



## Lets start with a poll.....

(Q1) Are CPTSD and Borderline Personality Disorder the same presentation?

(Q2) Should all people with Borderline Personality Disorder be re diagnosed with CPTSD

- (Q3) Should we
- (a) Remove BPD from diagnostic manuals entirely
- (b) Move BPD to sit under a 'stress and trauma conditions' category in diagnostic manuals (but don't name of the diagnosis)
- (c) Move BPD to sit under a 'stress and trauma conditions' category in diagnostic manuals and change the name of the diagnosis
- (d) No changes, leave BPD where it is.....

...... and a disclaimer / confession







## The relationship between CPTSD and BPD: Why it matters

As a new diagnosis, CPTSD has created a significant number of clinical debates

Perhaps the most critical and enduring relate to its relationship with personality disorder, specifically Borderline Personality Disorder

Diagnostic descriptor of CPTSD acknowledges this and states, "many individuals with Complex Post-Traumatic Stress Disorder may also meet the diagnostic requirements for Personality Disorder."

#### **Key questions**

- Is CPTSD distinguishable from Borderline Personality Disorder?
- Should CPTSD be diagnosed in place of Borderline Personality Disorder
- Does CPTSD inadvertently perpetuate 'unvictiming' that drives negative perceptions of this population?
- Some mental health services in the UK are transitioning from BPD to CPTSD framing, other services are reluctant to embrace CPTSD and remain focused on BPD, due to its 'stronger' links with risk

#### Why does it matter what diagnosis is given?

- Impact on the individual and perceptions of whose 'victimhood' gets recognised
- Access to treatment / services
- Type of treatment offered
- Need to ensure that we are offering optimised support given the impact either presentations can have on the lives of the individual
- Should we take into account social influences such as stigma and validation when making *diagnostic* decisions?



### Revisiting the role and function of diagnoses

• For diagnoses to be considered distinct, the same (or replaceable) they need to demonstrate four key criterion

• For clinicians, their key role is to inform decisions relating to treatment and support

Diagnois	Symptoms	Prognosis	Pathobiology	Pathogenesis
	Objective and subjective experiences	Predictions about course and outcome, over time (inclusive of the effectiveness of treatment	Physiological processes that change due to the disease and impacts on functioning	The 'cause', development or events that leads to the presentation / disorder
Borderline Personality Disorder				
Complex PTSD		??	??	



