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Article

Complex Post-traumatic Stress Disorder and Borderline Personality Disorder: The Discussion Goes on. Differential Diagnosis Proposal

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ABSTRACT

Following the inclusion in the ICD-11 of the diagnosis of complex post-traumatic stress disorder (c-PTSD) in 2020, there has been a succession of publications debating the relevance or lack thereof of this entity and regarding its distinction from borderline personality disorder (BPD). The present reflection article aims to: 1. understand whether c-PTSD and BPD are different entities; 2. understand the state of the art regarding this issue; and 3. propose a differential diagnosis that will help to distinguish between the two. To account for the first two questions, a qualitative (non-systematic) literature review was carried out between 2020 and 2022 (the period of validity of c-PTSD in the ICD-11). Based on the theoretical and empirical information found, and achieving the third objective, a differential diagnosis is proposed in order to shed light on the nosological distinction between the two constructs.

Trastorno por Estrés Postraumático Complejo y Trastorno Límite de la Personalidad: El Debate Continúa. Propuesta de Diagnóstico Diferencial

Palabras clave
Trastorno límite de la personalidad
Trastorno por estrés postraumático complejo
Trauma
Trastorno por estrés postraumático
Trauma complejo

RESUMEN

Tras la inclusión en la CIE-11 del diagnóstico de trastorno por estrés postraumático complejo (TEPTc) en 2020, se han sucedido las publicaciones que debaten sobre la pertinencia o no de tal entidad y sobre su distinción del trastorno límite de la personalidad (TLP). En el presente artículo de reflexión se persigue: 1. conocer si el TEPTc y el TLP son entidades distintas; 2. conocer el estado de la cuestión respecto a este tema; y 3. proponer un diagnóstico diferencial que ayude a su discriminación. Para dar cuenta de las dos primeras cuestiones, se ha realizado una revisión bibliográfica (no sistemática) de tipo cualitativo entre los años 2020 y 2022 (tiempo de vigencia del TEPTc en la CIE-11). En función de la información teórica y empírica hallada, y cumpliendo con el tercer objetivo, se propone un diagnóstico diferencial con el fin de arrojar luz a la distinción nosológica entre ambos constructos.

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The traumatic origin of many mental disorders arouses the interest of scientists in the field of psychopathology and psychiatry; since Felix Platter in the 17th century it has been considered that certain extreme situations can provoke psychotic, dissociative, depressive, borderline, etc. symptoms. In a way, by contemplating these antecedents in many mental disorders (borderline personality disorder - BPD - among them) we are continuing the trauma theory proposed by Freud in 1893.

Following the Vietnam War (which ended in 1975) and its psychological consequences, the American Psychiatric Association introduced *Post Traumatic Stress Disorder* (PTSD) in the DSM-III (APA, 1980). For the first time, a nosological entity was defined by its observable etiology.

Years later, Judith Herman (1992) observed the symptoms of people subjected to extreme situations (domestic violence, sexual or child abuse), which did not fit the diagnosis of PTSD, proposing *Complex Post-Traumatic Stress Disorder* (c-PTSD), with six characteristics: alteration in the regulation of affect, consciousness, self-perception, altered perception of the aggressor, problems in relationships, and changes in the value system. Its origin lies in long-lasting, continuous, cumulative, invasive, interpersonal experiences (child sexual abuse, maltreatment, abandonment or neglect by caregivers, domestic and/or gender violence, sexual exploitation, genocide, torture, etc.), often experienced in childhood (although the events can occur at any moment in development), in high-risk environments from which the person cannot escape (Felding et al., 2021; Herman, 1992; Krause-Utz, 2021). It is the continuity, the interpersonal nature, and the impossibility of escape that differentiates it from PTSD, whose trigger is usually a single or time-limited event, of an interpersonal nature or otherwise.

