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REVIEW ARTICLE

Transforming Trauma: The Role of EMDR in Treating Borderline Personality Disorder

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ABSTRACT
Borderline personality disorder (BPD) is a complex psychiatric condition marked by emotional dysregulation, unstable interpersonal relationships, and self-harming or suicidal behaviors. It is linked to a combination of biological vulnerabilities, maladaptive early environments, and invalidating caregiver responses, BPD has been addressed through various psychotherapeutic modalities such as Cognitive Behavioral Therapy, Dialectical Behavior Therapy, Schema-focused Therapy, Transference-Focused Psychotherapy, and Mentalization-based Therapy. As research increasingly recognizes the pivotal role of traumatic experiences, interest in trauma-focused interventions for BPD has grown. Therefore, Eye Movement Desensitization and Reprocessing (EMDR) therapy, rooted in the Adaptive Information Processing model, offers a structured approach to integrate and resolve trauma-related memories that may underlie BPD's clinical presentation. Although initially developed and validated for Post-Traumatic Stress Disorder, EMDR's application in BPD treatment shows promise, especially when tailored to address the unique challenges of this population. This review synthesizes the current literature on EMDR's theoretical rationale, clinical adaptations, and preliminary empirical support for its efficacy in BPD. Integrating EMDR into multidisciplinary treatment protocols may advance individualized, effective strategies that improve outcomes and overall quality of life for individuals with BPD.
Key Words: Borderline Personality Disorder, EMDR, Trauma Treatment

Introduction

Borderline personality disorder (BPD) is a serious psychiatric problem which has an estimated prevalence of %1.8.[1] It can be characterized as an intense fear of abandonment, suicidal tendencies, lack of emotional regulation skills, and impulsivity.[2] Although there are different perspectives towards etiology of the disorder, the common assumption is that there is an interaction among genetics, maladaptive early experiences and caregiver reactions. Traumatic experiences are not a distinctive feature of borderline personality disorder as it is in other psychiatric problems.[3] Instead, the relationship between parenting style and child's temperament causes depriving effects.[4] It is frequently linked to a significant history of childhood trauma, including experiences of physical and sexual abuse, neglect, and witnessing domestic violence. Experiencing various forms of

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maltreatment during different stages of development intensifies the severity of symptoms.[5] Early trauma is believed to disrupt cognitive and emotional development, impair the integration of thoughts and emotions, and hinder the recognition of emotional states, leading to post-traumatic reactions, dissociation.[6] Children who experience maltreatment may internalize negative beliefs about themselves and others, perceiving themselves as inherently flawed, unworthy, or weak, and others as dangerous, rejecting, or unavailable. This internalization may result in a negative self-view and distorted expectations about relationships, viewing maltreatment as deserved. Also, insecure attachment and maladaptive emotion regulation serve as mediating factors linking childhood trauma to BPD, playing a significant role in the emotional instability and interpersonal challenges that define disorder.[7] They frequently display elevated levels of attachment anxiety and avoidance. While attachment anxiety demonstrates a stronger association with BPD traits, attachment avoidance also plays a meaningful role. Both attachment styles significantly contribute to the interpersonal challenges commonly observed in BPD.[8] Moreover, the biological vulnerabilities can be related to neurobiological structures, personality characteristics can be linked to neuroticism and maladaptive environment can be portrayed as unstable, punitive and depriving.[3]

There are different psychological treatments for borderline personality disorder aimed at addressing issues such as interpersonal difficulties, emotional dysregulation, and suicidal behaviors.[1] Among these, Eye Movement Desensitization and Reprocessing (EMDR) stands out as a focus of this study, specifically evaluated for its effectiveness in addressing trauma-related symptoms within this population.

1. Psychotherapy Approaches for Borderline Personality Disorder

Cognitive Behavioral Therapy (CBT) focuses on identifying and modifying core beliefs and maladaptive behaviors that hinder emotional and social functioning. It has evolved to address the complex challenges of treating BPD, despite its initial focus on short-term, problem-focused interventions for Axis-I disorders. CBT for BPD primarily targets maladaptive schemas—core cognitive structures formed through early life experiences that influence perceptions, emotions, and behaviors.[8] These schemas often develop from a combination of temperament and adverse early environments, such as unmet emotional needs or childhood abuse. In one study, participants that received CBT+TAU (Treatment as Usual) demonstrated significant reductions in dysfunctional beliefs, state anxiety, and psychiatric distress, suggesting CBT's potential to address cognitive and emotional aspects of BPD.[8]

