INTEGRATING TREATMENT FOR PTSD INTO DIALECTICAL BEHAVIOR THERAPY FOR BORDERLINE PERSONALITY DISORDER

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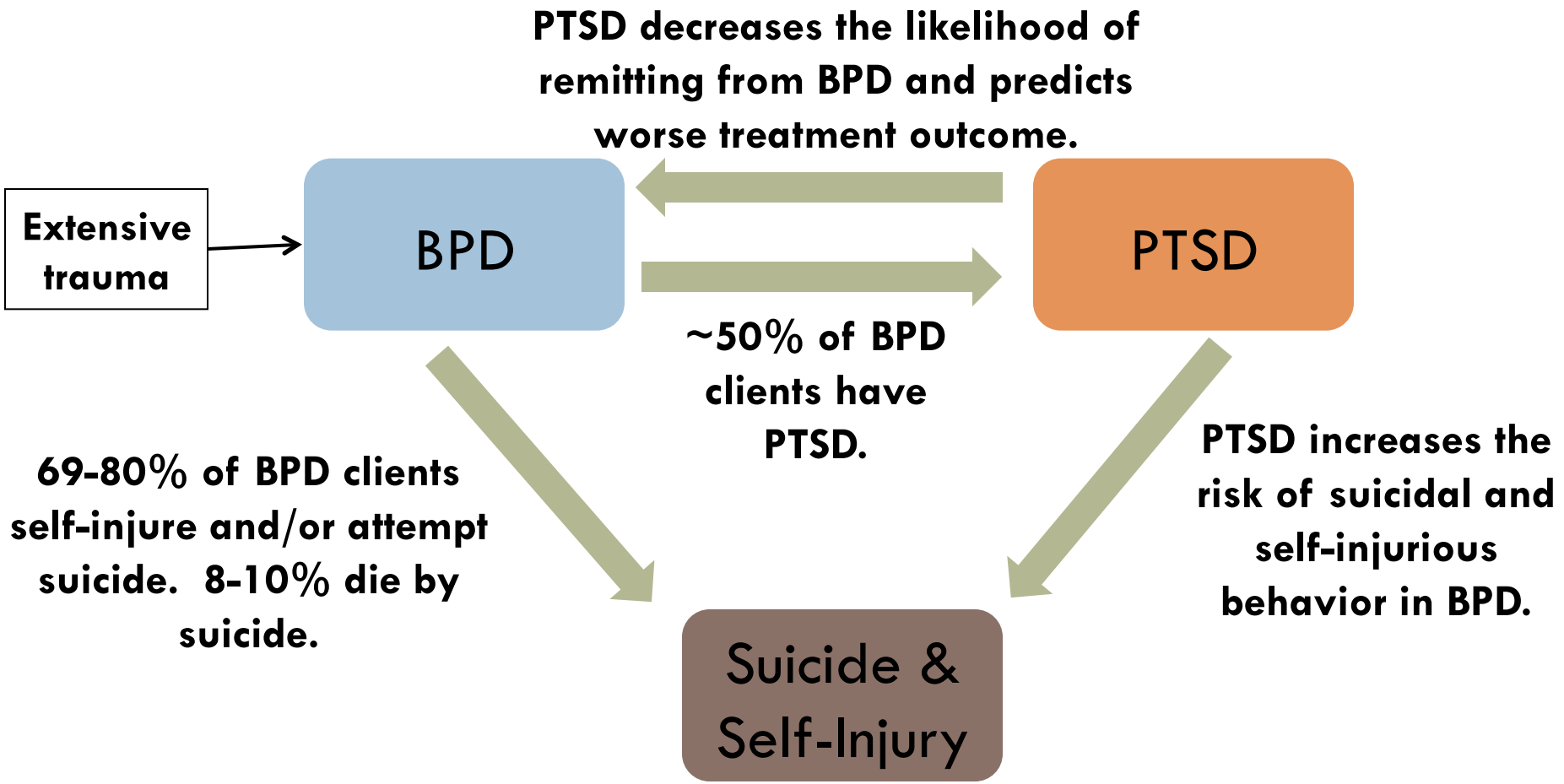
Why is this Treatment Needed?

The Problem


PTSD decreases the likelihood of remitting from BPD and predicts worse treatment outcome.
Extensive trauma
BPD
PTSD
~50% of BPD clients have PTSD.
69-80% of BPD clients self-injure and/or attempt suicide. 8-10% die by suicide.
PTSD increases the risk of suicidal and self-injurious behavior in BPD.
Suicide & Self-Injury

Treatment Options

PTSD Treatments: The Problem of Exclusion

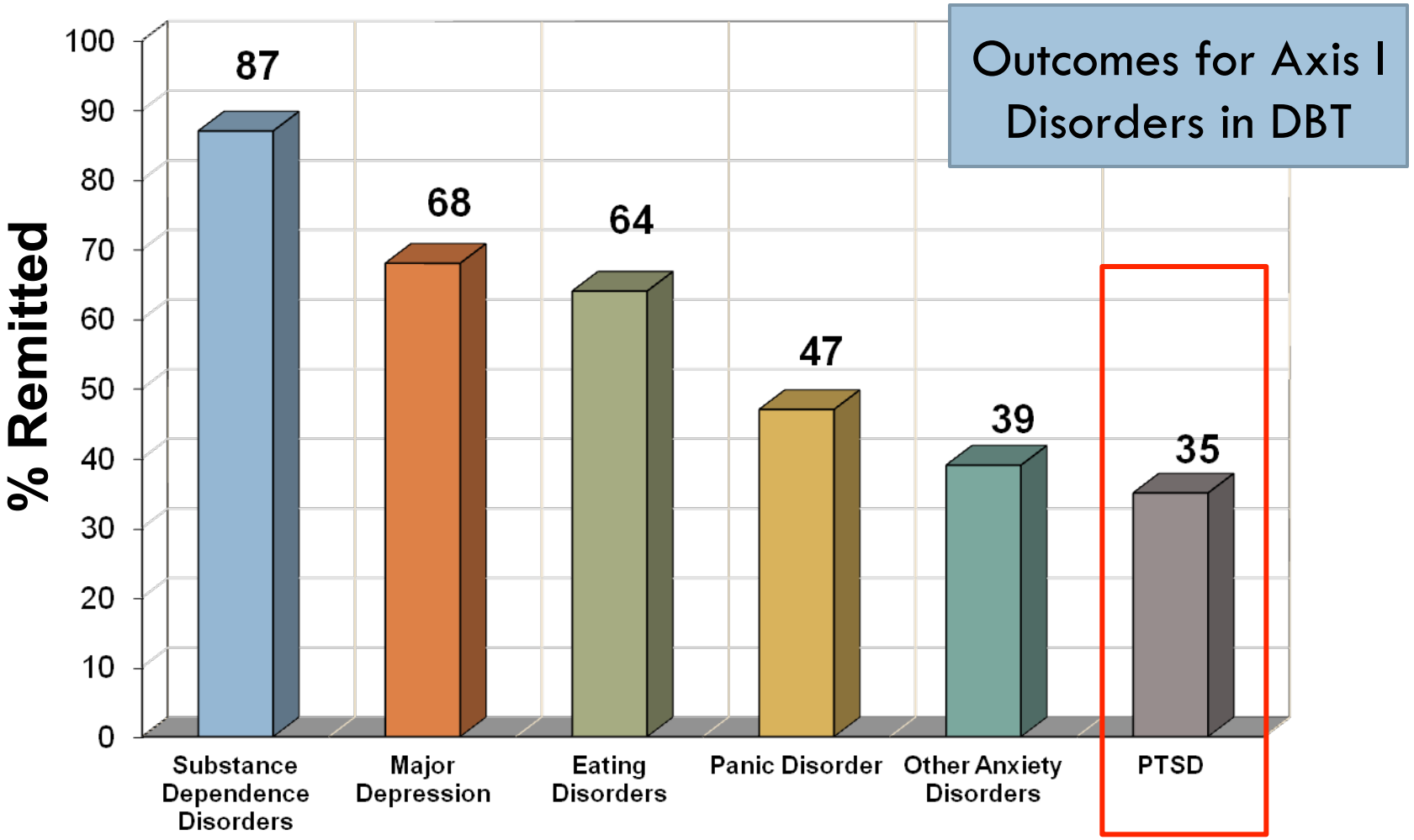
- Clinical trials for PTSD have excluded ~30% of patients referred for treatment.
- The number of exclusion criteria used is positively related to outcome.
- Common exclusion criteria:
  - Suicide risk (46%)
  - Substance abuse/dependence (62%)
  - "Serious comorbidity" (62%)

