Borderline Personality or Complex Posttraumatic Stress Disorder? An Update on the Controversy

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There remains controversy surrounding the nature of the relationship between borderline personality disorder and posttraumatic stress disorder, with strong arguments that it would be more accurate and less stigmatizing for the former to be considered a trauma spectrum disorder. This article reviews the major criticisms of the DSM-IV diagnosis of borderline personality disorder that have fueled this controversy, including the absence of an etiology for the disorder, which is widely believed to be associated with early traumatic experiences. Also reviewed are recent attempts to redefine the disorder as a trauma spectrum variant based on the apparent overlap in symptomatology, rates of diagnostic comorbidity, and the prevalence of early trauma in individuals with a borderline diagnosis. The conceptual and theoretical problems for these reformulations are discussed, with particular reference to discrepancies in theoretical orientation, confusion of risk with causation, and the different foci of interventions for borderline personality disorder and posttraumatic stress disorder. (Harv Rev Psychiatry 2009;17:322–328.)

Keywords: **borderline personality disorder, diagnosis, DSM-IV, etiology, posttraumatic stress disorder, trauma**

The term *borderline personality disorder* (BPD) continues to be controversial. Since the disorder is conceptually and phenomenologically similar to posttraumatic stress disorder (PTSD), a term such as *complex PTSD* would, it is argued, be both more accurate and less stigmatizing.[1–4] Although officially introduced as a diagnostic entity only in 1980 with the third edition of the *Diagnostic and Statistical Manual of Mental Disorders*,[5] the history of the term *borderline* is extensive and controversial.[6,7] Originating in a psychological context with Adolf Stern in 1938,[8] *borderline* was generally applied to patients who exhibited features of mental instability but seemed to defy the standard psychotic or neurotic categories, thus placing them, as Stern suggested "on the border line between neurosis and psychosis." For the next few decades, the notion of borderline was predominantly dealt with in the psychoanalytic literature,[6] in which the term was used to describe a distinct cluster of individuals who exhibited features such as poor impulse control, poor frustration tolerance, problems with identity, inappropriate aggression, and unstable emotions.[7]

It was the works of Kernberg,[9] however, and his psychodynamic concept of borderline personality organization (BPO) that generated what proved to be widespread interest in the borderline concept as a personality dysfunction. According to Kernberg,[9] BPO is best characterized by identity diffusion (i.e., lack of coherent concept of self and others)—a process theorized to derive from the lack of integration between early positive and negative object relations experiences.[10] The role of trauma in the genesis of this lack of integration was acknowledged from the outset. It should be noted that BPO is not synonymous with BPD as represented in the DSM. Indeed, while BPO is theorized to represent the common assumptions underlying the DSM

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personality disorders,[11] BPD is one among many disorders that can derive from the impairment of the three core internal psychological processes of BPO—namely, identity diffusion, primitive defenses, and intact reality testing.

Unlike PTSD, BPD has undergone relatively little modification since it was first introduced in DSM-III. Originally diagnosed according to eight specific criteria, current conceptualizations[12,13] have remained relatively stable except for the addition of a ninth criterion (transient stress-related paranoia), the removal of intolerance for aloneness, and a few structural and wording refinements. As defined in the text revision of DSM-IV, BPD is a persistent and highly disabling mental disorder that is characterized by patterns of unstable relationships, self-image, affect, and marked impulsiveness. It is also associated with marked distress and impairment in social and occupational functioning.[13]

Another DSM disorder that has generated considerable controversy is PTSD. The modern conception of PTSD appeared in 1980 with DSM-III.[5] Originally developed as an attempt to capture the symptoms experienced by Vietnam veterans (although its origins derive from "shell shock" in World War 1), the DSM-IV PTSD diagnosis has been subject to substantial alteration and permutation,[14] the most significant being related to the nature and definition of the stressor (DSM criterion A), with current versions broadening the boundaries on what constitutes a qualifying stressor. These developments in the PTSD construct, however, have also been subject to considerable criticism and controversy.[15] One of the most significant controversies is whether PTSD should be included in the DSM at all, with some prominent authors arguing that the disorder may be, in part, socially constructed.[16] Others however, have declared the DSM conception of PTSD to be a useful diagnostic construct, whose applicability can extend to various populations beyond that from which it was derived.[17]