Dialectical Behavioral Therapy (DBT) is a structured form of psychotherapy combining cognitive behavioral therapy and mindfulness techniques.[1] It is utilized to treat suicidal aspect of BPD [9,10] improve emotional regulation skills [1], encourage client to perform adaptive behaviors [10], stabilize dangerous behaviors and enhance motivation [9,10] demonstrated that there are five essential goals of the behavioral methods: First of all, management of life crisis and identification of self-destructive behaviors are targeted. Then, therapist delivers skills training in several areas such as emotional regulation, mindfulness, interpersonal relationships and stress management. In the third step, clients generalize the skills they learned into the real life. After this, therapists

are supervised to prevent experience overwhelming feelings. Finally, a comprehensive treatment is done to accomplish optimal functioning in different life domains.

Another evidence-based treatment for borderline personality disorder is the schema-focused therapy which has roots from both cognitive behavioral through dysfunctional coping mechanisms and psychodynamic therapies through maladaptive childhood themes1. Schema-focused therapy aims to take therapist as a role model and internalize her as a healthy parent (or healthy adult schema) in their lives. In this way, they can learn how to meet their emotional needs.[4] Also, therapists' purposes are bonding, changing schema modes and developing self-autonomy. Moreover, transference-focused psychotherapy is a form of psychodynamic treatment that is based on Kernberg's object relations model of borderline personality disorder.[3, 11] The main assumption is that there is a significant relationship between individual's emotional vulnerability and environmental experiences.[3] On the other hand, mentalization-based therapy is based on psychodynamic and attachment theories, and its main premise is that borderline personality disorder patients have lack of ability of mentalizing which causes related symptoms to occur. [2] The purpose of treatment is to increase mentalizing capacity [1], understanding on other's thoughts and emotions[3], improving daily social interactions[2] and emotion regulation skills.[1]

2. The Role of EMDR in Treating Borderline Personality Disorder

Borderline Personality Disorder is a complex mental health condition characterized by emotional dysregulation, unstable interpersonal relationships, and a fragmented sense of self. Research has consistently linked BPD to adverse and traumatic experiences during early development, particularly those affecting attachment processes.[12] EMDR therapy, grounded in the Adaptive Information Processing (AIP) model [13], offers a structured approach to address these foundational traumas. While EMDR has demonstrated efficacy in treating Post-Traumatic Stress Disorder (PTSD), its application to BPD requires specific adaptations to accommodate the unique challenges presented by this population.[14]

The effectiveness of EMDR is partly attributed to the use of bilateral stimulation, such as eye movements, which may facilitate information processing similar to mechanisms in Rapid Eye Movement (REM) sleep.[15] Research has demonstrated positive effects of bilateral stimulation on reducing imagery vividness, emotional disturbance, and enhancing memory retrieval.[16] These effects are particularly relevant for individuals with BPD, as the condition often involves heightened emotional dysregulation and intrusive memories, making EMDR a valuable therapeutic approach for addressing these core challenges.

EMDR is based on the AIP model, which explains how traumatic experiences can disrupt normal information processing, leading to dysfunction.[13] The AIP model suggests that new experiences are naturally integrated with existing memory networks, promoting adaptive resolution. However, intense emotional distress from trauma can impede this process, causing memories to become isolated and easily triggered by similar future events.[13] Therefore, psychopathology arises when traumatic experiences disrupt the brain's inherent information processing system, preventing adaptive resolution.[13] In BPD, early adverse experiences often result in maladaptive coping mechanisms, affect dysregulation, and impaired self-soothing

abilities.[17] EMDR therapy facilitates the reprocessing of traumatic memories, enabling integration into adaptive memory networks and promoting psychological healing.