## How do we approach answering this question?





Diagnostic (symptom) overlap



Treatment needs



Experience and outcomes of mental health services and therapy

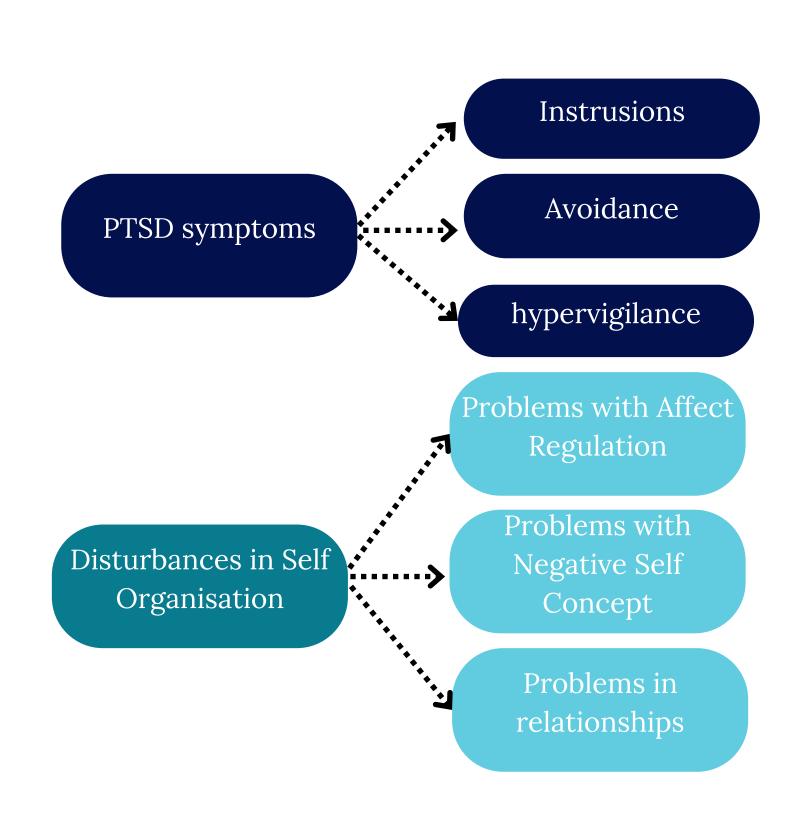


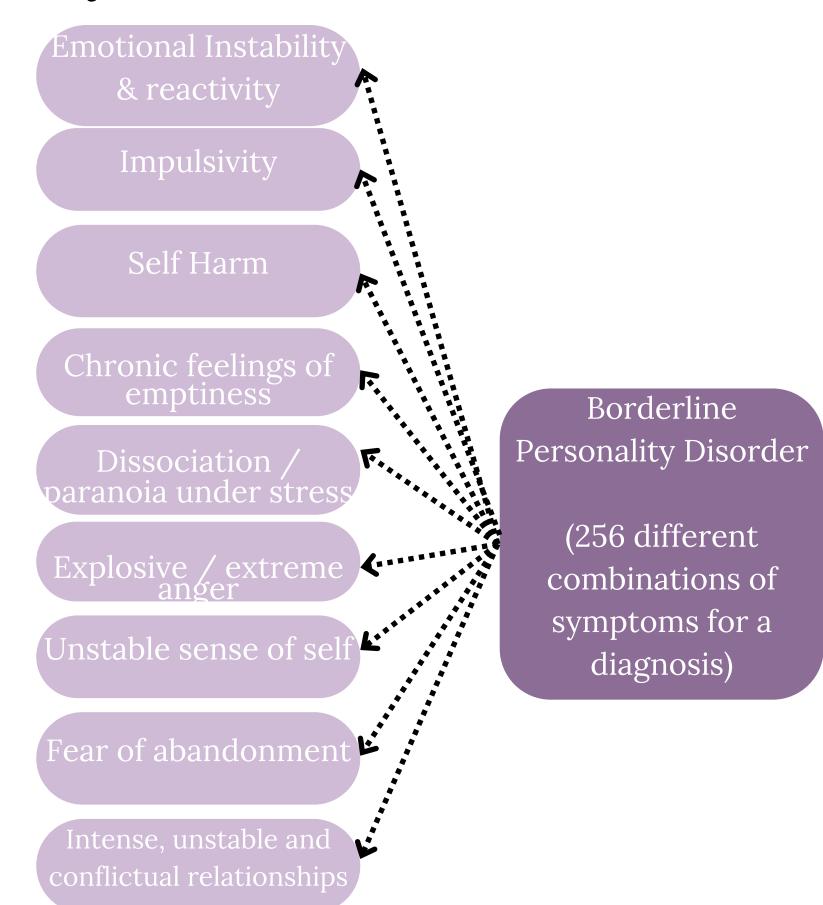
## Pathogenesis: The 'cause'

Personality disorder	CPTSD		
Genetic Environmental Cultural	'Criterion A' experience		
Social Childhood adversities • Emotional abuse • Emotional neglect	"Exposure to an event or situation (either short- or long-lasting) of an extremely threatening or horrific nature.		
<ul> <li>'invalidating environments'</li> <li>Direct abuse also noted (physical / sexual)</li> </ul>	<ul> <li>Such events include, but are not limited to,</li> <li>directly experiencing natural or human-made disasters, combat, serious accidents, torture, sexual violence, terrorism, assault or acute life-threatening illness (e.g., a heart attack);</li> </ul>		
Exposure to adversity or traumatic events is not required for the diagnosis	<ul> <li>witnessing the threatened or actual injury or death of others in a sudden, unexpected, or violent manner;</li> <li>and learning about the sudden, unexpected or violent death of a</li> </ul>		
SRMA (Porter et al., 2020) - 70% experience exposure to adversity / traumatic events in childhood	loved" one.		



# CPTSD & Borderline Personality Disorder Symptoms: Are they the same, in all but name?







## Systematic Review & Meta Analysis : <u>Preliminary</u> Findings





N = 3472

10 studies (awaiting data for 4 additional studies for MA)





