DIALEKTICKÁ BEHAVIORÁLNÍ TERAPIE V LÉČBĚ ZÁVISLOSTÍ

AMY GAGLIA ESSLETZBICHLER, MSW

CONSULTANT TRAINER WITH BIDBT

WHAT IS DBT?

- A treatment designed for regulating emotions
  - Originally for treatment of suicidal behaviors
  - It's continually evolving
- A treatment based on theoretical foundations and assumptions
  - A treatment that assumes that skills are essential
- A programme intended to meet specific functions
- A structure for organizing treatment
- A set of strategies, procedures, and protocols
  - Skills!!!

WHY APPLY DBT?

- Treatment for multi-disordered individuals with persistent and severe problems
- Combines scientific, objective approach with compassion
- Extensive evidence based and built on efficacious principles and procedures

FOR WHOM WAS DBT-SUD CREATED AND WITH WHOM WAS IT TESTED?

- Multi-disordered, substance-dependent individuals with Borderline Personality Disorder
  - 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

OVERLAP OF SUBSTANCE ABUSERS WITH BPD

- Longitudinal twin study of adolescents: BPD traits and substance use moderately correlated
  - Both behaviors are likely a vulnerability towards "behavioral disinhibition" (Bornovalova et al., 2012; Beauchaine et al., 2009)
- Of 716 opiate abusers in methadone treatment (47% women), 9.5% met criteria for BPD (Brooner, et al., 1997)

OVERLAP OF BPD WITH SUBSTANCE ABUSE

- In sample of 2,462 in/outpatients, 21% with BPD also had a primary substance abuse diagnosis. (Koenigsberg, et al., 1985)
- 23% of study participants who met criteria for BPD also met lifetime criteria for substance abuse. (Links, et al., 1988)
- Individuals with BPD were 5-10 times more likely to meet criteria for SUD diagnosis over course of lifetime as compared to non-BPD individuals. (Trull et al., 2010)
- BPD behaviors predicted alcohol-related problems two years later. (Tragesser et al., 2007)
- 67% of study participants with BPD also met criteria for a substance use disorder. When substance abuse was not used as a criterion of BPD, the incidence dropped to 57%. (Dulit, et al., 1990)

OVERLAP OF BPD WITH SUBSTANCE ABUSE

- An epidemiological study, using face to face interviews with nearly 35,000 participants, found that the lifetime prevalence of any SUD (substance use disorder) was nearly **73%** among individuals diagnosed with BPD
  - 81% in men
  - AUD (alcohol use disorder) was nearly 60% among individuals diagnosed with BPD

