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Depress Anxiety. Author manuscript; available in PMC 2012 May 1.

Published in final edited form as:
Depress Anxiety. 2011 May ; 28(5): 393–399. doi:10.1002/da.20798.

Affect Intensity and Lability: The Role of Posttraumatic Stress Disorder Symptoms in Borderline Personality Disorder

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Abstract

Background—Emotion dysregulation is likely a core psychological process underlying the heterogeneity of presentations in borderline personality disorder (BPD) and is associated with BPD symptom severity. Emotion dysregulation has also been independently associated with posttraumatic stress disorder (PTSD), a disorder that has been found to co-occur with BPD in 30.2% of cases in a nationally representative sample. However, relatively little is known about the specific relationships between emotion dysregulation and PTSD among those diagnosed with BPD. The purpose of the current study was to evaluate relations between PTSD symptom severity and negative affect intensity and affective lability among individuals with BPD.

Method—Participants were 67 individuals diagnosed with BPD (79% women; M_{age} = 38, *SD* = 10), who reported one or more *DSM-IV* PTSD Criterion A events.

Results—Hierarchical multiple regression analyses indicated that when examined concurrently with BPD symptom severity, PTSD symptom severity, but not BPD symptom severity, was related to negative affect intensity and affective lability. Reexperiencing symptoms uniquely predicted affective lability, and hyperarousal symptoms uniquely predicted negative affect intensity, lending additional support to emerging literature linking reexperiencing and hyperarousal symptoms with emotion dysregulation.

Conclusions—PTSD symptom severity among individuals with a BPD diagnosis is related to elevations in emotion dysregulation. It is important to evaluate whether early treatment of PTSD symptoms provided concurrently with BPD treatment leads to enhanced improvements in emotion regulation among individuals with co-occurring PTSD and BPD.

Keywords

posttraumatic stress disorder; trauma; anxiety disorders; borderline personality disorder; emotion

Borderline personality disorder (BPD) is characterized by symptoms of severe mood disturbance, impulsive behaviors, inappropriate anger, self-harm behaviors, relationship problems, and identity disturbances [1]. One of the prevailing theories in the BPD field suggests that emotion dysregulation is the disorder's central feature [2, 3, 4]. According to this perspective, the multitude of impulsive behaviors in which individuals with BPD engage - such as self-injury, impulsive spending, substance use, or unsafe sexual behavior -

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represent maladaptive attempts to modulate the intense and rapidly fluctuating affects these individuals experience. Further, emotion dysregulation may be of sufficient intensity to alter the individual's thoughts about the self and others, resulting in both the identity disturbances as well as the interpersonal difficulties (e.g., fluctuations between idealizing and devaluing others) observed in the disorder. Aside from self-injurious behavior, emotion dysregulation has been found to be the BPD criterion most predictive of prospective suicidal behavior, and the only BPD criterion significantly predictive of suicide attempts [5]. Further, research suggests that levels of emotion dysregulation are stable over time [6] and are the best longitudinal predictor of self-reported self-harm, identity, and interpersonal problems [7].

Adding additional complexity to the understanding of the heterogeneity of BPD, and the role of emotion dysregulation in BPD, is the incidence of high rates of co-occurring Axis I diagnoses. In one sample of 59 outpatients meeting criteria for BPD, all but one met criteria for an Axis I condition and 70% met criteria for 3 or more Axis I conditions [8]. High rates of mood disorders [9, 10, 11, 12], eating disorders [13], substance use disorders [14, 15], and anxiety disorders [12, 16, 17, 18] have been documented in BPD. Among the anxiety disorders, a recent large nationally representative study examined the comorbidity of posttraumatic stress disorder (PTSD), specifically, with BPD. Thirty percent of individuals diagnosed with BPD were also diagnosed with PTSD, and 24% of individuals diagnosed with PTSD were also diagnosed with BPD [19]. Further, co-occurring BPD-PTSD was associated with poorer quality of life, increased odds of a lifetime suicide attempt, more Axis I diagnoses, and a higher prevalence of repeated childhood traumatic events.

Of the Axis I conditions, PTSD is of particular interest to the study of BPD and emotion dysregulation. Exposure to traumatic events has been linked to emotion dysregulation in the absence of PTSD or BPD [20, 21], and emotion dysregulation has been related independently to PTSD. In one study, PTSD symptom severity, as well as a PTSD diagnosis, was related to greater self-reported emotion dysregulation; and similarly, emotion dysregulation was associated with greater PTSD symptom severity, above and beyond the variance accounted for by trait-level negative affectivity [22]. Recent work suggests that emotion under-modulation may be particularly relevant for reexperiencing and hyperarousal PTSD symptoms [23, 24]. Furthermore, psychobiological deficits in emotion regulation mechanisms among individuals with PTSD continue to be documented in laboratory-based psychophysiology and neuroimaging studies [21].

