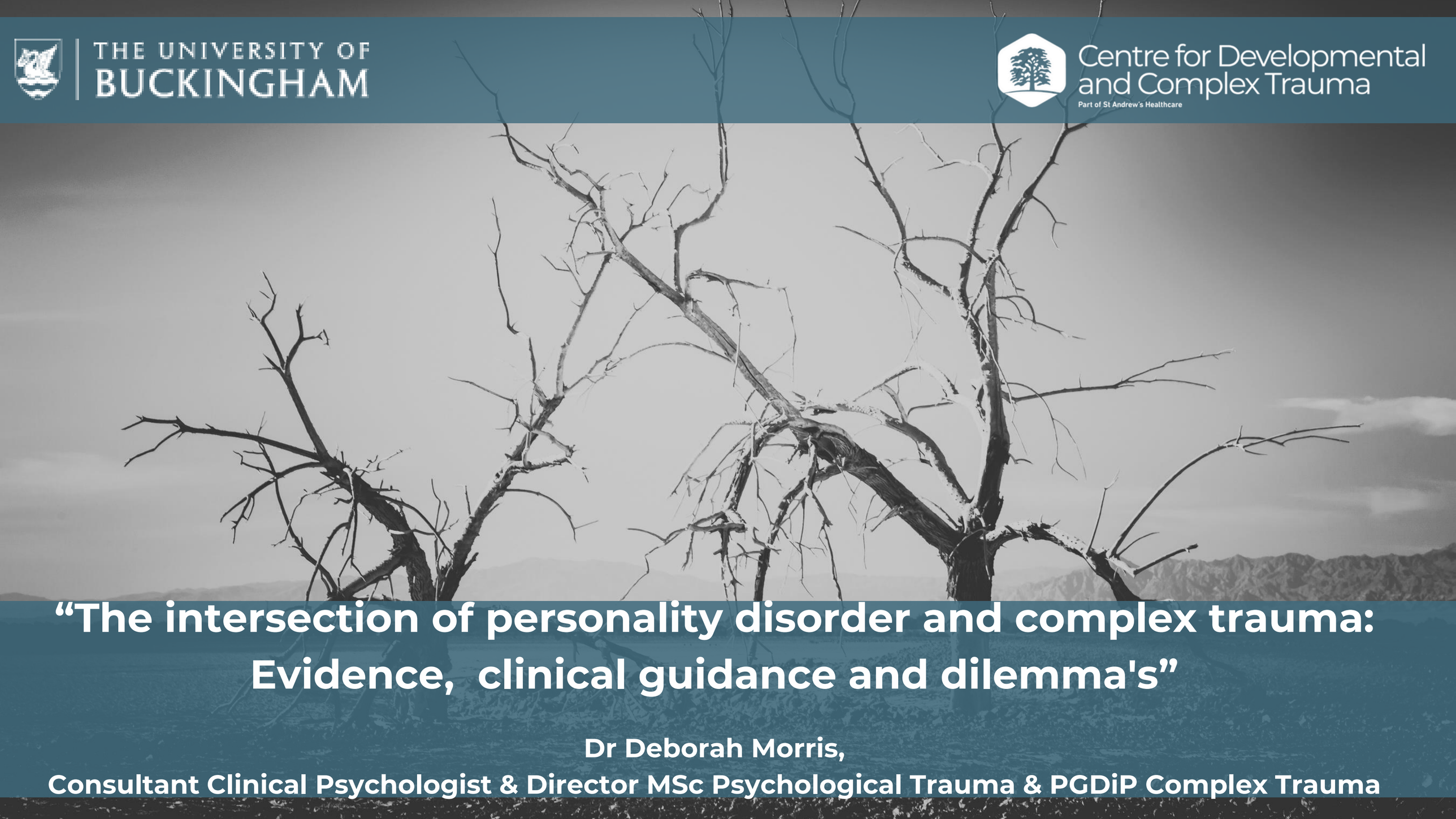

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"The intersection of personality disorder and complex trauma: Evidence, clinical guidance and dilemma's"

Dr Deborah Morris,
Consultant Clinical Psychologist & Director MSc Psychological Trauma & PGDiP Complex Trauma

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The relationship between CPTSD and BPD

Debate

Unique contributions & shared aetiology

Language and Stigma

Relatonship

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Levels of comorbidity between BPD and CPTSD

Atkinson et al., 2024

- Co-morbidity rates between CPTSD and BPD
  - 45.1% -52.2% (clinical trial for PTSD and national sample)
- Predominantly female, US samples

Some caveats

- Males are largely absent from analyses relating comorbidity
- Western samples
- Neurotypical populations

Inpatient settings

- Inpatient DBT service (100% EUPD) UK
- 66.7% (n=28) met diagnostic criteria for either
  - PTSD (n=5, 11.9%)
  - CPTSD (n=23, 54.8%)

MEANING 37.3% of service users with EUPD didn't meet criteria for any trauma diagnosis

- By contrast, 33 participants (78.5%) met criteria for either PTSD (n=8, 19.0%) or CPTSD (n=25, 59.5%), when based on symptom thresholds only, exclusive of FI (significant difference)

Service evaluations in clinical settings: Community

Mather & Jopling (2022)

- complex needs community service – UK
- 100% EUPD
- 63% (n=15) met diagnostic criteria for either
  - PTSD (n=3, 12%)
  - CPTSD (n=23, 52%)

MEANING 37.3% of service users with EUPD didn't meet criteria for any trauma diagnosis

