

TOPICAL WEBINAR FOR APA MEMBERS

An Educational Resource from McLean Hospital

Treating BPD & Substance Use Disorders: Practical Approaches for Addiction Treatment Providers

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Dr. Rocco Iannucci and Dr. Emily Volpe have working relationships with McLean Hospital. As such, they have both a financial and an intellectual interest in the webinar content. The purpose of this presentation is to provide best practices for the treatment of people with co-occurring borderline personality disorder and substance use disorders.

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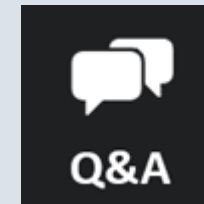
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Rocco Iannucci, MD

PRESENTER

Rocco Iannucci, MD, began his psychiatric career at Massachusetts General Hospital and McLean Hospital, where he served as chief resident in addiction psychiatry and as assistant director of psychiatric residency training. He then practiced general community and hospital psychiatry for 5 years at Berkshire Medical Center, an experience that shaped his collaborative approach to working with patients and other health care providers. Dr. Iannucci returned to McLean Hospital in 2012 as director of McLean's Fernside residential addiction treatment program, where he continues to focus his career on the integrated treatment of people with substance use disorders and other co-occurring mental health conditions. For 10 years, he also directed Fernside's postdoctoral fellowship in addiction psychology, teaching and learning from the many outstanding psychology trainees at McLean. He has published on the treatment of people with stimulant use disorder, with co-occurring bipolar disorder and addiction and with co-occurring borderline personality disorder and substance use disorders.



Emily Volpe, PsyD

PRESENTER

Emily Volpe, PsyD, earned her doctorate in clinical psychology from William James College. She completed her fellowship at Fernside, an addiction recovery program at McLean, and joined the staff in 2017. At Fernside, Dr. Volpe provides evidence-based treatment to individuals with substance use disorders and other co-occurring psychiatric conditions (dual diagnosis), offering both individual and group therapy to residential patients. She also leads the program's family support and patient education group and has expertise in working with families and children using a resiliency and strengths-based approach. Dr. Volpe's research interests have focused on improving communication of co-parents who have experienced high conflict divorce or separation. She has also conducted research exploring the impact of microaggressions on marginalized groups.

- Overview of fundamental principals
- Structured treatments for Borderline Personality Disorder (BPD)
- Treatments developed for Borderline Personality Disorder and Substance Use Disorders (BPD+SUD)
- Good Psychiatric Management for Alcohol Use Disorder (GPM-AUD)

Epidemiology

- The prevalence of borderline personality disorder in community samples is estimated at 2% to 3%
- The prevalence of past year substance use disorder (SUD) in the United States was estimated at 17.3% in 2022
- People with BPD have significantly increased risk of SUD (48.8% outpatient, 27.8% inpatient with current SUD)
- People with SUD have significantly increased risk of BPD (prevalence 15.8% outpatient, 26.7% inpatient/residential)



Prognosis

- Presence of SUD makes remission of BPD less likely
- Absence of SUD is the strongest predictor of BPD remission
- Co-occurrence of BPD and SUD increases suicide risk beyond either disorder alone
- Co-occurrence of BPD and SUD is associated with greater social and psychological dysfunction and with a more persistent course of both disorders

Zanarini et al. 2024; Webber et al., 2015; Links et al 1995;
Van den Bosch et al. 2001

Co-occurring BPD and Opioid Use Disorder

- In a 20-year study of people who used heroin, BPD at baseline was associated with
 - *Persistent heroin dependence*
 - *Increased needle-sharing and injection-related health problems*
 - *Overdose*
 - *Criminal involvement*
 - *Worse mental health*
 - *Other substance use*

Marel et al., 2023

BPD Specialty Clinical Services

- BPD+SUD specific treatments
- Structured treatment for BPD with additional treatment components to address substance use disorder

General or SUD Clinical Services

- Standard treatments for substance use disorders with structured but flexible approach for BPD

Fundamentals of treatment

- Anticipate progress, and be patient

Timing of improvements in BPD+SUD

- Longer duration of treatment is associated with greater improvement in depressive symptoms and GAF for people with co-occurring SUD, MDD, and PD
- An inpatient study showed greater initial symptomatology but comparable improvements in BPD vs. non-BPD patients during treatment. BPD patients were less likely to follow-up.
- In an outpatient study of BPD/SUD-specific treatment, people with BPD/SUD had greater initial symptom severity than those with only SUD, but the gap narrowed over time.
- Treatment retention is considered an important outcome for SUD.

