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Examining the Relationship Between Childhood Trauma, Interpersonal Difficulties, and Attachment Styles in BPD

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Abstract: ***Almost 1.8% of the world's population is diagnosed with borderline personality disorder (BPD). Individuals with BPD are prone to exhibit self-destructive behaviour and are also associated with higher drop-out rates from therapy as well as research studies due to impulsivity, affective instability or emotional dysregulation, and significant interpersonal difficulties. This paper will review the body of literature related to the question of how certain environmental factors are associated with a higher risk of developing BPD. Further, the paper also looks at how these factors affect an individual's interpersonal relationships. This research could help minimize environmental risk factors from an early age and inform the development of tools for individuals working to maintain stable relationships with someone diagnosed with BPD.***

Keywords: Borderline Personality Disorder, environmental risk factors, emotional dysregulation, interpersonal relationships, early intervention, childhood trauma, attachment styles, interpersonal difficulties, development, etiology

1. Introduction

Borderline personality disorder (BPD), as defined in the Diagnostic Statistical Manual, Fifth Edition (DSM-V), is a complex and debilitating condition that is most often characterized by difficulties in emotional regulation, interpersonal functioning and self-identity (American Psychiatric Association, 2013). According to the DSM-V TR (2025), a BPD diagnosis can be made based on two broad criteria. The first is impairment in personality functioning in an individual, which is manifested by characteristic difficulties in two or more areas. These characteristics include identity, self-direction, empathy and intimacy. The second criteria is four or more pathological personality traits from a list of seven, being observed in an individual, at least one of which must be impulsivity, risk taking, or hostility. The seven personality traits are emotional liability, anxiousness, separation insecurity, depressivity, impulsivity, risk taking and hostility.

Data suggest that approximately 1.8% of the global population meets criteria for BPD (Grant et al., 2008), highlighting its significance as a public health concern. Despite its low prevalence compared to mood or anxiety disorders, BPD is associated with high levels of impairment and suicidality, making it an urgent focus for intervention. Pooled estimates (about 34,832 BPD patients) found estimates for lifetime suicidal ideation (≈ 80%), lifetime suicide attempts (≈ 52%) and death by suicide (≈ 6%) (Lak et al., 2025). Studies have commonly reported about 10–12% of psychiatric outpatients and 20–22% of psychiatric inpatients as meeting criteria for BPD (Leichsenring et al., 2024). Thought of as one of the most challenging disorders to treat, BPD causes instability in relationships and self-image as well as impulsivity. Indeed, BPD has historically been stigmatized as "untreatable" due to several reasons. When Stern (1938) introduced the term borderline, he meant patients who didn't fit neatly into neurosis or psychosis and since existing frameworks did not fit these groups of patients, they were often viewed as confusing, unpredictable, and "hard to help". Further, BPD patients often had intense interpersonal patterns which meant rapid shifts between idealizing and devaluing therapists, anger outbursts and a fear of abandonment. This led to burnout in clinicians, who in turn would describe patients as manipulative or demanding or view patients as "difficult" or "troublemakers" hence reinforcing stigma. This could then tie to the suicide rates, where 75–80% of BPD patients attempted suicide at least once and 6–10% died by suicide due to not receiving enough or proper treatment.

In the late 18th century BPD was termed as "borderline insanity" by Charles H. Hughes (1884) or "excitable personality" by Emil Kraepelin (1921) which now maps onto elements of what BPD is seen as today (Ritschel & Kilpela, 2014). The label "borderline" comes from early perspectives that framed the disorder as a borderline condition between neurosis and psychosis (Stern, 1938). Neurosis generally refers to mental disorders characterized by anxiety, emotional distress, and maladaptive behaviors, without a loss of reality testing, whereas psychosis involves a disconnection from reality, including hallucinations, delusions, and impaired insight (Dholakia et al., 2015). A study conducted by Roy Grinker, Werble & Drye (1968) is also often considered one of the first empirical studies of what we now call BPD (Lenzenweger & Cicchetti, 2005).