The purpose of the current study was to examine the relationship between PTSD and emotion dysregulation, conceptualized as negative affect intensity (strength of emotional reaction to stressful life events) and affective lability (instability of emotional states), in a sample of individuals who met diagnostic criteria for BPD and a *DSM-IV* Criterion A event. Given the established independent relationship between PTSD and emotion dysregulation and the more varied and complex presentation of BPD pathology by comparison, it was hypothesized that, in an all BPD sample, PTSD symptoms, but not BPD symptoms, would evidence significant positive relations to emotion dysregulation when examined simultaneously. Further, given previous research suggesting that under-modulation of affect is associated with re-experiencing and hyperarousal PTSD symptoms, it was hypothesized that these symptom clusters would be more strongly associated with the dimensions of emotion dysregulation assessed here (i.e., affective lability and negative affect intensity).

Method

Participants

Participants in the current study were part of a larger study on impulsivity and emotion regulation in BPD [25]. Participants were 67 individuals diagnosed with BPD (79% women;

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M_{age} = 38, *SD* = 10). All participants in the current study reported one or more *DSM-IV* PTSD Criterion A events [1] on the Traumatic Life Events Questionnaire [26]. See Table 1 for demographic data for the current sample.

Measures

Structured Interview for DSM-IV Personality [27]—The Structured Interview for DSM-IV Personality is a semi-structured diagnostic interview for Axis II disorders, wherein symptoms are rated as: 0 (*not present or limited to rare isolated examples*), 1 (*subthreshold*), 2 (*present*), or 3 (*strongly present*). This interview has strong psychometric properties [28]. The current study utilized the Structured Interview for DSM-IV Personality to assess BPD diagnostic status and dimensional BPD symptom severity.

Diagnostic Interview Schedule-Computerized for DSM-IV *(CDIS)* [29]—The Diagnostic Interview Schedule-Computerized for DSM-IV is a computer-assisted structured diagnostic clinical interview, evidencing good psychometric properties [30]. The current study utilized this interview to diagnose current and lifetime substance use diagnoses (i.e., abuse and dependence).

Mini International Neuropsychiatric Interview [31]—The Mini International Neuropsychiatric Interview is a structured diagnostic interview, demonstrating good psychometric properties [31]. One advantage of the Mini International Neuropsychiatric Interview is its brevity compared to other structured clinical interviews. Therefore, to reduce participant burden, the current study utilized the Mini International Neuropsychiatric Interview to diagnose anxiety, mood, and eating disorders.

Traumatic Life Events Questionnaire [26]—The Traumatic Life Events Questionnaire is a self-report measure assessing DSM-IV Criterion A traumatic event exposure. Specifically, it assesses frequency of trauma exposure, level of perceived threat to self or others, and emotional reaction to a number of types of events. The Traumatic Life Events Questionnaire has good psychometric properties, as well as predictive validity, in a variety of trauma-exposed samples [26]. In the current study, this measure was used to establish PTSD Criterion A.

PTSD Checklist – Civilian Version for DSM-IV *(PCL-C)* [32]—The PTSD Checklist-Civilian Version for DSM-IV is a 17-item self-report measure assessing to what degree individuals have been affected by PTSD symptoms in the past month. Items are rated on a 5-point Likert-type scale from 1 (*"Not at all"*) to 5 (*"Extremely"*). The PTSD Checklist has good convergent validity with other PTSD assessment tools, such as the Structured Clinical Interview for DSM-IV [33] and the Clinician-Administered PTSD Scale [34]. The PTSD Checklist total score and subscales were utilized in the current study as measures of past-month PTSD symptom severity. In addition, the PTSD Checklist, in combination with the Traumatic Life Events Questionnaire, was used to diagnose PTSD using established procedures [35].

Affect Intensity Measure [36]—The Affect Intensity Measure is a 40-item self-report measure assessing frequency of emotional reactivity and variability with regard to positive, negative, and neutral emotional stimuli. Items are rated on a 6-point Likert-type scale from 1 (*"never"*) to 6 (*"always"*). The Affect Intensity .Measure has good internal consistency, temporal stability, and construct validity [36]. The current study utilized the negative affect intensity subscale (e.g., *"When I feel guilty, this emotion is quite strong;" "Sad movies deeply touch me;" "The sight of someone who is hurt badly affects me strongly"*). The internal consistency of this subscale in the current sample was adequate (α = .77).

