DEVELOPMENTAL PSYCHOPATHOLOGY PERSPECTIVE ON CO-MORBID BORDERLINE PERSONALITY DISORDER AND SUBSTANCE USE DISORDERS

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ABSTRACT

Borderline personality disorder and substance use disorders are two forms of psychological problems that are often diagnosed within the same person. As those people sometimes remain highly stigmatized and largely neglected, and at the same time pose a major public health problem, we decided to focus on this co-morbidity by using developmental psychopathology perspective. The aim of the paper was to present this co-occurrence, explore some of the common risk and protective factors and offer an approach that could be used for preventing both disorders. Potential relatedness of concept of risk and protecting factors, attachment, developmental cascades and preventive intervention was explained by the sequential causal model.

KEY WORDS: ***borderline personality disorder, common risk and protective factors, prevention, substance use disorders***

INTRODUCTION

Borderline personality disorder and substance use disorders are two forms of psychological problems that are often diagnosed within the same person. Despite the general acknowledgment of this co-occurrence, a systematic and comprehensive review of this co-morbidity is lacking (Trull et al., 2000), although there are few surveys that explore the co-existence of these two disorders. For instance, survey conducted by Bornovalova et al. (2005) indicates an especially high rate of co-morbidity between these two disorders. Likewise, there is evidence that co-morbid borderline personality disorder negatively impact the clinical courses and outcomes of substance use disorders (Lee et al., 2010). Furthermore, substance abuse appears to be a devastating

complication in the patient with borderline personality disorder (Miller et al., 1993).

Since borderline personality disorder is a significant public health problem characterized by persistent problems with emotional, behavioural, cognitive, and interpersonal functioning, we decided to pay particular attention to this disorder. Taking into account the fact that substance use can contribute to problems of affective instability and interpersonal problems, and can be seen as one example of impulsivity in the criteria set for borderline personality disorder, (Trull et al., 2000), the aspect of substance use is also considered in the text.

Having on mind the concept of multifinality, i.e. the fact that the same risk and protective factors can result in multiple outcomes (Hosman, 2011), we are particularly interested in exploring the connection between the two aforementioned disorders. In accordance with our interest, the aim of this paper is to present knowledge and theoretical principles of co-morbidity between these two disorders and to explore and understand the implications for designing effective prevention.

In this paper emphasis will be put on developmental psychopathology perspective thru exploring common risk and protective factors. Since attachment has been identified as a generic (risk or protective) factor for developing mental health or mental disorder(s), this concept will be explored in more details. In addition, some of the leading questions in this work are focused on exploring the role of developmental cascades model in development of these two disorders, finding the common basis that could be influenced by preventive interventions and identifying the sensitive periods in which this intervention would be the most effective.

Since understanding the developmental processes and courses of these disorders can be used for prevention and for investment in mental health promotion, the second part of the paper will try to describe implications of the presented knowledge with the long-term goal of translating the theoretical and scientific findings into the practice.

1. CO-MORBIDITY BETWEEN BORDERLINE PERSONALITY DISORDER AND SUBSTANCE USE DISORDERS: PROBLEM ANALYSIS

1.1. Definitions and core concepts

At the beginning of this paper it is essential to define some of the core concepts that will be used in the further text. Since developmental psychopathology offers a theoretical and conceptual framework that helps understand the complexity of the multiple person – environment interactions

that impact the development of normal mental health and psychopathology across the lifespan and serves as scientific fundament to ground effective prevention, developmental psychopathology perspective will be used as a starting point in understanding borderline personality disorder and substance use disorders. Some of the theoretical basis that will be used are the concept of common (generic) risk and protective factors (Saxena, Jané-Llopis & Hosman, 2006), the knowledge that cumulative consequences for development of the many interactions and transactions occurring in developing systems can influence the development and can work as developmental cascades (Masten & Cicchetti, 2010), the fact that person and environment mutually influence each other over time (i.e. transactional approach) (Trull et al., 2000), and that outcomes of earlier developmental stages have an impact on later stages (a lifespan approach) (Hosman, 2011).

