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Symptom correlates of posttraumatic stress disorder in clients with borderline personality disorder

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Abstract

Limited research has examined the clinical and functional impact of concurrent posttraumatic stress disorder (PTSD) in people with borderline personality disorder (BPD). Such information is particularly lacking for BPD clients with the most disabling symptoms: those who meet criteria for severe and persistent mental illness. We evaluated individuals with severe mental illness to assess whether PTSD in individuals with BPD was associated with more severe symptoms and impaired functioning than BPD alone and replicated these findings in an independent sample. In both the studies, the clients with PTSD and BPD reported significantly higher levels of general distress, physical illness, anxiety, and depression than those with BPD alone. Because individuals with both of these disorders are likely to require more intensive clinical services to reduce distress and improve functioning, work is needed to develop and evaluate interventions designed to address these comorbid conditions.

1. Introduction

The relationship between borderline personality disorder (BPD), trauma, and posttraumatic stress disorder (PTSD) has long been a topic of debate [1-4]. However, there is considerable agreement among researchers and clinicians that people with BPD are more likely to have experienced trauma in their lives than those in the general population [5]. Furthermore, rates of current PTSD in individuals with BPD are high, ranging between 25% and 56% [6-8], compared with the lifetime rate of PTSD in the general population of approximately 10% [9]. Considering the high prevalence of these 2 disorders, there is a need to evaluate whether PTSD in BPD is associated with more severe symptoms and functional impairment than BPD alone. To examine this question, we conducted a secondary analysis of an index study of persons with severe mental illness that included individuals with BPD and measures of PTSD. We hypothesized that clients with BPD and PTSD would have more severe symptoms than clients with BPD alone, including more overall distress, physical illness and general health concerns, depression, and anxiety. We then examined a second data set, using some shared and some alternative standardized scales to assess the same set of variables in an independent sample of clients with BPD and severe mental illness.

Data from several recent studies largely support our predictions, although some inconsistent results have been reported. For example, Zlotnick et al [10] compared 4 groups of outpatients (BPD only, PTSD only, BPD and PTSD, and major depression) at a general hospital private practice, on PTSD and BPD symptoms and overall psychiatric impairment (defined as psychiatric hospitalizations, suicide attempts, social functioning, work, and comorbid diagnoses). They reported that comorbid PTSD and BPD was not associated with an increase in severity of PTSD symptoms, BPD traits, or overall impairment when compared with individuals with a diagnosis of PTSD or BPD alone. In a subsequent study of primary care patients, Zlotnick et al [11] reported that clients with BPD and PTSD had significantly more Axis I disorders, more severe personality features (including mistrust, suicide proneness, eccentric perceptions, and impulsivity), worse global functioning, and more hospitalizations, both recent and lifetime. Thus, these 2 studies suggest that the additional diagnosis of PTSD in clients with BPD is not associated with the severity of PTSD and BPD symptoms but that it may be associated with additional interpersonal difficulties and greater use of services.

Heffernan and Cloitre [12] examined the additional impact of BPD on individuals with PTSD. They found individuals with both disorders had more severe difficulties

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with anger, dissociation, anxiety, and interpersonal problems than those with PTSD only, although the 2 groups did not differ in PTSD symptoms. In addition, Connor et al [13] found in their community sample that individuals with a combined diagnosis of PTSD and BPD had greater health status impairment, higher use of mental health services, and more severe impairments in social and occupational functioning than individuals with PTSD alone.

In summary, limited research suggests that people with co-occurring BPD and PTSD experience greater interpersonal and functional problems but do not appear to differ in the severity of their BPD or PTSD symptoms compared with people with either of these disorders alone. Yet, research findings vary as to whether BPD and PTSD are associated with more severe overall psychiatric symptoms and distress compared with each disorder alone.

Most research on PTSD and BPD has been on community-based treatment-seeking samples. Although these studies are informative, they have not focused on individuals at the most impaired end of the borderline continuum of severity: those who have severe and persistent mental illness, defined as a psychiatric disorder with a profound effect on the ability to work or attend school, to engage in rewarding interpersonal relationships, or to care for oneself [14]. Understanding the possible interactions between PTSD and BPD among persons with severe mental illness is important because individuals with these diagnoses are high users of publicly funded mental health services [15,16]. In addition, research has shown that both trauma and PTSD are common co-occurring disorders in other severe mental illnesses, including schizophrenia, schizoaffective disorder, bipolar disorder, and treatment refractory major depression [17-19]. In these diagnostic groups, trauma and PTSD are associated with more severe symptoms, greater functional impairment, and more hospitalizations [20-22]. Thus, we examined individuals with severe mental illness to evaluate whether PTSD in BPD was associated with more severe symptoms and impaired functioning than BPD alone.

2. Methods

The study subjects were drawn from 2 prior studies of persons with severe mental illness. The first (index study) was composed of a 2-site sample conducted in New Hampshire and Maryland and examined rates of trauma and PTSD in 275 persons with severe mental illness (30 with BPD), drawn from both inpatient and outpatient settings at each site [7]. The second (replication group) was drawn from a study of rehabilitation programs of persons with severe mental illness, conducted in Hartford, Conn. The Hartford Vocational Study involved 204 persons (20 with BPD) who were randomly assigned to 1 of 3 different vocational rehabilitation programs: supported employment, a psychosocial rehabilitation program, or standard vocational services [23]. Because of the differences in assessment techniques, we did not pool the results for our analyses but rather used the larger (New Hampshire–Maryland) study to test our primary hypotheses and the smaller (Hartford) study as a replication study.

2.1. Subjects

The criteria for participation in the New Hampshire–Maryland Trauma Study were that the person had a severe mental illness, as defined by each respective state, and that they were willing to provide informed consent to participate in the assessment interviews. Although the specific definitions of severe mental illness differed somewhat between the states, all study participants were significantly functionally impaired by their psychiatric disorder, as reflected by either an inability to care for oneself, to work or attend school, or to meet other major role obligations (eg, parent). In addition, all of the participants were receiving Social Security Disability Insurance or Supplementary Security Income. The criteria for participation in the Hartford Vocational Study were that the person had a severe mental illness, as defined by the state of Connecticut, they were not currently competitively employed, they wanted competitive employment, and they provided informed consent to participate in the study. In the New Hampshire–Maryland Trauma Study, a total of 30 clients (11%) had chart diagnoses of BPD. In the Hartford Vocational Study, a total of 20 clients (10%) had diagnoses of BPD, based on the *Structured Clinical Interview for DSM-IV II* [24].

The demographic characteristics of clients with BPD in each study are summarized in Table 1. The 2 samples differed most markedly in sex (80% female in New Hampshire–Maryland vs 50% in Hartford), ethnicity (86.7% white in New Hampshire–Maryland vs 13.6% in Hartford), and education (69% high school graduate in New Hampshire–Maryland vs 40.9% in Hartford).

2.2. Measures

In both studies, clients reported demographic information, trauma exposure history, PTSD symptoms, health

Table 1
Demographic characteristics of the 2 samples

	Site	
	New Hampshire–Maryland (n = 30)	Hartford (n = 20)
Sex (male)	20	50
Ethnicity		
African American	10.0	22.7
Hispanic	0.0	63.6
White-non-Hispanic	86.7	13.6
All other	3.3	0.0
Age	34.8 ± 10.9	37.33 ± 8.26
Educational level		
<High school	31.0	59.1
>High school	69.0	40.9
Marital status		
Never married	65.5	54.5
Ever married	34.5	45.5

Values are presented as percentage or mean ± SD.