High Prevalence of BPD Among SUD Population

- BPD in general population: Approximately 5% (Grant, 2008, NIAAA).
  - 9% in community samples
  - 9% - 65% in treatment samples
- Opiate addiction
  - 9.5% (Brooner, et al., 1997) to 12% (Kosten, et al., 1989)

Among Patients 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% (Dullit et al., 1990).
Troublesome Combination
BPD + Substance Abuse/Dependence
Links et al., 1995; Stone, 1990

**BPD + SUD**

**BPD only or SUD only**
- Psychological Problems/Severity
- Suicide Risk / Suicidal Behaviors

Longitudinal Data on BPD and SUD (Stone, 2010)

<table>
<thead>
<tr>
<th>BPD Suicide rate</th>
<th>9%, typically during mid-20’s to early 30’s</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Increases to 38% if alcoholic and not in AA</td>
</tr>
<tr>
<td>Best outcomes</td>
<td>Artistic talent, high IQ (over 130), conventionally attractive, good sense of self-discipline (self-management)</td>
</tr>
<tr>
<td></td>
<td>Abstinence from alcohol and drugs</td>
</tr>
<tr>
<td>Poorest outcomes</td>
<td>Trauma: Transgenerational incest, history of rape, cruel parent</td>
</tr>
<tr>
<td></td>
<td>At least one night in jail</td>
</tr>
<tr>
<td></td>
<td>Antisocial features</td>
</tr>
<tr>
<td></td>
<td>In men, eloped from hospital</td>
</tr>
</tbody>
</table>

The Solution

? Sadely, one did not exist.
NIDA’s Question:
Will DBT work for drug dependent people with BPD?

Marsha’s Question:
What if anything will I have to change to make it work?

Why Apply DBT?
• Established behavioral EST for multi-disordered, severe, complex patients with emotion-based problems.
• Applies principles of effective compassion
• Offers a BIG HOUSE in which to embed other evidence based principles & procedures.
• Structures up the treatment environment

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.
**Essence of DBT-SUD**

Abstinence (mostly) + Functionality

**Primary Modifications**

- Dialectical approach to abstinence
- DBT Path to Clear Mind
- Encourage Quick Reengagement in functional activities (e.g., work, school)
- Attachment strategies (to treat “butterflies”)
- Replacement medications when available, provided in non-contingent fashion
- Routine drug testing

**Practice Dialectical Abstinence Model**

[Diagram showing abstinence and harm reduction]
**Dialectical Abstinence Model**

Total Abstinence =
- Before Use &
  - "Only-in-the-moment"

Harm Reduction =
- After Use &
  - "Only-in-the-Moment"

---

**Staying Off Drugs Requires Clear Mind Actions & Skills!**

- **Clean Mind**
- **Addict Mind**

---

**Stage 1 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.
Path to Clear Mind

- Decrease SUBSTANCE ABUSE
- Decrease PHYSICAL DISCOMFORT from Abstaining
- Decrease URGES AND CRAVINGS TO USE DRUGS
- Decrease the OPTIONS, CONTACTS, AND CUES TO USE DRUGS
- Decrease CAPITULATING TO USE DRUGS
- Increase COMMUNITY REINFORCEMENT OF "CLEAR MIND" Behaviors

Attachment Strategies

DBT assumes that engaging reluctant clients in treatment is a therapeutic task for the DBT therapist
(as opposed to a client requirement before starting treatment)

DBT Skills for SUDs Part 1 of 2

- Burning Bridges
  or “Cutting off your (drug use) options to keep your options for a decent life open”
- Urge Surfing
- Adaptive Denial
DBT Skills for SUDs  Part 2 of 2

• Alternate Rebellion (satisfying the wish to rebel without destroying your life)
• Avoiding & Eliminating Cues to Use
• Building a Life Worth Living

Who is DBT-SUD For?

