Dialectical Behavior Therapy for Severe Substance Use Disorders *and* Borderline Personality Disorder:

Skills for Attachment & Commitment, Relapse Prevention, and Self-Management Strategies

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Dialectical Behavior Therapy for Severe Substance Use Disorders *and* Borderline Personality Disorder:

Skills for Attachment & Commitment, Relapse Prevention, and Self-Management Strategies

- ❑ What is Dialectical Behavior Therapy (DBT)?
- ❑ Why Use DBT with Substance Use Disorders (SUDs)?
- ❑ When Wouldn't You Use DBT with SUDs?
- ❑ What's the Difference Between DBT and DBT for SUDs?
- ❑ How to Modify the Treatment Target Hierarchy to Focus on SUDs?
- ❑ How Does DBT Get People to Stick (a.k.a. "attachment & commitment strategies")?
- ❑ How Does DBT Treat Relapse Behaviors, Cravings, and Urges (What's in your DBT tool box?)?
- ❑ Try It On! Urge surfing…

DBT is…

Modalities	*Functions of Treatment…**
I. Individual therapy	*Motivational Enhancement*
II. Skills Group	*Capability Enhancement*
III. Phone Coaching	*Generalization*
IV. Consultation Team	*Capability & Motivation of Therapist*

*5th Function: Structuring of the environment via programmatic emphasis on sobriety & adaptive behaviors

Why Use DBT for BPD With SUDs?

- Co-occurrence of BPD with SUDs is 2nd only to mood disorders and antisocial personality disorder

  Trull, T.J., & Widiger, T.A. (1991). The relationship between borderline personality disorder criteria and dysthymia symptoms. *Journal of Psychopathology and Behavioral Assessment, 13(2), 91-105.*

- Impulsivity in areas that are potentially self-damaging, which can include substance abuse, is a diagnostic criteria for BPD in the DSM-V
  - The overlap is not unexpected…

WHY USE DBT FOR BPD WITH SUDs?

Patients with BPD + SUD can be More Difficult to Treat

- Higher Suicide Rates
- More legal, behavioral, medical problems such as
  - Alcoholism
  - Depression
  - more extensive involvement with substance abuse
- Remission of BPD can be impeded by SUD

WHY USE DBT FOR BPD WITH SUDs?

- In response to the need to provide an integrated approach for concurrent disorders
  - *Prior sequential approaches to treatment resulted in individuals being barred access to specialized mental health services until their substance abuse was stabilized*
- 1st integrated treatment model developed for people with concurrent substance abuse and BPD

Shares many Commonalities with Prominent Addictions Treatments…

PROMINENT SUD TREATMENTS	DBT FOR SUDs
12-STEPS CORE PHILOSOPHY	DIALECTICAL BALANCE “MIDDLE PATH”
SELF-MEDICATION HYPOTHESIS	DBT’S BIOSOCIAL THEORY
COGNITIVE BEHAVIORAL STRATS	DBT CHANGE STRATEGIES
MOTIVATIONAL INTERVIEWING	DBT VALIDATION STRATEGIES

EMPIRICAL FINDINGS…

RCT'S

1. Linehan et al. (1999)

n = 12, BPD women 1-year DBT; *n = 16*, BPD women 1-year TAU; 74% polysubstance users

- Results: DBT more effective in reducing drug abuse at 1-year & at 16-mo. Follow-up; DBT group showed greater social functioning and global adjustment at 16-mo.

2. Linehan et al. (2002)

- *n = 23* opiate-dependent women with BPD
- 1-year DBT Vs. Comprehensive Validation Therapy (CVT) with 12-step intervention
- Both effective at reducing opiate use at 8-mos.; 12-mos., CVT increased opiate use, but had greater retention rate

REPLICATION STUDY

3. Verheul et al. (2003)

- RCT 58 women with BPD with & without SUD, TAU Vs. DBT
- DBT more effective in reducing dropouts, frequency of self-injurious behaviors, & alcohol
- NO DIFFERENCE B/T conditions on other drugs of abuse
- Standard DBT used

4. McMain et al. (2004)

- *n* = 27, RCT with DBT with modifications for SUD Vs. TAU
- Both showed improvement at outcome; TAU had greater overall improvement in drug use
- *Similar findings to Verheul et al., DBT may have added advantage of improving other difficult to treat behaviors, self-injury/harm and impulsivity*

When Not To Use DBT for BPD with SUDs…

USE DBT IF…

- Emotion Dysregulation is greatly associated with drug use
- Multidiagnostic SUD patient (both personality and mood/anxiety disorders) **&**
  - *has failed multiple times in prior EBTs*

USE ANOTHER EBT IF…

- If there is a proven treatment that already exists
- Wiser to begin with a simpler & efficient treatment (is it more than what's needed for the patient?)
- Drug use is affected little by affective dyscontrol (i.e. APD)

…BE PARSIMONIOUS

DBT is…

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*5th Function: Structuring of the environment via programmatic emphasis on sobriety & adaptive behaviors