With the purpose of better understanding the connection between these two disorders, each disorder will be defined by using internationally accepted classifications. Although these classifications are not the best solution for defining disorders, while they define disorders in terms of lacking elements of mental health and use psychiatric terminology for describing human and social problems, in order to be understandable and clear, it is inevitable to use worldly accepted terminology.

In accordance with the aforementioned, International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10), under the code F 60.3 describes emotionally unstable personality disorder as a personality disorder characterized by a definite tendency to act impulsively and without consideration of the consequences; while the mood is unpredictable and capricious (WHO, 2010). Furthermore, two types of this disorder may be distinguished: the impulsive type, characterized predominantly by emotional instability and lack of impulse control; and the borderline type, characterized by disturbances in self-image, aims, and internal preferences, by chronic feelings of emptiness, by intense and unstable interpersonal relationships, and by a tendency to self-destructive behaviour, including suicide gestures and attempts. In addition, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), Section II, defines borderline personality disorder as a pattern of instability in interpersonal relationships, self-image and affects, and marked impulsivity. Due to complexity of the personality disorders phenomenon, DSM-5 in Section III offers a dimensional model for personality disorders. In this context, personality disorders represent maladaptive variants of personality traits that merge imperceptibly into normality and into one another. Characteristic difficulties in borderline personality disorder are apparent in identity, self-direction, empathy and / or intimacy, along with the specific maladaptive traits in the domain of Negative Affectivity, Antagonism and / or Disinhibition (American Psychiatric Association, 2013).

In the ICD-10, substance use disorders are defined under the codes F 10-19. These disorders are seen as mental and behavioural disorders due to psychoactive substance use that contain a wide variety of disorders that differ in severity and clinical form but that are all attributable to the use of one or more psychoactive substances, which may or may not have been medically prescribed (WHO, 2010). According to DSM-5, substance use disorders are classified among substance-related disorders, and they are characterized by a cluster of cognitive, behavioural, and psychological symptoms indicating that the individual continues using the substance despite significant substance-related problems. Overall, the diagnosis of substance use disorder is based on a pathological pattern of behaviours related to use of the substance (American Psychiatric Association, 2013).

It is important to emphasise that aforementioned disorders are not only medical problems, but social phenomena, as well. Their development could be influenced with many different factors; therefore they should be seen from holistic perspective.

Since the topic of the paper is related to co-morbidity between these two disorders, it is important to say that co-morbidity refers to two or more disorders that are concurrently present in one person (concurrent co-morbidity), or sequentially with shorter or longer time intervals (sequential co-morbidity) (Jané-Llopis et al., 2006).

1.2. Problem description

The borderline personality disorder diagnosis rarely occurs in isolation. The highest rates of co-morbidity occur between this disorder and mood, substance use, and non-borderline personality disorders (Widiger & Trull, 1993; according to Trull et al., 2000). Likewise, numerous cross-sectional studies have documented high rates of co-occurring mood, anxiety, substance use, and eating disorders in outpatients and inpatients with borderline personality disorder (Zanarini, Gunterson & Frankenburg, 1989; Oldham et al., 1995; Zanarini et al., 1998; Zimmerman & Mattia, 1999; Mcglashan et al., 2000; according to Zanarini, et al., 2004). The data show that the presence of certain co-occurring conditions impedes the symptomatic recovery of patients with borderline personality disorder and interferes with their psychosocial adjustment as well (Zanarini et al., 2004).

One of the important classes of explanations of this co-morbidity is that substance use disorders can lead to borderline personality disorder (or vice versa) (Trull et al., 2000). In other words, one condition may be the consequence of the other. For example, individuals with a neurobiological vulnerability to borderline personality disorder might be especially susceptible to this neuropharmacological sequel of substance use, as well as these

individuals might turn to psychoactive substances in order to "self-medicate" affective disturbance or to cope with feelings of emptiness or abandonment. In this case, borderline personality disorder might influence the development of substance use disorders. It is also possible that once co-morbidity develops, each disorder serves to maintain the other, which can be seen as a reciprocal effects model (Dulit et al., 1990; according to Trull et al., 2000).