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Affective Lability Scale [37]—The Affective Lability Scale is a 54-item self-report measure evaluating unstable emotional shifts from neutral to various affective states (i.e., anger, depression, elation, and anxiety), as well as the tendency for one's mood to oscillate between depressive and elated states, and between anxious and depressive states. Participants rate the degree to which they feel the statements apply to them on a 4-point Likert-type scale from 0 (*"very undescriptive"*) to 3 (*"very descriptive"*). The Affective Lability Scale has good reliability [37]. Sample items include: *"At times I have very little energy, then I have about the same energy level as most people;" "One minute I am feeling okay and the next I'm tense, jittery, and nervous;"* and *"Many times I feel very nervous and tense and then I suddenly feel very sad and down."* Internal consistency of the scale in the current sample was excellent ($\alpha = .95$).

Procedure

Participants were recruited from inpatient psychiatric units at a university medical center (study participation occurring post-discharge), local community mental health centers, and local newspaper and flier advertisements. Interested individuals completed informed consent procedures, followed by a diagnostic and psychosocial assessment conducted by experienced Bachelors- or Masters-level research assistants, with the exception of the Structured Interview for DSM-IV Personality and Mini International Neuropsychiatric Interview, which were administered by Masters- or Doctoral-level research staff. To be included in the clinical group for the larger study, individuals had to meet current diagnostic criteria for BPD on the Structured Interview for DSM-IV Personality [27]. To be included in the current analyses, individuals also had to report at least one lifetime Criterion A traumatic event on the Traumatic Life Events Questionnaire [26]. Exclusionary criteria for the larger study included a current psychotic disorder or active manic episode. Participants were not excluded for current suicidality or self-harming behaviors, but participants recruited from inpatient units were not able to participate until post-discharge. The study was approved by the Institutional Review Board at the University of Mississippi Medical Center, and all participants were compensated for their involvement in this study.

Data Analysis

Analyses were conducted in PASW Statistics 18.0. Procedures to assess the impact of a third variable on the relation between two related variables were followed [38]. First, zero-order relations were evaluated among the variables studied. Second, two hierarchical multiple regression analyses were conducted to evaluate whether PTSD total symptom severity was significantly related to the criterion variables of negative affect intensity and affective lability. Due to the previously documented relation between trauma exposure and affect dysregulation [20, 21], the covariate of number of Criterion A events was entered into level one of the regression equations in cases where it was associated with the outcome variable at the zero-order level, and BPD symptom severity and PTSD total symptom severity were entered simultaneously into level two. Third, two multiple regression analyses were conducted to examine PTSD symptom cluster-emotion vulnerability relations. Re-experiencing, avoidance, and hyperarousal symptom clusters were simultaneously entered as predictors in the regression equations. The criterion variables were negative affect intensity and affective lability. All tests were two-tailed with an alpha level set at .05.

Results

Reliability of BPD Diagnostic Interview, Descriptive Statistics, and Zero-Order Relations

BPD interviews were audiotaped to assess interrater reliability. A doctoral-level psychologist independently rated a random sample of audiotapes (20%) of the BPD interviews. The agreement between raters for the diagnosis of BPD was 100%. Ratings on

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the Structured Interview for DSM-IV Personality were compared by computing intraclass correlations. The results indicated a high degree of interrater reliability (.89).

See Table 2 for descriptive statistics and Pearson correlations for the variables studied. The covariate of number of Criterion A events was significantly positively related to both BPD symptom severity ($r = .26$, $p < .05$) and PTSD (total and symptom cluster) severity (rs = .37 – .48, ps < .01), as well as Affect Intensity Measure (Negative Affect subscale) scores ($r = .32$, $p < .01$). [Note: Given the lack of zero-order relation between number of Criterion A events and Affective Lability Scale scores, number of Criterion A events was not entered as a covariate in that regression analysis.] The predictor variables of BPD symptom severity and PTSD (total and symptom cluster) severity were significantly positively related (rs = .29 – .43, ps < .05). PTSD (total and symptom cluster) severity and BPD symptom severity were related to both criterion variables (negative affect intensity and affective lability; ps < .05).

