Scientific Research Publishing

Psychology, 2024, 15, 293-296
https://www.scirp.org/journal/psych
ISSN Online: 2152-7199
ISSN Print: 2152-7180

Borderline Personality Disorder Is Not Trauma-Induced: A Case for a Reformulation

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How to cite this paper: Jeyasingam, N. (2024). Borderline Personality Disorder Is Not Trauma-Induced: A Case for a Reformulation. *Psychology, 15,* 293-296.
https://doi.org/10.4236/psych.2024.153017

Received: February 6, 2024
Accepted: March 10, 2024
Published: March 13, 2024

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Abstract

Borderline Personality Disorder is associated with high degrees of mental health service engagement due to distress, and is classically described as being strongly associated with trauma, specifically childhood sexual abuse. This is despite low prevalence of trauma histories, as well as studies suggesting a paucity of evidence for trauma as a primary contributory factor. This article aims to outline the literature regarding the debate and advocates for reformulation of the condition as a condition with a biological origin and a multifactorial presentation.

Keywords

Borderline Personality Disorder, Mental Health Service Engagement, Evidence for Trauma

1. Introduction

Borderline Personality Disorder was coined by Adolph Stern in 1938 to describe a pervasive pattern of behaviour believed to lie on the "borderline" between psychosis and neurosis (Al-Alem & Omar, 2008). Although believed only to affect 1% of the population, it nonetheless contributes to up to a quarter of emergency department mental health presentations (Grenyer, 2014). It is described in DSM-5 as:

A pervasive pattern of instability of interpersonal relationships, of self-image, and affects as well as marked impulsivity beginning by early adulthood and present in a variety of contexts as indicated by five 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 two areas that are potentially self-damaging, for example, spending, substance abuse, reckless driving, sex, binge eating, etc. Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5).

5) Affective instability is caused by a marked reactivity of mood, for example, intense episodic dysphoria, anxiety, or irritability, usually lasting a few hours and rarely more than a few days.

6) Chronic feelings of emptiness.

7) Inappropriate, intense anger, or difficulty controlling anger, for example, frequent displays of temper, constant anger, recurrent physical fights.

8) Transient paranoid ideation or severe dissociative symptoms.

As demonstrated, diagnosis is not dependent on suspected contributory factors.

2. Diagnostic Concerns

For a condition that is so prominent in mental health service, there has nevertheless been longstanding controversy regarding the diagnosis itself. Criticism has been levied regarding the issue that borderline personality disorder diagnosis (as per the DSM-IV, which are identical to DSM-V) is dominated by discrete symptoms rather than personality traits—a feature shared with schizotypal personality disorder (Tyrer, 2009). Furthermore, a cluster analysis of personality traits from 1976 to 1978 did not identify a personality profile consistent with a borderline grouping. Much has been written regarding the difficulties of separating bipolar disorder from borderline personality disorder, with a review in the area finding at least 20% comorbidity between the two conditions (Sanches, 2019).

3. Trauma

Psychological theories have predominated in describing the development of borderline personality disorder, often as a response to trauma—hence some proponents advocating for it to be reframed as "Complex Post Traumatic Disorder" (Sansone et al., 2008). Psychodynamic theories suggested include describing early damage to object relations (Kernberg, 1967), pathognmic patterns of attachment (Bowlby, 1973). These have been suggested to induce emotional hypersensitivity, vulnerablilty to abandonment, and other key symptomatology.

Borderline Personality disorder is rarely described in clinical practice without discussion of trauma, specifically sexual abuse. Systematic studies, however, do not demonstrate a satisfactory prevalence, with only a third reporting sexual abuse or severe abuse (Sansone et al., 2008). Efforts to treat the condition by exploration of trauma have limited success, with an increase in patient distress, as well as a vulnerability to developing false memories (Sansone et al., 2008). This is not the case with symptom-targeted psychotherapies such as dialectical behaviour therapy or brief supportive therapy, which provide measures that address primary pa-

tient experiences without historical exploration (Grenyer, 2014).

4. Genetic Studies

Studies identifying genetic factors (Amad et al., 2014) have demonstrated over 50% heritability, greater than that for major depression. Critical evidence in this area is a 2022 discordant twin study of 2808 twins, which specifically assessed childhood trauma as a potential causal agent. After controlling for shared genetic and environmental features, analysis did not find evidence to support childhood trauma as a causative factor, even when attempting to analyse for different kinds of trauma (from sexual abuse to witnessing violence) (Skaug et al., 2022). Genetic contributors consistently were identified as being more reliable in association with the development of borderline personality disorder than any other contributory factor.

5. Therapeutic Guidance for Causation

Prior to the discovery of lithium, bipolar disorder was presumed to have a psychoanalytic course (Shorter, 2009). Formulations described manic episodes as being reactions to internal distress and external pressures. This changed once lithium was identified as being an effective treatment, redefining a previously exclusively psychological condition into one with a biological onset, but multifactorial presentation. The challenge in bringing away trauma from being central to the dialogue of borderline personality formulations is the absence of satisfactory biological treatments.

However, this may be reflective of the age of onset of the condition and the disparity of research in treatments for this age group. Numerous antisuicidal agents have been well described in the adult population (Mann & Currier, 2012), with purported mechanisms in addressing serotonin dysfunction, noradrenergic dysfunction, and unique properties of lithium and clozapine. In adolescents, only serotonergic agents are well described in their use, with limited descriptions of any other agents. Due to a focus on trauma, or suspected trauma, as being causative in the development of borderline personality disorder, this may be prejudicing treatment trials in this vulnerable population, allowing development of the condition without potential benefits of early intervention.

6. Conclusion

Whilst the prevailing paradigm, trauma as a primary causative factor in the development of borderline personality disorder is unsatisfactory and difficult to substantiate with current evidence. It is even difficult to regard the condition as being a personality disorder at all, given symptom rather than trait dependence for presentation (Tyrer, 2009).

No mental health condition is satisfactorily described via a "root cause", as the presentation is always multifactorial, with good mental health formulation able to identify how symptoms have connections to social, psychological and cultural

issues, regardless of cause. A multifactorial approach assists with treatment planning, understanding the patient experience, and improving outcomes, regardless of mental health condition.

Nevertheless, a dialogue advocating trauma as the primary contributing factor to the condition does not have evidence to support it, and interferes with the recovery from the condition. Borderline Personality Disorder should be regarded as a condition with a likely biological origin, but unfortunately not yet a satisfactory biological treatment. Maintaining a paradigm of a biological origin, however, increases the likelihood that such a treatment can be found, whilst still respecting the considerable advances in psychotherapy associated with its relief.

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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