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Joanna Solarz-Bogusławska
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Case Report

Interrelationship Between Borderline Personality, PTSD and Complex PTSD

Joanna Solarz-Bogusławska

Lipno Hospital, General Psychiatric Ward.

***Corresponding Author:** Joanna Solarz-Bogusławska, Lipno Hospital, General Psychiatric Ward.

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Abstract:

This article contains a presentation of the most important elements of the definition of Complex PTSD (Complex Post-traumatic Stress Disorder). Since it is possible to discuss the new aspects of the disease which consists on: Borderline Personality Disorder (BPD), Post-traumatic Stress Disorder (PTSD), and - as a new disease - Complex PTSD (cPTSD). The text is showing on the accuracy to make distinctions of the Complex PTSD from other known disease entities, because modern studies are clearly demonstrating this need. This is evidenced by studies of people exposed to chronic social stress combined with depression relationships. The experiences referred to as "boundary" for the human psyche and making up this type of disorder are long-lasting and leaving significant traces in the psyche of the patients (affective dysregulation).

The introduction of a new disease entity is caused by the necessity to adjust clinical diagnoses to new observations, which significantly beyond the accepted definition of PTSD (range: symptoms, treatment time). It seems legitimate to define a new comprehensive trauma; the symptoms largely depend on the characteristics of the individual patient.

Keywords: borderline personality disorder; post-traumatic stress disorder

Introduction

This paper is a partial literature and study report review regarding interdependencies between borderline personality disorders (BPD), post-traumatic stress disorder (PTSD) and Complex PTSD (cPTSD). ICD-11, which will probably be published in 2017, may include a new nosological unit: Complex PTSD (cPTSD). It has not been included either in ICD-10 or DSM V. This was due to the argument that most people who could be diagnosed with cPTSD have already met criteria of existing disorders (i.e. PTSD and/or BPD). Today, studies show that PTSD diagnosis in not enough to describe all patients with chronic stress.

Complex PTSD

PTSD diagnosis does not fully reflect the clinical picture of persons in a chronic stress situation with trauma lasting several weeks, months, or years. The term 'Complex PTSD' includes, apart from basic PTSD criteria, additional symptoms regarding disrupted regulation in three areas: emotional processing, self-image, and establishing interpersonal relations. 'Emotional dysregulation' means constantly high reactivity, violent episodes of rage, self-destructive behaviour, tendency to dissociation, etc. Additionally, emotional freezing and inability to feel pleasure have been noted. Negative self-esteem, low self-assurance, omnipresent shame and guilt were reported in persons diagnosed with 'self-perception' disorder. 'Interpersonal difficulties' mean problems with sustaining relations and avoiding contact with other people. These persons have relationships but have troubles becoming emotionally involved. There are, however, two BPD criteria that are completely different from PTSD or Complex PTSD: fear of abandonment and devaluation and idealisation of others. Studies show that physiological reactivity of persons diagnosed with BPD with child trauma (sexual abuse) was the strongest upon abandonment or rejection by others; whereas in persons with PTSD without BPD, during exposure to a trauma-like situation [1].

M. Zanarini found already in 1997 [2] that person who are subjected to prolonged stress during childhood exhibit signs of affect dysregulation, impulsivity, disturbed interpersonal relations, suicidal thinking, experience emptiness, anger, and dissociation. These conditions have been named Complex PTSD. They are symptoms present in persons with diagnosed BPD as well [3–5]. J. Herman suggested that an additional diagnosis is necessary to describe a situation of chronic stress; this way Complex PTSD diagnosis was introduced. Another term, DESNOS (Disorders of Extreme Stress Not Otherwise Specified) proposed by van

der Kolk, Pearlman, or Roth [3-5] among others or DTD (Developmental Trauma Disorder) are also used in literature [6]. Owing to the fact that 92% of persons with diagnosed Complex PTSD met criteria for PTSD, the new nosological unit was not included in DSM V. Many scholars believe that patients experiencing chronic stress need other treatment methods and therefore this category needs to be set apart.

Complex PTSD was proposed as an alternative unit for people who experience chronic trauma and were diagnosed with borderline personality disorder [7]. The question is, is cPTSD just another instance of BPD or a new category for BPD patients in prolonged trauma [8]?

Axis I or II?

The debate whether Complex PTSD is something different than borderline personality concomitant with PTSD. The fundamental problem with this issue is the lack of clear-cut characteristic of Complex PTSD. The World Health Organisation (WHO) suggested treating Complex PTSD as a new diagnosis separate from PTSD [9]. ICD-11 defines Complex PTSD as a disorder related to chronic and repeated stress; it includes not only symptoms of PTSD but also disturbed emotional regulation, self-esteem, and problems with interpersonal relations [10].

