Dialectical Behavior Therapy of borderline patients with and without substance use problems: Implementation and long term effects

L.M.C. Van den Bosch

- Amsterdam Institute for Addiction Research (AIAR)
- Academic Medical Center - University of Amsterdam (AMC-UvA)
  - Substance Abuse Treatment Center ‘De Jellinek’
  - Forensic Psychiatric Hospital ‘Oldenkotte’
Research group efficacy study
Amsterdam Institute for Addiction Research

- Wim van den Brink  Principal Investigator (PI)
- Louisa M.C. van den Bosch  Co-PI, leader of research project
- Roel Verheul  Co-PI
- Eveline A. Rietdijk  Graduate research assistant
- Wijnand van der Vlist  Graduate research assistant
- Maarten W.J. Koeter  Statistician
- Maria A.J. de Ridder  Consultant
- Theo Stijnen  Consultant
Background

• High prevalence of BPD, both in psychiatric AND substance abuse samples

• Some support for Dialectical Behavior Therapy (DBT), but substance abuse is exclusion criterion

• Rigid separated treatment programs for substance abuse and BPD
Situation of BPD-SUD patients

Addiction Centers
- SUD female patients
  with comorbid BPD
- Many other problems
- Frequent Crisis
- Treatment of Substance abuse
- ‘Revolving Door’
  Patients

Mental health Care
- BPD female patients
  with comorbid SUD
- Many other problems
- Frequent Crisis
- Treatment of (para)
  suicidal behaviour
- ‘Revolving Door’
  Patients
Criteria for pilot group

• **Inclusion criteria**
  ◆ BPD primary diagnosis (Substance dependence or abuse not excluded)
  ◆ Female gender
  ◆ Agreement with treatment conditions
  ◆ Recent parasuicide

• **Exclusion criteria**
  ◆ Chronic psychosis
  ◆ Bipolar disorder
  ◆ Mental retardation
Results of pilot study

• No suicide
• Enthusiastic patients (although a drop-out rate of 30%)
• Enthusiastic therapists

therefore

Start of treatment program and research program
Study description: Aims

• To replicate Prof. Linehan’s original study

• To investigate the efficacy of DBT for female BPD patients with comorbid SUD

• To investigate the impact of the level of base-line severity of BPD problems on the efficacy of DBT
Treatment conditions

- **TAU:**
  - ongoing outpatient treatment from original referral source
  - N=31: N=11 addiction center, N=20 CMHC

- **DBT:**
  - 1 year - according to manual (Linehan 1993)
  - 27 patients divided over 3 groups of 8-10 patients
  - N=27: N=8 addiction center, N=19 CMHC

- **Therapists:**
  - Individual: psychiatrists & clinical psychologists
  - Group: social workers & clinical psychologists
# Patient characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>DBT</th>
<th>TAU</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never married</td>
<td>56%</td>
<td>68%</td>
<td>62%</td>
</tr>
<tr>
<td>No work</td>
<td>82%</td>
<td>77%</td>
<td>80%</td>
</tr>
<tr>
<td>Age</td>
<td>35.1±8.2</td>
<td>34.7±7.4</td>
<td>34.9±7.7</td>
</tr>
<tr>
<td># BPD criteria</td>
<td>7.3±1.3</td>
<td>7.3±1.3</td>
<td>7.3±1.3</td>
</tr>
<tr>
<td>Suicide attempt ever</td>
<td>70%</td>
<td>71%</td>
<td>71%</td>
</tr>
<tr>
<td>Self-mutiliation ever</td>
<td>93%</td>
<td>94%</td>
<td>93%</td>
</tr>
<tr>
<td>Lifetime # acts (med)</td>
<td>13.1</td>
<td>14.4</td>
<td>14.2</td>
</tr>
</tbody>
</table>
Variation in Substance Abuse behavior among the participants

EuropASI  \( N = 58 \)  

<table>
<thead>
<tr>
<th>Substance</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis</td>
<td>30%</td>
<td>9</td>
</tr>
<tr>
<td>Heroin</td>
<td>9%</td>
<td>3</td>
</tr>
<tr>
<td>Cocain</td>
<td>17%</td>
<td>5</td>
</tr>
<tr>
<td>Methadone</td>
<td>13%</td>
<td>4</td>
</tr>
<tr>
<td>Alcohol</td>
<td>50%</td>
<td>15</td>
</tr>
<tr>
<td>Medication (sedatives)</td>
<td>64%</td>
<td>19</td>
</tr>
<tr>
<td>Poly drug abuse</td>
<td>56%</td>
<td>17</td>
</tr>
</tbody>
</table>

Average number of years of SA: 7.6
Average number of treatments: 4
Summary of findings: Results on BPD symptomatology and SUD (12 and 18 months)

1. DBT → better treatment retention (63% vs. 23%)
2. DBT → greater reductions of self-mutilating & self-damaging impulsive acts, ESPECIALLY among those with higher baseline frequency
3. Standard DBT has a beneficial impact on alcohol problems, but not on drugs problems

but

after one year of treatment (DBT), treatment needs to be continued in order to sustain the effect

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Conclusions

• The AIAR-DBT study supports the conclusion that DBT is efficacious in reducing high-risk behaviour with chronic parasuicidal BPD patients, even when they have co morbid (alcohol) substance abuse problems.

• DBT keeps patients alive, stabilizes them and thereby creates the possibility to treat underlying problems.
**Recommendation**

Because patients with BPD tend to have multiple problems simultaneously, or, tend to shift from one to another type of problem behavior, and because the development of symptom specific programs would introduce an undesirably high degree of differentiation that poses an enormous, if not impossible organizational challenge for the mental health field, treatment programs for BPD, knowledge of borderline problems and knowledge of substance abuse problems should be integrated, that is to say, integrated programs should be created.

L.M.C. van den Bosch, AIAR