

Dialectical Behavior Therapy for Co-morbid Substance Use Disorder

Marsha M. Linehan
University of Washington

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News You Can Use

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Overlap of Clients with SUD Who Meet Criteria for BPD

- **9.5% of 716 opiate abusers**
 - Brooner, et al., 1997:
- **66% of outpatient drug abusers**
 - Vaglum & Vaglum, 1985:
- **13% of 94 alcoholics**
 - Nace, et al., 1983:
- **12% of 150 opiate abusers**
 - Kosten et al., 1989:

Overlap of Clients with BPD Who Meet SUD Criteria

- 21% of BPD inpatients and outpatients
 - Koenigsberg et al, 1985:
- 23% of BPD clients met SUD lifetime criteria
 - Links, et al., 1988:
- 56.5% of suicidal BPD clients met SUD lifetime criteria and 26.1% met criteria for current SUD
 - Linehan, et al., 2006
- 67% of BPD met criteria for current SUD;
- 57% when substance abuse was not used as a criterion of BPD
 - Dulit et al., 1990:

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Troublesome Combination: When SUD and BPD are combined

- BPD substance abusers present with significantly more psychological problems than non-BPD substance abusers and non-substance abusers with BPD.
- Substance abusers with BPD have more suicidal behaviors than patients with only BPD or substance abuse (Link, et al., 1995).

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Clinically Observed Differences between BPD Clients with Primary SUD compared to Suicidal Behavior as Primary

- Tendency to regulate emotions via quick acting drugs rather than interpersonal interactions.
- Frequently fall out of contact with primary therapist.
- Therapist more prone to feeling demoralized and apathetic.
- Far fewer positive social supports to rely on.
- Likely to live with dysfunctional male partner

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Implications of Co-morbidity for Treatment of BPD+SUD

- Severe psychopathology upon admissions predicts poorer outcomes and early relapse among drug abusers (Saxon & Calsyn, 1995; McLellan et al., 1992, 1983; Woody, et al., 1985).
- Patients with severe psychopathology frequently screened out of treatment outcome studies (Carroll, 1996).
- Possible therapist burn-out.

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Similarities in Treating Clients Meeting Criteria for BPD and SUD

- Very difficult to treat.
- Disliked by public and providers alike.
- Chronic disorders.
- Clients are at increased risk of dying.

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Lifetime Suicide Risk for Schizophrenic, Affective, Addiction and Borderline Personality Disorders

