PTSS & persoonlijkheidsstoornissen - een update

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What treatment in PTSD?

Psychological therapies in PTSD

Bisson et al., 2013

70 studies, n = 4761

- TFCBT vs. WL/TAU: very high effect size (SMD = -1.62; n = 1256)

- EMDR vs. WL/TAU: high effect size (SMD = -1.17; n = 183)

- Effect non-TFCBT = TFCBT (stress management)!

Higher drop-out in TFCBT vs. WL/TAU (RR 1.64)

Dropout from PTSD therapies

Systematic review on RCTs, Lewis et al 2020

Pooled dropout rate: 16%

TF-treatments significantly greater dropout, compared to non-TF treatments

No greater dropout in:

- Group vs. individual format
- Recruitment in clinical services vs. advertisements
- In military personnel/veterans
- In participants with sexual traumas;
- In female participants
- In lower education.

What treatment in PD?

‘Big four’ BPD psychotherapies

CBT based

- DBT = dialectical behavior therapy
- SFT = schematherapr or schema focused therapy

Psychodynamic based

- MBT = mentalisation based treatment
- TFP = transference based psychotherapy

In het algemeen 1-3 jaar therapie; maar korte modules lijken net zo effectief (bv 20 vs 50 sessies)

Psychological therapies in BPD

Storebo/Winterling et al., 2020)

75 RCT, n = 4507 (more females)

Psychotherapy vs. TAU, moderate effect
- BPD severity (SMD -0.52, n = 1244)
- psychosocial functioning (SMD −0.45, n = 1314)

DBT vs. TAU, mild/moderate effect
- BPD severity (SMD −0.60, n = 149),
- self-harm (SMD −0.28, n = 376),
- psychosocial functioning (SMD −0.36, n = 225)

MBT vs. TAU, moderate effect
- self-harm (RR 0.62, n = 252),
- suicidality (RR 0.10, n = 218)
- depression (SMD −0.58, n = 333).

Drop-out in BPD psychotherapies Arntz et al 2022

- Dropout in BPD **up to 50%**
- 111 studies (N = 9100) psychotherapy for non-forensic adults with BPD
- Dropout highest in first quarter of treatment
- Of 'big four', schematherapy lowest dropout overall
- MBT lowest dropout in first two quarters
- Individual less dropoput than group format

What treatment if both PTSD and PD?

Combine DBT + PE in comorbid PTSD-BPD

Harned et al., 2012; Bohus et al., 2013

pilot n = 13

Adult women with BPD, PTSD + suicidal behavior or serious NSSI
DBT outpatient; 1 year + DBT-PE 13 sessions

Harned et al., 2012

RCT n = 74

CSA related PTSD; 50% BPD
DBT-PE inpatient 12-week vs. WL
CAPS: strong effect (g = 1.35)

Bohus et al., 2013

PTSD therapy (PE, IPT, RT) is enough!

Markowitz et al., 2015

At baseline: 47% (N = 99) paranoid, obsessive-compulsive, avoidant PD

Posttreatment (wk 14, N = 78):

