Borderline Personality Disorder and Posttraumatic Stress Disorder: Time for Integration?

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The increasing prevalence of borderline personality disorder (BPD) and posttraumatic stress disorder (PTSD) diagnoses among women illustrates problems and limitations of the medical model system (Diagnostic and Statistical Manual of Mental Disorders, fourth edition; American Psychiatric Association, 1994). In particular, diagnoses of BPD continue the trend of overpathologizing women’s issues and reinforcing a patriarchal system of diagnosis and treatment. A PTSD diagnosis, with similar criteria, is preferred for traumatized women because it portrays them in a more positive context. This article explores the overlapping relationship between BPD and PTSD and critiques how both are viewed within the mental health community. Previous research on BPD and PTSD is explored, as well as concerns and limitations regarding both diagnostic categories.

Within the last decade, the diagnosis of borderline personality disorder (BPD) in women has become a fixture in mental health circles (Becker, 2000). It has been suggested that the increase in such BPD diagnoses in women has its genesis in the revisions of the diagnostic code. Specifically, in the American Psychiatric Association’s (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) category, the definition of the term borderline has been recut to resemble that of the affective disorders, which has resulted in a diffusion of the “border” between psychosis and neurosis from which the disorder is named (Kroll, 1993). BPD is conceptualized to a substantial degree in terms of maladaptive interpersonal behavior. The presence of significant, intense, disharmonious relationships is among the most useful criteria in identifying individuals with BPD (Widiger & Francis, 1989). Research has indicated that individuals with BPD have more hostile representations of significant relationships (Benjamin & Wonderlich, 1994) and seem to have a more insecure attachment style (Sack, Sperling, Fagen, & Foelsh, 1996).

Designations of normality and pathology have their origins not only in biological and psychiatric circles but also in sociocultural contexts. The characterization of BPD in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV; APA, 1994), reflects a view that the individual experiencing borderline symptoms had a problematic early mother–child relationship resulting in the arrest of healthy boundary development. According to this view, the result is that an individual with BPD has an intense and irrational fear of abandonment, resulting in severe deformation of character. Posttraumatic stress disorder (PTSD), in contrast, is one of only a few diagnoses in the DSM-IV whose symptoms are attributed to situational causes alone. This more favorable language has made PTSD the diagnosis of choice with gender-sensitive counselors, who favor this “non-blaming” label and see it as a means of acknowledging the environmental origins of psychological distress faced primarily by women. Conversely, BPD, which is defined in sweeping language and using broad categories, has acquired a pejorative connotation. The underlying view characterizing an individual placed in one diagnostic category as “disordered” due to a character flaw versus another category that depicts an individual’s symptoms as a consequence of circumstances has significant implications both for the counselor and the client. Becker (2000) characterized individuals diagnosed with BPD and PTSD as “bad girl” and “good girl” respectively.

In this article, I address issues of whether using the preferred label of PTSD rather than BPD actually holds promise for viewing “borderline” women in a developmental context. I also stress that the pejorative view of the BPD category has resulted in what some have termed a “caste system” of diagnosis and treatment that fails to adequately serve women labeled with BPD. Issues that I examine are the problematic result of labeling women as “borderline”; the subjectivity of BPD criteria; the overlapping comorbidity with BPD and PTSD; and the difficulties created by attempting to fit BPD into the category of trauma disorders.

**NEBULOUS DIAGNOSTIC CATEGORY**

The BPD category grew out of the original diagnosis of hysteria, which as a medical diagnosis dates back to the early 1800s. Originally, this term was used when the clinician...
was unsure of the correct diagnosis, because the client manifested a mixture of neurotic and psychotic symptoms. Many clinicians thought of these clients as being on the border between neurotic and psychotic, and thus the term *borderline* came into the diagnostic lexicon (Beck & Freeman, 1990). The *DSM-IV* reports that the lifetime prevalence rates for PTSD range from 1% to 14% (APA, 1994). Sperry and Mosak (1993) noted, "the borderline personality disorder is becoming one of the most common Axis II presentations seen in both the public sector and in private practice" (pp. 356–358). Beck and Freeman summed up BPD in the following hypothetical dialogue:

