Examining the impact of comorbid Complex PTSD and Emotionally Unstable Personality Disorder on risk incidents within a female inpatient DBT service

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INTRODUCTION

Complex post-traumatic stress disorder (CPTSD) and Emotionally Unstable Personality Disorder (EUPD) are distinct diagnostic categories with significant overlap within their core features (Jowett et al., 2020) Specifically both diagnoses have been previously associated with exposure to trauma and adversity (Porter et al, 2020; Karatzias et al., 2017). Relatedly, in clinical samples there has been found to be a high level of morbidity between the two presentations (Morris et al., 2021) and the relationship between EUPD and CPTSD has been subject to ongoing exploration.

Previous research has shown that individuals with EUPD who also meet the diagnostic criteria for CPTSD, self-reported increased risk towards themselves, compared to individuals with a EUPD-only diagnosis (Morris et al, in press). There is need for further investigation as to whether this finding is corroborated by objective risk data. Additionally, exploration of the relationship between risk and the different symptom clusters of the CPTSD diagnosis, aims to increase insight into the potential differential clinical needs of these individuals.

STUDY AIMS

(i) whether the number of risk-related incidents (separated into risk towards self, risk towards others, seclusions, and restraints) differed between females with EUPD-only and EUPD+CPTSD
(ii) whether there was a relationship between the severity of transdiagnostic symptom clusters and the number of these risk-related incidents

References

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METHODOLOGY

Design

This study utilised a cross-sectional design to explore the difference in risk incidents between individuals with a diagnosis of EUPD only, and individuals who also meet the diagnostic criteria for CPTSD (EUPD+CPTSD).

Demographics

Using convenience sampling, the data of 51 females residing in an inpatient DBT service, with an average age of 26.4 (range 19-53, at point of ITQ administration) were included. Participants were most commonly of a White British ethnicity (84.3%), and the majority of participants (86.3%) were detained under section 3 of the Mental Health Act.

Procedure

The ITQ was administered and scored by members of the clinical team
Datix data was extracted from clinical records in October 2023. The total number of risk incidents (separated into self-harm and physical or verbal aggression towards others), restraints, and seclusions, for the 6 months after ITQ administration was calculated for each participant.

Ethics

The study received approval from research governance structures within the organisation as a service evaluation project to review the clinical utility of implementing the ITQ.

RESULTS

Demographics. All participants had a diagnosis of EUPD, 45.1% had a co-morbid diagnosis of another ICD-10 disorder (WHO, 1992) and 9.8% had a joint primary diagnosis of EUPD and additional ICD-10 disorder.

Prevalence of CPTSD.
The data of 5 participants were excluded from the current analysis as they met the criteria for PTSD, but not CPTSD. Of the 46 remaining participants, 69.6% met diagnostic criteria for probable CPTSD (inclusive of the functioning impairment criteria) based on their scores on their initial ITQ assessment.

Group Comparisons.
There were no significant differences between the EUPD-only and EUPD-CPTSD groups across all domains: total risk behaviours, verbal and physical aggression, self-harm, restraints, seclusion (all $p>.05$).

Spearman's Correlations
Spearman's correlational analyses revealed that, when exploring the relationship with each symptom cluster and risk incidents there was a significant positive correlation between the 'disturbances in relationships' symptom and aggressive behaviours towards others and frequency of restraints (both $p<0.05$). Additionally there was a significant positive correlation between impairments in affect dysregulation and number of restraints ($p<.01$).

DISCUSSION

- CPTSD is prevalent in women with EUPD who are accessing a comprehensive DBT inpatient programme
- At a diagnostic level, EUPD and EUPD+CPTSD groups were not distinguishable on the observed risk outcomes, indicating that risk behaviours and the use of restrictive practices is not significantly related to this comorbity.
- However, severity of transdiagnostic symptom clusters were found to hold significant associations with risk outcomes. Specifically:
  - Disturbances in relationships was found to be significantly related to both numbers of aggressive behaviours and number of restraints
  - Affective dysregulation was also significantly associated with number of restraints.
- There were no significant correlations between core PTSD symptom clusters and risk outcomes

IMPLICATIONS AND LIMITATIONS

- Both emotional dysregulation and interpersonal disturbances are key difficulties for individuals with a diagnosis of EUPD and or CPTSD. These findings indicate that these symptoms specifically are important contributors to increased risk presentation for individuals with a diagnosis of EUPD.
- Accordingly, as is already addressed within common treatments for EUPD (specifically DBT), it is evident these symptoms should be key targets for intervention.
- The direction of causality is unclear within these findings and the sample size was noted to lack power required for examination of predictive effects. Consequently, replication in a larger sample is needed.