- USA
- UK
- HongKong
- Italy
- Denmark



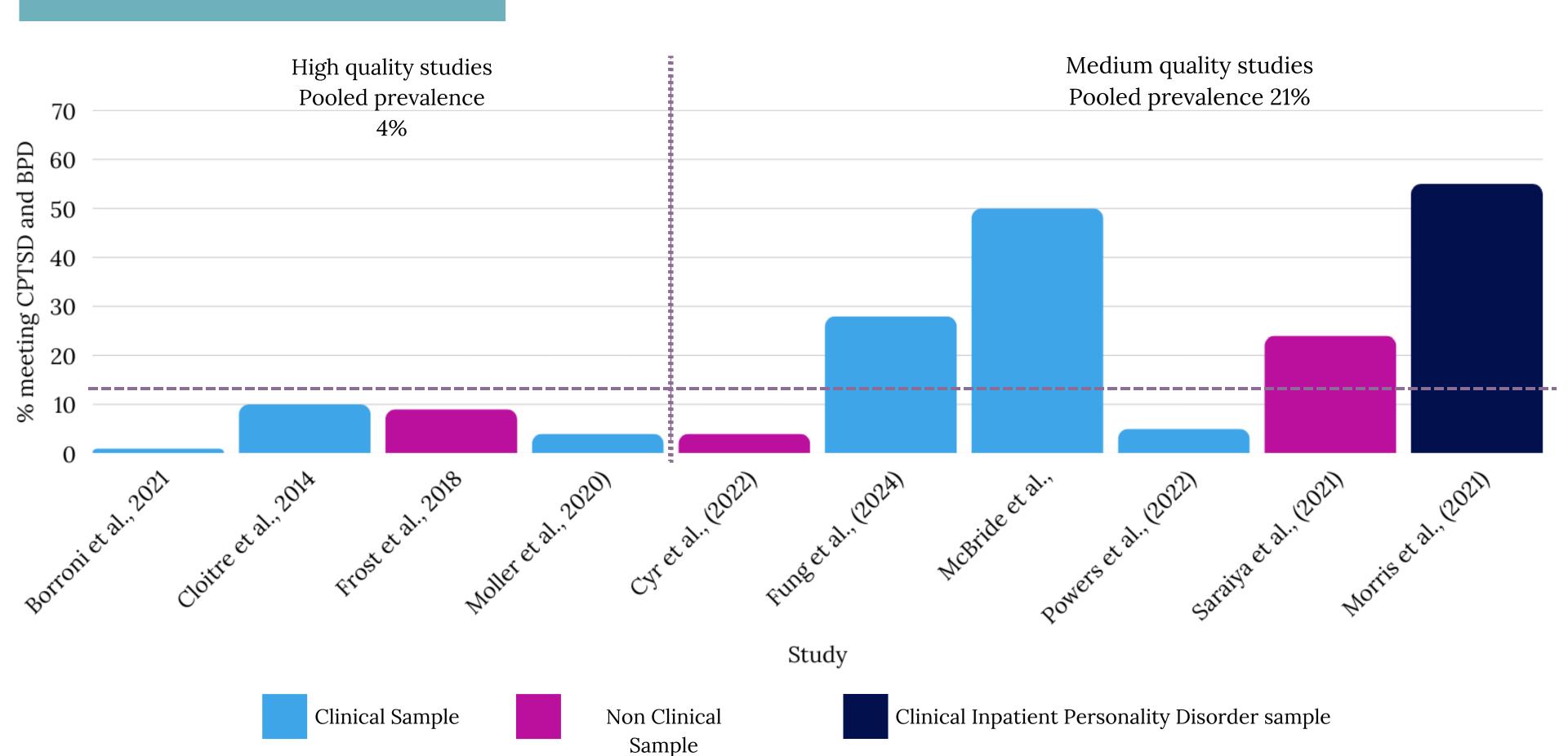
- Not consistently reported
- Predominantly Caucasian



- 6 studies used diagnostic classification for 'caseness'
- 4 used statistical class
   classification



## Systematic review and Meta Analysis: What is the overlap between CPTSD and Borderline Personality Disorder?

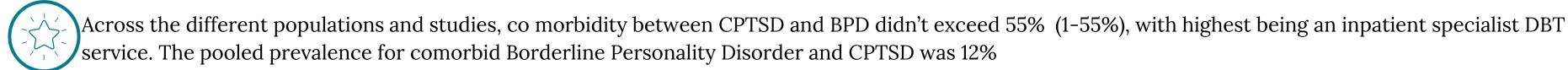




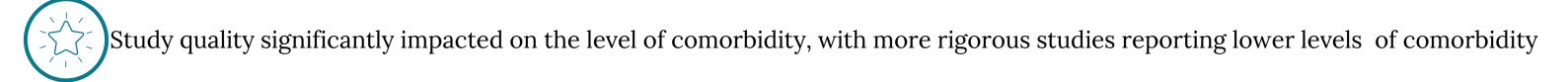
# Systematic review and Meta Analysis: Sub group analyses and Key findings



Data is reflective of a limited population: gender, nationality and of different trauma populations (e.g. neurotypical, no offending, veteran, displaced populations



- CPTSD can present alone
- Borderline Personality Disorder can present alone
- A small group endorse both presentations