"[T]he common confluence of exclusion criteria for suicide risk and substance abuse/dependence is likely to exclude many patients with borderline features…"

(p. 224)

BRADLEY, GREENE, RUSS, ET AL.
Am J Psychiatry 162:2, February 2005

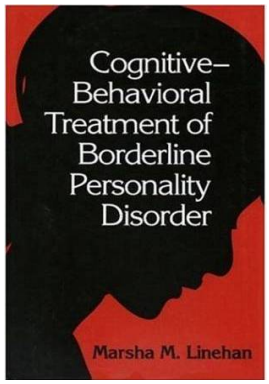
DBT: The Problem of not Targeting



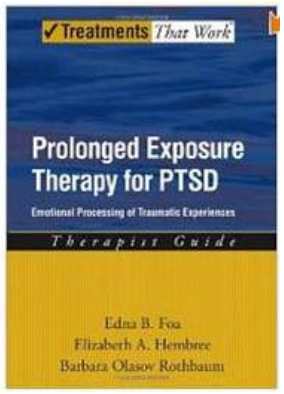
(Harned, Chapman, Dexter-Mazza, Murray, Comtois, & Linehan, 2008)

The Treatment Development Process

Integrating DBT with Prolonged Exposure therapy for PTSD



- Standard DBT (1 year)
  - Individual DBT therapy (1 hour/wk)
  - DBT group skills training (2.5 hours/wk)
  - Telephone coaching (as needed)
  - Therapist consultation team (1 hour/wk)



- DBT Prolonged Exposure Protocol
  - Modified Prolonged Exposure therapy for PTSD
  - Occurs concurrently with standard DBT
  - Administered by the individual DBT therapist