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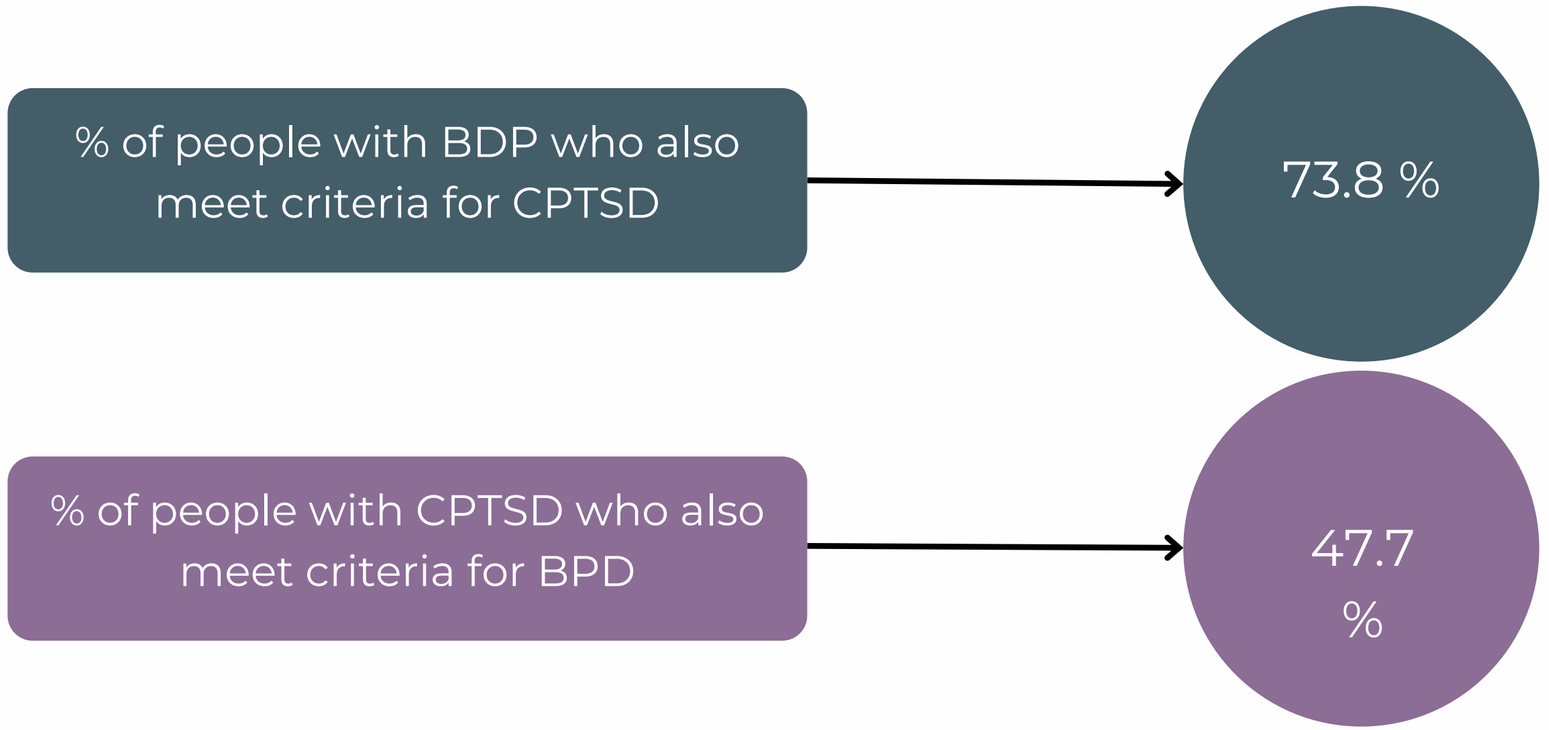
The nature of the overlap

- Overall comorbidity rate of 28.2 % between CPTD and BPD (Fung et al., 2024)



Fung, H., Lam, S., Wong, J., & , (2024). DSM-5 BPD and ICD-11 complex PTSD: Co-occurrence and associated factors among treatment seekers in Hong Kong. Asian Journal of Psychiatry, 104195

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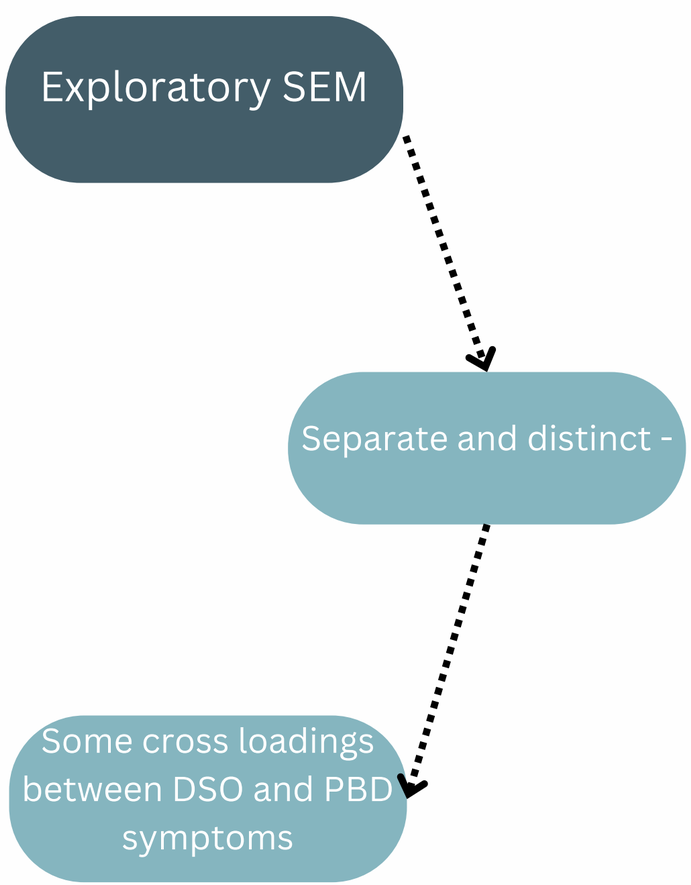
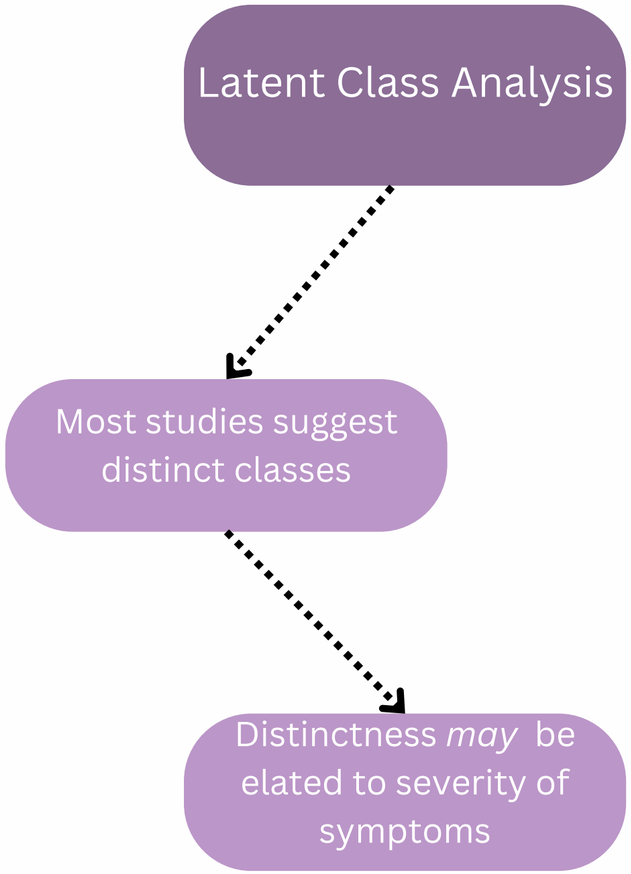
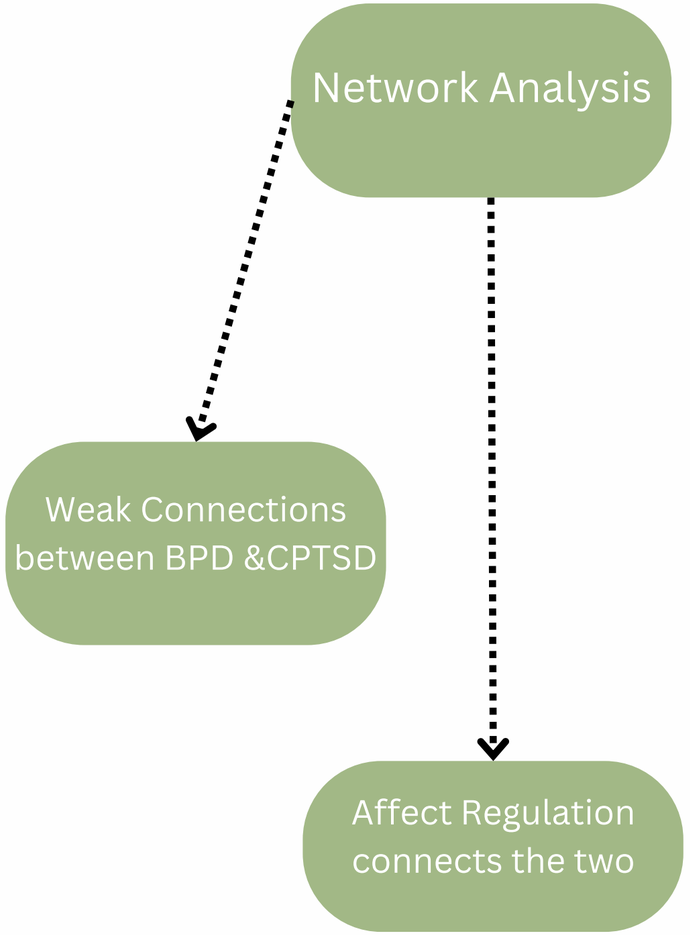
The empirical basis of the relationship between BPD and CPTSD

