

Webinar Title: Treating BPD and Substance Use Disorders, Practical Approaches for Addiction Treatment Providers
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Moderator: Hello, and welcome to today's webinar, Treating BPD and Substance Use Disorders, Practical Approaches for Addiction Treatment Providers. This topical webinar is paid for by McLean Hospital, a top-ranked free-standing psychiatric hospital, a leader in psychiatric care, research, and education, and the largest psychiatric teaching hospital of Harvard Medical School. Some important points before we get started.

Dr. Rocco Iannucci and Emily Volpe have a working relationship 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. APA does not endorse any products or services. The content was created by McLean Hospital and does not reflect the views of APA or its editorial staff. Email advertising at apa.org to learn more. Next, this program does not offer CE. However, we will email everyone watching live today a certificate of attendance. Certificates may only be issued to those who watch for a minimum of 45 minutes. A recording of this presentation will be emailed to everyone in two weeks' time. The recording will include the presentation slides. During our time together, you will be on mute. You can communicate with us using the Q&A box located on your webinar screen. The Q&A is enabled for attendee interaction with submitted questions. Attendees can view all submitted questions and upvote those they find important. This helps the presenter identify questions that many attendees want answered.

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Now, let me introduce our presenters. Rocco Iannucci, MD, is a psychiatrist specializing in addiction treatment and co-occurring mental health conditions. He began his career at Massachusetts General Hospital and McLean Hospital, where he served as chief resident in addiction psychiatry. After several years in community and hospital practice, he returned to McLean in 2012 and now directs the Fernside Residential Addiction Treatment Program. Dr. Iannucci focuses on integrated care for substance use and co-occurring disorders and has published on stimulant use disorder, public bipolar disorder, and addiction, and borderline personality disorder with substance use disorders.

Emily Volpe, PsyD, is a clinical psychologist at McLean Hospital's Fernside Residential Addiction Treatment Program. She completed her fellowship at Fernside and joined the staff in 2017, providing evidence-based individual and group therapy for individuals with substance use and co-occurring disorders. Dr. Volpe also leads family support and patient education groups with expertise and strength-based work with families and children. Her research has focused on co-parent communication in high-conflict situations and the impact of microaggressions on marginalized groups. Welcome, Drs. Rocco Iannucci and Emily Volpe.

Rocco Iannucci: I'll start with a brief outline of what to expect from today's talk. I'm going to give a little bit of background information that I think will underscore why it's important for us to learn more about how to treat borderline personality disorder, substance use disorders, and, of course, the situation where they co-occur. I'll move pretty quickly into some fundamental principles that I think really apply with treatment of any people. In particular, we can tend to be pushed off course in remembering these fundamental principles when we're treating people with borderline personality disorder or BPD, so I want to highlight them.

Then I'll discuss the structured treatments that we already use for people with BPD in terms of how they may apply to folks who also have substance use disorders. I'll review some of the research and some basic elements of treatments that were developed specifically for the treatment of people who have co-occurring BPD and substance use disorders or SUD. Then, finally, I'm going to wrap up with an outline of good psychiatric management for alcohol use disorder, which I think has some particular advantages in certain treatment contexts. I'll say a little bit more about that later, before turning the presentation over to Dr. Volpe, who can highlight some of these points and some of the treatment principles with a clinical case to hopefully make it really come a little more to life.

I'll start with some basic epidemiology and just underscore the point that these are very common conditions that we all see. Borderline personality disorder has an estimated prevalence of somewhere in the 2% to 3% range in the general population, but of course, is overrepresented in any clinical sample of people. In our practices, we're going to see more than 2% to 3% of people with borderline personality disorder. Even though that's a small percentage of people, that's a lot of people when you think about the entire country and the entire world. The prevalence of substance use disorders is even higher in the United States, over 17% in a recent estimate.

If you look at people who have borderline personality disorder, there's an even higher prevalence of substance use disorder in those folks. Almost half of people being treated on an outpatient basis and over a fourth of people on an inpatient basis have a current substance use disorder. People with substance use disorders also have an increased risk of borderline personality disorder. The relationship goes in the other direction as well, with almost 16% on an outpatient basis, screening positive for borderline personality disorder, and over a quarter who are being treated in inpatient and residential, more acute treatment settings.

What's more is when the two disorders co-occur, they impact each other, and they can lead to a worse clinical course of either disorder. In fact, substance use disorders and the presence of substance use disorder is one of the strongest predictors of whether or not a person with borderline personality disorder gets into remission, with the presence of the substance use disorder predicting they're not getting into remission of borderline personality disorder. The co-occurrence also is associated with worse social and psychological functioning and increased risk of suicide.

That's on the background of these disorders independently each having a significant suicide, a substantial suicide risk. This is over and above that. It's very impactful on the people it affects. I think this is really brought home by a 20-plus-year study of

people who use heroin, the Australian Treatment Outcomes Study, that found that borderline personality disorder in those people at baseline was associated with worse outcomes over the course of the 20-year history where they were followed, including persisting heroin dependence, increased likelihood of sharing needles, and then having consequent health problems.