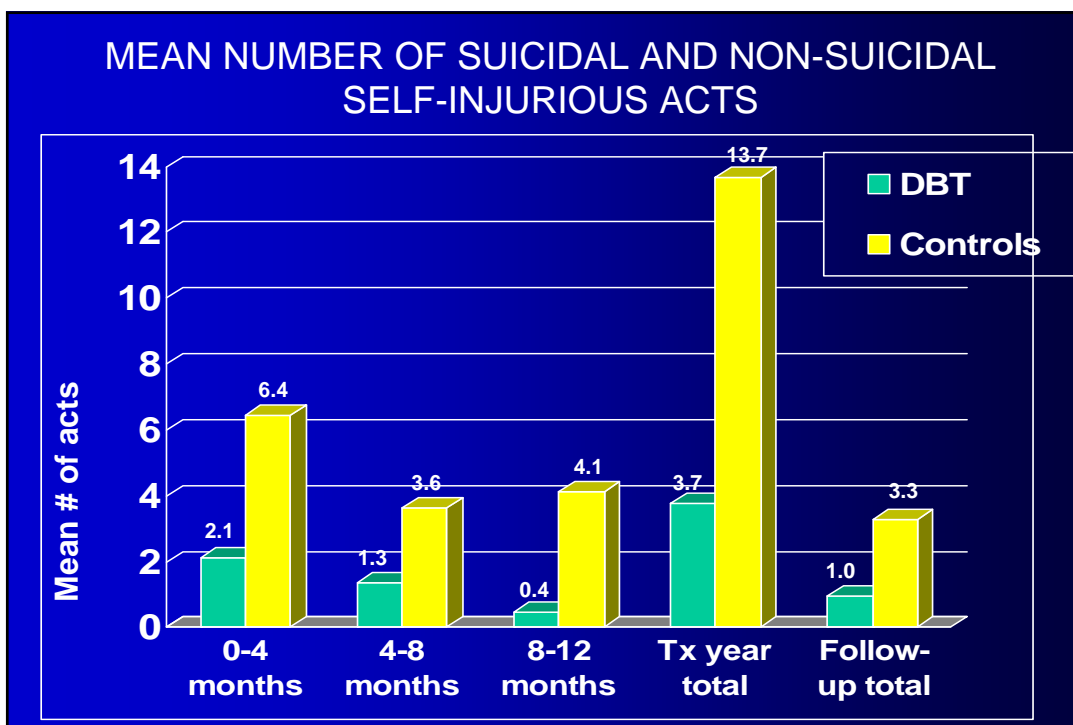
Review of 83 mortality studies

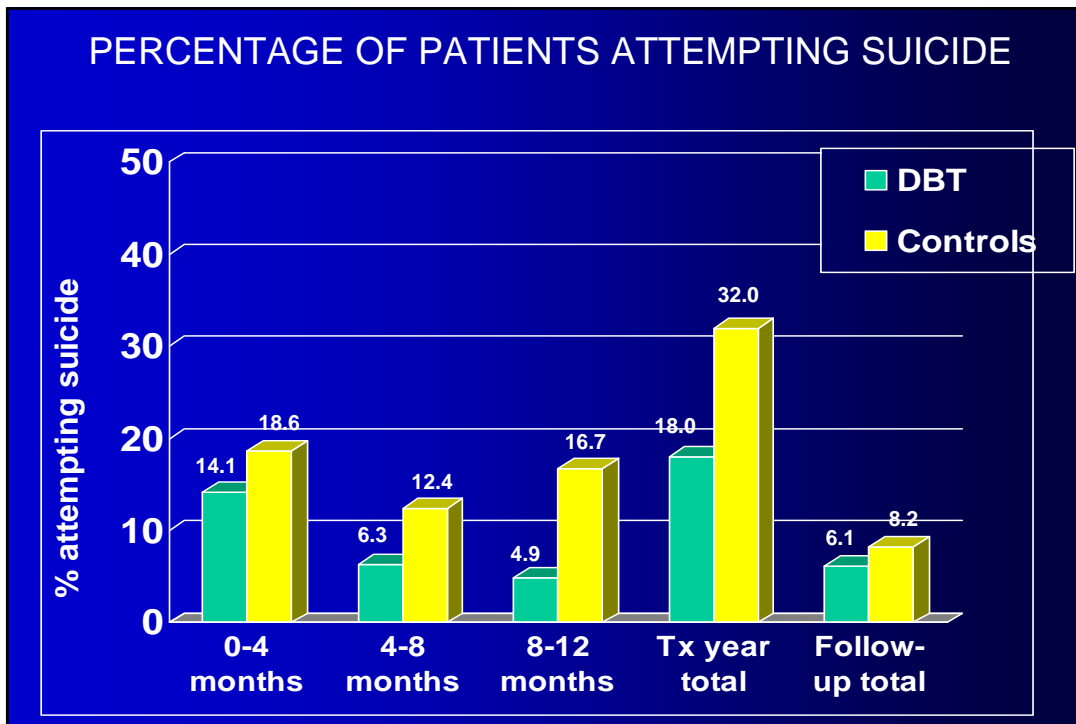
- Schizophrenia.....4%
- Affective Disorders.....6%
- Addiction Disorders.....7%
- Borderline Personality Disorder10%

Inskip HM: Br J Psych 1998

Yen study: Axis I Disorders as Predictors of Suicide Attempt Group

<i>Diagnosis</i>	<i>Wald χ^2</i>	<i>OR</i>
<i>MDD</i>	.43	1.22
<i>Panic d/o</i>	.85	.71
<i>PTSD</i>	.72	1.33
<i>Alc use d/o</i>	.08	1.12
<i>Drug use d/o</i>	4.96*	2.22
<i>SIB Criterion</i>	11.98***	3.45





Dialectical Behavior Therapy (DBT)

The Basics

Linehan, et al., 2001

BPD is a Pervasive Disorder of the Emotion Regulation System



BPD criterion behaviors function to regulate emotions or are a natural consequence of emotion dysregulation.

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Structure the Goals of Treatment