- **Recent systematic review: CPTSD & BPD are distinct constructs (10 studies) Only 1 study concluded that CPTSD and BPD are not distinct (Saraiya et al., 2021) (Atkinson et al., 2024)**







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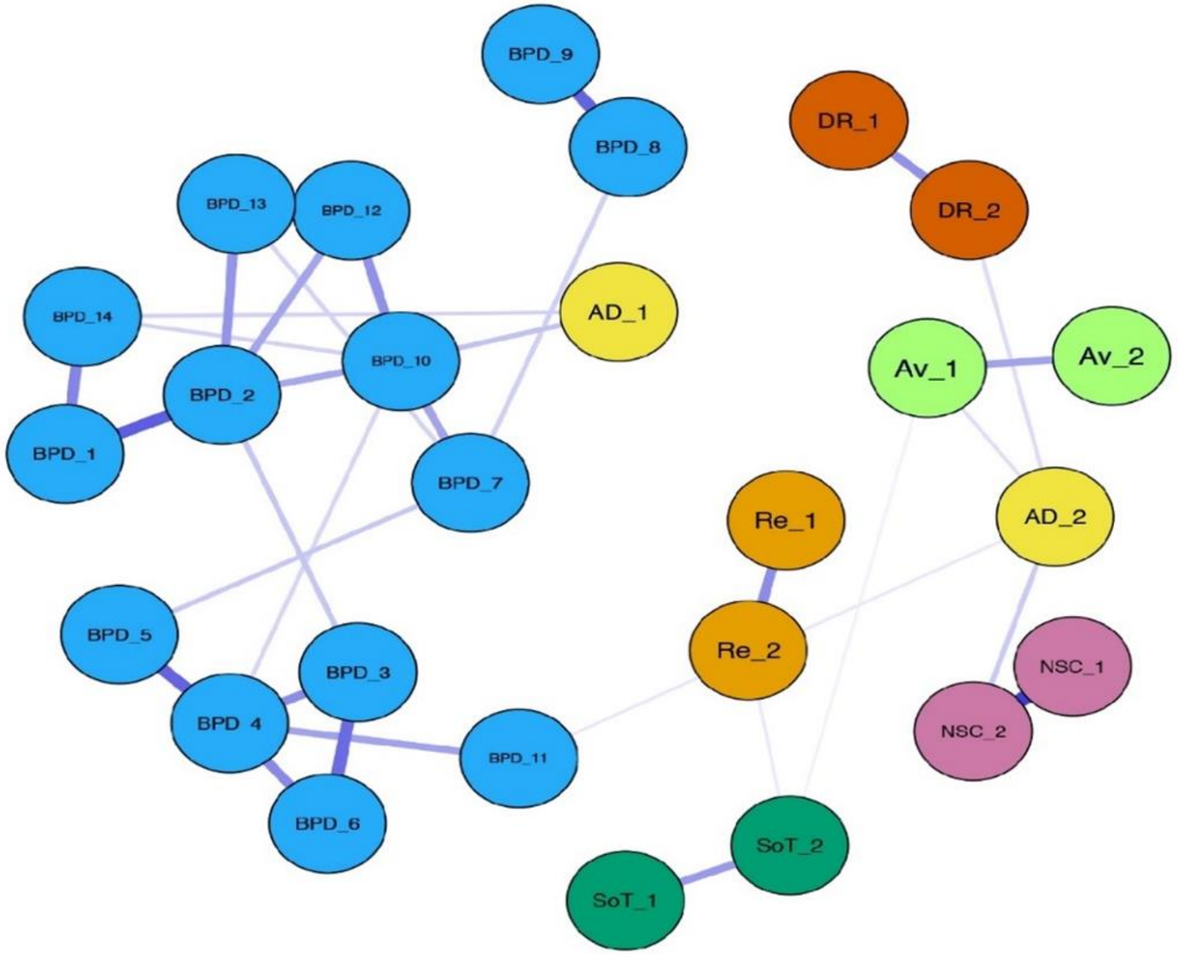
CPTSD & BPD: A network analysis in a highly traumatized sample



Re-experiencing

- Re_1: Having upsetting dreams that replay part of the experience or are clearly related to the experience?
- Re_2: Having powerful images or memories that sometimes come into your mind in which you feel the

Avoidance

- Av_1: Avoiding internal reminders of the experience
- Av_2: Avoiding external reminders of the experience (for example, people, places, conversations, objects,

Sense of Threat

- SoT_1: Being "super-alert", watchful, or on guard?
- SoT_2: Feeling jumpy or easily startled?

Affective disregulation

- AD_1: When I am upset, it takes me a long time to calm down.
- AD_2: I feel numb or emotionally shut down.

Negative self-concept

- NSC_1: I feel like a failure.
- NSC_2: I feel worthless.

Disturbed relationships

- DR_1: I feel distant or cut off from people.
- DR_2: I find it hard to stay emotionally close to people.

Borderline Personality Disorder

- BPD_1: Have you often become frantic when you thought that .... was going to leave you?
- BPD_2: Do your relationships with people you really care about have lots of extreme ups and downs?
- BPD_3: Have you suddenly changed your sense of who you are and where you are headed?
- BPD_4: Does your sense of who you are often change dramatically?
- BPD_5: Are you different with different people or ....hat sometimes you don't know who you really are?
- BPD_6: Have there been lots of sudden changes in your goals, career plans, religious beliefs, and so on?
- BPD_7: Have you often done things impulsively?
- BPD_8: Have you tried to hurt or kill yourself or threatened to do so?
- BPD_9: Have you ever cut, burned, or scratched yourself on purpose?
- BPD_10: Do you have a lot of sudden mood changes?
- BPD_11: Do you often feel empty inside?
- BPD_12: Do you often have temper outbursts or get so angry that you lose control?
- BPD_13: Do you hit people or throw things when you get angry?
- BPD_14: When you are under a lot of stress, do you get ...people or feel especially spaced out?