McCarter et al., 2016; Ball et al., 2011; Ross et al., 2003

Fundamentals of treatment

- Anticipate progress, and be patient
- **Engage and retain patients in treatment**
 - *Completing training can help*

Benefit of clinical training

- Treatment involvement and retention involve at least 2 parties: the patient and the clinician
- Training (8 hours) in Good Psychiatric Management improves clinician sense of competence and willingness to treat people with BPD

Masland et al., 2018; Choi-Kain and Connery, 2025

Fundamentals of treatment

- Anticipate progress, and be patient
- Engage and retain patients in treatment
 - *Completing training can help*
- **First do no harm: Prevent iatrogenesis**
 - ***Follow standards of care***

Adhere to standards of care

- American Psychiatric Association (APA) Practice Guideline for the treatment of patients with Borderline Personality Disorder (APA, 2025)
 - *Structured **psychotherapy**: **Primary***
 - ***Medications**: **Adjunctive**, focused on symptoms, and time-limited*
- APA Practice Guideline for the treatment of patients with Substance Use Disorders (APA, 2006; APA, 2007)
 - *Evidence-based **psychotherapy**: **Essential***
 - ***Medications**: **Beneficial** for particular patients/ disorders*
 - *Medications are **evidence-based standard of care** for the treatment of people with some substance use disorders (ASAM, 2020; APA 2018)*

ALCOHOL USE DISORDER	OPIOID USE DISORDER	TOBACCO USE DISORDER
Naltrexone (Opioid receptor antagonist)	Naltrexone (Opioid receptor antagonist)	Bupropion (Norepinephrine/Dopamine reuptake inhibitor and nicotine receptor antagonist)
Acamprosate (Glutamate modulator)	Buprenorphine (Opioid receptor partial agonist-antagonist)	Varenicline (Nicotine receptor partial agonist-antagonist)
Disulfiram (Aldehyde dehydrogenase and dopamine beta-hydroxylase inhibitor)	Methadone (Opioid receptor agonist)	Nicotine (Nicotine receptor agonist)

Naloxone to treat opioid overdose

- Antagonist (blocker) of the opioid receptor
- Longstanding use in emergency rooms, pharmacologically highly effective (though there are concerns re: high potency opioids)
- Overdose education and naloxone distribution (OEND) programs are associated with decreased overdose deaths on a community level



Razaghizad et al., 2021

Fundamentals of treatment

- Anticipate progress, and be patient
- Engage and retain patients in treatment
 - *Completing training can help*
- **First do no harm: Prevent iatrogenesis**
 - *Follow standards of care*
 - ***Avoid emotionally-driven clinical interactions (countertransference enactments)***

Structured Treatments for BPD: Do they work for people with SUDs?

