DIALECTICAL BEHAVIOR THERAPY AND SUBSTANCE USE APPLICATIONS

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LEARNING OBJECTIVES

By the end of this presentation participants will be able to:

• name three observed differences in those with Borderline Personality Disorder (BPD) and substance use disorder (SUD) compared to those without SUD.
• define Dialectical Abstinence
• generate two examples of attachment strategies
DIALECTICAL BEHAVIOR THERAPY

Acceptance & Change

✓ Validation
✓ Zen Mindfulness
✓ Problem Acceptance
✓ Reciprocal Communication
✓ Tolerating Distress
✓ Environmental Intervention
✓ Self Disclosure
✓ Supportive
✓ Acceptance

✓ Problem-Solving
✓ CBT Strategies
✓ CHANGE NOW!/Benevolent demanding
✓ Irreverent Communication
✓ Consultation-to-Patient (self management)
✓ Dialectical Strategies

Dialectics
HIGH PREVALENCE OF SUD AMONG BPD POPULATION

- BPD in general population: Approximately 5.9% (Zanarini et al. 2011, NIAAA).
- BPD in Substance Use Disorder populations: (Trull, et al., 2000):
  - 9% in community samples
  - 9% - 65% in treatment samples
- Opiate addiction
  - 9.5% (Brooner, et al., 1997) to 12% (Kosten, et al., 1989)
HIGH PREVALENCE OF SUD AMONG BPD POPULATION

- 21% of clinical population of BPD also had a primary substance use disorder (Koenigsberg et al, 1985).

- 23% of those with BPD met lifetime criteria for substance use disorder (Links, et al., 1988).

- 67% with BPD met criteria for a substance use disorder. When substance use disorder was not used as a criterion of BPD, the incidence dropped to 57% (Dulit et al., 1990).
TROUBLESOME COMBINATION
BPD + SUD
LINKS ET AL., 1995; STONE, 1990

BPD + SUD

> 

BPD only or SUD only

- Psychological Problems/Severity
- Suicide Risk / Suicidal Behaviors
BPD Suicide rate = 9%, typically during mid-20’s to early 30’s
– Increases to 38% if alcoholic and not in AA

Best outcomes
– Artistic talent, high IQ (over 130), conventionally attractive, good sense of self-discipline (self-management)
– Abstinence from alcohol and drugs

Poorest outcomes
– Trauma: Transgenerational incest, history of rape, cruel parent
– At least one night in jail
– Antisocial features
– In men, eloped from hospital
WHO IS DBT-SUD FOR?

Multi-disordered, substance-dependent individuals with severe, complex problems and Personality Disorders

- NIDA 1/UW: Poly-substance dependent
- NIDA 3/UW: Heroin Dependent (many poly)
- NIDA 5/UW: Heroin Dependent (many poly)
- Amsterdam: Alcohol and/or drug dependent
DBT for multi-disordered individuals with Multiple Problems & SUD is mostly an abstinence-based treatment.
WHY APPLY DBT?

- Established for multi-disordered, severe, complex patients.
- Applies principles of effective compassion (important for marginalized group)
- Offers a BIG HOUSE in which to embed other evidence-based principles & procedures.
- Structures up the treatment environment
AREAS OF DYSREGULATION

- Emotional Dysregulation
- Behavioral Dysregulation
- Interpersonal Dysregulation
- Cognitive Dysregulation
- Self Dysregulation
BIOSOCIAL THEORY (BIOLOGY)

Sensitivity to Emotion Cues

Reactivity to Emotion Cues

Slow return to baseline
BIOSOCIAL THEORY (SOCIAL)

✓ Pervasively punishes/ridicules or ignores private experiences irrespective of their actual validity

✓ Punishes/ignores displays of emotion (and often reinforces up-escalated emotion expression)

✓ Oversimplification of problem-solving. Communicates unrealistic expectations of problem-solving (i.e. willpower)
SECONDARY TARGETS

Emotion

Vulnerability

Unrelenting Crises

Active Passivity

Biological

Apparent Competence

Self-Invalidation

Social

Inhibited Grieving
DIALECTICAL DILEMMAS

Emotion Vulnerability

• Fear of “The Abyss”
• “I’ll never get out!”
• “I can’t stand/tolerate this pain.”