The prevalence of trauma in the BPD population suggests that EMDR could be particularly beneficial in addressing early traumatic experiences contributing to the disorder. Traumatic experiences are categorized within the AIP model as "*large-T*" or "*small-t*" traumas.[13] "Large-T" traumas involve significant events like assaults or natural disasters, commonly associated with PTSD. In contrast, "small-t" traumas may include pervasive experiences of humiliation, rejection, or neglect, which, although less intense individually, can cumulatively impact the information processing system. These "small-t" traumas are relevant in the context of BPD, where invalidating environments contribute to the disorder's development. [9] Additionally, inadequate parental mirroring and regulation of an infant's negative affect may be considered traumatic, affecting attachment and emotional regulation. [18]

To effectively address the complexities of BPD within EMDR therapy, it is essential for clinicians to integrate the structured eight-phase treatment protocol with a nuanced understanding of the disorder's specific challenges. This requires tailoring interventions to the unique needs of individuals with BPD, ensuring the therapeutic process not only adheres to the protocol but also accommodates the heightened emotional sensitivity, defense mechanisms, and potential dissociation often associated with this population. The eight-phase treatment protocol involves accessing and processing disturbing life events, current triggers, and anticipated future challenges.[13] These phases include client history, preparation, assessment, desensitization, installation, body scan, closure, and reevaluation. The approach integrates all aspects of a traumatic memory—images, beliefs, emotions, and physical sensations—while using bilateral stimulation to facilitate processing.

Mosquera, Leeds and Gonzalez[19] summarized the eight phases of EMDR therapy for BPD as below:

1. History Taking (Phase 1): This initial phase involves a comprehensive assessment of the client's current symptoms and relevant biographical information, particularly focusing on traumatic and adverse life events. Clients with BPD may not readily disclose critical information such as attachment issues, substance abuse, or high-risk behaviors unless specifically queried.[14]

2. Preparation and Stabilization (Phase 2): Prior to engaging in trauma processing, clients require stabilization to enhance affect tolerance and develop coping strategies. [20] This phase emphasizes building a strong therapeutic alliance, providing psychoeducation on emotions and self-care, and equipping clients with affect regulation skills. [21] Addressing self-care patterns is crucial, as individuals with BPD often exhibit problematic self-care behaviors, including self-harm and neglect of personal needs.[22]

3. Assessment (Phase 3): Specific traumatic targets are identified during this phase, incorporating the client's disturbing images, negative beliefs, emotions, and physical sensations associated with the memories. [13] Clients with BPD may struggle with overwhelming negative self-beliefs and difficulty identifying positive cognitions, necessitating therapist support to navigate this process.[14]

4. Desensitization (Phase 4): The therapist guides the client in processing the targeted memory using bilateral stimulation (BLS), such as eye movements, to reduce the emotional distress linked to the memory. [13] Clients with BPD may experience "spreading activation," where one memory triggers multiple others, potentially overwhelming the client. [14]

5. Installation (Phase 5): This phase aims to strengthen the positive cognition identified earlier, facilitating its integration with the traumatic memory. [13] Due to challenges with positive self-perception, clients with BPD might require assistance in formulating realistic and adaptive positive beliefs. [14]

6. Body Scan (Phase 6): Clients are instructed to observe their physical sensations while holding the memory and positive cognition in mind, identifying and processing any residual tension or discomfort through BLS until neutrality is achieved. [13]

7. Closure (Phase 7): After ensuring the client's emotional stability, therapists may employ self-soothing techniques, grounding exercises, and review any insights gained, fostering a sense of safety and containment. [14]

8. Reevaluation (Phase 8): At the beginning of subsequent sessions, therapists assess the client's current psychological state, revisit previous targets, and determine the next steps in therapy.[13]

These stages are demonstrated in a case study by Hafkemeijer and her colleagues, involving two individuals diagnosed with BPD. Both participants underwent 10 sessions of EMDR therapy, each lasting 90 minutes, over four consecutive days. [23] The first participant is a 42-year-old single woman, who experienced significant emotional neglect and extreme emotional abuse during her upbringing. The second participant is a 31-year-old woman with a background of physical and sexual abuse throughout her childhood. In the Phase 1 (History Taking), comprehensive case conceptualization was conducted to identify distressing memories and symptoms. The first woman had memories primarily centered on emotional neglect, while the other one had traumatic memories included war crimes and childhood abuse. In the Phase 2 (Preparation), participants were prepared for therapy with psychoeducation and affect regulation techniques. For the first woman, building trust was essential, given her tendency toward suspicion. For the second, preparation involved addressing her resistance to confronting certain memories, particularly the near-drowning event. In the Phase 3 (Assessment), negative cognitions were identified as "I am not good enough," for the first one, whereas “I am powerless” for the second. Next, Phase 4 (Desensitization) involved processing memories emotionally neglectful experiences, confronting memories of abuse and near-drowning, and reframing the experiences. Both participants experienced a marked reduction in emotional distress during this phase. Phase 5 (Installation) included replacing negative belief with “I am worthy”, and “I am brave”, which were resulted as fostering self-compassion and reducing self-criticism. Phase 6 (Body Scan) continued with processing physical tension linked to traumatic memories, and they reported the feeling of lighter and more grounded. Phase 7 (Closure) concluded with grounding exercises and a review of progress. In the final Phase 8 (Reevaluation), there have been follow-up assessments that showed significant reductions in symptoms for both participants. At the three-month follow-up, the first participant experienced lasting peace and self-control, while the second one showed symptom reduction with continued therapy.

