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REVIEW

Borderline Personality Disorder Revisited: A Theory-Driven Rationale for Trauma-Focused Treatment

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ABSTRACT

Borderline personality disorder (BPD) has long been conceptualized as a chronic and pervasive disorder characterized by emotional dysregulation, an unstable self-image, and disturbed interpersonal functioning. Dominant treatment approaches have emphasized lengthy psychotherapeutic and skills-based interventions based on assumptions of patient fragility and limited affect tolerance. However, converging evidence from clinical trials increasingly challenges this paradigm. Drawing on the Adaptive Information Processing (AIP) model and recent empirical advances in this field, this study aims to substantiate the proposition that the core features of BPD can be conceptualized as manifestations of maladaptively stored traumatic and attachment-related memories originating from adverse childhood experiences. From this perspective, BPD symptomatology reflects the state-dependent activation of pathogenic memory networks. We reviewed and integrated empirical findings demonstrating that trauma-focused therapy can be safely and effectively applied to individuals with BPD, leading not only to significant symptom reduction but also to improvements in functioning in daily life and, in many cases, remission of the BPD diagnosis. We argue for trauma-focused therapy as a time-efficient intervention that targets the developmental origins of BPD, even in the absence of comorbid posttraumatic stress disorder.

Keywords: Borderline Personality Disorder, Trauma-focused therapy, EMDR therapy, Adaptive Information Processing, Pathogenic Memories, Intensive Treatment, Emotional Dysregulation

Introduction

Borderline personality disorder (BPD) is one of the most severe and burdensome mental health disorders encountered in clinical practice. Individuals diagnosed with BPD experience profound emotional suffering, marked instability in affect and self-concept, recurrent interpersonal crises, and high levels of functional impairment across relational, occupational, and social domains, as well as elevated rates of self-harm and suicidality[1,2].

Historically, BPD has been conceptualised as a disorder of personality organisation, characterised by enduring maladaptive traits and deficits in emotion regulation[3,4]. This view has informed several psychotherapeutic models focusing on managing intense emotions, unstable self-image, and relationship difficulties by exploring deeper

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patterns, changing distorted thinking, and building healthier functioning through the therapeutic relationship, as well as practical techniques such as skill training. Although research on the effectiveness of treating PTSD in people with comorbid BPD began more than a decade ago[5], trauma processing is often still regarded as potentially destabilising or even contraindicated, particularly in patients with high emotional reactivity or dissociative symptoms [6,7]. Therefore, trauma-focused therapy is usually only considered if the person is less sensitive to crises[8].

This notion has increasingly been called into question as a growing body of developmental, epidemiological, and neurobiological research demonstrates that adverse childhood experiences (ACEs), such as physical and sexual violence, as well as emotional neglect, abuse, and attachment disruption, are highly prevalent among individuals with BPD and play a central role in its aetiology [9,10,11]. These findings point toward a developmental trauma model in which symptoms emerge as adaptations to early and chronic interpersonal threats[11]. In parallel, advances in trauma-focused psychotherapy raise fundamental questions about the necessity of long-term treatment courses for the BPD population. Recent randomised controlled trials have shown that this treatment approach can be safely and effectively delivered to this target group within a relatively short period of 5 weeks, resulting in significant reductions in symptom severity and improvements in daily life functioning[12,13].

Therefore, this study advances a theory-driven conceptualisation of BPD grounded in recent research. We propose that the hallmark features of BPD can be understood as manifestations of maladaptively stored traumatic and attachment-related memory. From this perspective, trauma-focused treatment may become a treatment for BPD and not solely an add-on option for regular interventions for BPD.

The societal, burden of BPD

BPD is one of the most complex and challenging conditions in modern psychiatry[14]. While its prevalence in the general population is estimated to be 1.6% to 5.9%, these figures rise dramatically in clinical settings, where patients with BPD account for up to 20% of psychiatric inpatients and 10% of outpatients[14]. The economic and social burden associated with BPD is high. Studies across European healthcare systems indicate that the annual societal costs per person with BPD range from €16,852 to over €40,000[15]. Much of this economic impact stems from non-health sectors, including productivity loss, work disability, and reliance on social assistance[15]. A nationwide registry study in Denmark found that the cost of care for a BPD patient was more than 16 times higher than that of healthy controls[15]. Moreover, high rates of self-harm and suicide completion between 3% and 10% place an immeasurable psychological burden on families, caregivers, and society[14].