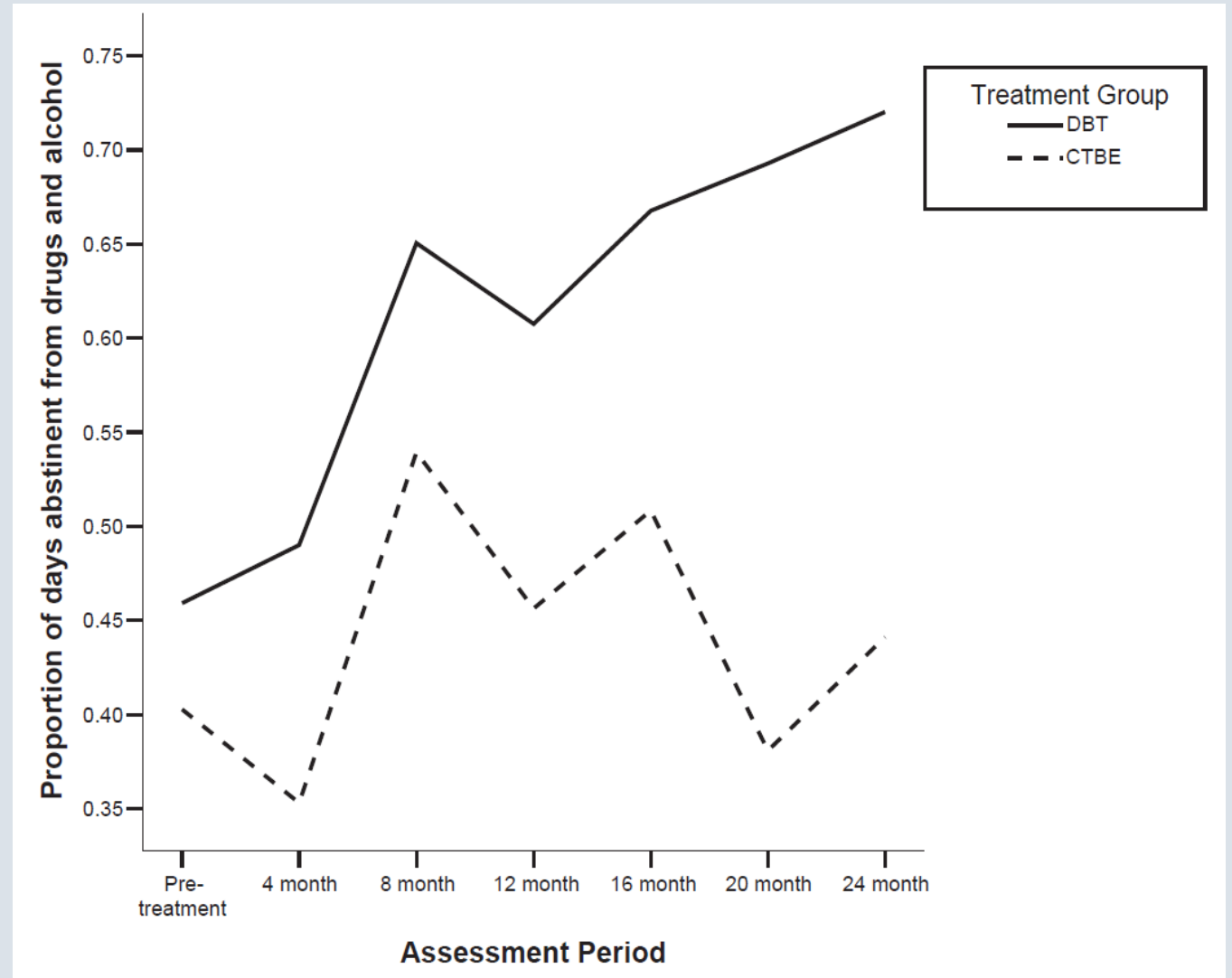
Psychosocial Intervention	Inclusion/ Exclusion of People with SUDs
Dialectical Behavior Therapy	73.3% lifetime SUD, 29.7% current SUD
Transference-Focused Psychotherapy	Excluded current substance dependence (9/207)
Mentalization-Based Therapy	>50% had a current SUD
Dynamic Deconstructive Psychotherapy	Underwent clinical trial for people with AUD
Good Psychiatric Management	Excluded substance dependence in previous 30 days 9.4% current SUD, 59% lifetime SUD
Systemic Training for Emotional Predictability and Problem Solving	Excluded SUD in past 30 days
Schema Therapy	Did not exclude SUD, after withdrawal management if needed

Linehan et al., 2006; Clarkin et al., 2007; Bateman and Fonagy, 2009; McMain et al., 2009; Blum et al., 2008; Giesen-Bloo et al., 2006

Secondary analyses of structured BPD treatments for people with BPD-SUD

- Reanalysis of a GPM clinical trial found a similar reduction of general psychiatric symptoms and greater reduction of borderline symptoms in those with SUD. Therapeutic alliance improved more over time in those with SUD than in those without (Penzenstadler et al., 2018).
- 12-month standard DBT was associated with improvements in BPD symptoms irrespective of whether or not patients had substance use disorders (Van den Bosch, 2002)

- In a reanalysis of a DBT clinical trial, patients assigned to DBT spent more time in partial remission, had a greater proportion of substance-free days, and were more likely to experience full remission of SUD.



