BPD or CPTSD

Understanding The Overlap & Key Differences

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SPECIALITIES

- *Complex Trauma*
- *Self-Harm & Suicide*
- *Personality Disorders*
- *Chronic Pain/Illness*

MODALITIES

- *DBT*
- *EMDR*
- *MBCT*
- *Sensorimotor Psychotherapy*

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Learning Objectives

01. **Identify** at least **three core clinical differences** between Borderline Personality Disorder (BPD) and Complex Post-Traumatic Stress Disorder (C-PTSD) for accurate assessment and diagnosis.

02. **Utilize** at least **two evidence-based therapeutic interventions** specific to each condition (BPD and C-PTSD) within clinical practice.

03. **Explain** the impact of **chronic childhood trauma** on neurobiological development and symptom expression in individuals diagnosed with BPD and C-PTSD.

01. Working Definitions:

What is BPD? What is CPTSD?

What Is Borderline Personality Disorder?

What Is Borderline Personality Disorder?

A pervasive **pattern** of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by **early adulthood** and present in a **variety of contexts**, as indicated by **five (or more)** of the following:

BPD DSM Criteria

01. **Frantic** efforts to avoid real **or** imagined abadonment

02. **A pattern** of **unstable & intense** relationships, alternating between extremes of **idealization and devaluation**

03. **Identity disturbance:** markedly and persistently **unstable self-image** or sense of self

04. **Impulsivity** in at least 2 areas that are **potentially self-damaging**

05. **Recurrent** suicidal behavior, gestures, or threats, **OR** self-mutilating behavior

06. **Affective instability** due to a marked reactivity of **mood**

07. **Chronic** feelings of **emptiness**

08. **Inappropriate, intense anger** or difficulty controlling anger.

09. **Transient,** stress-related **paranoid** ideation OR severe **dissociative** symptoms

A: What Is Trauma?

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APA Definition:
“Trauma is an emotional response to a terrible even like an accident, rape, or natural disaster. Immediately after the even, shock and denail are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships, and even physical symptoms like headaches or nausea.”

Practical Definition:
Trauma is any event that leaves the nervous system in a semi-permanent state of dysregulation.

B: What Makes Trauma ‘Complex’?

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1. **Chronicity** - Repeated, prolonged exposure to traumas that take shape over a significant period of time.
2. **Interpersonal Nature** - Typically, trauma occurs in relation to attachment figure, or other significant relational figure with a significant amount of trust
3. **Developmental Timing**- Typically occurring in childhood, impacting and affecting concurrent developmental milestones (ref: Neurosequential Development Theory)

C: What Is CPTSD?

Remember:

CPTSD is NOT in the current DSM!

(Should It?)

C: What Is CPTSD?

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.

Following the traumatic event, **the development of all three core elements** of Post-Traumatic Stress Disorder, lasting for at least several weeks:

CPTSD ICD-11 Criteria

01. **Re-experiencing** the traumatic event after the traumatic event has occurred... **experienced as occurring again in the here and now**

02. Deliberate **avoidance** of reminders likely to produce **re-experiencing** of the traumatic event(s)

03. Persistent perceptions of **heightened current threat**, for example... **hypervigilance** or an enhanced startle reaction

04. Severe and pervasive problems in **affect regulation**

05. **Persistent beliefs** about oneself as **diminished, defeated or worthless,** accompanied by deep and pervasive feelings of **shame, guilt**

06. The disturbance results in significant **impairment** in personal, family, social, educational, occupational or other **important areas of functioning**

07. **Suicidal ideation** and behavior, substance abuse, depressive symptoms, psychotic symptoms, and **somatic complaints** may be present.

08. Persistent **difficulties in sustaining relationships** and in feeling close to others. The person may consistently avoid, deride or have little interest in relationships and social engagement more generally. Alternatively, there may be **occasional intense relationships**, but the person has difficulty sustaining them.

Case Study 1

BPD or CPTSD: You Decide

1. Based on this narrative, which diagnosis do you believe best fits this client: Borderline Personality Disorder (BPD), Complex PTSD (C-PTSD). Why?
2. What specific DSM-5 or ICD-11 diagnostic criteria are you seeing (or not seeing) that inform your decision?
3. Are there symptoms or patterns in this case that could "belong" to both BPD and C-PTSD?
    a. How are you weighing these overlapping symptoms?
    b. What additional assessment questions or clinical information would you want to gather to make a more confident diagnosis?
4. What potential risks are there if we misdiagnose or over-focus on one diagnosis versus another with this client?