Borderline personality disorder and adverse childhood experiences

A substantial body of research indicates that the development of personality disorders is shaped by a complex interaction between biological vulnerability and environmental adversity, with adverse childhood experiences (ACEs) playing a particularly central role[16,17]. ACEs encompass a range of negative childhood experiences, including emotional, physical, and sexual abuse, neglect, and family dysfunction[10,18]. Epidemiological studies have consistently demonstrated a strong dose-response relationship between the number of ACEs and the risk of developing psychopathology in adulthood (11). This also

applies to the relationship between ACEs and personality disorders (PDs). Up to 85% of individuals with personality disorders report childhood adversity, with neglect (up to 82%) and abuse (approximately 73%) occurring at markedly elevated rates[19,16]. This association is most pronounced in BPD, in that individuals with BPD report, on average, up to 13 times more ACEs than non-clinical controls, underscoring the cumulative developmental trauma load characteristic of this disorder[11].

Developmental consequences of early trauma

Exposure to chronic interpersonal stress during sensitive developmental periods disrupts the maturation of neural systems involved in cognition, affect regulation, threat detection, and self-referential processing[9,20,21,22,23]. These neurobiological alterations are closely associated with the development of negative internal structural or cognitive beliefs about oneself and others, typically characterised by persistent expectations of rejection, danger, and unworthiness[24,25]. Increasing numbers of distinct trauma types have been found to be incrementally associated with greater symptom severity, particularly in the domains of affect dysregulation and interpersonal instability, and a higher likelihood of developing (BPD)[18]. Furthermore, it has been found that when these experiences occur during sensitive developmental periods, they exert significant and enduring effects on later personality pathology[19,26,24].

The Adaptive Information Processing Model

The Adaptive Information Processing (AIP) model provides a comprehensive theoretical framework for understanding how early adverse experiences give rise to enduring psychopathology[27]. This model posits that the human nervous system is inherently oriented toward adaptive processing and integration of experiences. However, when individuals are exposed to overwhelming stress or threats, this processing capacity may become disrupted, resulting in memories that are encoded and stored in a maladaptive form[27]. According to this framework, these maladaptively stored memories, often conceptualised as pathogenic memory networks, retain the affective, somatic, and cognitive elements present at the time of the original experience[27]. Because they remain insufficiently integrated with adaptive memory networks, they are particularly susceptible to reactivation by present-day cues, especially in interpersonal contexts resembling earlier adverse experiences[28,27]. This persistent sensitivity to stress has been conceptualised as *latent vulnerability*, reflecting a lasting alteration in emotional and interpersonal functioning that originates in early adversity and continues to shape psychological responses across the lifespan[21].

Pathogenic memories and personality functioning

From an AIP perspective, chronic exposure to threats, neglect, and interpersonal adversity results in the formation of maladaptive memory networks that increasingly dominate perception, affect, and behaviour[28]. Once activated, these networks give rise to rigid and context-insensitive responses that are disproportionately driven by past experiences rather than present circumstances[21]. In individuals vulnerable to BPD, activation of attachment-related pathogenic memory networks, particularly those organised around abandonment, rejection, and mistrust, can trigger intense affective states and negative self-referential beliefs, such as expectations of being unwanted or ultimately abandoned[28]. These internal activations often precipitate maladaptive coping responses, including anger outbursts, impulsive behaviours, or frantic attempts to prevent perceived rejection. Such behaviours, in turn, frequently elicit distancing or withdrawal responses from

significant others, thereby reinforcing the original abandonment-related memory networks and confirming negative beliefs about the self and others. Within this self-reinforcing cycle, current interpersonal stressors not only reactivate earlier memories of abandonment but also generate new adverse experiences that are incorporated into existing maladaptive networks. Over time, this iterative process deepens and consolidates the underlying memory structures, leading to escalating difficulties in emotion regulation, an increasingly negative self-concept, and pervasive interpersonal dysfunctions. From this perspective, the core features of BPD - emotional instability, disturbed interpersonal functioning, and recurrent relational crises - can be conceptualised as dynamic manifestations of repeatedly activated pathogenic memory networks rather than as fixed personality traits or enduring deficits[11,28]. This formulation highlights how persistent symptom patterns characteristic of BPD arise from the progressive strengthening of maladaptive memory networks across repeated interpersonal experiences.

