National Institute for Health Research

Imperial College London

Personality disorder and post-traumatic stress disorder: Implications for DBT and MBT

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Personality disorder and PTSD

- 25-60% of patients with BPD have PTSD [Barnicot & Priebe 2013, Golier et al. 2003, Harned et al. 2010]
- Patients with BPD and PTSD:
- More frequently hospitalised [Zlotnick et al. 2003]

  -Less likely to achieve remission from BPD

  [Zanarini et al. 2006]

  -Lower quality of life, greater emotional dysregulation, greater Axis I comorbidity, greater rates of self-harm and suicide attempts [Harned et al. 2010, Pagura et al. 2010]

PTSD and dialectical behaviour therapy

- 13% PTSD remission after 12 months of DBT [35% at 1 year follow-up, Harned et al.2008, pers. comm.]
- Initial PTSD severity predicts lower likelihood of self-harm cessation during DBT [Harned et al. 2010]
- If trauma is targeted during DBT using prolonged exposure:

DBT alone (N = 9)	DBT plus PE (N = 18)
40% recovered from PTSD	80% recovered from PTSD
	2.4 times less likely to commit suicide
	1.5 times less likely to self-harm

[Harned et al. 2014]

PTSD and mentalization based therapy

- Recovery rate = ?
- Effect on treatment outcomes = ?

Research Questions

- What is the prevalence of PTSD in UK specialist DBT and MBT personality disorder services?
- What is the effect of standard DBT and MBT on PTSD prevalence & severity?
- Do clients with PTSD or with more severe PTSD experience poorer outcomes from standard DBT and MBT?
- How feasible and acceptable for clients and therapists is a combined DBT-PE intervention for trauma?

Methods

- NIHR funded Post-doctoral Fellowship
- N = 92 individuals with any personality disorder
- Recruited from six personality disorder services:

3 MBT approach

3 DBT approach

- 2 DBT services piloting DBT + PE

Sample

- 72% female
- Mean age 29 years (s.d. 9.3)
- 58% white british, 14% mixed race, 9% black british, 9% british asian, 7% white other, 3% asian other
- 98% borderline personality disorder

Research Question One

What is the prevalence of PTSD in UK specialist DBT and MBT services?

Prevalence of PTSD

Traumatic Antecedents Questionnaire & SCID-I interview for PTSD

At the start of treatment:

- 75% of participants met criteria for PTSD.
- Index trauma:

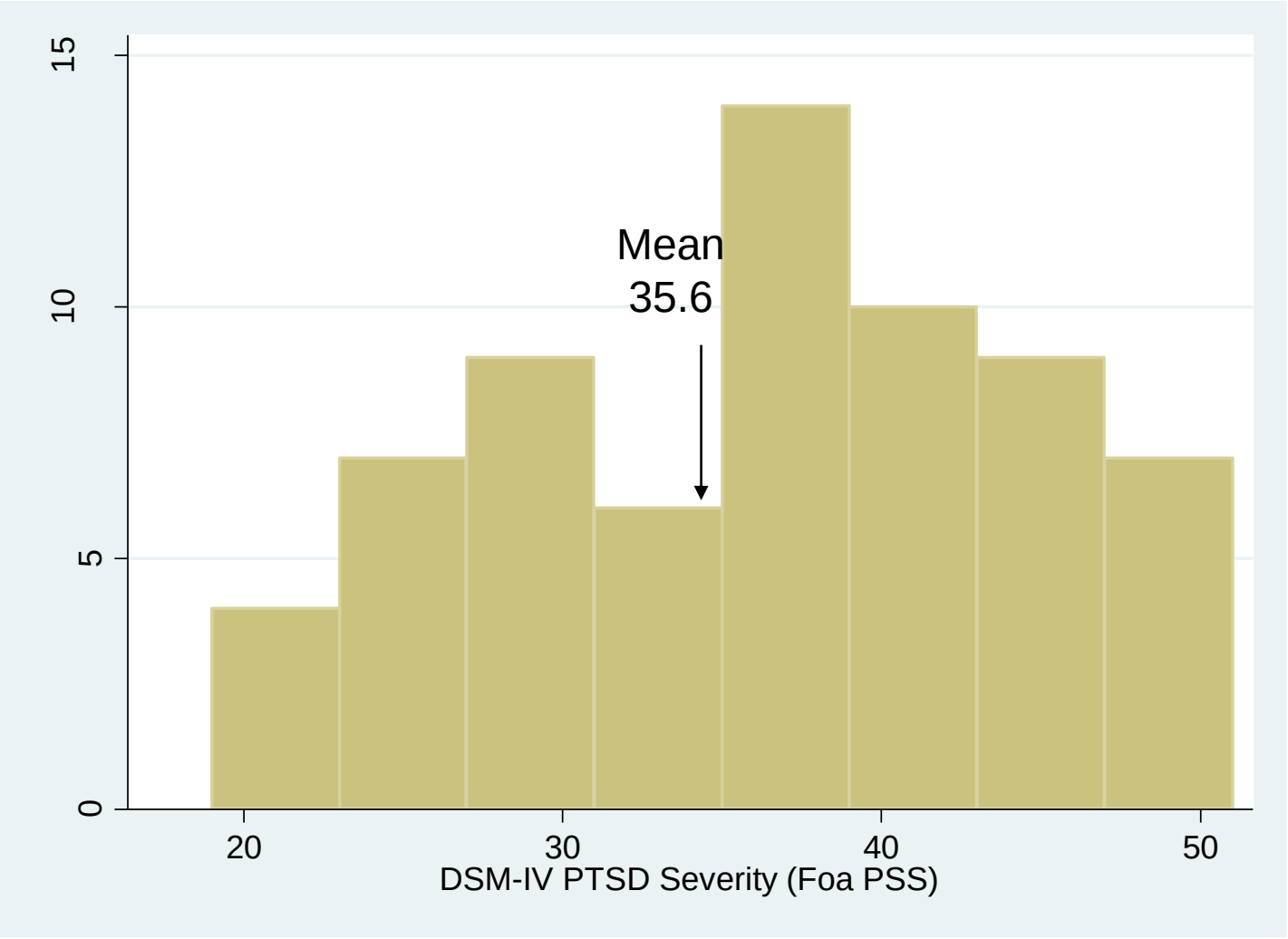
69% Sexual violence

29% Non-sexual violence

2% Witnessing violence

- MBT clients less likely to meet criteria (OR = 0.29, p = 0.01)

