

# Borderline Personality Disorder and Substance Use Disorders

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# AN INTRODUCTION TO CO-OCCURRING BORDERLINE PERSONALITY DISORDER AND SUBSTANCE USE DISORDERS

This *In Brief* is for health and human services professionals (e.g., social workers, vocational counselors, case managers, healthcare providers, probation officers). It is intended to introduce such professionals to borderline personality disorder (BPD)—a condition with very high rates of suicide and self-harm that often co-occurs with substance use disorders (SUDs). This *In Brief* presents the signs and symptoms of BPD, with or without a co-occurring SUD, alerts professionals to the importance of monitoring clients with BPD for self-harm and suicidal behavior, and encourages professionals to refer such clients for appropriate treatment. This *In Brief* is not meant to present detailed information about BPD or treatment guidelines for BPD or SUDs.

## What Is Borderline Personality Disorder?

BPD is one among several *personality disorders* (e.g., narcissistic personality disorder, paranoid personality disorder, antisocial personality disorder). According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*,<sup>1</sup> personality disorders are generally characterized by:

- Entrenched patterns of behavior that deviate significantly from the usual expectations of behavior of the individual's culture.

### How Common Is BPD?<sup>1</sup>

Estimates of BPD prevalence in the U.S. population range from 1.6 percent to 5.9 percent. BPD affects approximately 10 percent of all psychiatric outpatients and up to 20 percent of all inpatients.

- Behavior patterns that are pervasive, inflexible, and resistant to change.
- Emergence of the disorder's features no later than early adulthood (unlike depression, for example, which can begin at any age).
- Lack of awareness that behavior patterns and personality characteristics are problematic or that they differ from those of other individuals.
- Distress and impairment in one or more areas of a person's life (often only after other people get upset about his or her behavior).
- Behavior patterns that are not better accounted for by the effects of substance abuse, medication, or some other mental disorder or medical condition (e.g., head injury).

BPD is a complex and serious mental illness. Individuals with BPD are often misunderstood and misdiagnosed. A history of childhood trauma (e.g., physical or sexual abuse, neglect, early parental loss) is more common for individuals with BPD.<sup>1,2</sup> In fact, many individuals with BPD may have developed BPD symptoms as a way to cope with childhood trauma. However, it is important to note that not all individuals with BPD have a history of childhood trauma. It is also important to note that some of the symptoms of BPD overlap with those of several other DSM-5 diagnoses, such as bipolar disorder and posttraumatic stress disorder (PTSD). Therefore, a diagnosis of BPD should be made only by a licensed and experienced mental health professional (whose scope of practice includes diagnosing mental disorders) and then only after a thorough assessment over time.

Individuals with BPD often require considerable attention from their therapists and are generally considered to be challenging clients to treat.<sup>3,4,5</sup> However, BPD may not be the chronic disorder it was once thought to be. Individuals with

BPD often respond to appropriate treatment and may have a good long-term prognosis,<sup>1,5</sup> experiencing a remission of symptoms with a relatively low occurrence of relapse.<sup>6,7</sup>

The DSM-5 indicates that BPD is diagnosed more often in women than in men (75 percent and 25 percent, respectively).<sup>1</sup> Other research, however, has suggested that there may be no gender difference in prevalence in the general population,<sup>5,6</sup> but that BPD is associated with a significantly higher level of mental and physical disability for women than it is for men.<sup>6</sup> In addition, the types of co-occurring conditions tend to be different for women than for men. In women, the most common co-occurring disorders are major depression, anxiety disorders, eating disorders, and PTSD. Men with BPD are more likely to have co-occurring SUDs and antisocial personality disorder, and they are more likely to experience episodes of intense or explosive anger.<sup>8,9</sup>

## What Are the Symptoms of BPD?

The DSM-5 classifies mental disorders and includes specific diagnostic criteria for all currently recognized mental disorders. It is a tool for diagnosis and treatment, but it is also a tool for communication, providing a common language for clinicians and researchers to discuss symptoms and disorders. According to the DSM-5, the symptoms of BPD include:<sup>1</sup>