**SUPERVISOR:** Why are you having trouble with Mr. Schultz?
**THERAPIST:** Because he's borderline.
**SUPERVISOR:** Why do you consider him borderline?
**THERAPIST:** Because I'm having so much trouble with him. (p. 178)

Despite BPD's prominence as one of the most widely researched disorders, there is no consistent proof of either its reliability or validity (Becker, 1997; Francis & Widiger, 1987). Furthermore, it is a diagnosis that has been applied to women at a rate 7 times greater than for men (Schwartz, Blazer, & Winfield, 1980). Despite questions about efficacy, scores of books, professional journal articles, and numerous presentations at national conferences demonstrate that the mental health field continues to be mesmerized by this dubious diagnostic category, often depicting it in negative terms. Kernberg (1984) referred to BPD as a "psychological cancer" (p. 262), and Gilbert (1992), taking a cue from Kernberg, devoted an article to the immense strains that the "impulse ridden and raging borderline client" (p. 696) places on college and university counseling centers and suggested an approach more akin to containment than therapy.

Like many psychiatric diagnoses, BPD has been subject to society's shifting sociocultural norms. Criteria for the disorder have been sculpted in such a way that BPD could be viewed as an affective disorder, given its features of mood lability and dysphoria (Kroll, 1993). It may be no coincidence that this transformation began at a point when interest in and funding for research on affective disorders has increased substantially over the past two decades (Kroll, 1993). Given that women report symptoms of major depressive disorders more frequently than do men (Kessler, Sonnegra, Bromet, Hughes, & Nelson, 1995), it is hardly surprising that the core of affective disorder criteria in *DSM-IV* has made the BPD diagnosis a more common diagnostic category for women (Becker, 1997).

Like PTSD, a diagnosis of BPD may be attained in numerous ways, further complicating the diagnostic profile. Stone (1990) outlined 93 ways to meet criteria for a BPD diagnosis (*Diagnostic and Statistical Manual of Mental Disorders*, third edition [DSM-III]; APA, 1980). Individuals with BPD are also likely to receive three or four other Axis I labels (Zimmerman & Mattia, 1999). The addition of a new criterion in the *DSM-IV* only adds to the bewildering, and perhaps disturbing, array of combinations currently possible. Given the broad range of criteria, there is little wonder that about 22% of patients carry a label of "borderline" (Stefan, 1998). Not surprisingly, BPD has become one of the most popular (and perhaps pejorative) psychiatric categories. There is an entire professional journal devoted to BPD (*Journal of Personality Disorders*) and numerous books, articles, and workshops focus on counseling the client with BPD. Recently, I received through the mail a 5-pound, 626-page book on the topic. In a recent excursion to a major bookstore retailer, I noticed that in the psychology section, books dealing with BPD outnumbered those for other diagnostic categories. Given such mass marketing, one may well wonder if the diagnosis drives publication or whether publication drives the diagnosis.

Zanari et al. (1998) attempted to isolate characteristics of BPD. They identified "demandingness," entitlement, treatment regressions, and the ability to evoke inappropriate responses in one's therapist as significant behavioral characteristics of clients with BPD. Identification of these behavioral indices as support for BPD indicates just how far the profession is willing to go in accepting a diagnostic label. In an extreme variant on this theme, the borderline diagnosis is referred to as if it were equivalent to a symptom (e.g., the outcome of group treatments was said to be adversely affected when a group member had high levels of dissociation and a diagnosis of borderline personality disorder; Curtios, 1999). Arguing that a client is demanding because she has BPD or that a counselor responded inappropriately because her client has BPD are self-effacing strategies that do little to advance unbiased clinical understanding of BPD.

Although the late 1970s ushered in an era when it was standard fare for counselors to treat survivors of sexual abuse, professionals have become increasingly aware of the risks implicit in this treatment process. Along with clients claiming "recovered memories," the clients who incite the greatest anxiety and fear among counselors are those with "borderline personality disorder" (Curtios, 1999, p. 308). BPD has the distinction of being one of the few diagnoses for which a failure to thrive in treatment and the countertransference reactions of the counselor serve as evidence of validity (Becker, 1997).