Since Stern's initial conceptualization, research has refined the understanding of BPD, highlighting its distinct patterns of emotional dysregulation, interpersonal difficulties, and identity disturbances, rather than viewing it solely as a midpoint between neurosis and psychosis. Still, despite significant progress, important gaps in the literature remain, such as there being very few longitudinal studies with precise, accurate or high quality data. Such longitudinal studies could help identify early markers of BPD as well as effects of early intervention thus reducing long-term morbidity. Further there is also a lack of representative data for adolescents as well as a lack of research on how factors interact to affect treatment outcomes and overall condition of an individual diagnosed with BPD.

Addressing these gaps carries clinical and social importance, as improved understanding could help build and enhance early prevention strategies, minimize environmental risk factors among children, and help optimize assessment among adults who show signs or symptoms of the disorder but have not yet been diagnosed or treated for it.

This paper seeks to explore the relationship between childhood trauma, attachment, and interpersonal functioning in BPD. Nine peer-reviewed journal articles are reviewed in the following three sections of this paper. These journal articles include cross-sectional studies, literature reviews, comparative studies and correlational studies. The findings of this body of research are summarized, strengths and weaknesses are considered, and implications for research and practice are discussed.

Childhood Trauma

While BPD has a complex etiology that includes a variety of factors, empirical research has consistently highlighted the significance of early experiences, particularly childhood trauma, in its development (Bozzatello et al., 2021). Childhood trauma, including physical, emotional, and sexual abuse and physical and emotional neglect, have been linked to disruptions in emotional regulation, attachment patterns, and identity formation, all of which are core features of BPD (Kuo et al., 2015). Evidence suggests that early traumatic experiences can heighten vulnerability to unhealthy coping mechanisms (Vaughn-Coaxum et al., 2017). Understanding the relationship between childhood trauma and the onset of BPD is crucial not only for early identification and prevention of the disorder but also for the development of targeted and informed interventions.

Trull (2001) performed a cross-sectional study to determine the relationship between borderline features, parental mental illnesses, childhood abuse, and current functioning. Trull recruited 1,907 students enrolled in an introductory psychology course to complete the Personality Assessment Inventory - Borderline Features (PAI-BOR) scale. From this initial screening pool, 65 individuals total scoring both above and below the threshold for BPD (21 PAI-BOR BPD-positive and 44 PAI-BOR BPD-negative individuals) were randomly selected to participate in the subsequent laboratory phase of the study. Selected participants then completed the PAI-BOR scale again to determine whether they remained above or below the threshold, with the time between the initial test and retest ranging from 3-12 weeks. Participants were made to complete the PAI-BOR scale twice in order to determine whether their scores were consistent or not. Those who scored above or below the threshold on both instances completed several structured interviews in a 4-hour laboratory session. These interviews included the Inventory of Interpersonal Problems (IIP), The BPD criteria section of the DSM-IV (SIDP-IV), Diagnostic Interview for Borderlines Revised (DIB-R), Familial Experiences Interview (FEI) selected items from the Family History Research Diagnostic Criteria (FH-RDC) and the Social Adjustment Scale.

The researchers found that scores on the three measures of BPD (PAI-BOR, SIDP-BOR, and DIB-R) were significantly correlated to each other. A history of childhood sexual abuse was not significantly related to any borderline measure, which the authors postulated was likely due to the low prevalence of sexual and physical abuse present in the sample. Notwithstanding, physical abuse was significantly related to the borderline scores. Parental mental illness was also significantly related to borderline scores. The study concluded that BPD features were influenced by multiple interacting risk factors such as parental mental illness and to a lesser extent childhood abuse. The authors also highlighted the non-clinical nature of the sample, arguing that, as opposed to patients who have received BPD diagnoses and are participating in treatment, their study participants better represented those in the general population who may experience subclinical features but may go on to receive full diagnoses later on.

