety and sensitivity to rejection. These medicines also reduce aggressive outbursts of anger and self-harm. Mood stabilizers – they are used to stabilize mood, reduce anxiety and improve the ability to manage impulsive behaviour, aggression, irritability and anger. Antipsychotics – they are indicated for the treatment of initial symptoms of perceptual distortions, such as paranoid thoughts, dissociative symptoms and feelings of unreality. Anxiolytics – they are used in acute states of anxiety, but they may increase impulsive behaviour. Their use is also connected with the risk of habit formation (Kreisman & Straus, 2017).

Pharmacotherapy, usually in the form of low doses of psychotropic drugs, is used to reduce symptoms connected with mood changes, anxiety or micropsychotic episodes. Psychotherapy also has an important role. The optimal approach is long-term outpatient psychiatric treatment, which may include individual as well as group psychotherapy, or extended outpatient care in the form of a day hospital. Long-term psychotherapy appears to be effective in influencing personality disorder, because it allows a change in maladaptive patterns of emotional reactions, thinking and behaviour, increasing frustration tolerance, reducing impulsivity and fear of rejection and loneliness (Heretiková Marsálová, 2016).

Education is also part of the therapeutic process. It provides the patient with an explanation of his problems, their causes and mutual connections. Within therapy, it is possible to choose from various psychotherapeutic approaches (Grambal et al., 2017).

Treatment of BPD includes various psychotherapeutic methods. Among the most common are long-term psychodynamic psychotherapy and cognitive-behavioural approaches. In addition to individual sessions, patients may also use group and supportive psychotherapy.

The optimal approach to therapy should be adapted to the specific needs of the patient. It is important to choose the most suitable technique from various therapeutic directions depending on the concrete circumstances (Heretiková Marsalová, 2016).

For patients with a severe form of BPD who are exposed to increased risk, dialectical behaviour therapy (DBT) appears to be a very effective therapeutic approach. This therapeutic model is focused on improving emotional regulation and provides patients with tools for effective management of negative emotions. In this way, risky behaviour, such as self-harm or overdose, is prevented.

As an additional update to the original text, recent literature also states that pharmacological treatment in BPD is mainly used for symptom reduction and not as a specific treatment of the personality disorder itself. No pharmacological agent has been formally approved specifically for the treatment of BPD by regulatory bodies such as the FDA or EMA. For this reason, pharmacotherapy is usually used as supportive and off-label treatment (Stoffers-Winterling et al., 2022; Bohus et al., 2021). Current literature also supports the use of structured psychotherapeutic approaches, including DBT, especially in patients with high emotional instability and self-destructive behaviour (Leichsenring et al., 2024).

Model Processing of a Case Study

General description

In November 2024, a 28-year-old man sought psychiatric help because of frequent and intense outbursts of anger, which significantly disturbed his interpersonal relationships and caused social and work problems. The patient described his internal experience in detail. He complained of persistent feelings of emotional emptiness and inability to regulate his emotions effectively. Mentions of extreme mood lability indicated marked instability of his emotional reactions. These reactions appeared mainly in response to situations that he considered minimal or negligible, but which caused intense outbursts of anger in him.

In his description of symptoms, there was also a tendency to impulsive behaviour, which was not always adequate to the circumstances. Outbursts of anger often appeared in social or work situations, which were connected with the perception of criticism or misunderstanding from colleagues, close friends or family. The patient stated that these episodes of anger usually lead to later remorse, feelings of guilt and reconsideration of his behaviour. To regulate anger and escape from interpersonal problems, he occasionally sought alcohol, which, according to him, dulled his emotions. Later, however, he started to solve many situations through self-pity and attacks on others through social networks.

The patient describes frequent fear without a present stimulus. He describes that he sometimes feels as if in a dream, as if the surroundings were not real. This causes him problems in thinking and functioning. According to his words, people around him like him, but some close people recommended that he seek professional psychiatric help because of his emotional fluctuations.

Family history

Patient: age – 28 years, sex – male, second-born, marital status – single, lives in his own household, education – completed second level of university education, Master's degree, field: Management, socio-economic status: upper middle class, works full-time as an HR assistant in a corporation.

Mother: age – 61 years, marital status – in a relationship, completed secondary vocational education with school-leaving examination, works full-time as an assistant in a company.

Father: age – 63 years, marital status – in a relationship, completed secondary vocational education with school-leaving examination, works full-time as a receptionist. Head of the family.

Siblings – older brother, 30 years old, first-born, marital status – single, lives in his own household outside the territory of the Slovak Republic, completed secondary vocational education with school-leaving examination, works as an operations manager.

Family environment during childhood and adolescence – complete, harmonious, style of upbringing – liberal-directive. Wider family – no knowledge of mental disorders in the family and hospitalizations in psychiatric facilities, no knowledge of social abnormalities.

Personal history

Mother's pregnancy and delivery – calm, early psychomotor development within the norm. At the age of 16, the patient had an accident on a bicycle, when he was hit by a car, with concussion and a broken finger on the right hand – index finger. He describes this event as traumatic, and to this day he does not have a driving licence. The patient does not use any medication, does not report intolerances or allergies. Legal and illegal psychotropic substances – he smokes an electronic cigarette, occasionally uses alcohol, approximately once every two weeks. He does not use illegal psychotropic substances.