Severity of PTSD

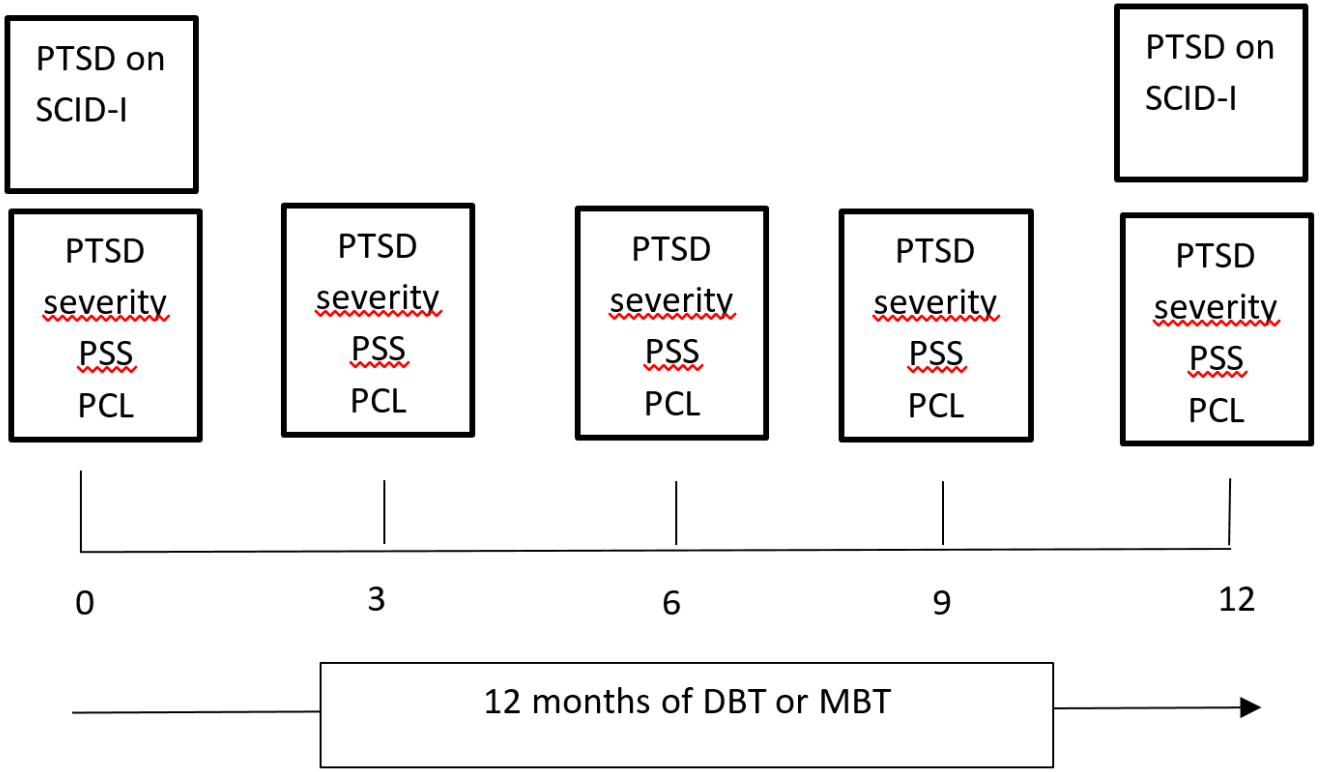


Harned et al.
2014
Mean 32.8

Research Question Two

What is the effect of standard DBT and MBT on PTSD prevalence & severity?