Other studies investigated broader forms of childhood trauma across clinical and epidemiological studies, reinforcing the link between early adversity and BPD while highlighting the importance of multiple types of trauma.Ball and Links (2009) conducted a literature review in order to assess whether the current body of research, including clinical, cross-sectional, and epidemiological research published between 1995–2007, supported a causal relationship between childhood trauma and the later development of BPD. This was done by evaluating studies against Hill’s causation criteria which is a set of 9 viewpoints, used to assess whether an observed association between an exposure and an outcome is likely to be causal. The articles reviewed by the authors concerned traumatic experiences involving sexual abuse, physical abuse, emotional neglect, and invalidating environments, and assessed BPD using previous diagnoses as well as validated scales and clinical interviews for diagnosis. In sum, this review demonstrated that there is consistent evidence of a strong association between childhood trauma (especially sexual and emotional abuse) and BPD. Experiences of severe or multiple traumas also correlated with greater severity of BPD symptoms. Additionally, such symptoms tended to be more severe when trauma occurred within invalidating or unsupportive environments. Ball and Links concluded that, when viewed within a multifactorial model that includes genetic and environmental components, childhood trauma likely represents an important contributor to the development of BPD.

In addition to Ball and Links (2009) review of the broader forms of childhood trauma across clinical and epidemiological studies, Zashchirinskaia & Isagulova (2023) dove deeper into the concept of childhood trauma and investigated how it could be a risk factor for the development of high risk behaviour, hence tying childhood trauma further to BPD patients’ impulsive behaviors.

Zashchirinskaia & Isagulova (2023) further investigated the role of childhood trauma as a risk factor for the development of high-risk behaviours (e.g., suicidal behaviours, eating disorders, addictive behaviours, sexual risk behaviours) through a cross sectional study. This investigation was done by comparing results found from this study, of non-BPD adolescents to those diagnosed with BPD. The study included 120 adolescents, 60 participants diagnosed with BPD and 60 without BPD. Participants’ ages ranged from 12 to 18 years. The BPD group included 22 males and 38 females, while the non-BPD group included 25 males and 35 females. Participants had to be recently referred to psychiatric clinical centers, with no prior psychiatric medication history. The diagnostic assessment for BPD was done for participants based on the DSM 5 criteria. Participants completed self-reporting through various measures such as Childhood Trauma Questionnaire (CTQ-28), Sexual Addiction Screening (SAST), Eating Attitudes test (EAT-26), chemical dependence screening (RAFFT test) and Suicidal Behaviour Questionnaire. Demographic and trauma history data was also collected.

It was found that all adolescents with BPD had experienced at least one form of childhood trauma. Trauma prevalence for emotional trauma (76.7% vs 56.7%), physical abuse (30% vs 11.7%), emotional neglect (43.3% vs 25%), physical neglect (30% vs 13.3%) and harassment (23.3% vs 8.3%) were all higher for the BPD group as compared to the control group. High risk behaviours in BPD such as suicidal behaviour (23.3%), eating disorders (23.3%), addictive behaviours (30%) and promiscuity (16.6%) were also observed. Correlations among emotional abuse and eating disorders were seen for girls, whereas emotional abuse correlated more to suicidal behaviours in boys. Emotional abuse and neglect also led to more addictive behaviours overall. The study concluded that childhood trauma is significantly more prevalent in adolescents with BPD than the control group and that specific forms of trauma predicted different high-risk behaviours in BPD adolescents. These results show how trauma is a core risk factor in the development of BPD symptoms and maladaptive coping mechanisms among adolescents.

Together, the findings from these studies demonstrate that while childhood trauma may not act as a sole or universal predictor of BPD, it represents an early and significant risk factor for the development of the disorder. Whereas Trull (2001) highlighted the role of parental mental illness and physical abuse as interacting influences on borderline features in non-clinical populations, Ball and Links (2009) highlighted that childhood trauma and other early adversity are strongly linked to both the onset and the severity of BPD symptoms. These findings illustrate the importance of targeting etiological factors, such as early trauma involving experiences of abuse or parental mental illness, in psychotherapeutic interventions for BPD, so that early interventions can be put into place and development of BPD can be controlled through therapeutic methods. These studies also collectively emphasize that early experiences, especially those involving parents and caregivers, play a central role in shaping the development of BPD.

Attachment Style

A growing body of research has linked BPD to patterns of insecure and disorganized attachment. Attachment theory states that early relationships with primary caregivers form the foundation for emotion regulation.