TROUBLESOME COMBINATION: BPD + SUBSTANCE ABUSE

BPD + SA > BPD or SA

- Psychological Problems
- Suicidal Behaviors

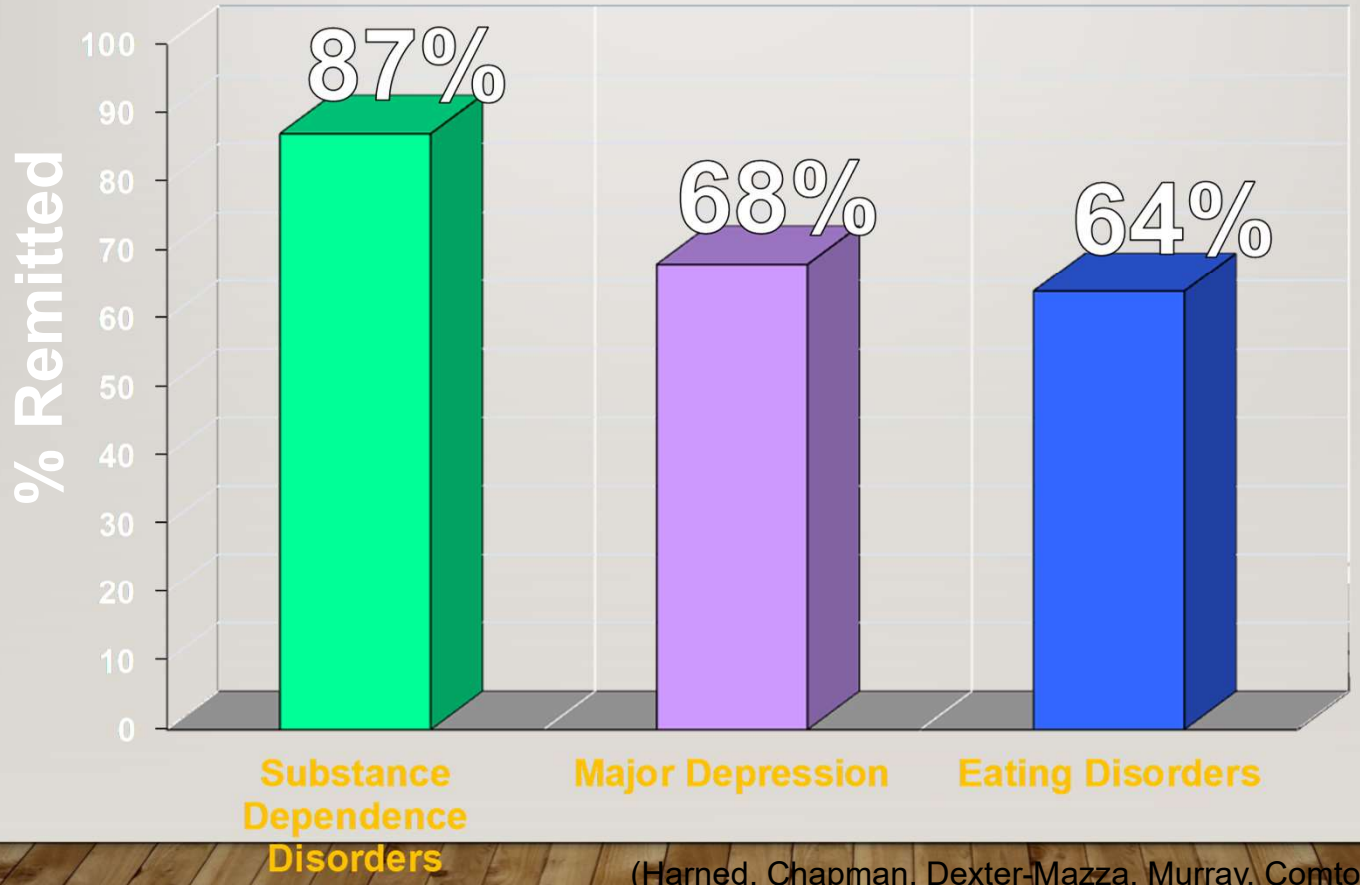
(Link, et al., 1995; Stone, 1990; Bornovalova & Daughters, 2007)

IMPLICATIONS OF COMORBIDITY FOR TREATMENT OF BPD+SA

- Severe psychopathology upon admissions predicts poorer outcomes and early relapse among drug abusers.
  - (Saxon and Calsyn, 1995; McLellan, et al., 1992, 1983; Woody, et al., 1985)
- Rates of treatment drop out for patients with BPD +SUD: nearly 80%
  - (Bornovalova & Daughters, 2007)
- Patients with severe psychopathology frequently screened out of treatment outcome studies.
  - (Carroll, 1996)

Is DBT effective at treating substance use disorders?

Improvements for Axis I Disorders



(Harned, Chapman, Dexter-Mazza, Murray, Comtois, & Linehan, 2008)

PUBLISHED DBT-SUD
SUMMARY OF DATA TO DATE

- University of Washington: DBT vs. TAU
  - (Linehan, Schmidt, Kanter, Craft, et al., 1999)
- University of Washington: DBT vs. CVT
  - (Linehan, Dimeff, Reynolds, Comtois, et al., 2002)
- Amsterdam Institute for Addiction Research: DBT vs. TAU
  - (van den Bosch, Verheul, Schippers, et al., 2002)

RANDOMIZED CONTROLLED TRIAL

DBT vs. Treatment-as-Usual with BPD Substance Abusers

University of Washington

(Linehan, Schmidt, Kanter, Craft, Dimeff, Comtois, McDavid, 1999)

RCT: DBT VS. TREATMENT-AS-USUAL WITH BPD SUBSTANCE ABUSERS

- DBT < TAU
  - Drug Use
  - Drop Out
- DBT > TAU (at 16 months)
  - Global Adjustment
  - Social Adjustment
- DBT gains continued at follow-up

(Linehan et al., 1999)