The presence of borderline personality disorder is associated with an earlier onset age of substance use disorders, which has been shown to be linked to more severe physical, emotional, and social consequences (Linehan, 1993a). In the survey on co-morbidity among patients with borderline personality disorders, Zanarini et al. (2004) found out that the absence of a substance use disorder was a stronger predictor of remission from borderline personality disorder than the absence of any other type of disorder and that abusing drugs and/or alcohol could easily lead to greater impairment in all four core sectors of borderline psychopathology: decreased mood, heightened distrust, increased impulsivity, and even more turbulent relationships. In addition, Rhode et al. (2001) showed that adolescent alcohol use disorder significantly predicted further alcohol use disorder and other substance use disorders, depression, and elevated levels of antisocial and borderline personality disorder symptoms by age 24.

In contrast with the relatively low prevalence of borderline personality disorder in the general population (approximately 2%), the prevalence of this disorder among substance users is estimated as 5 to 32% (Bornovalova & Daughters, 2007; according to Lee at al., 2010). Likewise, almost up to 60% of individuals with borderline personality disorder have a co-morbid substance use dependence (Trull et al., 2000). Both disorders are often associated with early adverse life experiences (e.g., childhood physical/sexual abuse and a dysfunctional family), which may also contribute to the development of aforementioned psychopathology (Trull et al., 2000).

There is a lack of data on co-morbidity of these two disorders in Croatia. Glavak Tkalić et al., (2012) found out that 16% of the sample (N=4 756; 15-64 year) of the survey on substance abuse among general population in Croatia had consumed any illicit drug during their life. Up to date, there are no data on prevalence of borderline personality disorder among general population in Croatia. However, Katalinić and Huskić (2014) showed that, among 7 857 persons that were treated within Croatian health system for psychoactive drug abuse in 2013, 6.9% had at least one co-morbid diagnose. Co-morbidity has been more registered among opiate (7.0%) than non-opiate addicts (6.4%). Among persons treated for opiate abuse, the most prevalent were disorders related to alcohol drinking (31.1%), affective disorders (20.6%) and personality disorders (15.4%). Non-opiate addicts had co-morbidity with alcohol abuse (39.8%), psychoses (21.4%), personality disorders (11.2%),

affective disorders (11.2%) and unspecified organic or symptomatic mental disorder (11.2%).

The literature has documented the deleterious impact of co-morbid borderline personality disorder among substance users on various clinical outcomes, including more severe drug use, higher rates of needle sharing, a higher likelihood of suicide attempt, poorer global psychological health, and poorer treatment outcomes for substance use disorders (Kruedelbach et al., 1993; Nace, Saxon & Shore, 1986; according to Lee et al., 2010). Even though these patients pose a major public health problem, they often remain highly stigmatized and largely neglected (Gunterson, 2009).

1.3. Development analysis

There are plenty of theoretical approaches that can be used for understanding the development of mental disorders. In this paper three concepts that could explain both, borderline personality disorder and substance use disorders, will be presented: the concept of common risk and protective factors, attachment theory and developmental cascades model. The logic for aforementioned choice is the fact that attachment can be seen as a risk or protective factor, and since attachment emerges in the early parent (caregiver)-child relationship, attachment problems can be seen as a cascade transmitted from parents (caregivers) to a child.

At the same time it is important to take into the consideration the fact that personality traits play a major role in the development of mental disorders, as well as the fact that personal and environmental risk and protective factors are not mutually exclusive (Trull et al., 2000). For instance, it is conceivable that personality traits are inherited, that parental psychopathology leads to an environment in which bad parenting is more likely, or that adverse experiences influence the development of personality traits.