Table 1: Attachment Styles, Key Features and their Manifestation in BPD (Mosquera et al., 2014)

Attachment Style	Key Features	Manifestation in BPD
Secure	Comfortable with closeness and autonomy, trusts others, seeks support when needed, but can self-soothe and has a positive view of self and others.	Rare in BPD populations (though not absent) and when it is present, it acts as a protective factor against severe symptoms. Also linked to better emotion regulation, more stable relationships, lower suicidality, and better therapy outcomes.
Anxious/ Preoccupied	Intense fear of abandonment, excessive need for closeness, hyperactivation of attachment system (such as clinginess and worry about rejection) and negative self-image but positive view of others.	Very common in the BPD population. Extreme sensitivity to real or perceived abandonment. Clinging, dependency, and frantic efforts to maintain closeness. Heightened emotional reactivity when attachment needs are not met and frequent crises in relationships, unstable bonds, repeated reassurance-seeking.
Dismissive/ Avoidant	Downplays the importance of relationships, values independence and suppresses attachment needs and emotions. Has a positive view of self but negative view of others.	Less common than anxious/disorganized, but still commonly present. Manifests as apparent self-reliance masking fear of closeness, avoids vulnerability through emotional detachment, withdrawal, or “coldness” in relationships. Swings between avoiding closeness and suddenly fearing abandonment. May resist dependency on therapist, drop out early or present as “hard to reach” in therapy
Disorganized/ Fearful	Combination of anxious and avoidant due to simultaneous desire for closeness and fear of it. Often develops from abuse, neglect, or trauma by caregivers. Has a negative view of self and others and is characterized by contradictory behaviors.	Most strongly linked to BPD in research. Manifests as intense push and pull dynamics Characterized by dissociation, emotional flooding, sudden rage or shutdown in relationships. History of trauma or maltreatment often underlies this pattern. Also associated with the most severe BPD features such as identity disturbance, self-harm, dissociation and chronic suicidality.

Disruptions in attachment relationships (e.g., inconsistent caregiving, neglect, abuse, or other relational traumas, contribute to prominent symptoms of BPD) do not only lead to attachment insecurity, but also shape prominent symptoms of BPD, including high levels of attachment anxiety and avoidance, heightened sensitivity to rejection and abandonment, and emotion dysregulation (Bungert et al., 2015). Investigating the relationship between attachment and BPD is essential for understanding its developmental origins and for informing therapeutic approaches, specifically ones that emphasize the repair and restructuring of attachment systems. Further, irregular or negative attachment patterns have been constantly portrayed as one of the factors for the causation of BPD as well as a factor highly affected by the development of this disorder. Those with symptoms or a diagnosis of BPD have varying attachment styles but all are severe. A trend seen across studies shows that disorganized, preoccupied, and dismissive attachments are consistently elevated in BPD but this may differ based on comorbidities or relationship contexts (Beeney et al., 2017).

For example, a study by Barone et al (2011) investigated whether individuals diagnosed with BPD and another psychiatric disorder (i.e., mood/anxiety, substance use, alcohol use, and eating disorders) were more likely to exhibit attachment insecurity. 140 Italian inpatients and outpatients

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aged 18–54 with a BPD diagnosis (61% female) were divided into four subgroups based on comorbidities: mood/anxiety disorders (n = 40; 29% of the sample), substance use and abuse disorders (n = 40; 29% of the sample), alcohol use and abuse disorders (n = 40; 29% of the sample) and eating disorders (n = 20; 13% of the sample). Participants had no prior history of engagement in psychotherapy but were users of inpatient psychiatric units and outpatient psychiatry facilities in Italy. Each participant was administered diagnostic assessment via SCID-I and II (DSM-IV) as well as the Adult Attachment Interview (AAI) one to two months before beginning psychotherapy.