Methods



Intention to treat sample
Follow-up rate: 84%

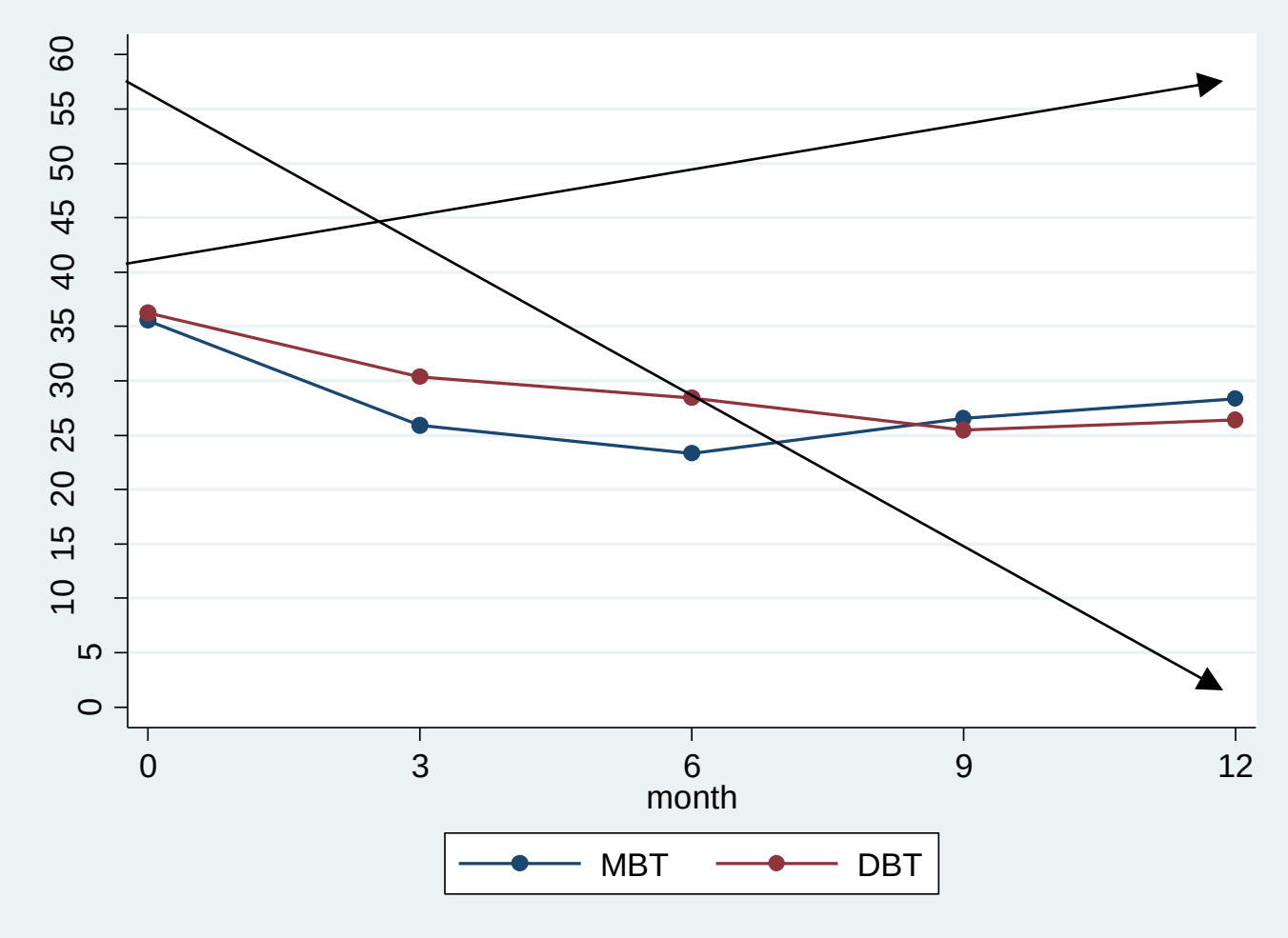
Change in PTSD diagnosis

PTSD at month 12	Whole Sample	DBT (ITT)	DBT (completers)	MBT (ITT)	MBT (completers)
YES	49 (82%)	38 (88%)	15 (75%)	11 (65%)	9 (60%)
NO	11 (18%)	5 (12%)	5 (25%)	6 (35%)	6 (40%)

P = 0.04

Harned et al. 2008: 13% full remission following 12 months DBT (35% at 1 year follow-up).

Change in PTSD severity



Significant reduction over time: β = -0.78, 95% CI -0.55 to -1.01, p < 0.01
No difference between DBT and MBT or between completers and dropouts

Research Question Three

Do clients with PTSD experience poorer outcomes from standard DBT and MBT?

Methods

- Collect outcome data every 3 months over a 12 month period
- Compare participants with PTSD to those without PTSD on:

- Self-harm (Linehan Suicide Attempt Self-Injury Interview)
  - Did they continue self-harming
  - How often did they self-harm
  - Suicide attempts
- BPD severity (BEST)
- Dissociation (DES)
- Emotional dysregulation (DERS)

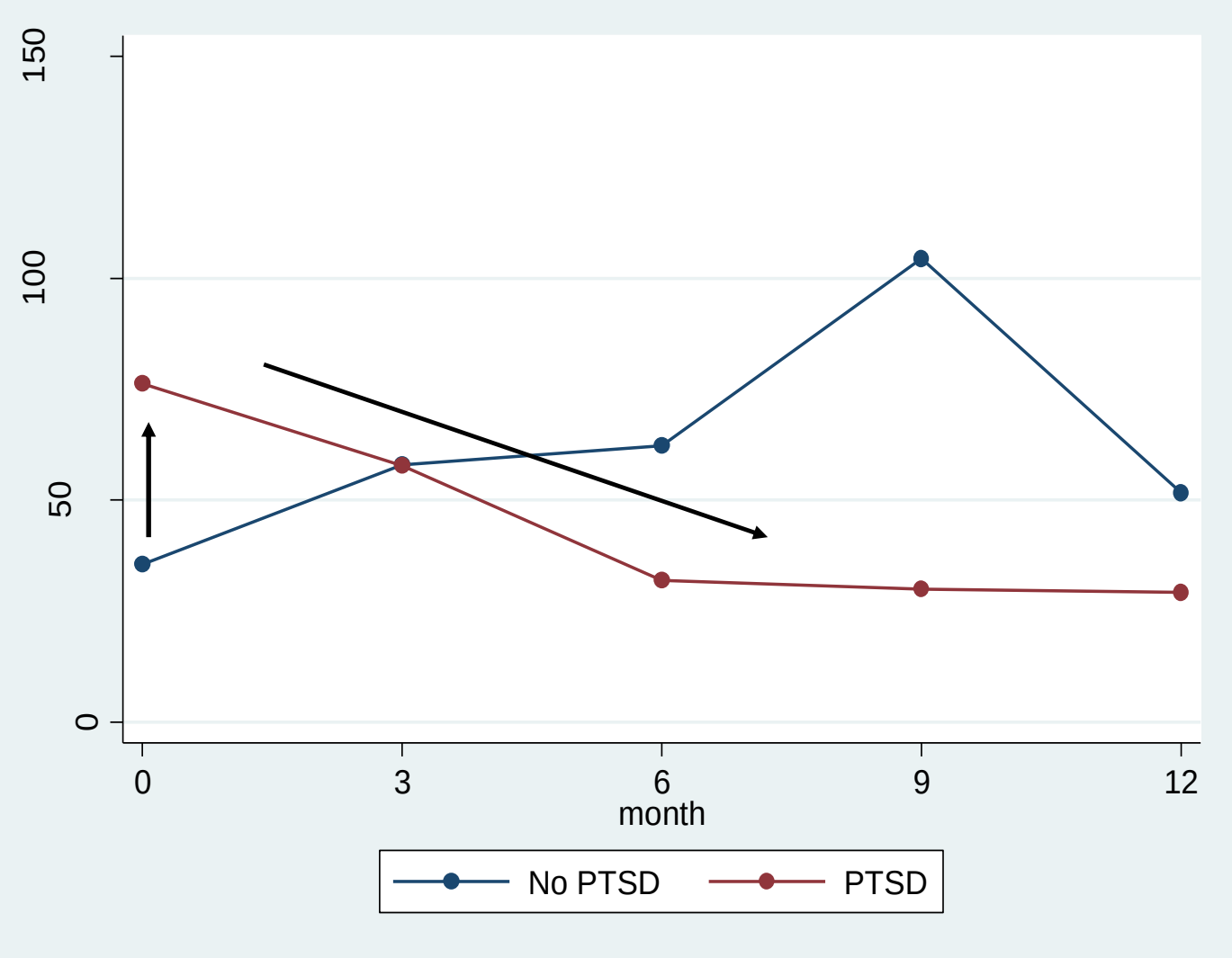
Where PTSD does not make a difference

- Whether someone continues to self-harm during treatment
- How severe someone's BPD is during treatment
- How likely someone is to be hospitalised, use A&E or attempt suicide during treatment