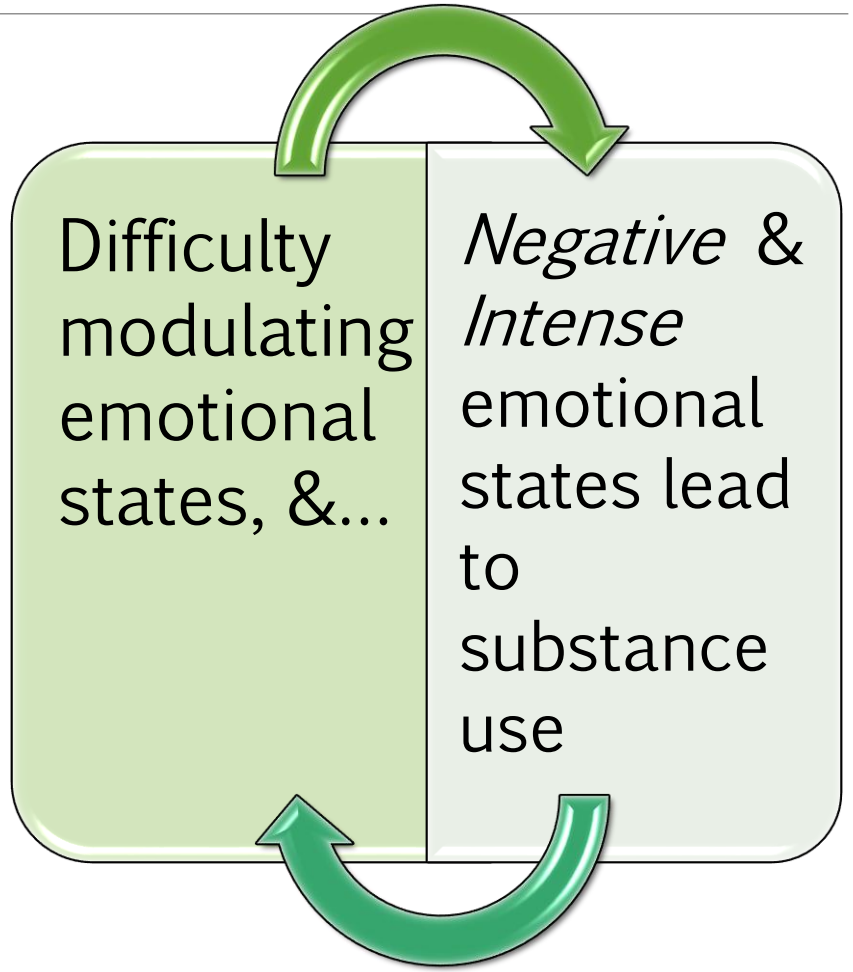
DBT for SUD's is…

I. Modalities
   I. Individual therapy *(Emphasis on substance use)*
   II. Skills Group
   III. Phone Coaching
   IV. Consultation Team

I. Foundational Skills
   I. Core Mindfulness *(Skill modifications)*
   II. Emotion Regulation
   III. Interpersonal Effectiveness
   IV. Distress Tolerance *(Skill Modifications)*

DBT's Conceptual Framework: Biosocial Model

- Emotion dysregulation is the core of BPD-criterion behaviors[1]
- "Self-Medication Hypothesis", people use substances to modulate emotional states



1. McMain, S., Sayrs, J.H.R., et al. (2007c.). Dialectical Behavior Therapy for Individuals with Borderline Personality Disorder and Substance Dependence (pp.145-173). In L.A. Dimeff, & K. Koerner (Eds.), Dialectical Behavior Therapy in Clinical Practice. New York: Guilford Press.

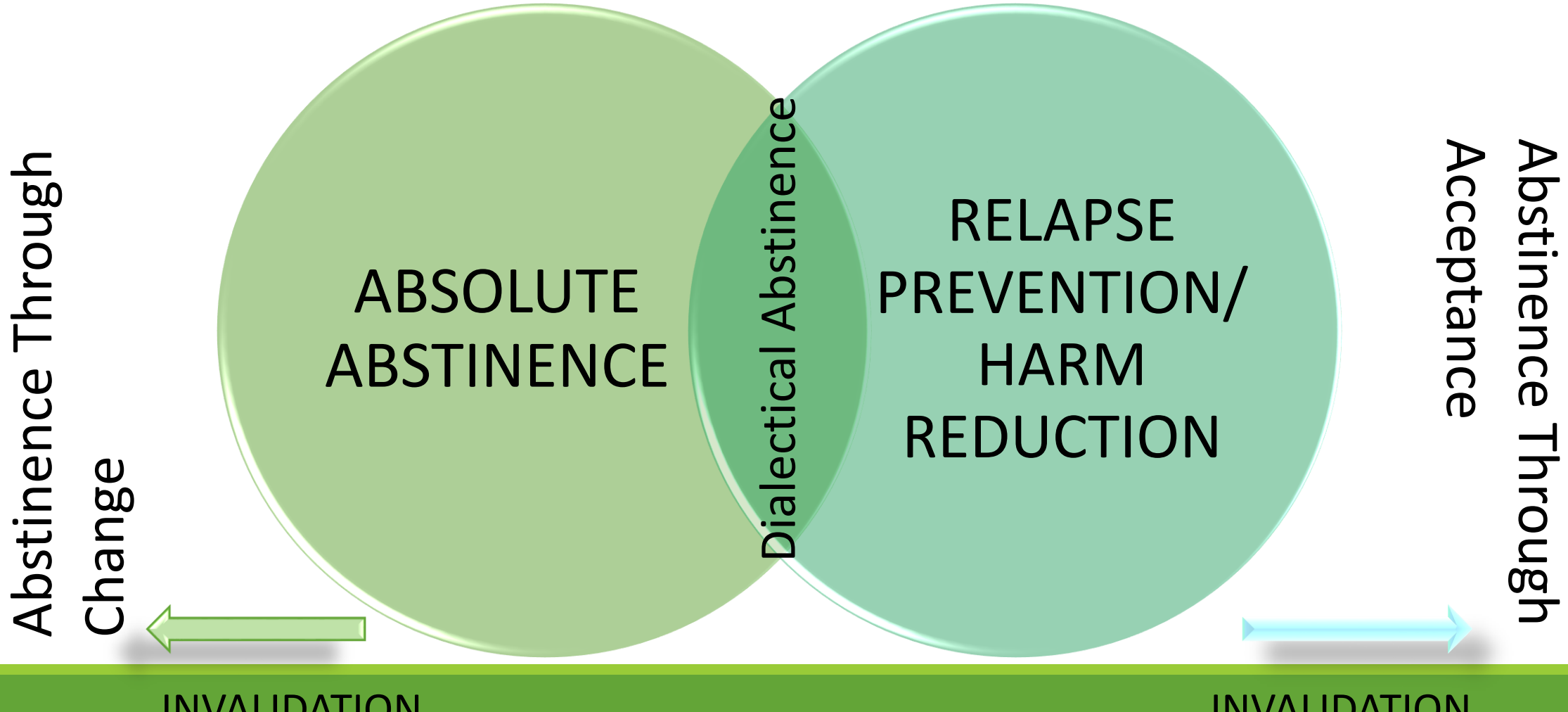
DBT for BPD with SUD's: Core Adaptations