PTSD Total Symptom Severity in Relation to Negative Affect Intensity and Affective Lability

See Table 3 for a summary of the regression results. With regard to negative affect intensity, the first regression model significantly predicted 21.8% of variance in Affect Intensity Measure (Negative Affect subscale) scores. Level one of the model (number of Criterion A events) accounted for a significant 10.0% of variance. Level two of the model accounted for an additional significant 11.8% of variance, with PTSD symptom severity, but not BPD symptom severity, being a significant predictor at that level.

With regard to affective lability, the second regression model significantly predicted 24.7% of variance in Affective Lability Scale scores, with PTSD symptom severity, but not BPD symptom severity, being a significant predictor at that level.

PTSD Symptom Clusters in Relation to Negative Affect Intensity and Affective Lability

See Table 4 for a summary of the regression results. In the model with PTSD symptom clusters as predictors of negative affect intensity, the model significantly predicted 21.2% of variance in Affect Intensity Measure (Negative Affect subscale) scores. Hyperarousal PTSD symptom severity was the only significant predictor in the model. In the model with PTSD symptom clusters as predictors of affective lability, the model significantly predicted 27.9% of variance in Affective Lability Scale scores. Re-experiencing PTSD symptom severity was the only significant predictor in the model.

Discussion

The current study investigated the relationship between PTSD total symptom severity, as well as symptom cluster severity, and emotion dysregulation (conceptualized as negative affect intensity and affective lability) among individuals meeting diagnostic criteria for BPD. Consistent with the first hypothesis, PTSD symptom severity, but not BPD symptom severity, was significantly related to emotion dysregulation. Specifically, when examined concurrently with BPD symptom severity (and controlling for number of Criterion A events for the outcome of negative affect intensity) greater levels of PTSD symptom severity were related to greater negative affect intensity and affective lability. These findings replicate and extend past work evidencing relations between PTSD symptoms and emotion dysregulation to a sample of individuals meeting criteria for BPD. The observed effects are particularly noteworthy, given that within a sample of individuals characterized by deficits in emotion regulation, PTSD symptoms were related to even greater levels of dysregulation not accounted for by variability in BPD symptoms.

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Results were partially consistent with the second hypothesis, that re-experiencing and hyperarousal PTSD symptoms would be significantly related to emotion dysregulation. Specifically, when the symptom clusters were examined concurrently, hyperarousal symptoms were significantly positively related to negative affect intensity, and re-experiencing symptoms were significantly positively related to affective lability. This pattern of findings extends past work suggesting that certain PTSD symptom clusters may correspond to distinct deficits in emotion regulation, such that re-experiencing/hyperarousal symptoms may be particularly relevant for emotion under-modulation [23, 24].

Taken together, the current findings suggest that PTSD symptom severity, particularly re-experiencing and hyperarousal symptoms, is related to greater emotion dysregulation among individuals with a diagnosis of BPD. It may be the case that treating PTSD via Prolonged Exposure therapy (a treatment specifically targeting re-experiencing and hyperarousal symptoms) [39] or Cognitive Processing Therapy [40] among individuals with BPD is indicated early in treatment in conjunction with an effective treatment for BPD, such as Dialectical Behavior Therapy [2] or Schema Focused Therapy [41], to facilitate improvements in emotion regulation. The literature provides some direct and indirect support for this notion. First, among non-BPD individuals in treatment for PTSD, PTSD symptom reduction over the course of treatment was related to improvements in emotion regulation [42]. Therefore, treating PTSD among individuals experiencing extreme levels of emotion dysregulation (i.e., those with a BPD diagnosis) may lead to substantial gains in both disorders. Second, Harned and Linehan [43] have provided preliminary evidence via two case studies that trauma-focused exposure therapy may be used safely and effectively among patients with co-occurring BPD and PTSD in conjunction with Dialectical Behavior Therapy. In both cases, PTSD symptoms markedly improved, and in one case, PTSD symptom improvement was associated with BPD symptom improvement. It is important to note that the patients in this case series received Dialectical Behavior Therapy skills prior to and concurrent with PTSD treatment; therefore, the effects of PTSD treatment prior to provision of BPD treatment, or at the onset of BPD treatment as a concurrent treatment, are not known. Third, there is some, albeit limited, evidence that treatment of Axis I conditions does, in fact, have positive effects on Axis II symptoms. Specifically, Hofmann and colleagues [44] found that treating panic disorder predicted reductions in a variety of Axis II characteristics. It is important for future work to address similar processes among individuals suffering from co-occurring BPD and PTSD. Finally, emerging evidence indicates that PTSD may be treated concurrently with other disorders (e.g., substance use disorders); PTSD treatment is related to improvements in co-occurring pathology [45, 46, 47, 48, 49]; and individuals with BPD characteristics are equally likely to complete and benefit from PTSD treatment [50]. Therefore, it is possible that PTSD may be successfully addressed early in BPD treatment. The field would greatly benefit from investigations of PTSD treatment that occurs during the course of BPD treatment versus that which occurs following emotion regulation training. Related to this point, the field would also benefit from studies identifying those BPD-PTSD patients who might safely benefit from trauma-focused therapy prior to or concurrent with emotion regulation training and those patients who may indeed need the installation of emotion regulation skills to safely benefit from PTSD treatment (see Harned and Linehan [43] for a discussion of clinical decision-making when attempting to implement PTSD treatment in patients with co-occurring BPD and PTSD). Similarly, it is not known whether certain individual difference variables would influence PTSD treatment outcomes among individuals early in their treatment of BPD. Extensive work is necessary to understand the optimal clinical strategy in treating individuals with these co-occurring pathologies.