In recent years, with the growing knowledge that many women diagnosed with BPD have experienced physical and sexual abuse (G. R. Brown & Anderson, 1991; Goodwin, Cheeves, & Connell, 1989), there has been an impetus to move away from viewing the victim as having a flawed character, a view that is inherent in the intrapsychic explanations for the etiology of BPD. BPD symptoms are increasingly discussed in terms of their relationship to external forms of stress, and perhaps for this reason, BPD and PTSD are often paired together. The comorbid diagnoses of BPD and PTSD thus are firmly rooted in the stress paradigm of psychopathology.

**BPD, STRESS, AND SOCIAL FUNCTIONING**

It has long been an underlying belief of those in the field of mental health that there is a correlation between disordered behavior and certain preceding stressors (Daley, Burge, &
Hammen, 2000). Severe stress, such as changes in life circumstances and sudden or prolonged trauma, produce aftereffects in the form of stress reactions, depression, flashbacks and so forth, from which the individual seeks relief by enlisting coping mechanisms intended to manage the corresponding symptomatology. Those who are exposed to such stressors and who lack an adequate support system or coping mechanism may experience psychiatric disorders (e.g., PTSD; Benjamin & Wonderlich, 1994).

Any discussion of the relationship between stress and BPD must take into account the social structure within which stressful conditions exist. Such conditions, and the options available to cope with them, are shaped by the sociohistorical context of a person's life (Cloward & Piven, 1979). BPD, for instance, has been shown to be associated with a lower likelihood of being married (Zimmerman, 1994) and a higher number of acrimonious endings of significant relationships (LaBonte & Paris, 1993) as well as a shorter duration of friendships, lack of a confidant or a romantic partner, and fewer social activities for adults and adolescents (Bernstein et al., 1993).

There are several limitations in the BPD literature related to stress and social functioning. First, most of the available research into BPD has relied on retrospective or cross-sectional methods of assessment (Perry, 1993). Second, many of the previous studies have relied on limited measures of self-reported social functioning (Daly et al., 2000). Much of the work on personality disorders has relied on participant personality measures such as marital status and the participant's self-report of interpersonal functioning. The results of such measures may fluctuate widely, depending on the mood and circumstances of the participant at the time of completing a survey. Third, the majority of research has been based on individuals who have met formal diagnostic criteria for BPD, typically in treatment-seeking populations. Such clinical populations may be characterized by a greater level of dysfunction than would be seen in the general community (Cohen & Cohen, 1984). In addition, the existing literature indicates that BPD symptomatology may best be conceptualized as existing across a broad continuum, with meaningful individual differences being observed beyond the simple presence or absence of a categorical diagnosis (Klein, 1993). Given that many of the thresholds for diagnosing BPD are fairly arbitrary (Kutchins & Kirk as cited in Becker, 2000; Widiger, 1992), BPD becomes a "projective" diagnosis, with clinicians possibly assigning such a diagnosis for reasons clear only to them. Given the arbitrariness of BPD criteria, a prudent counselor may be left with serious questions regarding the validity of a BPD diagnosis.

THE PREVALENCE OF PTSD

The rise of PTSD as a popular diagnosis has paralleled that of BPD. This has occurred due to an alteration in the method of defining the onset of PTSD. In the past two decades, PTSD has evolved from being defined as a new syndrome (APA, 1980) to the status of a commonly used and researched diagnosis (Andreason, 1995). In the diagnostic manual that preceded DSM-IV (i.e., DSM-III), stressful precipitating events had to be "outside the range of normal human experience" (APA, 1980, p. 236). With the publication of the current edition of the manual (Diagnostic and Statistical Manual of Mental Health Disorders, text revision [DSM-IV-TR]; APA, 2000) trauma was revised to include exposure to "an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or to others" (p. 467), but events that are not outside the range of normal experience. This revision has made it possible to conceive of the sexual and physical abuse perpetrated on large numbers of women as stressors that could lead to PTSD (Kutchins & Kirk, as cited in Becker, 2000). Curtois (1999) has broadened the scope of the definition of PTSD, suggesting that women subjected to long-term sexual abuse may have a more complex form of PTSD. For many, this was also an acknowledgment of the serious effects of such abuse and that PTSD is a broad diagnostic category.