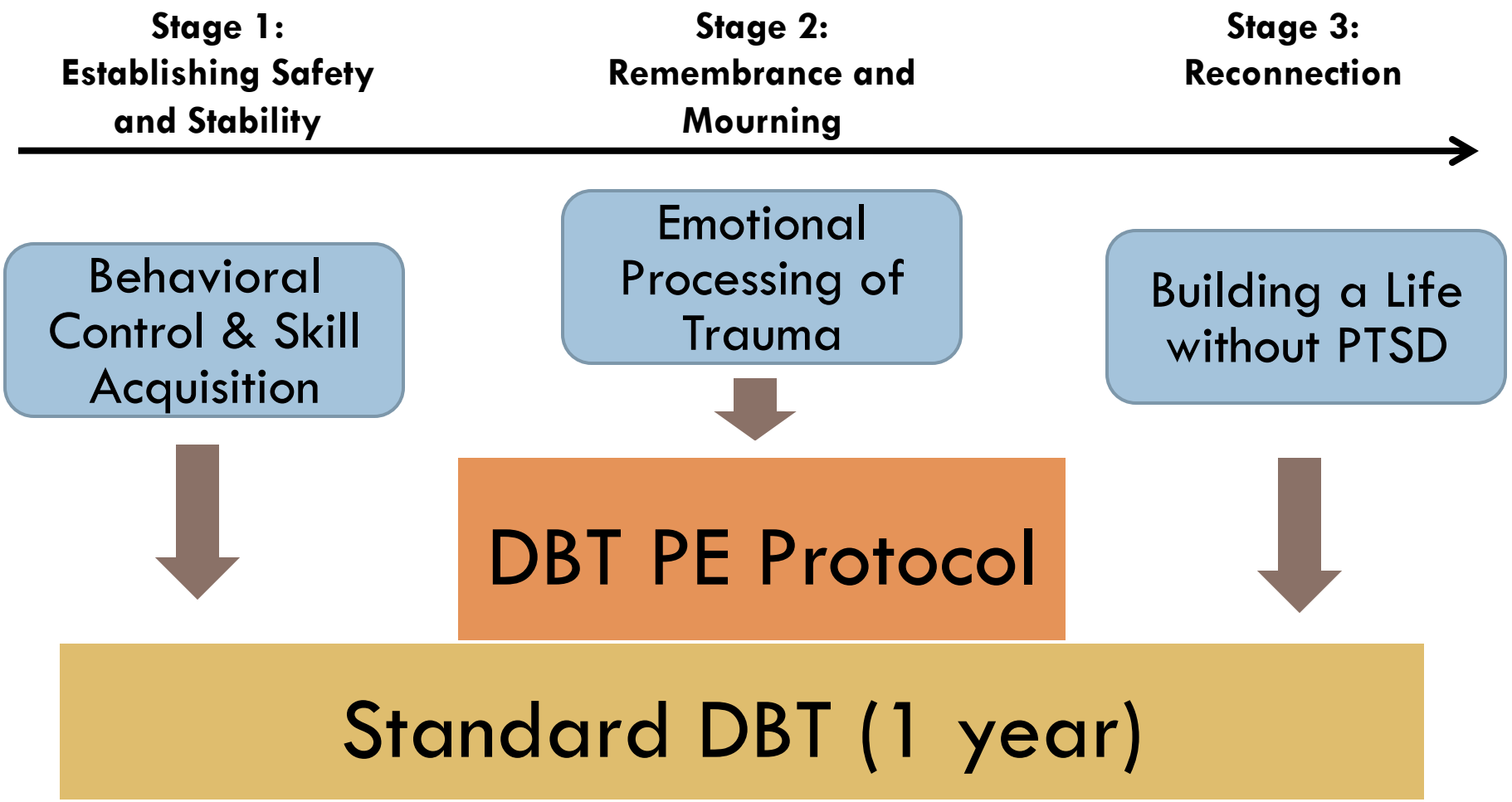
Problems to Solve

1. Suicide risk and other high-priority problems made targeting PTSD untenable.

2. Poor distress tolerance made exposure therapy also untenable.

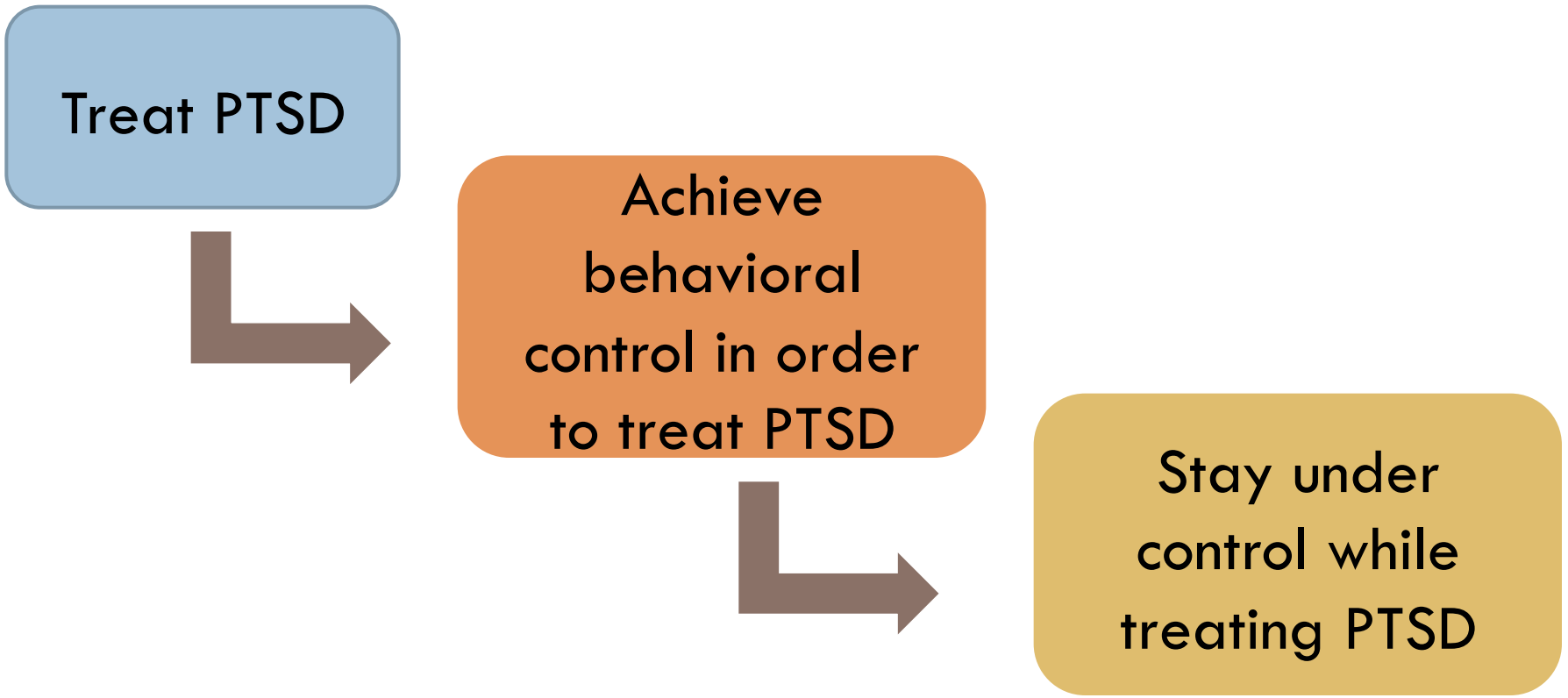
Solution Was to Use a Stage-Based Treatment Model

Judith Herman's Stages of Trauma Recovery (1992)



Solution Was Also to Apply

- DBT contingency management and commitment strategies to increase motivation to:



Problems to Solve

3. No clear criteria existed for determining when suicidal and self-injuring BPD clients are ready for PTSD treatment.

Solution Was to Develop

BPD-specific readiness criteria

and

Test them through an iterative process of treatment development

Deciding when to Start PTSD Treatment

- Not at imminent risk of suicide.
- No recent (past 2 mos.) life-threatening behavior.
- Ability to control life-threatening behaviors in the presence of cues for those behaviors.
- No serious therapy-interfering behavior.
- PTSD is the highest priority target for the client and the client wants to treat PTSD *now*.
- Ability and willingness to experience intense emotions without escaping.