The adult attachment scoring and classification system includes a number of rating scales with a score of 1 to 9, organized into three sections. The first section includes a group of eight scales, four related to the mother and four related to the father, on the subject's reported subjective experience of childhood. The second includes six scales for current mental states related to attachment figures. The third section includes several scales for assessing overall states of mind, independently of the caretaker considered. Attachment states were further also classified: F - Secure-Autonomous, Ds - Dismissing, E - Enmeshed-Preoccupied, U - Unresolved, CC - Cannot Classify (implies a form of disorganization which corresponds to the presence of both kind of insecurity categories, i.e. Ds and E). Every AAI text was then assigned to one of the three organized patterns (F, D, or E) as a primary or secondary classification or to the disorganized classification (U-CC), covering inferred developmental experiences and current states of mind. Based on their results, the authors concluded that BPD patients tend to demonstrate high insecurity in attachment, with specific patterns tied to comorbidities. Additionally, Ds (72 participants) at 51% and E (49 participants) at 35% were overrepresented patterns in this sample. Differences were also present, where comorbidities were internalized (60%), meaning comorbidities were caused due to internal factors (e.g., mood/ anxiety) and higher preoccupied/enmeshed (i.e. E classifications) states were found. When comorbidities were externalized (58%), meaning comorbidities were caused due to external factors or external symptoms (e.g., substance/ alcohol abuse and eating disorders), more dismissing (i.e. Ds classifications) states were found.

The study done by Van Dijke & Fore (2015) builds on or contrasts with Barone's findings regarding fear of abandonment or emotional regulation and thus provides more insight into attachment styles of the population affected by BPD.

Van Dijke and Ford (2015) investigated whether BPD diagnoses, either on their own or together with somatoform disorder (SoD), are linked to particular patterns of emotion regulation difficulties and adult attachment styles. Specifically, this study tested the following hypotheses: (1) people with BPD would be more likely than those with SoD or other mental disorders to show intense fear of abandonment and under-regulation of their emotions due to an overactive internalized attachment system, and (2) people with SoD would be more likely than those with BPD or other mental disorders to fear closeness and over-regulate their emotions due to an underactive internalized attachment system. These hypotheses were tested using a cross-sectional study of 472 participants, including patients with BPD only (n = 120), Somatoform Disorder (SoD) only (n = 159), BPD + SoD (n = 129) and psychiatric comparison groups with depression/anxiety but no BPD/SoD (n = 64). Two-thirds of the sample were female and participants were aged X-X years, with a mix of education levels. The intake diagnosis was confirmed by a clinician using DSM-IV structured interviews (CIDI, BPDSI). The constructs of interest were measured using the SIDES-rev-NL (emotion dysregulation subscale), Bermond Vorst Alexithymia Questionnaire (BVAQ) and Relationship Style Questionnaire (RSQ). Reliability checks were then conducted. The study then found that under-regulation of emotions moderately correlated with fear of abandonment and weakly correlated with fear of closeness. These results show that BPD is associated with under-regulation and fear of abandonment more strongly, as compared to somatoform disorders, which are associated more often with over-regulation of emotions and inhibited/denied fears of abandonment/closeness. BPD and somatoform disorders together, were associated with both fear of abandonment and fear of closeness (disorganized attachment features). This study then concluded that insecure attachment patterns were central in both BPD and SoD but manifested differently. In BPD patients, hyperactivating strategies (emotional under-regulation, high fear of abandonment) were manifested whereas in SoD patients, deactivating strategies (emotional over-regulation, suppressed fears of closeness/ abandonment) were manifested.

Similarly, Charnas et al. (2024) can also be linked back to the earlier studies by showing how relationship targets influence specific attachment patterns.

Charnas et al (2024) investigated whether there were differences in insecure attachment styles toward a primary caregiver among adults with BPD. The sample contained 64 adults, professionally diagnosed with BPD which were recruited through social media and mental health groups. Online informed consent was taken from all participants. Self-report questionnaires were then taken on attachment toward each target. Participants were also asked to self-report on BPD symptoms in the past week. Fearful-disorganized and avoidant-dismissing styles were significantly higher for primary caregivers, whereas preoccupied-anxious styles were found more significantly in relation to romantic partners. While insecure styles were prevalent, certain insecure type attachment styles were linked to greater symptom severity. The study then concluded that BPD was associated with elevated insecure attachment, but the patterns differed according to the relationship target. Fearful-disorganized and avoidant-dismissing styles toward caregivers, and preoccupied-anxious toward significant others, were also particularly linked to higher symptom levels.