Owczarek, Karatzias et al. (2022) Journal of Personality Disorders

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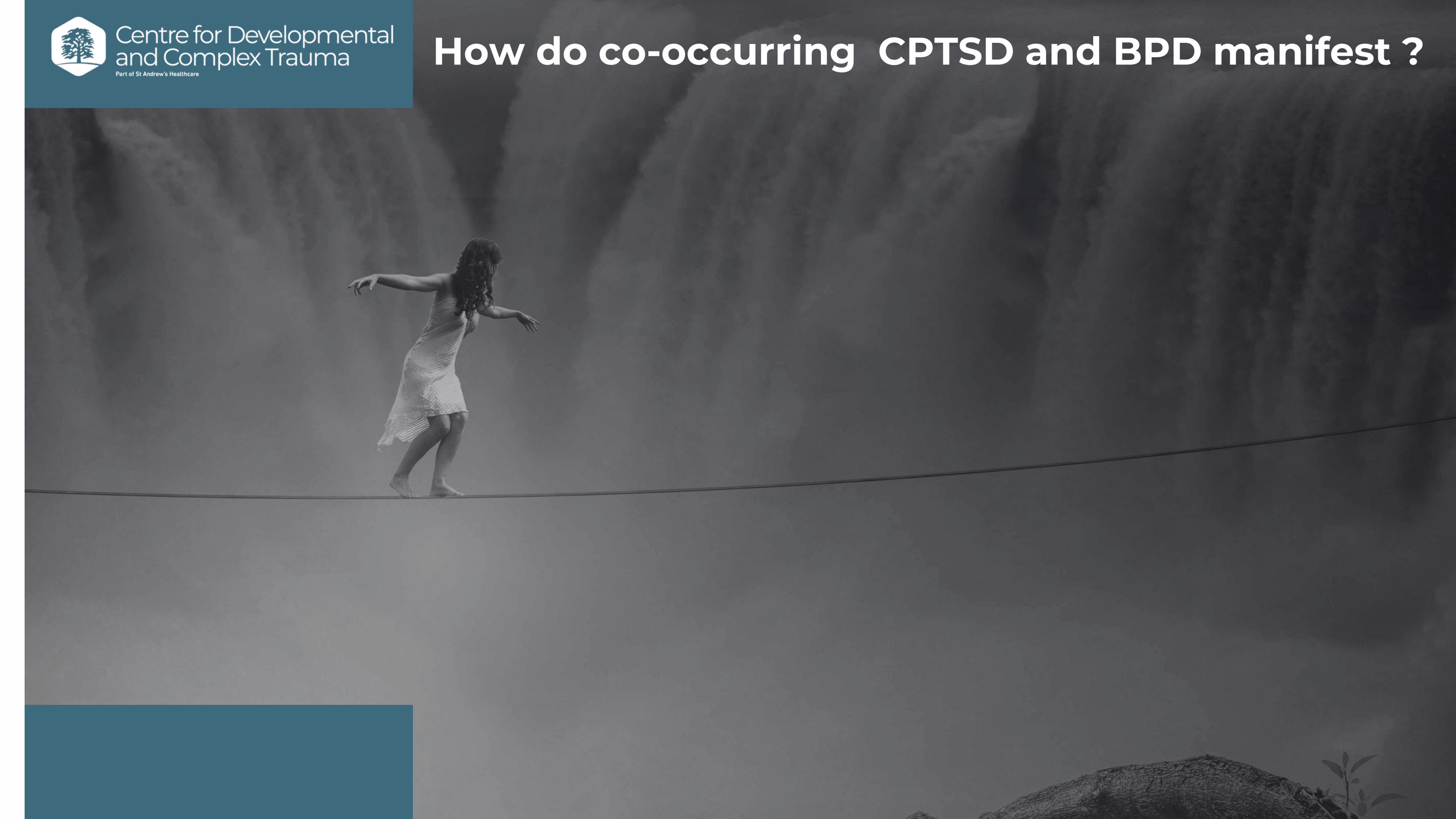
How do co-occurring CPTSD and BPD manifest ?



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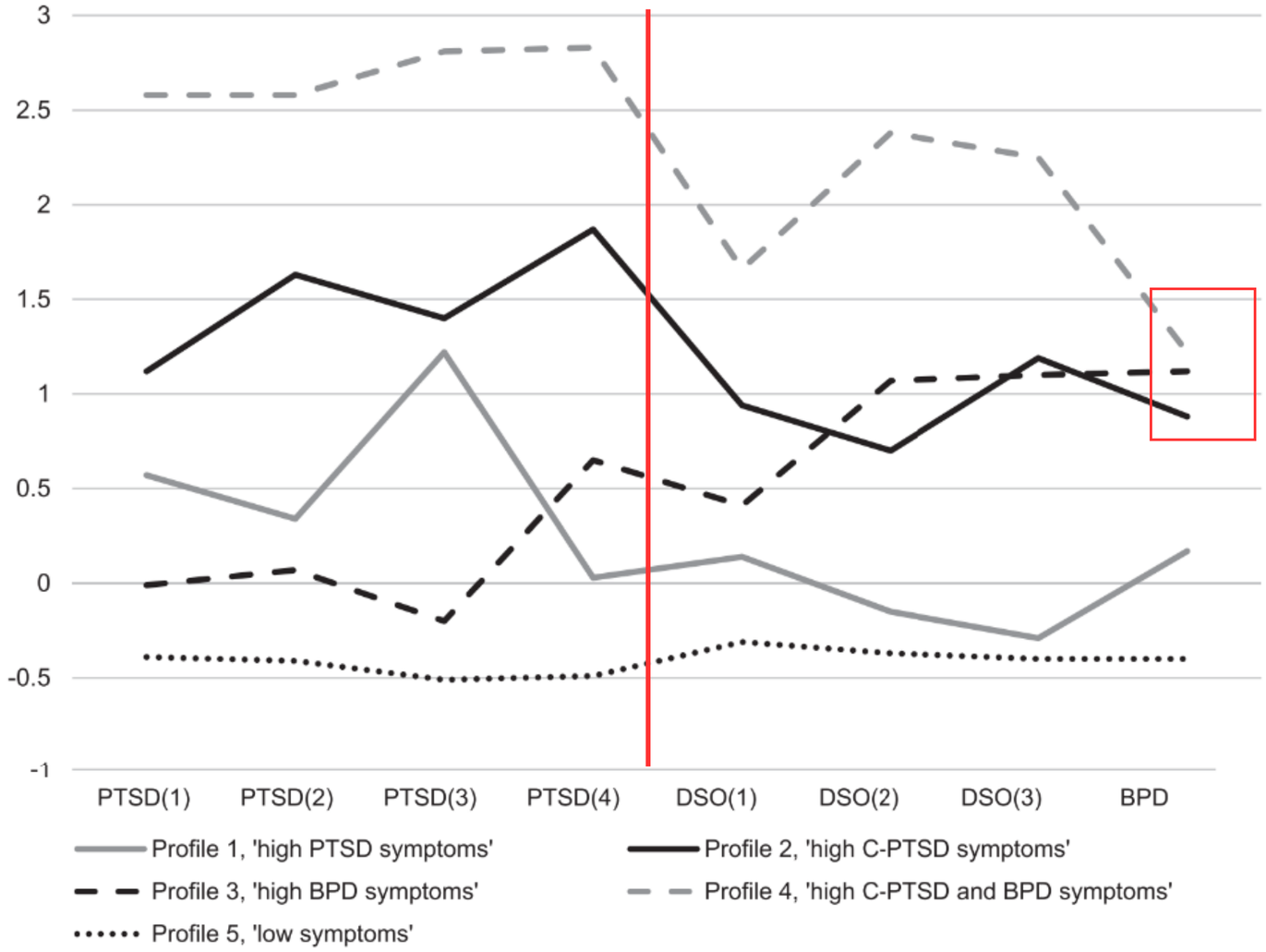
What does co-existing CPTSD and BPD look like?