Treatments developed for people with BPD + SUD

Psychosocial Intervention	Overall Approach
Dialectical Behavior Therapy for Substance Use Disorders (DBT-S)	DBT coping skills (Mindfulness, emotion regulation, distress tolerance, interpersonal effectiveness) for BPD symptoms Coping skills for relapse prevention Dialectical abstinence Strategies to maintain treatment engagement
Dynamic Deconstructive Psychotherapy (DDP)	Verbalize emotional experiences Integrate opposing attributions of self/ others Deconstruct anticipated responses in others to create corrective experiences
Dual-Focus Schema Therapy (DFST)	Educational, cognitive, behavioral, experiential, and interpersonal strategies to address maladaptive cognitive/ emotional patterns (schemas) Coping skills for relapse prevention

Dimeff and Linehan, 2008; R. Gregory, <https://www.upstate.edu/psych/pdf/manual.pdf>; Young, 2013; Ball, 2005

Raw Retention Rates

Study	Intervention	Control
Linehan '99 (DBT/TAU) Duration: 1 year	55-64% ¹	19-27%
Linehan '02 (DBT/CVT+12S) Duration: 1 year	64% ¹	100% ¹
Harned '08 (DBT/CTBE) Duration: 1 year	69% (calc)	29% (calc)
Gregory '08 (DDP/TAU) Duration: 1 year	67-73%	60-67%
Ball '07 (DFST/12SF) Duration: 6 months	42% ²	42% ²
Ball '11 (DFST/IDC) Duration: 6 months	NR	NR

¹Subjects received opiate agonist treatment

²Retention rates were not broken down by intervention group

NR Outcomes not reported

Outcomes across different studies

Substance-related outcomes

Study	Intervention	Control
Linehan '99 (DBT/TAU)	++	-
Linehan '02 (DBT/CVT+12S)	++	+
Harned '08 (DBT/CTBE)	++	-
Gregory '08 (DDP/TAU)	+	-
Gregory '10 (DDP/TAU)	++	-
Ball '07 (DFST/12SF)	++	+
Ball '11 (DFST/IDC)	NR	NR

*Significant outcome difference (intervention vs control)

NR Outcomes not reported

Outcomes across different studies

Study	Substance-related outcomes		Improvement in BPD symptoms	
	Intervention	Control	Intervention	Control
Linehan '99 (DBT/TAU)	++	-	+	+
Linehan '02 (DBT/CVT+12S)	++	+	NR	NR
Harned '08 (DBT/CTBE)	++	-	NR	NR
Gregory '08 (DDP/TAU)	+	-	++	-
Gregory '10 (DDP/TAU)	++	-	++	-
Ball '07 (DFST/12SF)	++	+	NR	NR
Ball '11 (DFST/IDC)	NR	NR	+	+

*Significant outcome difference (intervention vs control)

NR Outcomes not reported

Outcomes across different studies

Study	Substance-related outcomes		Improvement in BPD symptoms		Improvement in psychiatric symptoms	
	Intervention	Control	Intervention	Control	Intervention	Control
Linehan '99 (DBT/TAU)	++	-	+	+	++	-
Linehan '02 (DBT/CVT+12S)	++	+	NR	NR	+	+
Harned '08 (DBT/CTBE)	++	-	NR	NR	+	+
Gregory '08 (DDP/TAU)	+	-	++	-	++	-
Gregory '10 (DDP/TAU)	++	-	++	-	++	-
Ball '07 (DFST/12SF)	++	+	NR	NR	+	++
Ball '11 (DFST/IDC)	NR	NR	+	+	+	++



Well-structured
control groups

*Significant outcome difference (intervention vs control)
NR Outcomes not reported