Currently available treatments for BPD

Currently, various therapies for personality disorders have been studied and recognised as effective, with no treatment method proving to be superior[28]. Most of these therapies focus on addressing problems characteristic of personality disorders, with the aid of transferring unconscious feelings and conflicts within a therapeutic relationship [psychodynamic psychotherapy[3]], promoting mentalization and learning to regulate emotions [Mentalization-based Therapy[4], restructuring deep-rooted dysfunctional schemas and behavioural patterns [schema-focused therapy[29]], or teaching skills to manage intense emotions, improve relationships, and cope with stress by balancing acceptance and change [dialectical behaviour therapy[30]]. Although these psychotherapies have dominated the field (14), they have significant limitations (31). That is, they yield moderate effect sizes, with approximately half of the patients failing to respond sufficiently[32,14,31]. Furthermore, treatment typically lasts for at least 12 months, making it inaccessible to many owing to high costs and a lack of sufficiently trained therapists[14]. In addition, nearly one-third of patients discontinue treatment prematurely[31].

The effects of trauma-focused treatment on BPD symptoms

Given the central role of ACEs in the aetiology of borderline personality disorder (BPD), an increasing number of studies have examined the effects of trauma-focused therapy on BPD-related symptoms. These interventions have been delivered either as stand-alone treatments or embedded within broader therapeutic frameworks, most notably dialectical behaviour therapy (DBT). In this context, DBT for PTSD (DBT-PTSD) has emerged as a phase-based synthesis combining skills training with trauma-focused exposure, primarily developed for individuals with posttraumatic stress disorder (PTSD) and comorbid BPD. In contrast, the effects of trauma-focused therapy on BPD symptoms in patients without a PTSD diagnosis have received far less empirical attention and have been investigated in only a limited number of studies to date. Table 1 provides an overview of these studies and summarises their main findings. The results are discussed in the following section.

The effects of trauma-focused treatment of PTSD on BPD symptoms.

To date, seven randomized controlled trials have examined the effects of trauma-focused treatment for PTSD on borderline personality disorder (BPD) symptomatology (see also 33).

Collectively, this body of work spans more than a decade and reflects a clear developmental trajectory in both treatment approaches and methodological scope, moving from early residential and inpatient studies to larger, more heterogeneous outpatient trials employing a broader range of trauma-focused interventions. Early work in the 2010s primarily focused on Narrative Exposure Therapy (NET) and cognitive-behavioural approaches, often conducted in residential or inpatient settings and characterised by relatively small sample sizes[34,35,36]. These studies consistently demonstrated that reductions in PTSD symptoms were accompanied by parallel improvements in BPD symptom severity, even in the absence of prolonged stabilisation phases. Three studies did not detect statistically significant differences between trauma-focused interventions and control conditions other than trauma-focused therapy[36,35]. However, the number of sessions was four times higher in the DBT condition than in the NET condition in the latter study.

A subsequent large-scale randomised controlled trial in the early 2020s demonstrated robust reductions in PTSD severity alongside significant improvements in BPD symptomatology. In this trial, DBT-PTSD was found to be superior to Cognitive Processing Therapy (CPT) with respect to PTSD outcomes, while also yielding higher remission and recovery rates and lower dropout (37). Earlier work had already indicated meaningful remission rates for BPD following DBT-PTSD, when compared with treatment-as-usual control conditions[5]. Together, these findings provide strong empirical support for the feasibility and clinical relevance of trauma-focused treatment in patients with complex PTSD and prominent borderline features.

More recently, studies published in the 2020s have extended this trajectory through the application of eye movement desensitisation and reprocessing (EMDR) therapy. Randomised controlled trials indicate that EMDR therapy can be safely administered to patients with personality disorders and significant borderline pathology, resulting in clinically meaningful reductions in both PTSD and BPD symptom severity, improvements in emotion regulation and functioning, and substantial remission rates compared with control conditions[38,13]. Notably, EMDR therapy has been shown to be effective as a stand-alone intervention with a short duration of treatment.