Increased risk of overdose, involvement with the criminal justice system, worse mental health overall, and increased likelihood of other substance use. Really impactful on each other. These are folks who definitely need our help. Because of how common this condition is, particularly in the population of people that we treat, people who are seeking clinical care, we're all going to see them, and it's important for us to know how to help them. Again, thank you for being here today.

This depiction essentially divides the world in very simple terms, at least the treatment world in very simple terms. In the blue on the left, borderline personality disorder specialty clinical services. These are the places where all day, all night, all their patients have BPD or other personality disorders. There are certain types of treatments that will make sense in those settings. Based on the fact that everyone has borderline personality disorder, if that's what you're doing, if you're running, say, a DBT clinic, and based on the fact that clinicians who are working in those programs already have that background, they have a strong background in those things.

In these settings, it probably makes sense. It's most feasible to use specific treatments for BPD with SUD or the structured treatments that have already been developed. At this point, fairly well disseminated, particularly for DBT, and add on additional treatment components that may address substance use disorders. I'll talk more about what that might look like and what the evidence for that approach is. Then on the right in the yellow, you have other treatment settings like the one that Dr. Volpe and I work in, which is focused on substance use disorders or general treatment settings.

In those settings, you will have a substantial minority of people who have borderline personality disorder, so you have to be ready and able to treat them. You need some sort of an approach that has the flexibility where it's also serving people who don't have borderline personality disorder, and it lets you do other things. In our program, for instance, we need to be able to focus on treating substance use disorders, but then also give people with BPD the help that they need. I'll wrap up the talk with one particular approach for doing that. I want to start with fundamentals. Again, these are the things that we try to remember with all our patients, but they really are important to keep in mind with this group of people. First of all, getting better takes time. Being engaged in treatment is a helpful thing, and we want to deliver a message of hope to our patients so that they understand that they can and will get better, but that it might take time. We have some clinical evidence for this. A one-year study of people who had co-occurring substance use disorder, major depression, and personality disorders were provided integrated treatment, and it was shown that they got better and better over time if they stayed engaged in treatment. Treatment continued to work over a longer duration of time, with the longer duration being associated with the most improvement.

In an inpatient study of people in a substance use treatment setting, people with versus without borderline personality disorder, those that had BPD started out with more symptoms at the beginning compared to those that did not have it, but the improvements in symptomatology were comparable over the course of treatment. The slope of improvement was similar between the two groups.

In an outpatient study, again, looking at people with and without BPD who all had substance use disorders, the people who also had BPD, again, they had more symptoms at the beginning of the study, but the gap actually narrowed over time, really demonstrating a steeper slope of improvement for people with BPD, so they got better at a more rapid rate. Once more, for a long time within the substance use treatment field, treatment retention in and of itself has been considered an important outcome because people who stay in treatment just generally do better. Whether or not they achieve abstinence as an outcome, they tend to do better if they stay within treatment. We want to engage and retain patients in treatment. The first point in that is to bring patients into treatment.

Completing training for clinicians can help. Again, thanks for being here today. We're doing that at least at an initial level. I started some training here and some basic information on this. Treatment involvement and retention certainly involves our learning about how to keep the patient engaged, how to bring them back into treatment. Some of the approaches that I'll talk about today have that embedded in the treatment itself, in the treatment protocol, what to do if the patient drops out of treatment. Involvement and retention involves two parties. We want to help patients be willing, but we have to be willing ourselves to bring them into treatment in the first place.

There's evidence that even fairly minimal training for clinicians improves our willingness and perceived sense of confidence anyway to bring people into treatment and to be willing to work with people with borderline personality disorder, which, of course, is a very important first step in getting them help. Then my third point in terms of fundamentals is first, do no harm. Prevent the iatrogenesis. We don't want to make the patients worse.

This is something we're at risk of when treating particularly borderline personality disorder because we can tend to shoot from the hip, or there can tend to be situations where there are multiple crises coming into us, and we're moving from one to the other to the other. That especially happens with people who prescribe medications, where you can have a snowball effect of adding medications each week and not removing anything. We want to follow standards of care as a helpful guideline to keep us on track with our patients, so we don't drift off into things that end up being unhelpful or even harmful.

There are some basic standards of care. These guidelines that I'll mention here, there's a lot more detail that can be found in them if you actually look at the guideline, and these are available. I wanted to highlight this at a very high level, that the American Psychiatric Association guideline for the treatment of people with borderline personality disorder identifies structured psychotherapy as the primary treatment for borderline personality disorder. There are no FDA-approved medications, and it identifies specifically medications as adjunctive and symptom-

focused, meaning you identify a target symptom, and you see if it actually gets better with the medication. If it does not, you withdraw the medication.

Even if it does get better, use of medications is meant to be time-limited with borderline personality disorder. Then you would work with the patient collaboratively to consider deprescribing, especially if you're adding new medications, looking at taking something away if you're adding something new, if that's appropriate. Likewise, the practice guidelines for treatment of patients with substance use disorders identifies evidence-based psychotherapies as essential, and medications as beneficial for particular patients and disorders.