I. Dialectical Abstinence
(a dialectical philosophy)

II. "Pretreatment"
(& modified treatment target hierarchy)

III. Clear Mind
(the goal of SUD treatment targets)

Dialectical Abstinence



Dialectical Abstinence

Absolute Abstinence

- BPD emotional dysregulation
- Harm Reduction alone will not be effective as a result
- IT WORKS, lengthens intervals between use (Hall, Havassy & Wasserman, 1990)
- REQUIRES A STRONG COMMITMENT: 5-minutes, 1-day, 1-month, 1-year
- With SUD: Emotional dysregulation results in drug use (self-medication) & drug use results in emotion dysregulation

Relapse Prevention

- PROBLEM TO SOLVE Vs. EVIDENCE OF TREATMENT FAILURE
- CHAIN ANALYSIS, nonjudgmental observation of EXACTLY what happened
- Function: Increase memory and awareness of negative consequences when they use drugs
- Repair with SELF & OTHERS, "Justified Guilt"
- IT WORKS: Decreases frequency & intensity after a period of abstinence (Marlatt & Donovan, 2005)

CHANGE **ACCEPTANCE**

ABSTINENCE VIOLATION EFFECT (AVE)[2]

- MISSING SKILLS TO DO ABSTINENCE
- EMOTIONS GET IN THE WAY
- SKILLS COME OUT AT THE WRONG TIME
- ENVIRONMENT IS PUNISHING SKILLFUL BEHAVIOR(S)

- PUSHING FOR ONLY CHANGE → INVALIDATION
- SEE LASPES AS "ALL OR NOTHING"; INDICATIVE OF TREATMENT FAILURE
- CREATES INTENSE NEGATIVE EMOTIONAL STATE(S) & UNABLE TO MANAGE WITHOUT DRUG(S):
  - JUSTIFIED SHAME
  - JUSTIFIED GUILT
- CREATES "SCREW-ITS"; "ALREADY BLOWN IT, WHY BOTHER…"; "MIGHT AS WELL GO ALL THE WAY…"

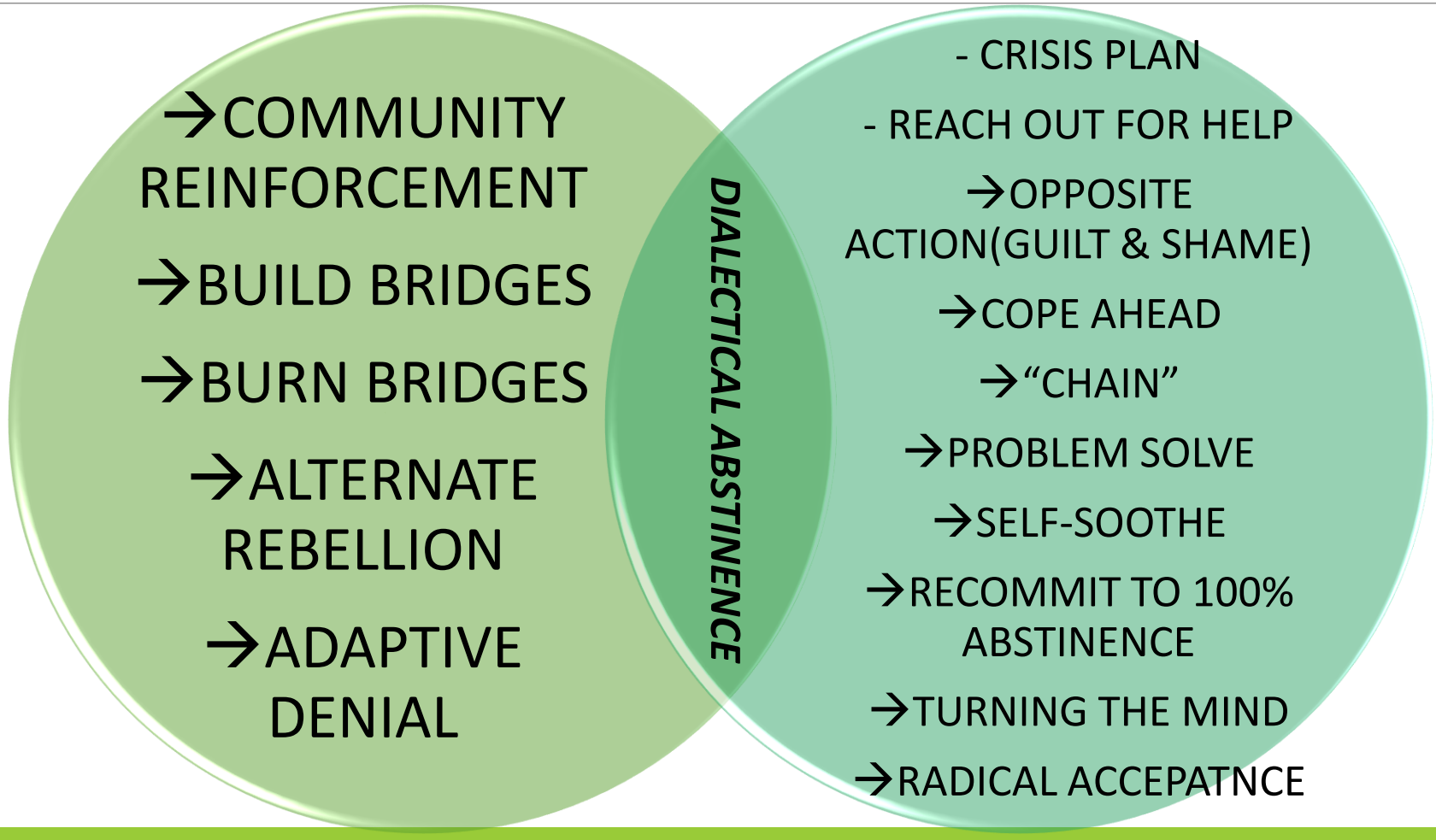
[2]Marlatt, G.A., & Gordon, J.R. (Eds.). (1985). *Relapse Prevention: Maintenance strategies in the treatment of addictive behaviors.* New York: Guilford Press.

