CESIST CHILE
Centro de Estudios Sistémicos

Trauma complejo y TLP: Una relación estrecha

Dr. Felipe E. García
Académico Universidad de Concepción
Director General Cesist-Chile

1

ORIGEN DEL DIAGNÓSTICO DE TLP

Surge en 1884 (C. Hugues)

Aludía a las afecciones que se encontraban entre la neurosis y la psicosis

Origen desconocido durante muchos años

Hoy se creen que confluyen factores genéticos, familiares y sociales

Causas más probables:

- Experiencias de abandono
- Experiencias de abuso
- Disfunción familiar

2

ORIGEN DEL CONCEPTO DE TRAUMA COMPLEJO

Surge en 1992 (Herman)

Alude a la presencia de un TEPT de mayor complejidad que presentaban personas que habían experimentado eventos traumáticos continuos en la infancia (TEPT-C)

Los eventos tienen como características:

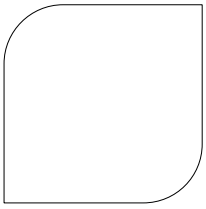
- Son negativos.
- Son continuos o acumulativos.
- Afectan la relación del niño/a con sus cuidadores.

Entre los posibles eventos adversos se encuentran:

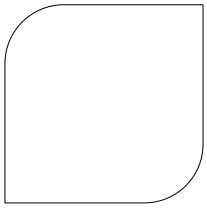
- abuso
- abandono
- negligencia parental
- violencia intrafamiliar
- consumo de drogas por parte de los cuidadores

3

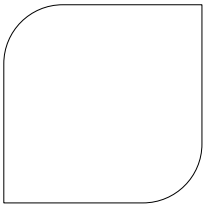
Relación entre el TEPT-C con TLP



¿TRAUMA COMPLEJO ORIGINA EL TLP?



¿TEPT-C ES LO MISMO QUE EL TLP?



¿AMBOS DIAGNÓSTICOS SON ENTIDADES DIFERENTES?

4

- Más del 75% de las personas con diagnóstico de TLP presentan historias de abuso físico, sexual o emocional en la infancia

Journal of Traumatic Stress, Vol. 20, No. 4, August 2007, pp. 391–400 (© 2007)

Applications of Dialectical Behavior Therapy to the Treatment of Complex Trauma-Related Problems: When One Case Formulation Does Not Fit All

Amy W. Wagner
Portland VA Medical Center, Portland, OR
Shireen L. Rizvi
Department of Psychology, New School for Social Research, New York, NY
Melanie S. Harned
Department of Psychology, University of Washington, Seattle, WA

In this article, the authors take the perspective that effective treatment of complex trauma-related problems requires, in the absence of empirically supported treatments, a reliance on theory, idiographic assessment, and empirically supported principles of change. Dialectical behavior therapy (DBT; M. M. Linehan, 1993) is used to demonstrate the applicability of this approach to the treatment of multiproblem, heterogeneous populations in general. Two case studies are presented that highlight the utility of DBT principles to complex trauma-related problems specifically.

The need for effective treatments for complex trauma-related problems has been clearly stated by many (see van der Kolk & Courtois, 2005) and reflected in the recent special series in the *Journal of Traumatic Stress* (2005). Nonetheless, there remains a lack of consensus on the best approach to treatment. The special series of symposia, "Responding to the Clinical Complexities of Trauma," at the 2006 annual convention of the International Society of Traumatic Stress Studies was an exciting effort to further this dialogue. At one of the final symposia, there was a lively discussion between members of the audience and the panel on the merits of various approaches, during which an audience member asked a particularly poignant question, "What ever happened to *theory* in our approach to treatment development?" He went on to argue that, historically, treatment development has been guided by theory and that in the absence of empirically supported treatments (which is the current reality in our efforts to treat complex populations in novel settings) there is much to be gained by drawing from empirically supported theories. This is our main premise in the current article. Here we highlight empirically supported principles, largely derived from behavioral theory, which may aid case formulation and treatment planning in adults who present with complex problems and histories of trauma. We use dialectical behavior therapy (DBT; Linehan, 1993) as the foundation for this discussion. Finally, we present two case studies to demonstrate the application of DBT principles and strategies to case formulation and treatment among individuals with histories of trauma and complex presentations.