***Cyr et al., 2022**



High CPTSD & high BPD group

- no difference in severity of BPD symptoms from high PTSD, high BPD or high CPTSD group

- Highest level of DSO & PSD symptoms, cross all symptom clusters
  - highest levels of psychological distress
  - traumatic event history,
  - adverse childhood experiences
  - Shame significantly differentiated the classes
  - lower levels of quality of life, compared to low symptom groups

Note. DSO = disturbances in self-organization; PTSD(1) = reexperiencing; PTSD(2) = avoidance; PTSD(3) = perception of threat; PTSD(4) = negative alterations in cognitions and mood; DSO(1) = affect; DSO(2) = beliefs about oneself; DSO(3) = relationships.

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Can the relationship be accounted for by severity of BPD / CPTSD symptoms? Core BPD and CPTSD symptoms in people meeting both diagnoses

Lee & Choi, (2023)

- Comorbid CPTSD & BPD group
- Highest level of endorsement across all groups on
  - Core PTSD
  - DSO
  - Borderline symptoms
  - Externalising (under controlled, impulsive, or aggressive behaviours) BPD yielded overall, higher symptoms than internalising / avoidant BPD (withdrawal, anxiety and depressive symptoms

  - Large differences in the groups between PTSD and DSO symptoms, but not on BPD symptoms between Comorbid and externalising group

Saraiya et al., 2021 - non clinical sample

- CPTSD & BPD not distinct

- "high PTSD+CPTSD+BPD"
  - endorsed class highest levels of psychological distress
  - traumatic event history,
  - adverse childhood experiences
  - PTSD symptoms.
  - Shame significantly differentiated the classes

Jowlett et al., 2020

- Clinical sample, specialist trauma centre
- 3 classes CPTSD / high BPD
  - Greater culmination of childhood adversity, especially emotional abuse and physical neglect

  - Multiple types of childhood trauma

  - More likely to experience interpersonal trauma

  - More likely to experience childhood and adulthood victimisation

  - More likely to be prescribed psychotropic medication.
  - Higher overall levels of functional impairment

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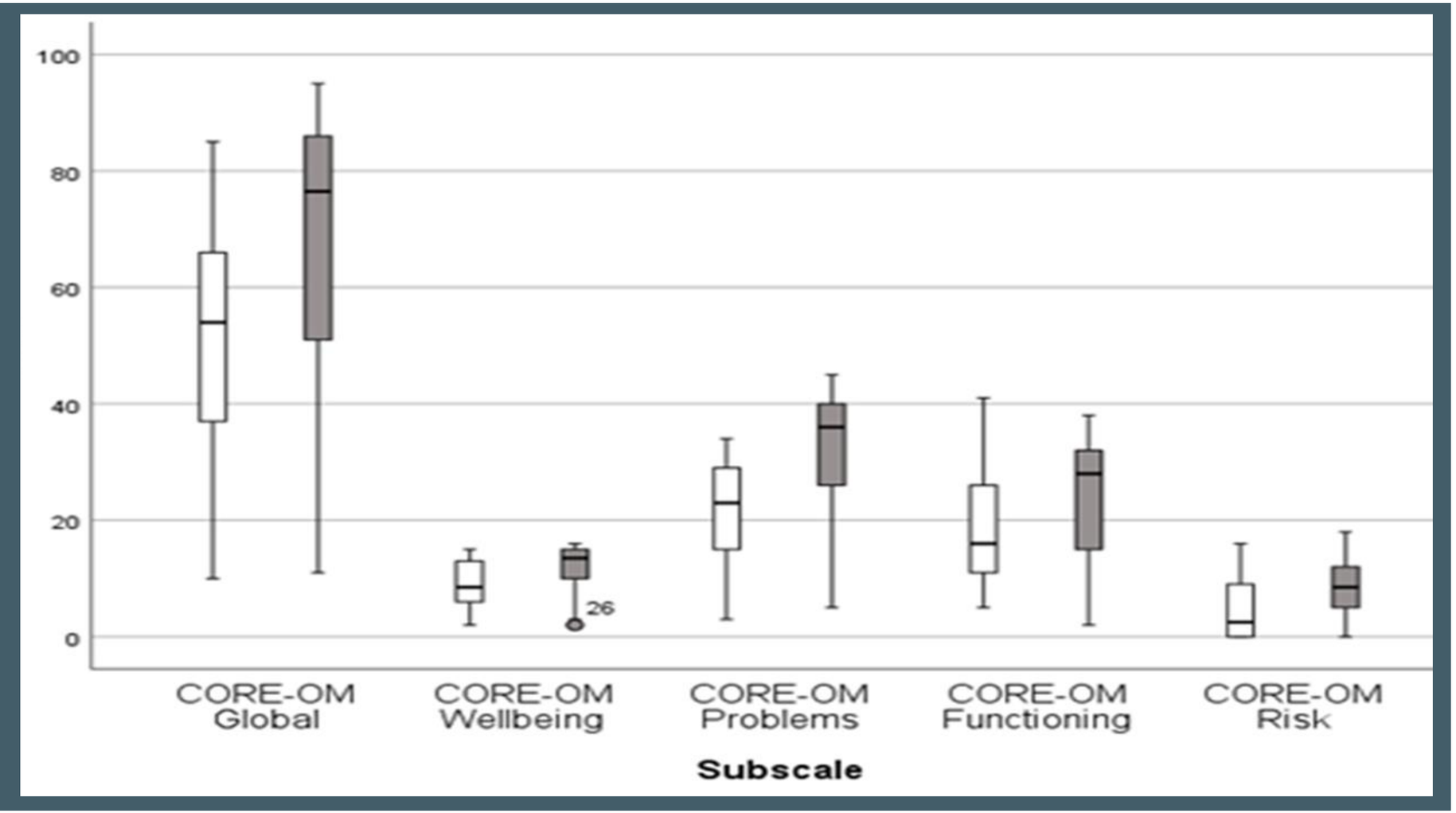
Generalised Distress symptoms in people meeting both diagnoses



2 groups (inpatient DBT service)

- BPD only
- BPD & CPTSD

PTSD &CPTSD symptoms

- Functional impairment (FI) for PTSD symptoms significantly higher in CPTSD=BPD group (but not higher PTSD symptoms)
- DSO symptoms and DSO FI, CPTSD+ BPD group

Psychological Distress

- Higher scores represent greater problems
  - significantly higher scores for CPTSD group
- Differences in risk only related to risk to self, not others

- Regression analyses demonstrated that only DSO affect regulation predicted CORE-OM global scores ($p=0.002$) and Risk ($p=0.02$)

