



Dialectical Behavior Therapy for Individuals Living with Borderline Personality Disorder and Substance Use Disorder

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Webinar Objectives

- Name three observed differences in those with Borderline Personality Disorder (BPD) and substance use disorder (SUD) compared to persons with BPD without SUD.
- Define Dialectical Abstinence
- Generate two examples of attachment strategies



Dialectical Behavior Therapy (DBT)

DBT is a highly efficacious treatment developed by Marsha M. Linehan, PhD, for multiple diagnoses and disorders with pervasive emotion dysregulation. DBT was originally developed for individuals with BPD who are complex and challenging to treat.

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What is Borderline Personality Disorder (BPD) ?

BPD is one among several personality disorders (e.g., narcissistic personality disorder, paranoid personality disorder, antisocial personality disorder). According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), personality disorders are generally characterized by:

- entrenched patterns of behavior that deviate significantly from the usual expectations of behavior and the individual's culture
- behavior patterns that are pervasive, inflexible, and resistant to change.

American Psychiatric Association (2013)

What is Borderline Personality Disorder (BPD)?

- emergence of the disorder's features no later than early adulthood (unlike depression, for example, which can begin at any age).
- lack of awareness that behavior patterns and personality characteristics are problematic or that they differ from those of other individuals.
- distress and impairment in one or more areas of person's life (often only after other people get upset about his or her behavior).
- behavior patterns that are not better accounted for by the effects of substance abuse, medication, or some other mental disorder or medical condition (e.g., head injury).

American Psychiatric Association (2013)

DSM-5 BPD Criteria include

- intense fear of abandonment and efforts to avoid abandonment (real or imagined).
- turbulent, erratic, and intense relationships that often involve vacillating perceptions of others (from extremely positive to extremely negative).
- lack of a sense of self or an unstable sense of self.
- impulsive acts that can be hurtful to oneself (e.g., excessive spending, reckless driving, risky sex).

American Psychiatric Association (2013)

DSM-5 BPD Criteria include

- repeated suicidal behavior or gestures or self-mutilating behavior.
- chronic feelings of emptiness.
- episodes of intense (and sometimes inappropriate) anger or difficulty controlling anger (e.g., repeated physical fights, inappropriate displays of anger).
- temporary feelings of paranoia (often stress-related) or severe dissociative symptoms (e.g., feeling detached from oneself, trancelike).

American Psychiatric Association (2013)

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BPD is a Complex and Serious Mental Health Disorder that:

- is often misunderstood and misdiagnosed
- usually have a history of childhood trauma (e.g., physical or sexual abuse, neglect, early parental loss)
- developed BPD symptoms as a way to cope with childhood trauma
- symptoms overlap with those of several other DSM-5 diagnoses, such as bipolar disorder and post traumatic stress disorder (PTSD).

American Psychiatric Association (2013)

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BPD is a Complex and Serious Mental Health Disorder that :

- should be diagnosed by a licensed and experienced mental health professional (whose scope of practice includes diagnosing mental disorders) and then only after a thorough assessment over time.

American Psychiatric Association (2013)

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BPD Criteria Reorganized

Emotion Dysregulation

- Affective lability
- Problems with angers

Interpersonal Dysregulation

- Chaotic relationships
- Fears of abandonment

Self Dysregulation

- Identity disturbance/difficulties with sense of self/sense of emptiness

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BPD Criteria Reorganized

Behavioral Dysregulation

- Suicidal behaviors
- Impulsive behaviors

Cognitive Dysregulation

- Dissociative responses, paranoid ideation

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Prevalence Rate

- Borderline Personality Disorder (BPD) general population:
 - ✓ approximately 2.7% (Kienast, T., Stoffers, J., Bempohl, F., & Lieb, K. 2014)
- BPD in Substance Use Disorder (SUD) populations (Trull, et al., 2000):
 - ✓ 9% in community samples
 - ✓ 9% - 65% in treatment samples
- Opiate addiction
 - ✓ 9.5% (Brooner, et al., 1997) to 12% (Kosten, et al., 1989)

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Among Individuals Seeking Treatment for BPD

- 21% of clinical population of BPD also had a primary substance abuse diagnosis (Koenigsberg et al, 1985).
- 23% of those with BPD met lifetime criteria for substance abuse (Links, et al., 1988).
- 67% with BPD met criteria for a substance use disorder. When substance abuse was not used as a criterion of BPD, the incidence dropped to 57% (Dulit et al., 1990).

