TREATING PTSD IN SUICIDAL AND SELF-INJURING CLIENTS WITH BORDERLINE PERSONALITY DISORDER

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Disclosures

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☐ Dr. Harned is a trainer and consultant for Behavioral Tech, LLC

Goals of the Workshop

☐ Describe the rationale for and structure of the Dialectical Behavior Therapy Prolonged Exposure protocol.
☐ Review criteria for determining when a severe BPD client is ready to begin PTSD treatment.
☐ Discuss strategies for addressing common problems encountered during PTSD treatment with severe BPD clients.
Overview of the Treatment

The Problem

Extensive trauma

BPD

PTSD decreases the likelihood of remitting from BPD.

~50% of BPD clients have PTSD.

PTSD more than doubles the frequency of self-injury in BPD.

Suicide & Self-Injury

69-80% of BPD clients self-injure and/or attempt suicide. 8-10% die by suicide.

PTSD decreases the likelihood of remitting from BPD.

Does DBT work to treat PTSD in Suicidal and Self-Injuring BPD Clients?
Recommended Strategies for Addressing PTSD in DBT

Stage 1 DBT
- Primary target is behavioral dyscontrol.
- Focus is on increasing behavioral skills.
- Use a here-and-now approach to address PTSD-related problems.
- Avoid emotionally processing past trauma.

Stage 2 DBT
- Primary target is PTSD.
- Use DBT exposure-based procedures in a very focused fashion
  OR
- Integrate an established exposure-based PTSD treatment into DBT.

Remission of Axis I Disorders in DBT for Suicidal/Self-Injuring BPD Women

Why?
What are the barriers to effectively treating PTSD in suicidal and self-injuring BPD clients during DBT?
Do Existing PTSD Treatments work for Suicidal and Self-Injuring BPD Clients?

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)

Prolonged Exposure Therapy for PTSD

- Imminent threat of suicidal or homicidal behavior
- Serious self-injury (past 3 months)
- Current psychosis
- Current high risk of being assaulted
- Insufficient memory of traumatic event(s)

"In general, we recommend that if another disorder is present that is life threatening or otherwise clearly of primary clinical importance, it should be treated prior to initiation of PE." (p. 29)
When these Exclusion Criteria are Used

- Clients with and without BPD characteristics improve comparably during PE:
  - BPD Characteristics (n=9)
  - No BPD Characteristics (n=49)

Therefore...

- If you have a client with BPD who:
  - Is not at imminent risk of suicide
  - Has not attempted suicide or self-injured in the past 3 months, and
  - Has a primary diagnosis of PTSD

Use standard PE (without DBT)

Who Are We Trying To Treat?

- BPD clients who are typically excluded from PTSD treatments
- Imminent risk of suicide
- Recent (past 2 months) suicidal and/or non-suicidal self-injury
- Serious (primary) comorbidity
  - Severe BPD
  - Severe dissociation
  - Substance dependence
- All forms of chaos allowed, except...
  - Psychotic and bipolar disorders
Integrating PE into DBT: Problems and Solutions

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 Apply

- Standard DBT
- Higher-Priority Problems
- Skills acquisition

**Goal:** To prepare clients to be able to complete exposure therapy safely and effectively.
A Model for Integrating DBT and PE

Judith Herman's Stages of Trauma Recovery (1992)

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

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

Problems to Solve

3. No clear criteria for determining when suicidal and self-injuring BPD clients are ready for exposure therapy for PTSD.
Solution Was to Develop

- BPD-specific readiness criteria
- Test them through an iterative process of treatment development

Deciding when to Start the DBT PE Protocol

- 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. PE does not include structured methods for monitoring suicide risk and other potential negative reactions to exposure.
Solution Was to Apply

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

5. No clear guidelines for addressing suicidality and other major problems that may occur during PE.

Solution Was to Apply

Standard DBT

Exposure-related problems
Exposure-interfering problems
Other concurrent problems
Solution Was Also to Develop

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

Problems to Solve

6. Some therapist strategies that are recommended in PE are:
   - Incompatible with DBT therapist strategies, and/or
   - Do not address the specific cognitive, emotional, and behavioral characteristics of severe BPD clients.

Solution Was to be a DBT Therapist who does PE

Team Consultation

- CHANGE
  - Irreverence
- ACCEPTANCE
  - Reciprocity

Validation

Problem Solving

Environmental Intervention

Core
Review of Research Findings

- Pilot cases (n=7) by Harned & Linehan, 2008
- Open trial (n=13) by Harned, Korslund, Foa, & Linehan, 2012
- Ongoing pilot RCT (n=26)

Research Progress

Treatment Feasibility: Open Trial Results

- Intent-to-Treat Sample (n=13)
  - DBT PE Protocol Started (n=10)
    - Completed (n=7)
    - Did not Complete (n=3)
  - DBT PE Protocol not Started (n=3)
    - Treatment drop (n=3)