Dialectical behavior therapy has strong empirical support for the treatment of borderline personality disorder (BPD; Salsman & Linehan, 2006). Given the complexity and variability of problems among individuals with

Correspondence concerning this article should be addressed to Amy W. Wagner, Portland VA Medical Center, Box 1035, V3-SATP, Portland, OR 97207. E-mail: amy.wagner@va.gov.
 DOI: 10.1002/jts.20268

5

- Un número significativamente mayor de sujetos con diagnóstico TLP (81%) proporcionaron historias de trauma infantil, incluyendo abuso físico (71%), abuso sexual (68%) y haber sido testigos de violencia doméstica grave (62%)

Childhood Trauma in Borderline Personality Disorder

Judith Lewis Herman, M.D., J. Christopher Perry, M.P.H., M.D., and Bessel A. van der Kolk, M.D.

Subjects with borderline personality disorder (N=21) or borderline traits (N=11) and nonborderline subjects with closely related diagnoses (N=23) were interviewed in depth regarding experiences of major childhood trauma. Significantly more borderline subjects (81%) gave histories of such trauma, including physical abuse (71%), sexual abuse (68%), and witnessing serious domestic violence (62%); abuse histories were less common in those with borderline traits and least common in the subjects with no borderline diagnosis. These results demonstrate a strong association between a diagnosis of borderline personality disorder and a history of abuse in childhood.
(Am J Psychiatry 1989; 146:490–495)

In the past two decades, borderline personality disorder has become the subject of intensive theoretical and clinical investigation. Beginning with Stern (1), successive investigators have refined their descriptive formulations, culminating in the development of *DSM-III* criteria for a reliably identifiable syndrome, stable over time, with serious morbidity (2–9). It is generally agreed that patients with borderline personality disorder are difficult to treat because of the intensity of their engagement with caregivers, the sometimes overwhelming nature of their demands for care, and the strong emotions and conflicts that they provoke in others (10, 11).

Attempts to conceptualize the underlying pathology of borderline personality disorder have generally invoked either a biologic model of affective disorder (12–15) or a psychodynamic model of developmental arrest (10, 11, 16). In the developmental formulation, disruptions in relations with primary caretakers are thought to be an important factor in the genesis of the disorder. Parental neglect and unprotectiveness are cited by Walsh (17), Frank and Paris (18), Gunderson (6), and Feldman and Guttman (19). Early, prolonged separation from or permanent loss of primary caretakers is described anecdotally by Adler (11) and demonstrated in a significant proportion of patients in retrospective studies by Akiskal (13), Soloff and Millward (15), and Bradley (20).

Although disruption of early attachments is frequently cited, the role of childhood trauma, including parental abuse, in the development of this disorder has received less systematic attention. Data from three small clinical studies offer suggestive evidence that histories of childhood abuse may be especially common in borderline patients. A study of 12 hospitalized borderline patients reported by Stone (21) indicated that 75% had a history of incest. In a chart review study of psychiatric outpatients at an urban teaching hospital, Herman (22) found that eight (67%) of 12 patients diagnosed as borderline according to *DSM-III* criteria had a history of abuse in childhood or adolescence; such histories were found in only 22% of the entire outpatient population. Bryer et al. (23), in an interview study, found that 12 (86%) of 14 hospitalized borderline patients diagnosed by *DSM-III* criteria had a history of sexual abuse before age 16, whereas early sexual abuse was reported by 21% of the entire inpatient population. Although all of these studies involve small numbers of patients, their findings are consistent and provide sufficient evidence to warrant further investigation.