Morris et al., 2023

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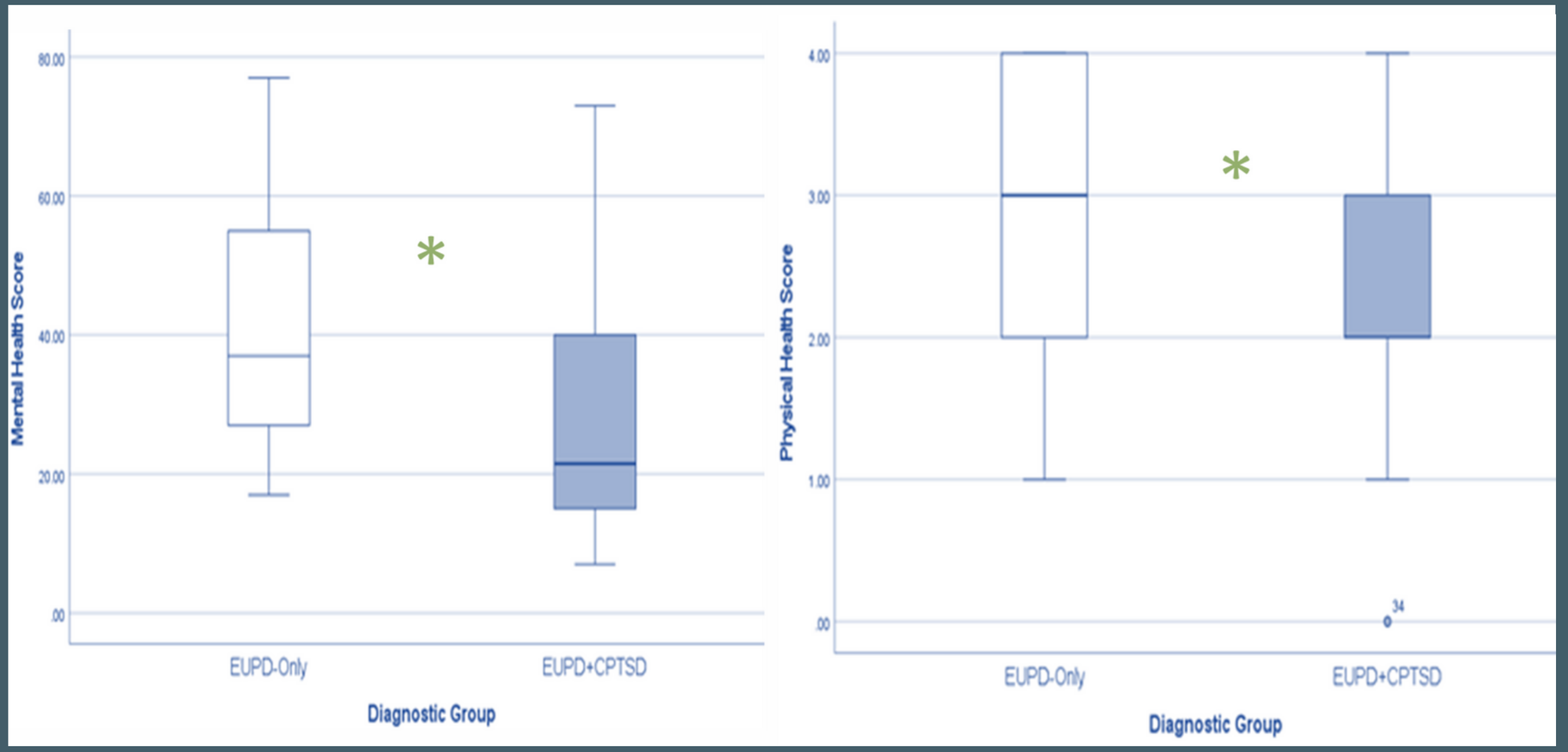
Quality of life (ReQOL; Mental Health & Physical health)



Quality of Life

- Lower scores reflect lower perceptions of QoL
- BPD & CPTSD group report significantly lower levels of QoL in relation mental health compared to EUPD alone
- BPD & CPTSD group report significantly lower levels of QoL in relation physical health compared to EUPD alone
- Regression analyses demonstrated that only DSO affect regulation predicted ReQOL Mental Health Scores (p=0.001)

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What we need to know...

The impact of treating one symptom cluster on others (e.g do some symptoms over shadow others and longitudinal perspectives

Which symptom clusters are more impactful than others - to target for change

Webb et al., 2022 (pilot data)

- Negative sense of self was the highest endorsed DSO cluster cross a BPD+ CPTSD cohort
- All PTSD and CPTSD symptom cluster were associated with FI, BUT only sense of threat (PTSD cluster) and disturbances in relationship(DSO cluster) predicted FI (whilst controlling for other symptom cluster)
- Can't assume that the most (highest) endorsed symptoms are the most impactful

Experiences of mental health services for those with CPTSD & EUPD

- The experience of this population in accessing services
- Therapeutic alliance and optimisation of care

Wider symptom and outcomes

- Research exploring the two groups have prioritised exploring [core] symptoms with wider psychological profiles under explored
- Impact of dual needs on physical health and premature mortality, key question given that initial data suggests a higher and more chronic trauma exposure profile

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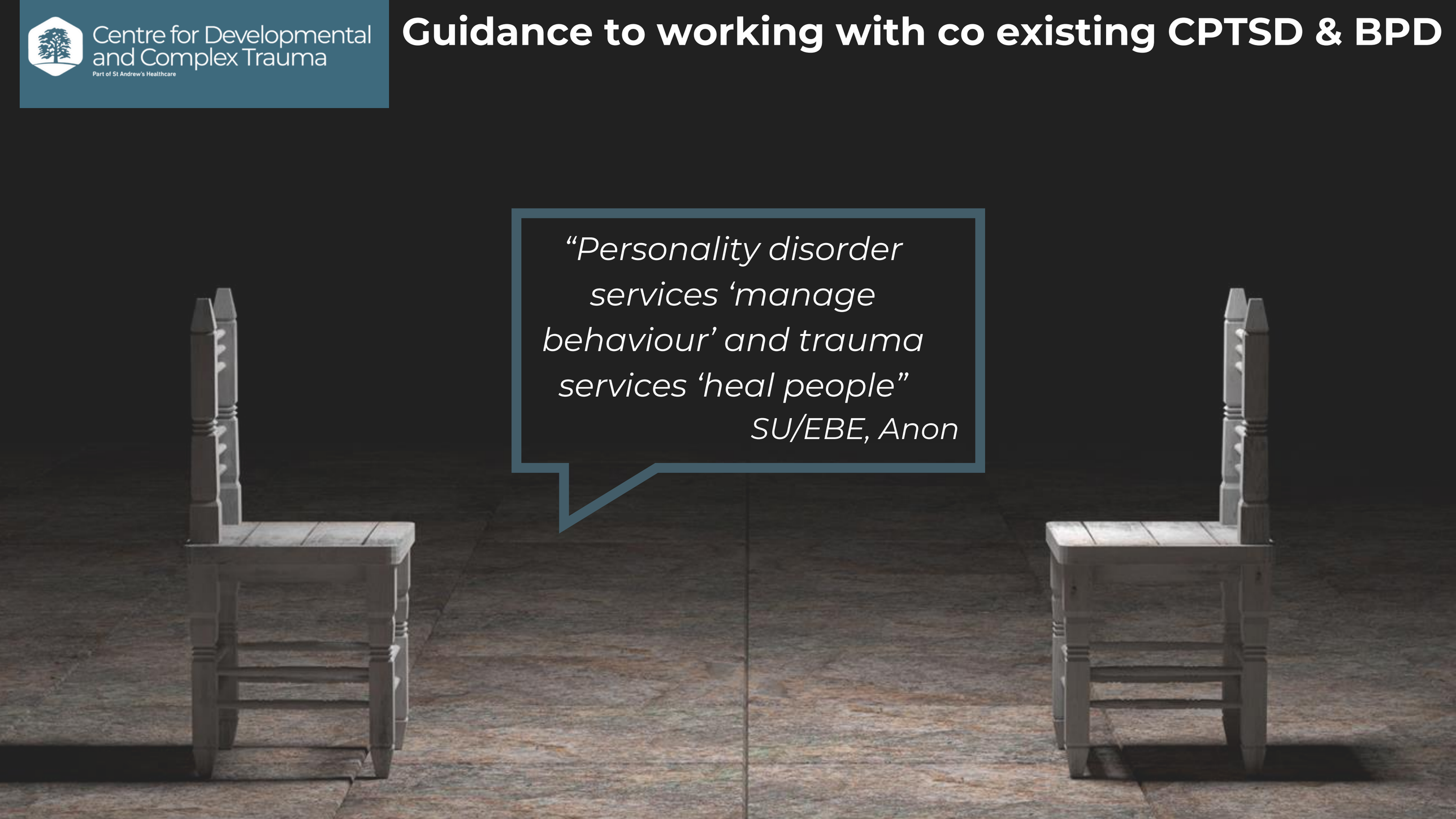
Guidance to working with co existing CPTSD & BPD



