A GUIDE FOR FAMILY & LOVED ONES

Borderline Personality Disorder / EUPD

Understanding emotional intensity, relationships and crises; supporting recovery without losing yourself; and building safer, more sustainable family support.

Language matters

Borderline Personality Disorder (BPD) is also called Emotionally Unstable Personality Disorder (EUPD) in some UK services. Many people find one or both labels stigmatising. A diagnosis describes a pattern of difficulties; it does not define character, worth or intent. This guide uses BPD/EUPD for recognisability while keeping the person, their history and individual formulation at the centre.

What BPD/EUPD can involve

People given this diagnosis may experience emotions with unusual intensity and speed. Fear, shame, anger, grief or rejection can feel overwhelming before there is time to think through what is happening. Returning to emotional baseline may take longer. The person may understand later that their reaction was larger than the situation, while in the moment the threat or loss can feel completely real.

Common difficulties can include intense fear of abandonment, unstable or highly charged relationships, rapidly shifting views of self or others, uncertainty about identity, impulsive behaviour, self-harm, suicidal thoughts or behaviour, intense anger, chronic emptiness, and brief stress-related paranoia or dissociation. Not everybody has every feature, and the same outward behaviour can have very different meanings for different people.

Emotional dysregulation: what may be happening underneath

Emotional dysregulation does not mean somebody is choosing to be dramatic. A relatively small cue - a delayed reply, changed tone of voice, cancelled plan or facial expression - may trigger a powerful threat response. Once arousal is high, reflective thinking becomes harder. The person may desperately seek closeness, demand reassurance, withdraw, become angry or act impulsively.

Families can help by separating the emotion from the behaviour. The emotion may deserve validation even when the behaviour needs a limit. 'I can see that you feel abandoned and terrified' can sit alongside 'I will not stay in the room while I am being threatened.' Validation is not agreement, permission or surrender.

Fear of abandonment and attachment

Some people become acutely sensitive to signs that an important person may leave. Ordinary separations can feel dangerous. Reassurance may bring short relief but can become impossible to satisfy if the underlying fear remains. A partner may feel pressured to answer immediately, cancel plans, prove love repeatedly or avoid mentioning normal independence.

Predictability can help more than endless reassurance. Be clear about when you will return, what contact is realistic, and what happens if plans change. Avoid threatening to leave during every argument if you do not mean it. At the same time, loved ones need freedom to work, sleep, see friends and have private time. Secure connection is not the same as permanent availability.

Black-and-white thinking and rapid relationship shifts

Under intense stress, a person may struggle to hold mixed truths at once: 'You love me and you are angry with me'; 'you made a mistake and you still care'; 'I feel rejected and I am not actually being abandoned.' Someone can seem idealised one day and experienced as uncaring or dangerous the next. This is sometimes described as splitting, but the term should not be used as an insult.

Do not respond by trying to prove that the person is irrational. Slow the conversation and reintroduce complexity: 'I hear that right now it feels as though I do not care. I am angry about what happened and I still care about you.' Holding two truths can model the middle ground that intense emotion temporarily makes difficult to access.

Identity, emptiness and shame

Some people describe not knowing who they are, changing goals or self-image rapidly, or feeling empty when not connected to another person. Shame can become severe after an argument, impulsive act or self-harm episode. Families may see a rapid move from anger at others to hatred of self. Avoid using shame as a behaviour-management tool; humiliation rarely creates emotional regulation.

Impulsivity

Impulsive behaviour can involve spending, substances, sex, eating, driving or sudden decisions. It may function as escape from unbearable emotion, an attempt to feel something when numb, or a rapid response before consequences can be considered. Understanding function does not remove consequences. Support can include slowing decisions, using agreed delay strategies and accessing appropriate treatment.