Now, I will say this is a fairly dated guideline. It's 10-plus years old now, and medications as a component of treatment really are an evidence-based standard of care for particular substance use disorders. I won't belabor the point with this slide too much, but I just wanted to identify that for three substance use disorders, alcohol use disorder, opioid use disorder, and tobacco use disorder, we have FDA-approved medications, and they are effective for many people and can be a helpful component of care.

The best evidence we have right now is that our medication approach for people with borderline personality disorder, when we're treating co-occurring substance use disorder, is to treat them like anyone else. We don't need to necessarily do anything differently. I will highlight with the use of disulfiram or Antabuse, which can make people sick if they drink on it, with any patient, irrespective of their diagnosis, we would consider whether or not they're likely to impulsively try to drink on the medication because that could cause some medical problems. That's not a diagnostic consideration. That's more of an individual trait, even if it's a state they're in where they're more impulsive.

The same goes for distribution of naloxone to treat opioid overdose. At a community level, this has been shown to be a helpful thing, meaning if you get more naloxone into a community, you have fewer overdose deaths in that community. It's a helpful thing in that way. That's a little different than a clinical trial that might speak to your patient. Giving naloxone to your patient in their hand is that going to help the-- Well, it will help their community. If we disseminate this well in a community, there's no reason to think that having it in the hands of someone with BPD is any less helpful than someone without BPD. In fact, they might be more likely to be around people who overdose that they can provide rescue to in this way.

Finally, a related fundamental here is to avoid emotionally driven clinical interactions. We can have a lot of emotions about people with substance use disorders, and we can have a lot of emotions about people with borderline personality disorder. Even if it's not in general, interactions can lead us to have some pretty strong emotions. We want to carefully consider before we act on our emotions. Even if they're emotions to be really helpful to a patient, that may or may not be the most helpful thing in that moment to take over around, say, getting something done for the making an appointment for them, unless it's what makes the most sense at that time.

That's where I think structured treatments it's one of the benefits of structured treatments. If you have a manual, if you have a prescribed path to work from, it helps us stay on track with people so that we're not moving into shooting from the hip and

doing things that just feel good, even if they're not helpful for people. That's one of the points. There's a lot more to these treatments than just that they provide an overall structure. I do think that's a general benefit of structured treatments.

My other point on this slide, and I know it's a busy slide, on the left, I just listed what are generally considered to be the evidence-based treatments for borderline personality disorder. On the right, I put in whether they included or excluded people with substance use disorders. My point is just that, to a greater or lesser extent, they all included people with substance use disorders. There may be some applicability of these treatments to our folks who have substance use disorders anyway, who, as I was revealing, is happy to see that they weren't excluded from these studies, as had oftentimes been practiced in clinical trials in the past.

We've also had a little more of a deep dive in some of the studies where they've done secondary analyses of the information to compare people with substance use disorders to people who did not have substance use disorders. One study of Good Psychiatric Management, GPM, found that, comparing those two groups, the people who had substance use disorders improved similarly in terms of their general psychiatric symptoms to those without substance use disorders. They actually saw greater improvements in their borderline symptoms and therapeutic alliance compared to the people without substance use disorders.

Similarly to the other co-occurrence within people who have borderline personality disorder, they started out sicker. That gives them more room to improve, but you did see considerable improvements and even greater improvements in the areas as specified. Similarly, standard dialectical behavior therapy was re-analyzed. One of the original trials was re-analyzed, comparing people with and without substance use disorders. Both groups had improvement in their symptoms of borderline personality disorder. It didn't really matter whether they had a substance use disorder or not.

At least some of these treatments seem likely to be useful tools in our toolbox. That's the sort of help that you may provide if you're on that blue side, where you're mostly treating borderline personality disorder all day. Then it can make sense to figure out which elements do we need to add to help people who also have a substance use disorder. There have been several treatments that have been developed and trialed for borderline for people who have co-occurring BPD and SUD. I'll briefly describe these. It's going to be a bit of a caricature. It's a relatively short session. I plan to provide some resources where you can learn more about these at the end of the talk, as we get to the questions.

The first is an adaptation of DBT called DBT-S, DBT for substance use disorders. That involves standard DBT, so the core modules and all that other good stuff that DBT provides. It's not in the workbook. Added to that, coping skills for relapse prevention. Essentially, some techniques from relapse prevention therapy developed by Marlatt. It adds the concept of dialectical abstinence, which is acknowledging a full commitment to abstinence, but at the same time, the dialectic is, there may not be abstinence, and you have to address that and plan for it and make sure it's acknowledged.

Then finally, specific strategies to help patients stay into care and to bring them back in care if they drop out. You don't have the initial DBT standard that they missed

three sessions or four sessions, they're considered to have dropped out treatment, yet you try to bring them back in. I'll present some clinical trial information on all three of these in a minute. Let me move to dynamic deconstructive psychotherapy, which was developed for high-risk patients, particularly people with severe personality disorders and suicide risk, and co-occurring illnesses, including substance use disorder. It was trialed among people who all had alcohol use disorder and personality disorders.