ABSTINENCE THROUGH ACCEPTANCE: RELAPSE PREVENTION/HARM REDUCTION

- LAPSES ARE VIEWED AS A PROBLEM TO BE SOLVED
- TEACH HOW TO “FAIL WELL”
- REPAIR WITH SELF & OTHERS (STEPS 8 & 9 OF THE 12 STEPS)
- CHAIN ANALYSIS & SOLUTION ANALYSIS TO GET “BACK ON THE WAGON”
- PUSH AWAY ALL-OR-NOTHING AND EXTREME THINKING
- RADICAL ACCEPTANCE & NONJUDGMENTAL STANCE

Dialectical Abstinence

ABSOLUTE ABSTINENCE



HARM REDUCTION "FAIL WELL"

PRETREATMENT: *PHASE 1* DBT DOES NOT BEGIN WITHOUT SOME PERIOD OF **ABSTINENCE**

I. ABSTINENCE → REQUIRES IRON-CLAD & ON-GOING COMMITMENT, EX. PEARLS STRUNG 1 BY 1 ON A NECKLACE

II. QUALITY Vs. QUANTITY:
→5 MINS Vs. 5 MOS

III. COMMITMENT STRATEGIES
- FOOT-IN-THE DOOR
- DOOR-IN-THE-FACE
- DEVIL'S ADVOCATE

1st 4-SESSIONS:

- ORIENT: 4-MISS, MODES OF TREATMENT, DURATION
- ASSESS GOALS
- TARGETS → GOALS
- COMMITMENT STRATEGIES
- CRISIS PLANNING
- TROUBLESHOOT BARRIERS TO TREATMENT
- WEAVE IN ATTACHMENT STRATEGIES

DBT for BPD with SUDs Target Hierarchy

STANDARD DBT

I. LIFE THREATENING BEHAVIORS

II. TREATMENT INTERFERRING

III. QUALITY OF LIFE

DBT FOR BPD WITH SUD'S

I. LIFE THREATENING BEHAVIORS

II. TREATMENT INTERFERRING

III. QUALITY OF LIFE
    1. SUBSTANCE ABUSE

Additional Targets…

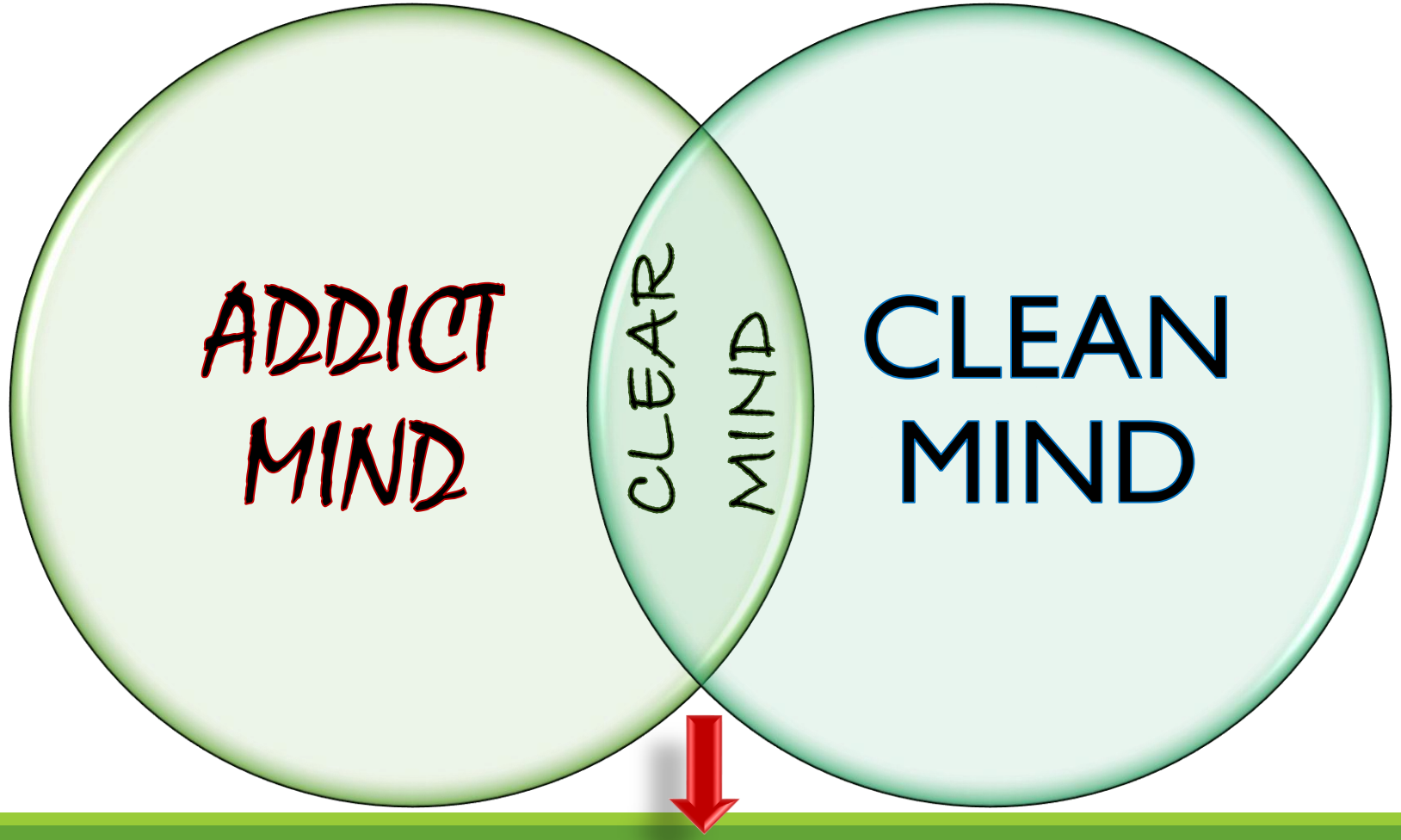
- Decrease Substance Use
- Decrease Physical Discomfort
- Decrease Urges, Cravings, & Temptations
- Decrease the Option to Use Drugs
- Decrease Contact with Cues
- Increase Reinforcement of Clear Mind Behaviors
- Clear Mind, *the ultimate goal*

CLEAR MIND

- ULTIMATE GOAL OF ALL THE SUBSTANCE ABUSE TARGETS
- THE PREREQUISITE FOR GETTING INTO WISE MIND
- A DIALECTIC: A SYNTHESIS OF ‘ADDICT MIND’ & ‘CLEAN MIND’