As Van der Kolk (2015) tells us, he and other professionals on his team (Herman among them) looked at children who had suffered or were suffering disturbances in early relationships with their caregivers: emotional, physical, and/or sexual abuse; neglect; or domestic violence. They considered that their symptoms did not fit either the diagnosis of PTSD or c-PTSD, choosing to call it *developmental trauma disorder* (DTD), *attachment trauma,* or *early relational trauma* (Schore, 1994, 2022), as a way of adapting c-PTSD to childhood. It involves multiple symptoms in different areas (attachment, biology, emotional regulation, self-regulation, consciousness, behavioral control, cognition, and self-concept) derived from repeated exposure to interpersonal trauma in childhood in the daily context of attachment relationships (Cervera-Pérez et al., 2020; López-Soler, 2008; Maercker, 2021; Spinazzola et al., 2021).

However, these proposals were scarcely included in the official diagnostic classifications. The only reference was reflected in the appendix of the fourth edition of the DSM (APA, 1994), which included a provisional diagnosis: *disorders of extreme stress not otherwise specified* (DESNOS).

In 2009, when the DSM-5 was in preparation, van der Kolk and his team sent to the APA the proposal for c-PTSD and DTD to be included in the new version; the proposal was rejected with the argument that "the idea that adverse childhood experiences cause substantial alterations in development is more a clinical intuition than a fact based on research" (Van der Kolk, 2015, p. 169). After the surprise of the dispute, when the DSM-5 came out it was evident that DESNOS had also disappeared, with a new item merely being added to PTSD: cognitive and mood disturbances (APA, 2013). In the revision that has just appeared, the DSM-5-TR (APA, 2023), there has been no modification in this regard.

In addition to introducing PTSD, ICD-10 (OMS [WHO], 1992) included an entity called *Enduring Personality Changes after Catastrophic Experience* (EPCACE) although this diagnosis went virtually unnoticed. But in 2020, with the publication of the new version, ICD-11, c-PTSD acquired the official recognition that researchers had been pursuing.

The ICD-11 definition of c-PTSD (OMS [WHO], 2020) implies that the person has to meet the criteria for the diagnosis of PTSD: 1. Re-experiencing the traumatic event, 2. Avoidance of situations or memories of the event, and 3. Permanent sense of threat in the form of hypervigilance and/or heightened startle reaction. Added to this are what are known as the *disturbances in self organization*: 1. Problems of affect regulation, 2. Feeling of being diminished, defeated, or worthless; shame, guilt, or failure, and 3. Difficulties maintaining relationships and feeling close to others.

The WHO's official recognition of c-PTSD has led to an increase in research on it, to its being linked to certain disorders, and to the emergence of controversies. Prominent among the latter is the one that questions the validity of c-PTSD as an independent diagnosis given the overlap of its symptoms with both PTSD and BPD, with which it (apparently) shares problems in the regulation of affect, self-perception, and interpersonal relationships.

Perhaps we should consider what we call trauma. When a person is confronted with a scenario (directly or as a witness) that involves threat, risk of death, physical injury, or sexual violence, or if he or she discovers that someone close to him or her has been exposed to these circumstances, the person has been involved in a traumatic situation that can have psychological consequences such as PTSD. But another set of circumstances that Kwon (2022) calls "little t" traumas must also be considered: distressing experiences such as verbal abuse, abandonment, bullying, emotional invalidation, neglect, etc. These are contexts which, due to their continuous nature, generate a stress reaction that leaves its mark on the brain and on the hypothalamic-pituitary-adrenal axis, especially if this stress is experienced in childhood or adolescence and if, in addition, they are situations that go unnoticed externally and have a cumulative character. Therefore, things that did not happen when they should have happened-a look, a smile, being taken into account, or a comforting hug-can also have a harmful impact.