I'll talk about that next as well. Just to give a brief description, it's a fairly sophisticated but very accessible treatment. You can find everything online and really go through, bring yourself through trainings if you want to. The early stages are helping people with borderline personality disorder verbalize their emotional experiences, which is something that can be challenging for them. They tend to talk about things in black and white terms or in generalities. "Everyone hates me. I'm terrible. That person's a horrible person." The technique is to try to bring them to a more specific narrative description of things. "I had hoped for this. This person did that. I responded this way. I felt like that."

Really making it a more coherent, single event. This really can be profoundly grounding for people with BPD. It seems like a really simplistic intervention, but it can be really helpful, having seen it in action. In later stages, this treatment focuses on integrating opposing attributions of self and others. Basically, thinking in shades of gray instead of people being amazing, people being terrible. That's always my goal as a therapist. "He's okay. He's all right. I'll keep working with him," because that's a more realistic, three-dimensional view than being thought to be amazing or terrible.

Then, deconstructing anticipated responses. In other words, as an example, the patient comes in angry, on the attack. Emotionally, our response can be either to want to avoid them, get away, or get them away, or to go on the counter-attack. Instead, sitting with them might be a way to deconstruct that. Learning more about what they're upset about, being curious. Helping them to learn to be curious about their emotional experiences.

Then, finally, dual-focus schema therapy. It involves schema therapy, which is essentially trying to focus on correcting maladaptive cognitive and emotional patterns called schemas using a bunch of different techniques. Added to that, again, relapse prevention therapy. This next slide is a fairly busy slide. There's a lot on it. I'm going to go through it for just a minute. I do want to say I'm going to present some outcomes in tables. This is not a comparison. These studies were different. They're not set up to be compared to each other. It's really meant to be a summary. I want to summarize. I thought a table would be the easiest way to do that.

I'll highlight some things that I think are worth focusing on. This gives you some information on the clinical trials. The top three trials listed under study are DBT trials. The Gregory one is for dynamic deconstructive psychotherapy. Then the bottom two, the two-ball citations, are dual-focus schema therapy. I also then wanted to highlight some of these studies compared the intervention to a very unstructured control group, TAU, treatment as usual, or, in the case of DBT, community treatment by experts, which was basically self-identified experts. If someone said, I'm an expert in borderline personality disorder, they were taken as an expert in borderline personality disorder.

Some, in blue, were highly structured, manualized control groups. It makes a difference in terms of what sort of outcomes you see. Whether you're able to separate from control, how good your control group is, essentially. The DBT study, one of them, compared itself to comprehensive validation therapy, which essentially pulled all the validation steps out of DBT and added a 12-step group to it. Then 12SF is 12-step facilitation, individual drug counseling. Those were manualized. Very structured treatments focused on substance use disorder. Very 12-step focused, especially 12-step facilitation that were developed for very big clinical trials, national clinical trials. They work for substance use disorder.

Those are tough comparisons. I just want to highlight a one-year 100% retention rate for comprehensive validation therapy with 12 Steps. The reason I want to highlight is that how many of you have your individual practices or your groups have 100% retention rate over any sort of a time period? That's pretty impressive. I think it underscores that, first off, people with BPD can tolerate 12 Steps and maybe benefit from it, which I'll come back to. How important validation is, validation of emotional experiences, it's something we want to keep in mind in working with people. Maybe that should be one of the retention strategies when we want to keep people in care.

I'm going to talk about outcomes across the studies. Again, not a comparison, but a summary across the different studies. Start with substance-related outcomes, where they all did pretty well. If there's a plus, it means that group improved in terms of outcome measures over time, so from beginning to end. If there's an asterisk, it means that there was a significant difference between intervention and control. You can see that there was improvement in all of these from baseline.

Then all of them, there's two DDP studies here. The 30-month DDP one is the one in 2010. That separated from control where the shorter study did not. They all had separation from control. They all had, what I'd say, very broad generalization, but they had good outcomes for substance-related measures.

Improvement in BPD symptoms, unfortunately, they didn't really look at all these. NR means outcomes weren't reported. A lot of the studies didn't look at whether BPD itself improved. You had beginning-to-end improvement in one of the DBT studies and one of the dual-focus schema therapy studies. Then the DDP studies, they both separated from, it was an unstructured control, but separated from control and improved beginning to end. We had more information on improvement in psychiatric symptoms. There was improvement beginning to end in the Linehan, in the DBT studies, and one of them separated from control.

Both DDP, dynamic deconstructive psychotherapy studies, separated from control and improved beginning to end. Then we found there was an interesting finding in the dual-focus schema therapy studies in that the control actually statistically outperformed a treatment that is known to help people with borderline personality disorder from other clinical studies. I thought that was a really interesting finding. Again, it may underscore that there might be something in 12 Steps for people with borderline personality disorder if they have a substance use disorder.

At least in this case, they seem to improve. These are manualized. This is not sending somebody, go to the 12-step group, and let's see how it goes. This is a manualized, it's a protocol. You work them through the first couple of steps. There's

some things that look more like CBT, a little bit like CBT, although they're things that are commonly said in 12 Steps, like being aware of people, places, and things, triggers, or precipitants. At least many people can tolerate 12 Steps. It's not for everyone, though. I'm not saying everyone needs to go to 12 Steps. I'm just saying we should consider it in our toolbox.