02. Similarities & Differences:

Q: Is BPD Really CPTSD In Disguise?

Similarities & Differences in Diagnosis

s BPD Re
CPTSD In Disgu e?

Similar ies & Differences i Diag osis

LET'S REWIND

02. What Makes Trauma 'Complex'?

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Q: Can A Pattern of Interaction Be In-And-Of-Itself Traumatizing?

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“Trauma is any event that leaves the nervous system in a semi-permanent state of dysregulation.”

If The 'Traumatic Event' Is An Attachment Relationship, Then...

***...Could* Any Of These Criteria Be An Adaptation To Trauma?**

BPD DSM Criteria

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...*Could* Any Of These Criteria Be An Adaptation To Trauma?

ICD Criteria: CPTSD

'Deliberate avoidance of reminders likely to produce re-experiencing of the traumatic event(s)'

'Persistent difficulties in sustaining relationships and in feeling close to others....there may be occasional intense relationships, but the person has difficulty sustaining them.'

'Persistent perceptions of heightened current threat, for example... hypervigilance or an enhanced startle reaction'

DSM Criteria: BPD

'Frantic efforts to avoid real or imagined abadonment'

'A pattern of unstable & intense relationships, alternating between extremes of idealization and devaluation'

'Severe and pervasive problems in affect regulation'

Q: Why Bother Differentiating Between Diagnosis At All?

Why Bother Differentiating Between BPD & CPTSD?

01. Access To Care

BPD is one of the most stigmatized diagnosis in the DSM. It has a long history of stigmatization, even intraprofessionally within the mental health community.

02. Treatment vs. Management

BPD has traditionally been addressed from a “symptom management” perspective. If this disorder is at the core of who the client is, clinicians don’t seek symptom “remission”. The opposite is true for trauma disorders.

03. Pathology vs. Adaptation

Both of these disorders are marked by symptoms of negative self-image. BPD has typically been viewed through the “pathology” model. Shifting to an “adaptation” lens challenges the self-image at the core of both of these diagnosis.

03. The Role of Trauma

The Role Of Childhood Trauma:

Etiology of BPD & CPTSD

Both conditions are rooted in trauma, particularly chronic relational trauma during childhood. A child exposed to neglect, abuse, or emotional invalidation learns to adapt in ways that may become maladaptive in adulthood.

While **BPD** is often associated with unstable attachments and emotional sensitivity, **C-PTSD** typically develops from sustained, inescapable trauma — like growing up in a violent, neglectful, or controlling environment. In both cases, the nervous system becomes wired for survival, not safety.

Key Difference:

Trauma +

In the case of BPD, the ‘origin story’ doesn’t always involve what we think of as “capital T” trauma. Instead, BPD can develop from a chronic “poorness of fit” between a child’s emotional needs and their environment. This might look like a highly sensitive or emotionally intense child being raised by well-meaning parents who are emotionally unavailable, overwhelmed, or simply unequipped to validate or mirror that child’s internal world.

Over time, this mismatch can result in chronic invalidation, confusion about one’s identity, difficulty trusting emotional experiences, and intense fear of abandonment. In this way, BPD can be thought of as a developmental response to emotional disconnection, even in the absence of overt trauma.

In contrast, C-PTSD is more often linked to capital T trauma—prolonged exposure to overwhelming experiences such as chronic abuse, neglect, violence, captivity, or exploitation, often beginning in childhood. It may also include emotional neglect, especially when it occurs in tandem with fear, isolation, or betrayal by caregivers.