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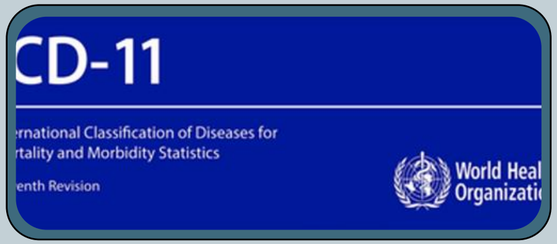
Sources of Practice Based Guidance: Mostly focus on differentiating between the two diagnoses



"6B41 -ICD-11 CPTSD descriptor

acknowledges the overlap

"many individuals with Complex Post-Traumatic Stress Disorder may also meet the diagnostic requirements for Personality Disorder."

"The utility of assigning an additional diagnosis of Personality Disorder in such cases depends on the specific clinical situation."

No specific guidance in PTSD NICE for co existing personality disorder a population of specific interest (2018 edition Aug 2024 updates)

NICE Guidance for BPD

- Acknowledges co existence
- Advocates treatment of trauma within 'well structured programme for BPD'

APA & BABCP under review

UKPTS -CPTSD

- Acknowledges overlap and distinction between the two presentations (emerging evidence)
- Not all people with BPD /dissociative presentations have a history of trauma exposure
- Treatment suggestions are not specifically made for BPD& CPTSD, although it highlights DBT, MBT and PE, which are evidenced for BPD

British Journal of Psychiatry Expert Guidance (2023)

- Distinguishing between the two presentations
- Working with comorbid needs

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Karatzias, T., Bohus, M., Shevlin, M., Hyland, P., Bisson, J. I., Roberts, N., & Cloitre, M. (2023)
British Journal of Psychiatry

Symptoms included in the diagnosis	**CPTSD** Characterized by **feelings of threat**, low self-efficacy, and relational distancing	**BPD*** Characterized predominantly by **instability** in affect, sense of self and relationships
1. Trauma-related symptoms		
Trauma history required for dx	Yes	No
Re-experiencing symptoms	Yes	No
Avoidance of trauma-related symptoms	Yes	No
Heightened sense of threat	Yes	No
2. Emotional Disturbance		
Emotional reactivity hard to calm down or feeling numb or dissociated	Yes	No
Intense affective instability	No	Yes
Intense anger	No	Yes
Impulsivity in at least 2 areas that are self-damaging	No	Yes
Recurrent suicidal behaviours or self-mutilation	No	Yes
Transient stress related paranoid ideation or severe dissociative symptoms	No	Yes
Chronic feelings of emptiness	No	Yes
3. Sense of Self		
Persistent and pervasive negative sense of self as worthless or defeated	Yes	No
Marked and persistently unstable self-image or sense of self.	No	Yes
3. Interpersonal Relationships		
Difficulty staying close maintaining relationships, tendency to distance, avoid or break off with conflict	Yes	No
Frantic efforts to avoid real or imagined abandonment	No	Yes
Unstable and intense interpersonal relationships that alternate between idealization and devaluation	No	Yes

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Karatzias, T., Bohus, M., Shevlin, M., Hyland, P., Bisson, J. I., Roberts, N., & Cloitre, M. (2023)
British Journal of Psychiatry

Key clinical guidance: British Journal of Psychiatry

Starting point: Acknowledging co existence

- Acknowledged that distinguishing between the two is more challenging if the individual has a history of trauma (Criterion A)
- Both conditions can co occur in the same person
- false positive diagnoses for CPTSD can occur when self report measures are used alone.

Problems of double scoring pathology

- Need to avoid over pathologising and 'double scoring symptoms'
- Recommends a 'hierarchical' approach, as opposed to the DSM approach
- For example is a symptom is ID'd for a primary diagnosis, it is not repeatedly assigned (endorsed) in secondary diagnoses that are being explored.

When to assign both diagnoses

- "A diagnosis of BPD comorbid with PTSD versus a diagnosis of CPTSD is likely to be assigned if there is significant presence and continued risk of suicidal or self-injurious behaviours, unstable sense of self or instability in relationships." (Karatzias et al., 2023)

- CPTSD and comorbid BPD is indicated if DSO symptoms (differentiated from BPD traits) are met

- For those who endorse both diagnoses a trauma-informed approach may be the most appropriate treatment framework

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CPTSD & BPD: Clinical Example 'Markus' -composite: Diagnosed with BPD at the start of Trauma work

Diagnostic process

- Semi structured interview (several sessions)
- Personality disorder psychometrics
- Zanarini Rating Scale
- ITQ
- General psychological wellbeing
- Consensus discussions with team & SU
- CPTSD added to clinical notes

BPD symptoms

- Impulsive behaviour without consideration of the consequences (e.g. repeatedly throwing away essential medication & spending money).
- Explosive episodes of anger
- Recurrent self harm (not severe)
- Chronic feelings of emptiness
- Avoiding abandonment (calls mum 10+ times day, but relationship is quite stable)

X unstable sense of self, varied mood swings, Stress-related paranoia or loss of contact with reality, lack of ongoing conflict in relationships. Not suicidal, but indifferent to death

PTSD Symptoms

- **Exposure:** 10 ACEs by the age of 5 years
- **Re experiencing:** Frequent vivid memories and nightmares, strong emotions (fear++ / disgust++)
- **Avoidance:** (conscious and deliberate)
  - (E) Busy places, groups of men
  - (I) Bodily sensations associated with toileting, experiential avoidance++
- **Chronically heightened sense of threat**: constantly scanning environment

DSO symptoms

- **Negative sense of Self:** Stable Self loathing
- **Relationships:** Avoidant++ anticipates betrayal
- **Affect regulation:** Prolonged periods of return to baseline, numbing.