There are limitations of the current study that warrant attention. First, the data presented are cross-sectional; therefore, causality and temporal relations of the variables studied cannot be

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determined. That is, it is currently not clear whether PTSD leads to greater emotion dysregulation among individuals with BPD or whether individuals with greater emotion dysregulation pre-trauma exposure are more likely to develop PTSD. Future work investigating such relations would be useful in terms of better understanding an overall model of emotion dysregulation in BPD with co-occurring PTSD. Second, the current study relied on self-report of two facets of emotion dysregulation (i.e., negative affect intensity and affective lability). Future work would benefit from replicating and expanding the current findings using additional methodologies and measurement techniques (e.g., laboratory paradigms of emotion regulation). Third, given that participants in the current study were required to meet criteria for BPD (i.e., endorse 5 items on the Structured Interview for DSM-IV Personality as 2 or greater in severity), the variable of BPD symptom severity necessarily evidenced a truncated range (i.e., observed range of 11 – 27). It is likely that BPD symptom severity in a sample with a complete Structured Interview for DSM-IV Personality range would be related to emotion dysregulation in the context of PTSD symptoms, and the relationship between PTSD symptoms and emotion dysregulation observed in the current study is above and beyond the emotion dysregulation inherent in a BPD diagnosis. Future work is needed to determine relations among BPD symptom severity, PTSD symptom severity, and emotion dysregulation in non-BPD samples. Fourth, the current sample consisted primarily of female participants, which did not allow for the study of possible sex differences. Future work would benefit from recruiting mixed samples and investigating potential sex and gender differences in emotion dysregulation within these populations. Fifth, it is currently unclear whether certain measures of emotion dysregulation are more relevant for BPD versus PTSD. Future work would benefit from examining a diverse range of emotion dysregulation measures and constructs in relation to symptoms of both disorders. Finally, the current study assessed traumatic event exposure and PTSD symptom severity using self-report measures. Future work would benefit from the use of structured clinical interviews.

In sum, the current findings indicated that individuals with a BPD diagnosis and co-occurring PTSD symptoms (particularly re-experiencing and hyperarousal symptoms) experience elevated emotion dysregulation. Early treatment of PTSD among individuals in BPD treatment may lead to greater overall improvements in emotion regulation.

Acknowledgments

This research was supported, in part, by National Institute of Mental Health grant MH069627 (PI: Coffey).

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Table 1

Sample characteristics of participants with borderline personality disorder (*n*=67)

Variable	Mean or %	SD
Sex (% Female)	79%	
Age (Years)	38	10
Race/Ethnicity (%)		
White/Caucasian	76%	
Black/African American	19%	
Other	5%	
Marital Status		
Married/Co-habitating	22%	
Divorced	33%	
Separated/Widowed	18%	
Never Married	27%	
Last Grade Completed (%)		
Less than HS degree	15%	
Graduated HS/GED	30%	
Post-HS	48%	
Completed graduate/professional school	8%	
Current Employment Status (%)		
Unemployed	64%	
Full-time student/Homemaker	11%	
Employed part-time	9%	
Employed full-time	15%	
Retired	1%	
Gross income for past year	19,922	18,367
Current Psychiatric Diagnoses		
Current substance use disorder diagnosis	39%	
Panic Disorder	25%	
Social Anxiety Disorder	38%	
Obsessive-Compulsive Disorder	30%	
Posttraumatic Stress Disorder	69%	
Generalized Anxiety Disorder	42%	
Bulimia Nervosa	11%	
Number non-substance use disorder Axis I diagnoses	3	2
Number of Self-Harm Incidents (Past 12 months)	15	86
Number of Suicide Attempts (Past 12 months)	1	1