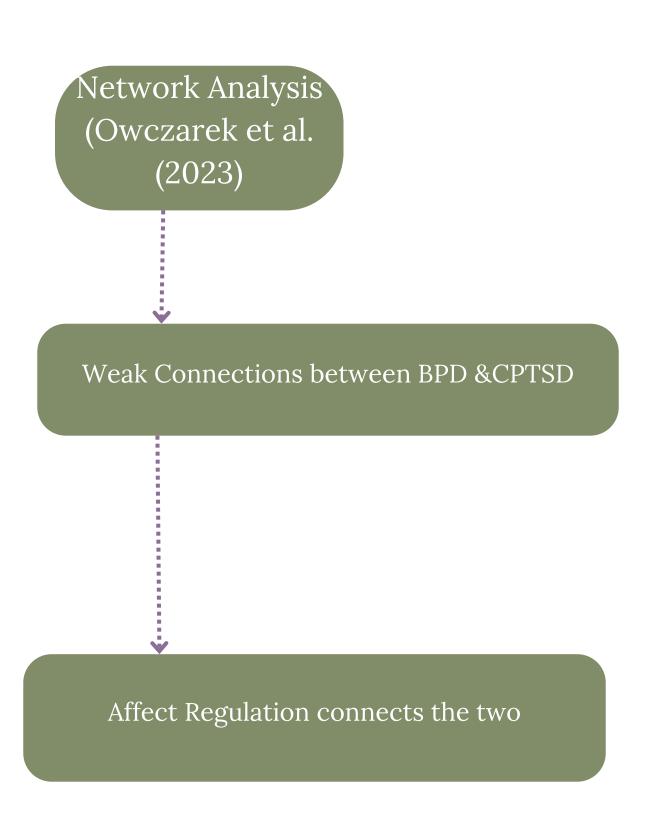


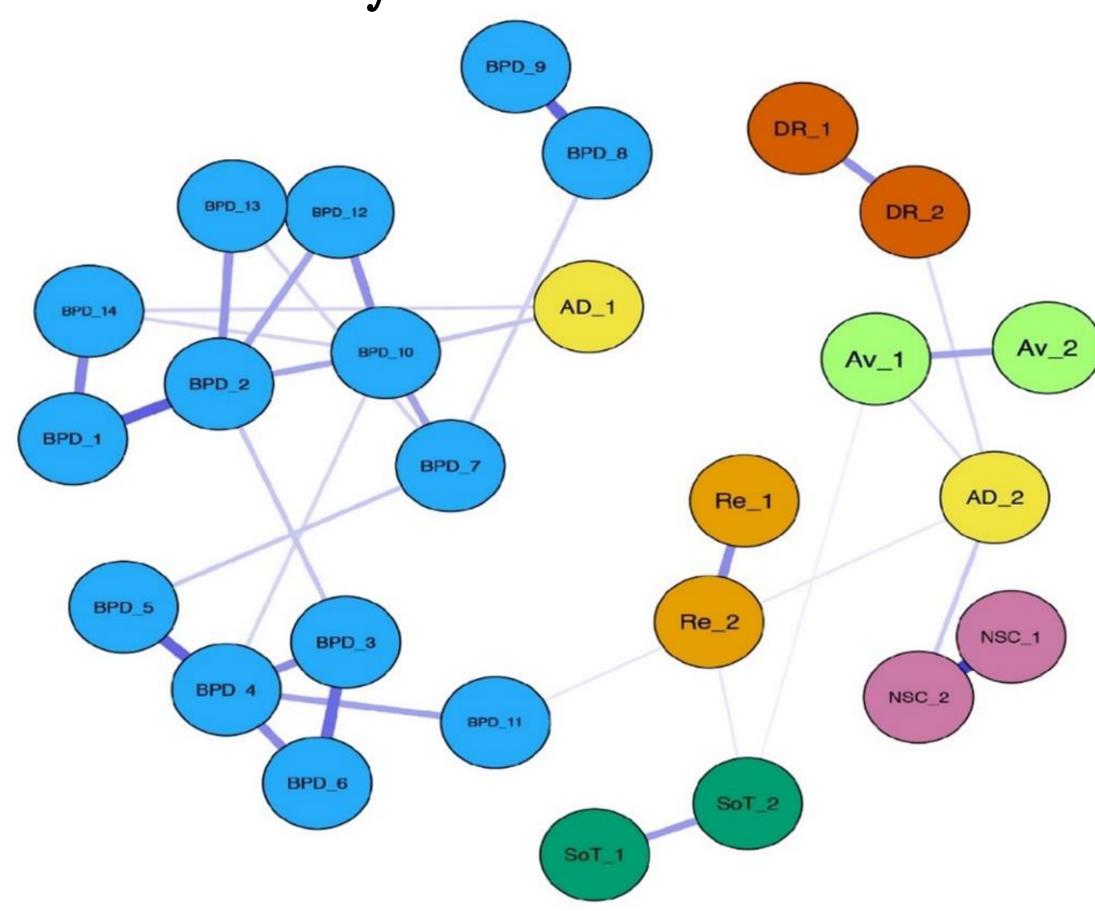
The method of comorbidity classification didn't impact on prevalence - generally considered that statistical class rather than diagnostic can 'inflate' findings (diagnostic =13% pooled prevalence Statistical =10% pooled prevalence)