Specifically, complex trauma refers to early negative experiences involving neglect, and/or abuse, which occur in an attachment relationship with the primary caregiver, implying that the figure who is supposed to give affection, love, and protection to the child is, at the same time, a source of anxiety, threat, neglect, and/or abuse (Luyten et al., 2020). What often happens is that complex trauma does not occur in isolation, but is part of a "risk environment" (Cicchetti & Toth, 2005, as cited in Luyten et al., 2020), with sexual, physical, psychological abuse, abandonment, emotional invalidation, and/or bullying occurring simultaneously (Bozzatello et al., 2021; Jowett et al., 2020; Lawless & Tarren-Sweeney, 2022; Luyten et al, 2020).

Many authors have pointed to the existence of a history of childhood trauma in subjects with adult BPD, proposing that BPD is a form of expression of c-PTSD, or a complex or chronic form of PTSD (Herman, 1992; Herman et al., 1989; Kroll, 1993;

Kulkarni, 2017; Zanarini, 2000) with which it shares alterations in five core areas: affect regulation, impulse control, reality testing, interpersonal relationships, and self-integration (Fonagy & Luyten, 2016; MacIntosh et al., 2015).

However, others have also spoken up against this equation, calling it simplistic and pointing to the confusion between risk and cause. How is it explained, according to this criterion, that many people with BPD do not have a history of traumatic events? The presence of adverse events in childhood is a risk factor, although neither necessary nor sufficient to explain the emergence of BPD, since this factor is not capable of providing a solution to the dilemma of why some survivors of abuse or maltreatment develop BPD while others do not. It is true that the presence of such events does not come without consequences, but the idea that certain childhood traumas will lead to specific disorders (such as BPD) lacks foundation, ignoring the principle of equifinality/multifinality or multidetermination (Paris, 2015; Talarn et al., 2013) and the interrelation with biological and temperamental factors that exert as elements of vulnerability (Bozzatello et al., 2021; Goodman & Yehuda, 2002; Krause-Utz, 2021). Thus, these are events that can aggravate BPD symptoms and its course, worsening the prognosis, but they are not essential for its diagnosis (unlike PTSD and c-PTSD).

Discussion Points

The questions raised by the c-PTSD construct arose from the moment it was formulated; considering that, frequently, BPD patients report having suffered adverse experiences, the debate was on regarding the comorbidity or the relevance of the c-PTSD diagnosis. Let us look at some of the points around which the controversy revolves.

Ford and Courtois (2014, 2021) point to the frequency of a history of extreme interpersonal trauma in BPD subjects, although it is emotional and physical neglect that plays a basic role in its development, whereas sexual abuse and maltreatment are more likely to provoke c-PTSD. For Bozzatello et al. (2021), both in subjects with c-PTSD and BPD, exposure to certain recent experiences can reactivate early traumas, leading to revictimization. Likewise, in BPD subjects, emotional dysregulation, impulsivity, exposure to risky situations or intense emotional response can lead them to become involved in adverse circumstances in adult life, giving rise to polytraumatization that can trigger comorbid PTSD and/or c-PTSD. In addition, emotional regulation difficulties may also increase the tendency to perceive certain events (especially interpersonal events) as threatening and traumatic (Ford & Courtois, 2014, 2021; Hyland et al., 2019; Jowett et al., 2020; Kulkarni, 2017), increasing vulnerability and risk for comorbidity.

Many studies find clear commonalities between c-PTSD and BPD. Van Dijke et al. (2013) note the elevated risk of childhood trauma or c-PTSD in BPD subjects, but state that c-PTSD is not exclusive to BPD and therefore they are not synonymous concepts. Hyland et al. (2019) highlight that it is unreasonable to expect PTSD, c-PTSD, and BPD symptoms to be completely distinct from each other; overlaps and commonalities exist (as among so many diagnostic entities), but that does not make them equivalent. Along the same lines, Jowett et al. (2020) indicate that the areas involved in the two conditions are similar (emotional regulation, sense of self, and interpersonal relationships), but the phenomenological manifestations are different in one and the other. In this regard, the literature reviewed is dominated by the conception that c-PTSD should be considered a separate entity from both PTSD and BPD (Cloitre, 2020; Ford & Courtois, 2021; Luyten et al., 2020; Maercker, 2021; Nestgaard Rød & Schmidt, 2021). The most detailed analysis is by Ford and Courtois (2021), whose study is an update of the one carried out by the same authors in 2014. Both works constitute a fundamental contribution to understanding the difference between the constructs, concluding that BPD, c-PTSD, and PTSD are different syndromes, although often comorbid.