There is no doubt that taking into consideration the ways in which long-term traumatic stress influences the development of girls and women is significantly preferable to a conceptualization of women's distress as being derived from intrapsychic phenomena. Recent changes in PTSD diagnostic criteria seem to indicate a much needed validation of and response to victimized women. Naturally, the emerging trend to use PTSD more frequently as a diagnosis has its drawbacks. The restructuring of the definition of trauma in the DSM-IV has increased by millions the number of those eligible for a PTSD diagnosis and has associated women who have been given this diagnosis with having a mental disorder (Kutchins & Kirk as cited in Becker, 2000). In addition, as abuse increasingly becomes linked with PTSD, such a large array of symptoms and syndromes is being substituted under the category "abuse" that one wonders if the term disorder is misleading. In her analysis of interviews with more than 40 feminist therapists, Maracek (as cited in Becker, 2000) observed that many of them found PTSD to be the only acceptable (i.e., nonstigmatizing, nonblaming) psychiatric diagnosis for women, as this portion of an interview with one of the therapists illustrates:

Almost my clients have PTSD and I tell them what it means. I say, "This means you are having a normal reaction to trauma. You're not having a sick reaction to trauma. You're having a normal response to trauma." (p. 425)

Despite the good intentions of the therapist just quoted, normalization of PTSD may be difficult to accomplish given the broad scope of current criteria. After all, even the current PTSD criteria continue to reflect the traditional stress-disease model. Yet, there is no single stressful event that triggers PTSD (Yehuda & McFarland, as cited in Becker, 2000). Because PTSD is not necessarily a universal response to abuse and because its symptoms are considered involuntary, those symptoms can exist only as constituents of disease (Lamb, 1999). PTSD, therefore, cannot be conceptualized as a "normal" response to trauma and simultaneously be called a "disorder" (Hamilton & Jenzvold, 1992). Naturally, when
a series of responses to stress is termed a \textit{disorder}; science has been used to justify it as a psychiatric issue, and the response is typically medical. As Becker (2000) noted:

Not only does acceptance of the widespread use of the PTSD diagnosis for women imply acceptance of a reductionistic theoretical framework that subordinates context to individual reaction, but also medicalization further separates that reaction into its psychological and biological components. (p. 425)

Mental health professionals insist on describing counseling as a science seem intent on validating the psychodiagnostic system through the identification of psychobiological substrates (Andreason, 1995; Seligman, 1975). PTSD, originally conceived of as an acute psychological reaction to a severe stressor, is increasingly being viewed as a medical disorder. Numerous studies are now being performed to determine the biological concomitants of PTSD (Yehuda & McFarland, as cited in Becker, 2000). The dichotomization of the psychological and environmental stressors is pervasive, as evidenced by Wolfe and Kimering's (as cited in Becker, 2000) statement, "Whether a differential vulnerability for PTSD in women relates to underlying or intrinsic characteristics...as opposed to external factors remains unclear" (p. 426).

**OVERINCLUSIVENESS OF DIAGNOSTIC CRITERIA**

With the rewriting of the criteria for diagnosis of PTSD and BPD, it has become difficult to view them as distinct and separate categories. Both of these categories have been termed "garbage can" categories because of the amplitude of their boundaries (Kroll, 1993). They overlap so frequently, and each is comorbid with so many other disorders, that it is difficult to justify the perceived close relationship between the two diagnoses on the basis of comorbidity alone. Then again, given the far-reaching methods of justifying such a diagnosis and the large numbers of women with the diagnosis (e.g., BPD), a counselor may begin to seriously question whether BPD is a disorder at all.

Personality disorder categories are hardly mutually exclusive, because most who have been diagnosed with a personality disorder such as BPD also meet criteria for at least one additional personality disorder (Pryor, Francis, Sullivan, Hurt, & Charkin, 1988). Roughly half of those who qualify for either a BPD or a histrionic personality disorder diagnosis meet criteria for both of these disorders.

