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

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Abstract

Objective: The aim of this article is to examine whether standard Dialectical Behavior Therapy (DBT) (1) can be successfully implemented in a mixed population of borderline patients with or without comorbid substance abuse (SA), (2) is equally efficacious in reducing borderline symptomatology among those with and those without comorbid SA, and (3) is efficacious in reducing the severity of the substance use problems. **Method:** The implementation of DBT is examined qualitatively. The impact of comorbid SA on its efficacy, as well as on its efficacy in terms of reducing SA, is investigated in a randomized clinical trial comparing DBT with treatment-as-usual (TAU) in 58 female borderline patients with ($n = 31$) and without ($n = 27$) SA. **Results:** Standard DBT can be applied in a group of borderline patients with and without comorbid SA. Major implementation problems did not occur. DBT resulted in greater reductions of severe borderline symptoms than TAU, and this effect was not modified by the presence of comorbid SA. Standard DBT, as it was delivered in our study, however, had no effect on SA problems. **Conclusions:** Standard DBT can be effectively applied with borderline patients with comorbid SA problems, as well as those without. Standard DBT, however, is not more efficacious than TAU in reducing substance use problems. We propose that, rather than developing separate treatment programs for dual diagnosis patients, DBT should be "multitargeted." This means that therapists ought to be trained in addressing a range of severe

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manifestations of personality pathology in the impulse control spectrum, including suicidal and self-damaging behaviors, binge eating, and SA.

Keywords: Borderline personality disorder; Substance abuse; Dual diagnosis; Dialectical Behavior Therapy

1. Introduction

Borderline personality disorder (BPD) is a persistent and severe mental disorder. Studies have shown significant comorbidity between BPD and substance use disorders (SUD) or substance abuse (SA) (Akiskal, Chen, & Davis, 1985; Dulit, Fyer, Haas, Sullivan, & Frances, 1990; Links, Heslegrave, Mitton, & van Reekum, Patric, 1995; Loranger & Tulis, 1985; Oldham et al., 1995; Trull, Sher, Minks-Brown, Durbin, & Burr, 2000; Zanarini, Gunderson, Frankenburg, & Chauncey, 1989; Zimmerman & Coryell, 1989). The reported prevalence rates of SUD among patients with BPD range from 39% to 84% with a median rate of 67% (Dulit et al., 1990; Links et al., 1995; Zanarini et al., 1989, 1998; Zanarini, Gunderson, Frankenburg, & Chauncey, 1990). Within SA populations, the prevalence of BPD ranges from 2% to 66% with a median rate of 18% (Verheul, van den Brink, &Hartgers, 1995). Comorbidity of SUD and BPD can partly be accounted for by overlapping diagnostic criteria (Dulit et al., 1990; Rounsaville et al., 1998), but prevalence rates of BPD remain high even when SA is excluded as a diagnostic criterion of BPD (e.g., Dulit et al., 1990; Rounsaville et al., 1998). Some have suggested that SUD and BPD are causally linked in some way(Verheul, Ball, & van den Brink, 1997). For example, some have hypothesized that SUD and BPD may share a common etiology and may be viewed best as being in the same domain of psychopathology, i.e., affective dysregulation (Linehan, 1991, 1993) or impulse control disorders (Siever & Davis, 1991; Zanarini, 1993). Many authors view substance use as a manifestation of impulsivity, which is a core feature of BPD (Links, Heslegrave, & van Reekum, 1999; van Reekum, Links, & Fedorov, 1994).

Since SA can be considered as a typical borderline manifestation rather than an independent comorbid condition, it is interesting that borderline patients comorbid with SA often are treated differently from those without SA. For example, it has been reported that borderline patients with SA experience difficulties when applying for treatment. Anecdotal data indicate that this group may be caught in a therapeutic "Catch-22" situation in which they cannot enter the mental health service system until they stop using substances and cannot enter SA treatment until their suicidal and self-damaging behaviors are under control (e.g., National Institute of Alcohol Abuse and Alcoholism (NIAAA), 1993; van den Bosch, 1996; Verheul et al., 1997). Several factors may account for this phenomenon, including (1) segregations in the mental health field, (2) the assumption that addictive behaviors should be applied as an exclusion criterion for treatment programs and studies, and (3) program differentiation.

First, mental health centers and addiction treatment programs in some countries exist separately. This health care segregation has a strong tradition in the Netherlands, where the