In 2021, Nestgaard Rød and Schmidt carried out a literature review of previous contributions (similar to the present study although with a different objective), observing that all the papers analyzed consider c-PTSD to be different from BPD except one (that of Saraiya et al., 2021), a conclusion similar to that reached in the present paper, as will be seen below. Other studies provide specific elements, such as the importance of complex trauma in the development of the diffusion of self-identity characteristic of BPD and c-PTSD, an analysis framed in the theory of mentalization (Luyten et al., 2020), or the presence of dissociative symptoms as a core element of both diagnoses (Krause-Utz, 2022).

In this debate there also appeared the proposal to consider BPD as a trauma spectrum disorder (Ford & Courtois, 2014, 2021; Giourou et al., 2018, Nestgaard Rød & Schmidt, 2021), that is, a group of disorders that have in common the history of trauma and that form a continuum in terms of symptom severity. Thus, c-PTSD would constitute an intermediate point of severity between PTSD (milder end) and BPD (greater severity). Giourou et al. (2018) recognize that BPD is a heterogeneous diagnostic category that may include many subtypes, so that only some cases of BPD would be included in the continuum proposed above, with a more etiological than descriptive classification being necessary.

Due to the confusion it causes, some authors dispute the usefulness of the c-PTSD diagnosis for clinical practice, pointing out that c-PTSD is nothing more than the sum of PTSD plus BPD (Cloitre et al., 2014; Cloitre, 2020); others stress that it is not a valid diagnosis for adolescents in foster care, suggesting a more appropriate name for this population group: "adolescent complex disorder" (Lawless & Tarren-Sweeney, 2022); another study rules out that there are differences between BPD and c-PTSD, so its existence contributes nothing (Saraiya et al., 2021).

Bibliometric Study

The objectives of the present work were threefold: 1. to find out whether c-PTSD and BPD were independent entities; 2. to gauge the state of the art since the "official" diagnosis of c-PTSD; and, based on the documents analyzed, 3. to propose a differential diagnosis between the two entities.

Method

As well as the analysis and study of theoretical documents on the subject, a qualitative, non-systematic literature review was carried out (although some guidelines for systematic reviews were followed), by means of a search in the Scopus, Web of Science, *Psicodoc*, PsycInfo, and Medline databases.

Search and Selection Strategy

The search included articles in a time frame between January 2020 and June 2022 (time of validity of the ICD-11 c-PTSD diagnosis) applying inclusion and exclusion criteria (see Table 1). The search terms were "borderline personality disorder" AND "complex trauma", "borderline personality disorder" AND "complex post-traumatic stress disorder" in the title or keywords. Once the results were compiled and the abstracts analyzed, the full text was reviewed to check that the papers matched the purpose of the search. The result is shown in Figure 1. Table 2 specifies the studies included in the review.

Since the aim of this study was not to carry out a systematic review in the strict sense of the word, no criteria were considered in terms of the type of sample used in the studies, age range, or design used in them, as the purpose of the study was merely a nosological review.