Self-Invalidation

• Fatally-flawed; self-loathing: “I shouldn’t be this way” or “I’m disgusting! Look at me!”
• Identity of individuals who use substances; seeking out other individuals who use substances in the community as self-verification.
• Denial of severity of problem; oversimplification and/or unrealistic judgment: “I’ll never do this again!” or “I can be perfect today.”
SUBSTANCE USE AND PTSD

Foa et. al | Harned el. al

Prolonged Exposure embedded within DBT or Standalone

Agreement to reduce alcohol consumption

Agreement to not use within 2 hours of treatment sessions or homework assignments

Best results with naltrexone plus PE

• Not at imminent risk of suicide
• No suicide or self-harm behaviors for 8 weeks
• No serious therapy interfering behavior
• Willingness to experience intense emotion without escape
• PTSD is highest of Quality of Life interfering behavior
• Client wants to treat PTSD now
OBSERVED DIFFERENCES: SUD+BPD VS. SUICIDAL + BPD

- High avoidance of cues associated with negative affect
- Regulate emotions via quick acting drugs (vs. interpersonal interactions)
- Frequently fall out of contact with primary therapist
- Therapist more prone to feeling demoralized and apathetic
- Far fewer positive social supports on which to rely
IMPLICATIONS FOR TREATMENT

Treatment Goal

Abstinence + Functionality
...while ALSO addressing higher-order treatment targets while building a life worth living.

(Think functionality).
ORDER UP BEHAVIORAL TARGETS

Stage 1 DBT Behavioral Targets
(after commitment)

- DECREASE Imminent Life Threatening Behavior
- DECREASE Therapy Interfering Behaviors
- DECREASE Quality of Life Interfering Behaviors
- INCREASE Behavioral Skills (to compensate for skills deficits) and motivation.
DBT-SUD SPECIFIC TREATMENT AGREEMENTS

• Get off of all illegal substances;
• Don’t sell illegal substances to other people in the program;
• Must appear to the astute observer (including other individuals who use substances) that they are not using substances when at the clinic;
• Take Medication-Assisted Treatment for Substance Use and Urinary Analysis three times weekly;

…while ALSO addressing (as needed) higher-order primary targets
PREPARING THE GROUND WELL BEFORE YOU START

1. Know what matters MOST to your client
   • Given how hard it is to get off of drugs, why in the world do it?
   • Get at their Wise Mind values/reasons for doing so.

2. Know their wise mind goals/wishes/hopes for a better life…
   • Time travel 10 years forward, what would you see? Who are you with? What are you doing?
PRE-TREATMENT GOALS

Goals of Treatment

Verbal Commitment to

Stop Using Drugs Now!

(mostly)
CONNECTING THE DOTS & GET COMMITMENT BEFORE MOVING FORWARD WITH TREATMENT

You have to sell change…

1. In order to have X, you will need to do Y.

2. It’s going to be hard to do Y. If it were easy, you would have already done it.

3. You could decide it’s too hard, to turn back.
COMMITMENT STRATEGIES

- Selling Commitment: Evaluating Pros & Cons
- Playing the Devil’s Advocate
- Foot-in-Door & Door-in-the-Face Techniques
- Connecting Present Commitment to Prior Commitments
- Highlighting Freedom to Choose and Absence of Alternatives
- Shaping
DBT: DIALECTICAL ABSTINENCE MODEL
DIALECTICAL ABSTINENCE MODEL

Total Abstinence = 

Before Use &
“Only-in-the-moment”

Harm Reduction = 
After Use &
“Only-in-the-Moment”
POLARITIES IN SUBSTANCE USE TREATMENT

Abstinence Only Model vs. Harm Reduction Model
THE ABSTINENCE MODEL

Pros

• Increased length of time until next use

Cons

• Abstinence Violation Effect
• Deficient attention to capacities for coping with failures of self-control
ABSTINENCE VIOLATION EFFECT

Causal attributions

• Internal
• Stable
• Global

Negative affective experiences

Factors thought to increase AVE

• degree of commitment to the goal
• effort exerted
• time spent maintaining goal
• value associated with progress
THE HARM REDUCTION MODEL

Pros

• Focus on teaching moderation skills => resuming goals more quickly after a slip; relapse is not as long or harmful.