I'm going to return to the left in yellow and really briefly outline good psychiatric management because I work in a setting where everyone has substance use disorders, as I said, and I need to have something that can run in the background to treat people with borderline personality disorder. Then I can pull some tools to focus with them, maybe individually. The advantages of good psychiatric management, and where I feel like it fits, I would, I guess, draw the comparison for trauma. You might say you have cognitive processing therapy on one side. That's an evidence-based, pretty directed treatment. You know what you're doing. It's very focused on PTSD. On the other side of the spectrum, you have something like trauma-focused care or trauma-informed care, where you may be doing other things, but you're keeping the trauma in mind, and you're providing an environment, and you're doing it in a way that's conducive to people getting better if they have PTSD. I would put GPM as somewhere in the middle. A lot of it is about how you do things and not what you do. It gives you plenty of room to do something different, including DBT, if that's what you're doing.

At the same time, it gives you some tools that you can use because alcohol use disorder treatments themselves, they're helpful for alcohol use disorder and substance use treatments for substance use disorder. They might be helpful for borderline personality disorder and alcohol use disorder based on some of what I showed in the earlier slide. Most clinicians find they don't provide all the tools we need because we run into pretty complicated dynamics with our patients with BPD. GPM has some evidence for being effective for BPD. It'd be nice to have more clinical trials. I'll acknowledge that. It's got the flexibility to integrate with programs that are focused on other things.

I want to give a brief outline here of some principles. Most of this is how you do things. Psychoeducation, you provide psychoeducation. I'll say a little more. That's a what you do. Everything else on here is how you do things. Having an active but thoughtful stance. Basically, modeling curiosity and not necessarily knowing things, working with the patient to try to collaborate to figure them out. A real and professional relationship. Having healthy boundaries with patients, but at the same time acknowledging our limitations, acknowledging and even apologizing to make mistakes, conveying hope through an expectation of change, combined with some accountability on both parts.

We'll help them, and we need their help as well with ensuring things get better. To borrow a phrase from DVT, a focus on a life worth living, but really a focus on life outside of therapy. That's where life is. Therapy is in the service of life and not the other way around. Fundamentally, a practical approach that's not necessarily wedded to any kind of a complex theoretical formulation.

Then I have two final slides on the what of GPM. Making a diagnosis, disclosing it, and educating people about it is a pretty powerful intervention. It does a few things, but it primarily does two things. It instills hope, letting people know that generally

remission is attainable, treatments are available that are evidence-based, and can work. In the process of education, you medicalize the diagnosis to let people understand there's a genetics to it, there's a heritability to it, that it's not a moral failing. Neither diagnosis is a moral failing. The framework is flexible, so it's not a set time that it has to run a year or 12 weeks.

In the AUD adaptation, there's a greater emphasis on keeping people in treatment because, overall, that's helpful. The alliance is focused on, and that includes seeking consultation, having other team members that you talk to so you're not getting into enactments, using structured approaches, and collaborating with the patient on making sure the relationship is going well. On things such as managing suicidality, we need them as a partner, and we teach them to be a part.

Medications are identified as adjunctive. I think I said enough about this already, but we follow the standard of care for alcohol use disorder or for other co-occurring problems that are medication-responsive. Then we encourage split treatment, but not splitting. What that means is GPM really prescribes multiple team members with clearly defined roles, case management being emphasized, and group therapy, because sometimes people can hear things and receive certain kinds of support from peers that are harder to receive elsewhere. Education for family, there's some guidelines and ways to do that, and I'll provide some more of that later. Then communication by treaters. The AUD adaptation also specifically goes over techniques to help engage patients and their families in different forms of self-help. It doesn't have to be 12 Steps, it can be other things, but that's often very accessible to people, whether it's 12 Steps. There's meditation-based self-help now, and there's SMART Recovery, which is a little bit more of a relative of cognitive behavioral treatment.

I want to return to this and say I want to turn the talk over to Dr. Volpe now to highlight a clinical situation where someone who was mainly in substance use treatment has symptoms suggestive of borderline personality disorder and how we're able to use some of these techniques to help them. Do I go to your first slide?

Emily Volpe: Yes, thanks. I appreciate the opportunity to share this case with you. This is Laura, a 34-year-old female coming in for residential treatment. At intake, she is reporting that one of the most distressing things recently was a fight with her boyfriend, and he said that he's asking for space. She is acknowledging feeling depressed, has passive suicidal ideation. There's been a recent increase in both her alcohol use and cannabis use. She's feeling hopeless. "I ruined the only good thing I had going for me."

Of course, at admission, we gather some history. We learn that she does have a history of threatening suicide, with one attempt last year. She also has a history of impulsivity, relationships that she describes as rocky, difficulty controlling emotions, particularly anger, and some abandonment fears. Then, given the opportunity to contact family, that's always usually really helpful. They have concerns over certain patterns of behavior. Most recently, at a family event, she was quite intoxicated and had some anger outbursts with relatives. Of course, in an outpatient setting, oftentimes if someone is trying to cut down or is trying to maybe they have an abstinence goal, but I think highlighting substance use risk and suicidal ideation risk are going to be paramount, particularly in an outpatient setting. While she's in

residential treatment, she's agreeing to be abstinent. We are going to offer some accountability for that, breathalyzing, urine tox screens, but she's agreeing to that goal while in treatment. Then also, we're going to continue to do risk assessment each session, safety planning, and checking in with her about the SI.