BPD Specialty Clinical Services

- BPD+SUD specific treatments
- Structured treatment for BPD with additional treatment components to address substance use disorder

General or SUD Clinical Services

- Standard treatments for substance use disorders with structured but flexible approach for BPD

HANDBOOK OF
**Good Psychiatric
Management** FOR
**Borderline
Personality Disorder**

AND
Alcohol Use Disorder

EDITED BY

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GPM-AUD

- AUD treatments
 - *Effective for AUD*
 - *Possibly helpful for BPD/ AUD*
 - *However, do not provide all the tools needed for complex dynamics*
- GPM
 - *Effective for BPD*
 - *Flexibility enables integration with programs primarily focused on other diagnoses*

Good Psychiatric Management

- Core principles
 - *Psychoeducation*
 - *Active but thoughtful stance*
 - *Real and professional relationship*
 - *Expectation of change*
 - *Accountability*
 - *Life worth living*
 - *Practical approach*

Gunderson and Links, 2014

GPM-AUD

■ Core Interventions

- *Disclose diagnosis. Educate patient and significant others.*
 - Education on both BPD and AUD
- *Establish flexible framework based on patient needs and progress.*
 - Greater emphasis on treatment retention
- *Actively build alliance. This includes seeking consultation and/ or supervision regarding countertransference and enactments.*
- *Collaborate with patient and colleagues in managing suicidality and self-harm. Teach patient to collaborate.*

Gunderson and Links, 2014; Choi-Kain and Connery, 2025

GPM-AUD

■ Core Interventions

- *Identify medications as adjunctive. Explain likely effects realistically. Actively avoid polypharmacy.*
 - Follow standard of care for AUD treatment, which may include a relatively greater role for medications.
- *Encourage split treatment, but not splitting. Case management, group therapy, family education. Treaters must communicate.*
 - Discusses techniques to engage patients and families in self-help and other supports.

Gunderson and Links, 2014; Choi-Kain and Connery, 2025

BPD Specialty Clinical Services

- BPD+SUD specific treatments
- Structured treatment for BPD with additional treatment components to address substance use disorder

General or SUD Clinical Services

- Standard treatments for substance use disorders with structured but flexible approach for BPD

Clinical Case Study

Case Example: Laura

- 34yo female, recent fight with bf and he's asking for space, depression w/ passive SI, increase in alcohol/cannabis use, feels hopeless, "I ruined the only good thing I had going for me"
- Hx of threatening suicide, one attempt last year (ingested pills, had second thoughts and called someone, taken to ER)
- Hx of impulsivity, "rocky" relationships, difficulty controlling anger, afraid people will leave her
- Family concerned about behavior at recent family event (substance use, anger outbursts)

Case Example: Laura

- Agrees to abstinence while in residential tx, agrees to routine risk assessment each session (GPM Principle: Check the facts)
- Diagnoses shared in session: MDD, SUD, BPD: discuss heritability and impact of trauma & attachment instability (GPM Principle: Offer psychoeducation)
 - *Laura questions BPD dx (stigma), resonates more with impact of trauma, is open to targeting unhelpful bxs through this lens*
- SI and sobriety are stable while engaged in tx; however, texting her bf escalates (distraction throughout day, interrupting sleep)
 - *Target bx: increase consecutive days of no contact with ex, utilize staff support when dysregulated and unable to tolerate distress*

Case Example: Laura

- Laura brings recent texts with bf into session, describes feeling incredible distress when she doesn't hear from him or when she practices restraint
- Lashes out at clinician: "It's your fault I feel like this. You don't understand me at all! Telling me not to text him means you're taking his side. He says I'm 'too much' and you think that, too, don't you?!"
 - *Opportunity to reflect: "It's important to you that I know how painful this is for you" (GPM Principle: Be active, not reactive)*
 - *Bring focus back to her reasons for not texting bf: "It sounds like you had good impulse control when you didn't text him last night. This is something you've been trying to practice and have been working really hard at. I recognize how difficult this is for you and you've stuck with it. Can we take a moment to reflect on your skillfulness?"*
 - *Continue to review skills: support effective coping, process moments when she wasn't skillful (GPM Principle: Foster accountability)*