Cons

• Moderation Effect: If you expect that using is not so bad, you’ll use => less time to drug use.
TOTAL ABSTINENCE
(“ONLY-IN-THE-MOMENT-BEFORE-USE”)

- “Turning the Mind” completely for the time you can be certain of.
- Repetitive “Turning of the Mind”.
- Radical Acceptance that ANY use ==> DISASTER!
- Denial of any Option to Use.
TOTAL ABSTINENCE
(“ONLY-IN-THE-MOMENT-BEFORE-USE”)

- “Inner deal” that commitment is only until it’s remade
- Option to use left open for in the future
- Promise of use at death.
HARM REDUCTION

- Teaching of “what if” and “just in case” skills (e.g., emergency preparedness drill).
- Teaching the concept of learning to “fail well.”
- Monitoring of use and immediate chain analysis and problem-solving of use.
- Radical acceptance that use does NOT equal disaster.
• Explicit (“front-of-the-mind” expectations vs. implicit (“back-of-the-mind) relapse planning

• “Touchdown Every Time Mentality” vs. “Winning Isn’t Everything” mentality

• Balances total abstinence with harm reduction
GETTING/STAYING OFF DRUGS IS A PROCESS, NOT AN END-POINT.

As a process, may involve slips, lapses, and at times what appears to be worsening
REFRAMING “RELAPSE” AND SLIPS AS “PRO-LAPSE”
THREE STRIKES AND YOU’RE CLOSER TO YOUR…

ultimate goal(s)
STAYING OFF DRUGS REQUIRES CLEAR MIND ACTIONS

- Clean Mind
- Clear Mind
- Substance Users Mind
PATH TO CLEAR MIND

- Decrease **Substance use**
- Decrease **Physical Discomfort** from Abstaining
- Decrease **Urges and Cravings** to use drugs
- Decrease the **Options, Contacts, Cues** to use drugs
- Decrease **Capitulating** to using drugs
- Increase **Community Reinforcement** of functional behaviors
DBT SKILLS FOR SUDS

- Burning Bridges or “Cutting off your (drug use) options to keep your options for a decent life open”
- Urge Surfing
- Adaptive Denial
- Alternate Rebellion
- Building Structure & a Life Worth Living
- Avoiding | Eliminating Cues to Use
DECREASE PHYSICAL DISCOMFORT: PAIN MANAGEMENT

• Rationale:
  • to reduce risks of early treatment drop out;
  • to prevent drug use.

• How:
  • Medication-Assisted Treatment with quick induction
  • Application of DBT skills, particularly distress tolerance, mindfulness, and PLEASE.
DECREASE URGES & CRAVINGS

- Mindfully self-monitor urges
- Normalize presence of urges (Didactic Strategy)
- Label urges and detach from them.
  - Observe & Describe Skills.
- Develop and use imagery.
  - Urge Surfing
TARGETING URGES AND CRAVINGS

(SHIFFMAN, ET AL., 1997)

• Intensity: high
• Duration: longer
• Timing: upon awakening
• Momentum: building

Not frequency
DIDACTIC ON URGES
THE NATURAL LIFE OF AN URGE

- Urges are episodic and not constant; they come and go.
- May fluctuate in intensity during an episode and do not by themselves predict lapse.
- Urges do not increase dramatically upon cessation, but gradually decrease over time (so long as they are not reinforced).
DECREASE THE OPTIONS, CONTACTS, CUES FOR DRUGS

Targeting all overt and covert behaviors that maintain avenues & possibilities for future substance use.
**DECREASE THE OPTIONS, CONTACTS, CUES FOR DRUGS**

- **Examples**
  - Changing phone/pager numbers
  - Getting rid of drugs, paraphernalia, and drug contacts
  - Moving to housing away from users/dealers
  - Not stealing, *not truth telling (lying)*, selling drugs
  - Making public commitment not to use
DBT-SUD APPROACH TO NOT TRUTH TELLING

• Incompatible with abstinence and recovery
• Monitored on diary card
• Special designation for whether they are telling the truth on card
• Dialectical approach to not truth telling
DECREASE OPTIONS, CONTACTS, CUES FOR SUBSTANCE USE

• Decreasing CUE Examples
  • Avoid people, places, things, activities, thoughts associated with substance use
  • Not going to or by places where drugs are available
  • Not socializing with substance users or dealers
  • Not listening music associated with prior substance use
  • Not sitting in the back of NA/AA meetings if attended
DECREASE CAPITULATING TO DRUG USE