Again, I highlighted in blue some of the GPM principles here. The psychoeducation, we do want to share with her diagnoses that she meets criteria for major depressive disorder, both alcohol and cannabis use disorder, and borderline personality disorder. We would discuss the heritability and the impact of trauma and attachment instability. More often than not, I do find that patients, they really resonate sometimes with the borderline personality diagnosis. They feel like it really captures their experience and are relieved to be able to put a name on it. Sometimes also, maybe they've heard of it before. They don't like that term, borderline. Maybe there's a stigma attached to it.

That was the case with Laura. What she does share, though, is that she resonates more with the impact of trauma. She is opening to targeting unhelpful behaviors through this lens. Again, it's really important to just keep her in treatment and to help her with some of the behavior changes she's wanting to work on. This is how we move forward. The SI and sobriety become stable while engaged in residential treatment. We come up with targeting some new behaviors that are interfering. The texting that's escalated. It's become a distraction throughout the day. It's interrupting her sleep. This becomes a target behavior.

We're going to try to increase the consecutive number of days that she's not had contact with her ex. We also want her to utilize the staff that's in the program to support her when she's dysregulated or having distress tolerance issues. Fast forward a little bit, Laura decides to bring a recent text with her boyfriend into session. She describes feeling really distressed when either she doesn't hear back from him or when she is able to practice some restraint.

In this session, here's an example of maybe her lashing out at the clinician, saying something to the effect of, "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?" Again, Dr. Iannucci highlighted before that, of course, we're going to have some knee-jerk reactions to this. We're being accused. Maybe we want to bring up some evidence why this isn't the case.

GPM really sees this as an opportunity to be active and not reactive. Again, sticking with that validation, leaning into something like, "It's really important to you that I know how painful this is." We can bring the focus back to her reasons for not texting the boyfriend. "It sounds like you've had really good impulse control when you didn't text him last night. This is something that you've been really practicing. You've been working really hard at it. I recognize how difficult this is for you, and you've stuck with it. Can we take a moment to reflect on that?"

We continue to review skills, supporting moments where Laura is able to use coping skills effectively. Also, fostering accountability means that we do talk about and process moments when maybe she wasn't so skillful. Maybe later session, she's talking a little bit about past trauma, childhood relationships. She brings this example into session. She describes this recurring event from childhood where her mother

would lock herself in her bedroom when Laura did something wrong. Laura can remember lying outside her mother's room with her nose pressed to the gap under the door, crying and screaming to Mom, yelling, "I'm sorry, please come out," and her mom would not respond.

We want to just stay with Laura in this moment and again, help her to identify the emotional impact and what she was feeling. She can identify feeling ignored, scared, dismissed, helpless, alone, desperate. This maybe is a little bit of a difficult session. While we're in the middle of processing this, Laura says, "I got to call Mom immediately. I got to let her know I'm remembering this, and this is terrible. I'm so angry." Again, this is an opportunity to be thoughtful so we can respond.

One example might be, "I can see how upsetting this is, and I can really appreciate your willingness to talk to me about your mom. I do want to pause, though, and hold off on calling her right now so that we can keep exploring this. I want to keep the focus on you and what you're experiencing."

She might respond okay to that and take a step back. If the impulse to call Mom remains, we can try again and say that, "I really do agree that having a conversation with your mom at some point is important. Let's take the time to prepare for that conversation, though. It doesn't have to happen right now. It doesn't have to happen today." We can emphasize to her that her message is a really important one. "It's important that we take the time to prepare for that conversation so that you have the best chance of ensuring that your mom hears it." Again, modeling and collaborating with her and trying to be thoughtful, holding back that impulsive behavior, and coming up with maybe a better plan.

A little bit of progress here. Laura is able to connect some of the emotions in childhood with how she feels when she's texting her boyfriend and waiting for his response. She begins to explore the relationship between these emotions and her impulse. She feels like she needs to do anything to just demand a response from the other person in that moment. She clarifies her desire to be closer to her boyfriend, and she can start to understand that some of her behaviors are doing the opposite. They're really pushing him away.

A little perspective taking here, she can understand that she's violated some of his boundaries and how her behavior has affected him, particularly heavy substance use and the suicidal statements. Again, clinician, we want to validate her successes and also acknowledge that this is going to be an ongoing process. Successes, she's been able to resist urges to text her boyfriend for up to one week. She's using coping skills with some effect. She's demonstrated increased capacity for perspective-taking. We want to support her engagement in other positive activities, so that life outside of treatment that life worth living.

Also, it comes up sometimes that she's feeling frustrated because progress feels really slow. Sometimes it's two steps forward, three steps back. Just trying to reset expectations that change is gradual and that there may be bumps in the road.