DBT Structures Treatment by Levels of Disorder and Stages of Treatment

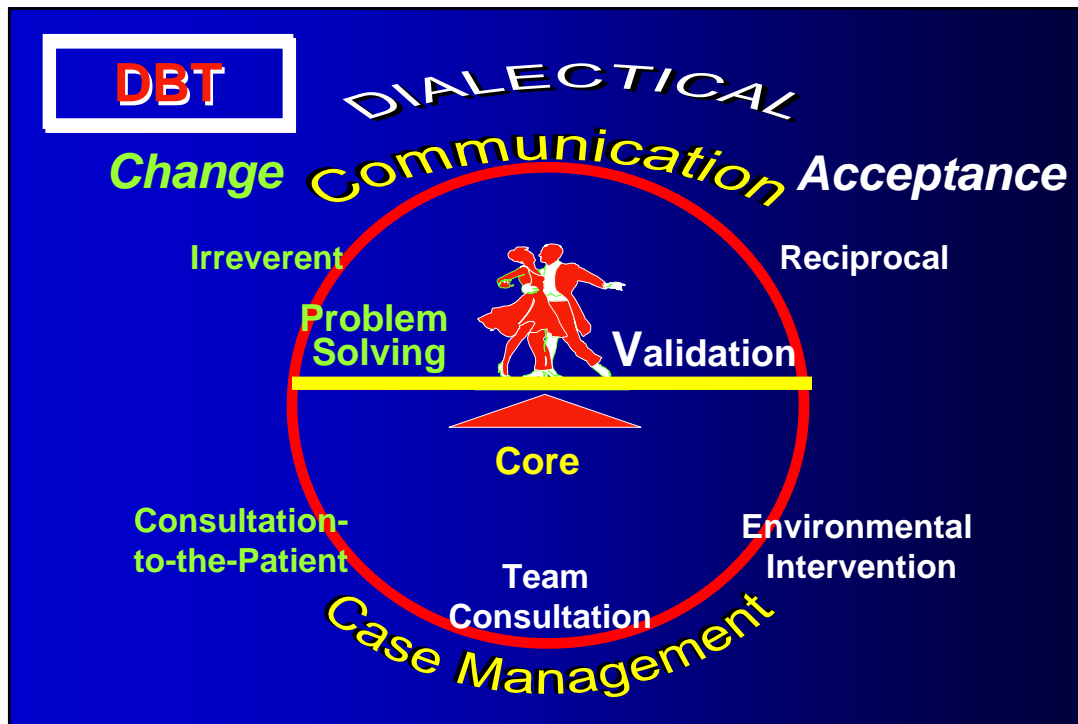


Functions of Comprehensive DBT

1. Enhance capabilities
2. Improve motivation
(Focus on inhibiting/interfering emotions, cognitions, & actions and reinforcement contingencies)
3. Assure generalization to the natural environment
4. Structure the environment
5. Enhance therapists' capabilities and motivation to treat effectively

DBT

- 1st: **Structure**
- 2nd: **DO BEHAVIOR THERAPY**
- 3rd: *add*
Validation
- 4th: **Add Dialectics**
- 5th: *add mindfulness*



DBT Therapist Strategies

1. **Balanced communication styles:**
irreverence/confrontation
reciprocity/warmth
2. **Balanced management of environment:**
consulting-to-the-patient
intervening in environment
3. **Balanced use of direct interventions:**
problem solving/behavioral interventions
validation/radical acceptance

Levels of Validation

1. Staying Awake: Unbiased listening and observing
2. Accurate reflection
3. Articulating the un verbalized emotions, thoughts, or behavior patterns
4. Validation in terms of past learning or biological dysfunction
5. Validation in terms of present context or normative functioning
6. Radical Genuineness

Additions to DBT for Substance Abusing Women with BPD

- Expand and organize drug-related target behaviors
- Organize skills around issues relevant to drug use
- Add to didactic and orienting strategies information specific to substance abuse.

Additions to DBT for Substance Abusing Women with BPD

- **Attachment Strategies (for “butterflies”)**
- **Biological Strategies (“how to” aspects of using replacement medication)**

Drug-Related Target Behaviors DBT Path to Clear Mind

Decrease Substance Abuse

(e.g., using illegal drug; abusing legally prescribed drugs; using legally prescribed drugs not as prescribed)



Decrease Urges and Cravings to Use Drugs



Decrease Physical Discomfort from Abstaining



Decrease “Apparently Unimportant Behaviors”

(e.g., selling drugs; socializing with drug-users or dealers, keeping drug dealer phone numbers)

DBT: Dialectical Abstinence Model

Total Abstinence =
Before Use &
“Only-in-the-moment”

Harm Reduction =
After Use &
“Only-in-the-Moment”

Decrease Physical Discomfort from Abstaining: Pain Management

Rationale:

- to reduce risks of early treatment drop out;
- to prevent drug use.

How:

- Suboxone, quick induction
- Application of DBT skills, particularly distress tolerance, mindfulness, and PLEASE.

“Apparently Irrelevant Behaviors”

Adapted from Marlatt's Apparently Irrelevant Decisions

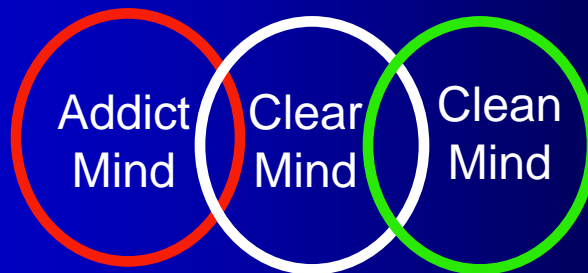
- All public and private behaviors that are indeed relevant to the client's use of drugs but are treated by the client as irrelevant.
- Links in the behavioral chain to drug use.