Problems to Solve

4. Therapists were sometimes afraid to treat PTSD, even when clients were eligible.

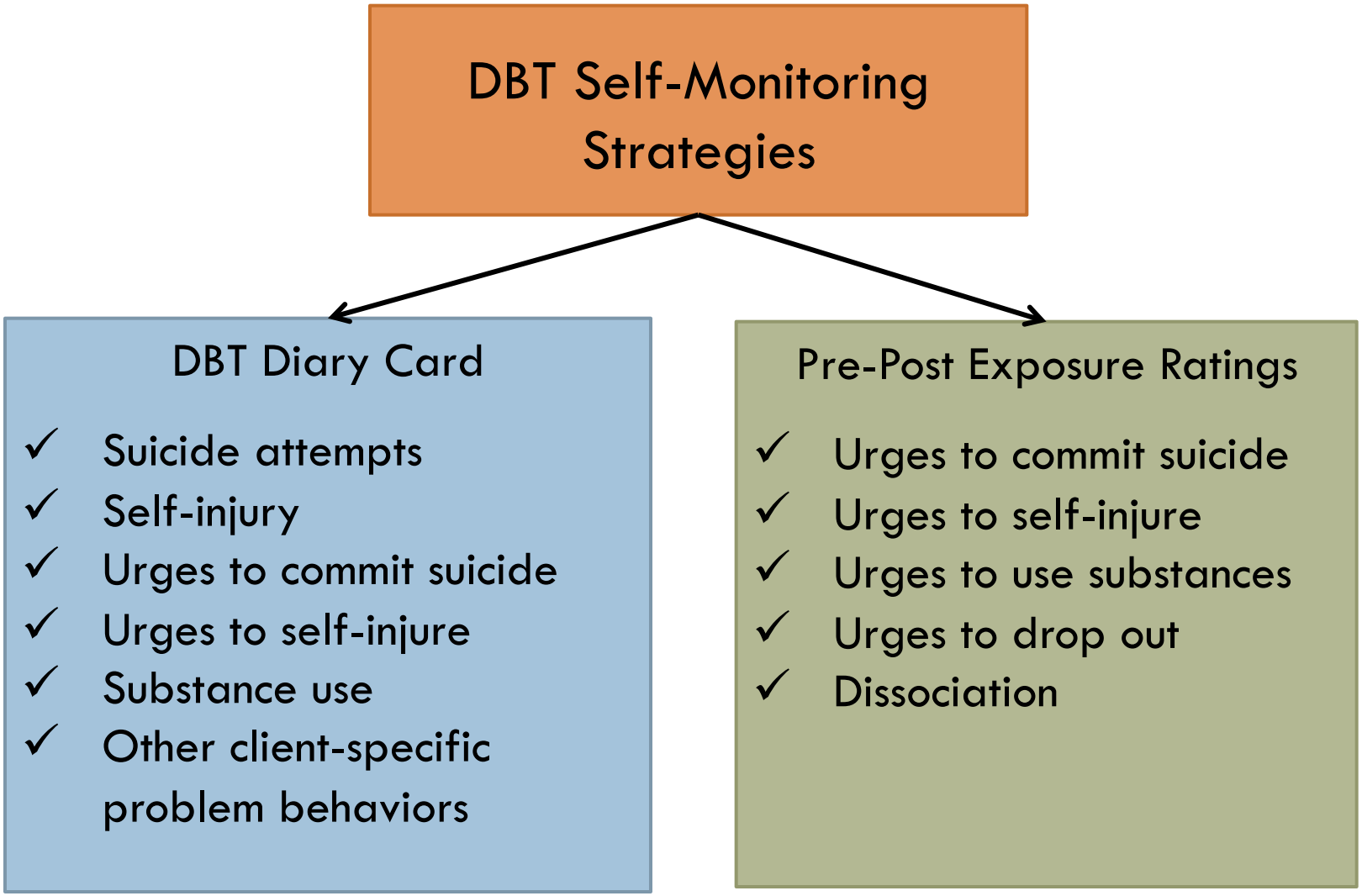
Solution Was to Use

- DBT Therapist Consultation Team to assess and problem-solve therapist factors that interfere with PTSD treatment:
  - Fear of making the client worse
  - Uncertainty about client readiness
  - Lack of confidence in ability to treat PTSD
  - Burnout

Problems to Solve

5. PE does not include structured methods for monitoring suicide risk and other potential negative reactions to exposure.

Solution Was to Apply



Problems to Solve

6. BPD clients often have difficulty achieving effective levels of emotional engagement during exposure.

Solution Was to Use DBT Skills During Exposure As Needed to

Down-regulate Emotions

- Opposite action
- TIPP skills
- Self-soothe
- Distraction
- IMPROVE the moment

Up-regulate Emotions

- Observe and describe
- One-mindfulness
- Mindfulness of current emotion
- Mindfulness of thoughts
- Radical acceptance
- Willingness

Problems to Solve

7. BPD clients have multiple problems and chaotic lives that make focusing only on a single problem (or disorder) difficult.

Solution Was Also to Use DBT to Address

- Any other serious problems that may occur during PTSD treatment (whether or not they are related to PTSD treatment).
  - Increased suicide or self-injury urges or behaviors
  - Treatment noncompliance
  - Major life problems (e.g., relationship, employment, housing, financial, and health problems)
  - Other Axis I or II disorders (e.g., eating disorders, major depression, substance use disorders)

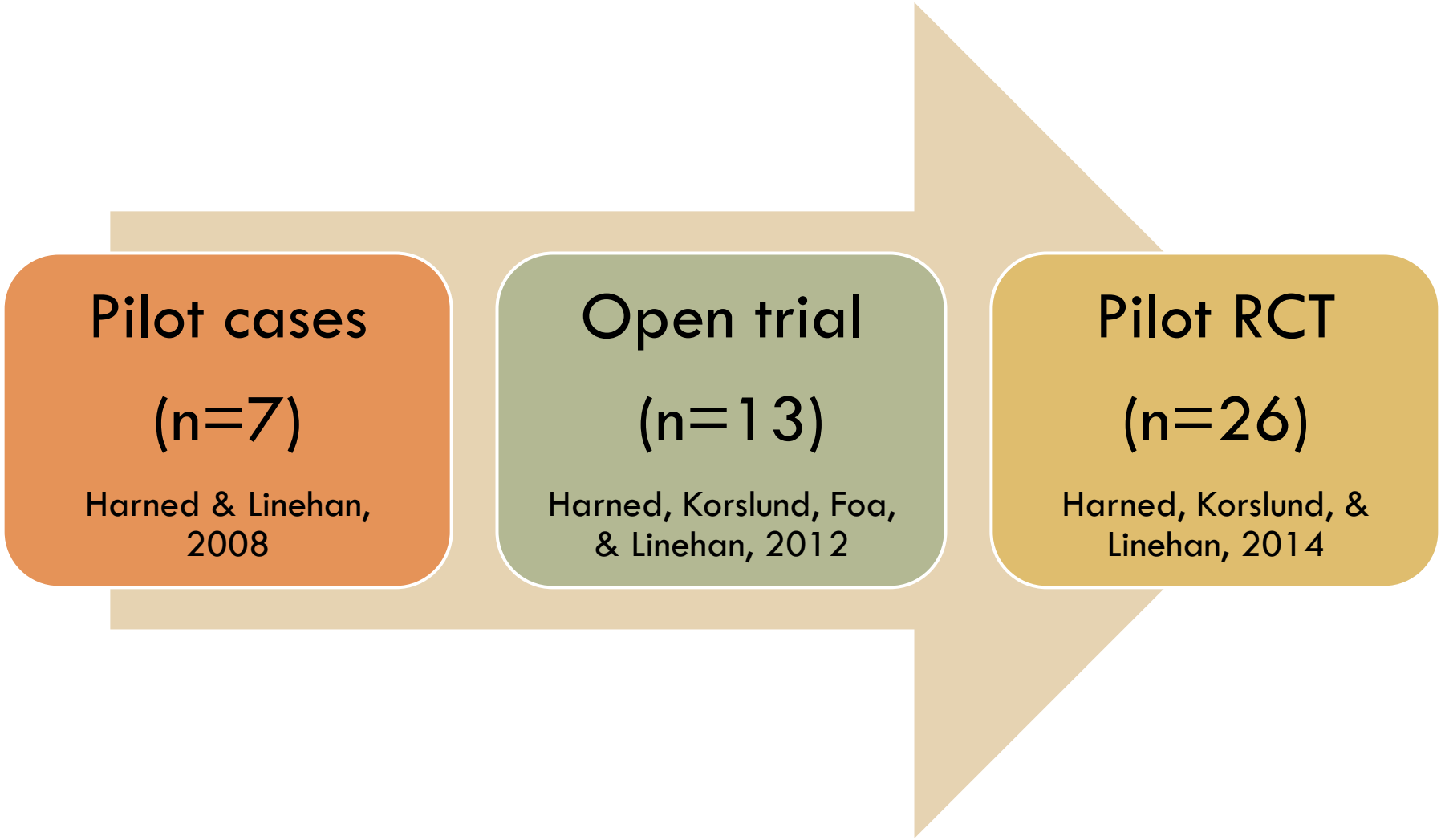
Use standard DBT strategies, skills, and protocols to target these problems, ideally without having to stop PTSD treatment.