A couple of slides here, and then I'll finish up just on family engagement. Again, I think it's really important, both with substance use disorders and borderline personality disorder, to involve the family members who are involved and have likely

been affected by their loved one in various ways. Providing psychoeducation to them on the chronic nature of both of these. We want to offer hope that effective treatments are available. Remission is possible. Offering some guidance on setting realistic expectations. That can be similar to what we did with Laura, that it could be a little bit of a bumpy road, but the trajectory can be good.

Then also, it can be, especially maybe coming out of intensive treatment. Family members are pretty eager. They have momentum. They want their loved one to go right back to work or right back to school. Just trying to temper those expectations, letting them know that a focus on recovery and ongoing treatment may have to be the immediate priority. We want to encourage family members to practice less emotionally latent reactions to accusations and attacks, and also to acknowledge mistakes. This is something that we're going to be doing as clinicians. It's a really good tool to help model to families and patients, repair as possible in these difficult interactions.

Then offer communication tools and also the rationale for use. I'm sure most of you are aware of this, but those true I feel statements, I feel that next word should be an emotion, that tends to minimize defensiveness in the person we're talking to. We want to use validating language and also try to replace but with and. That's very DBT. I know you're upset, but anything that comes after but implies it doesn't matter. I know you're upset, but it doesn't matter. Trying to use and as much as we can, it's weird, but I think a really good tool for families to start using.

Then also, back to, if the message is important, we want the communication to be effective because sometimes if we're coming in hot, they're going to hear my volume, my tone, my non-verbal, and the message is just not going to be heard. Then last couple bullet points here, helping family members to clarify boundaries. Boundaries are often perceived as ultimatums. Using clear language is important. One example I'll give here, "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 go if you do start using again."

That sounds very different than, "You're not allowed to live with me if you relapse." Trying to coach them through some language. We can also emphasize that just having a plan in place is really important. Peace of mind if someone's suicidal ideation escalates, if someone does have a slip, returns to substance use. We're not predicting that they're going to fail. This is just good practice. These are chronic issues that we need to have a plan for.

Then, also, troubleshooting ways to disengage. Ideally, these conversations would be really productive and effective all the time. That's just not the case. I think setting some ground rules for how to disengage from difficult conversations, we can always come back to them at a later time.

Rocco: I think we can move to questions. I'm just going to scroll through the sources so you can see, and then I'll have some resources shortly.

Moderator: Wonderful. We're now moving into the live Q&A. Thank you to everyone who submitted questions during registration and to those adding them in the Q&A box today. Today's presenters will do their best to answer as many as possible. They

may not get to all of them. Your questions are appreciated. Let's dive in. It looks like we have one question that asks, "What resources do you recommend?"

Rocco: This was submitted in advance, so I have some things that I'm putting into the chat. Let me make sure I do this correctly. Hopefully, you can cut and paste. I put the Good Psychiatric Management the book citation there. What I tried to do is also put in a bunch of free resources that are easily accessible, so you can just check them out. There's some video demonstrations on YouTube, and it takes you through the original version of Good Psychiatric Management, but a lot of it holds for GPM-AUD. The paper initially describing DBT for substance use is actually out and available on the internet free through PubMed, so I put that citation.

Then Dr. Gregory, who developed Dynamic Deconstructive Psychotherapy, on SUNY Upstate their website, he has a whole training there for free videos, a manual for individual treatment, a manual for group treatment. It's really worth checking out. Even if you don't intend to do the whole treatment, it's worth reading. I put an important family guideline that we use, a family handout. It's embedded in the resources for families from the Massachusetts chapter of NAMI. There's other places you can find this. If you just web search Gunderson Family Guidelines borderline, you find it in a bunch of places. It includes a 14-page handout. It's a pretty short pamphlet for families to read.

In our practices, typically, we give it to the patient to read first, they okay it, they almost always do, and then we send it to the family. If they're not agreeing with the diagnosis of borderline personality disorder, we also send the message of, this also, a lot of this applies to other diagnoses as well, and just recovery overall, which is true. Then they usually give us permission to send it to their family as well.

Then, finally, I put the 12-step facilitation manual. It's not a long read. It's not complicated. If you feel like your patient would benefit from 12-step connection, and they're not able to connect well on their own, then this helps you get them connected to 12 Steps, or at least you can learn some techniques. Whether you use these resources in whole or in part, I think they offer some useful things. Like I said, most of them are just freely available.

Moderator: Brilliant. We have another question that asks, "How can you enhance a patient's ability to accept responsibility and exit victim mode?"

Rocco: Yes, it is a great question. It's something that in different ways we can encounter with patients, particularly with BPD. Remembering there's a lot of pain and suffering with BPD. The person who suffers the most is the person who has the BPD, even though people around them can feel it as well. That's where I do draw things from, dynamic deconstructive psychotherapy, where there's a section of the treatment that talks about states of being that are commonly encountered by people with borderline personality disorder. A couple of them are labeled as victim mode. There's the helpless victim mode and the angry victim mode.