BPD

Fear of abandonment

Fluctuating Self-Image

Impulsivity

Emotional Outbursts

‘Favorite Persoing’

CPTSD

Deep Shame

Emotional Numbing

Avoidance/ Hypervigilance

Negative Self-View

Withdrawal & Mistrust

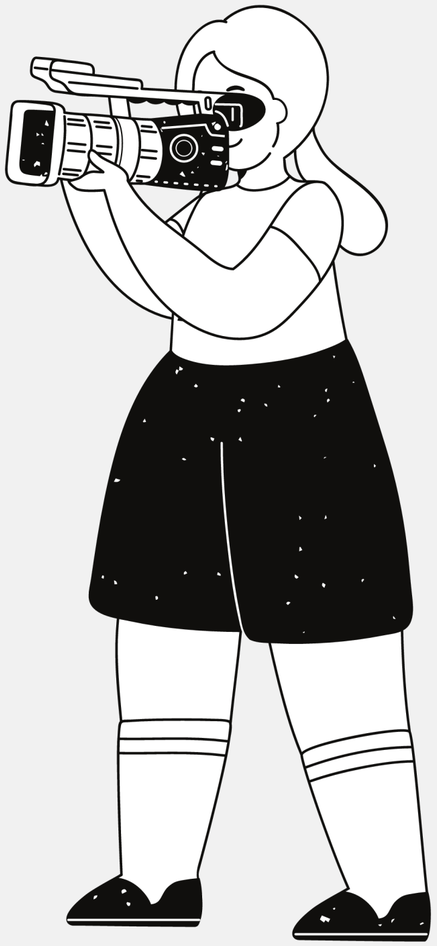
Intense Emotional Reactions

Difficulty Trusting Others

“Bad Person” Narrative

Self-Harm Bx

Identity Confusion



LET’S REWIND

Q: Is BPD Really CPTSD In Disguise?

LET’S REWIND

Q: Is BPD Really CPTSD In Disguise?

A: Maybe Not. But...

Q: Is BPD Truly a “Personality” Disorder?

Q: Is BPD Truly a "Personality" Disorder?

Would Our Clients Be Better Served If "BPD" Was Considered a 'Trauma' Disorder?

Case Study 2

BPD or CPTSD: You Decide

1. Based on this narrative, which diagnosis do you believe best fits this client: Borderline Personality Disorder (BPD), Complex PTSD (C-PTSD). Why?
2. What specific DSM-5 or ICD-11 diagnostic criteria are you seeing (or not seeing) that inform your decision?
3. Are there symptoms or patterns in this case that could "belong" to both BPD and C-PTSD?
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04. Accurate Assessment

Clinical Strategies For Differential Diagnosis

Accurate Assessment

Differentiation between BPD and CPTSD can be tricky! Accurate assessment is a culmination of three seperate factors:

01. *Continuing Education*

02. *Structured Clinical Interviews*

03. *Self-Report Measures*

01. Continuing Education

On Topics Such as:

01

Human Development

Ex: Neurosequential Developmental Theory.

The "when" something happened matters as much as the "what" happened. Theory helps frame this.

02

Attachment Theory

Ex: Dan Siegel's Work

More than romance. Clinicians need a deep developmental understanding of the role of attachment: identity, relationships, emotion regulation, etc.

03

Trauma's Impact On Neuro-Physiology

Ex: Epigentics

A deep understanding of the ways in which trauma changes the brain and body.

04

Evidence-Based Interventions

Ex: EMDR, Somatic Experiencing, etc.

Healing from either of these conditions require more than 'just talk' therapy.

02. Structured Interviews & 03. Self-Report Measures

The Importance of Data Collection

Key Interview Question:

'How do you typically respond when you feel rejected or abandoned?'

'How do you typically respond to stress?'

Key Interview Question:

'What kind of relationships did you have growing up?'

Adult Attachment Interview

Ex: 'Before the age of 7, what 3 adjectives would you use to describe your relationship with your mother? With you Father?'

'Tell me a story about each of these adjectives.'

PCL-5 & ACEs Questionnaire

The PCL-5 is a measure of PTSD symptom severity. It can be administered at the outset of treatment and at regular intervals as a measure of treatment efficacy.

The ACEs Questionnaire is a trauma screen related to childhood experiences. It covers both "Capital-T" traumas and more subtle, potentially complex traumas.

DES-II & DSS-B

Both the DES-II and DSS-B are assessments for dissociation symptom severity. These measures can be used at the outset of treatment, as a "screener" prior to trauma processing, and as a regularly scheduled measure to assess treatment efficacy.

Borderline Evaluation Severity Over Time (BEST)

The BEST is an assessment aimed at screening for Borderline Personality Disorder. It can also be used as a measure of symptom intensity across time.