CLEAR MIND

- ✓ RULED BY ADDICTION
- ✓ IMPULSIVE
- ✓ ONE-MINDED
- ✓ DO-ANYTHING-FOR-A-FIX

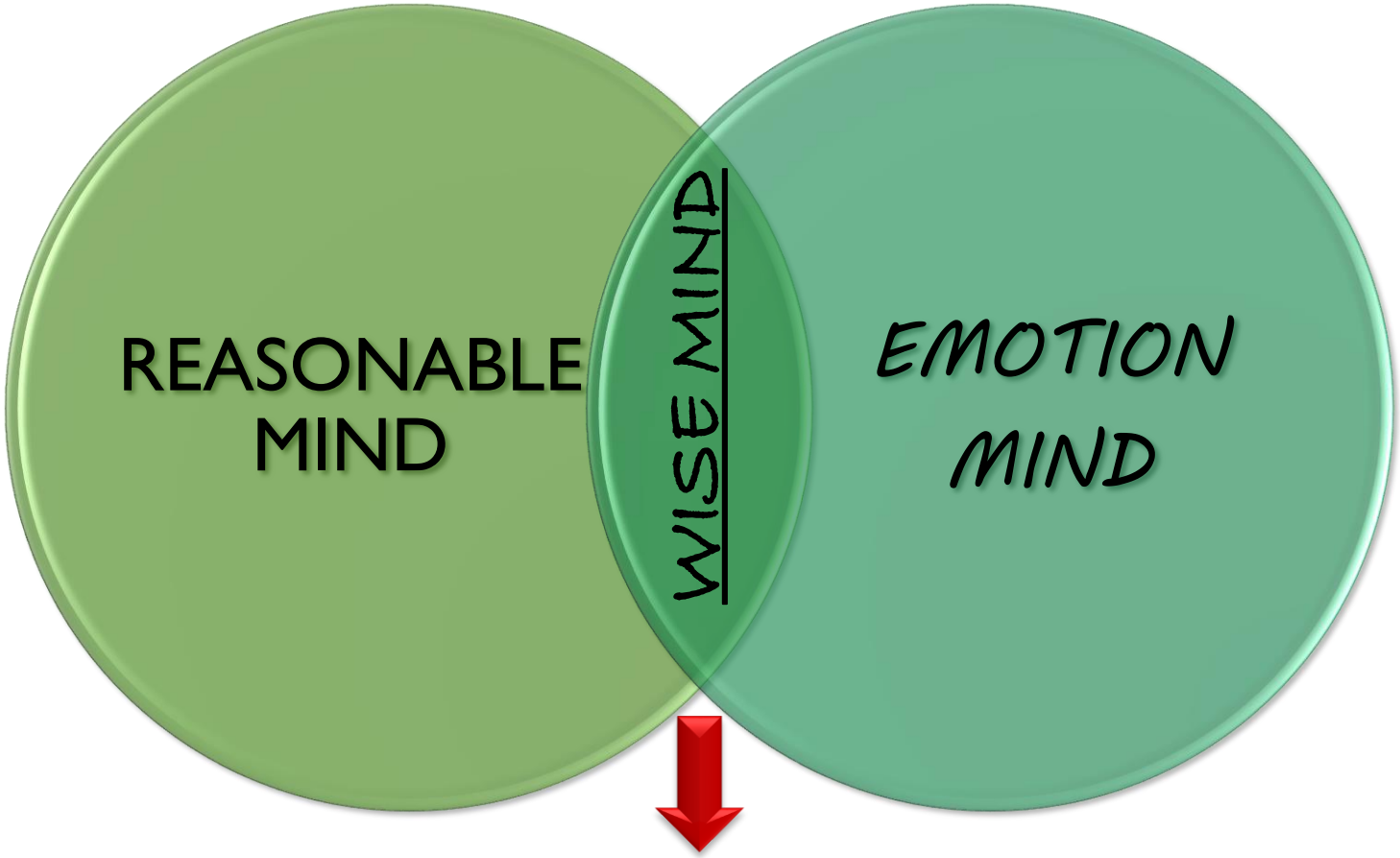


- ✓ NAÏVE
- ✓ RISK-TAKING
- ✓ OBLIVIOUS TO DANGERS
- ✓ "INVINCIBLE"
- ✓ "IMMUNE"
- ✓ "TOP OF THE MOUNTAIN"

HAVE SOBRIETY & AWARE OF VULNERABILITY; PLAN FOR STAYING CLEAN

CLEAR MIND LEADS TO…

LOGIC WITHOUT EMOTION



EMOTION WITHOUT OF LOGIC

WISEST POSSIBLE DECISIONS;
DOING JUST WHAT IS NEEDED; EFFECTIVE

DBT for BPD with SUDs: Additional Treatment Strategies

I. ATTACHMENT STRATEGIES

II. "ADDICTION PROBLEM SKILLS" (Urges, Cravings, & Relapse)

III. "GETTING A NORMAL LIFE" SKILLS (Self-Management & Building Structure Skills)

“Butterflies”:
Patients who attend intermittently, fail to return phone calls, & “flit” in treatment engagement

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ATTACHMENT STRATEGIES:

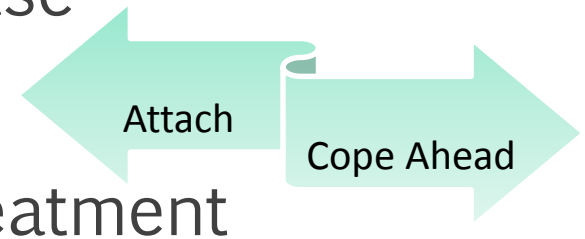
The Butterfly Problem

- *Therapist “competing” with the drugs, often have less leverage initially*
- *Therapist must enhance motivation to change*
- *Therapist works to address these issues from the initial meeting*

ATTACHMENT STRATEGIES: The Butterfly Problem

What To Do From the Get-Go…:

- ❑ Orientation/Pretreatment Phase
- ❑ Orient Patient to Problem
- ❑ Target potential barriers to treatment
- ❑ Discuss early warning signals
- ❑ Develop a plan for dealing with them when they happen
- ❑ Develop a crisis plan