Case Example: Laura

- Laura describes the following recurrent event from childhood:
 - *Her mother would lock herself in her bedroom when Laura did something “wrong.” Laura recalls lying outside her mother’s room, nose pressed to the gap under the door, crying and screaming to her mother, “I’m sorry, please come out,” mother would not respond*
 - *Identifies feeling ignored, scared, dismissed, helpless, alone, desperate*
- While processing this in session, Laura voices desire to call her mother immediately to tell her how angry she is
 - *Clinician response: “I can see how upsetting this is and appreciate your willingness to talk with me about your mom. I want to pause and hold off on calling her so that we can explore this a bit more, keep the focus on you and what you’re experiencing.” (GPM Principle: Be thoughtful)*
 - *Additional response if impulse to call mom remains: “I agree that having a conversation with your mom at some point is important, so let’s take the time to prepare for that conversation. It doesn’t have to happen right now or even today. Your message to her is an important one, so let’s take the time to prepare for that conversation so you have the best chance of ensuring your mom hears it. How does that sound to you?” (GPM Principle: Be thoughtful)*

Case Example: Laura

- Laura connects emotions in childhood with how she feels when texting her bf and waiting for response, she begins to explore relationship between these emotions and her impulse to do anything to demand a response
- Clarifies her desire to be closer to her bf and that her behavior ultimately pushes him away, becomes increasingly aware of boundaries she's violated and how her behavior (substance use, suicidal statements) has scared him
- Clinician validates Laura's successes AND acknowledges remaining challenges (GPM Principle: Change is expected)
 - *Laura has been able to resist urges to text bf up to one week, is using coping skills with some effect, demonstrates increased capacity for perspective taking*
 - *Support her engagement in other positive activities (GPM Principle: Life outside of tx)*
 - *She feels frustrated that progress is slow, reset expectation that change is gradual with bumps in the road*

Family Engagement

- Psychoeducation on chronic nature of SUD & BPD
- Offer hope: effective treatments available, remission of sx's is possible
- Guidance on setting realistic expectations for their loved one
 - *Ex: focusing on recovery and ongoing treatment may be immediate priority over returning to full-time school or employment*
- Encourage family to practice less emotionally laden reactions to accusations/attacks, acknowledge mistakes
 - *Ex: Clinician's tool in session ([GPM Principle: Relationship is real](#)), models that repair in relationships is possible*
- Offer communication tools and rationale for use
 - *Ex: True "I feel" statements, validating language lowers defenses (use AND not BUT)*
 - *Ex: If the message is important, we want the communication to be effective*

Family Engagement

- Help family members clarify boundaries, explore ways to communicate these
 - *Boundaries are often perceived as ultimatums, clear language is important*
 - *Ex: “I know staying sober has to be your choice, and I respect that. I ask that you also respect my need to have a substance free home. Let’s come up with a plan so that we know where you can stay if you start using again.”*
 - *Can emphasize that you’re NOT predicting they will fail, relapse prevention and release management planning is a necessary tool due to chronic nature of illnesses*
 - *Having a plan will increase peace of mind, plus it’s harder to problem solve in the middle of a crisis*
- Troubleshoot ways to disengage from conversations

Sources

- The American Psychiatric Association Practice Guideline for the treatment of patients with Borderline Personality Disorder (second edition). Washington, DC: American Psychiatric Association Publishing, 2024.
<https://psychiatryonline.org/doi/epdf/10.1176/appi.books.9780890428009>
- The American Psychiatric Association Practice Guideline for the treatment of patients with Substance Use Disorders (second edition). Washington, DC: American Psychiatric Association Publishing, 2006.
https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse-1410197810077.pdf
- The American Psychiatric Association Practice Guideline for the pharmacological treatment of patients with Alcohol Use Disorders. Washington, DC: American Psychiatric Association Publishing, 2018.
<https://psychiatryonline.org/doi/epdf/10.1176/appi.books.9781615371969>
- ASAM National Practice Guideline for the treatment of opioid use disorder: 2020 focused update. American Society of Addiction Medicine, 2020. Available at: <https://www.asam.org/quality-care/clinical-guidelines/national-practice-guideline>
- Ball SA. Comparing Individual Therapies for Personality Disordered Opioid Dependent Patients. Journal of Personality Disorders 2007; 21(3): 305-321.