1.3.1. Common risk and protective factors

The concept of risk and protective factors is very useful in understanding the developmental course of mental disorders, while risk factors can influence negative outcomes in several ways. Risk factors are referring to conditions that increase the probability of onset of some disorder, while protective factors refer to conditions that improve people's resistance to risk factors and disorders (Rutter, 1987). The more risks a child is exposed to, the more likely the child will develop some mental disorder (National Institute on Drug Abuse, 2003). In other words, individual factors do not predispose to a mental problem on their own, but it is the interplay between risk factors, the absence of protective factors and the accumulation of risk situations that predispose individuals to a continuum from increased vulnerability, to a mental

problem or a full-blown disorder (Jané-Llopis et al., 2006). It is necessary to stress that risk and protective factors could be different in different cultures, therefore the context is very important. Furthermore, European Monitoring Centre for Drugs and Drug Addiction (2008, 2010) emphasise that some factors change from risk to protective as a result of their interaction with other factors, some factors are relevant only in the presence of others, and the presence of only one risk factor is not usually relevant, but the combination of several of factors increases the risk. Risk and protective factors can be recognized among different life domains: environmental, individual, family, personality etc. Among risk factors for substance use, European Monitoring Centre for Drugs and Drug Addiction (2010) recognizes parental rejection, impulsivity and mental health problems - factors usually connected with the increased likelihood for borderline personality disorder relapse (Quigley, 2003). In addition, Barone (2003) confirmed the hypothesis that some developmental relational experiences seem to constitute pivotal risk factors underlying borderline personality disorder. In this context, as some of the protective factors for substance use, National Institute on Drug Abuse (2003) identifies self-control and positive relationships, concepts that could play important role in preventing borderline personality disorder as well.

Furthermore, child abuse and neglect is often mentioned in the literature as a common risk factor for multiple negative outcomes (Saxena, Jané-Llopis & Hosman, 2006). Trull et al., (2000) emphasise that childhood trauma (especially physical and sexual abuse) has been associated with both adult substance use disorders and borderline personality disorder, while these two disorders co-occur at greater than chance frequency because they share common risk factors. Ogata et al. (1990) mentioned a high prevalence of physical and sexual abuse during the childhood of persons with borderline personality disorder. According to Linehan (1993), researchers have estimated that up to 75% of individuals with this disorder have experienced some sort of sexual abuse in childhood. Furthermore, Teicher (2000) states that child abuse can lead to borderline personality disorder due to the fact that abused patients have diminished right-left hemisphere integration and a smaller corpus callosum. With less well integrated hemispheres, borderline patients may shift rapidly from a logical and possibly overvaluing left-hemisphere state to a highly negative, critical, and emotional right hemisphere state. This seems consistent with the theory that early problems of parent (caregiver)-child interaction undercut the integration of right and left hemispheric function. Likewise, very inconsistent behaviour of a parent (for example, sometimes loving, sometimes abusing) might generate an irreconcilable mental image in a young child that remains unintegrated, as the child grows up. This "invalidating environment" presents the crucial developmental circumstance in producing emotion dysregulation (Linehan, 1993), typical for borderline personality disorder.

Results of the survey on developmental cascade model that explored a path from child abuse to adolescent cannabis abuse and dependence indicated significant paths from child abuse to early externalizing and internalizing problems and social competence, as well as to cannabis abuse and dependence symptoms in adolescence (Rogosch, Oshri, Cicchetti, 2010).

It is important to emphasise that some risk factors may be more powerful than others at certain stages in development, which are known as sensitive periods. These periods refer to periods in which the onset of risk behaviours and specific disorders is most prevalent than during other periods. At the same time, during these periods children are out of balance and more sensitive to the impact of educational interventions or are more in need for social and emotional support (Hosman, 2011).

1.3.2. Attachment theory

Attachment theory has been conceptualised as an affect regulation theory, proposing that attachment is associated with the expression and recognition of emotions as well as interpersonal functioning (Thorberg & Lyvers, 2010). This theory allows specific predictions about the role of attachment representations in organizing behaviour.

The primary assumption of attachment theory is that humans form close emotional bonds in the interest of survival. These bonds facilitate the development and maintenance of mental representations of the self and others or "internal working models", i.e. expectations about the self, significant others, and the relationship about the two (Pietromonaco & Feldman Barrett, 2000). The development of secure attachment relationships thus appears to mark a transition from extrinsic control (parenting) to dyadic control (the emerging attachment relationship) (Cox et al., 2010). Bowlby (1969, according to Brumariu & Kerns, 2010) suggested that the quality of attachment between parents and children sets the stage for later personality development.