43% (N = 15/35) lost PD dx

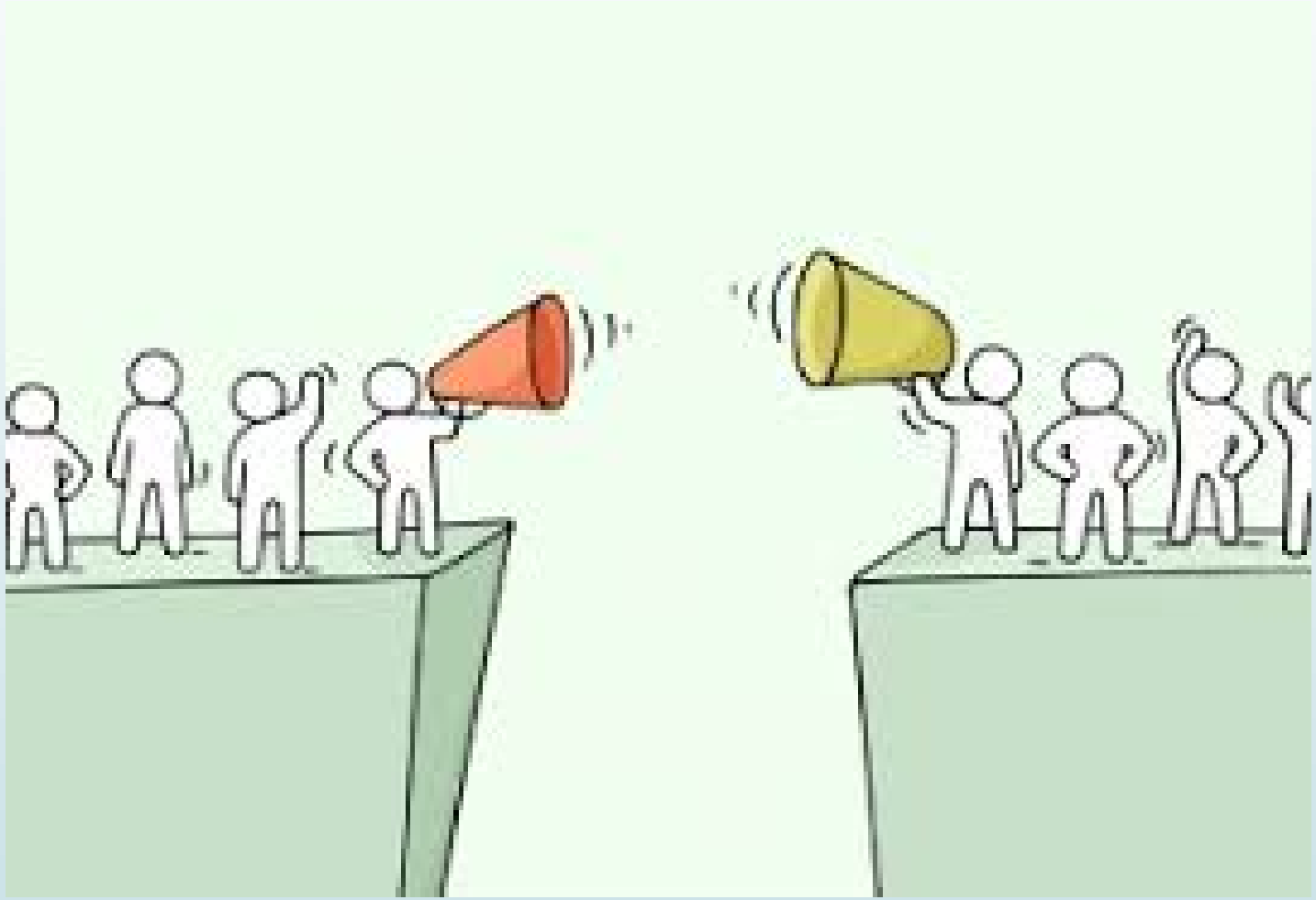
Follow-up (wk 26, n = 44)

56% of responders no PD

Note: BPD being excluded!

- Pilot, N = 11
- 10-week inpatient program
- Drop-out 1 / 11
- No aggravations in symptom severity
- Low rate of self-harming behaviors (18.2 %).
- Positive effects on PTSD and BPD symptom severity

NET in patients with PTSD and BPD Steuwe et al., 2016



Zorginstituut Nederland

Verbetersignalement Posttraumatische stress-stoornis

Zinnige Zorg | ICD-10: F43.1

9 JUNI 2020 | DEFINITIEF

Verbeterpunten zorg voor mensen met PTSS

- meer mensen met PTSS krijgen een traumagerichte behandeling;
- mensen met PTSS gaan minder benzodiazepinen gebruiken;
- PTSS wordt vaker herkend;
- de informatie-uitwisseling tussen GGZ en huisarts wordt verbeterd.