- Intense fear of abandonment and efforts to avoid abandonment (real or imagined).
- Turbulent, erratic, and intense relationships that often involve vacillating perceptions of others (from extremely positive to extremely negative).
- Lack of a sense of self or an unstable sense of self.
- Impulsive acts that can be hurtful to oneself (e.g., excessive spending, reckless driving, risky sex).
- Repeated suicidal behavior or gestures or self-mutilating behavior. (See the section below on suicide and nonsuicidal self-injury.)
- Chronic feelings of emptiness.
- Episodes of intense (and sometimes inappropriate) anger or difficulty controlling anger (e.g., repeated physical fights, inappropriate displays of anger).

- Temporary feelings of paranoia (often stress-related) or severe dissociative symptoms (e.g., feeling detached from oneself, trancelike).

Anyone with some of these symptoms may need to be referred to a licensed mental health professional for a complete assessment. Exhibit 1 presents some examples of how a person with BPD might behave.

## Suicide and nonsuicidal self-injury

BPD is unique in that it is the only mental disorder diagnosis that includes suicide attempts or self-harming behaviors among its diagnostic criteria.<sup>3</sup> The risk of suicide is high among individuals with BPD, with as many as 79 percent reporting a history of suicide attempts<sup>10</sup> and 8 percent to 10 percent dying by suicide—a rate that may be 50 times greater than the rate among the general population.<sup>11</sup>

More than 75 percent of individuals with BPD engage in deliberate self-harming behaviors known as *nonsuicidal self-injury* (NSSI) (e.g., cutting or burning themselves).<sup>12</sup> Unlike suicide attempts, NSSI does not usually involve a desire or intent to die. Sometimes the person with BPD does not consider these behaviors harmful.<sup>4</sup> One study involving 290 patients with BPD found that 90 percent of patients reported a history of NSSI, and over 70 percent reported the use of multiple methods of NSSI.<sup>10</sup> Reasons for NSSI vary from person to person and, for some individuals, there may be more than one reason. The behaviors may be:<sup>4,13,14</sup>

- A way to express anger or pain.
- A way to relieve pain (i.e., shifting from psychic pain to physical pain).
- A way to “feel” something.
- A way to “feel real.”
- An attempt to regulate emotions.
- A form of self-punishment.
- An effort to get attention or care from others.

NSSI may include:<sup>4,13,14</sup>

- Cutting.
- Burning.
- Skin picking or excoriation.

### Exhibit 1. Examples of Symptomatic Behavior (BPD)

- **Patterns of intense and unstable relationships**

John comes in to see his case manager, George, and announces that he plans to marry a woman he met at a speed-dating event the night before. George has heard this same story from John at least once a month for the past 4 months.

- **Emotions that seem to change quickly from one extreme to another**

Suzie has been working with a vocational rehabilitation counselor, Tony, for 2 weeks to prepare for job retraining. One day, just after Tony gets everything set up for Suzie to begin her training, Suzie storms out of the office screaming at him, “You’re just trying to get rid of me! You don’t understand me at all! I hate you!” Later, when Tony calls to suggest that maybe Suzie would prefer to work with another counselor, Suzie begins to cry and says, “Please don’t drop me, Tony! I need you!”

- **Evidence of self-harm or self-mutilation**

José is a probation officer. During his weekly appointment with his client, Annie, José notices a pattern of recent cuts across her left forearm. José asks her about them, and Annie becomes defensive and says, “Okay, I cut myself sometimes, so what? It’s none of your business. I’m not hurting anybody!”

- **Pattern of suicidal thoughts, gestures,\* or attempts**

Maria is a nurse. As she looks over the health history of her new patient, Sally, she notices that Sally has been hospitalized three times in the past 4 years after suicide attempts, and that she has seen six different therapists. Sally tells her, “Yeah, I get suicidal sometimes. I just can’t seem to find the right therapist who can help me.”

