Opioid use disorder and borderline personality disorder

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Takeaways

- 33% of patients with an OUD have BPD
- 75% of patients with BPD will have an SUD during their life; 50% right now
- BPD complicates all outcomes in OUD, but is treatable
- High risk patients: negative emotion is normal. Need a system for managing.

Why it matters

- “It doesn’t matter how many times a person tells me they like me… always, the fear of rejection. I dont’ know how many times I have to fight off the thoughts of everyone hates me. I know it may not be reality but i**t feels real”**

- “Having BPD is like living with 3rd degree burns all over the body - lacking emotional skin, they feel agony at the slightest touch or movement”

- “It’s like being a child in an adult body”

Why it matters

- Patients with BPD and SUD have greater impairment and worse prognosis than either alone (Kienast et al 2014, Wedig et al 2013)
    - Higher levels of substance use, polysubstance use
    - Higher rates of risky drug behaviour (Eg IV use)
    - Increased risk of completed suicide
    - Less abstinence, more frequent dropouts, relapse into SUD after remission

Why it matters

- BPD and SUD review - Trull et al 2018 - **highly comorbid (or co-occurring)**
  - 70 studies from 2000-2017, 10000 people.
  - People with a SUD
    - 22% of people with SUD met criteria for BPD (1 in 5)
    - **34%** of people with OUD met criteria for BPD (1 in 3)
  - People with BPD
    - 75% of BPD met criteria for SUD in lifetime (¾)
    - 45% of people with BPD *currently had a SUD* (almost ½)
  - Conclusion:
    - Cannot say whether SUD are a cause or consequence of BPD
    - SUD likely *exacerbate* (not *cause*) PD symptoms
    - ?common factor *prior to both* (early affective instability, impulsivity)

Why it matters

- BPD increases dropout from residential addiction treatment (Tull and Gratz 2012)
  - 160 men, USA, residential treatment 30-45 days.
  - 20% met criteria for BPD: significantly more likely to drop out
  - What can be done to help them stay in treatment?

- BPD and opioid use
  - More likely to become addicted to prescription opioids

- **Patients with BPD are commonly excluded from RCTs for patients with SUD**
- **Patients with SUD are commonly excluded from RCTs for patients with BPD**

Personality

Personality - we all have one.

- Enduring patterns of inter-related emotion, behaviour and cognition
- That comprise one's *unique adjustment to life*
- Relatively stable, but can change over long time periods

Example of a measurement tool - the Big 5

- openness to experience (inventive/curious vs. consistent/cautious)
- conscientiousness (efficient/organized vs. extravagant/careless)
- extraversion (outgoing/energetic vs. solitary/reserved)
- agreeableness (friendly/compassionate vs. critical/judgmental)
- neuroticism (sensitive/nervous vs. resilient/confident)

- BPD: can conceptualise as maladaptive variant of general personality traits we all have
  - Eg High in neuroticism, high in antagonism, low in conscientiousness

BPD Basics

- Why
  - Why? abandonment, emotional neglect, discrete trauma (but not everyone has “Trauma”)

- Core symptoms
  - Emotionally sensitive and unstable, feel negative emotions very intensely
  - This leads to interpersonal problems: Inter-personal disability; cannot form healthy relationships
  - Regulate this emotions in “maladapative” ways (anger, provocative threates, self harm, substance use)
  - Functionally impairing

BPD Basics

- DSM-5 = 5 out of 9 criteria

Table 1. DSM-5 Criteria for Borderline Personality Disorder[a]

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
(1) frantic efforts to avoid real or imagined abandonment. ***Note:*** Do not include suicidal or self-mutilating behavior covered in criterion 5.
(2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
(3) identity disturbance: markedly and persistently unstable self-image or sense of self
(4) impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). ***Note:*** Do not include suicidal or self-mutilating behavior covered in criterion 5.
(5) recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
(6) affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
(7) chronic feelings of emptiness
(8) inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
(9) transient, stress-related paranoid ideation or severe dissociative symptoms

- ICD-10 - “Emotionally Unstable Personality Disorder” (**better name, in my opinion**
- ICD -11 - general personality disorder + mild/moderate/severe + ?borderline ?antisocial etc