Removing personality disorder diagnosis would leave 45-99% of people who currently have a Borderline diagnosis, with NO diagnosis, if CPTSD is used as an alternative



# What is the connection between CPTSD and Borderline Personality Disorder?







## What is the relationship between symptoms of CPTSD and Borderline Personality Disorder?

CPTSD Symptoms		Borderline Personality Disorder items		
Re experiencing Avoidance Sense of threat****		_		
DSO Affect regulation		Hyper Arousal B10: Sudden mood changes; Hypo Arousal: B11: Feel Empty;B14: When you are under a lot of stress feel spaced out		
DSO Negative Self Concept		B3: Suddenly changing sense who you are and goals B4: Does sense of self change dramatically B5: Are you different with people and not know who you are? B6: Have you had lots of sudden changes in career plans, religious beliefs etc		
DSO Disturbance in relationships		B1: *****Frantic when you thought was going to leave you B2: Relationship ups and down		
		B7: Impulsive behaviour B8: Have you tried to hurt or kill yourself B9: Have you ever cut, burnt of scratched self on purpose B12: Temper / anger B13 Do you hit people or throw things when you get angry		



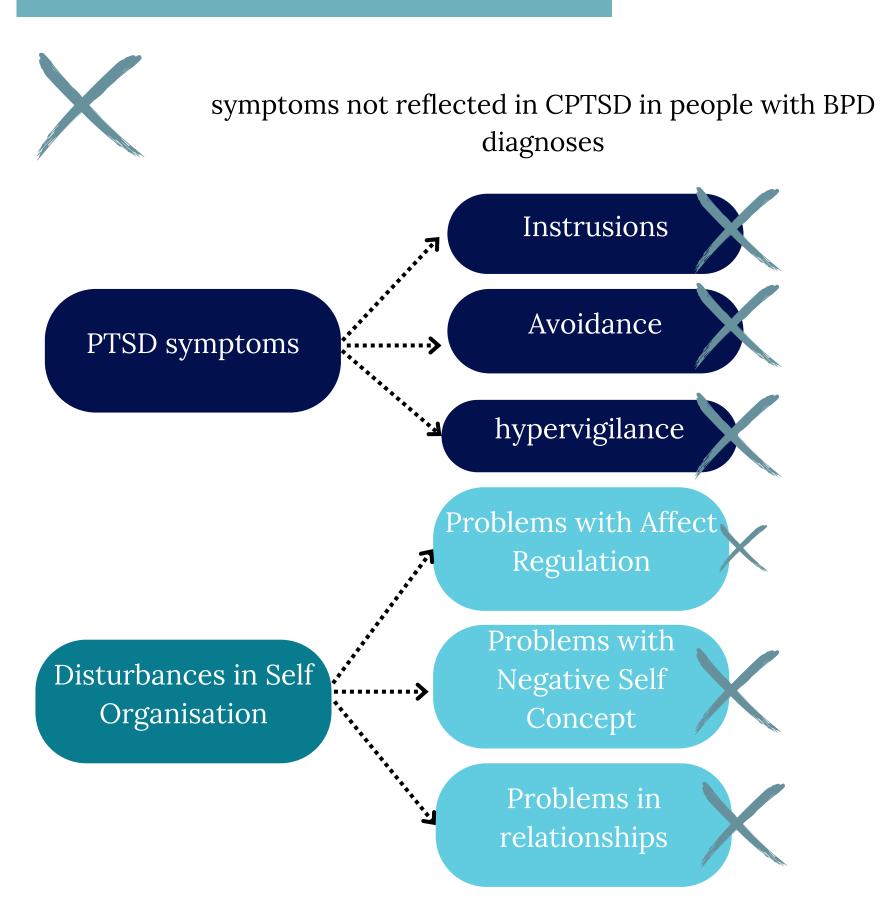
No network connection/ relationship betweenANY PTSD / DSO or BPDsymptoms