Overall, the evidence across these studies concludes that insecure attachment is a core feature of BPD, but its manifestation varies depending on comorbidities and relationship contexts. As stated in the studies, individuals with BPD consistently show elevated rates of disorganized, dismissing, and preoccupied attachment, often accompanied by heightened fears of abandonment, emotional under-regulation, and relational instability. The type of insecure attachment expressed by individuals may also differ across different relationship types. Individuals may develop dismissive or fearful attachment toward caregivers whereas the development of preoccupied attachment would manifest in romantic relationships. This highlights the specific relational forms of attachment disturbances in BPD. Collectively, these findings show that attachment insecurity is not only prevalent in BPD but also central to its symptoms.

Interpersonal Functioning

Alongside difficulties with emotion regulation, identity diffusion, and attachment insecurity, interpersonal dysfunction represents a core aspect of BPD that generates significant distress for affected individuals as well as those supporting them. Such dysfunction often manifests as intense and unstable relationships, heightened rejection sensitivity, fears of abandonment, and ongoing difficulties trusting others. Given that interpersonal stressors often cause symptoms to worsen. Thus, it is important to understand the link between interpersonal functioning and BPD in order to avoid symptoms from getting worse. Some trends were also seen across studies, such as heightened conflict, rejection sensitivity and relational instability among participants with a BPD diagnosis. There were also differences in measurement approaches as well as types of relationships examined, further highlighting why understanding interpersonal functioning is necessary.

For example, Abdevali et al (2021) performed a comparative study of individuals with BPD and non-clinical individuals in order to assess for significant differences in preferred Comfortable Interpersonal Distance (CID). CID refers to the physical distance humans prefer towards others during social interactions (Shilat Haim-Nachum et al., 2024). 36 outpatients with BPD and 40 healthy control patients were sampled through convenience sampling. This included 17 men and 19 women with a mean age of 26.58 years. The patients that were recruited met at least 5 of 9 symptoms as listed in the DSM-IV criteria for BPD. Participants completed a computerized version of the CID task, in both passive (being approached) and active (approaching) modes. CID was measured for seven relationship types: mother, partner, close friend, childhood self-image, current self-image, salesperson (neutral) and thief (threatening). Repeated measures ANOVA test and post hoc Bonferroni tests were also performed. The study concluded that BPD patients preferred significantly larger interpersonal distances from all relationship types except the salesperson. The most notable distances were observed with childhood and current self-images, suggesting self-alienation in those affected by BPD. The BPD group also perceived familiar or close figures as potential threats, indicating heightened rejection sensitivity and threat perception.

Stepp et al. (2009) further extends the findings made by Abdevali et al (2021) by examining real-world social interactions rather than just preferred interpersonal distance.

Stepp et al (2009) aimed to research whether individuals with BPD differ from Outpatient Department (OPD) and non-outpatient department (NOPD) groups in terms of the quantity and quality of social interactions. The sample included 111 adults (ages 21-60; 78.4% female) recruited from Western Psychiatric Institute and Clinic in Pittsburgh. Out of this sample, 42 participants were part of the BPD group, 46 part of the OPD group and 23 part of the NOPD group. A structured clinical interview for DSM-IV Axis I and II Disorders (SCID-I and SCID-II) was conducted for each participant. Then, a three-session best-estimate diagnostic evaluation was made, after which the final diagnosis was made through a clinician consensus conference. Participants completed electronic social interaction diaries (SID) twice a day for 7 consecutive days. Each entry described one salient interaction (≥10 minutes), detailing the relationship type (e.g., romantic, friend, family), interpersonal experiences (e.g., control, closeness, conflict, ambivalence) and emotional reactions (e.g., anger, anxiety, sadness, emptiness, positive emotions). Overall, the researchers found that the BPD group had fewer unique contacts per day than NOPD, but similar interaction quantity and duration as OPD/NOPD. The BPD group also reported more disagreement and ambivalence, especially in romantic and family contexts, implying interpersonal difficulties. BPD participants also specifically experienced more anger, emptiness, and sadness than OPD/NOPD groups.

Similarly, the study done by Lazarus et al. (2020) could be tied to the other studies due to the research on how BPD-related interpersonal difficulties translate into measurable friendship instability.