- ✓ JUST IN CASE LIST
- ✓ INCREASE CONTACT
- ✓ GO WHERE THEY ARE
- ✓ SHORTEN SESSIONS

JUST IN CASE LIST

(1.) List 3 friends whom you use(d) with, list numbers & addresses

(2.) List 3 places where you typically go to use

(3.) List 3 people who are supportive of your treatment and will help reach you in case of relapse

GO WHERE THEY ARE

(1.) Home Visits

(2.) Meet at Starbucks

(3.) Meet at a park

Butterfly Attachment

INCREASE CONTACT

(1.) Home Visits

(2.) Meet at Starbucks

(3.) Meet at a park

(4.) HIPAA Secure texts

SHORTEN SESSIONS

"ADDICTION PROBLEM SKILLS": (Urges, Cravings, & Relapse)

MINDFULNESS SKILLS

Clear Mind

Synthesis between "Addict Mind" & "Clear Mind"

Urge Surfing

Observe urges in a detached manner; observe & describe; ride out the "crest"

Alternate Rebellion

Effectiveness; serves the "need" to rebel against authority, boredom of abiding by rules.
Piercings, tattoos, shave head, wear funky underwear, etc….

DISTRESS TOLERANCE SKILLS

Burning Bridges/Building Bridges

Cut off all options to drug use → Radical Acceptance not going to use; people, cues, places.
Create new visual & sensory experiences that compete with cravings.

Adaptive Denial

Convince yourself you want something other than the drug, i.e. urge to have alcohol vs. wanting a sweet.

Pro's & Con's

(-) consequences of using & (+) consequences of abstinence

URGE SURFING

OBSERVE YOUR URGE…

- Step back and just watch/notice your urge
- Notice without judging; allow, be willing
- Experience it as a wave, coming and going
- Imagine surfing the wave
- Try to stay on the crest of the wave without being “wiped out”

- Denial = surfing a wave with your eyes and ears closed
- Try not to Block or Suppress the urge
- Don’t try to “get rid of the wave” or push it away

ALTERNATE REBELLION

STAY FOCUSED ON THE LONG-TERM GOAL & DO WHAT WORKS…

- Stay mindful of your long-term goals & values in the situation
- Play by the rules
- Let go of willfulness
- REPLACE DESTRUCTIVE BEHAVIORS & STAY ON YOUR PATH TOWARDS YOUR GOALS

- ❑ Shave Your Head
- ❑ Wear crazy underwear
- ❑ Do random acts of kindness
- ❑ Print slogans on t-shirts
- ❑ Body piercing/tattoo
- ❑ Secretly wear something "against the rules" under your work/school clothes
- ❑ Express unpopular views
- ❑ Have secret thoughts

GETTING-A-NORMAL-LIFE SKILLS: Self-Management Strategies

Self-Management Through Behaviorism:
How to use reinforcers; How to extinguish; How to shape

- Chain Analysis "Chain"
- Solution Analysis

Build Structure & Stability

- ❑ Secure Accommodation
- ❑ Develop healthy relationships
- ❑ Gain education/employment
- ❑ Attend to physical/health issues

Community Reinforcement
Replace addiction reinforcers with abstinence reinforcers

- ❑ Search for people to hang out with who aren't addicted
- ❑ Increase activities you can do without the addiction
- ❑ Sample different groups and activities
- ❑ Abstinence Sampling: commit to ___ days off your addiction and observe all the benefits that occur naturally as a result; avoid triggers during this period