Solution Was Also to Develop

- Specific guidelines for:
  - When to stop PTSD treatment
    - If higher-priority behaviors occur (or recur)
  - What to do while PTSD treatment is stopped
    - Targeting higher-priority behaviors
  - When to resume PTSD treatment after stopping
    - When higher-priority behaviors have been sufficiently addressed

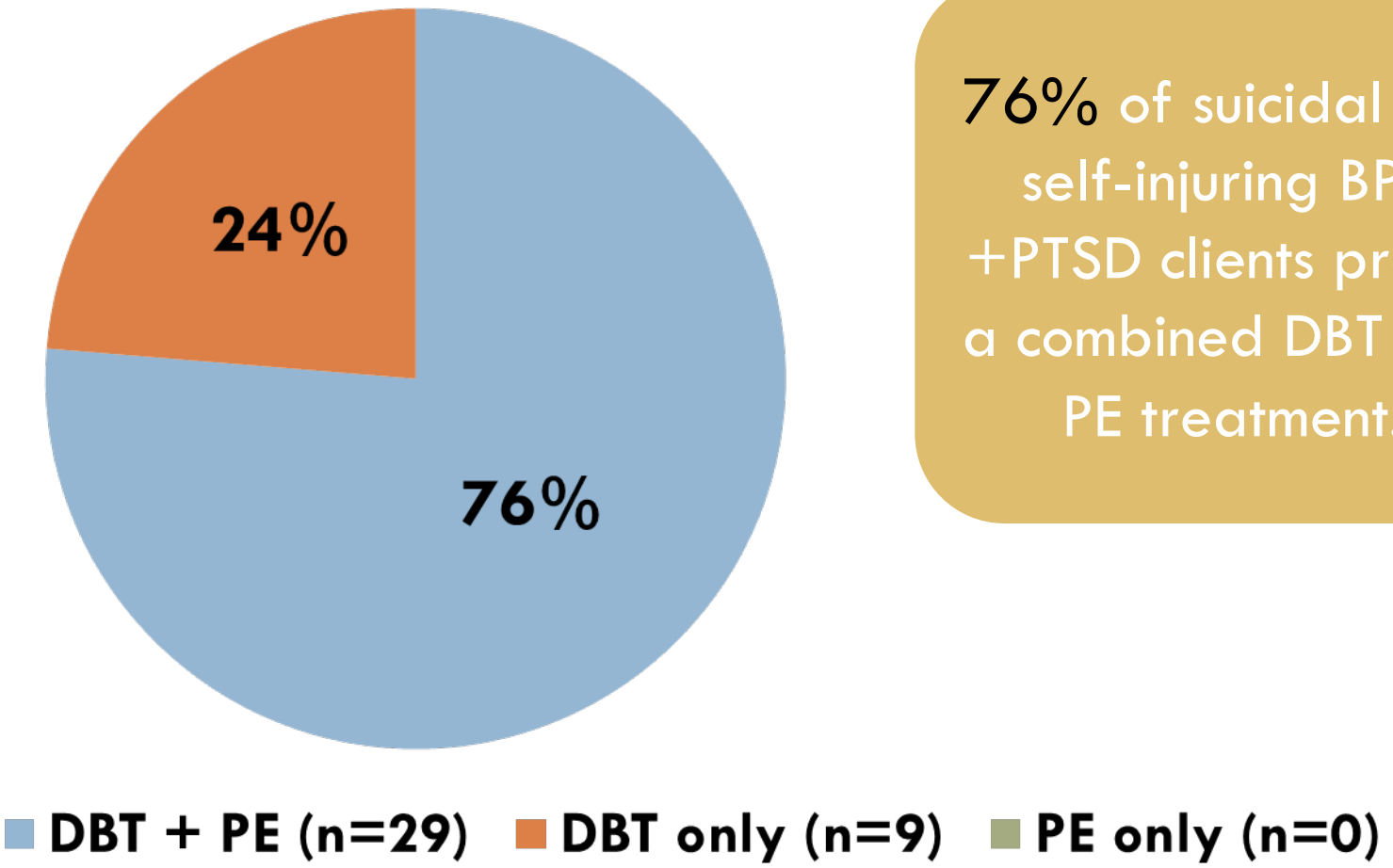
Research Findings

Research Progress



Treatment Acceptability and Feasibility

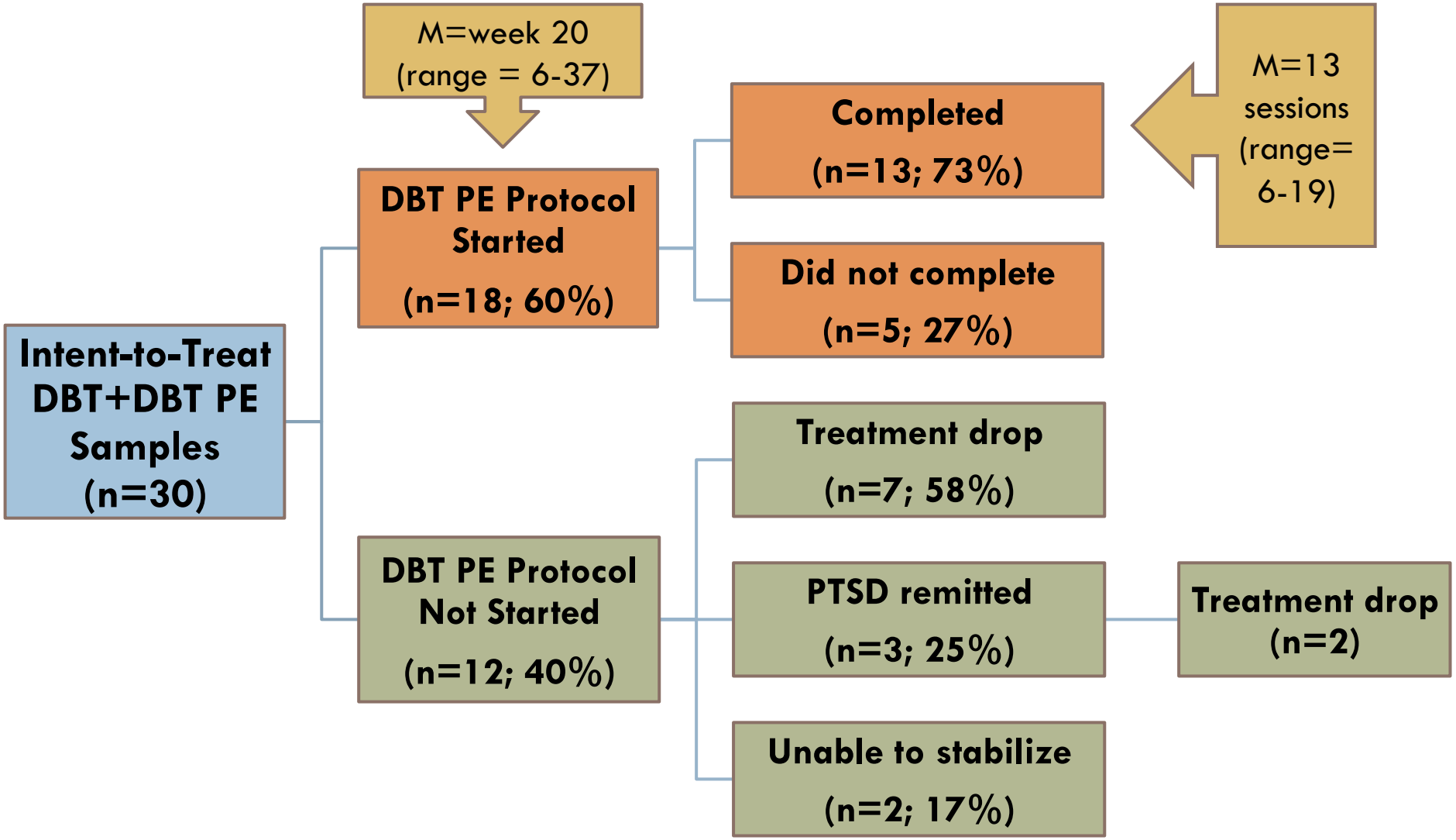
Treatment Preferences



76% of suicidal and self-injuring BPD +PTSD clients prefer a combined DBT and PE treatment.