Ex: Adult Attachment Interview Responses

‘Before the age of 7, what 3 adjectives would you use to describe your relationship with your mother? With you Father?’

‘Tell me a story about each of these adjectives.’

01.

“For my father, I’d say **playful, attentive, and consistent.** He used to build elaborate Lego castles with me after dinner, even when he’d had a long day at work. I always knew when he promised he’d play, he would. That consistency meant a lot.”

02.

“For my mother… **wow, um, that’s hard**. I guess **scary, loving sometimes, and confusing.** There was this one time I spilled milk, and she screamed at me so much I hid in my room. But other times, like when I was sick, she’d be really affectionate and take care of me. **I never knew which version of her I’d get.**”

03.

“Um…**I don’t know.** (silence). I guess I would say **fine, normal**, and…It was just a normal childhood. **I don’t remember** a lot of it, but I’m sure it was fine.”

Ex: PCL-5 Questions

* 1. Repeated, disturbing, and unwanted memories of the stressful experience?

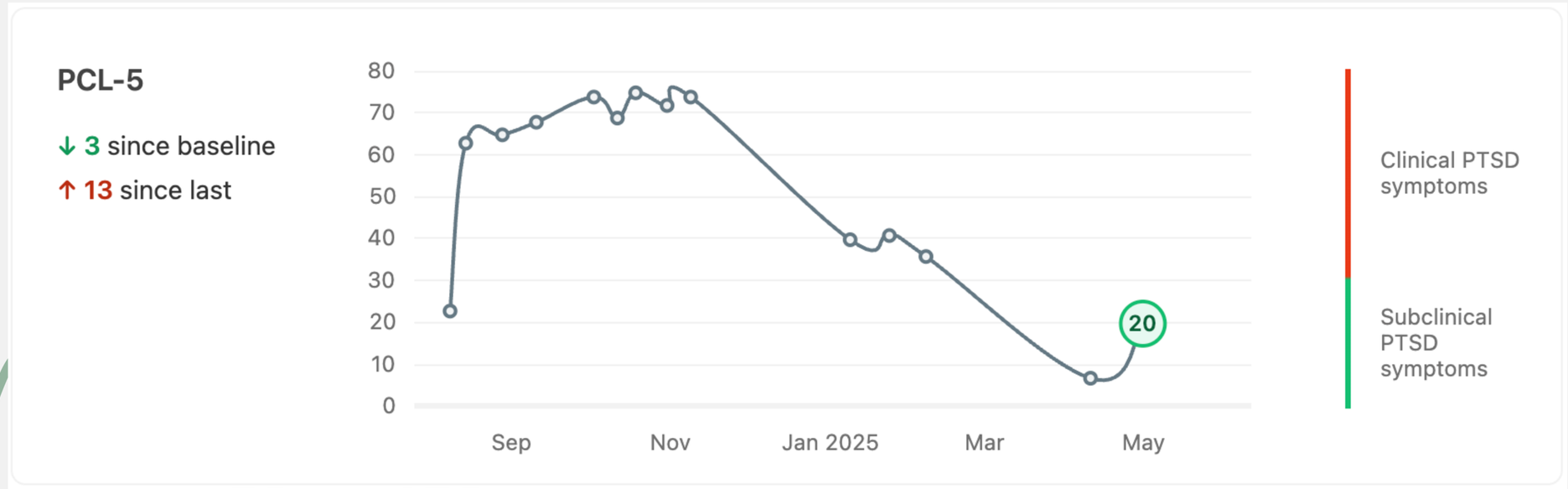
- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

* 5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?

* 12. Loss of interest in activities that you used to enjoy?

* 17. Being “superalert” or watchful or on guard?

Ex: PCL-5 Over Time



Remember: The Best Data = What Happens In The Room

Body Language

Does the client turn towards you or away from you?

Is there eye-contact?

Restlessness or a high startle response?

Person Of The Therapist

How do **you** feel when you're in the room with the client?

What happens in **your** body when a client is vulnerable?

Interpersonal Dynamics/Boundaries

Ex: Making everything a joke

Ex: "Doorknob confessions"

Ex: Inappropriate or excess use of coaching calls

Dissociation

Do clients dissociate in session?

When discussing...what?