The present study was undertaken to test the hypothesis that a history of childhood trauma is particularly common among patients with borderline personality disorder. A fuller exposition of this hypothesis has been published (24).

METHOD

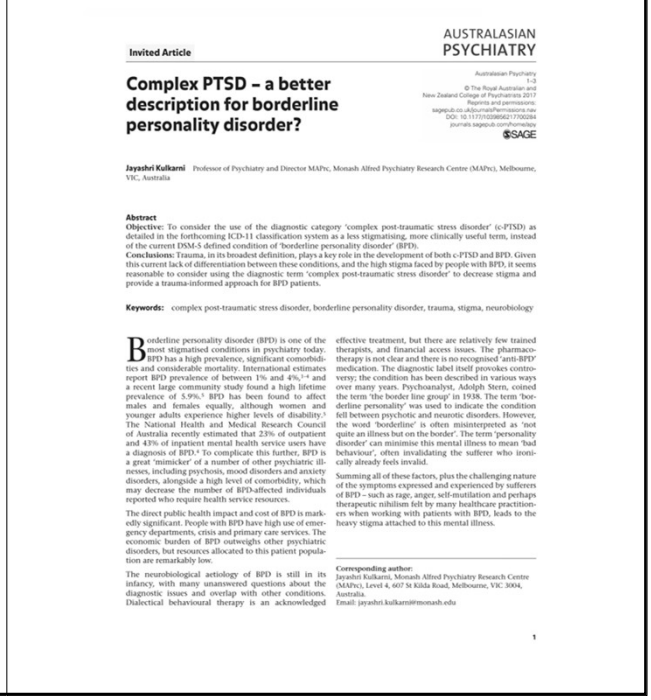
Subjects were drawn from an ongoing longitudinal study of borderline personality disorder in comparison to the closely related diagnoses of schizotypal personality disorder, antisocial personality disorder, and bipolar II affective disorder. Subjects were originally recruited from ambulatory mental health settings and from advertisements for symptomatic volunteers. The methods of subject selection have been previously described in detail (9, 25, 26). After full explanation of

Received March 28, 1988; revision received Sept. 22, 1988; accepted Oct. 18, 1988. From the Department of Psychiatry, Harvard Medical School, The Cambridge Hospital, Cambridge, Mass. Address reprint requests to Dr. Herman, 61 Roseland St, Somerville, MA 02143.
Supported in part by NIMH grant MH-34123.
The authors thank Idell Goldenberg, M.A., Beth Hoke, M.A., Barbara Matthews, and Chris Pagano, who served as research assistants.

6

Ambos refieren a lo mismo

- La categoría diagnóstica de TEPT-C es un término menos estigmatizante y más útil clínicamente que el de TLP.
- No existe una diferencia clara entre estas afecciones y debido al alto estigma al que se enfrentan las personas con TLP, parece razonable considerar el uso del término diagnóstico TEPT-C para reducir el estigma y proporcionar un enfoque basado en el trauma para los pacientes con TLP



AUSTRALASIAN PSYCHIATRY

Invited Article

Complex PTSD – a better description for borderline personality disorder?

Jayashri Kulkarni Professor of Psychiatry and Director MAPrc, Monash Alfred Psychiatry Research Centre (MAPrc), Melbourne, VIC, Australia

Abstract

Objective: To consider the use of the diagnostic category 'complex post-traumatic stress disorder' (c-PTSD) as detailed in the forthcoming ICD-11 classification system as a less stigmatising, more clinically useful term, instead of the current DSM-5 defined condition of 'borderline personality disorder' (BPD).

Conclusions: Trauma, in its broadest definition, plays a key role in the development of both c-PTSD and BPD. Given this current lack of differentiation between these conditions, and the high stigma faced by people with BPD, it seems reasonable to consider using the diagnostic term 'complex post-traumatic stress disorder' to decrease stigma and provide a trauma-informed approach for BPD patients.