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“Apparently Irrelevant Behaviors” = “Clean Mind” Behaviors



Drug-specific focus and change procedures in DBT targeting common precipitants of relapse

Negative emotional distress.

↳ Emotion Regulation & Distress Tolerance Training

Interpersonal conflict/social pressure to use.

↳ Interpersonal Effectiveness Training

Exposure to cues

↳ Exposure to cues + "coping ahead" rehearsal.

Proximal more than distal factors

↳ Behavioral analyses and diary cards.

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DBT Attachment Strategies

- Orient client to attachment problem.
- Increase contact during initial trimester.
- Contact using voice mail.
- Conduct therapy *in vivo*.
- Shorten or lengthen therapy sessions.
- Conduct supportive family and friends network meetings.
- Treat therapists who are getting demoralized.
- Phone to break avoidance.
- Find clients when they are lost.

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Changes in Form of Standard DBT

- Opiate Dependence:
 - Drug replacement as a mode.

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Challenges in Applying DBT for SUD

- Therapist find it difficult to stay persistent, focused and urgent about abstinence NOW!
- Therapists have deficits in one or more of four primary change strategies (skills training, cognitive restructuring, exposure, contingency management).
- DBT requires straight-forward, irreverent, confrontational style surrounded by "just sufficient" warmth and validation while remaining radically genuine: difficult when emotionally dysregulated.

DBT-101

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Randomized Controlled Trial of DBT vs. Treatment-as-Usual With BPD Substance Abusers (University of Washington)

*Linehan, Schmidt, Kanter, Craft,
Dimeff, Comtois, McDavid*

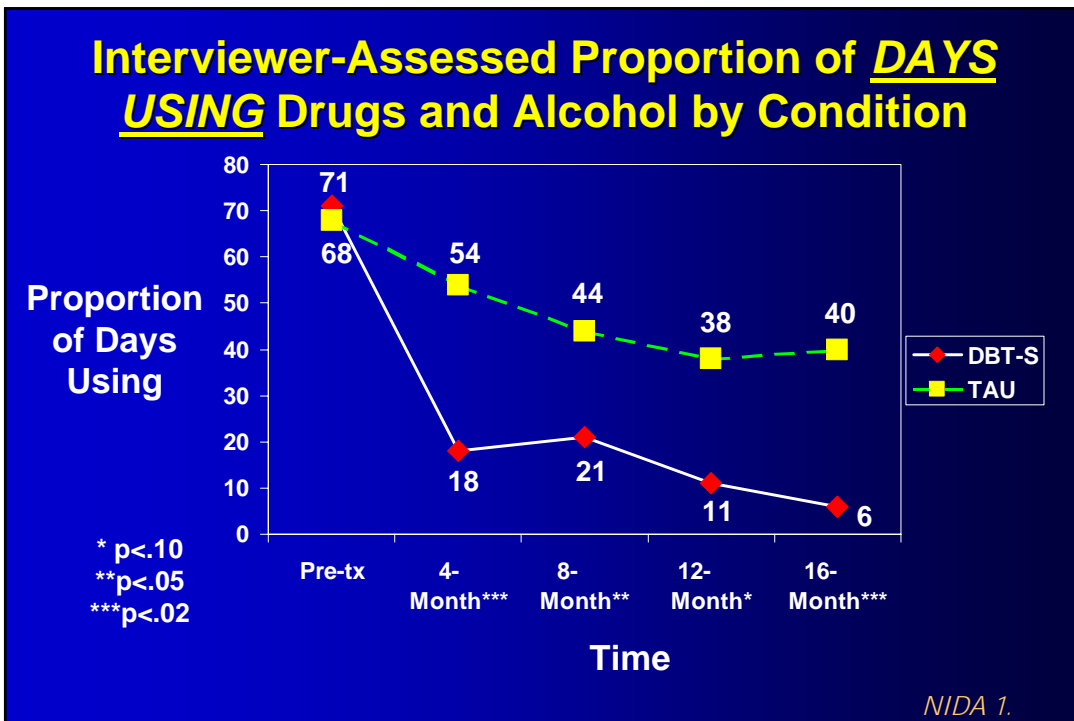
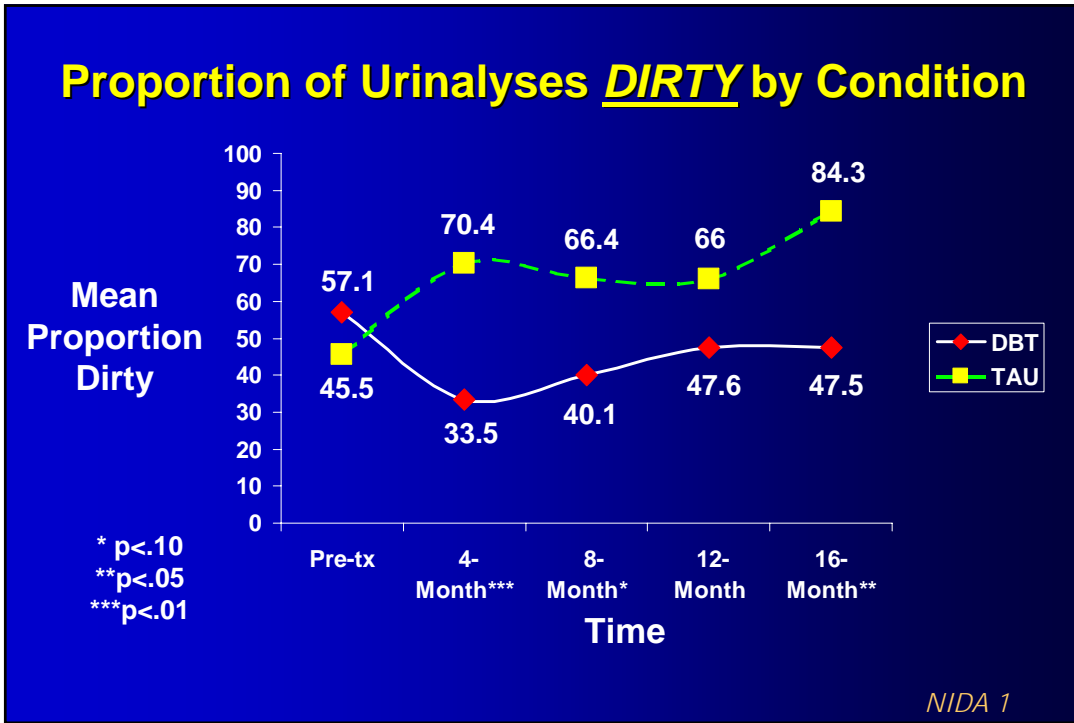
NIDA 1