• Examples
  • Making 99%, but not 100% effort to quit (e.g., the door is left open);
  • Keeping open the possibility of using drugs again (e.g., closing the front door, but not the back door)
  • Putting off the inevitable
  • Passivity in the face of threats to use drugs
  • Willful/artful denial (e.g., kidding yourself)
INCREASE COMMUNITY REINFORCEMENT OF “CLEAR MIND” BEHAVIORS

• Examples
  • Working for pay
  • Socializing with individuals who do not use substances
  • Joining groups with individuals who do not use substances (e.g., exercise, church, volunteer, political groups)
  • Becoming involved and participating in NA/AA or other support group
ATTACHMENT STRATEGIES

DBT assumes that engaging reluctant clients in treatment is a therapeutic task for the DBT therapist

(as opposed to a client requirement before starting treatment)
DBT ATTACHMENT STRATEGIES

- Orient people to attachment problems
- Increase contact during initial trimester
- Contact using text, VM, Email, Social media (with care)
- Conduct therapy in vivo
- Shorten or lengthen therapy sessions
- Conduct supportive family and friends network meetings.
DBT ATTACHMENT STRATEGIES

- Treat therapists, including Clinical Supervision to avoid compassion fatigue
- Phone, text to break avoidance.
- Find clients when they are lost.
- Provide Medication-Assisted Treatment
- Provide multiple therapists who coach clients on therapeutic relationships.
DBT ASSUMPTIONS ABOUT PERSONS LIVING WITH SUBSTANCE USE DISORDER

1. People are doing the best they can
2. People want to improve
3. People must learn new behaviors in all relevant contexts
4. People cannot fail in DBT
5. People may not have caused all of their own problems, but they have to solve them anyway
6. Individuals living with SUD should be more motivated to change
7. The lives of persons with suicidal behavior are unbearable as they are currently being lived
The ‘Dialectical’ Therapist

- Oriented to Change
- Benevolent Demanding
- Compassionate Flexibility
- Oriented to Acceptance
- Unwavering Centeredness
- Nurturing
This is ‘behavior'

This is ‘just’ behavior. These are problems to be solved. Going beyond the facts, haphazardly using theories will make you feel demoralized and confused.

Assess the target behavior and keep assessing. Failures in treatments are often failures in assessment.

Find the controlling variables. Apply solutions on the controlling variables. Evaluate the process
Contextual Factors
Who [was there]?
Where [did the behavior occur]?
When [in time]?

Describe Skills - Stick to the facts, reports, and observables
CHANGE THE VARIABLES…
CHANGE THE BEHAVIOR PLOT
1. **Not every part of a chain is a controlling variable**

2. With your client hypothesize about what is most influential. Questions like, “if this didn’t happen – do you think the target behavior would have occurred?” What got in the way of skillful behavior? What do you think was most influencing this target behavior?

3. Pick 2-3 potential controlling variables to treat with solution analysis

4. Insert a DBT skill if it was needed in the location of the chain required

5. (Appropriate) Solutions match controlling variables*

6. (if applicable) Repairs are relevant to Damage. Often the best repairs are figuring out how the target behavior started and to prevent it from not happening again
WHAT IS THE FUNCTION OF THE BEHAVIOR?

1. Obtain/Gain access to tangible reinforcers
2. Obtain/Gain access to adult, peer, staff attention*
3. Obtain/Gain access to sensory stimulation
4. Escape from emotions, thoughts, private sensory stimuli*
5. Escape from demanding or difficult tasks*
6. Escape from demanding social situations*

Adapted from Cipani Functional Behavioral Assessment, Diagnosis, and Treatment 2018
Solutions from Chain Analysis

Vulnerability Factors

Prompting Event

Problem Solving
Stimulus Control
Skills (PLEASE)

Contingency
Management

Distant
Consequence(s)

Close
Consequence(s)

Target Behavior

Emotion

Cognition

Sensations

Event

Exposure

Skill Insertion

Actions

Cognitive
Modification

Skills (PLEASE)