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Table 2

Descriptive statistics and zero-order correlations (n=67)

Variable	1	2	3	4	5	6	7	Mean	SD	Observed Range	Possible Range
1. Number of Traumas	1							8.1	4.3	1 – 18	--
2. BPD Symptom Severity	.26*	1						18.5	3.9	11 – 27	0 – 27
3. PTSD Symptom Severity	.47**	.43**	1					55.0	14.6	22 – 84	17 – 85
4. Re-experiencing Symptoms	.48**	.29*	.85**	1				15.5	5.4	5 – 25	5 – 25
5. Avoidance Symptoms	.37**	.42**	.85**	.56**	1			21.9	6.6	7 – 35	7 – 35
6. Hyperarousal Symptoms	.34**	.36**	.83**	.63**	.53**	1		17.6	5.2	5 – 25	5 – 25
7. Negative Affect Intensity	.32**	.30*	.43**	.39**	.30*	.44**	1	4.4	.8	2.92 – 6.00	1 – 6
8. Affective Lability	.06	.24*	.50**	.52**	.35**	.40**	.22	2.0	.5	.63 – 2.94	0 – 3

Note:

* $p < .05$,

** $p < .01$;

Number of Traumas = Number of Criterion A events endorsed on the Traumatic Life Events Questionnaire [26]; *BPD Symptom Severity* = Structured Interview for DSM-IV Personality – Borderline Personality Disorder symptom severity total [27]; *PTSD Symptom Severity* = PTSD Checklist – Civilian Version for DSM-IV; *Re-experiencing Symptoms* = Re-experiencing Symptom Subscale of PCL; *Avoidance Symptoms* = Avoidance Symptom Subscale of PCL; *Hyperarousal Symptoms* = Hyperarousal Symptom Subscale of PCL [32]; *Negative Affect Intensity* = Affect Intensity Measure – Negative Affect subscale mean [36]; *Affective Lability* = Affective Lability Scale – total score mean [37].

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Table 3

PTSD total symptom severity in relation to negative affect intensity and affective lability in participants with borderline personality disorder (*n*=67)

	F	R^2	t	β	sr^2
Criterion Variable: Negative Affect Intensity	5.86**	.22			
Level 1		.10**			
Number of Traumas			2.68**	.32	.10
Level 2		.12*			
Number of Traumas			1.07	.14	.01
BPD Symptom Severity			1.04	.13	.01
PTSD Symptom Severity			2.34*	.32	.07
Criterion Variable: Affective Lability	10.49**	.25			
BPD Symptom Severity			.28	.03	.00
PTSD Symptom Severity			4.01**	.48	.19

Note:

* $p < .05$,

** $p < .01$;

Negative Affect Intensity = Affect Intensity Measure – Negative Affect subscale mean [36]; *Number of Traumas* = Number of Criterion A events endorsed on the Traumatic Life Events Questionnaire [26]; *BPD Symptom Severity* = Structured Interview for DSM-IV Personality – Borderline Personality Disorder symptom severity total [27]; *PTSD total Symptom Severity* = PTSD Checklist – Civilian Version for DSM-IV [32]; *Affective Lability* = Affective Lability Scale – total score mean [37].

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Table 4

PTSD Symptom Clusters in Relation to Negative Affect Intensity and Affective Lability in participants with borderline personality disorder (*n*=67)

	F	R^2	t	β	sr^2
Criterion Variable: Negative Affect Intensity	5.65**	.21			
Re-experiencing Symptoms			1.13	.17	.02
Avoidance Symptoms			.23	.04	.00
Hyperarousal Symptoms			2.04*	.31	.05
Criterion Variable: Affective Lability	8.11**	.28			
Re-experiencing Symptoms			2.79**	.41	.09
Avoidance Symptoms			.49	.07	.00
Hyperarousal Symptoms			.74	.11	.01

Note:

* $p < .05$,

** $p < .01$;

Negative Affect Intensity = Affect Intensity Measure – Negative Affect subscale [36]; *Re-experiencing Symptoms* = Re-experiencing Symptom Subscale of PTSD Checklist – Civilian Version for DSM-IV (PCL); *Avoidance Symptoms* = Avoidance Symptom Subscale of PCL; *Hyperarousal Symptoms* = Hyperarousal Symptom Subscale of PCL [32]; *Affective Lability* = Affective Lability Scale – total score [37].