Golven komen en gaan

- ... in een wel wat Nederlands feestje ...

Childhood trauma related PTSD

Boterhoven de Haan et al., 2020

- RCT N = 155
- ImRs vs. EMDR
- 2 x/wk 90 min, up to 12 sessions
- Low dropout: 7.7%
- Effect size high: ImRs 1.72 = EMDR 1.73

PTSD with self-report comorbid BPD symptoms

- Pilot (n = 72) severe PTSD - 90.3% sexual abuse – 49% positive BPD screen
- Intensive 8-day TF treatment (EMDR, PE, physical activity, psychoeducation)
- CAPS, PCL-5 & self-report BSL-23.
- R/ significant decreased BPD symptoms (Cohen's d = 0.70)
- 11 of 35 (32.7%) with positive BPD screen lost 'BPD' at post-treatment
- No adverse events nor dropouts, nor symptom deterioration.

Psychotherapy for PTSD in BPD

Meta-analysis, Slotema et al., 2020

- N = 14 studies, incl. 4 RCTs
- In RCTs moderate effect on PTSD symptoms (Hedges' g = 0.54, FU 0.82).
- All: moderate-high effect on PTSD symptoms (Hedges' g = 1.04; FU 0.98).
- Also significant decrease in borderline symptoms (Hedges' g 0.48–1.04).
- No increase in self-injurious behaviour, suicide attempts, or hospitalization
- Dropout rate: 17%.

Does comorbid PD affect PTSD treatment?

Meta-analysis, Snoek et al., 2021

- N = 12 studies, n = 918
- In PTSD-PD vs. PTSD, no higher PTSD severity (Hedges' g = 0.23)
- In PTSD-PD vs. PTSD, no higher dropout (RR = 1.19)
- In PTSD-PD, large PTSD symptom improvements (Hedges' g = 1.31)
- In PTSD-PD, smaller symptom improvement than PTSD (Hedges' g = 0.22)

PTSD with clinical diagnosis BPD

Pre-post design, Kolthof et al., 2022

- N = 45 (60% female) mainly child abuse related PTSD and BPD
- Intensive 8-day TF treatment programme
- CAPS-5, BPDSI-IV +/- SCID-5-P.
- Sign decrease PTSD and BPD symptom severity (Cohen's d: 1.58, resp. 0.98)
- Maintained at 6- & 12-month FU
- 31/45 (69.2%) no longer met diagnostic criteria of PTSD at 12-month FU
- 33/45 (73.1%) no longer met diagnostic criteria of BPD at 12-month FU
- No significant worsening of symptoms occurred.
- Note: no control group

Adding EMDR to outpatient BPD treatment

Multiple baseline design, Wilhelmus et al 2023

- N = 12 patients with BPD and PTSD
- Outpatient 15 weekly 45-min sessions of TAU + 8 weekly 90-min EMDR
- PCL-5, self-report BSL, disability
- In the EMDR phase, PTSD severity scores decreased significantly between sessions
- No between-session drop in scores during TAU
- 25% dropout
- No adverse events

Child abuse related PTSD: comorbidities

RCT, Hoeboer et al., 2024

- RCT N = 149
- 3 variants of PE for PTSD
- Outcome: SCIDs
- Decreased depressive, anxiety, substance use and PD diagnoses, sustained at FU.
- Significant effect for avoidant, but not significant for borderline PD

PTSD and cluster C (PROSPER-C)
RCT, van den End et al., 2024

- N = 130 (85 % f) PTSD + comorbid cluster C PD
- Outpatient
- Add PD treatment (group schematherapy; 52-58 sessions) to trauma-focused treatment (ImRs, 12-18 sessions) vs. ImRs
- CAPS at 12-months
- Decrease in PTSD severity large in both ImRs+GST (Cohen's d = 2.44) and ImRs (Cohen's d = 2.42)
- No difference between conditions!