Self-harm: understand the function without normalising the risk

Self-harm can serve different functions: reducing emotional intensity, interrupting numbness or dissociation, expressing distress, self-punishment, or regaining a sense of control. It should not automatically be dismissed as 'attention seeking'. If somebody needs attention because they are in severe distress, that need still deserves a safe response.

Families should not become responsible for physically preventing every episode. Ask what the person's professional safety plan says, encourage clinical support, and respond to injuries appropriately. If there is serious injury, suicidal intent or immediate danger, seek urgent or emergency help.

A key family principle

Take **every statement about self-harm or suicide seriously** without making one family member the sole crisis service. Calmly assess immediate safety, follow the person's care or crisis plan where available, involve professionals when needed, and do not promise to keep dangerous information secret.

Suicidal thoughts, threats and crises

Suicidal thoughts can occur during overwhelming distress and must be taken seriously. Ask directly rather than avoiding the subject: 'Are you thinking about ending your life?' 'Have you made a plan?' 'Do you have access to what you would use?' Asking does not plant the idea. If risk appears immediate or serious, involve emergency or urgent mental-health services.

Sometimes a suicidal statement occurs during conflict or when a loved one is trying to leave the room, go to work or maintain a boundary. The safest response is neither to dismiss it as manipulation nor to surrender every boundary in order to stop the threat. Treat the risk as real and transfer the risk to appropriate professional support: 'I care about you and I take what you are saying seriously. I cannot be the only person responsible for keeping you safe, so I am getting help.'

This protects both people. If every boundary is withdrawn whenever suicide is mentioned, the relationship can become organised around crisis. If every statement is dismissed because it happened during an argument, genuine danger may be missed. Safety and boundaries need to exist together.

Anger and escalation

Intense anger may come from fear, shame, perceived rejection or feeling invalidated. Once arousal is very high, complex problem-solving is unlikely to work. Keep sentences short, lower your own volume and avoid following the person from room to room. If safe, agree to return to the issue after a defined cooling-off period.

Validation can sound like: 'I understand why that felt rejecting' rather than 'You are right, I deliberately rejected you.' If insults, threats or aggression begin, move from emotional processing to boundaries and safety. Nobody is required to remain in an unsafe conversation in order to prove that they care.

Dissociation and stress-related paranoia

During severe stress, some people experience depersonalisation, derealisation, memory gaps or transient suspiciousness. The person may seem suddenly distant, confused or convinced that others have hostile intentions. Reduce stimulation, orient gently to the present, avoid rapid confrontation and follow any grounding plan developed in treatment.

Communication that tends to help

Use clear, literal language. Say what you mean rather than testing whether the person will guess. Give advance notice of changes when possible. Validate the emotion before moving to problem-solving. Offer limited choices rather than unlimited negotiation during crisis. Keep promises realistic; repeated promises you cannot keep may increase mistrust.

Try: 'I can hear how hurt you are. I want to understand, and I can do that better when we are both calmer.' Or: 'I am not ending this relationship because we disagree. I am taking thirty minutes away from this argument and I will come back at 7.30.' Predictable return can reduce abandonment fear while preserving a necessary pause.

What often makes things worse

Mocking the diagnosis, calling the person manipulative or attention seeking, deliberately withdrawing affection to teach a lesson, threatening abandonment during every conflict, repeatedly changing boundaries, arguing about whether their emotion is justified, or trying to conduct therapy during a crisis can intensify shame and threat.

Families can also worsen the cycle through over-accommodation: answering hundreds of messages, abandoning all personal plans, providing endless reassurance or hiding every consequence. Compassion without limits can gradually become an unsustainable system.

Partners: love, intimacy and walking on eggshells

Partners may become hyper-alert to tone, timing and wording because previous disagreements escalated rapidly. They may stop raising legitimate concerns because they fear self-harm, anger or abandonment panic. This 'walking on eggshells' can create resentment and emotional distance.