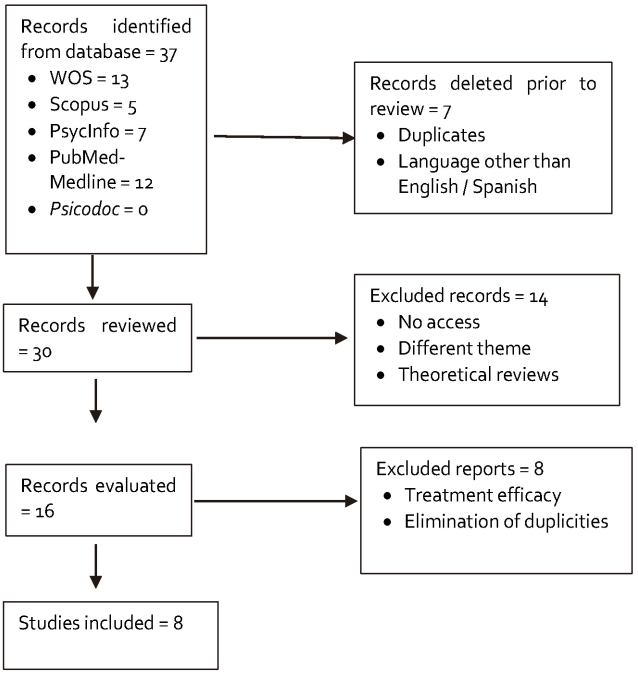
Results

As can be seen in Table 2, many studies coincide in methodology (latent class analysis predominates), type of sample-subjects with a history of traumatic event(s)-and instruments applied (self-report measures). Only the investigations by Karatzias et al. (2022), Gelezelyte et al. (2022), and Lawless and Tarren-Sweeney (2022) employ correlational analyses. As for the measurement instruments used, only Gelezelyte et al. (2022) used a semi-structured interview, the *International Trauma Interview* (ITI), for the assessment of c-PTSD symptoms according to ICD-11 criteria; the rest of the studies used self-applied instruments. Regarding the selected sample, only the work by Frost, Hyland et al. (2020) studied subjects who were victims of a specific trauma (sexual trauma); the rest used samples that had suffered traumatic events of different types.

Table 1
Inclusion and Exclusion Criteria

Inclusion criteria	Exclusion criteria
Academic articles	Theoretical / editorial reviews
Full text	No full access
English or Spanish	Language other than English or Spanish
Empirical articles	Influence of trauma on disorders other than BPD
	Efficacy of treatments

Figure 1
PRISMA Diagram of Article Selection (Page et al., 2021)



Regarding the results obtained, we agree with Nestgaard Rød and Schmidt (2021) in the practically general agreement on the similarities between BPD and c-PTSD, but that they should be considered different syndromes on the basis of phenomenological differentiating features. Frost, Hyland et al. (2020), Frost, Murphy et al. (2020), Karatzias et al. (2022), Gelezelyte et al. (2022), and Cyr et al. (2022) support this assumption. The latter focus on the new cluster added to the DSM-5 in their diagnosis of PTSD: disturbances in cognition and mood. In the opinion of the researchers, this addition is redundant with respect to the ICD-11 definition of c-PTSD and its elimination is recommended, as well as the recognition of c-PTSD as a separate entity by the APA.

Some investigations, whilst not contradicting the above, do qualify the conclusions. Jowett et al. (2020) agree on the difference between the two conditions, although in cases of highly traumatized individuals, this difference is diluted to the point of overlapping. Gelezelyte et al. (2022) and Frost, Murphy et al. (2020) point out that self-injurious behaviors and suicide attempts do not help us to distinguish between the two conditions, contrary to previous studies (such as Cloitre et al., 2014) that emphasized self-injurious behaviors as a core element of BPD, but not of c-PTSD. Lawless and Tarren-Sweeney (2022) also qualify the generalized opinion by pointing out that the c-PTSD construct is not valid to describe the symptomatology of adolescents with a history of maltreatment. However, as Cyr et al. (2022) point out, no study has detected subjects with BPD without a history of trauma, which is logical since the samples were composed of subjects who reported some traumatic event in their life history (in fact, only people who met this requirement were included in the sample).

Of the works found in the search, in line with what was pointed out by Nestgaard Rød and Schmidt (2021), indeed (at present) the only one that contradicts the generalized conclusions is that of Saraiya et al. (2021), which uses latent class analysis to propose the overlap of PTSD, c-PTSD, and BPD symptoms, pointing to the unnecessary addition of a diagnostic entity such as c-PTSD. Thus, in an attempt to verify the validity of the work of the Danish researchers since ICD-11 came into force and, therefore, exploring a different and shorter time span than the one used by them (2016-2019), the present study agrees with their statements.