Three studies have demonstrated that it is justified do separate PTSD and Complex PTSD. M. Cloitre carried out a Latent Profile Analysis (LPA) in 2013. The researchers have found that chronic stress was a predictor of Complex PTSD, which impaired patient's functionality much more than PTSD [10]. Other studies that have supported inclusion of Complex PTSD in ICD-11 are the studies by A. Elklit, P. Hyland, and M. Shevlin [11] and M. Knefel and B. Lueger-Schuster [12].

Is Complex PTSD a Combination of PTSD and BPD?

The high co-occurrence index of PTSD and BPD may be an argument that Complex PTSD is a combination of PTSD and borderline personality. This is exemplified by NESARC (National Epidemiologic Survey on Alcohol and Related Condition) data for the population of the United States of America. J. Pagura et al. have demonstrated that 24% of persons diagnosed with PTSD met BPD criteria as well; whereas 30% of persons with BPD had symptoms of PTSD, and 2% met both criteria, i.e. for PTSD and BPD [13]. B. Grande came to similar conclusions in his paper [14], also using NESARC data. In conclusions of his work, he included information demonstrating that 29% of persons who met PTSD criteria had met BPD criteria in the previous 12 months, and 32% of people with BPD were diagnosed with PTSD. The co-occurrence index is even higher in clinical samples; PTSD patients had BPD symptoms in 37%–68% [15, 16], and vice versa: 25%–58% of patients with BPD were diagnosed with PTSD [17, 18].

Several studies have demonstrated that occurrence of childhood trauma and PTSD is related to the following BPD symptoms: empathy display deficits [19], affect regulation disorder [20], attempted suicide and self-harm [21, 22], crises leading to hospitalisation [23], psychotic symptoms [24], and anxiety and guilt [25, 26]. There are, however, numerous studies, which show no connection between BPD and PTSD and childhood trauma [23, 27, 28, and 29]. BPD may complicate the course of PTSD, whereas it seems more specific to say that Complex PTSD may be 'required' to emphasize the role of trauma in BPD.

According to Heitzman, personality traits are given the primary role in increasing susceptibility to PTSD. Personality disorders related to repeated childhood trauma are not clearly related to PTSD. It will be inherit traits of each individual that decide whether the trauma leads to clinical signs of PTSD [56]. Davidson points to such traits as borderline, sociopathic, passive-dependent, and paranoid [57].

PTSD and BPD in DSM V

Despite the high rate of co-occurrence, clinical features of Complex PTSD and BPD are different and their diagnosis is important owing to the schedule of the treatment process. Trauma is not 'required' to diagnose BPD. Its clinical picture is dominated by fear of abandonment, emotional instability, frequent suicidal behaviours, and difficult relations. In order to diagnose PTSD, a catastrophic, traumatic experience is necessary. Both PTSD and BPD involve emotional regulation disorder, but its expression is completely different in both disorders. In Complex PTSD, it involves emotional sensitivity, reactive anger, and poor stress handling. Alcohol or other psychoactive substance abuse is also frequent. BPD includes some of the criteria listed before, but this diagnosis is primarily characterised by suicidal intent and self-destructive behaviours, which are less common in Complex PTSD [16].

Changed requirements for PTSD are identical in DSM V to four other requirements for BPD. These are: identity disorders, impulsivity, self-harm, and unstable affect. It is important because all the 'new' criteria in DSM V for PTSD that are potentially identical to those for BPD are the fundamental features of Complex PTSD, which include: affect dysregulation, changed self-image, dangerous impulsive behaviours, and self-mutilation [10]. Already in 1987 J. Herman and B. van der Kolk noted 5 core features common for PTSD and BPD, which include: affect regulation, impulse control, reality testing, specific interpersonal relations, and self-integration.

Therapeutic Approach

Treatment of BPD involves mainly reduction of dangerous behaviours, such as attempted suicides or self-mutilation, and recovery of identity stability by the patient. An example is dialectical behaviour therapy by M. Linehan. Whereas Complex PTSD therapy focuses mainly on reduction of social avoidance, development of positive self-image, and working through the trauma. Duration of treatment differs as well. American Psychiatric Association (ASA) experts recommended in 2013 that BPD be treated for at least a year. The period of the end of therapy may induce worse mental state in persons with BPD resulting from the sense of rejection and destabilisation of identity. The treatment duration for Complex PTSD is yet to be established, but it seems shorter than in the case of BPD. According to scholars, the sense of stability of 'self' and small risk of suicide attempt make the therapy shorter than for BPD. It is, nevertheless, longer than in the case of PTSD owing to the greater number and variety of symptoms [30].