Keywords: complex post-traumatic stress disorder, borderline personality disorder, trauma, stigma, neurobiology

Borderline personality disorder (BPD) is one of the most stigmatised conditions in psychiatry today. BPD has a high prevalence, significant comorbidities and considerable mortality. International estimates report BPD prevalence of between 1% and 4%,[1–4] and a recent large community study found a high lifetime prevalence of 5.9%.[5] BPD has been found to affect males and females equally, although women and younger adults experience higher levels of disability.[3] The National Health and Medical Research Council of Australia recently estimated that 23% of outpatient and 43% of inpatient mental health service users have a diagnosis of BPD.[6] To complicate this further, BPD is a great 'mimicker' of a number of other psychiatric illnesses, including psychosis, mood disorders and anxiety disorders, alongside a high level of comorbidity, which may decrease the number of BPD-affected individuals reported who require health service resources.

The direct public health impact and cost of BPD is markedly significant. People with BPD have high use of emergency departments, crisis and primary care services. The economic burden of BPD outweighs other psychiatric disorders, but resources allocated to this patient population are remarkably low.

The neurobiological aetiology of BPD is still in its infancy, with many unanswered questions about the diagnostic issues and overlap with other conditions. Dialectical behavioural therapy is an acknowledged effective treatment, but there are relatively few trained therapists, and financial access issues. The pharmacotherapy is not clear and there is no recognised 'anti-BPD' medication. The diagnostic label itself provokes controversy; the condition has been described in various ways over many years. Psychoanalyst, Adolph Stern, coined the term 'the border line group' in 1938. The term 'borderline personality' was used to indicate the condition fell between psychotic and neurotic disorders. However, the word 'borderline' is often misinterpreted as 'not quite an illness but on the border'. The term 'personality disorder' can minimise this mental illness to mean 'bad behaviour', often invalidating the sufferer who ironically already feels invalid.

Summing all of these factors, plus the challenging nature of the symptoms expressed and experienced by sufferers of BPD – such as rage, anger, self-mutilation and perhaps therapeutic nihilism felt by many healthcare practitioners when working with patients with BPD, leads to the heavy stigma attached to this mental illness.

Corresponding author:
Jayashri Kulkarni, Monash Alfred Psychiatry Research Centre (MAPrc), Level 4, 607 St Kilda Road, Melbourne, VIC 3004, Australia.
Email: jayashri.kulkarni@monash.edu

7

Ambos son constructos diferentes

- Se encontró que 4 síntomas del TLP aumentan la probabilidad de ser clasificado como TLP, comparada con la clasificación de TEPT-C:
  - esfuerzos frenéticos para evitar el abandono
  - sentido inestable del self
  - relaciones interpersonales inestables e intensas
  - impulsividad

EUROPEAN JOURNAL OF PSYCHOTRAUMATOLOGY — COACTION

CLINICAL RESEARCH ARTICLE

Distinguishing PTSD, Complex PTSD, and Borderline Personality Disorder: A latent class analysis

Marylène Cloitre[1,2]*, Donn W. Garvert[1], Brandon Weiss[1,3], Eve B. Carlson[1] and Richard A. Bryant[4]

[1]National Center for PTSD, Veterans Affairs Palo Alto Health Care System, Palo Alto, CA, USA; [2]Department of Psychiatry and Child & Adolescent Psychiatry, New York University Medical Center, New York, USA; [3]Department of Psychiatry and Behavioral Sciences, Stanford University School of Medicine, Palo Alto, CA, USA; [4]School of Psychology, University of New South Wales, Sydney, NSW, Australia