Discussion

The present study had three aims: 1. to determine whether c-PTSD and BPD are distinct entities; 2. to establish the state of the art regarding this issue after the recognition of c-PTSD by the ICD-11; and 3. to propose a differential condition that helps to distinguish between the two.

Table 2
Empirical Studies Period 2020-2022

Authors	Origin	Method	Objective	Sample	Instrum.	Conclusions
Frost, Hyland et al., 2020.	United States	Latent class and regression analysis	To distinguish between c-PTSD and BPD in a group of survivors of sexual violence	Overall sample selection with sexual trauma (N=956).	Self-report measures: AUDADIS IV-PTSD Scale AUDADIS IV BPD Scale *Child Abuse/Neglect Scale*	BPD distinct from c-PTSD
Frost, Murphy et al., 2020	Israel	Confirmatory bi-factor model and structural equation modeling	Differences and similarities between c-PTSD and BPD using dimensional models (HiTOP)	Convenience sample (N=617)	Self-report measures: *International Trauma Questionnaire* (ITQ) BPD subscale of SCID-II *Life Events Checklist for DSM-5* (LEC-5) *WHO-Five Well-Being Index* (WHO-5)	BPD and c-PTSD share a common latent structure but are phenomenologically different
Jowett et al., 2020	Scotland	Latent class analysis, structural equation modeling	To identify distinct profiles of c-PTSD and BPD associated with trauma history	Adults seeking treatment in trauma clinic (N=195)	Self-report measures: *International Trauma Questionnaire (ITQ)* BPD subscale of SCID-II *Child Trauma Questionnaire (CTQ)* *Life Events Checklist (LEC)* *Work and Social Adjustment Scale (WSAS)*	c-PTSD distinct from BPD, although they overlap in highly traumatized individuals
Saraiya et al., 2021.	United States	Latent class analysis	To determine whether c-PTSD is different from PTSD + BPD	Non-clinical adults exposed to trauma (N=197)	Self-report measures: *Life Events Checklist for DSM-5 (LEC-5)* *Adverse Childhood Experiences Scale (MINI-ACE)* *PTSD Checklist for DSM-5 (PCL-5)* *Brief Symptom Inventory (BSI)* *BPD subscale of SCID-II* *Tests of Self-Conscious Affect (TOSCA-3S)* *Brief Inventory of Interpersonal Problems Circumplex-Item Response Theory (IIP-C-IRT)*	Overlap of PTSD, c-PTSD, and BPD symptoms
Gelezelyte et al., 2022.	Lithuania	Descriptive and mediation analysis	Association between sexual abuse and suicidal risk through c-PTSD and BPD	Adults with history of trauma (N=103)	Semi-structured interview for c-PTSD (ITI) + Self-report measures: *Borderline Pattern Scale (BPS)* *Suicidal Behaviors Questionnaire-Revised (SBQ-R)*	Suicide risk after sexual abuse is mediated by symptoms of c-PTSD and BPD. Suicide risk should also be assessed in c-PTSD.
Karatzias et al., 2022.	Scotland	Correlational	Relationship between types of attachment and severity of c-PTSD	Clinical sample exposed to trauma (N=331)	Self-report measures: *Childhood Trauma Questionnaire (CTQ)* *International Trauma Questionnaire (ITQ)* *Relationships Questionnaire (RQ)*	BPD distinct from c-PTSD and PTSD in symptoms and attachment patterns
Lawless & Tarren-Sweeney, 2022	New South Wales (Australia)	Descriptive analysis	To test the construct validity of the c-PTSD construct in adolescents	Adolescents in foster care with a history of abuse and/or neglect (N=230)	Measures completed by caregivers: *Child Behavior Checklist (CBCL)* *Assessment Checklist for Adolescents (ACA)*	The c-PTSD construct is not valid for describing symptoms in adolescents with a history of maltreatment.
Cyr et al., 2022	Canada	Latent class analysis	To determine whether the c-PTSD symptom profile is different from that of PTSD and BPD.	Women with some traumatic experience (N=438)	Self-report measures: *International Trauma Questionnaire (ITQ)* *PTSD Checklist for DSM-5 (PCL-5)* *McLean Screening Instrument for BPD (MSI)* *Childhood Cumulative Trauma Questionnaire (CCTQ)* *Trauma Symptoms Inventory (TSI)* *Satisfaction with Life Scale (SWLS)*	c-PTSD as a relevant construct independent of BPD and PTSD. The PTSD criteria added by the APA are redundant, the recognition of c-PTSD being necessary.