A healthier relationship needs room for both people to have feelings, preferences and boundaries. The person with BPD/EUPD should not be reduced to a diagnosis, and the partner should not be reduced to a regulator. Couples work can sometimes help when both people can participate safely, but it is not appropriate as a substitute for individual risk management or where abuse is present.

Parents, siblings, friends and adult children

Parents may feel guilt and repeatedly ask what they did wrong. Siblings can feel invisible if family life revolves around crises. Friends may feel pulled between closeness and exhaustion. Adult children can become parentified, believing they must keep a parent emotionally stable. Each relationship needs its own boundaries and support.

Children should never be asked to monitor an adult's self-harm risk, medication or emotional state. Give age-appropriate explanations, protect routines and ensure another dependable adult is available when a parent's difficulties are severe.

Professional assessment and treatment

Assessment should explore the person's difficulties over time, relationships, emotional regulation, impulsivity, self-harm and suicide risk, trauma where relevant, dissociation, mood symptoms, neurodevelopmental differences, substance use, physical health and other possible diagnoses. Overlap with ADHD, autism, bipolar disorder, PTSD or complex trauma can complicate formulation, so careful assessment matters.

The diagnosis should not be used to deny care. People with BPD/EUPD can recover and should have access to evidence-informed psychological treatment. In the UK, NICE guidance emphasises structured psychological treatment and careful crisis planning. Treatment should be collaborative and based on individual needs rather than stigma.

DBT and other psychological approaches

Dialectical Behaviour Therapy (DBT) was developed for people with chronic suicidality and borderline personality difficulties. It teaches skills in mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness while balancing acceptance with change. Mentalisation-based therapy and other structured approaches may also be used in specialist services.

Families do not need to become DBT coaches unless this is explicitly part of a treatment programme. It is more useful to understand the principles: emotions make sense in context; behaviour still has consequences; skills can be learned; crises can be survived; and two apparently opposite truths can coexist.

Medication

There is no medication that specifically treats the core pattern of BPD/EUPD in the way medication may target some other conditions. Medicines may be prescribed for co-occurring problems or short-term clinical needs, depending on individual assessment. Medication decisions belong with qualified prescribers; families should not alter doses or use medication as a way to control behaviour.

What recovery can look like

Recovery can include fewer crises, reduced self-harm, greater ability to pause before acting, recognising emotions earlier, more stable relationships, tolerating separation without catastrophe, a stronger sense of identity, better occupational functioning and an increased ability to repair conflict. Progress is rarely perfectly linear.

People can and do improve substantially. A diagnosis should not be presented as a life sentence. Hope is important, but so is realistic skill-building, consistent treatment and a support system that does not depend on one exhausted relative.

After a crisis: repair rather than pretending

Once everyone is calm, review what happened. What was the trigger? What did the person fear? What behaviour followed? What helped? What crossed a boundary? What needs an apology, restitution or different plan? Repair is not about forcing shame; it is about acknowledging impact and learning from the episode.

A supporter can say: 'I understand you were overwhelmed, and being called those names hurt me. I want us to work out what we both do differently next time.' The person can be held accountable without being defined as bad.

A dialectical family stance

Try to hold both sides: **'Your distress is real AND this behaviour cannot continue.' 'I love you AND I need time away.' 'Your history helps me understand AND I still need safety.' 'You can need support AND build more independence.'**

Safeguarding yourself as a supporter

Repeated crises can consume family life. Supporters may sleep with their phone beside them, cancel work, stop seeing friends, monitor social media, hide sharp objects, lend money, answer messages through the night or believe that saying no could cause a catastrophe. Over time, the supporter's own nervous system can remain permanently activated.

Your wellbeing is not a lesser priority. A sustainable support system distributes responsibility across the person, professionals, crisis plans and a wider network. One partner or parent cannot safely become therapist, crisis team, financial protector and sole reason for staying alive.