Lazarus et al. (2020) investigated the association between BPD symptoms and the number, quality, and stability of friendships through a correlational study. The sample of participants contained 1,354 community-dwelling adults that were recruited from the University of Pittsburgh Adult Health and Behavior Project – Phase 2, out of which 49.7% were female. The ages ranged from 30–54 years. The sample was ethnically diverse and demographically representative of the surrounding region. Participants completed a battery of self-report questionnaires during a lab-based assessment. Data was then collected on BPD features through the Personality Assessment Inventory – Borderline Features Scale (PAI-BOR), personality traits, and friendship characteristics. The friendship variables used assessed friendship quality through factors like trust, satisfaction, closeness; friendship quantity through factors like number of close friends and friendship stability through factors like how many friendships ended over the past year. Lazarus then concluded that higher BPD features were linked to fewer close friends, lower trust, satisfaction, and closeness and more friendship instability. These effects persisted even after controlling for demographics and other psychopathologies. Traits like antagonism and negative affectivity partially mediated the relationship between BPD symptoms and poor friendship quality. Education and income were also positively associated with better friendship functioning.

Taken together, these studies highlight that individuals with BPD face difficulties in their interpersonal functioning, characterized by altered perceptions of closeness and threat that lead to heightened conflict, negative emotions in daily interactions, and diminished relationship quality and stability over time. The evidence reviewed in this section underscores that individuals with BPD demonstrate patterns of distance regulation, emotional reactivity, and long-term relational instability, which in turn contribute to the chronic distress that is central to the disorder. These findings highlight the importance of continuing to develop and refine targeted interventions that address the relationship dynamics that tend to emerge among individuals with BPD, especially given that such interventions have shown significant promise in reducing symptom severity and improving quality of life among individuals with the disorder.

2. Discussion

This review set out to explore the relationship between childhood trauma, attachment styles, and interpersonal functioning BPD. Research on childhood trauma (i.e. Zashchirinskaia & Isagulova, 2022; Trull, 2001; Ball & Links, 2009) consistently demonstrates that early experiences are significant risk factors for the development of BPD and for the emergence of maladaptive coping strategies, including high-risk behaviors such as suicidality, addictive behaviors, and disordered eating. Studies on attachment (i.e. Abdevali et al., 2021; Stepp et al., 2009; Howard et al., 2021) further confirm that individuals with BPD are likely to demonstrate insecure and disorganized attachment patterns. These attachment disturbances seem to vary across relationship contexts, with dismissing and fearful attachment styles more common toward caregivers, and preoccupied/anxious attachment styles more common in romantic relationships. Finally, research on interpersonal functioning (i.e. Barone et al., 2011; van Dijke & Ford, 2015; Charnas, 2024) highlights that people with BPD struggle to maintain stable and fulfilling social relationships, often reporting heightened rejection sensitivity, reduced interpersonal trust, and unstable or conflict driven interactions across different contexts. While childhood trauma, attachment styles and interpersonal functioning are all separate, independent risk factors for BPD, they still play a huge role in shaping symptoms and patterns when they interact and operate together. All 3 risk factors are highly linked to each other in a sense where if signs of one are observed in an individual, there is a high chance of the others developing and worsening the first symptoms, somewhat like a vicious cycle of symptoms which require well-developed intervention systems to stop.

Considering these findings together, studies show a mostly consistent picture:BPD is strongly shaped by an individual's childhood environment, which disrupts attachment and manifests as interpersonal dysfunction during adolescence and adulthood. At the same time, there are some mixed results in terms of the weight of specific risk factors. For example, while some studies find strong associations between sexual abuse and BPD, others emphasize emotional abuse and neglect as more central to causing the formation of BPD. Similarly, while attachment insecurity is widely supported as a core feature of BPD, the specific patterns of insecurity appear to be different based on accompanying comorbidities.

Although the findings are consistent, several limitations of existing research must also exist. Many studies rely on small, clinical samples, often from psychiatric outpatient or inpatient populations, which may not represent the broader population of individuals with BPD traits who may not be diagnosed with the disorder. Others use non-clinical, student-based samples, which provide insights into subclinical features but may not be generalizable to individuals with severe BPD. Most samples also include mainly participants from western backgrounds, with similar economical situations, which also may not be generalizable towards samples that aren't as westernised or exist in another economic situation. Longitudinal research is also scarce but is increasingly needed to receive clarity on the developmental pathways of BPD. Although tools such as the CTQ, PAI-BOR, AAI, and SIDP have strong reliability, relying on self-reports may introduce recall bias, leading to inaccurate results.