Very often, in the history of people with BPD, there are traumatic events, whether of an extreme type such as sexual abuse, maltreatment, and/or abandonment, or in the form of emotional maltreatment, invalidating environments, or triangulating families. In this regard, it seems that the key point for BPD to develop lies in abandonment, neglect, and emotional invalidation, rather than in sexual abuse and physical maltreatment, which are more likely to trigger c-PTSD. But it should not be forgotten that in an environment where physical abuse is the order of the day, it is more common that there are also failures in attachment relationships, feelings of abandonment, and lack of validation, which can lead to one diagnosis or the other, or comorbidity between the two. What is clear is that trauma (especially childhood trauma) is a risk factor for the development of BPD, but it is neither a necessary nor a sufficient condition; not all subjects with BPD have a history of trauma. However, the debate remains open as to what we consider a traumatic event, since as such we should include any situation with which the individual is not able to cope adaptively, be it sexual abuse or a lack of consolation in the face of failure. In this sense, most mental disorders would be "post-traumatic".

As already discussed, interest in complex trauma and c-PTSD has been alive for years, and has even been increasing in recent times. In 2021, the *Journal of Traumatic Stress* brought out a virtual issue on c-PTSD, compiling essential articles and focusing on some of the controversies it generates, such as that of its distinction from BPD that we have been discussing (https://onlinelibrary.wiley.com/doi/toc/10.1002/(ISSN)1573-6598.complex-ptsd). Likewise, the *Child Mind Institute* of California published the Child Mental Health Report 2022, in which reference is made to reactive attachment disorder and complex trauma (Sheldon-Dean, 2022). Likewise, in our country, in a well-known popular science journal, Diana Kwon

(2022) published her article "*La alargada sombra del trauma*" [The Long Shadow of Trauma], where she directly addresses the debate about whether BPD should be considered a trauma-related disorder. These are signs that complex trauma and its etiological role remain issues to be debated because of their impact on clinical practice. Indeed, all patients in consultation should be asked about their history with regard to these kinds of events.

Based on the documents reflected in this work, and from a purely descriptive perspective, we propose a table of differential diagnosis that can help with these distinctions in the clinic (Table 3).

Logically, studies on c-PTSD prior to 2020 are based on the concept formulated by Herman or the DESNOS construct in the DSM-IV. In reality, perhaps the psychopathology derived from trauma does not fit into the traditional diagnostic classifications based on categories, and a transdiagnostic profile, more dimensional, that recognizes the influence of trauma in the development of different disorders, such as BPD, would be more appropriate. MacIntosh et al. (2015), Hyland et al. (2019), Lawless and Tarren-Sweeney (2022), Jowett et al. (2020), and Frost, Murphy et al. (2020), among others, conclude in a similar vein, highlighting the need for research to move away from the categorical to explore common deficits in adults who have experienced trauma both as children and later in life. Indeed, a more etiologically adjusted and understandable model is the Hierarchical Taxonomy of Psychopathology (HiTOP, Kotov et al., 2017), proposed by Hyland et al. (2019) and Frost, Murphy et al. (2020) as a model that explains the logic of c-PTSD, PTSD, and BPD sharing symptoms given the importance of interpersonal trauma as a common risk factor.