How difficult is it to get them reregulated?

05. Interventions & Outcomes

For BPD & CPTSD

Always #1:

The Therapeutic Relationship

Remember Common Factors Research

BPD

Dialectical Behavior Therapy (DBT)

Includes individual therapy PLUS skills group, at minimum. Often coaching calls between session PLUS consultation for the therapist.

Schema Therapy

Focuses on identifying and changing deeply ingrained maladaptive schemas—negative patterns of thinking, feeling, and behaving—developed in childhood.

Mindfulness Based Therapies: MBCT & ACT

Helps clients accept difficult emotions, defuse from unhelpful thoughts, clarify personal values, and build committed action toward a more meaningful life, even in the presence of emotional pain.

Interventions

For BPD & CPTSD

CPTSD

EMDR & Brainspotting

Helps clients safely process and resolve traumatic memories, reducing distressing symptoms like emotional numbing, intrusive memories, and relational difficulties while promoting adaptive beliefs and emotional healing.

Somatic Approaches: Ex: Sensorimotor Psychotherapy & Somatic Experiencing

Helps clients tune into and release trauma held in the body, using techniques that restore nervous system regulation, enhance body awareness, and resolve chronic patterns of hyperarousal, dissociation, and emotional dysregulation.

Deep Brain Reorienting

Helps clients access and process deep, preconscious brainstem-level responses to threat—such as orienting reflexes and tension patterns—enabling the release of implicit trauma without overwhelming the nervous system.

Interchangeable?

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A 3-Phase Approach

Working with both BPD & CPTSD often requires stabilization AND a client/therapist trust & rapport. For this reason, a 3-phase approach to treatment is often most effective. The 3 recommended phases are as follow:

01.

Skills & Stabilization

DBT, CBT, Mindfulness Interventions, etc.

02.

Trauma Work

EMDR, IFS, Brainspotting, etc.

03.

Relapse Prevention

Building A Life Worth Living

Clinical Treatment Outcomes

For BPD & CPTSD

DBT & BPD

SUICIDE BX

Incidents of suicidal gestures, threats, and action have been shown to decrease by as much as 50% via treatment with DBT

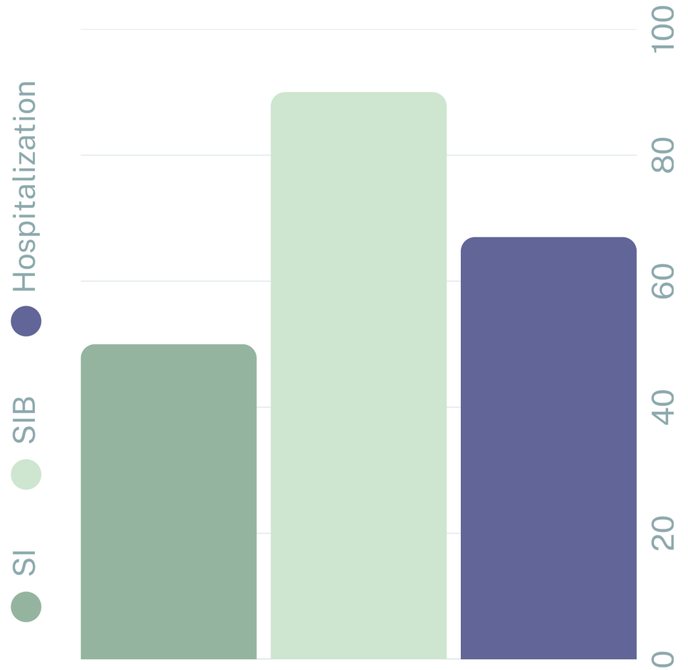
SELF-INJURY

Incidents of self-harm behavior have been shown to decrease by as much as 90% via treatment with DBT

HOSPITALIZATION

Incidents of hospitalization have been shown to decrease by as much as 65% via treatment with DBT

% REDUCTION IN:



10 YR STUDY

88%
Long Term Sx Remission

50%
'Full Remission' & Recovery

CPTSD OUTCOMES

EMDR

- EMDR has been shown to reduce symptoms of PTSD and C-PTSD by 60–90% in controlled studies.
- A meta-analysis found EMDR to be as effective as trauma-focused CBT but with faster symptom relief.