DBT CHAIN ANALYSIS

1. Do they have the skills?

→ ***TEACH SKILL***

2. Are ineffective behaviors being reinforced?

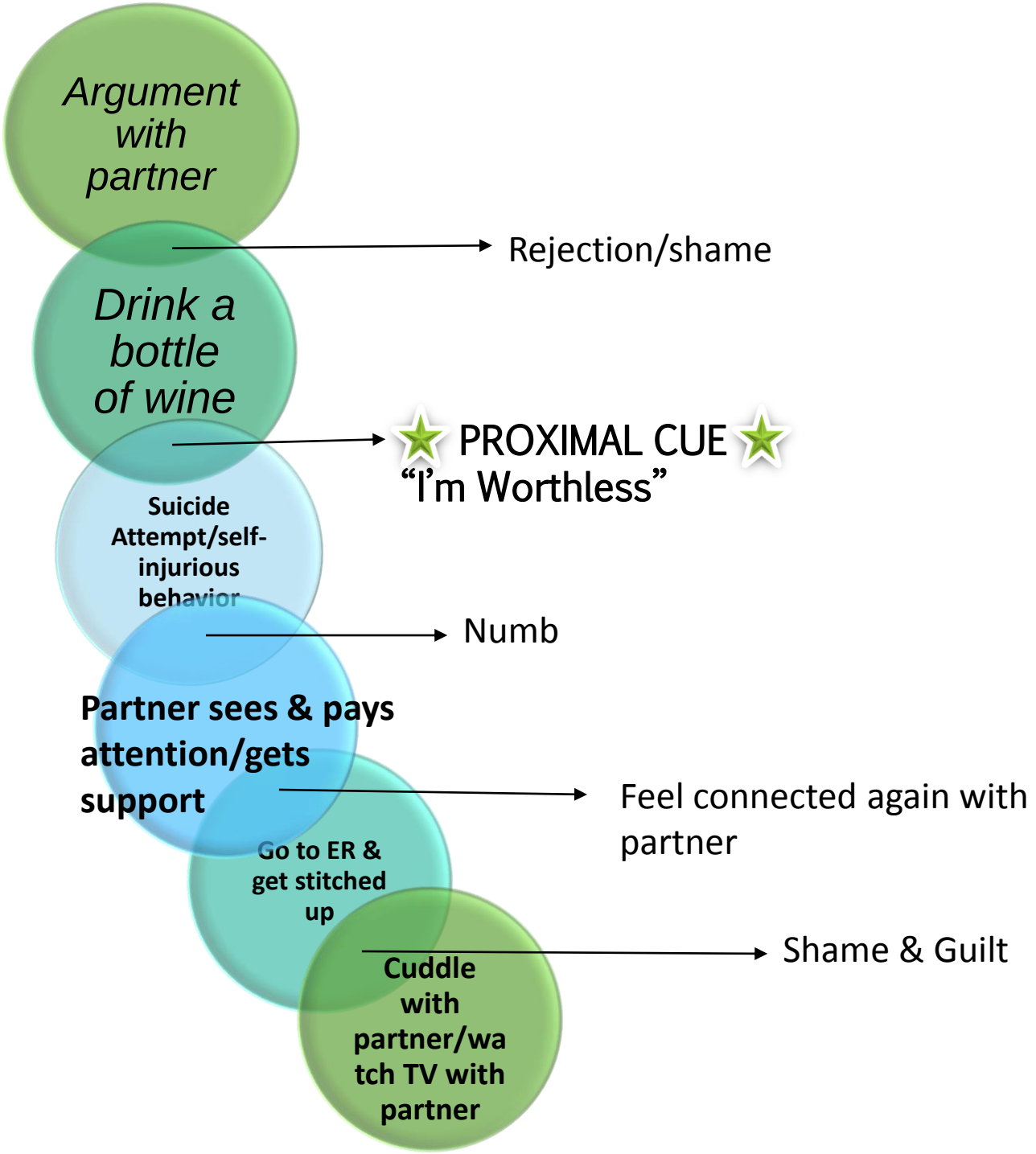
→ ***CONTINGENCY MANAGEMENT***

3. Are emotions getting in the way?

→ ***EXPOSURE***

4. Are faulty beliefs/ assumptions inhibiting effective behaviors?

→ ***COGNITIVE MODIFICATION/ RESTRUCTURING***



BEHAVIORAL ANALYSIS Vs. CHAIN ANALYSIS…

BEHAVIORAL ANALYSIS

1. "…an in depth analysis of one particular instance or set of instances of a problem or a targeted behavior." (Linehan, M. M., 1993)

2. Determines factors leading up to, following, and "controlling" the behavior.

3. "STEPS"…

- Define the behavior

- Do a "***chain"***

- Generate hypotheses about what's controlling behavior

CHAIN ANALYSIS

1. "…an exhaustive, step-by-step description of the chain of events leading up to and following the behavior." (Linehan, M. M., 1993)