BPD as defined in the DSM has been referred to as a nebulous diagnostic category,[4] and despite an exponential growth in research, it remains among the most controversial. Such controversies are based on its extensive symptom overlap with other mental disorders,[18] the heterogeneity of individuals receiving the diagnosis,[19] and the lack of support in the literature regarding the reliability and validity of BPD as a diagnostic entity.[20] The primary criticism of the BPD criteria, however, is the absence of reference to the etiological cause of the disorder, widely believed to be associated with early traumatic experiences.[3,21] In response to these criticisms, various theories have been proposed in the attempt to better classify this apparently poorly understood construct, with some suggesting that BPD should be classified as falling with one particular disorder spectrum or another—for example, a schizophrenia spectrum disorder,[22] an impulse spectrum disorder,[23] or an affective illness disorder.[24] To date, such attempts at reclassification have not greatly enhanced the etiological and theoretical understanding of the disorder.[1] Of most influence have been attempts to reclassify BPD as a trauma spectrum disorder or as complex PTSD.[1,25] The latter has gained more momentum than any other in the personality disorders literature. This body of research postulates that the successful reclassification of BPD as a variant of trauma disorder may not only offer etiological insight, but also inform appropriate treatment interventions.

Trauma and PTSD History in BPD

The literature on the association between a history of childhood trauma and the diagnosis of BPD is vast, though at times inconclusive. Many studies report a high incidence of child abuse in BPD patients, with some reporting as many as 81% to 91% of BPD individuals having suffered some form of childhood abuse or neglect—most notably, childhood sexual abuse.[3,26] Further, the rate of comorbid PTSD in individuals with BPD is particularly high, with studies reporting up to 58% of BPD individuals also meeting PTSD criteria, a proportion well above the 10% reported in the general population.[27] In our own Illawarra Affect Regulation Clinic for Borderline Personality Disorder, a chart review from 2004 to 2008 revealed that for every 100 BPD clients attending, 81 had a known history of significant childhood trauma (including sexual, physical, or emotional abuse, and neglect or abandonment). Moreover, using the Structured Clinical Interviews for DSM-IV Axis I and II disorders,[28] 52 out of 100 met criteria for comorbid Axis I PTSD.

Strong associations exhibited by correlational data, such as that presented above, has fueled the complex PTSD movement[25] and have led some prominent researchers to suggest that childhood trauma is the etiological determinant of BPD.[3] Proponents of this approach further argue that these associations may offer a plausible explanation for the overwhelming predominance of BPD in women,[29] with Herman and van der Kolk[25] positing that in view of the greater vulnerability of girls to abuse, particularly sexual, in childhood,[30] the observed gender difference[31] in BPD makes sense.

Complex PTSD: The Phenomenological Overlap with BPD Symptomatology

Complex PTSD refers to the occurrence of PTSD features in addition to a broad spectrum of psychopathology not captured by the DSM criteria for PTSD,[32] including, though not limited to, the impairment of a coherent sense of self, dissociation, unstable relationships, and self-injurious behaviors.[2] Although not formally recognized as a distinct

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psychiatric disorder, the complex PTSD symptom constellation described in the relevant literature has been incorporated into the DSM-IV-TR nomenclature under the associated features of PTSD.[33]

In addition to the prevalence of trauma and PTSD comorbidity rates, the phenomenological and conceptual overlap of BPD and PTSD has also raised questions about the relationship between these disorders.[1] Herman and van der Kolk[25] further observed that in both disorders, there appear to be similar disturbances in five core domains: affect regulation, impulse control, reality testing, interpersonal relationships, and self-integration. Further, specific symptoms within these core domains appear to be similar for both BPD and PTSD. In terms of affect regulation, disturbances such as depression, intense anger, irritability, and chronic emptiness are all features commonly observed in both disorders. Similarly, symptoms specific to problems in impulse control (e.g., substance abuse and self-destructive behaviors), reality testing (e.g., paranoid ideation and dissociation), interpersonal relationships (e.g., intense attachment and withdrawal), and self-integration (e.g., identity diffusion and sense of inner badness) are also common to both BPD and PTSD.[25]