It is important to note that across trauma-focused treatment studies in BPD), formal remission, defined as loss of diagnostic status, has been assessed in only a few studies. NET studies and DBT-PTSD research provided the earliest evidence that BPD remission can occur following trauma-focused treatment, often in parallel with PTSD remission, suggesting that diagnostic recovery is achievable rather than exceptional, although categorical BPD remission was not consistently reported as a primary outcome. More recently, Hofman's[13] EMDR therapy trial reported that 57% of patients no longer met the criteria for BPD three months after EMDR treatment. This is the only study that assessed remission at a longer-term follow-up, specifically one year after treatment[13]. Furthermore, dropout rates varied considerably, ranging from as low as 2-26% in brief or stand-alone trauma-focused interventions to substantially higher rates (26-61%) in longer, more intensive treatment programmes involving 40-45 sessions or more. Exceptionally high dropout rates have been reported in teletherapy-based trials, potentially reflecting setting-related rather than treatment-specific factors[39].

The added value of concurrent psychotherapy in trauma-focused treatment for BPD

The additional value of psychotherapy for BPD in trauma-focused treatment was directly tested in a large-scale randomised controlled trial (RCT) conducted by Snoek et al.[40]. Participants were randomised into two arms: a group receiving 12-18 sessions (75 min) of stand-alone standard EMDR therapy and a group receiving standard DBT (48 group sessions of 150 min). and 23 individual sessions) integrated with EMDR therapy. Although the findings revealed that both groups recorded statistically significant and large reductions in the severity of both PTSD and BPD symptoms, the most critical finding was that the EMDR+DBT combination was not superior to stand-alone EMDR therapy.

Treatment of personality disorders without comorbid PTSD

To date, only two studies have been conducted in which trauma-focused treatment was applied to individuals with a personality disorder *without* comorbid PTSD[12,41]. One study involving 97 outpatients with personality disorders explicitly excluded those with comorbid PTSD. The treatment group (24% BPD) received five weekly 90-min sessions of EMDR therapy, while the control group (17% BPD) consisted of individuals on a 5-week waiting list for the same treatment. Both groups subsequently received treatment as usual for personality disorders. General functioning and personality dysfunction decreased significantly and more rapidly in the EMDR therapy group than in the control group. The dropout rate was remarkably low (9%). A subsequent multicentre trial sought to replicate these findings and answer the question of whether EMDR therapy can influence the diagnostic status of "personality disorder"[13]. This study examined a large cohort of 159 patients with BPD (32%) with and without a diagnosis of PTSD and compared the results of 10 biweekly 90-min sessions of EMDR with a waitlist control group. This study reported significant improvements in symptom scores. Three months after treatment, 57% of the participants no longer met the diagnostic criteria for BPD, whereas dropout rates were low[13]. Given the brief treatment format of 10 sessions, these findings support the notion that EMDR therapy is both an effective and efficient therapeutic modality and can play a significant role in the treatment of individuals with BPD, even in the absence of comorbid PTSD.

Challenging the fragility paradigm

For many years, clinicians have expressed concern that trauma-focused treatment might destabilise individuals with complex trauma histories, leading to increased suicidality, dissociation, and behavioural dyscontrol[7]. These concerns gave rise to treatment models emphasizing (prolonged) stabilization phases, often lasting months or years, before trauma processing was attempted. However, a strikingly consistent finding across all empirical studies reviewed above is the absence of increased self-harm or suicide attempts following trauma-focused treatment, thereby challenging the fragility paradigm's validity[6,38,42]. This was particularly evident in the secondary analysis of Hafkemeijer et al. 's (2024) study, who examined session-to-session symptom exacerbations and found this rate to be 10% in the EMDR therapy group, whereas the symptom exacerbation rate in waitlist patients receiving no treatment was 28% [38]. Suicidal ideation was 28% in the EMDR group compared to 44% in the waitlist group. These data suggest that not processing trauma is

Table 1. Randomized controlled studies that investigated the effectiveness of trauma-focused treatments in patients with borderline personality disorder