RANDOMIZED CONTROLLED TRIAL

DBT vs. Comprehensive Validation Therapy (1 Year) with BPD Heroin Addicts

University of Washington

(Linehan, Dimeff, Comtois, McDavid, and Kivlahan)

TREATMENT CONDITIONS

DBT	CVT
Individual Therapy	Individual Therapy
Group Skills Training	NA 12&12 Group
Homework Review	NA 12&12 Sponsor
Phone Coaching	Crisis Intervention
Therapist Consult Meeting	Therapist Consult Meeting
Drug-Replacement	Drug-Replacement

(Linehan et al.,2002)

DBT VS. CVT+12S:NS

- Pre-treatment > 12-month
  - Drug Use, Self-Report
  - Brief symptom Inventory
  - Global Adjustment
  - Social Adjustment

(Linehan et al.,2002)

Dialectical Behavior Therapy of Borderline Patients with and without Substance Use Problems:

Implementation and Long-Term Effects

Amsterdam Institute for Addiction Research (AIAR)

University of Amsterdam (UvA)

Forensic Psychiatric Hospital ‘Oldenkotte’

(van den Bosch, Verheul, et al., 2002)

SUMMARY OF FINDINGS

Results on BPD and SUD (12 and 18 months)

1. DBT > TAU Treatment Retention (63% vs. 23%).
2. DBT < TAU self-mutilating and self-damaging impulsive acts, ESPECIALLY among those higher baseline frequency.
3. Standard DBT has a beneficial impact on alcohol problems, but not on drugs problems.

(van den Bosch et al., 2002)

DBT WITH COLLEGE-AGE PROBLEM DRINKING

Results on DBT-Skills:

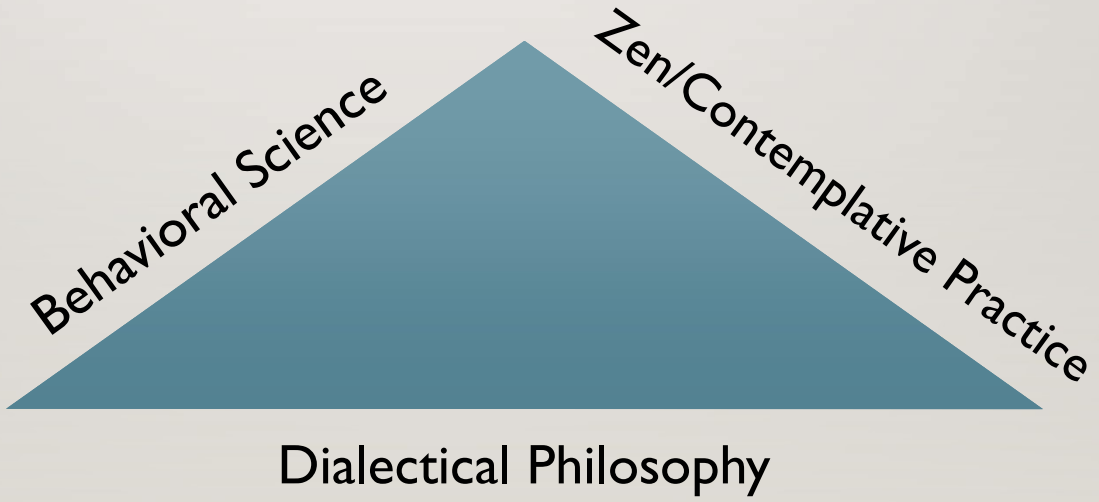
1. Reduction in problem drinking
2. Reduction in drinking to cope
3. Increases in emotion regulation
4. Improved mood

(Whiteside, 2010, unpublished dissertation)

DBT: A PRINCIPLE-DRIVEN TREATMENT THAT INCLUDES PROTOCOLS

- Principles
  - Tell you how to figure out what to do
  - Needed with multi-diagnostic and/or Axis II patients
- Protocol Driven Treatments:
  - One-size-fits-all with what to do instructions
  - Work for severe and chronic Axis I problems

PHILOSOPHICAL ASSUMPTIONS



DIALECTICAL….

WHAT'S THAT?