Harned, Korslund, Foa, & Linehan, 2012
Treating PTSD in Suicidal and Self-Injuring Clients with BPD

PTSD Remission Rates

- Meta-Analysis of Exposure Treatments for PTSD*
  - Compliers: 68%
  - ITT Sample: 53%

% Remitted from PTSD at Post-treatment

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* Bradley et al., 2005

PE does not Increase Suicidal and Non-Suicidal Self-Injury

- From pre- to post-treatment, large and significant improvements were also found for:
  - Suicidal ideation
  - Trauma-related guilt cognitions
  - Shame
  - Dissociation
  - Depression
  - Anxiety
  - Social adjustment

Harned, Korslund, Foa, & Linehan, 2012

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Common Problems during Exposure with Severe BPD Clients

Problem #1: Dissociation

Dissociation: Potential Solutions I

- Before starting formal exposure, test clients' ability to control dissociation (e.g., via exposure to a very low SUDs task).
- Make sufficient control a requirement to start.
- If dissociation is severe and out of control, need to target and treat it first via standard DBT.
- Start with cues from the hierarchy that elicit low SUDs (e.g., 20-40).
- Use skills during exposure.
  - Ice, sour candy, balance board, push-ups/squats, catching/throwing a ball
Dissociation: Potential Solutions II

- Contingency clarification
  - Dissociation will interfere with exposure working

- Contingency management
  - Reinforce non-dissociative behavior
    - Warmth, more contact, praise
  - Punish dissociative behavior
    - Withdraw warmth, decrease contact, self-disclosure of irritation, end session early

Dissociation: Potential Solutions III

- Modify exposure tasks to make them less distressing
  - e.g., include safety behaviors, focus on less feared parts of the situation or memory
- Allow controlled escape during exposure.
- Therapists get more active.
  - More praising, reassuring, coaching, prompting
- Keep trying things and do whatever works!

Problem #2: Emotional Suppression

This is for all of you who want me to show more emotion and anger.

I hope that didn't frighten anyone.
Emotional Suppression: Examples
- Does not achieve high SUDs levels (low emotional engagement)
- Engages in exposure, but with flat affect
  - e.g., trauma narrative sounds like a "police report"
- May be due to:
  - Intentional efforts to suppress or avoid emotions
    (“emotion-phobic”)  
  - Automatic emotional suppression responses

Emotional Suppression: Potential Solutions I
- Validate urges to suppress emotions
- Provide support and encouragement
- Reiterate rationale (e.g., avoidance of emotions will make exposure not work)
- Use DBT skills to up-regulate emotions
  - Mindfulness, radical acceptance, willingness
- Use chain analysis to assess and problem-solve emotional suppression
  - At what point did you decide to suppress emotions?
  - If it happened automatically (without intent), what was going on immediately before?
  - Identify problematic links and generate solutions

Emotional Suppression: Potential Solutions II
- Common cues for emotional suppression:
  - Fear of losing control if allow intense emotions
    - Suicide attempts, self-injury, substance use, violence
  - Lack of confidence in emotion regulation abilities
    - Belief that emotions can’t be regulated once they start
  - Intense shame and self-judgment
    - I’m bad, disgusting, and dirty
  - Fear of therapist rejection
    - My therapist thinks I’m bad, disgusting, and dirty
Problem #3: Shame as the Primary Emotion

Shame: Examples

- Shame-related beliefs
  - “I’m a bad person.”
  - “I’m disgusting because I was sexually aroused.”
  - “I’m dirty.”
  - “If anyone really knew me, they would hate me.”
- Shame-related behaviors
  - Avoiding eye contact, covering face
  - Leaving out most shame-eliciting details
  - Halted speech, low volume while talking
  - Appeasing: apologizing over and over
  - Seeking reassurance that therapist is not rejecting

Shame: Potential Solutions I

- If unjustified, use opposite action
  - Eye contact, confident tone and posture during exposure
- Validation
  - V4: Past behavior makes sense
  - Functional validation: post-exposure walk
  - Start with heavy therapist validation, move to eliciting client self-validation
- Irreverence
  - Use irreverence and humor when doing exposure to shame-inducing events
Shame: Potential Solutions II

In Vivo Exposure to Unjustified Shame

- Make a mistake
- Cry in front of others
- Ask a question about something you feel you should know
- Tell a friend about your trauma
- Receive praise
- Talk about something you are good at
- Ask for what you want
- Tell a (white) lie
- Be late for a meeting
- Miss a deadline
- Talk about your mental health problems
- Ask for help
- Look at yourself in a mirror
- Wear revealing clothes
- Say “no” to a request

Shame: Potential Solutions III

If behavior violates values or shame is justified:
- Focus on making repairs
- Commit to avoiding that behavior in the future
- Dialectical strategies: you are not all good or all bad
- Radical acceptance of past behavior
- Forgiveness and letting go

Recommendations for Further Reading


Recommendations for Further Reading (cont.)