Zanari et al. (1998), in studying the pattern of comorbidity of BPD with Axis I disorders, discovered that the symptoms of female inpatients with BPD overlapped frequently with symptoms of mood disorders and, to a lesser degree, with those of eating disorders and anxiety disorders. Instead of seeing this comorbidity as evidence of the blurred boundaries of BPD, the researchers emphasized that these comorbid disorders can "mask" an "underlying borderline psychopathology" (Zanari et al., 1998, p. 1733), thereby disguising "true" borderline symptoms. Zanari et al.'s solution to this dilemma was to maintain that the extensive comorbidity itself serves as a marker in establishing the uniqueness of the diagnosis by discriminating BPD from other Axis II disorders. The fact that 75% of the patients with BPD in one study exhibited a certain pattern of comorbidity and that 75% of other Axis II patients did not exhibit such a pattern was all the evidence these researchers needed to establish the validity of BPD.

The hypothesis that BPD is a separate diagnostic category rests on two assumptions. One assumption is that personality disorders are valid diagnostic categories. The second is that those clinicians who see BPD as a separate and distinct diagnostic category apply BPD criteria to inpatients as if this were proof of the validity of the disorder. Naturally, this second assumption could be seen as validation, but given the numerous ways to arrive at a diagnosis of BPD, one could cynically assert that clinicians \textit{find what they intend to find}. Thus, although the outcome is certain, the legitimacy of the process may be suspect.

Zanari et al. (1998) found that 56% of those with BPD diagnoses also met the criteria for PTSD. Like BPD, PTSD has criteria that overlap with symptoms of affective disorder. Major depression and dysthymia are among the diagnoses most frequently found to be comorbid with PTSD (Wolfe & Kimering, as cited in Becker, 2000), but the list also includes anxiety, social phobia, simple phobia, and panic disorder (Kessler et al., 1995). Research findings indicate that preexisting major depression may increase an individual's vulnerability to developing PTSD symptoms after exposure to severe traumatic stress (Resnick, Kilpatrick, Best, & Kamer, 1992). Because symptoms of anxiety and depression are frequently experienced by those diagnosed with PTSD and BPD, PTSD and BPD are significantly more prevalent among women than men (Kessler et al., 1995). Studies on the overlapping roles of gender, anxiety, and depression may prove more valuable than present attempts to separate the blurred boundaries between PTSD and BPD.

**CURRENT THOUGHTS ON PTSD AND BPD**

There are a variety of viewpoints regarding the relationship between PTSD and BPD. One school holds that BPD is best explained using a developmentally based theory maintaining that personality disorders manifest as the result of early, prolonged experiences of childhood abuse, rendering an individual particularly vulnerable to developing PTSD symptoms in reaction to stressors occurring in later life (Gunderson & Sabo, 1993). Their contention was that, currently, many adults with histories of childhood trauma are being misdiagnosed as having PTSD. This assertion does not concede the possibility that certain personality configurations may increase individuals' vulnerability to developing chronic symptoms of PTSD, that personality difficulties may function as a selector of those who are exposed to potentially trauma-inducing situations, or that personality disorder may follow from trauma (Wagner & Linehan, 1984). Kroll (2003) is very blunt regarding the overlapping between PTSD and BPD: "In a nutshell, the present concepts of PTSD and borderline are each so vague and encompass so many heterogeneous conditions that it is
impossible to know what each one is, let alone whether they are the same thing" (p. 70).

A current perspective is that BPD is actually a chronic form of PTSD that has become integrated into the personality framework (Landecker, 1992; Zimmerman & Mattia, 1999). This theory maintains that prolonged and repeated stress can result in the development of behavior patterns that are maladaptive but that cannot be readily distinguished from personality traits (Kroll, 1993). Thus, many women who have been exposed to chronic trauma are incorrectly misdiagnosed as having personality disorders, particularly BPD.