Conclusions

In line with what has already been discussed, and responding to the objectives set out in the present work, we have been able to verify that most of the investigations coincide in considering c-PTSD and BPD as different entities, while subject to occasional etiological and symptomatological coincidences, frequent comorbidity, and similar affected areas, although with different phenomenological expression. Likewise, and based on these statements, both diagnoses are considered relevant, so a differential diagnosis has been proposed that may be useful in the clinic.

Although not previously mentioned, the present study has also pursued a fourth objective: the presence of publications on this subject in Spanish, since we have not found any documents in our language in the databases mentioned above.

As with any work of review and reflection, there are obvious limitations in the present study: not having been able to analyze certain documents because of restricted access, the need for more detailed development of some aspects, and the performance of a stricter systematic review are weak points of the proposal. Regarding this last point, the bibliographic search was focused on the theoretical clarification of the assumptions formulated, so methodological aspects may have been ignored. Therefore, we have only focused on descriptive and classificatory factors, combining two different systems (DSM and ICD), venturing a comparison between the DSM diagnosis of BPD and ICD-11 diagnosis of c-PTSD.

Table 3
Differential Diagnosis BPD-c-PTSD

Areas	BPD	c-PTSD
Sense of self. Self-esteem	Fragmented and unstable. Changing self-image. Stable instability.	Stably negative. Devaluation, shame, and guilt.
Emotional regulation	Emotional dysregulation: Affective instability, dysphoria, irritability, anxiety, chronic feelings of emptiness, extreme reactivity to minor stressors, emotional outbursts.	Emotional dysregulation: Trauma-related self-perceptions (guilt, shame, helplessness), fear of intimacy and suppression of emotional expression. Emotional anesthesia.
Interpersonal functioning	Impulsive, intrusive, chaotic, intense, and aggressive relationships, hostile demands. Involvement and disinvolvement to avoid real or imaginary abandonment.	Feeling of isolation, fear of intimacy, and emotional withdrawal in relationships. Relationships characterized by avoidance and fear.
Etiology	**Probable** history of child abuse and neglect by caregivers, temperamental vulnerability, and biological predisposition. Etiological significance of emotional invalidation.	Continuous and cumulative interpersonal traumatic events.
Onset	The maladjustments begin in childhood or adolescence. If there has been a traumatic situation, the symptoms are not direct sequelae (the existence of trauma is **not** a requirement for diagnosis).	The maladjustments are a direct consequence of the ongoing traumatic situation (the existence of trauma **is** a prerequisite for diagnosis).
Duration	Persistent traits. It is a "way of being" that is established in childhood or adolescence prior to the traumatic event (if any).	Long-lasting symptoms from the situation. Often stable premorbid history.
Response to pain	Analgesia related to the use of dissociation.	Hyperalgesia; analgesia when there is dissociation.
Biological findings	Hypoactivation of orbital and dorsolateral prefrontal cortex; amygdala hyperactivity.	Hyperactivation of the dorsolateral prefrontal cortex, ventromedial cortex, and amygdala. (There are no neuroimaging studies, data are inferences from the DESNOS study).
Victimization and risk of revictimization	High risk of revictimization: involvement in risky behaviors and perception of situations as traumatic. Risk of severe interpersonal trauma in adulthood caused or perceived as such.	Continued victimization. Risk of the victim becoming an aggressor.
Dissociation	Core symptom in states of emotional dysregulation.	As an associated symptom.
Activation	Hyperarousal to relational stimuli. Hypervigilance due to the fear of being abandoned.	Hyperarousal at remembrance of trauma. Hypervigilance to fear of being harmed.
Basic fear	Fear of abandonment.	Fear of attack.
Suicide risk	Suicidal behavior or self-injury as a core element.	Suicidal behaviors and self-harm are not included as a core element, although they may occur (especially with a history of sexual abuse).
Child attachment	Insecure or disorganized.	It depends on when the traumatic situation began.

Conflict of interest

There is no conflict of interest.

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