2. Also helps to figure out ways to repair the damage

- detailed, blow-by-blow, slow-mo, play-back

- actions

- body sensations

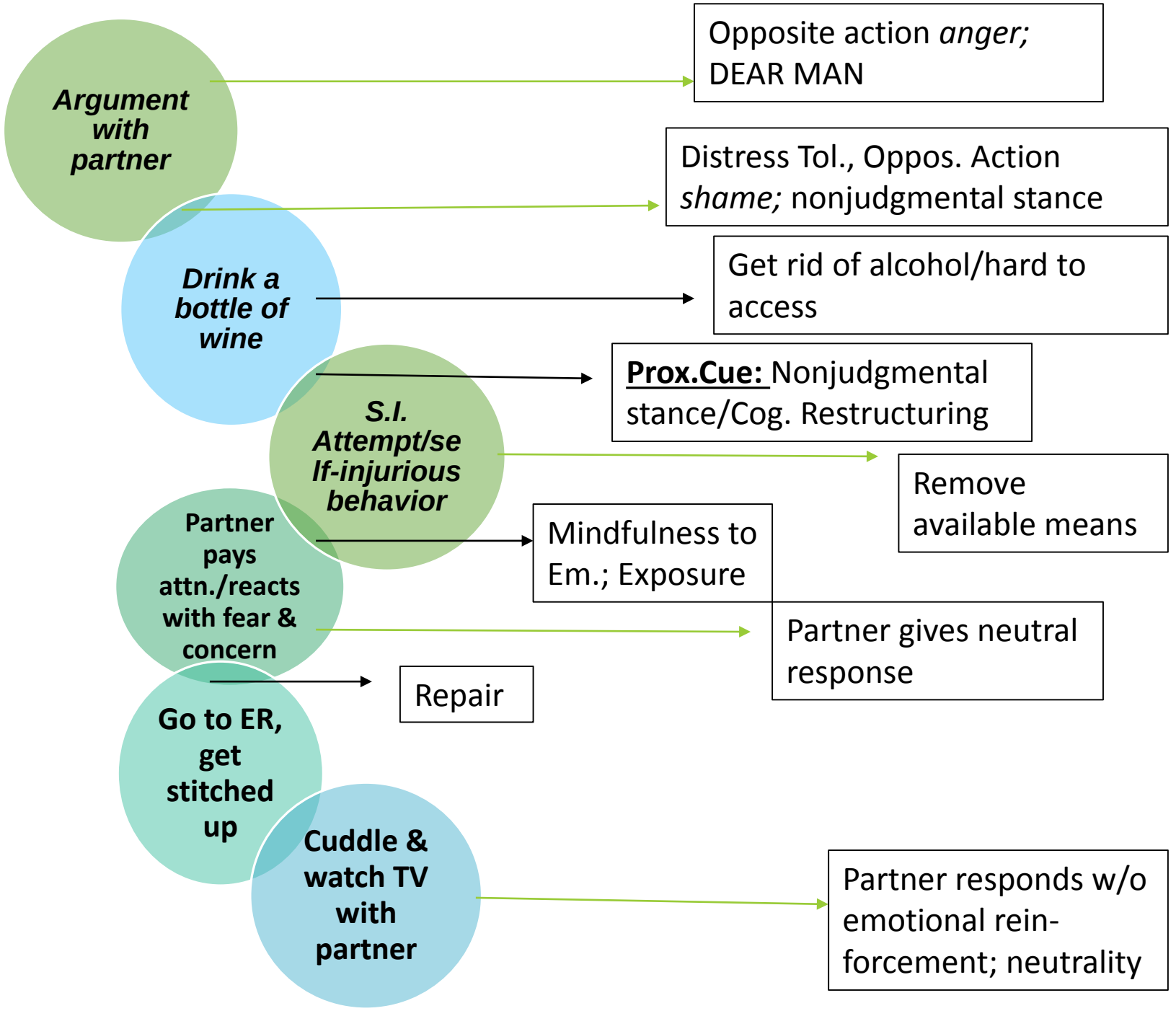
- events in the environment

- feelings & emotions that you are experiencing

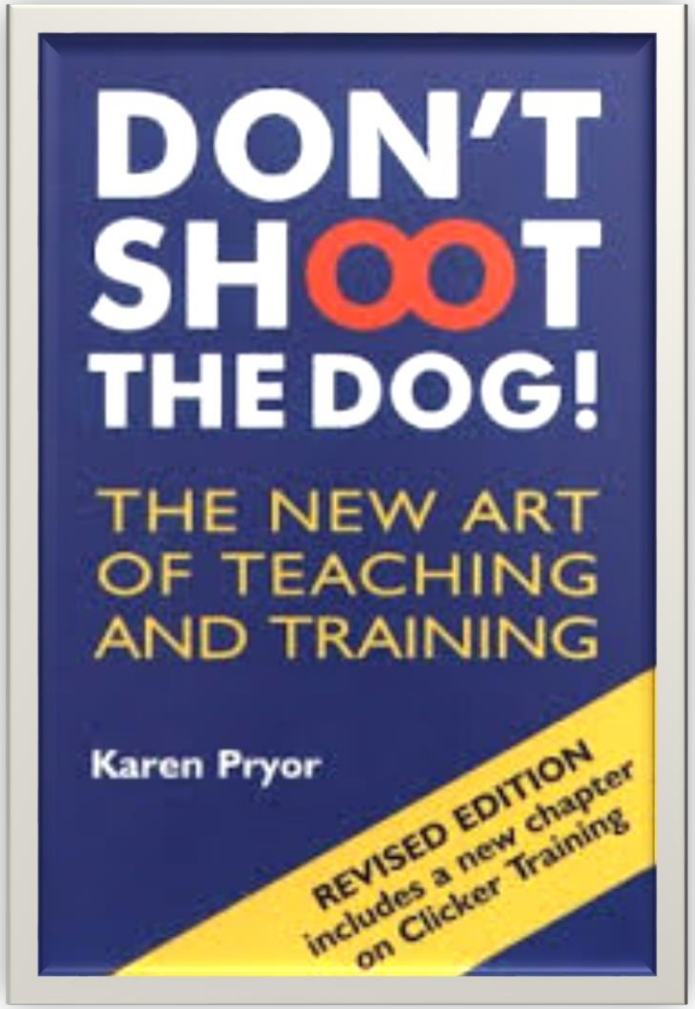
SOLUTION ANALYSIS

- Therapist MODELS solving problems, and elicits & reinforces the generation and use of solutions by the Client

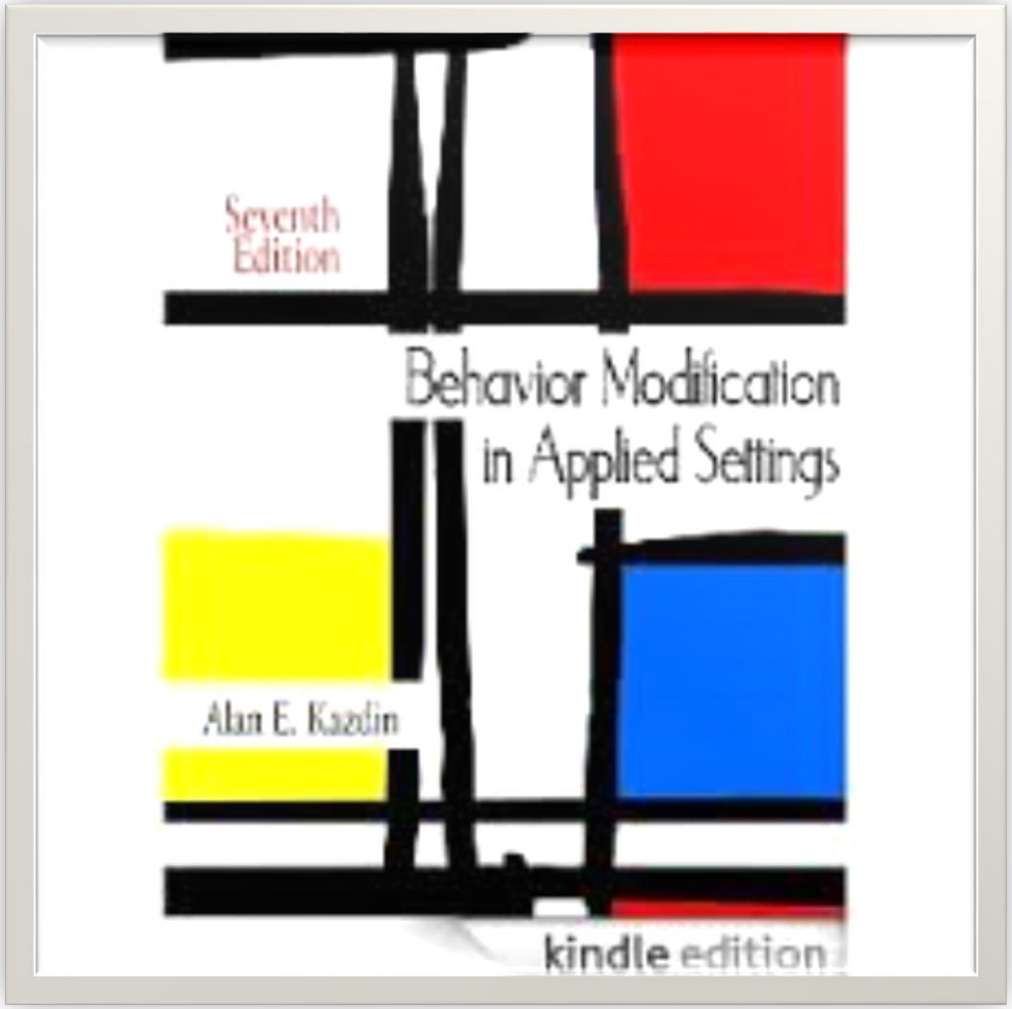
- Actively generate behaviors that can replace maladaptive ones & develop a plan for how to make the change come about



Don't Shoot the Dog, Karen Pryor



Behavior Modification in Applied Settings, Alan E. Kazdin



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