Where PTSD is linked to better outcomes

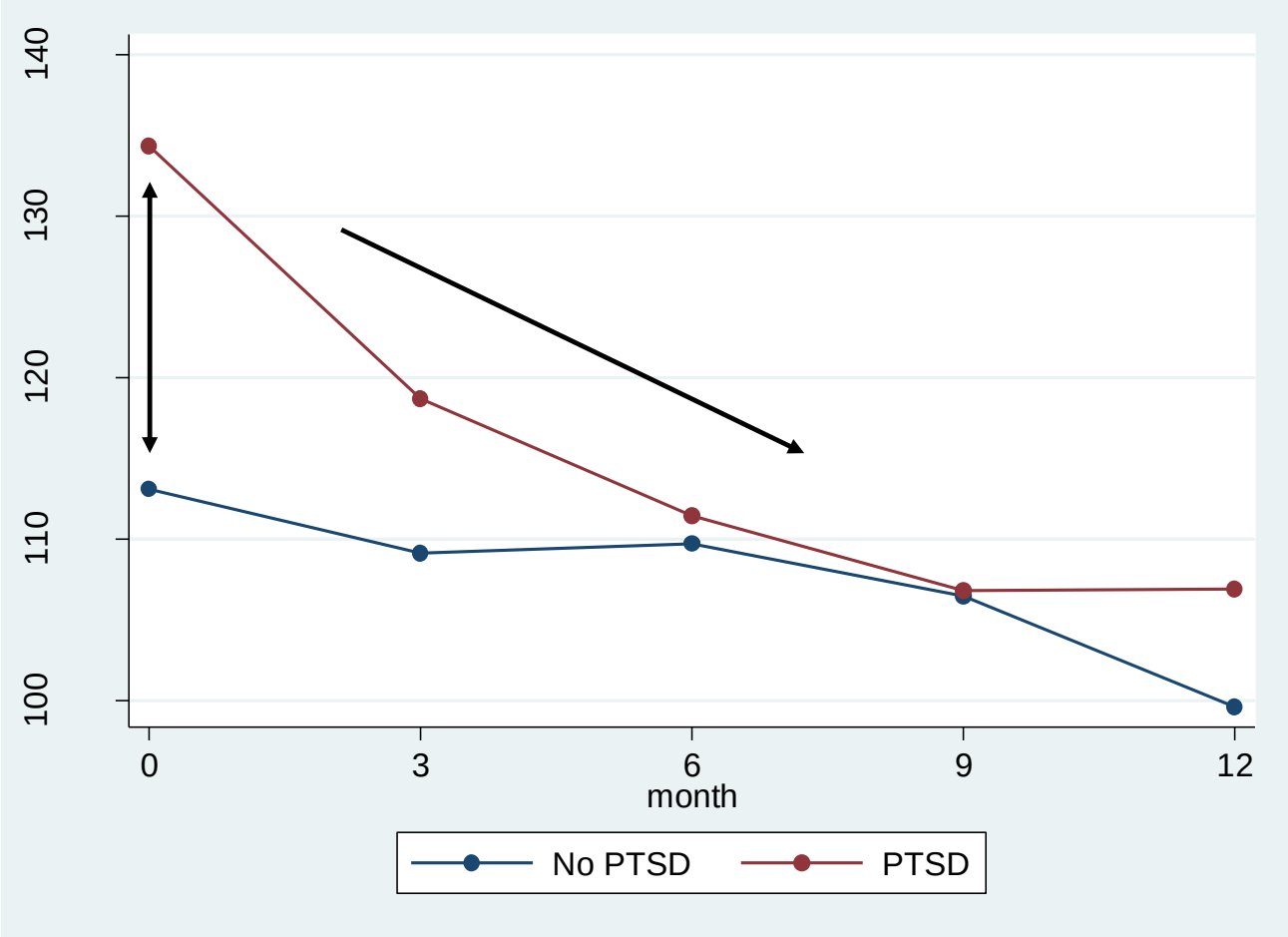
- Greater decrease in frequency of self-harm during treatment
- Greater decrease in emotional dysregulation during treatment

