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

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Why is this Treatment Needed?
The Problem

- **BPD**
  - Extensive trauma
  - PTSD decreases the likelihood of remitting from BPD and predicts worse treatment outcome.
  - ~50% of BPD clients have PTSD.

- **PTSD**
  - PTSD increases the risk of suicidal and self-injurious behavior in BPD.

- **Suicide & Self-Injury**
  - 69-80% of BPD clients self-injure and/or attempt suicide. 8-10% die by suicide.
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

Outcomes for Axis I Disorders in DBT

(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)

Stage 1: Establishing Safety and Stability
Stage 2: Remembrance and Mourning
Stage 3: Reconnection

Behavioral Control & Skill Acquisition

Emotional Processing of Trauma

Building a Life without PTSD

DBT PE Protocol

Standard DBT (1 year)
Solution Was Also to Apply

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

  - Treat PTSD
  - Achieve behavioral control in order to treat PTSD
  - Stay under control while treating PTSD
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

DBT Self-Monitoring Strategies

DBT Diary Card
- Suicide attempts
- Self-injury
- Urges to commit suicide
- Urges to self-injure
- Substance use
- Other client-specific problem behaviors

Pre-Post Exposure Ratings
- Urges to commit suicide
- Urges to self-injure
- Urges to use substances
- Urges to drop out
- Dissociation
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.
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

Pilot cases (n=7)
Harned & Linehan, 2008

Open trial (n=13)
Harned, Korslund, Foa, & Linehan, 2012

Pilot RCT (n=26)
Harned, Korslund, & Linehan, 2014
Treatment Acceptability and Feasibility
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

Intent-to-Treat DBT+DBT PE Samples (n=30)

- DBT PE Protocol Started (n=18; 60%)
  - Completed (n=13; 73%)
  - Did not complete (n=5; 27%)

- DBT PE Protocol Not Started (n=12; 40%)
  - Treatment drop (n=7; 58%)
  - PTSD remitted (n=3; 25%)
  - Unable to stabilize (n=2; 17%)

M=week 20 (range = 6-37)

M=13 sessions (range= 6-19)
Treatment Safety
# Exposure Rarely Causes Increases in Suicide and Self-Injury Urges

<table>
<thead>
<tr>
<th></th>
<th>Urge to Commit Suicide</th>
<th>Urge to Self-Injure</th>
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<tbody>
<tr>
<td>Increase in urges</td>
<td>7.7%</td>
<td>8.2%</td>
</tr>
<tr>
<td>No change in urges</td>
<td>80.5%</td>
<td>78.2%</td>
</tr>
<tr>
<td>Decrease in urges</td>
<td>11.8%</td>
<td>13.6%</td>
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*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
PTSD Remission Rates: Post-Treatment

Meta-Analysis of Exposure Treatments for PTSD*

- Completers: 68%
- Full Sample: 53%

* Bradley et al., 2005

No PTSD worsening

* Bradley et al., 2005
PTSD Remission Rates: 3 Months Follow-Up

- **Open trial (n=13):**
  - DBT + DBT PE (Completers): 46%
  - DBT + DBT PE (Full sample): 50%

- **Pilot RCT (n=26):**
  - DBT (Completers): 0%
  - DBT (Full sample): 0%
### Secondary Outcomes

<table>
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<tr>
<th>Post-Treatment Outcomes</th>
<th>Response*</th>
<th>Recovery**</th>
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<tr>
<td><strong>Depression (HAM-D)</strong></td>
<td>80%</td>
<td>60%</td>
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<tr>
<td><strong>Anxiety (HAM-A)</strong></td>
<td>80%</td>
<td>40%</td>
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<tr>
<td><strong>Trauma-related guilt (TRGI)</strong></td>
<td>60%</td>
<td>60%</td>
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<tr>
<td><strong>Shame (ESS)</strong></td>
<td>100%</td>
<td>100%</td>
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<tr>
<td><strong>Global Severity Index (BSI)</strong></td>
<td>100%</td>
<td>80%</td>
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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


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