Multi-disordered, substance-dependent individuals 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

Randomized Controlled Trial

DBT vs. Treatment-as-Usual
With BPD Substance Abusers

University of Washington
Linehan, Schmidt, Kanter, Craft, Dimeff, Comtois, McDavid, 1999
Initial Findings
DBT < TAU

- Drug use
- Drop out
- DBT > TAU (at 16 month)
- Global Adjustment
- Social Adjustment
- DBT gains continued at follow-up

Randomized Controlled Trial
DBT vs. Comprehensive Validation (1 Year) with BPD Heroin Addicts

University of Washington
Linehan, Dimeff, Comtois, McDavid, & Kivlahan

Treatment Conditions

<table>
<thead>
<tr>
<th>DBT</th>
<th>CVT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Therapy</td>
<td>Individual Therapy</td>
</tr>
<tr>
<td>Group Skills</td>
<td>NA 12&amp;12 Group</td>
</tr>
<tr>
<td>Training</td>
<td>NA 12&amp;12 Sponsor</td>
</tr>
<tr>
<td>Homework Review</td>
<td>Crisis Intervention</td>
</tr>
<tr>
<td>Phone Coaching</td>
<td>Therapist Consult Meeting</td>
</tr>
<tr>
<td>Therapist Consult Meeting</td>
<td>Drug-Replacement</td>
</tr>
</tbody>
</table>
DBT vs. CVT+12S: ns
Pre-treatment > 12-month
• Drug Use, Self-Report
• Brief Symptom Inventory
• Global Adjustment
• Social Adjustment

However...
• Treatment retention in CVT is outrageous (0% drop-outs compared to 36% in DBT)
• Reductions in opiate use trend toward significant by 16 months favoring DBT (27% vs. 33% positive).

Dialectical Behavior Therapy of borderline patients with and without substance use problems: Implementation and long term effects
Amsterdam Institute for Addiction Research (AIAR)
University of Amsterdam (UvA)
Forensic Psychiatric Hospital ‘Oldenkotte’
vander Bosch, Verheul, et al, 2002
Summary of Findings:
Results on BPD and SUD (12 and 18 months)

- DBT > TAU  Treatment Retention (63% vs. 23%)
- DBT < TAU  self-mutilating & self-damaging impulsive acts, ESPECIALLY among those with higher baseline frequency
- Standard DBT has a beneficial impact on alcohol problems, but not on drugs problems

NIDA 5 Multi-Site Study:
DBT vs. IGDC

- Dialectical Behavior Therapy (DBT)
  - Individual Psychotherapy
  - Group Skills Training
  - Team Consultation Meeting
  - Telephone Contact
- Individual & Group Drug Counseling (IGDC)
  - Individual Counseling
  - Group Counseling
  - Team Consultation Meeting
  - Telephone Contact

Designed to control for:

1. Hours of individual & group therapy
2. Hours of team-based case consultation
3. Availability of between-session phone contact
4. Provider-expertise and experience
5. Provider allegiance
6. Availability of treatment and assistance connecting with assigned provider
7. Opiate replacement medication and medication management
IGDC Treatment Summary

- EST published on NIDA website
- Endorses a disease philosophy of addiction and holds a spiritual element to recovery
- Treatment goal is abstinence and recovery
- Individual counseling
  - focuses on behavioral change, 12-step ideology and tools for recovery, and self-help participation
- Group counseling
  - emphasizes psychoeducation on addiction and skills for recovery
  - encourages giving and receiving support from group peers

Subject Criteria (N=125)

- Inclusion Criteria
  - Men and women 18 years+ (Men = 52% of sample)
  - BPD diagnosis by IPDE and SCID-II
  - Opiate dependence diagnosis by SCID-I (as primary drug of abuse)
  - Reside within commuting distance to treatment
  - Consent to outpatient treatment for drug addiction
- Exclusion Criteria
  - Bipolar disorder, schizophrenia, or other psychotic disorder
  - Other diagnosis requiring priority treatment
  - Court ordered to treatment
  - Street homelessness
  - Refusal to discontinue current treatment (including medications)
  - Not medically cleared for or unable to tolerate suboxone
  - IQ < 70

NIDA 5: Preliminary 12-Month Outcomes

- DBT < IGDC
  - Decreasing Other Drug Use

- DBT > TAU (starting at 7 months)
  - Improving depression
  - Improving anxiety
SUMMARY

- BPD-SUD people who receive a highly structured treatment (e.g., DBT, CVT, or IGDC) are likely to improve. (NICE Guidelines)
- DBT is more effective at retaining clients in treatment compared to other tested approaches.
- DBT is more effective than others in treating MH problems, and as good, if not better, than other approaches in treating SUDS.
- More work is needed to improve DBT as a treatment for SUD.

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