PTSD is located on axis I in DSM V. This suggests a disorder of shorter duration and better pharmacological effects. BPD is situated on axis II, which entails longer duration and worse prognosis. Still, diagnosis of BPD has a negative meaning for many clinicians for whom such patients are difficult [23]. Some say that PTSD 'sounds better' because this disorder is connected to being a victim, evoking sympathy, no stigma [31]. Despite these diagnostic differences, both the disorders may last for years on end [32, 33]. C. Zlotnick demonstrated in 2000 that co-occurrence of PTSD and BPD is significant, estimated in clinical picture at 56%–76%. Additionally, in such cases core symptoms of both disorders i.e., affective instability and interpersonal dysfunctions, overlap [34]. It is no surprise that some scholars believe BPD to be a chronic form of PTSD

or even suggest the name 'Complex PTSD' [35, 36].

BPD is characterised by emotional instability and disrupted self-integration. Instability is a rather rare symptom in PTSD or Complex PTSD. Self-esteem is usually negative; these persons avoid relations and feel alienated. BPD is more often diagnosed in women (75% of occurrences), which could be accounted for by the higher prevalence of violence against women [37]. In 2008, B. Grant [38] found that the disorder affects women as often as men but women are clinically more unstable and their disorder picture in clearer.

Trauma in BPD

J. Herman [39] has demonstrated that as many as 81% of patients diagnosed with BPD have undergone childhood trauma. This included in 71% physical abuse, 68% sexual abuse, and 62% witnessed domestic incidents. Apart the abuse-related factors, child neglect is believed to be a substantial contributor. This includes both actual abandonment and rejection; and perception of 'rejection', e.g. poor fit of the child and carer [40, 41]. A. Thomas and S. Chess [42] suggest that 'goodness of fit' or 'poorness of fit' of the child and its environment are decisive for understanding its future behavioural functioning. 'Good fit' occurs when child's environment properties and its expectations conform to the possibilities, traits, and behavioural style of the individual. 'Poor fit' occurs when a dissonance is noticeable between environmental circumstances and requirements; and the possibilities and traits of the child. Both cases result in deformed development and non-adaptive functioning [42, 43].

According to M. Linehan [44] the type of environment that establishes 'poor fit' is an invalidating environment, which most probably contributes to BPD. Parental neglect correlated with borderline and histrionic personality [45]. L. Young referred to childhood trauma experienced by patients diagnosed with BPD in his analyses. These experiences resulted in basic needs of the child remaining unaddressed. Based on these conclusions, L. Young formed his theory of early maladaptive schemas. According to the theory, stressful experience alone is not enough to produce a disorder. So-called biological predisposition, individual susceptibility is necessary. Both the aetiological factors often co-exist. A positive correlation has been noted between the level of severity of childhood abuse and the intensity of disorders [46, 47].

Sexual abuse is a risk factor of BPD, but these features are not specific to this personality type [48]. Disorders develop not from the traumatic experience alone, but are affected by the type of stress, its duration, and consequences. Studies by J. Lobbestal et al. on negative childhood experiences and occurrence of personality disorders have demonstrated that sexual abuse correlated with several types of personality disorders, primarily with: paranoid, schizoid, borderline, and avoidant. Physical abuse was usually correlated with antisocial personality [49].

According to studies by J. Paris, among persons diagnosed with borderline personality, 1/3 experienced serious abuse, 1/3 experienced stress that would not cause disorders in most people, and no domestic violence was found for 1/3 [50]. Trauma is an aetiological factor also of many other mental disorders (e.g. bipolar affective disorders, panic attacks, obsessive-compulsive disorders, etc.). It often happens that other disorders co-occur with BPD [51, 52], which substantially affects prognosis and hinders therapy [53, 54]. Some scholars believe that borderline personality often co-occurs with disorders for which trauma is one of the primary causes. This approach classifies Complex PTSD as a subtype of BPD. Studies by J. Golier have indicated that childhood trauma has stronger correlation with paranoid personality than borderline personality [55].

Conclusions

Persons who experienced childhood trauma are susceptible to signs of BPD, PTSD, and cPTSD. Although symptoms of BPD and cPTSD are identical to a large extent, it is unjustified to classify cPTSD as a substitute or subtype of BPD. According to reference literature, a subgroup of borderline patients can be identified who often, but not always, suffer from concomitant PTSD. In such a case it seems justified to diagnose Complex PTSD to stress the role of trauma.

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