Attachment (in children) is typically defined as an emotional long-lasting bond that a child forms with an attachment figure (Ainsworth, 1989, according to Brumariu & Kerns, 2010). Children feel secure in their relationships with attachment figures to the extent that they perceive those figures as consistently available, sensitive, and responsive to their needs. European Monitoring Centre for Drugs and Drug Addiction (2010) identified parent-child attachment as a factor that can be seen as a risk factor, or in the case of secure attachment, as a protective factor. Furthermore, Baumeister and Leary (1995) emphasise that the lack of attachments is linked to a variety of ill effects on health, adjustment, and well-being. For instance, unsupportive caretaking (e.g., rejection, neglect) during childhood is thought to be characteristic of dismissing attachment. As a result, individuals classified as dismissing are most commonly characterized as engaging in emotional distancing and greater

reliance on the self rather than others. Finally, inconsistent support from caretakers during childhood is most often associated with preoccupied attachment which is thought to produce persistent anxiety towards interpersonal relationships and exaggerated levels of negative affect (Caspers et al., 2006). Insecure attachment is hypothesized to predict maladaptive emotional regulation and clinical theories of borderline personality disorder identify attachment insecurity as the basis of its characteristic disturbed interpersonal functioning (Choi-Kain et al., 2009).

Although substance use disorders have been considered as attachment disorders, empirical support of the association between attachment and problematic substance use is less explored. However, scarce empirical research exists on the relationship of attachment in relation to affect regulation and interpersonal functioning in those with substance use problems. In their survey on substance use disorder, Thornberg and Lyvers (2010) confirmed that attachment is associated with and predicts affect regulation abilities and difficulties in interpersonal functioning in a sample of substance use disorder inpatients. Also, Kassel, Wardle and Roberts (2007) found out significant (positive) associations between anxious attachment (tapping neediness and fear of abandonment) and both drug use frequency and stress-motivated drug use.

While secure attachment develops within early mother (primary caretaker)-child relationship (Bowlby, 1969, according to Brumariu & Kerns, 2010), it can be concluded that sensitive period for healthy development (or mental disorders development) is prenatal and early neonatal stage of persons development. Since these early attachment experiences are associated with adult attachment styles (Thorberg & Lyvers, 2010), this leads us to the concept of developmental cascades and the role of intergenerational transmission of behaviours that are attachment-related.

1.3.3. Developmental cascades model

Developmental cascades refer to the cumulative consequences for development of many interactions and transactions occurring in developing systems that result in spreading effects across levels, among domains at the same level, and across different systems and generations (Masten & Cicchetti, 2010). The term cascade is used to describe processes by which function at one level / domain/ behaviour affects function at higher levels or the organization of competency in later developmental phases (Cox et al., 2010). Developmental cascades always alter the course of person's development. Speaking in these terms, the development of borderline personality disorder and substance use disorders can be seen as a developmental cascade resulting from adverse early life experience or insecure / preoccupied attachment (Masten & Cicchetti, 2010). For instance, literature on cascade knowledge in the case of developing drug abuse and internalizing disorders, show that these

disorders are often linked with early aversive experiences (Rogosch, Oshri & Cicchetti, 2010).

At this point, it is important to put an emphasis on intergenerational transmission of processes for the self-regulative behaviours in progeny behaviour, which can also be seen as a cascade effect linking multiple generations (Meaney, 2010; according to Masten & Cicchetti, 2010; Cox et al., 2010). Although understanding of cascade of postnatal environment shared by the mother (caregiver) and her newborn child is at the beginning, it seems that behaviours in this shared environment allow for experience-dependent changes in both mothers (caregiver) and children that promote differential shifts in control parameters across individuals (and domains within individuals) that ultimately impact the acquisition of self-regulatory abilities (Cox et al., 2010).