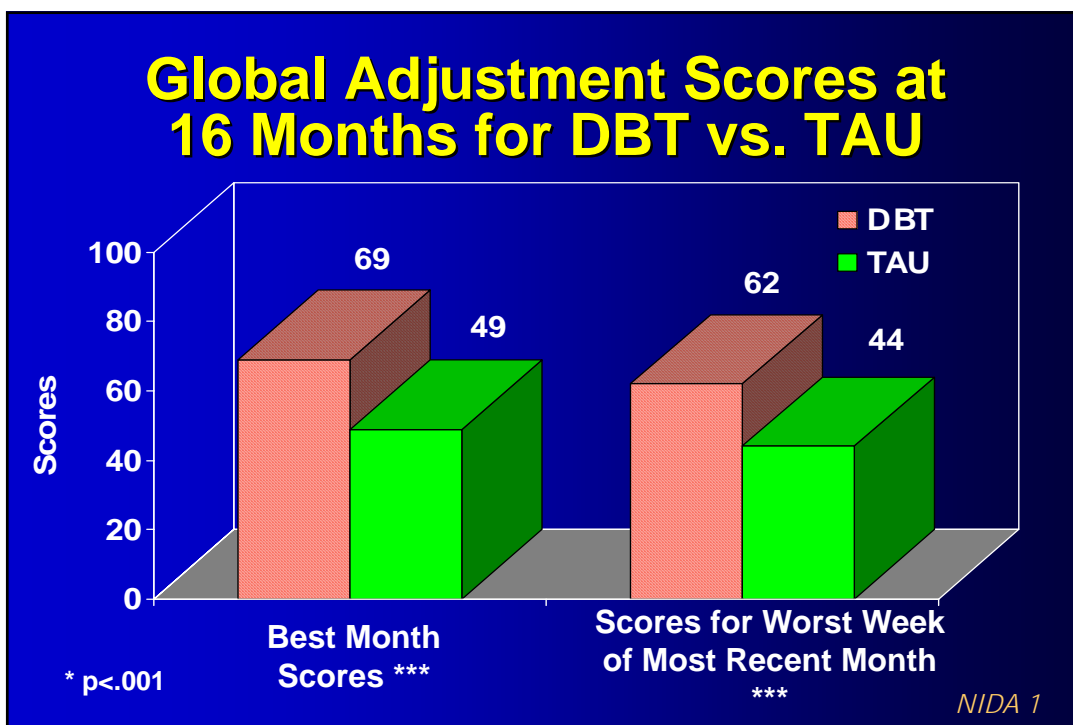
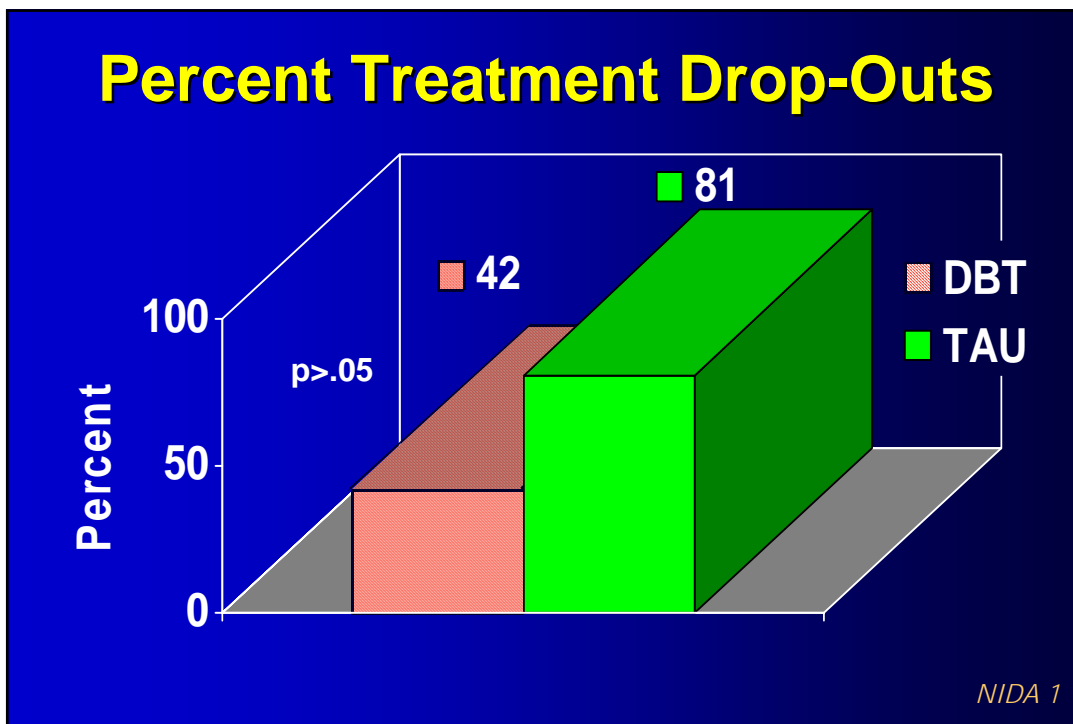
Treatment Conditions