Harned, Tkachuck, & Youngberg, 2013

Treatment Feasibility: Open Trial & Pilot RCT



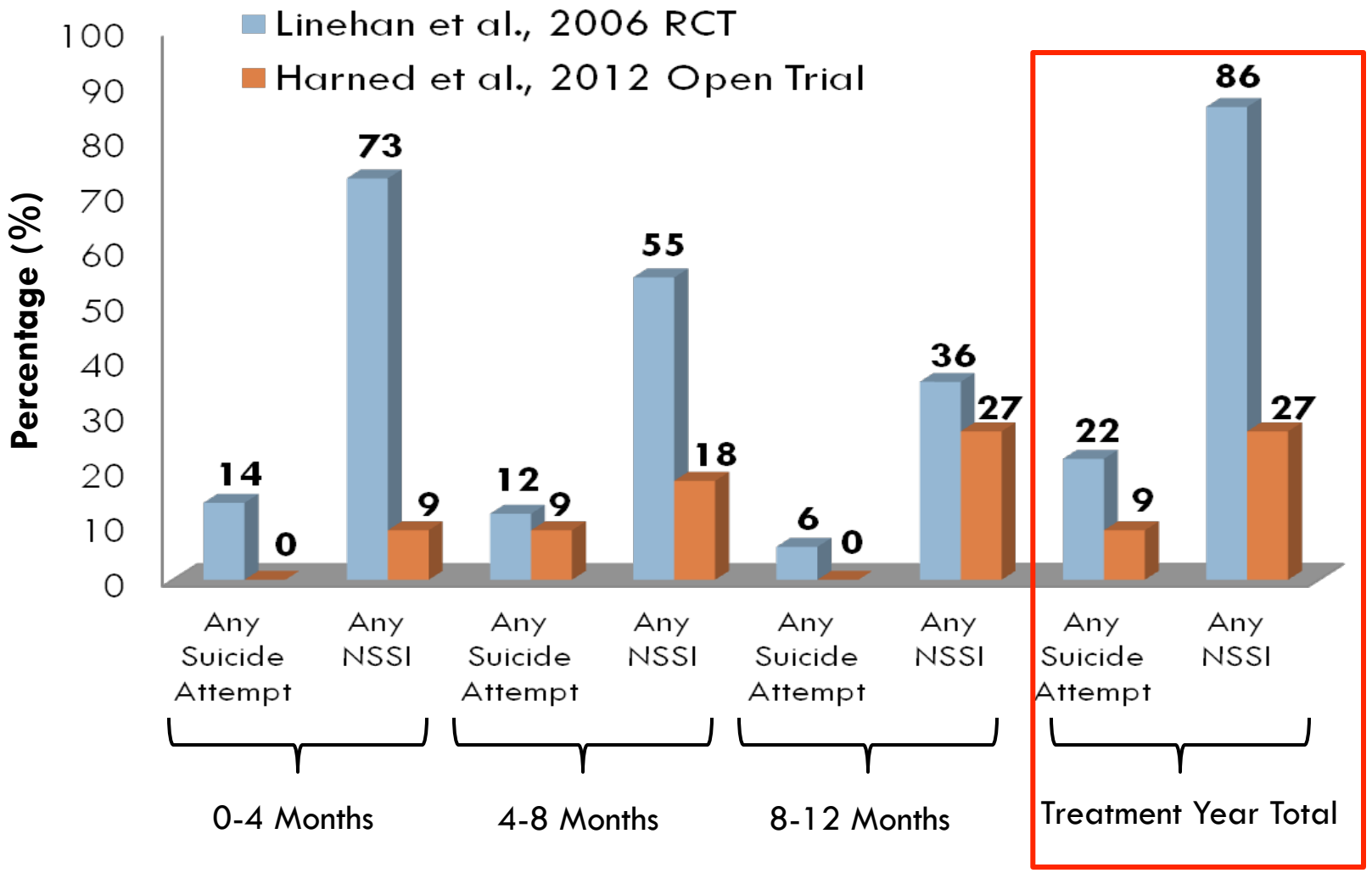
Treatment Safety

Exposure Rarely Causes Increases in Suicide and Self-Injury Urges

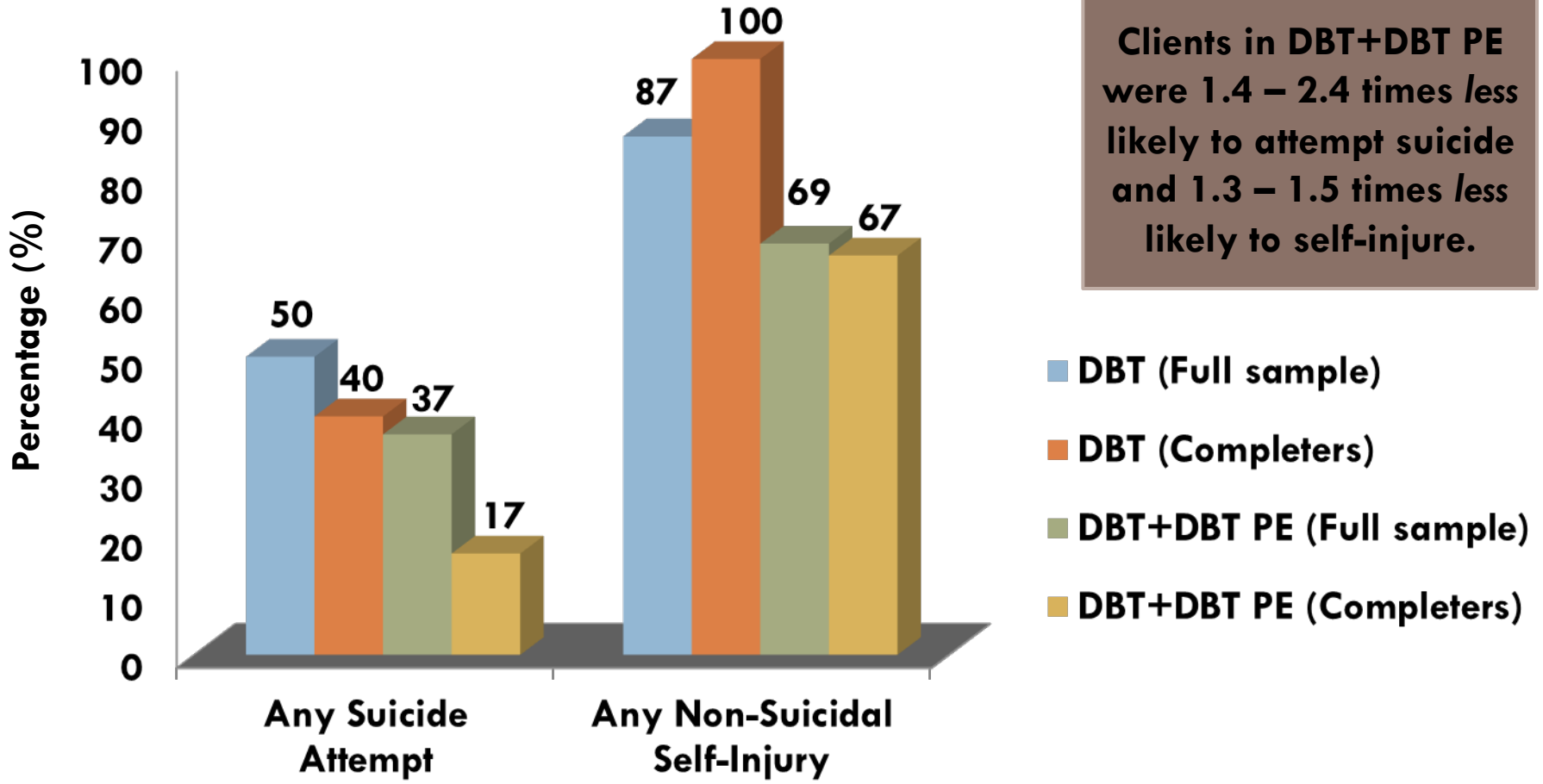
	Urge to Commit Suicide	Urge to Self-Injure
Increase in urges	7.7%	8.2%
No change in urges	80.5%	78.2%
Decrease in urges	11.8%	13.6%