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Longitudinal Data on BPD and SUD (Stone, 2010)

BPD Suicide rate = 9%, typically during mid-20's to early 30's

- **Increases to 38% if alcoholic and not in Alcohol Anonymous (AA)** CC158

Best outcomes:

- Artistic talent, high IQ (over 130), conventionally attractive, good sense of self-discipline (self-management)
- **Abstinence from alcohol and drugs**

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Longitudinal Data on BPD and SUD (Stone, 2010)

Poorest outcomes

- **Trauma:** Transgenerational incest, history of rape, cruel parent
- At least one night in jail
- Antisocial features
- In men, eloped from hospital

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Treatment Challenges for Serving Persons with Co-Occurring SUD and BPD

(Pennay, et al., 2011 Review)

- Higher rates of:
 - Psychosocial impairment
 - Substance Abuse
 - Suicidal behavior, including non-suicidal self-harm
 - Non-compliance
 - Relapse
- More severe psychopathology
- Poorer treatment outcomes

Link, et al., 1995; Stone, 1990.

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Challenging Combination
BPD + Substance Use/Disorder
Links et al., 1995; Stone, 1990

BPD + SUD

>

BPD only or SUD only

- Psychological Problems/Severity
- Suicide Risk / Suicidal Behaviors

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Implications for Treatment

Treatment Goal

Abstinence

+

Functionality

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Individuals with co-occurring disorders. . . .while ALSO addressing higher-order treatment targets while **building resiliency and** a life worth living.
(Think **functionality**).

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Why Apply DBT?

- Enhanced Skills Training (EST) for individuals with severe, complex multiple disorders.
- Applies principles of effective compassion (important for marginalized group)
- Offers a **BIG HOUSE** in which to embed other evidence based principles & procedures.
- Structures up the treatment environment

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Observed Differences: SUD+BPD vs. Suicidal + BPD

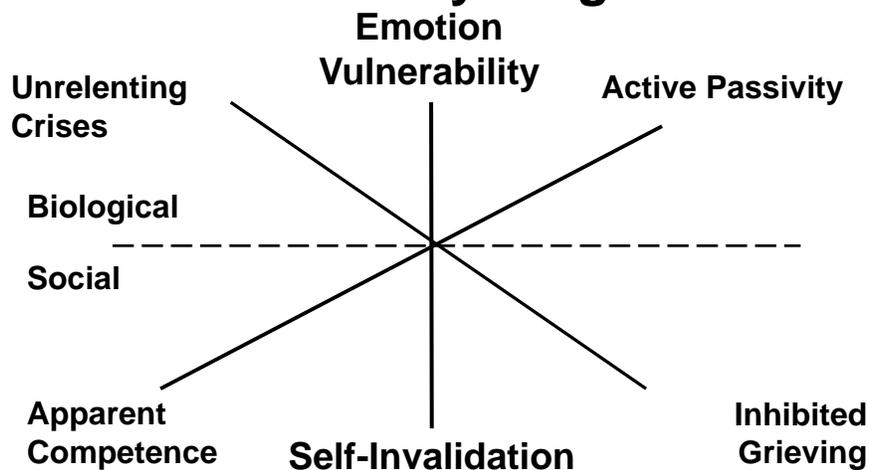
- High avoidance of cues associated with negative affect.
- Regulate emotions via quick acting drugs (vs. interpersonal interactions).
- Frequently fall out of contact with primary therapist.
- Therapist more prone to feeling demoralized and apathetic.
- Far fewer positive social supports to rely on.

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Change in Emphasis in Secondary Targets



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BPD + SUD: Dialectical Dilemmas

Emotion Vulnerability

- Fear of “The Abyss”
- “I’ll never get out!”
- “I can’t stand/tolerate this pain.”

Self-Invalidation

- **Fatally-flawed**; self-loathing: “I shouldn’t be this way” or “I’m disgusting! Look at me!”
- **Identity of individuals with drug use disorder**; seeking out drug user community as self-verification.
- **Denial of severity of problem**; oversimplification and/or unrealistic judgment: “I’ll never do this again!” or “I can be perfect today.”

Who is DBT-SUD For?

Individuals with co-occurring disorders with severe, complex problems and PDs

- NIDA 1/UW: Poly-substance dependent
- NIDA 3/UW: Heroin Dependent (many poly)
- NIDA 5/UW: Heroin Dependent (many poly)
- Amsterdam: Alcohol and/or drug dependent



**TIP: Recovery is a
PROCESS, not an end-
point.**



G. Alan Marlatt,
PhD

*As a process, may involve slips,
lapses, and at times what appears to
be worsening.*