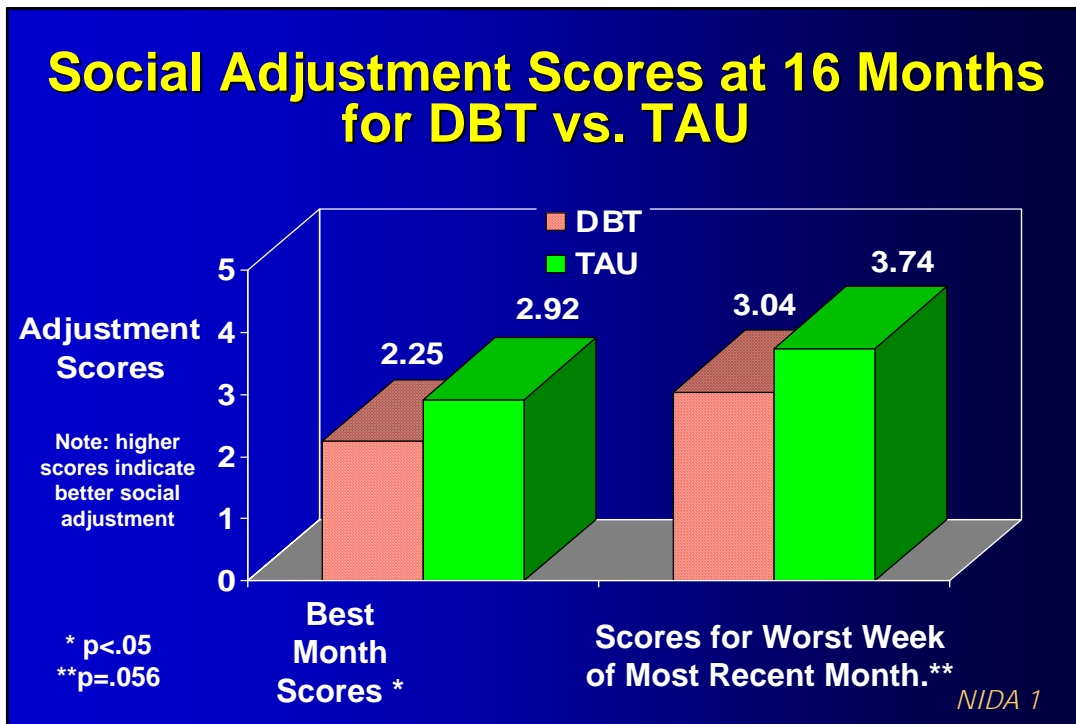
DBT: Weekly Individual Psychotherapy
Group Skills Training (2.5 hr.)
Skills Coaching Phone Calls (*prn*)
Therapist Consultation Group
Transitional Drug-Replacement