Note. Urges were rated immediately before and after each exposure task (n=701).

Adding DBT PE Does not Increase Suicidal and Non-Suicidal Self-Injury



And it May Even Decrease these Behaviors

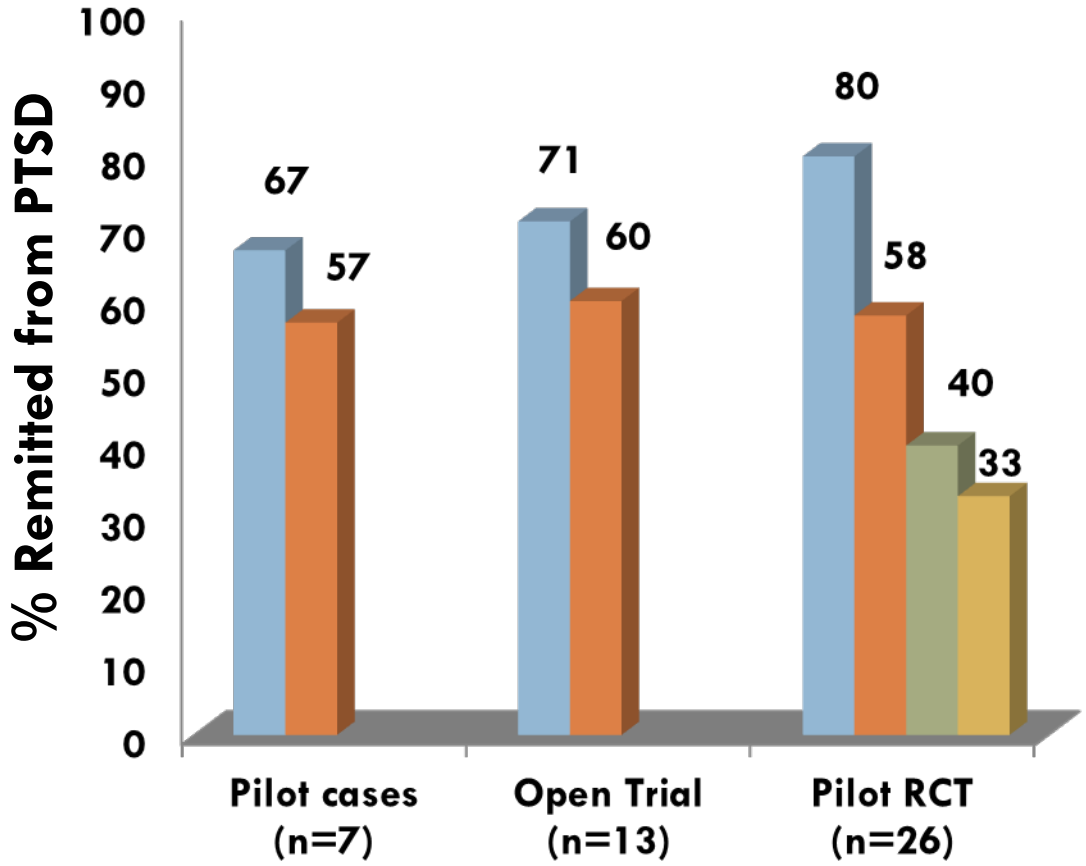


Clients in DBT+DBT PE were 1.4 – 2.4 times *less* likely to attempt suicide and 1.3 – 1.5 times *less* likely to self-injure.