- **Intense displays of emotion that often seem inappropriate or out of proportion to the situation**

Regina is a social worker at a domestic violence shelter. She notices one of her clients, Elena, sitting in the living room with a sketchpad in her lap. Regina asks if she can see what Elena is drawing. Elena turns the sketchpad around to reveal a beautiful, detailed drawing of the shelter house. Regina admires it and says how beautiful it is, then says, “That’s funny, I thought that the house number was on the right side of the door.” Elena, who had been smiling, takes the sketchpad from Regina, looks at the drawing, then rips it from the pad and begins tearing it up, saying, “You’re right, it’s all wrong! I’ll have to start all over again!”

\*Regarding the word *gestures*: It is dangerous to dismiss or label *any* suicidal behavior as a gesture. Anyone who exhibits suicidal thoughts or behaviors of any kind needs to be assessed by a licensed mental health professional.

- Head banging.
- Hitting.
- Hair pulling.

- **Social impairment**—failing to fulfill obligations at work, school, or home; continuing substance use in spite of the problems it causes; giving up or reducing other activities because of substance use
- **Risky use**—using the substance(s) in situations in which it may be physically dangerous to do so (e.g., driving) or in spite of physical or psychological problems that may have been caused or may be made worse by substance use (e.g., liver problems, depression)
- **Pharmacological criteria**—displaying symptoms of *tolerance* (need for increased amounts of the substance to achieve the desired effect) or *withdrawal* (a constellation of physical symptoms that occurs when the use of the substance has ceased)

## What Are the Symptoms of SUDs?

SUDs involve patterns of recurrent substance use that result in significant problems, which fall into the following categories:<sup>1</sup>

- **Impaired control**—taking more of the substance than intended, trying unsuccessfully to cut down on use, spending an increasing amount of time obtaining and using the substance, craving or having a strong desire for substance use

## What Is the Relationship Between BPD and SUDs?

One study<sup>15</sup> found that the prevalence of BPD among individuals seeking buprenorphine treatment for opioid addiction exceeded 40 percent, and another<sup>16</sup> found that nearly 50 percent of individuals with BPD were likely to report a history of prescription drug abuse. A large survey<sup>6</sup> found that 50.7 percent of individuals with a lifetime diagnosis (i.e., meeting the criteria for a diagnosis at some point during the individual's life) of BPD also had a diagnosis of an SUD over the previous 12 months. This same survey found that for individuals with a lifetime diagnosis of an SUD, 9.5 percent also had a lifetime diagnosis of BPD. This is a significantly higher incidence of BPD than that in the general public, which ranges from 1.6 percent to 5.9 percent.<sup>1</sup>

One longitudinal study<sup>17</sup> found that 62 percent of patients with BPD met criteria for an SUD at the beginning of the study. However, over 90 percent of patients with BPD and a co-occurring SUD experienced a remission of the SUD by the time of the study's 10-year follow-up. (Remission was defined as any 2-year period during which the person did not meet criteria for an SUD.) The authors also looked at whether there were recurrences of SUDs after periods of remission and found that the rate of recurrence was 40 percent for alcohol and 35 percent for drugs. The rate of *new* onsets of SUDs, while lower than expected, was still 21 percent for drugs and 23 percent for alcohol. Another study<sup>18</sup> found that individuals with BPD had higher rates of new SUD onsets even when their BPD symptoms improved (compared with new SUD onsets for individuals with other personality disorders).

A client with BPD and a co-occurring SUD presents some particular challenges. BPD is difficult to treat, partly because of the pervasive, intractable nature of personality disorders and partly because clients with BPD often do not adhere to treatment and often drop out of treatment. The impulsivity, suicidality, and self-harm risks associated with BPD may all be exacerbated by the use of alcohol or drugs.<sup>19</sup> In addition, the presence of BPD may contribute to the severity of SUD symptoms,<sup>20</sup> and the course of SUD treatment may be more complicated for clients who also have BPD.<sup>21</sup>

## Who Can Best Provide Treatment for People With BPD and SUDs?

Individuals who display some of the symptoms of BPD (as described above) should be referred to an experienced licensed mental health professional for a thorough mental health assessment and possible referral to treatment. It is important to know whether referral sources have experience treating clients with BPD. If individuals display symptoms of substance misuse, they should also be assessed for a co-occurring SUD.