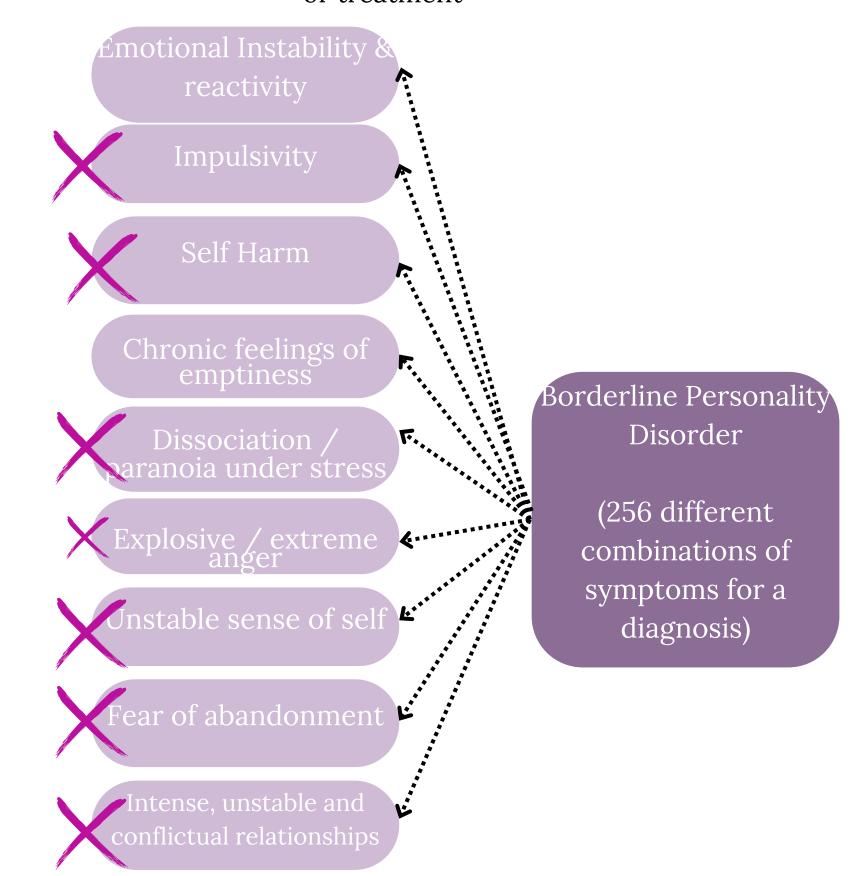


### What does this mean in relation to diagnosis and treatment needs?

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symptoms experienced in BPD that wouldn't be considered in CPTSD or treatment





## What are the results suggesting?

- CPTSD is not the by product of PTSD comorbid with PTSD
- The impacts of trauma and exposure to adversity can manifest differently, leading to different treatment needs
- That we need to have suite of treatments that address the differential symptom pathways that trauma can lead to
- They **<u>DO NOT</u>** suggest that people with diagnosed with personality disorders have not experienced exposure to traumatic events and other forms of adversities or harms
- The results do suggest that people with personality disorders can experience both personality disorder and CPTSD needs
- Post results rationalisations? looking beyond 'core diagnostic' symptoms



## Exploring this question beyond 'core' symptoms: common comorbidities

- Are some of the assumptions around the equivalence of the diagnoses based on commonality of co morbid needs rather than core symptoms?
- CPTSD and Borderline Personality Disorder have similar levels of elevated comorbidity with other psychiatric needs
- Is commonality of co existing needs firm evidence of being synonymous conditions? not within the framework for evaluating the validity of diagnoses yet arguably evidence of being 'related'



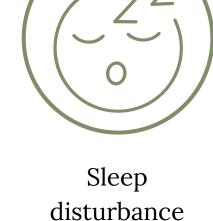




disorders









# Therapeutic and experience of services for CPTSD and Borderline Personality Disorder that may impact on clinician perceptions of 'sameness'



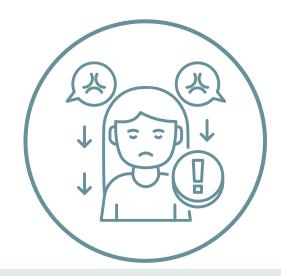
- Trauma and Personality disorder treatments both have comparatively higher levels of drop out rates, and drop out rates for (some) similar reasons
- Both groups often have multiple trials at different therapies before finding a good 'fit'



- Both groups can experience iatrogenic impacts from therapy, that have some similarities
  - Cost
  - Length of treatment
  - 'Side effects'
    - elevated distress during therapy
    - working with professionals who are ill equipped to meet needs



- Borderline Personality Disorder 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 to BPD



- Marked difference between CPTSD and Borderline Personality Disorder are
  - levels of social stigma
  - Negative perceptions by mental health workers
  - levels of empathy within services
  - Service focus heal vs 'manage'
  - recognition of traumatic or adverse experiences