**BPD and PTSD**

An emerging group of clinicians suggests that those women with abusive histories who are currently diagnosed as having BPD are experiencing this chronic form of PTSD (as described above) or fit into some category situated between BPD and PTSD (Alexander & Muenzennmaier, 1998; S. Brown, 1994). Frequently, the case is made that the PTSD diagnosis assists in creating a healthier treatment framework for women currently labeled as having BPD, because it eliminates the negative connotations associated with BPD, offering instead a situationally focused (as opposed to a blaming) approach to treatment. This notion of trauma-based counseling is more likely to elicit greater feelings of warmth and acceptance from the counselor, along with a greater willingness to identify with the client and to believe in her ability to make healthy changes (S. Brown, 1994).

There is little doubt that moving toward situational rather than intrapsychic antecedents for BPD represents a considerable advance in thinking regarding both the etiology and the treatment of this disorder. The movement toward replacing a diagnosis of BPD with one of PTSD is also problematic. It is difficult to conceive that sexual, physical, and verbal abuse are the sum of all difficulties experienced by women currently diagnosed as having BPD or that the existence of abuse alone determines the focus of therapy. It has been generally assumed that because women are more often subject to physical and sexual abuse than men, gender is a risk factor for the development of PTSD (Daley et al., 2000; Wolfe & Kimerling, as cited in Becker, 2000). Landecker (1992) supported this point of view and its corollary, that PTSD as the response to childhood abuse is "implicit in most borderline diagnoses" (p. 236).

Counselors and other clinicians have begun to recognize, however, that not all women diagnosed with BPD have been sexually or physically traumatized and that multiple factors can produce the varied symptomatology of BPD. Furthermore, some have asserted that these symptoms should not be considered as indicative of a unified disorder (Becker, 1997; Kroll, 1993). The belief that gender is a predisposing factor for victimization through sexual and physical abuse and for BPD or PTSD symptoms fails to take into account that the ways in which individuals express distress (i.e., deviate behaviors) are often socially determined. As previously noted, individuals' experience of stress is shaped by aspects of the societal concept of posttrauma, by their own interpretations of stressful events, and by their evaluations of the options available to them in coping with these events (Clovard & Piven, 1979). However, there are natural differences among individuals in their exposure to stressful events and the level of intensity of these events, as well as individuals' predisposition to overreact to stress. Furthermore, there are gender differences regarding perceptions of what is considered stressful (Kessler et al., 1995), and some researchers have asserted that there may be women who have a genetic predisposition to BPD (Linehan, 1993). Therefore, BPD may be a complex series of "disorders," each with various antecedents and potential causes.

When PTSD was considered for inclusion in the DSM-III, the question arose as to whether there should be a different diagnosis for symptomatic responses to each type of traumatic experience. The consensus was, however, that PTSD was a unitary disorder resulting from exposure to various types of traumatic events (Andraeason, 1995). Nevertheless, it has been argued that within the broad range of individual responses to different traumatic events, there are many symptomatic configurations, only some of which could be considered to be PTSD (Becker, 2000; Lamb, 1999).

A developmental perspective applied to the symptomatology of BPD and PTSD implies conceptualizing both the severity of the stressor(s) and the experience and expression of distress along a continuum. The severity of the stressor may or may not predict the kind, severity, or persistence of symptoms (Figueroa & Silk, 1997). A developmental framework accounts for multiple mediators of stress and response to stress that the current diagnostic system, with its insistence on medical disorders as categorical entities, cannot do. Others in the field have advocated similar approaches, such as Ivey and Ivey (1999) who have maintained that the broader DSM classification system could also benefit from a developmental approach. It is reasonable to maintain that dissociating from a painful memory may on occasion be a healthy coping mechanism. Thus, to conceive of chronic trauma in a unilateral fashion, identifying most women who have experienced trauma as psychopathological, only continues to distort the nature of trauma and how it is categorized. Furthermore, instilling hope, a healing factor that is particularly useful with clients who have a complex type of PTSD, is a developmental outcome of a healing counseling–client encounter (Marotta, 2000). Sadly, this latter construct is often overlooked in treatment (Ginter, 1999).

