**Is it possible to differentiate ICD-11 complex PTSD from symptoms of borderline personality disorder?**

The introduction of complex post-traumatic stress disorder (CPTSD) and the revised descriptions of personality disorders in the ICD-11[1] is being accompanied by some uncertainty in clinical practice regarding the differentiation between the diagnostic profiles of CPTSD and borderline personality disorder (BPD).

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"[1]. Such events include, but are not limited to, torture, slavery, genocide campaigns and other forms of organized violence, prolonged domestic violence, and repeated childhood sexual or physical abuse. At a symptom level, CPTSD includes the core PTSD symptoms of re-experiencing of the traumatic event in the present, avoidance of traumatic reminders, and persistent perception of heightened current threat, along with the three symptom clusters of pervasive problems in affect regulation, negative self-concept, and relationship difficulties.

BPD has been reformulated in the ICD-11, due to the introduction of a fundamentally different approach to the classification of personality disorders[1]. Instead of diagnosing these disorders according to categorical types, the ICD-11 now requires impairments of the self (e.g., identity, self-worth, accuracy of self-view, self-direction) and interpersonal functioning as core features. A borderline pattern qualifier 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 affects, and the marked presence of impulsivity (e.g., unsafe sex, excessive drinking, reckless driving, uncontrollable eating). These diagnostic features represent some problems in the same general symptom domains as CPTSD, i.e. those related to affect dysregulation, identity, and relational capacities.

For several decades, the overlap between symptoms of BPD and various forms of CPTSD has been a subject of debate. There have been several studies exploring the association between these conditions using disorder-specific measures. These studies have been conducted in general population samples as well as in clinical samples of traumatized individuals, and they include factor analysis, latent class analysis and network analysis designs. All these studies concluded that there is a group of individuals who fulfil criteria for both disorders, but CPTSD and BPD were generally found to be distinguishable at the symptom and individual level.

There are several differences in the diagnostic criteria for the two disorders that are clinically informative in this respect.

While exposure to traumatic life events can precipitate both conditions, a history of trauma is not required for a diagnosis of BPD, while it is for CPTSD. Nevertheless, it is also important to highlight that a significant number of people with BPD report exposure to traumatic life events such as sexual abuse[2].

Diagnostic items related to affect dysregulation are often equally endorsed across the disorders, and in network analyses these symptoms appear to be common in both CPTSD and BPD[3]. However, BPD is associated with high rates of impulsivity and suicidal and self-injurious behaviours, while in CPTSD these characteristics may be present, but do not occur as frequently as other CPTSD symptoms, nor as compared to that seen in BPD[4]. Indeed, addressing suicidal and self-injurious behaviours has been viewed as the defining concern and primary treatment target in BPD.

Our clinical observations of people with CPTSD suggest that difficulties in affect regulation are ego-dystonic, stressor-specific and variable over time. In BPD, affect dysregulation and unstable mood seem to be ego-syntonic and persistent over time[5]. In BPD, self-concept difficulties reflect an unstable sense of self which includes changing goals and

beliefs, whereas individuals with CPTSD have a consistent and stable negative sense of self. While it is frequently the case that individuals with CPTSD and BPD will both report feelings of low self-esteem, the additional presence of a changing view of self supports a BPD diagnosis.

Relational difficulties in BPD are characterized by unstable or volatile patterns of interactions, whereas in CPTSD they are defined by consistent difficulties in trusting others and avoidance of intimacy or closeness.

An important consideration in diagnosis is to avoid over-pathologizing the individual. For example, a symptom that is common to both disorders, such as emotional volatility, should be considered as part of each disorder when summing the totality of symptoms to determine whether the person meets criteria for a specific disorder. However, once a primary diagnosis has been made, the symptom should not be counted twice. The symptom should be counted once and designated to the diagnosis that been identified as primary, applying a "hierarchical" approach to diagnosis.

The clinical utility of formulating two diagnoses is primarily to guide treatment decisions and provide an intervention that optimizes outcomes by addressing the most impairing features associated with each disorder. Usually, BPD is likely the more severe disorder, with the greater impairment due to the presence of suicidality and self-injurious behaviours. We recommend that future research survey practitioners about what they find are the benefits and drawbacks of the current classification of these two conditions. In addition, the development of reliable and valid clinical interviews will further enable diagnostic accuracy.

There is a need to develop tailored treatments informed by the phenomenology and severity of the two conditions. A number of treatments with proven efficacy for PTSD, such as cognitive behavioural therapy or eye movement desensitization and reprocessing, might also be helpful for CPTSD[6]. It is also worth noting that dialectical behavioural therapy, a treatment that has been extensively used for people with BPD, has been modified and found effective for PTSD and comorbid BPD symptoms, BPD with comorbid PTSD, and BPD alone[7].

A trauma-informed modular approach has also been suggested for the treatment of CPTSD[8]. The modular approach proposes that symptom clusters of CPTSD should be targeted using a formulation-based model and based on a client's treatment goals and the severity of his/her symptoms. Modular approaches, such as skills training in affective and interpersonal regulation narrative therapy, have been found useful for those who have experienced PTSD related to childhood trauma[9] and have been adapted for CPTSD.

For those who meet the criteria for both conditions, a trauma-informed approach might still be the best treatment option. There is, however, an urgent need to explore the effectiveness of existing and new interventions for ICD-11 CPTSD, and for the new construct of personality disorder (including the new pattern qualifier for BPD).

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1. World Health Organization. ICD-11. International classification of diseases 11th revision. Geneva: World Health Organization, 2022.
2. de Aquino Ferreira LF, Pereira FH, Benevides AM et al. Psychiatry Res 2018;262:70-7.

3. Owczarek M, Karatzias T, McElroy E et al. J Pers Disord (in press).
4. Cloitre M, Garvert DW, Weiss B et al. Eur J Psychotraumatol 2014;5:25097.
5. Biskin RS, Paris J. CMAJ 2012;184:1789-94.
6. Voorendonk EM, De Jongh A, Rozendaal L et al. Eur J Psychotraumatol 2020;11:1783955.
7. Bohus M, Kleindienst N, Hahn C et al. JAMA Psychiatry 2020;77:1235-45.
8. Karatzias T, Cloitre M. J Trauma Stress 2019;32:870-6.
9. Cloitre M, Stovall-McClough KC, Nooner K et al. Am J Psychiatry 2010;167:915-24.