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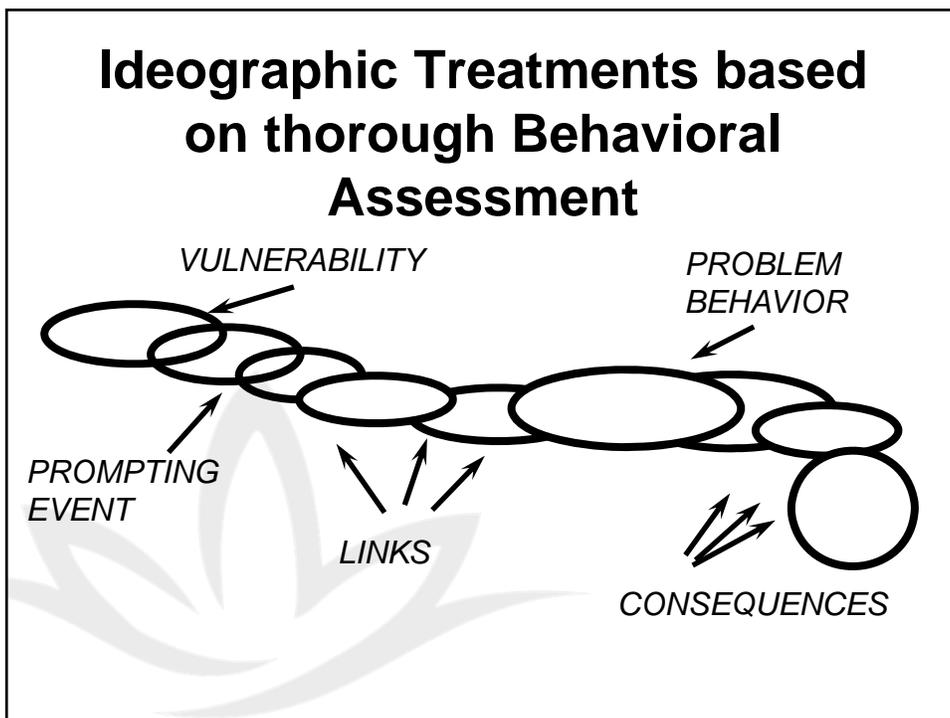
Reframing **“Relapse”** and
slips as **“Prolapse”**



Three Strikes and You're Closer to Your *Ultimate* Goal(s)



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DBT & Motivational Interviewing: Preparing the Ground For Change

Motivational Interviewing

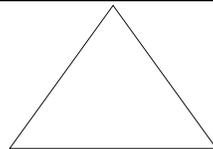
- Psychological Judo
- Self-Motivational Statements
- Non-confrontational

DBT

- Extending
- Playing Devil's Advocate
- Behaviorally confrontational

DBT-SUD shares a lot in common with 12-Step Programs

Change

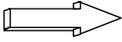


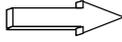
Accept

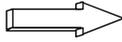
DBT & 12-Step Programs	
12-Step	DBT
<ul style="list-style-type: none">• Serenity Prayer• Includes problem-solving/social learning components• Repair harm caused to others (<i>Making Amends</i>)• Acknowledge nature of addiction• Focus on abstinence	<ul style="list-style-type: none">• Primary Dialectic: Change vs. Acceptance• Explicit use of problem-solving/social learning approach• Correction/Over-Correction• Acknowledge prior history of abuse• Focus on abstinence

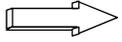
DBT-SUD Specific Treatment Agreements
<ul style="list-style-type: none">• Get off of all illegal drugs;• Don't sell drugs to other people in the program;• Have to appear to the astute observer (including other individuals who misuse/abuse drugs) that they are not on drugs when at the clinic;• Take replacement medications and UA three times weekly...
<p>32</p> 

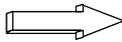
Stages of Treatment

Pre-Treatment:  Commitment and Agreement

Stage 1: Severe Behavioral Dyscontrol
 **Behavioral Control**

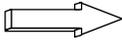
Stage 2: Quiet Desperation
 **Emotional Experiencing**

Stage 3: Problems in Living
 **Ordinary Happiness /Unhappiness**

Stage 4: Incompleteness
 **Capacity for Joy and Freedom**

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Primary Targets Dialectical Synthesis

Pre-Treatment:  Commitment & Agreement

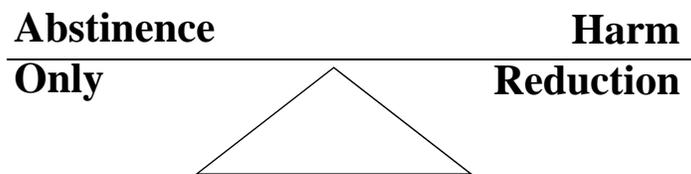
- Decrease
 - Life-threatening behaviors
 - Therapy-interfering behaviors
 - Quality-of-life interfering behaviors
- Increase behavioral skills using DBT skills (Mindfulness, Distress Tolerance, Emotion Regulation, & Interpersonal Effectiveness) as well as other behavioral skills.

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Path to Clear Mind

- Decrease **Substance Abuse**
- Decrease **Physical Discomfort** from Abstaining
- Decrease **Urges and Cravings** to use substances
- Decrease the **Options, Contacts, Cues** to use substances
- Decrease **Capitulating** to using substances
- Increase **Community Reinforcement** of functional behaviors

DBT: Dialectical Abstinence Model



Polarities in Substance Abuse Treatment

Abstinence Only Model

vs.