Sources

- Ball SA et al. Randomized Trial of Dual-Focused versus Single-Focused Individual Therapy for Personality Disorders and Substance Dependence. *J Nerv Ment Dis* 2011; 199(5): 319-328.
- Ball SA et al. Substance abuse and personality disorders in homeless drop-in center clients: Symptom severity and psychotherapy retention in a randomized clinical trial. *Comprehensive Psychiatry* 2005; 46: 371-379.
- Bateman A and Fonagy P. Randomized controlled trial of mentalization-based treatment versus structured clinical management for borderline personality disorder. *Am J Psychiatry*. 2009; 166: 1355-1364.
- Blum N, St. John D, Pfohl B, et al. Systems Training for Emotional Predictability and Problem Solving (STEPPS) for outpatients with borderline personality disorder: A randomized controlled trial and 1-year followup. *Am J Psychiatry*. 2008; 165(4): 468-478.
- Center for Behavioral Health Statistics and Quality. (2022). 2023 National Survey on Drug Use and Health (NSDUH): Final web screening specifications for programming. Substance Abuse and Mental Health Services Administration. Originating Office Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Services Administration.

Sources

- Choi-Kain LW and Connery HS. Handbook of Good Psychiatric Management for Borderline Personality Disorder and Alcohol Use Disorder. Washington, DC: American Psychiatric Association Publishing, 2025.
- Clarkin JF, Levy KN, Lenzenweger MF, et al. Evaluating three treatments for borderline personality disorder: A multiwave study. *Am J Psychiatry*. 2007; 164: 922-928.
- Connery HS and Kleber H. Guideline Watch (April 2007). Practice Guideline for the treatment of patients with Substance Use Disorders (second edition). *Focus* 2007; 5(2): 1-4.
- Dimeff LA and Linehan MM. Dialectical Behavior Therapy for Substance Abusers. *Addiction Science and Clinical Practice* 2008 June; 39-47.
- Giesen-Bloo J, van Dyck R, Spinhoven P, et al. Outpatient treatment for borderline personality disorder: Randomized trial of schema-focused therapy vs transference focused therapy. *Arch Gen Psychiatry*. 2006; 63: 649-658.
- Gregory RJ et al. Dynamic Deconstructive Psychotherapy versus Optimized Community Care for Borderline Personality Disorder Co-Occurring with Alcohol Use Disorders. *J Nerv Ment Dis* 2010; 198: 292-298.

Sources

- Gregory RJ et al. A Controlled Trial of Psychodynamic Psychotherapy for Co-Occurring Borderline Personality Disorder and Alcohol Use Disorder. *Psychotherapy: Theory, Research, Practice, Training* 2008; 45(1): 28-41.
- Gregory RJ. REMEDIATION FOR TREATMENT-RESISTANT BORDERLINE PERSONALITY DISORDER: Manual of Dynamic Deconstructive Psychotherapy. http://www.upstate.edu/psych/pdf/education/psychotherapy/ddp_manual.pdf. Accessed 3/8/2017.
- Gunderson JG and Links P. *Handbook of Good Psychiatric Management for Borderline Personality Disorder*. Washington, DC: American Psychiatric Association Publishing, 2014.
- Helle AC et al. “Alcohol Use Disorder and Antisocial and Borderline Personality Disorders.” *Alcohol Res.* 2019 Dec 30;40(1):arcr.v40.1.05. doi: [10.35946/arcr.v40.1.05](https://doi.org/10.35946/arcr.v40.1.05)
- Linehan MM, Comtois KA, Murray AM, et al. Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. *Arch Gen Psychiatry.* 2006; 63: 757-766.