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Problems with the Reformulation of BPD as Complex PTSD

Some have criticized Herman and van der Kolk's proposition as too simplistic, pointing to the lack of conclusive evidence behind the purported link between BPD and trauma.[34] In particular, the most frequently observed and obvious criticism of the complex PTSD movement is that it confuses risk with causation—namely, that the existence of a risk factor (trauma) is not necessary or sufficient to explain the genesis of the disorder. First, not all individuals with BPD have a history of childhood trauma, and not all individuals with this history go on to develop BPD. Indeed, while 81 to 91% of individuals with BPD have a history of childhood trauma,[25] the remaining 9% to 19% with the diagnosis have no such known history. Further, in their comprehensive meta-analysis of 21 studies on the relationship between BPD and childhood sexual abuse, Fossati and colleagues[35] reported only a small to moderate effect size for the association between childhood sexual abuse and the later development of BPD. Based on these data, Herman and van der Kolk[25] may have taken risk factors (trauma, in this case) to be actually causal in the development of psychopathology, despite studies that show the link between the two is not straightforward. Clinical and community studies of childhood trauma have demonstrated three important findings for this debate.

First, many trauma cases do not result in the development of any psychiatric illness.[36] A meta-analysis of college students[37] that examined the long-term psychological correlates of childhood sexual abuse reported much variation in effects, from severe to mild, and subsequent studies have also suggested variable, though adverse, effects.[38] In the context of the current article, such studies demonstrate the need also to investigate resilience and other etiological factors.[39,40] Second, almost all studies reporting on the relationship between childhood experiences and BPD rely on retrospective data, but the recall bias associated with such data is well documented. It is a common confound in such research for highly symptomatic patients to tell more emotionally charged stories of early events.[41] Third, evidence suggests that a vast array of psychological phenomena is associated with the occurrence of childhood trauma, including, though not limited to: attachment issues; difficulties relating to, and communicating with, others; dissociation; issues with behavioral control; problems modulating affect; incoherent self-concept; and cognitive impairment.[30,38,39] Although all these phenomena can occur in BPD and PTSD, they are not unique to these disorders.

The hypothesis that BPD is a variant of PTSD assumes that trauma is the primary cause of BPD rather than one etiological factor among many, with other biological, psychological, and social factors seemingly ignored. Research has demonstrated, however, that each of these factors interacts in multiple ways to shape the development and course of BPD. For example, some studies have reported that individuals with BPD are five times more likely than by chance alone to have a first-degree relative with BPD,[42] implicating the notion of heritability, and a recent twin study demonstrated that genetic influences explain 42% of the variance in BPD symptoms.[42] Other studies have also implicated a biological involvement. One study observed that characteristics such as impulsivity and affective instability are heritable and involve alterations in the serotonin and norepinephrine systems,[43] and functional neuroimaging studies have found BPD patients compared to controls have an intense activation pattern on both sides of the amygdala and in the medial and inferolateral prefrontal cortex.[44] Recent work has illustrated the known social deficits in more detail, showing that BPD patients compared to controls manifest deficits in brain processes that monitor trust in relationships.[45] Such studies suggest an interaction of heritable, biological, and environmental involvement in the development of symptoms, rather than only a trauma response. More recent models of BPD and other psychiatric disorders (including PTSD) are beginning to recognize their interactive, multifactorial etiology. For example, Goodman and Yehuda,[34] having criticized the "oversimplified" BPD etiology formulated by Herman and van der Kolk,[25] developed what they suggest is a more refined premise, positing that in certain individuals, personality dysfunction is the result of trauma interacting with temperament and biological vulnerabilities. These assumptions are consistent with those proposed by Linehan's biosocial theory,[46] which