Harm Reduction Model

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The Abstinence Model

Pros

- Increased length of time to use

Cons

- Abstinence Violation Effect
- Deficient attention to capacities for coping with failures of self-control

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Abstinence Violation Effect

- Causal attributions
 - Internal
 - Stable
 - Global
- Negative affective experiences
- Factors thought to increase AVE
 - degree of commitment to the goal
 - effort exerted
 - time spent maintaining goal
 - value associated with progress

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The Harm Reduction Model

Pros

- Focus on teaching moderation skills => resuming goals more quickly after a slip; relapse is not as long or harmful.

Cons

- Moderation Effect: If you expect that using is not so bad, you'll use => less time to drug use.

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Dialectical Abstinence Model

Total Abstinence =

Before Use &
“Only-in-the-moment”

Harm Reduction =

After Use &
“Only-in-the-Moment”

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Total Abstinence

(“Only-in-the-Moment-before-Use”)

- “Turning the Mind” completely for the time you can be certain of.
- Repetitive “Turning of the Mind”.
- Radical Acceptance that ANY use ==> DISASTER!
- Denial of any Option to Use.

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Total Abstinence

(“Only-in-the-Moment-before-Use”)

- “Inner deal” that commitment is only until it’s remade.
- Option to use left open for in the future.
- Promise of use at death.

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Harm Reduction

- Teaching of “what if” and “just in case” skills (e.g., emergency preparedness drill).
- Teaching the concept of learning to “fail well.”
- Monitoring of use and immediate chain analysis and problem-solving of use.
- Radical acceptance that use does NOT equal disaster.

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DBT Synthesis Summary Dialectical Abstinance

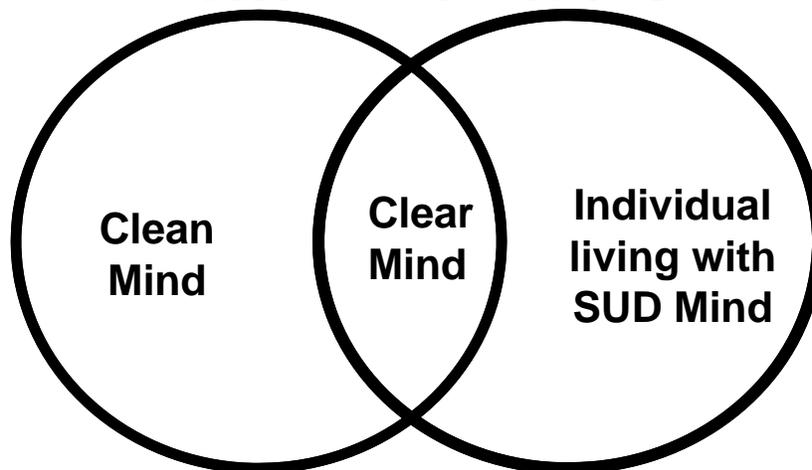
- Explicit (“front-of-the-mind” expectations vs. implicit (“back-of-the-mind) relapse planning.
- “Touchdown Every Time Mentality” vs. “Winning Isn’t Everything” mentality.
- Balances total abstinence with harm reduction.

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Sustained Recovery Requires Clear Mind Actions



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Attachment Strategies

DBT assumes that engaging reluctant individuals in treatment is a therapeutic task for the DBT therapist

(as opposed to an individual requirement before starting treatment)

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Self-Reporting vs. Drug Screening

- Weekly, ideally 3 times weekly
- Use reliable method
- Check primary drug of use on regular basis and periodic checks for other drugs at random
- Ideally YOU and THEY receive test results right away.
- Replacement medication dosing is not contingent on negative drug screen.

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DBT Skills for SUDs

- Burning Bridges
or “Cutting off your substance use options to keep your options for a hope for Recovery”
- Urge Surfing
- Adaptive Denial
- Alternate Rebellion
- Building Structure & a Life Worth Living
- Avoiding | Eliminating Cues to Use

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Additional Skills for Individuals with BPD-SUD

- **+1 Rule** (Julie Brown, PhD)
 - Assess Emotion Intensity: 0 – 5
 - Add 1 to your number
 - That’s how many skills you need to get through hard situation.
- **5 Minute Rule**
 - Make inner commitment to not use for ONLY five minutes.
 - Make another commitment for another 5 minutes at end of initial 5 to get through high risk situation.

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TIPP Skills

When You are Too Distressed to Figure Out a Better Skill

- Temperature
- Intense Exercise
- Progressive Muscle Relaxation
- Paced Breathing

SAMHSA (2014)

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QUESTIONS?

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CCI146
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