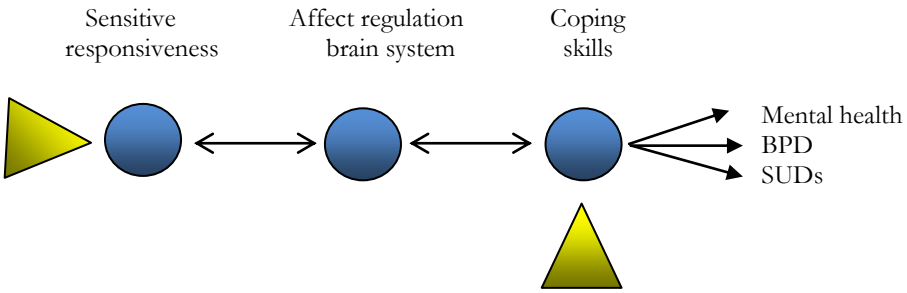
To sum up, poor parenting skills can be related with parent's insecure or preoccupied attachment style, which could lead to child's insecure or anxious attachment. The connection between these is explained in more details in the next section thru sequential causal model.

2. TRANSLATING KNOWLEDGE INTO PRACTICE

Although there is a lack of surveys on risk and protective factors in Croatia for development of specific negative outcomes (such as borderline personality disorders and substance use disorders), Bašić (2009) emphasises that different negative outcomes could be prevented by reducing risk levels, and at the same time by strengthening protective factors on the individual and community levels during the childhood. Furhermore, Kranželić, Ferić and Jerković (2013) emphasise that risk and protective factors, as well as their strength, may vary in different contexts, which is why it is important to take that fact into consideration in the process of planning preventive interventions. In addition, it is important to have in mind that data from international studies provide useful insight in these phenomena, but at the same time they should be carefully interpreted and translated in Croatian society.

Taking into account the aforementioned theoretical findings about the role of common risk and protective factors, the importance of secure attachment in healthy development and the significance of adequate parenting, we find appropriate to explain the potential connectedness of these concepts by a sequential causal model. Even though the model has a word "causal", it is important to emphasise that further text represents our understanding of these phenomena, and therefore should be seen as a hypothesis that yet needs to be explored and tested.

Picture 1 – Sequential causal model (van Doesum & Hosman, 2012) adapted to borderline personality disorder (BPD) and substance use disorders (SUDs)



Picture 1 shows (Doesum & Hosman, 2012) the relation between sensitive responsiveness, affect regulation brain system, coping skills and possible developmental outcomes: mental health, borderline personality disorder, substance use disorders. Links between the aforementioned elements are shown as a two was processes, since interactions between parent and a child are considered to be reciprocal.

Sensitive responsiveness could be seen as a component of a secure attachment style, which is at the same time a protective factor that influences the development of adequate affect regulation brain system. If a child develops good regulation system, it has a biological and psychological basis for developing adaptive coping strategies, which in the end should result in mental health. In accordance with this assumption, insensitive parent responsiveness would result in poor affect regulation brain system which could lead to poor coping skills and negative mental health outcomes.

The triangles stand for a sensitive period in which a preventive intervention could be effectively implemented. In that context, prenatal and early neonatal period are seen as sensitive periods for implementation of parent-child interventions, parental skills trainings and similar interventions. These interventions could be implemented thru local community centres, for example, as a component of the pregnancy course that can be implemented as universal prevention. For those parents that manifest some risk factors (e.g. history of child abuse, substance use etc.), a selective or indicated interventions could be offered. Furthermore, if required intervention is omitted in that period, there is also a possibility to influence child's coping skills during childhood, possibly with effective school-based prevention interventions that targets mentioned risk and protective factors for development of these disorders.

As Levin-Bizan, Bowers and Lerner (2010) showed in their survey on positive youth development, developmental cascades can have positive consequences at the later behaviour. If translating this knowledge into

preventive interventions, which could also be understood as cascades, prevention of attachment-related problems during early person's development might result in decreased occurrence of borderline personality disorder and substance use disorders in the later stages of life.