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conceptualizes BPD as the result of the combination of an inherited biological disposition to emotional dysregulation, coupled with an invalidating environment. More specifically, the disorder is considered to develop when emotionally vulnerable individuals grow up in environments where their beliefs about themselves were continually invalidated by significant others. Thus, although the biosocial model of BPD supposes that an invalidating environment (e.g., trauma) is often important, it does not suppose it is sufficient for the development of BPD.[46] At present, there is limited empirical evidence to validate Linehan's theory,[34] yet dialectical-behavioral therapy, in which validation of self is a core component, has been shown to be successful in the treatment of BPD.[47] Similarly, other recent studies and commentaries reinforce the likely interaction between genetic variants and early childhood experiences.[48] Specifically, Caspi and colleagues[49,50] demonstrated that certain genotypes moderate the impact of negative childhood experiences in the development of psychiatric behaviors and disorders. The importance of gene-environment interactions in the development of psychiatric disorders prodominates modern thinking in developmental psychopathology.[51]

There is little doubt among researchers that BPD individuals are more likely to meet the criteria for a PTSD diagnosis than those in the general population, but the problem of BPD comorbidity is not unique to PTSD. Indeed, numerous studies have demonstrated that BPD is also highly comorbid with a number of other Axis I and Axis II disorders[27,52]—and some to a greater extent than PTSD. In a study reporting that 58% of the BPD patients met the criteria for PTSD, BPD was also is highly comorbid with various other Axis I disorders, including major depression (86%), substance use disorders (62%), eating disorders (54%), and dysthymia (45%).[27] Further, Nurnberg[52] reported that 82% of the BPD patients in their sample met the criteria for at least one other personality disorder.

It should also be stressed that comorbid PTSD is not unique to BPD. One study reported that trauma was also highly associated with other personality disorders.[53] The same study further reported that paranoid personality disorder was associated with an even higher rate of PTSD than was found in BPD patients. If we were to accept the premise that a disorder may be a variant of another based on comorbidity and overlapping phenomenology, the implications of these data would be that paranoid personality disorder is potentially a variant of PTSD. However, such discussion is beyond the scope of this article.

What is the Nature of the Association Between Trauma and BPD?

Despite the link between trauma and BPD, merely stating that BPD is a complex form of PTSD remains problematic. Just because two disorders are similar in their symptomatic presentations and etiologies does not necessarily imply they are the same phenomenon. Given the apparent overlap in symptomatologies, it may be that they exist as separate entities, though often misdiagnosed and mistaken for one another. One researcher posits, however, that both the BPD and PTSD diagnoses are inadequate to address the psychological dysfunction exhibited by individuals with a history of early trauma.[29] Some researchers have also postulated that individuals with a history of childhood trauma who display features of BPD lie on some continuum between that disorder and PTSD.[20] This hypothesis gives rise, of course, to the categorical versus dimensional debate—an issue with implications for the diagnosis of personality and other mental disorders. Finally, given the problem of comorbidity in BPD, some theorists have postulated that BPD may be a "complex series of disorders, each with various antecedents and potential causes."[4]

Central to this debate is the lack of clarity around what constitutes a traumatic experience in relation to the etiologies of BPD and PTSD. For example, does a series of parent-neglect episodes constitute a trauma in the same way a violent rape would? The amount, severity, and length of the traumatic experience can affect the severity of symptoms developed,[26] and it has also been suggested that people who are exposed to the most severe and long-standing forms of trauma are more likely to develop symptoms that become integrated into the personality system.[29] Studies of abuse parameters suggest that specific types of abuse are more malignant in effect than others; for example, incest is known for its severe effects.[54] Thus, it may be that the distinction between BPD and PTSD is a matter of degree as measured by the type, severity, and length of traumatic experiences. This question can be resolved or illuminated only through further research.