Harned, Korslund, & Linehan, 2014

Clinical Outcomes

PTSD Remission Rates: Post-Treatment



Meta-Analysis of Exposure Treatments for PTSD*

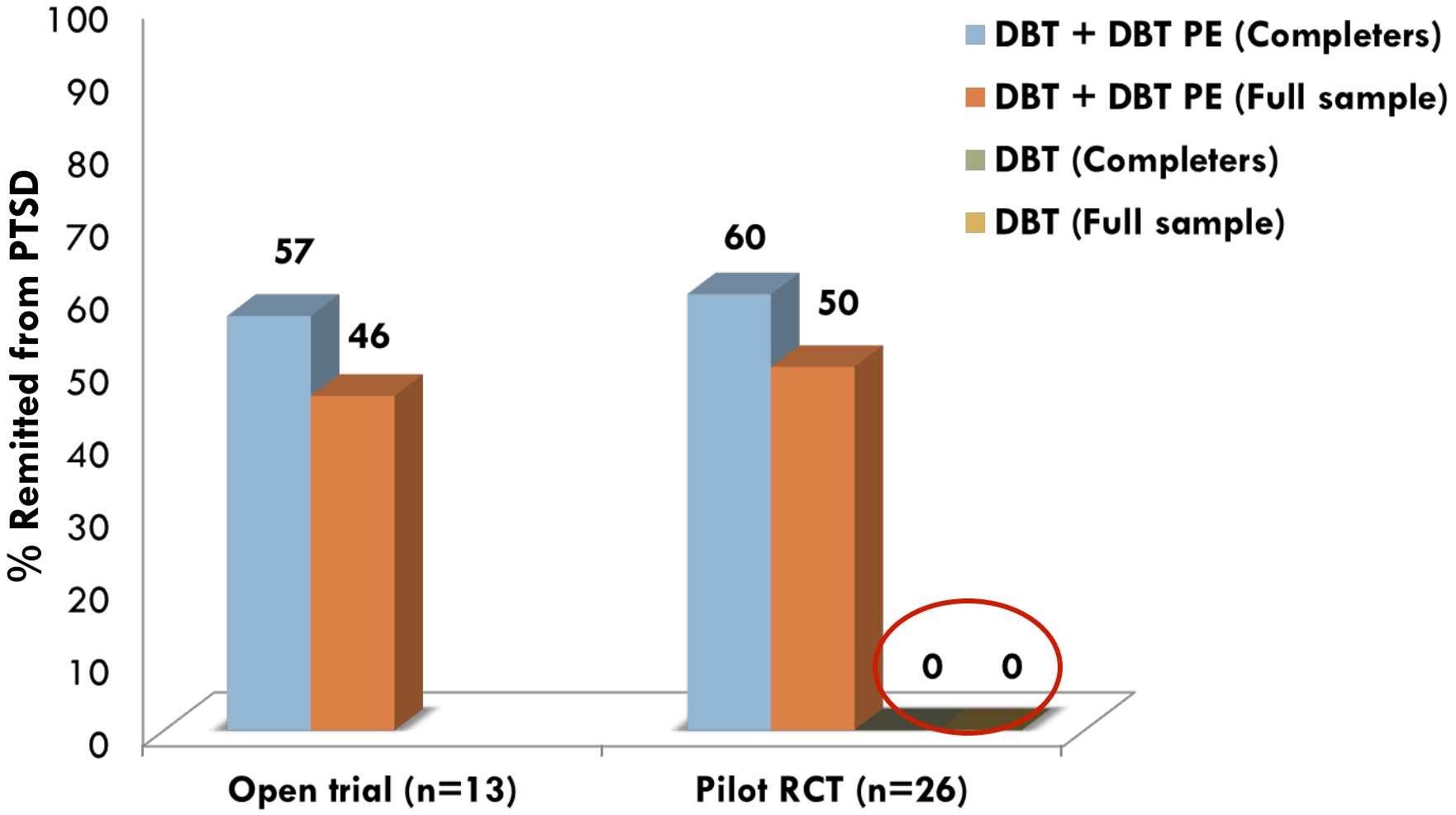
Completers: 68%

Full Sample: 53%

No PTSD worsening

* Bradley et al., 2005

PTSD Remission Rates: 3 Months Follow-Up



Secondary Outcomes

	Response*		Recovery**	
Post-Treatment Outcomes	**DBT+DBT PE**	**DBT**	**DBT+DBT PE**	**DBT**
Depression (HAM-D)	**80%**	**80%**	**60%**	**20%**
Anxiety (HAM-A)	**80%**	**80%**	**40%**	**0%**
Trauma-related guilt (TRGI)	**60%**	**20%**	**60%**	**20%**
Shame (ESS)	**100%**	**60%**	**100%**	**20%**
Global Severity Index (BSI)	**100%**	**40%**	**80%**	**0%**

Among treatment completers, recovery rates on secondary outcomes were 40-100% in DBT+DBT PE and 0-20% in DBT.

***Response** = reliable improvement

****Recovery** = reliable improvement + return to normal functioning

Conclusions

DBT with the DBT PE protocol:

- ✓ Is preferred by the majority of suicidal and/or self-injuring BPD clients with PTSD.
- ✓ Is feasible to implement for the majority of clients who complete one year of standard DBT.
- ✓ Can be delivered safely.
- ✓ Achieves rates of PTSD remission comparable to other PTSD treatments, but higher and more stable than those found in DBT.
- ✓ Is associated with large improvements in a variety of BPD and trauma-related outcomes that are greater than those found in DBT.

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Recommendations for Further Reading

1. Harned, M. S., Korslund, K. E., & Linehan, M. M. (2014). A pilot randomized controlled trial of DBT with and without the DBT Prolonged Exposure protocol for suicidal and self-injuring women with borderline personality disorder and PTSD. *Behaviour Research and Therapy, 55,* 7-17.

2. Harned, M. S., Korslund, K. E., Foa, E. B., & Linehan, M. M. (2012). Treating PTSD in suicidal and self-injuring women with borderline personality disorder: Development and preliminary evaluation of a Dialectical Behavior Therapy Prolonged Exposure protocol. *Behaviour Research and Therapy, 50*, 381-386.

3. Harned, M. S. (2013). Treatment of posttraumatic stress disorder with comorbid borderline personality disorder. In D. McKay & E. Storch (Eds.), *Handbook of Treating Variants and Complications in Anxiety Disorders* (pp. 203-221). New York, NY: Springer Press.

Recommendations for Further Reading (cont.)

4. Harned, M. S., Tkachuck, M. A., & Youngberg, K. A. (2013). Treatment preference among suicidal and self-injuring women with borderline personality disorder and PTSD. *Journal of Clinical Psychology, 69*, 749-761.

5. Harned, M. S. & Linehan, M. M. (2008). Integrating Dialectical Behavior Therapy and Prolonged Exposure to treat co-occurring borderline personality disorder and PTSD: Two case studies. *Cognitive and Behavioral Practice, 15*, 263-276.

6. Wagner, A. W., Rizvi, S. L., & Harned, M. S. (2007). Applications of DBT to the treatment of complex trauma-related problems: When one case formulation does not fit all. *Journal of Traumatic Stress, 20*, 391-400.

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