Exposure

Skills Replacement
Behavior

LINKS
E - Emotions
C – Cognition
A – Actions
U – Urges
S – Sensations
E - Events
<table>
<thead>
<tr>
<th>Controlling Variable</th>
<th>Potential Solutions (not exhaustive)</th>
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<tbody>
<tr>
<td><strong>Prompting Event</strong></td>
<td>Problem Solving</td>
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<td></td>
<td>DBT Skills (i.e. Problem-Solving Unwanted Emotion)</td>
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<tr>
<td><strong>Vulnerability Factors</strong></td>
<td>Problem Solving</td>
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<td>DBT Skills (i.e. PLEASE)</td>
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<tr>
<td><strong>Emotion/Physical Sensations</strong></td>
<td>(informal) Exposure</td>
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<td></td>
<td>Opposite-to-emotion-action</td>
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<td></td>
<td>Mindfulness to current emotion</td>
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<td></td>
<td>Validation</td>
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<tr>
<td><strong>Cognition</strong></td>
<td>Contingency Clarification (if… then… relationships)</td>
</tr>
<tr>
<td>[Images]</td>
<td>Catching judgments and moving to factual nonjudgmental describe</td>
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<tr>
<td>[Interpretation]</td>
<td>Cognitive Defusion (DBT skill Mindfulness to Current Thoughts)</td>
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<td>[Assumptions]</td>
<td>Dialectical thinking/balance</td>
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<td>[Dysfunctional allocation of attention]</td>
<td>(Repeated) cognitive reappraisal</td>
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<tr>
<td>[Judgments]</td>
<td>Treating Cognition like a Behavior Therapist (Function of thought, Container over Content)</td>
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<td>Highlighting (in)effectiveness or problematic thoughts, beliefs, assumptions, interpretations</td>
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<td>WISE MIND</td>
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<td><strong>Other external events</strong></td>
<td>Problem-solving or DBT Skills</td>
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<tr>
<td><strong>Consequences</strong></td>
<td>Contingency Management</td>
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<td>Have the patient change the contingencies (self-management)</td>
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<td>Obtain the function of the behavior without the behavior earlier in the chain</td>
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<td>Extinction (remove reinforcers) / DRA / P+/-</td>
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HABIT CHANGE IS HARD AND OFTEN INVOLVES SET BACKS. YOUR TOOL = BEHAVIORAL ANALYSIS

VULNERABILITY

PROMPTING EVENT

LINKS
E - Emotions
C - Cognition
A - Actions
U - Urges
S - Sensations
E - Events

TARGET BEHAVIOR

LINKS

CONSEQUENCES
ADDITIONAL SKILLS FOR INDIVIDUALS LIVING WITH BPD-SUD

• **+1 Rule** (Julie Brown, PhD)
  - Assess Emotion Intensity: 0 – 5
  - Add 1 to your number
  - That’s how many skills you need to get through hard situation.

• **5 Minute Rule**
  - Make inner commitment to not use for ONLY five minutes.
  - Make another commitment for another 5 minutes at end of initial 5 to get through high risk situation.
TIPP SKILLS
WHEN YOU ARE TOO DISTRESSED TO FIGURE OUT A BETTER SKILL

- Temperature
- Intense Exercise
- Progressive Muscle Relaxation
- Paced Breathing
TAKE THEM AT THEIR WORD VS. SYSTEMATICALLY DRUG SCREEN

• Weekly, ideally 3 times weekly

• Use reliable method

• Check primary drug of choice on regular basis and periodic checks for other drugs at random

• Ideally YOU and THEY receive test results right away.

• Medication Assisted Treatment dosing is not contingent on negative results of drug screen.
REFERENCES & RESOURCES


REFERENCES & RESOURCES


DBT Training

Our trainings offer a full orientation to DBT, from basics to courses developed to help DBT-savvy clinicians hone their skills. Our trainers include Dr. Linda Dimeff PhD, who developed DBT for substance abusers in her more than two decades working directly with Dr. Marsha Linehan. All members of our training team have completed the highest levels of training with Behavioral Tech and Dr. Linehan.

Our enthusiastic and knowledgeable trainers balance decades of experience with enthusiasm for the latest research. We offer on-site training and consultation, as well as our regularly scheduled program throughout the year.

Portland DBT Institute is an NBCC-Approved Continuing Education Provider (ACEP) and may offer NBCC-approved clock hours for events that meet NBCC requirements. The ACEP solely is responsible for all aspects of the program.

Upcoming Trainings

Working Well with the Suicidal Patient: Research-Informed Approaches to Ethical Suicide Assessment and Management
Friday October 27th
Andrew White, PhD

DBT in a Nutshell: Treating Multi-Diagnostic, Complex Individuals
November 2-3, 2017
Daphna Peterson, LCSW

Friends and Family Workshop
Saturday November 4th, 2017 | 9am to 12pm