Problems and Treatment Implications for the Current Conceptualizations

At present, there is little consistency concerning the nature of personality disorders and specifically whether they should be characterized by a set of traits or symptoms or seen more dimensionally. Although Kernberg[9] and other psychoanalytic theorists hold that disturbances in BPD patients reflect pathological features of underlying personality structures,[10] the major psychiatric diagnostic systems (e.g., DSM and the International Classification of Diseases) predominantly utilize a symptom-cluster approach to diagnosing personality disorders. Indeed, only a minority (three of nine) of the defining items for BPD in DSM-IV[12] stress actual personality traits, the remaining items representing symptoms or behaviors.[55] Thus, an individual can meet the

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criteria for a BPD diagnosis based on symptom clusters only rather than personality traits; given that the symptom presentations of BPD and PTSD are similar, it is no surprise the two are often confused.

Further, a diagnosis of BPD requires that any five (or more) of the nine DSM-IV criteria be met.[12] Consequently, there are 256 possible combinations of criteria in which a diagnosis can be made, and any two individuals with a borderline diagnosis are required to share only one of the nine diagnostic criteria. Similarly, there are 175 combinations in which a diagnosis of PTSD may be made. Thus, it seems the BPD and PTSD populations represent highly heterogeneous groups of individuals, and it has been argued that the amplitude of the populations' respective boundaries and their frequent overlap make it difficult to justify what is perceived as a close relationship between them.[4] Further, Kroll[56] suggests that "it is impossible to know what each one is, let alone whether they are the same thing."

Additionally, since its inception in DSM-III,[5] the diagnosis of BPD has acquired an increasingly pejorative connotation;[4] the consideration of BPD as a complex PTSD stems, in part, from the desire to reduce the stigma attached to patients. Indeed, the borderline label can be dangerous and dehumanizing to patients, and its reputation for being notoriously difficult to treat can sometimes lead to rejection by the mental health system.[20] In contrast, individuals diagnosed with PTSD are more likely to be viewed as victims of traumatic events rather than as having character problems.[57] Additionally, mental health practitioners often hold that while recovery is a possibility for PTSD, the outlook for those with BPD is typically considered bleak.[20] Given these attitudes, Becker[20] argues that BPD should be reclassified as a subcategory of PTSD in order potentially to "destigmatize posttraumatized women diagnosed with BPD."

As reviewed, the evidence available presents some difficulties for the view that BPD is a complex PTSD, with emerging research implicating the importance of interactive and multifactorial models for the development of BPD. In addition to the theoretical and research objections to the purported reformulation, consideration of the clinical utility and implications is required. The reformulation of BPD as a complex PTSD would suggest that the current treatments for BPD require major restructuring, with trauma amelioration becoming the primary focus of treatment strategies. However, it may be wise for clinicians to consider the two disorders as separate entities for the purpose of providing psychological and psychiatric treatment. Previous research on the treatments of choice for BPD and PTSD highlights the discrepancies in theoretical orientation and focus. For example, the treatment of choice for PTSD is short-term, evidence-based cognitive-behavioral therapy,[58,59] whereas the treatment of choice for BPD is generally long-term psychotherapy.[60] Further, all empirically supported treatments for BPD (e.g., dialectical-behavioral therapy,[46] transference-focused therapy,[61] schema therapy,[62] and mentalization-based treatment)[63] recommend that the treatment of BPD patients be sequential and that trauma experiences be addressed only when the patient's symptoms are sufficiently stable (generally after the first year of therapy) and the therapeutic alliance is well established.[64]

The controversy has implications for the future of psychiatry and the DSM. Not only does it raise questions about the atheoretical nature of the DSM and its distinction between Axis I and Axis II disorders, it also raises important questions about the validity of BPD as a diagnostic entity. BPD diagnosis remains controversial, with its overly ample boundaries, high comorbidity rates, and lack of consistent proof regarding the reliability and validity of BPD as a diagnostic entity; some have even questioned its uniqueness as an entity.[56] Thus, until we actually understand the varying presentations and etiology of BPD, and whether it exists as a unique entity, it seems that little can be achieved by merely changing its name.

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