3. CONCLUSION

Borderline personality disorder and substance use disorders are two forms of psychological problems that are often diagnosed within the same person (Trull et al., 2000). Since both of these disorders present a complex phenomenon, it is inevitable to observe them as social manifestations on which different risk and protective factors might influence during the person's lifespan. In an attempt to get an insight into these processes, a developmental psychopathology perspective was used. Special emphasis was put on three concepts that might be interlinked and useful for understanding the mentioned phenomena: risk and protective factors, attachment theory and development cascades model. In accordance with the aforementioned, the aim of the paper was to present co-occurrence of the mentioned disorders, explore some of the common risk and protective factors and offer an approach that could be used in preventive interventions.

Bašić (2009) emphasises that different negative developmental outcomes could be prevented by reducing risk levels, and by strengthening protective factors on the individual and community levels during the childhood. Although the concept of risk and protective factors assumes the likelihood and not certainty for development of certain disorder, it is considered to be useful model for understanding potential factors that could be reduced or strengthened in the context of prevention.

Existing literature recognizes a numerous risk and protective factors for substance use disorders, as well as for development of borderline personality disorders. In an attempt to better understand the role of multifinality, i.e. the fact that the same risk and protective factors could result in multiple outcomes (Hosman, 2011), in this paper a special emphasis was put on the role of the attachment between caregiver and a child. This is supported by different studies that have shown that borderline personality disorder and substance use disorders can be seen as attachment problems (Kassel, Wardle & Roberts, 2007; Choi-Kain et al., 2009; Thornberg & Lyvers, 2010). Furthermore, depending on the context, attachment could enhance the risks, as well as strengthen protection, and therefore is understood as an important concept that should be taken into account in prevention interventions.

In addition, intergenerational transmission of processes for the self-regulative behaviours could be seen as a developmental cascade linking

multiple generations (Meaney, 2010; according to Masten & Cicchetti, 2010; Cox et al., 2010). Therefore, to prevent possible negative caregiver-child dynamic, it seems useful to put focus of an intervention on attachment and parent-child relationship at early stages - during pregnancy or early periods of child's development.

Taking into account the presented theoretical findings, the sequential causal model was used as a model for explaining potential relatedness of concepts of risk and protective factors, attachment, developmental cascades and preventive interventions. Although the sequential model gives interesting perspective on risk and protective factors for different mental disorders, it is important to have in mind the complexity of the risk and protective factors concept. In that context, the results of scientific surveys should be carefully translated into prevention practice. In other words, presented interpretation of the model represents one possible explanation that should be tested in the future, and if confirmed, it could serve as a theoretical basis for prevention of attachment-related problems, such as borderline personality disorder and substance use disorders.

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RAZVOJNO-PSIHOPATOLOŠKA PERSPEKTIVA NA KOMORBIDNI GRANIČNI POREMEĆAJ OSOBNOSTI I POREMEĆAJE POVEZANE S UPORABOM SREDSTAVA OVISNOSTI

SAŽETAK

Granični poremećaj ličnosti i poremećaji povezani sa uporabom sredstava ovisnosti predstavljaju probleme mentalnog zdravlja koji se nerijetko dijagnosticiraju kod iste osobe. S obzirom da ove osobe često bivaju stigmatizirane i u velikoj mjeri zanemarene, a u isto vrijeme predstavljaju ozbiljan javno zdravstveni problem, u ovom smo radu odlučili usmjeriti pažnju na komorbiditet koristeći perspektivu razvojne psihopatologije. Cilj ovog rada jest predstaviti zajedničku pojavnost ovih poremećaja, istražiti neke zajedničke rizične i zaštitne čimbenike te ponuditi pristup koji bi se mogao koristiti u prevenciji oba poremećaja. Za tumačenje odnosa između rizičnih i zaštitnih čimbenika, privrženosti u djetinjstvu, razvojnih kaskada i prevencijskih intervencija koristio se sekvencijski uzročni model (sequential causal model).

KLJUČNE RIJEČI: ***granični poremećaj ličnosti, prevencija, zajednički rizični i zaštitni čimbenici, zlouporaba sredstava ovisnosti***