Background: There has been debate regarding whether Complex Posttraumatic Stress Disorder (Complex PTSD) is distinct from Borderline Personality Disorder (BPD) when the latter is comorbid with PTSD.
Objective: To determine whether the patterns of symptoms endorsed by women seeking treatment for childhood abuse form classes that are consistent with diagnostic criteria for PTSD, Complex PTSD, and BPD.
Method: A latent class analysis (LCA) was conducted on an archival dataset of 280 women with histories of childhood abuse assessed for enrollment in a clinical trial for PTSD.
Results: The LCA revealed four distinct classes of individuals: a Low Symptom class characterized by low endorsements on all symptoms; a PTSD class characterized by elevated symptoms of PTSD but low endorsement of symptoms that define the Complex PTSD and BPD diagnoses; a Complex PTSD class characterized by elevated symptoms of PTSD and self-organization symptoms that defined the Complex PTSD diagnosis but low on the symptoms of BPD, and a BPD class characterized by symptoms of BPD. Four BPD symptoms were found to greatly increase the odds of being in the BPD compared to the Complex PTSD class: frantic efforts to avoid abandonment, unstable sense of self, unstable and intense interpersonal relationships, and impulsiveness.
Conclusion: Findings supported the construct validity of Complex PTSD as distinguishable from BPD. Key symptoms that distinguished between the disorders were identified, which may aid in differential diagnosis and treatment planning.

Keywords: *Complex PTSD; posttraumatic stress disorder; Borderline Personality Disorder; WHO; ICD-11*

*Correspondence to: Marylène Cloitre, National Center for PTSD Dissemination and Training Division, VAPAHCS, 795 Willow Road, Menlo Park, CA 94025, USA. Email: Marylene.cloitre@nyumc.org

For the abstract or full text in other languages, please see Supplementary files under Article Tools online

Received: 3 June 2014; Revised: 22 July 2014; Accepted: 18 August 2014; Published: 15 September 2014

There has long been debate about whether Complex Posttraumatic Stress Disorder (Complex PTSD) is distinct from Borderline Personality Disorder (BPD) comorbid with PTSD. Part of the difficulty in this evaluation has been the lack of clear and consistent characterization of Complex PTSD. The World Health Organization (WHO) Working Group on the Classification of Stress-Related Disorders has proposed the inclusion of Complex PTSD as a new diagnosis related to but separate from PTSD (Maercker et al., 2013). Both of these disorders are viewed as distinct and separate from BPD. An emerging and accumulating empirical literature is demonstrating consistent and clear differences between ICD-11 PTSD and Complex PTSD. In addition, it is important to determine the construct validity of Complex PTSD as empirically distinct from BPD particularly among those with a trauma history. This investigation evaluated whether ICD-11 Complex PTSD could be distinguished from DSM-IV BPD in a treatment-seeking population of women with childhood abuse.

The WHO proposed that the development of ICD-11 be guided by the principle of clinical utility. Characteristics of clinical utility include the organization of disorders that are consistent with clinicians' mental health taxonomies, that contain a limited number of symptoms so that they can be easily recalled and used in the field, and that are based on distinctions important for management and treatment (Reed, 2010). The distinction between

8

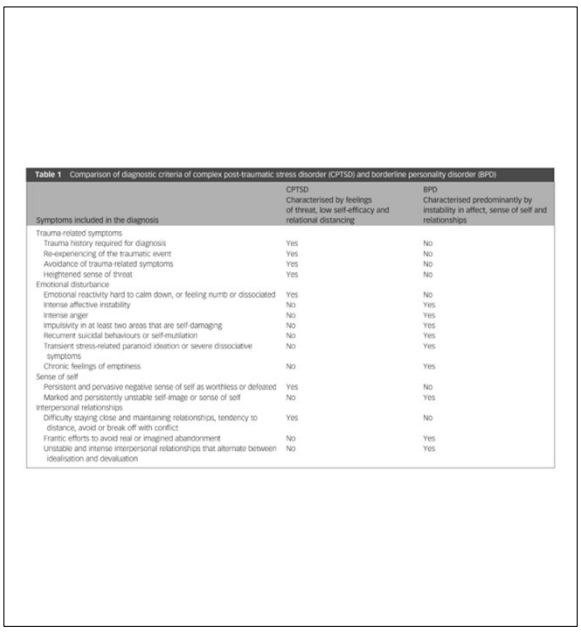


Table 1 Comparison of diagnostic criteria of complex post-traumatic stress disorder (CPTSD) and borderline personality disorder (BPD)