Boundaries are not abandonment

Good boundaries are specific and behavioural. 'I will answer one call after 11 pm unless it is an emergency.' 'I will not lend money I cannot afford to lose.' 'If you threaten me, I will leave and seek help.' 'I can listen for twenty minutes, then I need to sleep.' 'I will not keep suicidal intent secret.' 'I will

come back to this conversation at the time we agreed.'

Consistency matters. A boundary that changes according to guilt, shouting or threats becomes difficult for everyone to trust. If you cannot maintain a proposed boundary, make it smaller and realistic rather than repeatedly stating limits you do not keep.

Support versus rescue

Support says, 'I will sit beside you while you use your plan.' Rescue says, 'I must make the feeling stop.' Support encourages skills, treatment and autonomy. Rescue repeatedly removes consequences, makes every appointment, abandons all personal plans or accepts unsafe behaviour because the supporter fears what might happen if they do not.

The goal is not emotional coldness. Warmth, validation and practical help can be generous while still leaving the person responsible for practising skills and engaging with treatment.

When you feel manipulated or controlled

Supporters sometimes use the word manipulation when they feel pressured by threats, repeated crises or rapidly changing demands. Rather than arguing about intent, describe the interaction: 'When I say I am going to work and you say you will harm yourself if I leave, I feel trapped and frightened.' Then respond to the safety issue and maintain the appropriate boundary.

Some behaviours may function to prevent abandonment without being a calculated plan to control somebody. Understanding that function can increase compassion. It does not mean the supporter must comply with coercive behaviour.

Physical, emotional, sexual and financial safety

A diagnosis does not make someone inherently abusive or dangerous. Many people with BPD/EUPD are more likely to harm themselves than others. Nevertheless, if there are actual threats, violence, coercive control, sexual boundary violations, stalking, property destruction or financial exploitation, treat those behaviours seriously and seek appropriate support.

Protect personal accounts and credit. Do not repeatedly take on debt because you feel responsible for repairing impulsive decisions. If children or vulnerable adults are exposed to frightening behaviour, their safety and emotional welfare must be considered.

Carer fatigue and burnout

Signs include poor sleep, dread when messages arrive, irritability, resentment, losing concentration at work, feeling guilty when you enjoy yourself, abandoning friendships, constantly checking whether the person is safe, or feeling that your own emotions no longer have space. Burnout can make even compassionate people become numb or reactive.

Supporter wellbeing check-in

Ask yourself: **Am I safe? Am I sleeping? Do I have time that belongs to me? Can I disagree without fearing a crisis? Are my finances protected? Do I have someone I can tell the full truth to? Are children affected? Have I become the only crisis plan? What responsibility needs to move to professionals or back to the person?**

Getting support for yourself

Your own counselling, family work, carers' support, peer groups and trusted friends can help you process fear, grief, anger and guilt. You do not need to use your sessions to analyse the other person. Your experience deserves its own space.

Urgent and emergency help

Seek urgent professional help for serious self-harm, suicidal intent, a specific suicide plan, inability to remain safe, severe dissociation or psychotic symptoms, dangerous intoxication, or another immediate risk. If there is immediate danger to life, call 999 or attend A&E.; NHS 111 can provide urgent health advice. Follow an existing crisis-team or care plan where available. Samaritans can be contacted on 116 123 in the UK and ROI.

Do not place yourself in physical danger while attempting to manage a crisis. Involving emergency or professional services when the risk exceeds what family support can safely hold is not abandonment.

Practical family coaching tools

1. Trigger-to-response map. What happened? What did the person fear it meant? Which emotion appeared? What urge followed? What behaviour happened? What was the short-term result? What was the longer-term cost? Where could a skill, pause or boundary be inserted next time?

2. Validation practice. Separate validation from agreement. Write three versions: 'It makes sense that you felt hurt when the plan changed.' 'I understand that you feared I was leaving.' 'I can see how intense the anger became.' Then add the boundary or next step without using the word 'but'.