## Has mental health messaging created confusion and invalidation of some trauma experiences?

#### Diagnostic pathways: Not all trauma pathways lead to PTSD / CPTSD

- PTSD and CPTSD are the only, or the most important outcomes of trauma exposure
- However, trauma, as a 'risk factor' or cause of mental health problems is recognised in a significant number of diagnoses
- PTSD and CPTSD are only two of **many** potential mental health outcomes
- Yet, psychoeducation, trauma training and professional training about the impacts of trauma typically focus on PTSD and CPTSD as outcomes

#### Language: Trauma v's Adversity and 'Big T and little t'

- There is tension between 'trauma' and 'adversities' and the perception of the right type of 'experience'
- Experiences described as 'adversities' as opposed to 'Criterion A' trauma's can have significant, although potentially differential impacts -
- The use of the term 'Big T' (criterion A events) and 'little T (adversities) can also inadvertently create a 'hierarchy' in harms
- Remember it is Childhood **Adversities** (exposure) not trauma responses that are heavily associated with a range of negative biopsychosocial outcomes, the acronym is ACEs not ACT's, yet current messaging is reductionist and focuses on 'Big T'
- Little T gets lost in trauma discussions

#### Research 'not all traumas / adversities are explored equally'

• Direct traumas, within the ACEs framework are significantly more explored than indirect and household ACEs, yet they are typically less frequently experienced - adding to the comparative invisibility of adversities and our continued focus on abuse based traumas.

Lived experience Perception: 'Trauma services heal and personality disorder services manage behaviours"

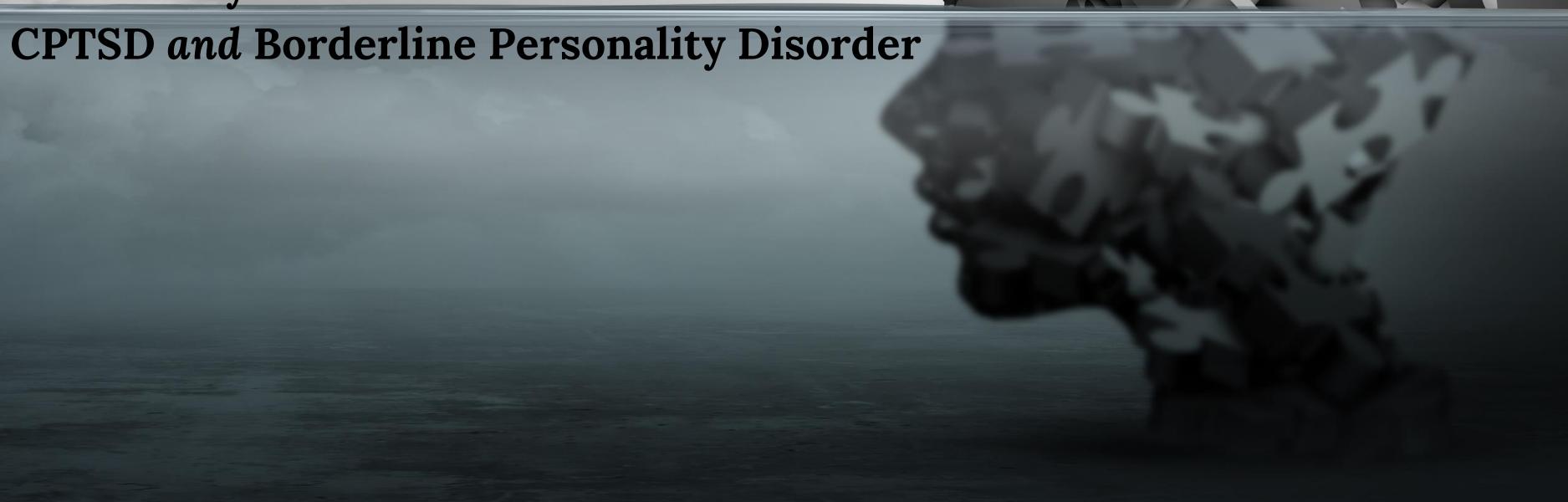
#### The calmative impact of current messaging is potentially...

- 1. Creating a hierarchy of trauma ahead of 'adversities' in terms of life impacts
- 2. 'unvictiming' some adversities / traumas and populations
- 3.Invalidates people's life experiences
- 4. Hence, we offer validation and hope through CPTSD diagnoses which creates another layer to 'gaslighting' people diagnosed with personality disorders



Looking beyond CPTSD V's Borderline Personality disorder.....