Study (Year)	N (Total)	% BPD at Baseline	BPD Assessment	Treatment(s)	Study Duration	No. of Sessions	Session Length (min)	Main Outcome
Bohus et al., 2013	74	45% full BPD diagnosis (mean 4.18 criteria)	International Personality Disorder Examination (IPDE)	Residential DBT-PTSD versus TAU waitlist	12-week treatment + 12-week follow-up	DBT-PTSD 23 individual sessions, multiple group sessions	45 (individual); 60–90 (group)	Decline in PTSD-symptoms and BPD-criteria was higher in the DBT-PTSD group. Both groups improved on the Borderline Symptom List without statistical differences between groups.
Kredlow et al., 2017 Study 1	27	100%	BPD-criteria	Cognitive Behavioral Therapy (CBT) vs TAU	6 months follow-up	CBT: 3 plus 9-13 sessions	Not reported	PTSD symptoms decreased in the CBT condition. No significant differences in SCID II BPD items, Dropout: CBT 14%
Kredlow et al., 2017 Study 2	55	100%	BPD-criteria	CBT vs brief therapy (breathing relaxation and psycho-education)	12 months follow-up	CBT: 3 plus 9-13 sessions vs 3 sessions	Not reported	PTSD symptoms decreased in both conditions. No significant differences in SCID II BPD items, Dropout CBT 26% vs 13%, Remission not mentioned
Bohus et al., 2020	193	48.2%	International Personality Disorder Examination (IPDE)	DBT-PTSD vs Cognitive Processing Therapy (CPT)	15 months	Up to 45 weekly sessions + 3 booster sessions	Not reported	Both treatments produced large PTSD symptom reductions and reductions in BPD symptoms; DBT-PTSD showed statistically significant superiority, lower dropout, and higher PTSD remission and recovery rates. Dropout: DBT-PTSD 26% vs CPT 39%
Hafkemeijer et al., 2020	97 (EMDR n=51; WL n=46)	23.7% borderline PD; mixed PD sample	SCID-5; PTSD excluded via MINI	Brief EMDR therapy vs waitlist, followed by treatment as usual (TAU)	5-week treatment period + 3-month follow-up	5	90	EMDR resulted in significantly greater improvements in psychological symptoms, psychological distress, and personality dysfunctioning compared with waitlist, with medium to large effect sizes maintained after subsequent TAU. Remission was not measured. Dropout was 2%.
Steuwe et al., 2021	60	100%	DSM-IV-TR BPD diagnosis	NET vs DBT-based treatment (DBT-bt), residential	10-week treatment + 12-month follow-up	NET 10-week 90-min sessions or DBT-bt during 10-week residential program 10 individual 50-min sessions, 10 skills training 180-min group sessions, 10 mindfulness and psycho-education sessions a 45 min and 10 supportive group sessions a 60 min		Both groups improved significantly; NET showed higher PTSD remission rates. PTSD remission was accompanied by BPD remission. Dropout: NET 14% vs DBT-bt 45%, BPD remission: NET 73% vs DBT-PTSD 20%.
Hafkemeijer et al., 2025 Hofman et al., 2025	159	BPD 32.9%	SCID-5-PD	EMDR therapy vs waiting list	3 months follow-up	10 sessions during 5 weeks	90 minutes	EMDR therapy produced significantly greater PTSD and personality disorder symptom reduction and improved functioning and emotion regulation than waitlist. Dropout: EMDR 5%. BPD-remission: 44%.
Snoek et al., 2025	124	All had ≥4 BPD symptoms	Structured assessment of BPD symptoms	EMDR alone vs concurrent EMDR + DBT	12 months	EMDR: 12-18 75-min sessions ; EMDR - DBT: EMDR 12-18 75-min sessions and DBT: 29 individual 45-min sessions, 48 150-min group sessions a concurrent over 1 year	Not reported	Both treatments led to large and comparable reductions in PTSD and BPD symptoms; EMDR-only showed lower dropout than combined EMDR-DBT (25 vs 61%).
Nvo-Fernandez et al., 2025	76 enrolled (18 completers)	BPD symptoms	No inclusion criteria reported	EMDR vs CBT (teletherapy)	Post-treatment	Number not clearly specified	Not reported	Both EMDR therapy and CBT significantly reduced trauma and BPD symptoms and increased post-traumatic growth. Dropout: EMDR 76% vs CBT 64%

BPD: Borderline Personality Disorder, CBT: Cognitive Behavioral Therapy, EMDR: Eye Movement Desensitization And Reprocessing, DBT: Dialectical Behavior Therapy

more dangerous and destabilising than treating it[38]. These findings are further in line with those of a meta-analytic study that entailed 12 studies involving patients predominantly diagnosed with borderline personality disorder and PTSD, which showed no increase in negative side effects, such as suicide attempts, severe self-harming behaviour, or hospitalisations[43]. Likewise, contrary to popular beliefs, high levels of dissociation have not been found to be a contraindication for EMDR therapy[44,12].