Decrease in frequency of self-harm



$p < 0.01$

Emotional dysregulation

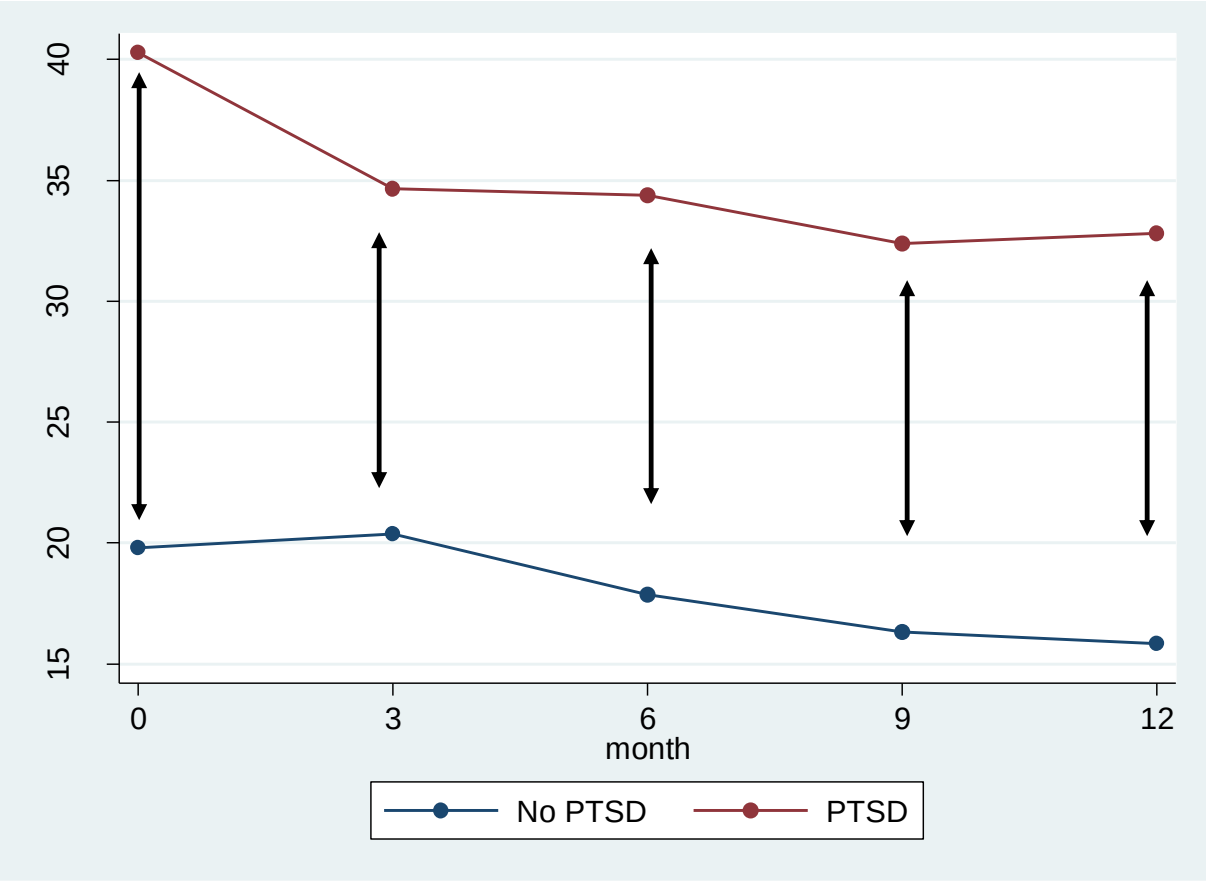


Greater emotional dysreg in PTSD before tx: β = 21.3, 95% CI 8.0 to 34.5, p < 0.01
More rapid decrease in emotional dysreg: β = - 1.32, 95% CI -2.40 to 2.40, p = 0.02

Where PTSD is linked to poorer outcomes

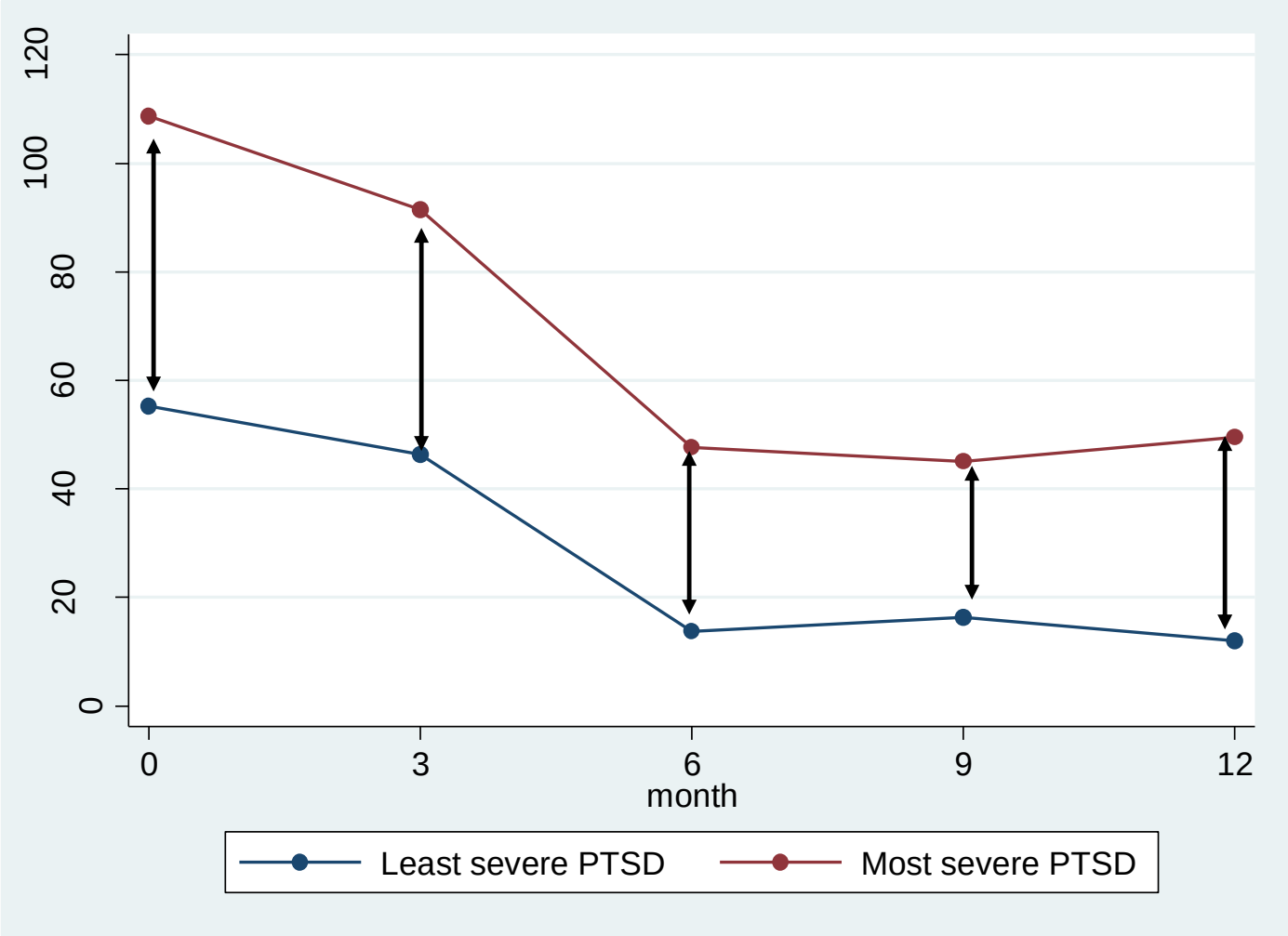
- Higher levels of dissociation throughout treatment
- Severe PTSD → more frequent self-harm during treatment
- PTSD worsening during treatment → more likely to carry on self-harming during treatment