By the six-month follow-up, neither participant met the criteria for PTSD, and both reported improved quality of life. [23]

Particularly in BPD, dissociative symptoms, heightened affect instability, and entrenched patterns of distrust can complicate every phase of EMDR therapy. [24] For instance, during Phase 1 (History Taking), while it was relatively straightforward to identify distressing memories, the participants' difficulties in trusting the therapeutic process and accurately recalling events without dissociating or feeling overwhelmed tested the therapist's ability to maintain stability and rapport. Similarly, in Phase 2 (Preparation), equipping participants with affect regulation strategies proved essential, but challenging; the first participant's suspicion demanded extra care in fostering a sense of safety, whereas the second participant's avoidance and overregulation of emotions meant more effort in making sure she could tolerate distress without becoming detached or emotionally numb.

During Phase 3 (Assessment), although negative cognitions were identified ("I am not good enough" and "I am powerless"), the inherent instability and self-criticism common in BPD often made it difficult for participants to settle on a consistent negative belief or to refrain from shifting into dissociative states when confronted with traumatic material. Phase 4 (Desensitization) required ongoing attention to signs of dissociation, intense emotional surges, and possible "looping" on negative thoughts. [12] Therapists needed to employ repeated cognitive interweaves and grounding techniques to prevent emotional overwhelm or complete withdrawal. Although both participants ultimately experienced a reduction in distress, reaching this point demanded close monitoring to ensure they could remain present without either emotionally "flooding" or dissociating. The subsequent Phases 5 (Installation) and 6 (Body Scan) also highlighted the complexities of treating BPD, as participants might struggle to fully accept and embody more adaptive beliefs ("I am worthy," "I am brave") or to remain attuned to their physical sensations without slipping into old patterns of avoidance or derealization. The latter stages—Phase 7 (Closure) and Phase 8 (Reevaluation)—further underscored the necessity of consistent, ongoing stabilization. Even after visible improvements, the participants' longstanding fears of abandonment and trust issues required careful handling at the end of each session. [24]

In sum, while EMDR can be effective, the complex symptom profile of BPD, including vulnerabilities to dissociation, emotional dysregulation, and trust deficits, demands that therapists remain highly flexible, attuned, and prepared to address a variety of obstacles at every stage of the eight-phase protocol.

3. The Efficacy of EMDR in Treating Borderline Personality Disorder

Research on BPD and EMDR therapy highlights the potential of EMDR as a promising intervention for addressing trauma-related symptoms and emotional dysregulation commonly observed in individuals with BPD. [25] It has been demonstrated that integrating EMDR therapy into early-stage treatment for BPD patients with comorbid PTSD is both feasible and effective. In this study, participants were randomly assigned to one of three conditions based on the duration of the baseline in TAU period before initiating EMDR therapy. All participants received 15 sessions of TAU and eight sessions of EMDR within the 15-week study period. In EMDR protocol, the most distressing memories were addressed first, and each target was desensitized before moving to

the next. On the other hand, TAU consisted of 15 individual 45-minute sessions delivered by therapists experienced in treating BPD, following the principles of Guideline-Informed Treatment for Personality Disorders (GIT-PD). In the end, EMDR not only reduced PTSD symptoms but also led to improvements in general psychopathology and daily functioning. The absence of significant changes during the TAU-only baseline period supports the conclusion that EMDR was the primary contributor to these positive outcomes. However, there are some potential challenges to adapt eight-stage protocol to the patients diagnosed with BPD.