"Good" Clients and "Bad" Clients

Clearly, BPD has become a very popular diagnosis for a variety of reasons. Despite its prevalent application by mental health counselors and related professionals, it has yet to be demonstrated that clinicians can make this diagnosis with any reliability (Kutchins & Kirk, as cited in Becker, 2000). Paradoxically, clinicians continue to find new and innovative methods of diagnosing BPD (Kutchins & Kirk, as cited in Becker, 2000; Walkner, 1994). Within the broader
mental health community, PTSD and BPD diagnoses are often loosely applied. Walker made the following observation:

Many therapists who treat incest survivors believe that such a diagnostic category [PTSD] would permit greater access to appropriate treatment focusing on the situational trauma and its subsequent sequelae... other therapists find the personality disorder diagnosis more to their liking. (p. 113)

Regardless of the ease with which the BPD label is applied to women, carrying such a label is no casual matter. In a study of court documents, Stefan (1998) discovered that women with BPD are often considered mentally unstable and are therefore subject to institutionalization, forced medication, and loss of parental rights. In a similar vein, they are also discredited as court witnesses in cases involving sexual assault. This contrasts significantly with the manner in which women diagnosed with PTSD are treated. These women often benefit from the law on the basis of disability yet are not considered to have a mental disability. It is interesting that the disability of women with a BPD label is not thought to be severe enough that they qualify for educational or disability benefits, or even to allow them to recover damages in cases of abuse.

Labeling Issues

The consideration of issues regarding transference and countertransference and the therapeutic relationship in general differs substantially depending on whether or not the client is diagnosed with PTSD or BPD. In the literature, discussions of countertransference provide substantial information regarding the counselor’s ability to understand and empathize with the client’s trauma (Segrin & Abramson, 1994). In fact, counselor empathy is considered essential in dealing with a variety of mental health concerns, from major depression to bereavement issues. Empathetic reactions are evoked as a result of the counselor’s exposure to the client’s experience. When the discussion on the role of counselor empathy focuses on the client with BPD, however, the literature warns of the dangers inherent in empathizing too closely with such clients (Gilbert, 1992). Ochberg (1991) stated, “collegiality (among BPD clients) may be interpreted as intimate friendship... and lead[s] to instable requests for help” (p. 14). The literature on treatment of clients with BPD often includes lengthy discussions of relational horrors that counselors might anticipate. A few years ago, I attended a national conference for directors of college and university counseling directors (Clinical Services in College, 1999) that included an entire workshop devoted to problematic issues of counseling students with BPD. One of the terms frequently used in the workshop referred to “containing” borderline students. Naturally, such negative descriptions serve to further marginalize those unfortunate enough to be given the label. As Beck and Freeman (1990) summarized, “The litmus test for any conceptualization is whether it explains past behaviors, accounts for present behaviors, and predicts future behaviors” (p. 352).

When responses to trauma constitute the means through which counselor and client attend to the client's idiosyncratic experience, trauma becomes centralized “as an essential category of human existence, rooted in individual rather than social dynamics and reflective more of medical pathology than of religious or moral happenings” (Kleinman, 1995, p. 177). Hasken and Schlap's (1991) argued that this centralization of trauma in counseling may obscure other events and relationships that exist concurrently with, or even predate, sexual abuse trauma. Furthermore, such exclusive focus often comes to define the client's sense of self, thereby potentially sealing off other important domains for exploration. The counselor's persistent focus on sexual abuse may even be perceived by clients as a demand to focus on this issue, and many women seeking to be “good” clients may have difficulty resisting this explicit or implicit message. The centralization of trauma in counseling may also place at risk those clients who cannot be considered either victims of specific abuse or compliant victims. Women with BPD, many of whom are given this diagnosis precisely because they present relational challenges (i.e., are not as likable) in counseling, may fall into this category. Although it is true that clients with BPD can be difficult to work with, they are, by no means the only difficult clients. Use of the term borderline simply as a pejorative label for difficult clients robs it of any utility (Beck & Freeman, 1990). Furthermore, it is reasonable to suspect that any client who has knowingly received the diagnosis of BPD could scarcely be faulted for being upset once the nature of the diagnosis has been revealed to them.