Dissociation



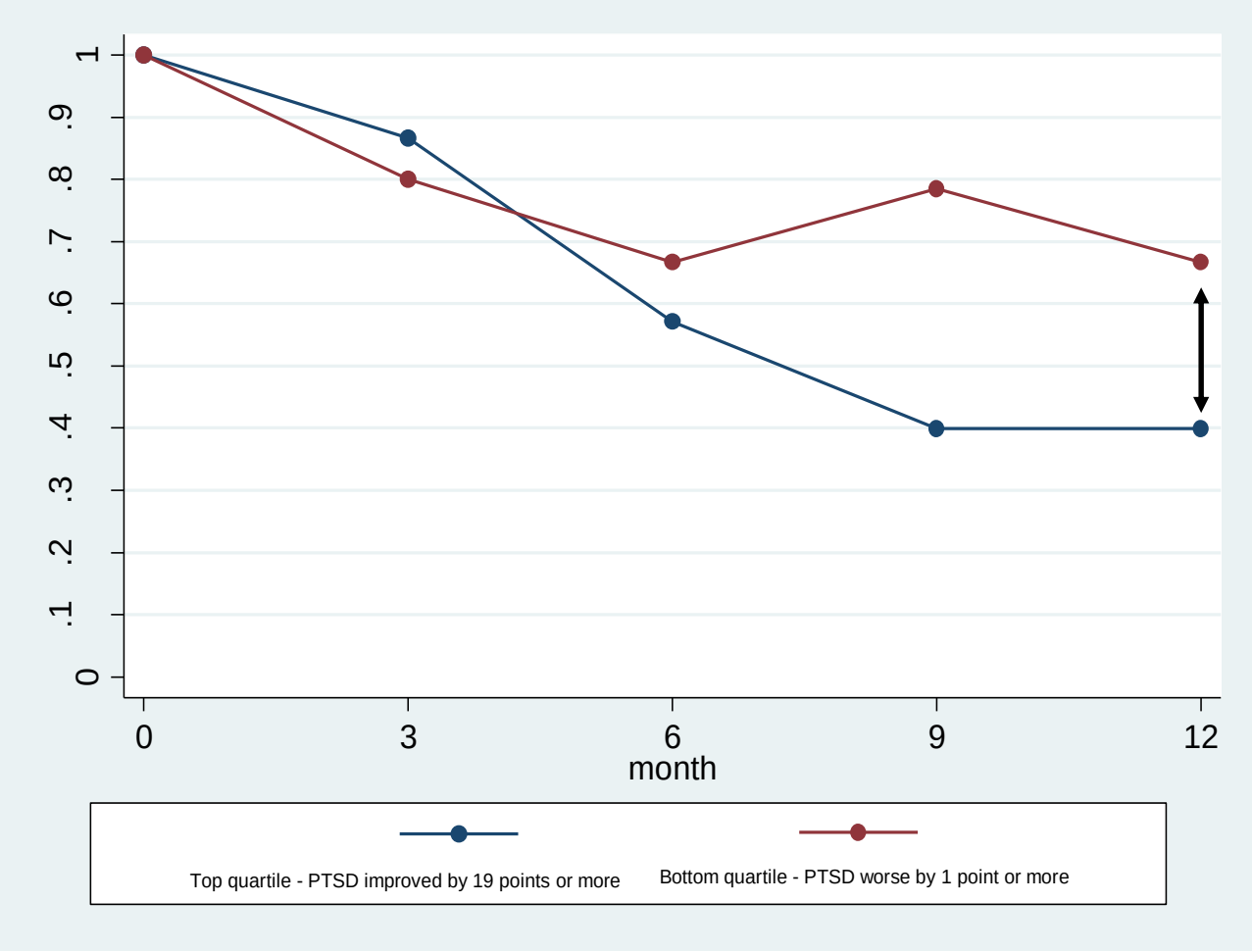
Decrease in dissociation over time: β = -0.60, 95% CI – 0.83 to -0.35, p < 0.01
Elevated dissociation in PTSD at tx start: β = 20.5, 95% CI 10.3 to 30.6, p < 0.01
Elevated dissociation in PTSD during tx: β = 15.9, 95% CI 6.8 to 25.0, p < 0.01