There's a few techniques that are described there. One of the most helpful ones is just to stay curious with them and getting to that be responsive but not reactive. If it's a helpless dependent situation, we want to stay engaged with them, and we don't want to take over and do for them. That might not be the most helpful thing. Just

staying curious and exploring with them can be a way to deconstruct that impulse and that response of someone just taking over and helping them, which can feel gratifying on one hand, but also can feel demeaning. It takes away their sense of agency.

If it's more of an angry situation where they're on the attack, again, staying curious can be a really helpful intervention where instead of running or instead of counterattacking, or you need to handle this, it's you that needs to straighten up. That's the anticipated response. That's what they usually get. That can make them just double down. Instead exploring with them a little bit, tell me more about what the situation is like, or if it's me, what's it like to have a doctor that's just heading off on his vacation right when you need him the most, and really being willing to hear those things from the patient can settle them down.

Just staying curious with it, you'll see the anger settle down, and the situation get more collaborative. That would be my first thought, would just be to stay curious with them and to try to explore a little bit.

Moderator: Wonderful. Thank you. We have another question that asks, "Can you please elaborate a bit on co-occurrence BPD and SUD with ADHD in adults?"

Rocco: That's a great question. I have to say it was something that I did a little more exploring on myself recently, and encountered some information recently. I was surprised to see just how high the co-occurrence rate is between ADHD and borderline personality disorder. I knew it was a high co-occurrence rate with substance use disorders. You can come up with different reasons for that. There's a certain amount of sensation seeking and impulsivity. Those traits also hold for people with borderline personality disorders. That may explain it. It does occur at a fairly high rate.

There are some, especially impulsivity, it's a shared trait between borderline personality disorder and ADHD. The rate's somewhere between a fifth to a third of people who have BPD have ADHD. The same thing the other way around, a fifth to a third of people with ADHD, if you go look for BPD, you find that they meet criteria for BPD as well. Some of that's probably overlap of some of the symptoms, but there's probably more to it than that. Many of the treatments for borderline personality disorder help people to bring the frontal lobes online, start to think, slow down, think before they act, and address impulsivity.

I would say medications to address impulsivity it's still being looked at, but there's some evidence, at least, that if people have ADHD and BPD, impulsivity is a risk factor for suicidality sometimes. There may be an argument there for using medications to treat the ADHD and perhaps helping the person with some of their symptoms of BPD. I'd say we need a little more study on that.

Moderator: Wonderful. Thank you. We have another question that asks, "Is motivational interviewing effective in co-occurring cases? How effective is counseling and therapy alone in such cases?"

Rocco: Yes. I'll maybe just reflect back quickly on what we talked about, where it's the primary recommendation for at least this co-occurrence is structured

psychotherapies because there aren't medications, there are not really other options for people with BPD anyway. I would say, in terms of motivational interviewing, the only study I saw it's a small study looking at using MI to keep people with personality disorders, keep them engaged in treatment. It looked promising, but we probably need to know a little more. That being said, the position of motivational interviewing is non-judgmental, it's questioning, it's curious, it's engaged.

It's really what we were talking about. I think motivational interviewing fits with some of these evidence-based approaches for people with borderline personality disorder, including people with co-occurring substance use disorder. I wish we had a clinical trial specifically of that treatment with this, but I'd say there's some evidence it should be helpful, we just don't have clinical trial evidence.

Moderator: Brilliant. Thank you. We have another question that asks, "How can providers adapt to these strategies to be more culturally responsive for minoritized clients?"

Emily: Yes. I do think there are some articles published looking specifically at cultural adaptations for DBT that are probably helpful to look at. I do think, in general, when we're admitting folks here, initial questions that can feel very validating and that we're trying to really get to know them as an individual. We ask people what their preferred pronouns are at admission. I do think including family, as we highlighted, is helpful. Getting a sense culturally if that would be important to the person. I think so much is focused on the individual treatment, but family involvement is really paramount, I think, in a lot of cultures.

Discussing cultural stigmas around these diagnoses, substance use in particular, how might you manage this with the people who you interact with at work or in your family? There can be different cultural stigmas, so trying to get a sense of that, I think, is really important. Two other thoughts I have.

One is, we talk about dysregulation, and I think there's a really negative connotation with that. Oh, someone's dysregulated, and that's labeled as bad. I think highlighting the adaptive function of dysregulation throughout someone's lifetime and how that's maybe served them well, it's helped them to protect themselves, it's not functional now, but there has been an adaptive function to that, I think, can feel very validating.

Then, also using patient-specific language as often as possible can be really helpful. Chain analysis in DBT, I think, is a really good tool for this because you can write down and target their specific language for a thought or a feeling that they're having. Then, referring to this as much as possible, I think, can really help lend a multicultural lens to this.

Moderator: Brilliant. Thank you. Thank you so much for joining us, Drs. Rocco Iannucci, and Emily Volpe. Thank you to all our listeners for your participation. We'd also like to thank McLean Hospital for making this webinar possible. A recording of this presentation will be emailed to everyone in two weeks' time. The recording will include the presentation slides. As soon as the webinar has ended, a short survey will appear on your screen. Please take the survey and give us your feedback. We thank you for your attention and hope you have a great day.

[00:58:26] [END OF AUDIO]