Trauma-based counseling fits nicely into the medical model, despite views to the contrary (Maracek, as cited in Becker, 2000). When trauma is central扎ed, the language is transformed to include terms such as injury, wound, and pain. Healing and recovery then become the goals of counseling (Maracek, as cited in Becker, 2000). The diagnostic criteria for PTSD emphasize the persistence of symptoms, and the experience of posttraumatic stress is deemed pathological because it persists. This opinion implies that it is not normal for individuals who have been traumatized to continue to “suffer” (Kleinman, 1995). The view of suffering apparently implied in the DSM-IV seems to be that pain is unnatural and that individuals should work through their memories of trauma. This minimization of pain seems to have taken root in Western society and is evidenced by the way major drug companies market directly to the public. One almost gets the sense that if one is feeling less energetic, products such as Prozac (and others) can enhance one’s life. This is a radical departure from the view of clinicians such as Frankl (1959), who considered suffering to be part of the human condition and not at all a sickness.

"Recovery" is held out as a possibility for clients with PTSD, whereas for those labeled with BPD, the outlook is bleak, even though research has not yet established that these are separate disorders (Kessler et al., 1995). This is dramatically illustrated in a child custody case involving a woman diagnosed with BPD, wherein the court found that the mother, because of her disorder, was "not likely to benefit from counseling" (Stefan, 1998).
CONCLUSION

Although the concept of recovery is in accord with Western ideals regarding the ability of human resiliency to endure against the odds, the mental health field seems to have acquired a sense of resignation in certain diagnostic areas, in particular that of BPD. This may simply mirror what Seligman (1975) has suggested is a societal sense of alienation and lack of community in a world that appears to be so destructive and where so much is beyond individuals’ sphere of influence.

A case could also be made that the mental health community’s continued adherence to the medical model, which has weak empirical support (Beutler, 1989; Duncan & Miller, 1999), may symbolize the human need to classify what we do not understand in order to create a sense of understanding it. In this case, “good” clients work with their counselor, and “bad” clients are those who fail to fit into the carefully constructed framework. The medical model contributes to the social control of many clients, especially women, by expanding the definition of psychopathology. This leads those of us in the field of mental health to pursue “cures” for the diseases of BPD and PTSD.

The medical model classification system has not helped mental health professionals to resolve the societal dilemmas implicit in treating abused women. The current literature on BPD, for example, is inconsistent in its methodology of assessment, has relied on small clinical samples (Bartholomew, Kwong, & Hart, 2001), and is overreaching in the numbers of clients who meet criteria for diagnosis (Stone, 1990). Rather, the literature has simply provided another complex nosology that fails to address deeper societal ills, namely, that the majority of those with PTSD and BPD are women who are experiencing the effects of abusive environments and relationships. In a new publication, Kroll (2003) made a strong statement regarding the antiquity of the term borderline:

I think the major struggle that we have about the issue of terminology here is that the term “borderline” is a terrible term and should be dropped from use. It does not convey anything helpful; it is a remnant of incorrect theoretical concepts of another era. (p. 78)

Given the psychosocial nature of where societal “power” and “control” reside (e.g., men), a focus on what ails society (as opposed to blaming the victims) would provide a much-needed change that could also influence the perspective within the field of mental health. The medical model only compounds the issue by expanding the parameters of illness (e.g., more diagnostic terms). Naturally, diagnosing individuals who have experienced severe abuse is a complex matter. Regardless of how survivors of domestic and sexual violence are categorized, treatment and recovery from abuse can be a long and difficult healing process. It is noted that diagnostic bias does also affect men—male clients are far more likely to generate labels such as Conduct Disorder and Antisocial Personality Disorder (Holmes, 2001). Although I do acknowledge this, the bulk of the evidence is that women experience far more negative consequences and stereotyp-


Clinical services in college and university counseling centers. (1999). Workshop conducted at the annual conference of the Association of University and College Counseling Center Directors, Miami, FL.


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TITLE: Borderline Personality Disorder and Posttraumatic Stress Disorder: Time for Integration?
SOURCE: J Couns Dev 81 no4 Fall 2003
WN: 0328802459003

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