DRUG ALCOHOL FINDINGS *Research abstract*

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Dynamic deconstructive psychotherapy versus optimized community care for borderline personality disorder co-occurring with alcohol use disorders (a 30-month follow-up).

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Broad and sustained improvement possible for people with co-occurring borderline personality and alcohol use disorders participating in deconstructive psychotherapy.

SUMMARY This US study evaluated the effectiveness of deconstructive psychotherapy for people diagnosed with both borderline personality disorder and active alcohol abuse or dependence. Very few studies have examined specific treatments for this population, despite borderline personality disorder being common amongst people with alcohol use disorders. One UK study found that 53% of patients accessing alcohol services had a form of personality disorder (based on 64 alcohol service patients, randomly sampled from four urban centres).

Symptoms of borderline personality disorder can include "strong emotions, rapid changes in feelings and moods, difficulties in controlling certain impulses [including drinking and taking drugs], poor self image, feelings of not fitting or belonging, and a deep sense of emptiness and isolation". Deconstructive psychotherapy involves a participant working with a therapist to address 'deficits' (the term used in this paper) in different types of emotional experiences. This includes helping the participant to explore and change how they perceive interactions with others and their emotional responses to events.

For the featured study a small sample of 30 participants had been randomly assigned (half to each) to receive deconstructive psychotherapy for 12 to 18 months or the best standard treatment available in their community – 'optimised community care', involving a combination of individual counselling, medication management, self-help groups and case management. An earlier article reported that in contrast to limited change during optimised community care, during the first 12 months of deconstructive psychotherapy there were significant decreases in heavy drinking days, suicide attempts and self-harm, and institutional care, as well as significant improvements in core symptoms of borderline personality disorder, depression, and perceived social support. The current study examined whether these in-treatment gains were sustained after treatment ended.

Main findings

Up to 30 months after the trial started the authors tried to follow up the 11 deconstructive psychotherapy patients who had completed at least at least six months of treatment and the 13 allocated to optimised community care who had stayed in the study for at least the same period. By the final follow up just eight patients in each set could be re-assessed.

Participants receiving deconstructive psychotherapy achieved greater improvements overall than those receiving optimised community care. Those who completed a follow-up assessment displayed large improvements between baseline and 30 months on almost every symptom, behavioural, and functional outcome. There were statistically significant improvements over time in core symptoms of borderline personality disorder, depression severity, suicide attempts and self-harm, heavy drinking days, and perceived social support.

Compared to optimised community care, at 30 months deconstructive psychotherapy had led to significantly greater improvements in symptoms of borderline personality disorder and depression. Though heavy drinking was virtually absent in the deconstructive psychotherapy patients and still occurring on average twice a week among comparison patients, this difference was not statistically significant so may have occurred by chance. However, there was a significant difference in use of recreational drugs, which by 30 months was on average no longer occurring at all among deconstructive psychotherapy patients.

The authors' conclusions

The findings from this study support the authors' theory that gains made during 12 months of deconstructive psychotherapy would be sustained after treatment ended, and suggest that deconstructive psychotherapy may be an effective treatment that can lead to broad and sustained improvement for people with co-occurring borderline personality and alcohol use disorders. Overall, deconstructive psychotherapy participants received less group therapy than those receiving optimised community care, but the same amount of individual treatment, making the favourable outcomes associated with deconstructive psychotherapy all the more notable.

FINDINGS COMMENTARY Personality disorders were once widely perceived to be 'untreatable', and on this basis many people were excluded from treatment. This is starting to change, as more evidence comes to light about how personality disorders may be responsive to clinical interventions. Given that borderline personality disorder often occurs alongside other mental health and substance use issues, health and social care professionals providing psychological treatments to this group are advised to "monitor the effect of treatment on a broad range of outcomes, including personal functioning, drug and alcohol use, self-harm, depression and the symptoms of borderline personality disorder".

This study offers a small but significant contribution to the evidence base on treatments for people with co-occurring borderline personality disorders and problem drinking. Large and sustained gains were observed in participants engaged with deconstructive psychotherapy. However, by the final follow up only about half the patients who started the study were reassessed, and the criterion for choosing who was followed up included retention in treatment for the deconstructive psychotherapy participants but not for the comparison patients, who merely had to have remained in the study. These considerations mean that the results seen at the 30-month follow-up in these 16 patients may not be representative of how well the whole sample did, nor the relative advantages of the treatments. Further research is needed in larger samples to confirm the promising results of the study.

Thanks for their comments on this entry in draft to research author Robert Gregory of the SUNY Upstate Medical University. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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