TAU: Treatment-as-Usual

NIDA 1







Summary of Outcomes by Condition

- DBT > TAU in improved:
 - Drug use
 - Global Adjustment (at 16-month follow-up)
 - Social Adjustment (at 16-month follow-up)
- Results most promising for individuals whose primary drug is not cocaine

NIDA 1

Randomized Controlled Trial of DBT vs. Comprehensive Validation (1 Year) with BPD Heroin Addicts

University of Washington

*Linehan, Dimeff, Comtois,
McDavid, & Kivlahan*

⁵⁰NIDA 3

Treatment Conditions

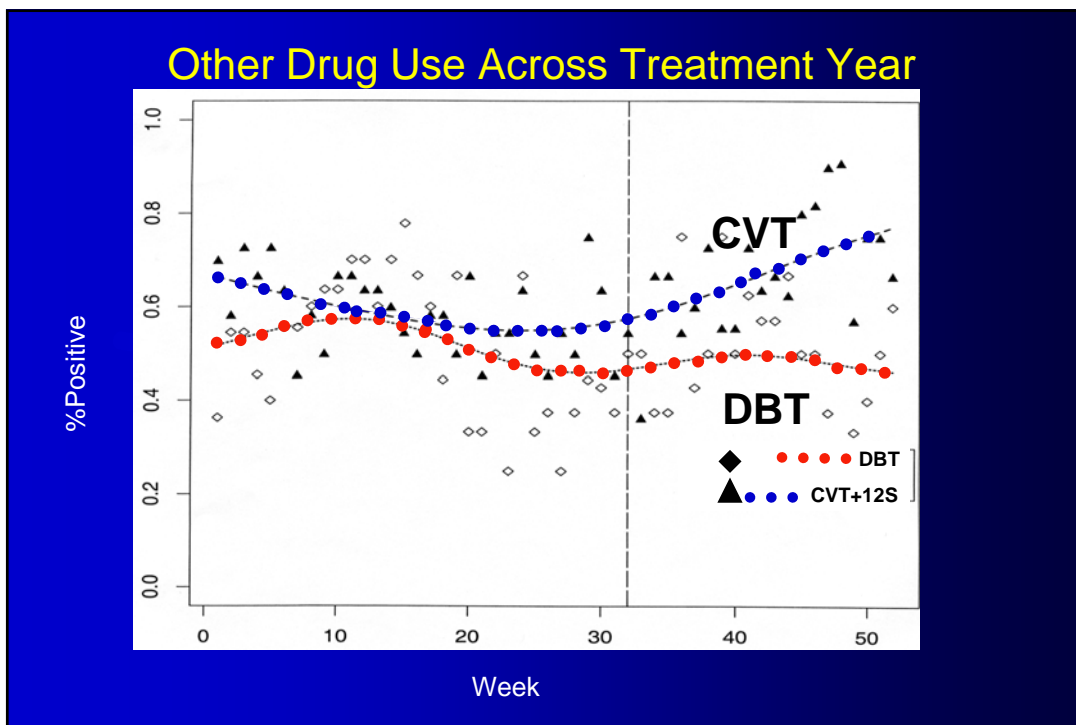
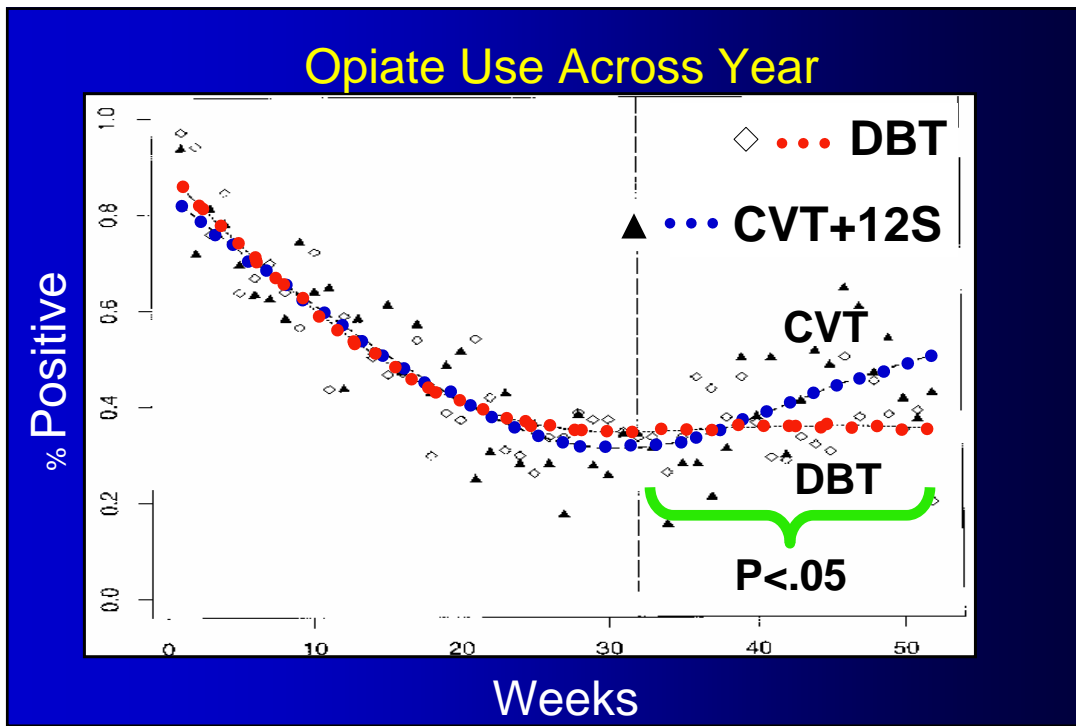
DBT