EMDR has been evaluated against other therapeutic methods for treating trauma-related disorders. For instance, Taylor et al. [26] found that while exposure therapy outperformed EMDR on two out of ten subscales, it also required an additional 50 hours of homework, highlighting efficiency considerations. Linehan [9] recommends exposure therapy alongside DBT; however, EMDR may offer advantages in efficiency and client compliance, as it typically requires fewer sessions and does not necessitate extensive homework, which some clients may find challenging. Additionally, the study by Snoek et al. [27] examined the comparative clinical efficacy and cost-effectiveness of integrated EMDR-DBT versus EMDR-only treatment in adults with PTSD and comorbid (sub)clinical BPD. EMDR therapists deliver 12-18 EMDR sessions, following the standard eight-phase protocol. Participants in the integrated EMDR-DBT group receive standard DBT alongside EMDR. DBT included 6 sessions focusing on treatment planning that is covering mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance skills. Findings indicated that the integrated EMDR-DBT approach led more substantial symptom reduction for PTSD and BPD compared to EMDR-only treatment. Despite higher direct medical costs, the integrated EMDR-DBT was expected to be more cost-effective due to its superior clinical outcomes, highlighting its potential for improving overall treatment efficacy and personalization. [27] Eventually, the group who took the treatment of EMDR-only had a success rate of 60%-70%, whereas EMDR-DBT group showed improved outcomes as 80%-90%. EMDR-only group showed a 20%-40% decrease in PTSD symptoms, while EMDR-DBT group achieved a 40%-60% reduction. Adding both of EMDR and DBT therapy to the standard treatment for BPD at the onset appears to be a safe and effective strategy for reducing PTSD symptoms and improving overall functioning. [27]

Between 2014 and 2018, Slotema et al. [28] conducted a pilot study that highlights the potential of EMDR to effectively reduce PTSD symptoms, dissociation, and insomnia among individuals with BPD and other personality disorders. Despite a dropout rate of approximately one-third, no serious adverse events, such as suicidal behavior or hospitalization, were reported. On the other hand, according to the results of Brown and Shapiro's [12] case study, the treatment targets of the client were problematic relationships and early attachment issues, revealing significant absence of attachment and insecure patterns. EMDR therapy sessions indicated substantial improvements in client's symptoms, and this case demonstrated that EMDR can lead to pronounced remediation of BPD symptoms and improved functioning within a relatively short period compared to traditional therapies. The eight-phase protocol provides a structured yet flexible framework that can be tailored to the client's needs.

In conclusion, BPD presents significant challenges due to its complex symptoms, including emotional dysregulation, impulsivity, and unstable interpersonal relationships. Traditional therapeutic approaches such as CBT, DBT, schema-focused therapy, transference-focused psychotherapy, and mentalization-based therapy have offered valuable strategies to address these symptoms by targeting maladaptive thought patterns, emotional regulation skills, and interpersonal functioning.

Even though EMDR offers a promising approach for treating BPD by addressing and resolving the traumatic experiences that contribute to the disorder, there might be some limitations. A notable proportion of individuals with BPD may discontinue EMDR therapy. In one study, approximately one-third of participants did not complete the treatment, though no major adverse events were observed. [28] Also, they frequently encounter dissociative symptoms, which can pose challenges to the EMDR process. Such dissociative episodes may make it difficult for patients to stay grounded during therapy sessions, complicating the overall treatment procedure. [14] However, when integrated into treatment plans for individuals with BPD and comorbid PTSD, EMDR has the potential to significantly enhance therapeutic outcomes. By focusing on the traumatic roots of BPD, EMDR therapy, when appropriately adapted, provides an effective avenue for promoting psychological healing and symptom reduction. Incorporating EMDR into clinical practice for BPD can improve therapeutic efficacy and client outcomes through its ability to facilitate adaptive information processing. These findings are consistent with previous research indicating that trauma-focused therapies can be highly beneficial for individuals with personality disorders and PTSD. Given its significant benefits, EMDR warrants further exploration and broader application in clinical settings.

This review makes an original contribution by synthesizing the existing evidence on borderline personality disorder treatments through a trauma-focused lens, highlighting the potential of EMDR as an integrative and complementary modality. By examining EMDR's theoretical foundations alongside established psychotherapeutic approaches, the review advances the discourse beyond merely outlining current practices and brings renewed attention to the role of unresolved trauma in BPD. Future research should prioritize large-scale, randomized controlled trials to more rigorously evaluate EMDR's efficacy within comprehensive treatment frameworks, as well as identify patient subgroups—based on attachment style, dissociation, or comorbid conditions—that may benefit most. To further refine EMDR's use, studies might explore adaptations that incorporate attachment-focused strategies, specialized protocols for clients with high dissociation levels, and enhanced stabilization techniques before trauma reprocessing.

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