PTSD severity and number of incidents of self-harm



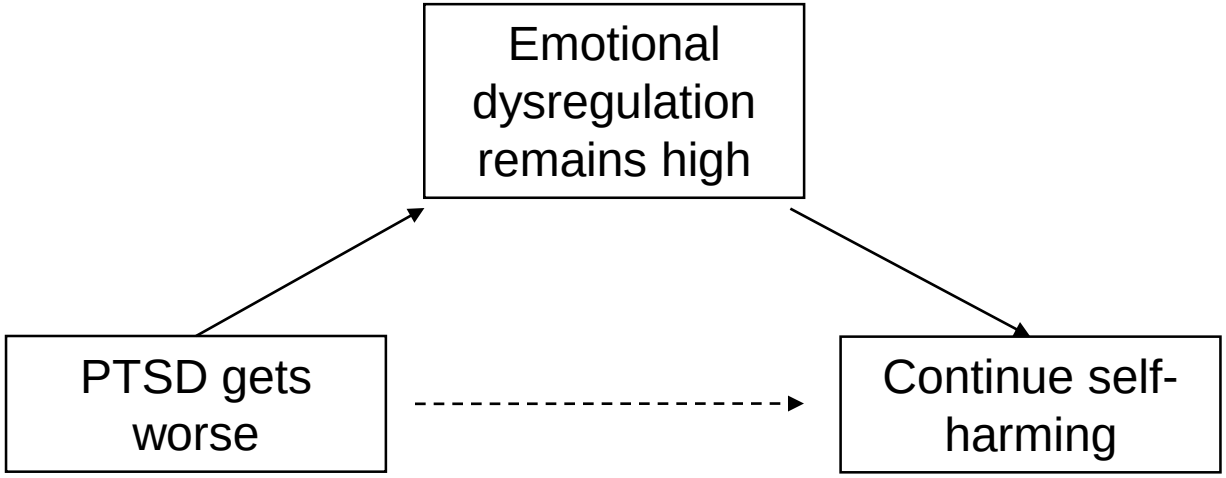
P = 0.02

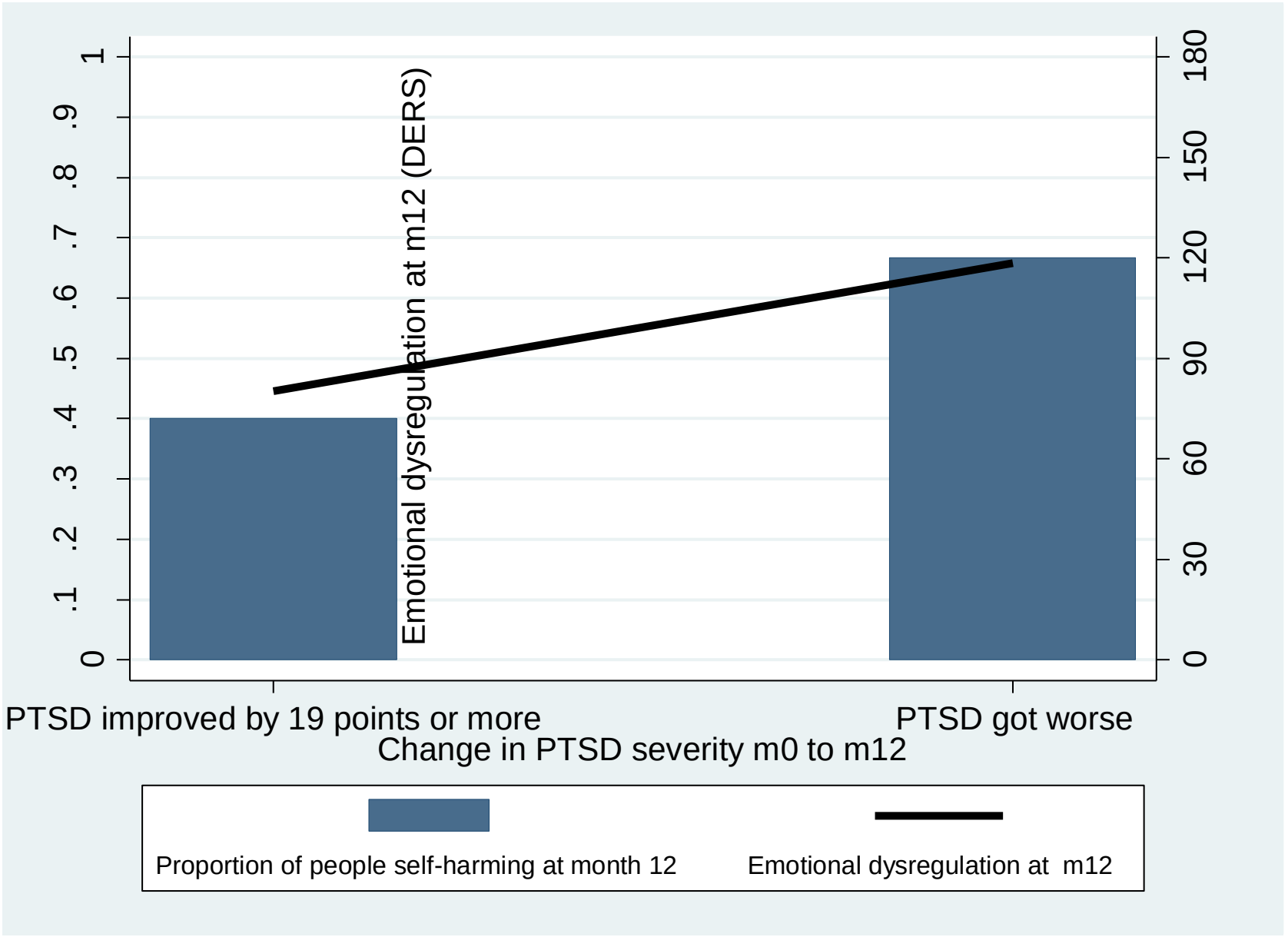
PTSD gets worse = carry on self-harming



P = 0.02

Why do people carry on self-harming if their PTSD gets worse?

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150
180
Emotional dysregulation at m12 (DERS)
PTSD improved by 19 points or more
PTSD got worse
Change in PTSD severity m0 to m12
Proportion of people self-harming at month 12
Emotional dysregulation at m12

Research Question Four

How feasible and acceptable for clients and therapists is a combined DBT-PE intervention for trauma?

Methods

- Two personality disorder services piloting DBT with prolonged exposure – training 2013
- 47 clients starting DBT March 2014 to August 2015
- Survey at treatment start to determine whether participants want PE and their reasons
- Determine numbers beginning and completing PE
- Qualitative interviews with clients and therapists

Survey about client interest in PE

- 21 out of 36 (60%) of participants with PTSD said they would try PE if offered

Reasons for interests in PE

- Impact of trauma on life (54%)

"I really desperately want to be free of flashbacks and nightmares"

"I want to get the trauma out of my system. I'm already distressed now by the PTSD so it doesn't concern me that PE could be distressing"

"I want to be able to get the memories out of my head... I think it is a big contributor to dysregulating my emotions"

Reasons for interest in PE

- Can see how it could help (26%)

"I know I really need it and it would be good for me"

"I'll give anything a go that might work"

- Would fit well with DBT (26%)

"DBT and PE are interlinked – it's all being aware of yourself and learning about myself"

"PE could give practice for the skills, and DBT sessions would give additional support – better to get everything out the way at the same time"

Reasons for not wanting PE

- Distress of undergoing exposure (60%)

"I couldn't cope with having to listen to myself reliving it"

"I wouldn't like to listen to myself talking about what happened... It would be too distressing"

"I don't want to talk about what happened"

"DBT on its own is already stressful and quite a lot to deal with"

- PE unlikely to be helpful (25%)

"I don't remember the trauma enough... So I wouldn't be able to benefit"

"I've already been through lots of treatment for PTSD and it just made it worse"

Reasons for not wanting PE

- Minor impact of PTSD on life (8%)

"I'm not affected by it that much"

- DBT alone sufficiently helpful (7%)

"DBT is helping enough"

Delivery of PE

- 7/21 (33%) who wanted PE have received it
  - 2 completed
  - 5 started but terminated early
- 1 received EMDR instead
- 3 completed DBT without PE
- 10 dropped out of DBT before accessing PE

Client and therapist experiences of PE

- Qualitative interviews with 9 clients
- In-depth qualitative interviews with 4 therapists + 3 still to be completed

Preliminary Findings: Benefits of PE

- **Understanding** effects of trauma on thinking and behaviour

"I **acknowledged** the main traumas that had got me **thinking I was worse** than everyone else, and I was crap"

- No longer **minimising** the trauma

"I **acknowledged quite how bad** it was, whereas a lot of the time I would say 'Oh it wasn't that bad'".

Preliminary Findings: Benefits of PE

- **Self-compassion**

"I **understood** more **why** I felt the sick feelings and the fear and the avoidance, and I was a bit more **compassionate** with myself"

- **Reduced shame** about trauma

"I do think after listening to something, over and over again, the sort of **shame** and all that does get replaced by 'here we go again' sort of thing! It does **desensitise** you."