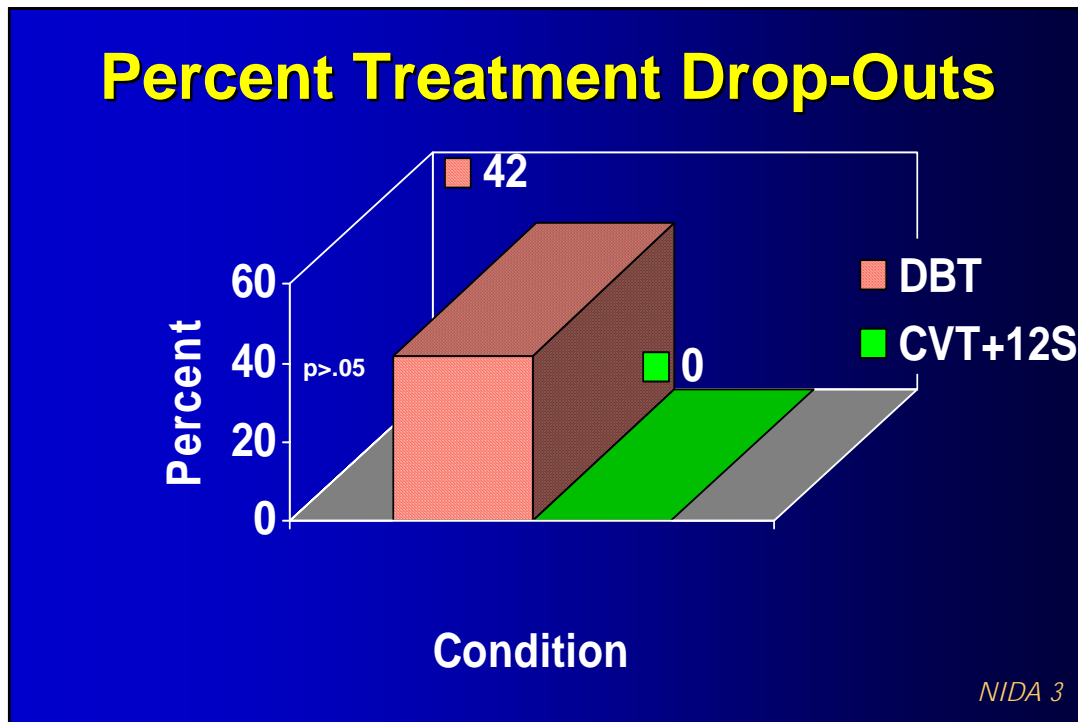
- Individual Therapy
- Group Skills Training
- Homework Review
- Phone Coaching
- Therapist Consult Meeting
- Transitional Drug-Replacement

TAU

- Individual Therapy
- NA 12&12 Group
- NA 12&12 Sponsor
- Crisis Intervention
- Therapist Consult Meeting
- Transitional Drug-Replacement

¹⁹NIDA 3





Randomized Controlled Trial of DBT vs. Treatment by Experts with BPD Suicidal + SUD

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