Social history

During adolescence, the patient had problems with creating his own identity. In adolescence, he often felt emotionally abandoned and had fluctuations in his goals and preferences. He focused on changes in appearance and behaviour in order to try to fit into various social groups. At primary and secondary school, in a group of people he knew, he felt

dominant and self-confident. In the case of other social groups, he was quiet, shy and closed. This changed after completing university studies.

Experience with school – primary school caused stress and tension in the patient, he did not feel comfortable. In the mornings he often had outbursts of anger and signs of anxiety. Regular vomiting was present during the first year of primary school. His average grades were twos. According to his words, he did not excel in any subject, but he also did not significantly fall behind. At secondary school, his results were excellent, which he described as being due to his interest in the field he had chosen. In school groups he was popular, but according to his words, members of other class groups gossiped about him.

Previous serious life events – he does not report learning difficulties, behavioural problems were absent. At school he was praised several times for exemplary behaviour. Employment – adequate to education, he does not report changes or fluctuation of employment. After completing university studies, he was never unemployed. The patient reports problematic relationships in the work team, with frequent outbursts of anger. This also appears in the company of friends. He describes that he is emotionally unstable. The patient's moods have a frequent, short-term alternating tendency. He causes conflicts, which he later regrets.

Sexual life – he had partners of both sexes. Physiological functions – sleep problems, many thoughts, loss of appetite. Height 185 cm, weight 75 kg – weight loss of 5 kg. Interests – literature, free time, watching series.

Conclusion

The patient shows clinical signs that indicate the presence of borderline personality disorder, anxiety and derealization. After psychiatric examination, pharmacotherapy was indicated, including the antidepressant Paretin (paroxetine), in the dose of one tablet in the morning, with the aim of stabilizing mood and reducing anxiety symptoms. In addition, Lexaurin (bromazepam), a benzodiazepine, was prescribed. It will be used as needed for managing acute anxiety states and tension.

In addition to pharmacotherapy, regular psychotherapy is recommended, specifically dialectical behaviour therapy, which is effective in the treatment of BPD. The patient will be followed regularly every month in order to evaluate progress and adjust therapeutic procedures as needed. Family support and improvement of his interpersonal relationships are also essential within the whole therapeutic approach.

Recommendations for Practice

In the diagnosis and treatment of BPD, it is necessary to approach the patient comprehensively and to involve a multidisciplinary team of specialists. BPD affects various aspects of the individual's life, including emotional regulation, interpersonal relationships and behaviour. This requires professional help from several areas. Therefore, it is important that psychiatrists, psychologists, therapists, social workers and, if needed, also family therapists take part in treatment. Such a team approach allows all dimensions of the disorder to be covered, from diagnosis to concrete therapy. This significantly increases the chance of long-term success.

Pharmacotherapy is an important tool in the treatment of BPD, especially when accompanying symptoms such as depression, anxiety or impulsive behaviour are present. Medicines may help stabilize mood and reduce the intensity of some symptoms. However, they are not sufficient by themselves for solving the basic problems connected with this disorder. Therefore, pharmacotherapy is only a supportive tool, which should be combined with psychotherapeutic methods. These methods allow the patient to process his feelings, thoughts and behaviour more effectively.

Psychotherapy has the main role in the treatment of BPD. Methods such as dialectical behaviour therapy (DBT) and cognitive-behavioural therapy (CBT) are considered the most effective therapeutic approaches. DBT is focused on developing the ability to regulate emotions, improve interpersonal relationships and manage impulsive behaviour. This is important for patients with BPD. These therapeutic techniques allow the patient to better understand his reactions, develop more effective coping mechanisms and achieve lasting changes in behaviour.

A multidisciplinary approach therefore ensures that the patient receives complex care. This care is not focused only on symptoms, but also on deeper causes of the disorder and on improvement of his overall functioning. Involvement of various specialists increases the chances of improving the patient's quality of life and his ability to function in everyday situations. This is necessary for successful treatment of borderline personality disorder.

Among the recommendations we would include the following aspects, which may help patients with BPD:

1. **Importance of early diagnosis and intervention programs:** early diagnosis of BPD is necessary for effective introduction of treatment. The sooner the disorder is identified, the greater the chance of successful management of symptoms and prevention of long-term negative consequences. Intervention programs that start in

early stages may significantly improve the patient's quality of life and reduce the risk of development of more serious problems in the future.

2. **Support of family and close persons:** for patients with BPD, it is important that their family members and close persons also participate in the treatment process. Family therapy may improve relationships in the family, which has a direct influence on the overall mental health of the patient. Education of the family about the characteristics of BPD and providing tools for better communication with the patient may significantly reduce stress and tension in the household. This improves treatment results.

3. **Emphasis on relapse prevention:** treatment of BPD is not a one-time but a long-term process. It requires continuous work of the patient and professionals. Relapse prevention is an important part of treatment, because symptoms of BPD may be cyclical during the patient's life. Continuation of therapy after stabilization, participation in support groups or community programs and continuous monitoring of the condition are important for maintaining progress and prevention of return of symptoms.