Symptoms included in the diagnosis	CPTSD Characterised by feelings of threat, low self-efficacy and relational distancing	BPD Characterised predominantly by instability in affect, sense of self and relationships
Trauma-related symptoms		
Trauma history required for diagnosis	Yes	No
Re-experiencing of the traumatic event	Yes	No
Avoidance of trauma-related symptoms	Yes	No
Heightened sense of threat	Yes	No
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 two 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
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
Interpersonal relationships		
Difficulty staying close and 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 idealisation and devaluation	No	Yes

BJPsych The British Journal of Psychiatry (2023) 223, 403–404. doi: 10.1192/bjp.2023.80

Analysis

Distinguishing between ICD-11 complex post-traumatic stress disorder and borderline personality disorder: clinical guide and recommendations for future research

Thanos Karatzias, Martin Bohus, Mark Shevlin, Philip Hyland, Jonathan I. Bisson, Neil Roberts and Marylène Cloitre

Summary

Although complex post-traumatic stress disorder and borderline personality disorder are distinct disorders, there is confusion in clinical practice regarding the similarities between the diagnostic profiles of these conditions. We summarise the differences in the diagnostic criteria that are clinically informative and we illustrate these with case studies to enable diagnostic accuracy in clinical practice.

Keywords:

Comorbidity; education and training; personality disorders; post-traumatic stress disorder; trauma.

Diagnostic accuracy is essential in clinical practice. A diagnosis can help clinicians formulate presenting complaints to enable treatment planning, to communicate accurate clinical information to other healthcare providers, as well as patients and their families, and to provide differential diagnosis and prognosis.[1] For many patients who experience distress, a diagnosis can instil hope for change and subsequent recovery.[2] The introduction of the new condition of complex post-traumatic stress disorder (CPTSD) and revised descriptions of personality disorders in ICD-11[3] have resulted in some confusion in clinical practice regarding the similarities between the diagnostic profiles of CPTSD and borderline personality disorder (BPD), which is identified in ICD-11 as personality disorder with the specifier 'borderline pattern'). In this report, we aim to disentangle the differences between the two conditions and provide some guidance on how to diagnose them accurately. This is especially important considering that CPTSD and BPD are commonly occurring disorders in some treatment settings and have overlapping symptom domains.[4]

Disorders associated with stress versus personality disorders

CPTSD has been included in ICD-11 as one of several diagnoses designated under the general category 'disorders specifically associated with stress'.[5] The CPTSD diagnosis requires 'exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible. Such events include, but are not limited to, torture, concentration camps, slavery, genocide campaigns and other forms of organised violence, prolonged domestic violence, and repeated childhood sexual or physical abuse'. At a symptom level, CPTSD includes the core PTSD symptoms of (a) re-experiencing of the traumatic event in the present, (b) avoidance of traumatic reminders and (c) persistent perception of heightened current threat and the three symptom clusters of (a) pervasive problems in affect regulation, (b) negative self-concept and (c) relationship difficulties.

Borderline personality disorder has been somewhat reformulated in ICD-11 owing to the introduction of a fundamentally different approach to the classification of personality disorders.[3] Instead of diagnosing them according to categorical types, ICD-11 now requires impairments of the self (e.g. identity, self-worth, accuracy of self-view, self-direction) and of interpersonal functioning as core features. A 'borderline pattern' specifier has been included, based on the nine DSM-5 diagnostic criteria for BPD, where the salient diagnostic features are instability in sense of self, relationships and affect and the marked presence of impulsivity (e.g. unsafe sex, excessive drinking, reckless driving, uncontrollable eating). These diagnostic features represent domains of problems and symptoms that overlap with some of those found in the identity and relational symptom clusters of CPTSD.