# What are the shared characteristics of those who meet both presentations?





childhood adversities+~\*



Victimisation - across the lifespan\*~+



General Distress #~\*



PTSD symptoms\*^



DSO symptoms \*^



Shame~\*



Risk to self#





life#\*



Functioning+





Personality disorder symptoms

**Key Finding:** Morris et al., (2024) Only **affective dysregulation** was a significant predictor of distress, risk to self, and quality of life (all p<.05) No other CPTSD symptom cluster predicted distress, risk or QoL

## Current clinical guidance

#### **NICE GUIDANCE**

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

NICE Guidance for Borderline Personality Disorder

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

#### **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; highlights DBT, MBT and PE, which are evidenced for Borderline Personality Disorder

#### Karatzias et al., (2023), For those who meet both diagnoses

#### (A) 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

#### (B) Problems of double scoring pathology

- Need to avoid over pathologising and 'double scoring symptoms' (symptoms not repeatedly assigned)
- · Recommends a 'hierarchical' approach, as opposed to the DSM approach

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



## Current clinical guidance

#### Key clinical guidance

- •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 (CPTSD) possible if self report measures are used alone.
- "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
- •E.g. Stable but chronically low / self loathing
- •E.g. Avoidant of relationships
- •AND 5/9 BPD symptoms are met.
- •For those who endorse both diagnoses a trauma-informed approach may be the most appropriate treatment framework

•			
Symptoms included in the diagnosis	CPTSD	BPD*	
	Characterized by	Characterized	
	feelings of threat,	predominantly by	
	low self-efficacy, and	instability in affect, sense	
	relational distancing	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	Vas	No	
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	Ma	Vas	
dissociative symptoms	No	Yes	
Chronic feelings of emptiness	No	Yes	
3. Sense of Self			
Persistent and pervasive negative sense of self as	Yes	No	
worthless or defeated	168	No	
Marked and persistently unstable self-image or sense	No	Yes	
of self.	NO	165	
3. Interpersonal Relationships			
Difficulty staying close maintaining relationships,	Yes	No	
tendency to distance, avoid or break off with conflict	168	No	
Frantic efforts to avoid real or imagined	No	Yes	
abandonment	INU	168	
Unstable and intense interpersonal relationships that	No	Yes	
alternate between idealization and devaluation	110	165	

### The role and function of diagnoses: Revisited

Diagnois	Symptoms	Prognosis	Pathobiology	Pathogenesis
	Objective and subjective experiences	Predictions about course and outcome, over time (inclusive of the effectiveness of treatment	Physiological processes that change due to the disease and impacts on functioning	The 'cause', development or events that leads to the presentation / disorder
Borderline Personality Disorder	Minimal of shared networks / relationships between symptom			exposure to early adversities and traumatic events are common, though not universal, evidence of biological vulnerabilities
Complex PTSD		??	??	Traumatic events



## Take home practice implications



The two presentations may have similar aetiology, although they are diagnostically distinct: However,

- A smaller group of people will meet criterion for both presentations
- Common co-existing needs
- The course may be experienced as similar
  - Would be prudent in personality disorder pathways to ask critical questions about *current* trauma needs



People meeting both diagnostic criterion *may* present with greater needs in relation to quality of life & risk to self



Re evaluating our relationship with trauma and diagnostic nosology

- Widen understanding of the clinical manifestation of trauma -
- CPTSD is not the only diagnostic pathway for trauma exposure
- Critical this is reflected in psychoeducation and training (reflect on language e.g. Big T and Little T)



Therapeutic experience: Some similarities between the two presentations and some key differences

- Record and report 'discontinue / didn't complete' rates to help increase our understanding of the experience of therapy, especially trauma therapies
- Record and address Iatrogenic impacts of therapy



Emotional / Affect regulation is a critical need to address for people who meet criterion for both presentations



## Lets re visit that poll.....

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### Conclusions

- Debates relating to the relationship between CPTSD and Borderline Personality Disorder reflect consideration of
  - Aetiology
  - core diagnostic factors
  - Co existing needs
  - Clinical journeys
  - The extension of the function of diagnoses for social rather than core diagnostic reasons
- Some aspects of diagnostic similarity can not yet be answered, CPTSD remains a novel diagnosis
- Using CPTSD as an alternative to BPD has become our way of 'solving' the problem of personality disorder and to understandably to validate those who are often maligned and invalidated by their life experiences, negative treatment in services and social perceptions
- Using CPTSD as an alternative could lead to significant numbers of people with no diagnosis, or only partial meeting of treatment needs Ironically leading to personality disorder having a 'second age' of being a diagnosis of exclusion
- Research a very long list!
  - Prioritise longitudinal designs
  - Lived experience of comorbidity
  - The development of models and treatments for those who experience both conditions
  - Better understanding of the impact of changes in one set of needs on the other part of the presentation



### Contact details



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