3. Crisis communication plan. Helpful words: _____. Unhelpful words: _____. Touch: yes / ask / no. Time-out length: _____. Reconnection time: _____. Professional contact: _____. What counts as an emergency: _____. What the supporter does if threatened: _____.

4. Relationship repair. What impact did the crisis have on each person? What needs acknowledging? Is an apology, repayment or practical repair needed? Which part was understandable in context? Which behaviour still needs to change? What would rebuild trust by 5%?

5. Boundary plan. I can... / I cannot... / My protected time is... / I will not keep secret... / If self-harm is threatened I will... / If I am unsafe I will... / My financial boundary is... / The responsibility that belongs to professionals is...

6. Supporter recovery plan. What have repeated crises cost me in sleep, work, friendships, health, money or confidence? Which part of my life needs rebuilding? What signs tell me I am becoming hypervigilant? Who supports me? What can I stop doing because it is not actually my responsibility?

Common myths worth challenging

'People with BPD are manipulative.' This stereotype is harmful and oversimplifies behaviour that may arise from intense fear, dysregulation or learned survival strategies. Harmful behaviour can still be named and bounded. **'They cannot recover.'** Many people improve substantially with time and appropriate treatment. **'Every emotion is an overreaction.'** Emotions can be understandable even when their intensity or behavioural expression creates problems. **'Validation means agreeing.'** It does not. **'Families must prevent every crisis.'** They cannot and should not be the sole safety system.

Recommended reading

Borderline Personality Disorder: A Guide for the Newly Diagnosed - Alexander L. Chapman and Kim L. Gratz offers accessible information and skills. **The Dialectical Behavior Therapy Skills Workbook** - Matthew McKay, Jeffrey C. Wood and Jeffrey Brantley provides practical DBT-informed exercises; it is not a substitute for individual therapy. **Loving Someone with Borderline Personality Disorder** - Shari Y. Manning focuses on validation and family relationships. Books should be used critically and alongside current clinical guidance.

UK information and clinical sources

Useful UK starting points include NHS information on personality disorders, NICE guideline CG78 on borderline personality disorder recognition and management, and Mind information on borderline personality disorder. Local NHS community mental-health, crisis and specialist personality-disorder services vary by area. Service details should be checked periodically.

Clinical note

This resource is educational, not diagnostic, and does not replace individual medical, psychological or psychiatric advice. Self-harm and suicidal thoughts require individual risk assessment. BPD/EUPD can overlap with trauma-related, mood and neurodevelopmental presentations; careful professional assessment matters.

A message from Maggie

When you love someone whose emotions can move from closeness to fear, anger or despair very quickly, it can be difficult to know whether to move closer, step away, reassure, challenge or say nothing at all. You may become so focused on preventing the next crisis that you stop noticing how much of your own life has disappeared.

I want this guide to help you see the person underneath the diagnosis. Intense reactions often make more sense when we understand the fear, shame, attachment needs or overwhelm underneath them. Understanding can soften judgement. It can help us respond with more care and less fear.

But understanding must include you as well. You are allowed to have needs. You are allowed to sleep, work, see friends and disagree. You are allowed to say that something hurt you. You are allowed to leave an unsafe room, protect your money and involve professionals when somebody's safety is beyond what you can hold.

You do not have to choose between compassion and boundaries. Often the healthiest support contains both. 'I love you and I will not accept being threatened.' 'I believe your pain is real and I cannot be your only crisis plan.' 'I am staying in this relationship and I still need time that belongs to me.'

Recovery is possible. Relationships can become steadier. Skills can be learned. Crises can become less frequent and less powerful. My hope is that nobody in the family has to disappear in order for somebody else to feel safe. Both people matter, and sustainable support should make room for both lives.

Maggie Learoyd
Space to Breathe Therapy

Final coaching question

What would change if your family stopped asking **'How do we prevent every difficult emotion?'** and started asking **'How do we respond safely, consistently and compassionately while helping everyone keep a life of their own?'**