Even though CPTSD is a new diagnosis, it has been used extensively in research and clinical practice for several decades and the overlap between BPD and symptoms of CPTSD has been a subject of debate in recent years. There have been multiple attempts to determine whether CPTSD and BPD diagnoses differ substantially enough to warrant separate diagnostic classifications. Different solutions have been offered in the literature. Some have suggested that CPTSD and BPD are distinct disorders with similar pathways, including neurological[6] and anthropogenic.[4] Others have suggested that CPTSD and BPD symptoms can only co-occur as one syndrome and the two conditions are not distinct.[7] Finally, it has been proposed that CPTSD is the by-product of comorbid BPD and post-traumatic stress disorder (PTSD).[8] Nevertheless, as shown below, there is some emerging evidence suggesting that the two conditions can be distinguished.

The evidence base

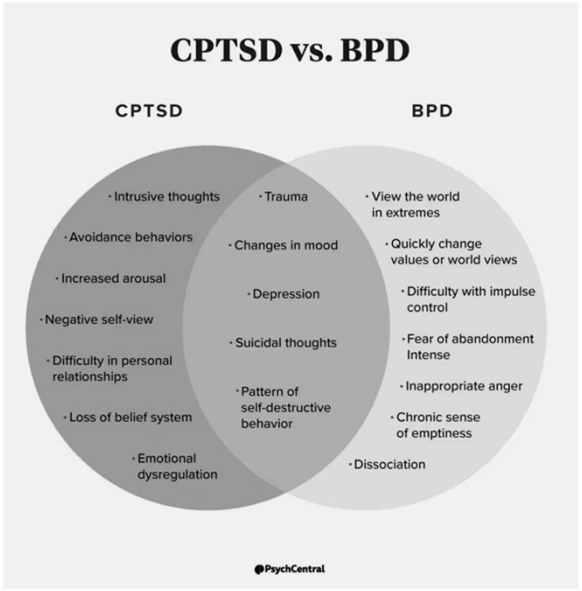
To date there have been seven studies exploring the association between BPD and ICD-11 CPTSD using disorder-specific measures. These studies have been conducted in general population samples as well as in clinical samples of traumatised individuals and they include factor analysis,[9,10] latent class analysis[11–13] and network analysis[14,15] designs. All these studies concluded that there is a group of individuals who endorse criteria of both conditions, but CPTSD and BPD were generally found to be distinct disorders.

9

SÍNTOMAS INCLUIDOS EN EL DIAGNÓSTICO	TEPT-C	TLP
Síntomas relacionados con el trauma		
Se requiere historia de trauma para el diagnóstico.	Sí	No
Revivir el evento traumático	Sí	No
Evitar los síntomas relacionados con el trauma.	Sí	No
Mayor sensación de amenaza	Sí	No
Alteración emocional		
Reactividad emocional difícil de calmar, o sentirse embotado o disociado	Sí	No
Intensa inestabilidad emocional	No	Sí
ira intensa	No	Sí
Impulsividad en al menos dos áreas que son autodestructivas.	No	Sí
Conductas suicidas recurrentes o automutilación.	No	Sí
Ideación paranoide transitoria relacionada con el estrés o síntomas de disociación grave.	No	Sí
Sentimientos crónicos de vacío.	No	Sí
Sentido de uno mismo		
Sentido negativo persistente y generalizado de uno mismo como inútil o derrotado.	Sí	No
Autoimagen o sentido de sí mismo marcado y persistentemente inestable.	No	Sí
Relaciones interpersonales		
Dificultad para permanecer cerca y mantener relaciones, tendencia a distanciarse, evitar o romper con el conflicto	Sí	No
Esfuerzos frenéticos para evitar el abandono real o imaginario.	No	Sí
Relaciones interpersonales inestables e intensas que alternan entre idealización y devaluación.	No	Sí

Diferencias entre TEPT-C y TLP

10



11

Muchas gracias

@felipegarciamartinez

12