Preliminary Findings: Benefits of PE

- **Reduced self-blame** for trauma:

"Thinking back now, **an 11 year old don't know** nothing. And [my therapist] has had to show me that to me. That at 11, you really didn't have a clue. So **don't beat yourself up** for it. "

- **Reduced re-experiencing** symptoms

"The dreams became **less frequent** and I have **more control** in them."

Preliminary Findings: Barriers to Completing PE

- Client trauma memory is **not sufficiently intact**:

"What's most challenging actually is for this group is that they very rarely have **three distinct memories**… the memories themselves **morph in to one another** so then there's a **vagueness** about it."

- Client **willingness fluctuates**:

"She was very **wary** and her **willingness almost moved** from week to week. Then we'd stop and then we'd start and then we'd stop …And eventually she said that actually no, **she felt she couldn't** do it"

Preliminary Findings: Barriers to Completing PE

- Client **cannot tolerate distress** of exposure:

"When we spoke about my trauma and I disclosed some things it brought back lots of **painful memories**, things I thought I'd forgotten about. Now I feel really **sad** and it's brought up lots of emotions. I'm **not really dealing** with it - that's why I've started **drinking** and doing lots of other risky things. I drink to **try to block it out** but then when I wake up the **memories and feelings** are there again so I just want to drink some more. "

Preliminary Findings: Barriers to Completing PE

- Therapist **lacks confidence** "it's about me [not] being able to **imbue enough confidence** in them that **they can survive** it….I think that might be one of the things that is getting in the way."

Lack of dedicated supervision:

"Do you take it to **consultation** or not? There's something about feeling quite **protective** towards your clients about the depth of information you get and **whether you want to share** it with people who are [just] involved in skills training…. my preference would be to have a small amount of time that we're just bringing up cases we are struggling with, **with the people who are doing PE work**. And the other folks leave."

- “There was consult but it was **nominal** and without that kind of support and someone making the decisions to free up the resources to do this, it **became one of just many tasks** that needed to be done without enough time to really do it…. having a more robust consult, would have been very helpful by **keeping it on the agenda**, by talking about when this was going to happen, **if it was still part of the client’s goals**…, by helping be a sounding board for any of my own **therapy interfering behaviours** that might have gotten in the way.”

Summary

- PTSD **highly prevalent** in specialist PD services
- Very **low remission rates**
- PTSD does not make a difference to whether clients continue to self-harm during treatment, nor BPD severity or service use
- **Clients with PTSD - do better at reducing frequency of self-harm, and reducing emotional dysregulation**

  - remain highly dissociated during treatment
- Clients with **more severe PTSD self-harm more often** during treatment
- Clients whose **PTSD gets worse continue self-harming** during treatment
- Many clients **want PE** but successful delivery was challenging – could PE-specific supervision be helpful?

Acknowledgements

THANK YOU TO:

Clients and therapists

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Measuring self-harm

- Linehan Suicide Attempt and Self-Injury Interview
- Self-harm = “Any overt, acute, nonfatal self-injurious act where both act and bodily harm or death are clearly intended (i.e., both the behavioral act and the injurious outcomes are not accidental) that results in actual tissue damage, illness, or, if no intervention from others, risk of death or serious injury.”
- Suicide attempt = as above, participant considers as a suicide attempt

Types of self-harm

- Picking at skin / re-opening wounds
- Scratching
- Hitting body / banging head / punching wall
- Cutting
- Overdose
- Self-poisoning
- Stepping into traffic
- Jumping from high place
- Strangulation / hanging
- Drowning

Medical risk of death from self-harm

INTERVIEWER: RATE MEDICAL RISK OF DEATH BASED ON METHOD AND ON OTHER SUBSTANCES PRESENT AT TIME

1 = Very low. Less than/equal to 5 pills (unless medication potentially lethal in low doses); scratching; reopening partially healed wounds; head banging, swallowing small, non-sharp objects; going underdressed into cold for brief time, lying down at night in the middle of a non-busy road but getting up when a car doesn't come or swimming out to middle of lake and returning upon getting tired. Minor heroin overdose 1.5 times usual dependent dose.

2 = Low. Superficial cut on surface or limbs; 6-10 pills (or fewer if medication potentially lethal in low doses); cigarette burn(s), jumping feet first from very low place (less than 10 feet). Heroin overdose 1.5 times usual dependent dose combined with other drugs and/or alcohol.

3 = Moderate. Overdose on 11-50 pills or two or more types of pills or 6-10 pills potentially lethal in low doses and combined with alcohol; deep cuts anywhere but neck, swallowing ≤ 12 oz shampoo or astringent, ≤ 2 oz. lighter fluid, or ≤ 4 tbsp. cleaning compounds; igniting flammable substance on limb. Moderate heroin overdose 2 - < 3 times usual dependent dose.

4 = High. Overdose with over 50 pills or 11-30 pills potentially lethal in low doses or combined with large amount of alcohol, stabbing to body; pulling trigger of a loaded gun aimed at a limb (arm or leg), swallowing > 2 oz lighter fluid, > 12 oz shampoo or astringent or > 4 tbsp. cleaning compounds, igniting flammable substance on multiple limbs and torso, walking into heavy traffic.
Heroin overdose 2 - < 3 times usual dependent dose combined with other drugs and/or alcohol.

5 = Very high. Overdose with over 30 pills lethal in small doses or combined with large amount of alcohol; poison (unless small amount not potentially lethal); attempted drowning; suffocation; deep cuts to the throat or limbs; jumping from low place (less that 20 feet), igniting flammable substance all over body, electrocution, throwing self in front of or from car going less than 30 miles/hr, strangulation. Serious heroin overdose 3 or more times usual dependent dose.

6 = Severe. Pulling trigger of loaded gun aimed at vital area (such as torso or head); Russian roulette, jumping from a high place (more than 20 feet); hanging (feet above the ground); asphyxiation (such as carbon monoxide suffocation); jumping in front of auto going faster than 30 miles/hr or off overpass in rush hour traffic, attempted drowning after ingesting alcohol or other drugs, swallowing nail polish remover, turpentine or similar substances. Serious heroin overdose 3 or more times usual dependent dose combined with other drugs and/or alcohol.