Discussion

This paper advances a theory-driven conceptualisation of BPD and its treatment. Drawing on AIP model, BPD symptoms are conceptualised as manifestations of maladaptively stored traumatic and attachment-related memories rather than as fixed deficits in personality structure. This view is supported by epidemiological and developmental evidence demonstrating a robust association between BPD and severe adverse childhood experiences, including physical, sexual, and emotional abuse and neglect[21,22,23]. Within this framework, the high prevalence of physical and emotional neglect and attachment disruption in individuals with BPD suggests that the disorder may be rooted in early interpersonal adversity[27]. Conceptualising BPD as a disorder of maladaptive memory processing shifts the therapeutic focus toward the effective processing of traumatic experiences which may prove to be a central mechanism in achieving broad and durable changes in borderline personality pathology.

Indeed, an emerging body of empirical research supports the safety and effectiveness of a trauma-focused approach in individuals with BPD, both with and without comorbid (PTSD). Across studies, trauma-focused interventions have been associated with robust reductions in BPD symptom severity, improvements in daily functioning, and, in a substantial proportion of patients, remission of the BPD diagnosis itself without evidence of increased risk, symptom destabilisation, or elevated suicidality[27,41,45]. Importantly, these findings apply not only to trauma-focused treatments integrated within broader psychotherapeutic frameworks for BPD but also to trauma-focused interventions delivered as stand-alone treatments with a limited number of sessions. Notably, EMDR therapy is currently the only trauma-focused intervention systematically examined in individuals with BPD in the absence of a PTSD diagnosis.

A major strength of the present study lies in its integrative scope, bringing together developmental theory, the AIP model, and an expanding body of empirical evidence into a coherent explanatory framework for both the phenomenology and treatment of BPD. Importantly, the consistent findings of low dropout rates and the absence of serious adverse events directly address longstanding concerns regarding the safety of trauma-focused interventions in this population group. Nevertheless, this study has several limitations. First, although the evidence base is rapidly growing, the number of large-scale randomised controlled trials specifically targeting individuals with BPD without comorbid posttraumatic stress disorder (PTSD) remains limited. Second, for patients with BPD without PTSD, empirical support for trauma-focused therapy currently exists only for EMDR therapy; however, it is plausible that other trauma-focused interventions may also be beneficial, a hypothesis that requires direct empirical testing. Third, future studies in this subgroup should incorporate active control conditions and extended follow-up periods to clarify the durability and specificity of the

treatment effects. Fourth, most existing studies have been conducted in highly specialised treatment centres with substantial clinician expertise in trauma-focused interventions, which may limit the generalisability of the findings to routine clinical settings. Accordingly, future research should prioritise implementation outcomes, therapist training requirements, and cost-effectiveness across broader mental health systems.

The clinical implications of these findings are substantial. Conceptualising borderline personality disorder as a mental health condition rooted in the cumulative impact of unprocessed adverse childhood memories and recognising that directly targeting these memories through trauma-focused therapy can lead to profound and enduring change broadens the range of available treatment options. Established psychotherapeutic approaches, such as dialectical behaviour therapy and mentalization-based therapy, are typically characterised by prolonged treatment trajectories and high dropout rates. In contrast, trauma-focused therapy appears to be capable of producing rapid and clinically meaningful improvements with relatively low attrition, even in individuals with severe symptomatology and complex trauma histories.

However, trauma-focused therapy may not be suitable for all individuals with BPD. Given evidence that symptom improvement may continue for at least three months following treatment[44,13], it is recommended that treatment outcomes be reviewed with patients after this period and that decisions regarding the need for additional interventions be made collaboratively.

In conclusion, this study proposes a paradigm shift in the conceptualisation and treatment of borderline personality disorder. Accumulating evidence suggests that a primarily trauma-focused approach may offer individuals with BPD an efficient and effective treatment. Further research is required to refine this approach, strengthen its empirical foundation, and support its integration into international treatment guidelines and routine clinical practices.

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