- **Dissociation++**

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Treatment dilemma's & key debates

- CPTSD is a relatively novel diagnostic framework, with an emerging positive evidence relating to treatments
- Currently, there is an absence of evidence based treatment for CPTSD and BPD
- The emerging evidence for for BPD and PTSD is promising, suggesting 'blended' trauma and personality treatments is tolerated, safe and efficacious (e.g. DBT, Prolonged Exposure Therapy, EMDR, STAIR)
- Whilst initial evidence suggests Affect Regulation is key symptom group to target, the lack longitudinal data precludes our understanding of relationships between symptom groups once treatment commences (what this may overshadow or change)

1. Phased Modular approach

- Current guidance advocates a modular approach that 'targets' symptom clusters of CPTSD
- Modular approach is personalised, based on the individual's goals and severity of symptoms

2. No stabilisation period

- Some clinicians / researchers question whether stabilisation is needed prior to commencing trauma processing work
- Based on a small number of community samples with PTSD (not CPTSD) and BPD, through EMDR
- Studies have reported positive outcomes in terms of symptom reduction and lack of AE's
- However, people who are acutely suicidal / activity suicidal in previous 6 months are typically excluded.
- Significant levels of attrition in take up rates and FU data

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Treatment: Markus: A Phased approach

Assessment (8 sessions (CPTSD and BPD) - some psychometrics completed with nurse colleagues in between sessions

Psychoeducation: Part I (4 sessions)

Stabilisation (1 year)
DBT framing: Elements of all four modules, additional focus on Emotional Regulation & Interpersonal effectiveness, CFT components also - service user particularly responded well to the 'other parts of me' elements

Psychoeducation Part II (2 sessions)

Trauma Processing: Part I (6 months - intermittent self harm)
Cognitive Focused CBT -e.g. imagined exposure, in vivo exposure, re-scripting, surveys, responsibility pie charts, behavioural experiments, nightmare work etc..

Back to stabilisation: Part II: Following adverse outcome of parole hearing and 2 x deaths and significant escalation of SH) - 4 months

Trauma Processing: Part II (9 months) (agreed threshold in the service for pausing TFT when SH escalated)

Consolidation & Relapse management work (4 month - but fortnightly sessions and tapered off)

Pre Therapy Maximum score on ITQ: (48 symptoms; 24 for both Functional Impairment scales)
End & Post Therapy ITQ: Non clinical range most gains in: (Re experiencing & avoidance) (Negative sense of self & Relationships (as well as functional impairments)

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What happens when CPTSD and BPD remit?

- Current treatment outcomes are focused on measuring symptom reduction and improving functioning
- Lack of focus on the impact of treatment to sense of 'self - other'
- We have limited understanding of the experience of both presentations remitting (qualitative and quantitative)
- Do we need to think about additional treatment components?
  - Grieving / bereavement and loss
  - Changes in behaviour: emerging recklessness?
  - Developing the skill of discernment?
  - Mentalisation skills

Reductions in impulsivity and reactivity capacity to plan and engage in consequential thinking

Overcoming intra and interpersonal avoidance

Changes in social cognition, relationship to self & beliefs trucutres

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"Is remission maintained?"

- BPD and PTSD, separately are associated with comparatively higher levels of the re emergence of symptoms, post treatment

- The long term outcomes of treatment for CPTSD co existing with BPD are unknown, yet we can anticipate that 'recovery' is unlikely to be 'linear' journey, based on data relating o BPD and PTSD

- Is working with this population an opportunity (and a need) to re frame language around normalising manage expectations relating the re-emergence of symptoms

Recovery vs 'in remission'

Relapse vs 're emergence or recurrent….'

- Given the (arguably) increased likelihood of symptoms r emerging is it more valid (and compassionate) to re frame dual CPTSD and BPD presentations as being 'in remission' rather than 'in recovery' and to talk about re-emergence' rather than relapse?

- Brooks & Greenberg, 2024 raise these questions in relation to PTSD, and arguably apply to CPTSD and BPD given the typically chronic nature.

- Devils advocate question
  - Is the term 'recurrent…" more appropriate, as defined by two or more episodes of symptoms / remission? (current definition of recurrent depression)
  - We use is framing in relation to depression and other presentations, why not for (co existing) CTSD and BPD

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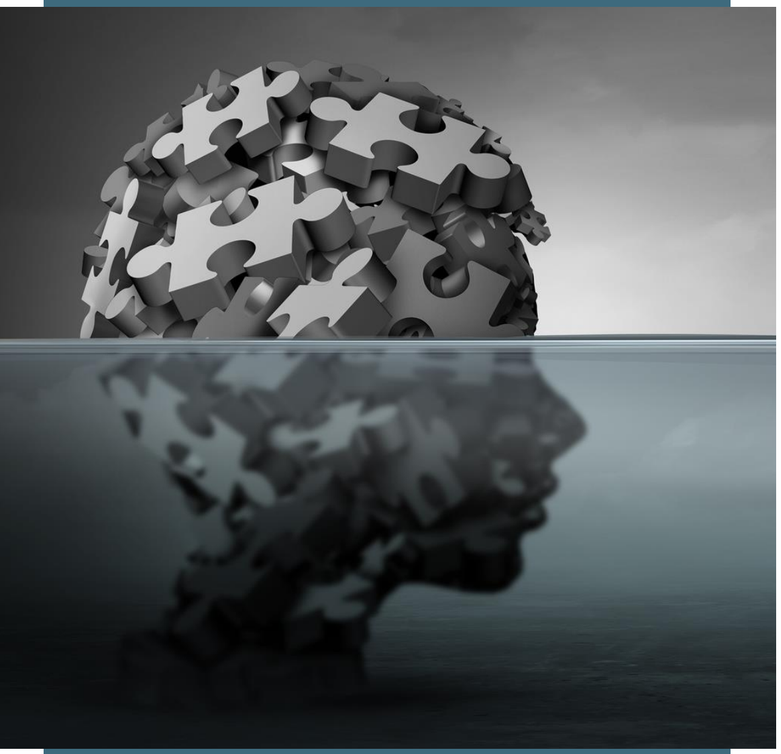
Summary:



Clinical presentation

- A small number of individuals endorse both CPTSD and BPD.
- A focus on emotional regulation as the cluster that connects the two presentations may be a key area to target for change.
- Those with dual needs may present with greater severity in PTSD and DSO symptoms
- increased risk to self and experiences of dissociation, but not risk to others
- Increased shame and greater severity in distress
- Reduced quality of life (mental health and physical health)
- Can't assume that core BPD symptoms are more severe in CPTSD & BPD

Clinical challenges

- We have 'emerging guidance' for the relationship between EUPD and CPTSD - although no empirically derived or evaluated treatments for meeting both conditions
- Perceptions from EBE's that personality disorders 'manage behaviour' and trauma services 'heal people' needs to inform how we develop services in the future

Theory driven challenges

- We have a limited understanding of many aspects of needs
  - the underlying factors that connect the two presentations, to drive therapeutic approaches for those who meet both diagnoses.
  - the mechanisms that accounting for both presentations and empirically derived models to frame interventions
- Differential impact of different common symptoms that can inform the development and delivery of treatment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