Future research should therefore focus on larger and more diverse samples, incorporating both clinical and community populations with several cultural, economic and religious backgrounds. Longitudinal studies should also be performed more often. Studies should also include more objective methods to test variables in order to strengthen validity. More attention should also be given to comorbidities as well as gender differences. For clinical practice, these findings demonstrate the importance of trauma-informed care in the treatment of BPD. Therapies such as DBT, MBT, and schema-focused approaches could be further enhanced by providing more attention to the trauma histories and attachment disturbances of each patient. This could also help during assessment, so clinicians can foresee challenges, including treatment dropout, and tailor interventions accordingly. Overall, the evidence reviewed suggests that childhood trauma, insecure attachment, and interpersonal functioning are interconnected and heavily contribute to the development and persistence of BPD. Addressing these factors both, in research and practice, will be crucial not only for improving treatment outcomes but also for advancing prevention strategies that could possibly reduce the burden of this disorder.

Summary Table

Childhood Trauma	
Study	***Findings***
Trull, 2001	BPD features were influenced by multiple interacting risk factors: parental mental illness, and to a lesser extent childhood abuse. BPD traits significantly affect daily functioning, suggesting interventions should target these features even in individuals without a full BPD diagnosis.
Ball and Links, 2009	Childhood trauma is likely a causal factor in the development of BPD when viewed within a multifactorial model that includes genetic and environmental components. Trauma alone is neither necessary nor sufficient, but it is a significant contributor to BPD risk.
Zashchirinskaia & Isagulova, 2023	Childhood trauma is significantly more prevalent in adolescents with BPD than the control group. Specific forms of trauma also predicted different high-risk behaviours in BPD adolescents. These results also show how trauma is a core risk factor in the development of BPD symptoms and maladaptive coping mechanisms among adolescents.
Attachment Style	

Barone et al, 2011	BPD patients tend to demonstrate high insecurity in attachment, with specific patterns tied to comorbidities. Additionally, insecure organized (Ds 51%, E 35%) and insecure disorganized (40%) patterns were overrepresented in this sample. Differences were also present, where comorbidities were internalized, meaning comorbidities were caused due to internal factors (e.g., mood/anxiety) and higher preoccupied/enmeshed states were found. When comorbidities were externalized, meaning comorbidities were caused due to external factors or external symptoms (e.g., substance/alcohol use), more dismissing/avoidant or disorganized states were found.
Van Dijke and Ford, 2015	Insecure attachment patterns were central in both BPD and SoD but manifested differently. In BPD patients, hyperactivating strategies (emotional under-regulation, high fear of abandonment) were manifested whereas in SoD patients, deactivating strategies (emotional over-regulation, suppressed fears of closeness/abandonment) were manifested.
Charnas et al, 2024	BPD was associated with elevated insecure attachment, but the patterns differed according to the relationship target. Fearful-disorganized and avoidant-dismissing styles toward caregivers, and preoccupied-anxious toward significant others, were also particularly linked to higher symptom levels.
Interpersonal Functioning	
Abdevali et al, 2021	Individuals with BPD tend to maintain greater interpersonal distance across various relational contexts, even with themselves. This behavior is interpreted as a psychological defense mechanism against perceived interpersonal threat and rejection.
Stepp et al, 2009	BPD patients do not differ in how often they interact socially but interact with fewer people and experience greater negativity during those interactions. Emotional patterns of anger, sadness, and emptiness during interactions are more severe and specific to BPD. The type of relationship (romantic, family, friend) had some influence, but negative patterns were pervasive across contexts.
Lazarus et al, 2021	Individuals with higher BPD traits experience significant challenges in maintaining high-quality and stable friendships. These challenges are not solely due to sociodemographic disadvantage or general psychopathology, but are specifically tied to personality pathology. Antagonism and negative affect are key mechanisms through which BPD affects friendship

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