Sources

- Linehan MM et al. Dialectical Behavior Therapy versus Comprehensive Validation Therapy plus 12-step for the Treatment of Opioid Dependent Women Meeting Criteria for Borderline Personality Disorder. *Drug and Alcohol Dependence* 2002; 67: 13-26.
- Linehan MM et al. Dialectical Behavior Therapy for Patients with Borderline Personality Disorder and Drug-Dependence. *American Journal on Addictions* 1999; 8: 279-292.
- Masland SR, Price D, MacDonald J, et al. Enduring effects of one-day training in good psychiatric management on clinician attitudes about borderline personality disorder. *J Nerv Ment Dis* 2018; 206(11): 865-869.
- McCarter KL, Halpin SA, Baker AL, et al. Associations between personality disorder characteristics and treatment outcomes in people with co-occurring alcohol misuse and depression. McCarter et al. *BMC Psychiatry* (2016) 16:210 DOI 10.1186/s12888-016-0937-z
- McMain SF, Links PS, Gnam WH, et al. A randomized trial of dialectical behavior therapy versus general psychiatric management for borderline personality disorder. *Am J Psychiatry*. 2009; 166(12): 1365-1374.
- Penzenstadler L et al. “Effects of substance use disorder on treatment process and outcome in a ten-session psychiatric treatment for borderline personality disorder”. Penzenstadler et al. *Substance Abuse Treatment, Prevention, and Policy* (2018) 13:10 <https://doi.org/10.1186/s13011-018-0145-6>

Sources

- Phillips B et al. “Mentalization-Based Treatment for Concurrent Borderline Personality Disorder and Substance Use Disorder: A Randomized Controlled Feasibility Study.” *Eur Addict Res* 2018;24:1–8. DOI: 10.1159/000485564
- Ralevski E et al. The Impact of Personality Disorders on Alcohol-Use Outcomes in a Pharmacotherapy Trial for Alcohol Dependence and Comorbid Axis I Disorders. *The American Journal on Addictions* 2007; 16: 443-449.
- Razaghizad A, Windle SB, Filion KB, et al. The effect of overdose education and naloxone distribution: AN umbrella review of systematic reviews. *Am J Public Health*. 2021; 111(8): e1-e12.
- Ross S et al. A Comparison between Dually Diagnosed Inpatients with and without Axis II Comorbidity and the Relationship to Treatment Outcome. *Am J Drug Alcohol Abuse* 2003; 29(2): 263-279.
- Timaus C et al. “Efficacy of Naltrexone in Borderline Personality Disorder, a Retrospective analysis in inpatients.” *Hum Psychopharmacol Clin Exp*. 2021;36:e2800.<https://doi.org/10.1002/hup.2800>

Sources

- Trull TJ, Freeman LK, Vebares TJ, et al. (2018). “Borderline personality disorder and substance use disorders: An updated review.” *Borderline Personality Disorder and Emotion Dysregulation*. 5:15. <https://doi.org/10.1186/s40479-018-0093-9>
- Van den Bosch LMC, Koeter M, Stunen MWJ et al. (2005). “Sustained efficacy of dialectical behaviour therapy for borderline personality disorder. *Behaviour Research and Therapy*, 43: 1231-1241.
- Van den Bosch LMC, Verheul R, Schippers GM, et al. (2002). Dialectical behavior therapy of borderline patients with and without substance use problems: Implementation and long-term effects. *Addictive Behaviors*, 27: 911-923.
- Webber TA, Kiselica AM, Arango A, et al. (2015). “Unidirectionality between borderline personality disorder traits and psychopathology in a residential addictions sample: A short-term longitudinal study.” *J Pers Dis.*, 29(6): 755-770.
- Young JE, Klosko JS, and Weishaar ME. *Schema Therapy: A Practitioner’s Guide*. New York: Guilford Publications, 2003.
- Zanarini MC, Frankenburg FR, Glass IV et al. (2024). “The 24-year course of symptomatic disorders in patients with borderline personality disorder and personality-disordered comparison subjects: Description and prediction of recovery from BPD. 85(3): 24m15370. doi: 10.4088/JCP.24m15370.

AUDIENCE Q&A

FINAL THOUGHTS

- A recording will be emailed to you in 2 weeks. It will include the presentation slides.
- Take our survey immediately after the webinar has concluded.

THANK YOU!

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