- Note: sought help for PTSD

PTSD and BPD (PROSPER-B)
RCT, Snoek 2025

- Is EMDR (12-18 sessions) + DBT (48 sessions) > EMDR-only?
- Randomly assigned to EMDR+DBT (n = 61) or EMDR-only (n = 63)

- Both conditions: large reductions in PTSD symptoms
- No sign. difference between conditions after 1 yr! (d = -0.23).
- Both: large reductions in BPD symptoms and quality of life.

- Dropout EMDR+DBT 2x more likely from EMDR vs. EMDR-only!
- Note: relatively ‘mild’ BPD

Nederlands feestje uitbreiden?

- Europa & VS: Bohus, Harned … ?
- Persoonlijkheidsstoornissen onderzoek

GGZ Standaarden

Deze pdf is gepubliceerd op 07-12-2022 om 09:22. Bekijk de meest actuele versie op www.ggzstandaarden.nl/zorgstandaarden/persoonlijkheidsstoornissen-zorgstandaard-2017

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Zorgstandaard

Persoonlijkheidsstoornissen (zorgstandaard 2017)

Zorgstandaard Persoonlijkheidsstoornissen (2017)

Cluster B

- Voorkeur specifieke BPS behandelingen:
  - DGT (Dialectische Gedragstherapie)
  - MBT (Mentalization-Based Treatment)
  - SFT (Schema focused therapy)
  - TFP (Transference-Focused Psychotherapy)

- Generieke behandeling iets minder effectief maar beter implementeerbaar
  - General Psychiatric Management (GPM),
  - In Nederland: Guideline Informed Treatment for PD (GIT-PD)

Most effective & acceptable BPD psychotherapy?

Network meta-analysis. Setkowski et al., 2023

- 2 network meta-analyses (NMAs) on BPD severity and suicidal behaviour
- RCTs in adults with (sub)clinical BPD
- 43 studies (n = 3273)
- Significant differences between several active comparisons (few trials)
- Some therapies were more efficacious compared to TAU
- **DBT: solid evidence of its effectiveness.**
- **Some treatments: halved the risk of attempted/committed suicide**
- Drop-out significantly differed between treatments.

Effective interventions and optimal context for personality disorders

Systematic review, Katakis et al., 2023

- RCTs in community or outpatient settings
- 54 trials (n = 3716)
- Large effect size favoring BPD-therapy vs. TAU/WL (g = 0.78; FU g = 1.01)
- Intervention types were equally effective in treating all symptom categories
- Treatment duration and intensity did not moderate effectiveness

Efficacy of DBT variants for PTSD

Meta-analysis, Prillinger et al., 2024

- 13 studies, n = 663
- RCTs + controlled clinical trials + pre-post designs

PTSD-specific DBT treatments showed moderate effects in reducing:

- PTSD symptom severity (Hedges' *g* = -0.69)
- dissociative symptoms (*g* = -0.72)
- BPD-associated symptoms (*g* = -0.82)
- NSSI frequency (*g* = -0.70)

Veteranen Intensieve Behandelunit
(VIBU, Sinai Centrum)

V+ REPORTAGE

‘Snelkookpan’ van therapieën biedt hoop voor veteranen met ernstige PTSS: ‘Wat was het vierde trauma? Ik ben het vergeten’