Sensorimotor Psychotherapy

- A 2019 pilot study found that SP significantly improved symptoms of PTSD, somatic symptoms, and emotion regulation. Participants reported a greater sense of body ownership.
- In a 2021 study, SP was associated with significant reductions in PTSD symptoms and dissociation.

Brainspotting

- A 2021 study comparing BS to EMDR and CBT found that BS produced significant reductions in anxiety and PTSD symptoms
- A 2017 exploratory study showed that BS reduced emotional reactivity and physical symptoms in clients with trauma histories.

Somatic Experiencing

- A 2017 study found that SE led to an average 44% reduction in PTSD symptoms, depression, and anxiety in survivors of sexual and physical abuse.
- A meta-analysis in 2023 showed moderate to large effect sizes for SE in reducing PTSD, somatic symptoms, and dissociation, particularly in cases of developmental trauma.

Trauma Therapies & BPD?

1. EMDR Reduces PTSD and Emotional Dysregulation in BPD

- A 2013 study by Hase et al. examined EMDR for clients with both BPD and PTSD.
  - Results showed significant reductions in both PTSD symptoms and BPD-related emotional dysregulation.

2. EMDR + DBT: An Effective Integration

- A 2020 clinical review by Harned et al. discussed integrating DBT and EMDR for clients with co-occurring BPD and trauma.
  - They found that EMDR can enhance outcomes for BPD clients when stabilization is achieved first through DBT.
  - This combination helps clients reduce trauma-related symptoms and increase emotional resilience without destabilization.

3. Improved Self-Image and Trauma Processing

- A 2017 case series using EMDR with BPD clients found improvements in:
  - Self-concept, Attachment security, & Emotion regulation
  - These gains were sustained at follow-up, suggesting EMDR may help address the shame and identity disturbances common in BPD.

DBT For CPTSD?

1. DBT Reduces C-PTSD Symptoms in High-Risk Populations

- A 2020 study of women with histories of childhood trauma and features of C-PTSD found that DBT significantly reduced:
  - PTSD symptoms, Dissociative symptoms, Emotion dysregulation
- The version used was DBT-PTSD, an adaptation of DBT that includes trauma processing components.
  - 51% of participants no longer met PTSD criteria after treatment

2. DBT-PTSD vs. Cognitive Processing Therapy (CPT)

- A randomized controlled trial (Bohus et al., 2020) compared DBT-PTSD to CPT in women with childhood abuse-related C-PTSD.
  - DBT-PTSD was significantly more effective in reducing PTSD symptoms and improving emotional regulation.
  - Dropout rates were lower in the DBT-PTSD group (less than 20%).

3. DBT Enhances Stability for Trauma Work

- DBT has been shown to help stabilize clients with C-PTSD who experience: Chronic dissociation, Self-injury, & Suicidal ideation
- This stabilization enables clients to safely move into deeper trauma processing using therapies like EMDR, Internal Family Systems (IFS), or Prolonged Exposure.

Resources

For Clients & Clinicians

For Clients

Self-Guided Learning & Support

Books For BPD

DBT Skills Training Handout & Workbooks by Marsha Linehan

Books For CPTSD

Complex PTSD: From Surviving to Thriving by Pete Walker
Healing the Fragmented Selves of Trauma Survivors by Janina Fisher
It Didn't Start with You by Mark Wolynn

Books For CPTSD 2

The Boy Who Was Raised As A Dog and/or What Happened to You by Bruce Perry

Online Resources for BPD

r/CPTSD on Reddit
BPDRecovery.com

App Recommendations

DBT Coach
Mood Tools

Group Recommendations

DBT Skills Groups

For Clinicians

Training, Tools, & Continued Learning

Online Trauma Resources

EMDRIA

The National Child Traumatic Stress Network (NCTSN)

Books For CPTSD

Sensorimotor Psychotherapy Institue

Assessment Tools

ACEs Questionnare
PCL-5
Dissociation
BPD Checklist

Online Resources for BPD

National Education Alliance for Borderline Personality Disorder (NEABPD)

- Offers webinars, family education, and professional training on BPD.

BPDRecovery.com

Always seek continued supervision!

Community Recommendation:

Consultation Groups & Interdisciplinary Collaboration

Thank you very much!

Any Questions?

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