4. **Adaptation of treatment to individual needs:** every patient with BPD is unique. Therefore, it is necessary that the treatment plan is adapted to individual needs. Taking into account the patient's personal experiences, life history, current problems and treatment goals ensures that treatment will be as effective as possible. Professionals should be flexible and willing to adjust therapeutic approaches according to how the patient reacts to treatment.

5. **Connection with other mental disorders:** BPD often occurs in combination with other mental disorders, such as depression, anxiety disorders, addictions or eating disorders. In treatment, it is important to take these comorbidities, that is, coexisting disorders, into account, because they influence the whole treatment plan. Joint management of several disorders may require specific therapeutic approaches and coordination among different professionals.

6. **Long-term support and maintaining the patient's motivation:** successful treatment of BPD often requires maintaining long-term motivation of the patient. Patients with BPD may have problems with maintaining stable functioning, especially when periods

of strong emotional disturbance occur. Providing support, encouragement and monitoring of progress are important for long-term success of treatment.

Conclusion

Dealing with personality disorders is important for improving the overall quality of life of individuals who encounter them, as well as for society as a whole. Personality disorders, including borderline personality disorder (BPD), have a significant influence on emotional, interpersonal and professional functioning of an individual, and this in different phases of life. Persons suffering from this disorder face constant challenges in regulation of their emotions, perception of themselves and others. This may lead to serious problems in personal relationships, work area and overall quality of life. Therefore, it is necessary to deal with diagnosis and treatment of personality disorders not only from the point of view of reducing symptoms, but also from the point of view of prevention and early intervention.

In BPD, it is important not to neglect professional psychiatric or psychological examination, because early diagnosis allows effective introduction of treatment measures. Psychiatric and psychological examinations provide important information that helps determine an adequate treatment plan and prevent possible complications connected with untreated or incorrectly treated disorder. It is important that people do not avoid professional examination, because the sooner BPD is diagnosed, the greater the probability of stabilization of the condition and achievement of long-term improvement.

It is necessary to emphasize that pharmacotherapy is not the only solution in the treatment of BPD. Medicines may be effective in managing accompanying symptoms, such as depression, anxiety or impulsive behaviour, but by themselves they are not sufficient for the overall treatment of personality disorder. Pharmacotherapy should be combined with psychotherapeutic approaches, such as dialectical behaviour therapy (DBT) or cognitive-behavioural therapy (CBT). These provide patients with tools for change of maladaptive patterns of behaviour and better management of emotions. Therapy should be adapted to individual needs of the patient and should be part of a long-term treatment process.

It is necessary to realize that treatment of BPD should not mean only reduction of symptoms, but also restoration of the individual’s ability to lead a functional and balanced life. Although treatment may be demanding and requires patience and involvement from the patient, professionals and family, there is still a real possibility to improve the quality of life of patients with BPD. The basis is a complex approach, which includes a combination of pharmacotherapy, psychotherapy, support from professionals, family and community

environment. With sufficient support and a correct treatment plan, patients with BPD may achieve significant improvement and live a full life.

Ultimately, it is important to emphasize that despite the complexity and challenges connected with BPD, the possibility of its solution and improvement of the condition of patients is real. Early intervention, correct diagnosis and an approach oriented to the individual may significantly improve prognosis and life well-being of patients. Treatment of borderline personality disorder is not only about elimination of symptoms, but about creating a path to greater stability and happiness in the life of the individual.

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Notes about the authors

Erich Schlesinger, PhDr., PhD., MSc., Department of Social Development and Labour, Faculty of National Economy, University of Economics in Bratislava. Research interests: psychology, psychiatry, management, social work, social policy, human resource development, and labour market economics and policy. Recent publications: Generation Gold (2026), Recruitment and Selection Practices (2026), Balancing Act (2025), Citizen Scientists in Space (2025).

György Pál, PÁPAY, doc. PaedDr. JUDr. PhDr., PhD., Wyższa Szkoła Biznesu – National Louis University w Nowym Sączu. Research interests: social work, politics, law, theology, psychology, and interdisciplinary approaches. Recent publications: „Determinants of Organizational Agility in Social Work in the Light of Own Research", „Fundamentals of Law for Psychologists". Contact: gpapay@wsb-nlu.edu.pl

Krzysztof Brocławik, PhD is a faculty member at WSB-NLU in Nowy Sącz, Poland. His academic and professional interests include small group and team dynamics, creative thinking and problem-solving techniques, organizational communication, team development, and leadership. He holds a Management Trainer Certificate from the U.S. Office of Personnel Management, as well as certificates in Counselling and Assessment and Training and Development awarded by Thames Valley University, London. Krzysztof Brocławik specializes in trainer development and in assessing and developing the potential of candidates for managerial and specialist positions. He is a strong advocate of active learning approaches, particularly the case study method, which he has extensively applied in management education. His work is inspired by the ideas of Kurt Lewin and by a commitment to fostering student learning and development. Contact: +48 605 441 288.