Drop-out TF-CBT in PTSD

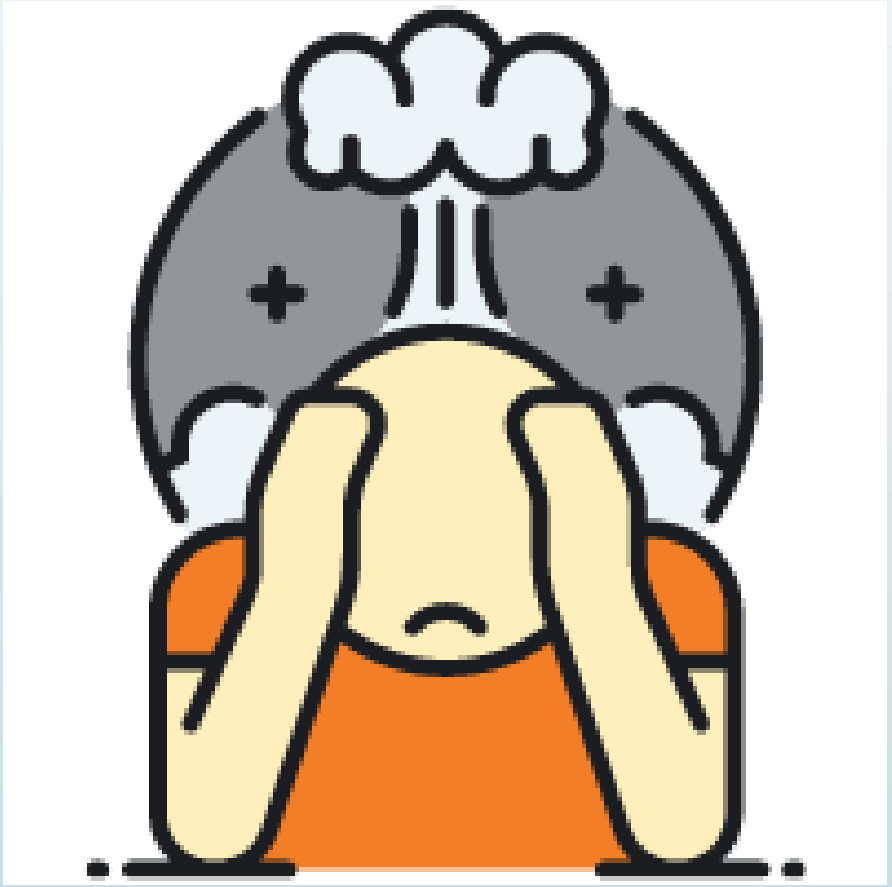
IPDMA Wright et al. 2024

- TF-CBT vs. WL, TAU or another therapy
- N = 25 CBT-TF studies (n = 823)
- Dropout 27%.
- Civilians 23%; military/**veterans 42% (RR 2.37)**
- Less dropout with advancing age (continuous; RR 0.98).

Drop-out PTSD & PD
van den End/ Snoek et al 2024

- N = 255 PTSD + PD
- 2 RCTs comparing TFT with or without concurrent PD therapy
- **High dropout: 40%**
- 5 (of 38) significant, independent predictors of attendance:
  1. Higher baseline PTSD severity (OR =1.04, p =.036)
  2. Higher education level (OR =1.22, p =.009)
  3. Stronger patient-rated working alliance (OR =1.72, p =.047)
  4. - Indequate social support from friends (OR =0.90, p =.042)
  5. - Concurrent PD treatment (OR =0.52, p =.022)

Oké, en nu?



Potentially traumatic events, DSM-5 PTSD, ICD-11 complex PTSD in the Netherlands

Hoeboer et al., 2025

- N = 1690, 16+ (LISS-panel) online: self-report PCL-5 & ITQ;
- Subset CAPS-5 interview (*n* = 204)
- Lifetime any PTE 81.5%.
- Lifetime DSM-5 PTSD 11.1%; current prevalence 1.3%.
- Current ICD-11 PTSD was 1.0 %; ICD-11 complex PTSD 1.6 %.
- At risk: females, younger adults, lower education, non- Dutch background

- 50% sought professional help; **33% received first-line PTSD treatment**
- Common reasons: lack of knowledge, shame and avoidance.

Take home

- Trauma focused treatment high effect sizes (on PTSD symptoms)
- Also in comorbid CPD and BPD
- Personality focused treatment moderate effect sizes (on PD symptoms)
- Personality symptoms decrease with trauma-focused treatment

Challenges:

- High dropout, especially in veterans and personality disorders
- In PTSD, only 33% PTSD receives TF treatment
- Only 50% seeks professional help (shame, avoidence, knowledge gap)