Empirically validated treatment for BPD + SUD

- 3 therapies
  - 1) DBT-SUD (dialectic behavioural therapy for substance use)
  - 2) DF-SFT (dual focus schema focussed therapy)
  - 3) Dynamic deconstructive therapy (DDT) - psychodynamic

- Up to 75% of people no longer meet diagnostic criteria after 1 year of DBT

Dialectic Behavioural Therapy

- **DBT (in brief)**
  - 6 months to 1 year of hard work
  - Weekly individual therapy
  - Weekly skills training
  - Weekly homework and practice
  - Phone access for skills coaching in crisis
  - Weekly DBT consult for therapsts

- **Skills**
  - 1) Mindfulness: observation of inner experience
  - 2) Interpersonal effectiveness: repair, maintain, establish healthy relationships
  - 3) Emotional regulation: long term
  - 4) Distress tolerance: here and now

Empirically validated treatment for BPD + SUD

- **Common factors**
  - Focus on relationships (between patient and therapist, patient and other)
  - Strengthen therapeutic alliance: validation, shared goal setting, targeting destructive behaviours, sharing case formulations
  - Address treatment interfering behaviours (avoidance, poor attendance, sabotage)
  - Clear treatment frame or “Rules of engagement” (eg every Wednesday at 1pm for 45 minutes, carry over issues till next review; rules around self-disclosure, phone calls in between)
  - Relapse are *expected:* plan in advance how to deal with these
  - Relapses are not failures but opportunities to problem solve (curiously, not judgementally)

Alternative to these

- **Good Psychiatric Management**
  - Less intensive
  - Designed for healthcare settings
  - Anyone working with BPD
  - Pragmatic

Opioid deficit model of BPD (Hansen et al 2022)

- Theory:
  - Release of endogenous opioids increase feelings of social connection (especially those with whom one has an existing relationship).
  - Ie endogenous opioids underlie the positive feeling associated with connection

- Evidence
  - Substantial evidence that opioids mediate social connection in non-human primates
  - Humans: far less research (some evidence that naltrexone reduces feeling of social connection)

Opioid deficit model of BPD (Hansen et al 2022)

- BPD = less natural opioids

- BPD behaviours (cutting, self harm)
  - Described as *relieving psychic pain*, rather than as a suicidal act
  - May be a method of *increasing natural opioids*.

- **If this were true (or if we acted as if this were true) - may make us more empathetic, reduce reflexive disgust and frustration, make incomprehensible behaviours comprehensible, improve therapeutic alliance and outcomes.**

Treatment interfering behaviours

- What?
  - Any behaviour that interferes with benefit of AOD treatment (patient or clinician)
- Examples
  - Non-attendance, aggression to clinician, suicidal threats, self harm: threaten retention
- Counter transference
  - Emotional response to a patient on the basis of your life experience and their behaviour.
- Acknowledge TIB in advance
  - Eg “you’ve said a few things that indicate it might be difficult to turn up, or that this will fail. I’m curious about these and how we can make it easier to help you stay in treatment. Do you want to talk about that now?
- Making Waves - Spectrum and Turning Point https://www.youthaodtoolbox.org.au/sites/default/files/documents_global/Recognising%20%26%20Managing%20Treatment%20Interfering%20Behaviours%20%28TIB%29%20-%20A%20Guide%20for%20Clinicians%20copy.pdf

Feelings that may be roused in you

- **Failure**: “I’m a failure, they keep getting worse, what’s wrong with me”
- **Frustration**: “I wish they’d just leave and become someone else’s problem”
- **Rage**: “They deserve their misery, if only they’d listen to me and stop doing crazy stuff”
- **Fear**: “What if they actually DO kill themselves this time? Should I have called the Police yesterday? Should I call them to check in over the weekend?”
- **Grandiosity** : “they recognise how good I am, if only my other patients knew this. I’m going to do the extra bits and save them where no-one else could”.

Tips

- Building therapeutic relationship = most important healing tool
- Communicate with all other clinicians in the care team
- Make them feel understood, valued and cared about
- Help them put their experience into words

Tips

- Beware of idealisation and denigration
- Weathering the crises
- Deliberate self harm and suicidality

- Build support into your practice, even if you “don’t need it”

- Monitor your own emotional temperature