Individuals with BPD sometimes trigger intense feelings of frustration and even anger in their therapists and other providers.<sup>12</sup> Clients with BPD often have difficulty developing good relationships, including productive working relationships with therapists and other providers (e.g., healthcare workers, case managers, vocational counselors). Some individuals with BPD may move from therapist to therapist (or other professionals) in an effort to find “just the right person.”

Individuals who have an SUD may receive treatment from an individual counselor or therapist or from an outpatient treatment program. However, a co-occurring diagnosis of BPD may complicate SUD treatment. It is important for the professionals treating the person for either diagnosis to work in consultation with each other.

Treatment for BPD—especially with a co-occurring SUD—sometimes involves a team approach. Depending on the treatment plan, a person may have an individual therapist, a group therapist, a substance abuse counselor, a psychiatrist, and a primary care provider; treatment may need to be planned and managed through the coordinated efforts of all providers. Regular consultation among all providers can ensure that everyone is working toward the same goals from each of their professional perspectives. For example:

- In individual therapy sessions, a *therapist* may help the client learn to tolerate gradually increasing levels of uncomfortable emotions (e.g., stress, anxiety) so that the client may begin to have more control over those emotions.
- A *psychiatrist* may consider the use of medication for the client or evaluate currently prescribed medications to determine adherence and their effect on the client's ability to engage in the emotional work of therapy.

- A *substance abuse counselor* may work with the client to achieve abstinence, identify relapse triggers that may come up as the client does emotional work in therapy, and identify coping strategies for remaining abstinent.
- A *vocational counselor* may need to work with the client on distress tolerance as it relates to employment issues, such as applying for jobs or beginning a new job. This may mean helping the client understand the importance of being at interviews, vocational training classes, or work on time (even if emotional problems make that difficult) and helping the client develop strategies to achieve a pattern of good work habits.

Some people with BPD may consciously or unconsciously attempt to sabotage treatment by providing conflicting information to providers or by trying to turn one provider against another. Consultation among all providers can help deter this.

## What Treatments Are Available for Individuals With BPD and SUDs?

Many studies have been done on treatment approaches for BPD or SUDs, but very few have involved participants with co-occurring BPD and SUDs.<sup>22,23,24</sup> However, based on the studies that have been done on co-occurring BPD and SUDs, a few approaches seem to show promise. Perhaps the most researched approach is Dialectical Behavior Therapy, which has been adapted for treatment of co-occurring BPD and SUDs (Dialectical Behavior Therapy-S [DBT-S]).

It is important to note, however, that DBT-S and other promising approaches involve structured, manualized treatments that are quite intensive and require a significant amount of training and resources (e.g., staffing, space, finances) that may not be available in all areas.<sup>25</sup> Many therapists work on their own with individuals who have BPD, using the best techniques that their training and experience have to offer—hopefully in regular consultation with an experienced clinical supervisor. Therapists often adapt psychotherapy to better meet the needs of an individual client, sometimes combining different therapeutic approaches or mixing techniques.<sup>4</sup> However, for clients with both BPD and SUDs, the therapist may

need to work with an SUD treatment provider to provide comprehensive care.

## Pharmacotherapy for BPD and SUDs

The Food and Drug Administration (FDA) has not approved any medications for the treatment of BPD. However, individuals with BPD may take medications to alleviate some of their symptoms.<sup>11,22</sup> For example, selective serotonin reuptake inhibitors may be prescribed for depressed mood, irritability, anger, and impulsivity.<sup>11</sup>

There are several FDA-approved medications for SUD treatment. For alcohol use disorder, these include acamprosate, disulfiram, and naltrexone.<sup>26</sup> For opioid use disorder, approved medications include buprenorphine, a combination of buprenorphine and naloxone, methadone, and naltrexone.<sup>27</sup> Some of these medications may be prescribed on a short-term basis (e.g., to ease withdrawal symptoms, lessen cravings), and others may be prescribed for long-term use (e.g., to facilitate longer periods of abstinence).<sup>26,27</sup>

Individuals may receive their prescriptions and medication management from a psychiatrist, from other types of healthcare providers, or from both (or, in the case of methadone, from an opioid treatment program). Individuals may take medication as one part of a treatment plan that also includes attending individual therapy, group therapy, group skill-building sessions, or a mutual-help group (e.g., 12-step program), or some combination of these.

## What Are Some Things To Remember When Working With Someone Who Has Co-Occurring BPD and SUDs?

Some of the same guidelines that have been identified as necessary for mental health professionals who work with clients who have these two diagnoses may also be helpful for all human services professionals. Working with a client who has co-occurring BPD and SUDs requires:

- **Strong (but not rigid) professional boundaries**—Be clear with the person about the expectations in the working relationship (e.g., length of appointments, level of support, contact outside regular appointments). Be aware of special requests to make exceptions

to the usual rules for working with clients. These requests sometimes escalate over time. If in doubt about making an exception to the rules, discuss the situation with a supervisor who is knowledgeable about working with individuals who have BPD (within applicable confidentiality requirements).<sup>11</sup>

- **A commitment to self-care**—If possible, schedule appointments with someone who has BPD right before lunch or before a break. Avoid scheduling back-to-back appointments with two individuals who have BPD. It is important to have some time between them to see clients with other diagnoses, to work on other tasks, or simply to take a break. Develop the habit of leaving work *at work* (i.e., don't “replay” interactions with individuals who have BPD).
- **An awareness of how BPD may affect any kind of work with the individual**—For example, fearing abandonment and avoiding abandonment are characteristics of BPD and may manifest in some unexpected ways. For example, if the professional relationship has focused on the person with BPD completing certain goals, that person may thwart his or her own progress to avoid the feelings of abandonment that would result from ending the working relationship.
- **Knowledge about what skills the individual who has BPD is learning in therapy**—The person may need assistance applying those new skills to broader life situations. For example, perhaps one skill the person has learned is how to break down a seemingly overwhelming task into a series of small steps. Work with the person to apply that particular skill to the situation at hand.

## Conclusions

It is important to remember that:

- Most human services professionals will encounter clients with BPD in the course of their work.
- Individuals with BPD often have co-occurring diagnoses (e.g., depression, SUDs).
- BPD is often characterized by intense emotional displays and impulsive acts (e.g., self-harm, suicide attempts).

- Working with an individual with BPD (with or without a co-occurring SUD) can be challenging.
- Individuals with BPD (with or without a co-occurring SUD) deserve to receive appropriate treatment and deserve to be treated with compassion and respect.
- Individuals with BPD often respond to appropriate treatment and experience a remission of symptoms with a relatively low occurrence of relapse.
- Individuals with BPD (with or without a co-occurring SUD) may have a team of professionals who provide different aspects of care (e.g., therapist, psychiatrist).
- It is important for all professionals involved in the care of an individual with BPD to communicate and work together.

## Resources

### SAMHSA resources

#### National Registry of Evidence-based Programs and Practices

<http://nrepp.samhsa.gov>

#### Treatment Improvement Protocols (TIPs)

(see back page for electronic access and ordering information)

TIP 36: *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues*

TIP 42: *Substance Abuse Treatment for Persons With Co-Occurring Disorders*

TIP 44: *Substance Abuse Treatment for Adults in the Criminal Justice System*

TIP 50: *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment*

### Web resources

#### American Psychiatric Association

<http://www.psych.org>

#### American Psychological Association

<http://www.apa.org>

#### Borderline Personality Disorder Resource Center

<http://bpdresourcecenter.org>

## National Education Alliance for Borderline Personality Disorder

<http://www.borderlinepersonalitydisorder.com>

## National Institute of Mental Health

<http://www.nimh.nih.gov>

## National Institute on Drug Abuse

<http://www.drugabuse.gov>

## Notes

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