DIALECTICS

- Thesis
- Antithesis
- Synthesis

DIALECTICS AS A WORLDVIEW

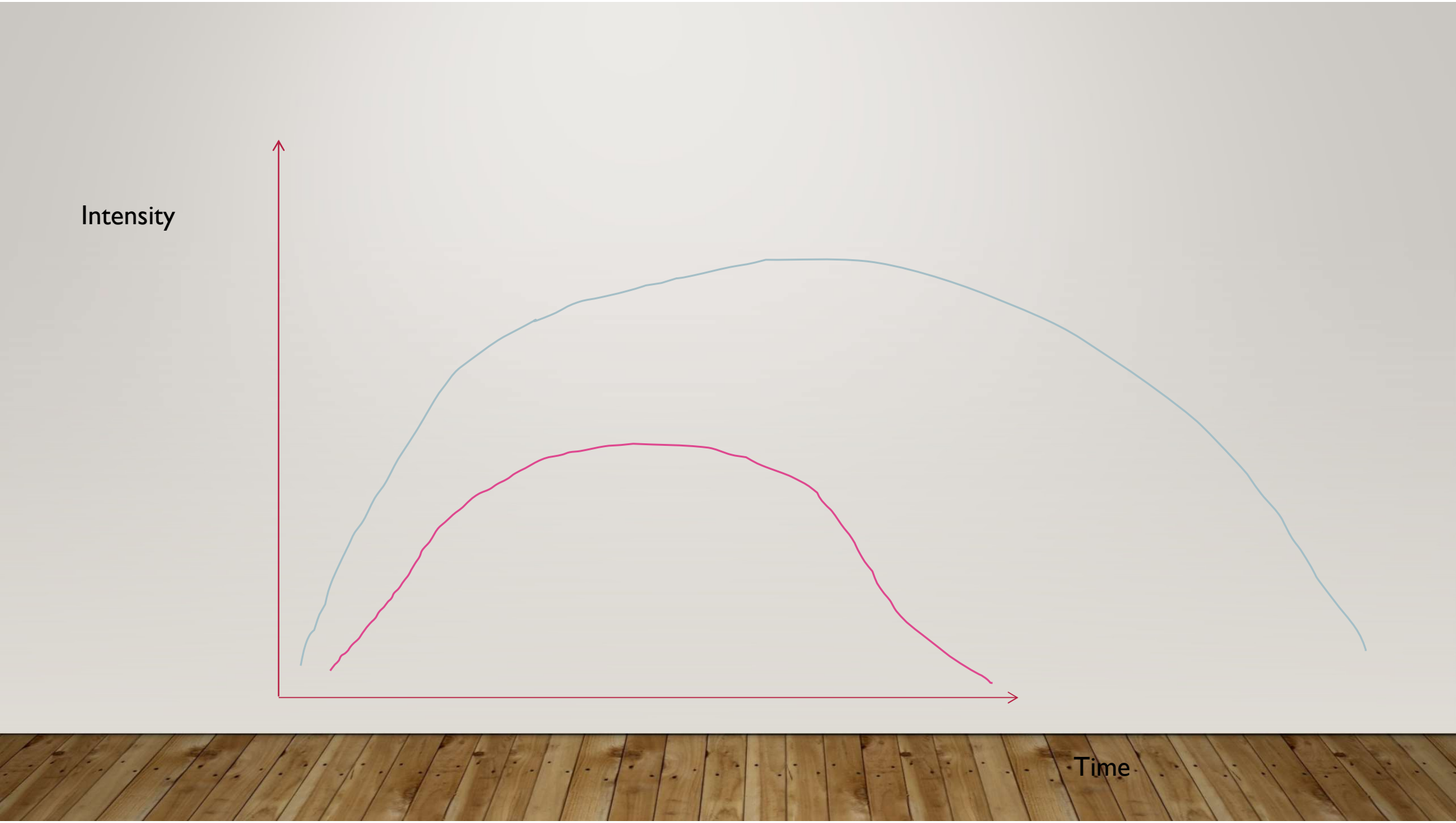
- Holistic, connected, and in relationship
- Complex, oppositional, and in polarity
- Change is continual
- Change is transactional
- Identity is relational and in continuous change

CENTRAL DIALECTICAL DILEMMA

- Balancing Validation with Change

BIOSOCIAL THEORY

- Some people may be biologically predisposed to experience their emotions more intensely and for longer than other people.


Intensity
Time

An Invalidating Environment:

Pervasively negates, punishes, corrects, ignores or dismisses behavior independent of the actual validity of the behavior

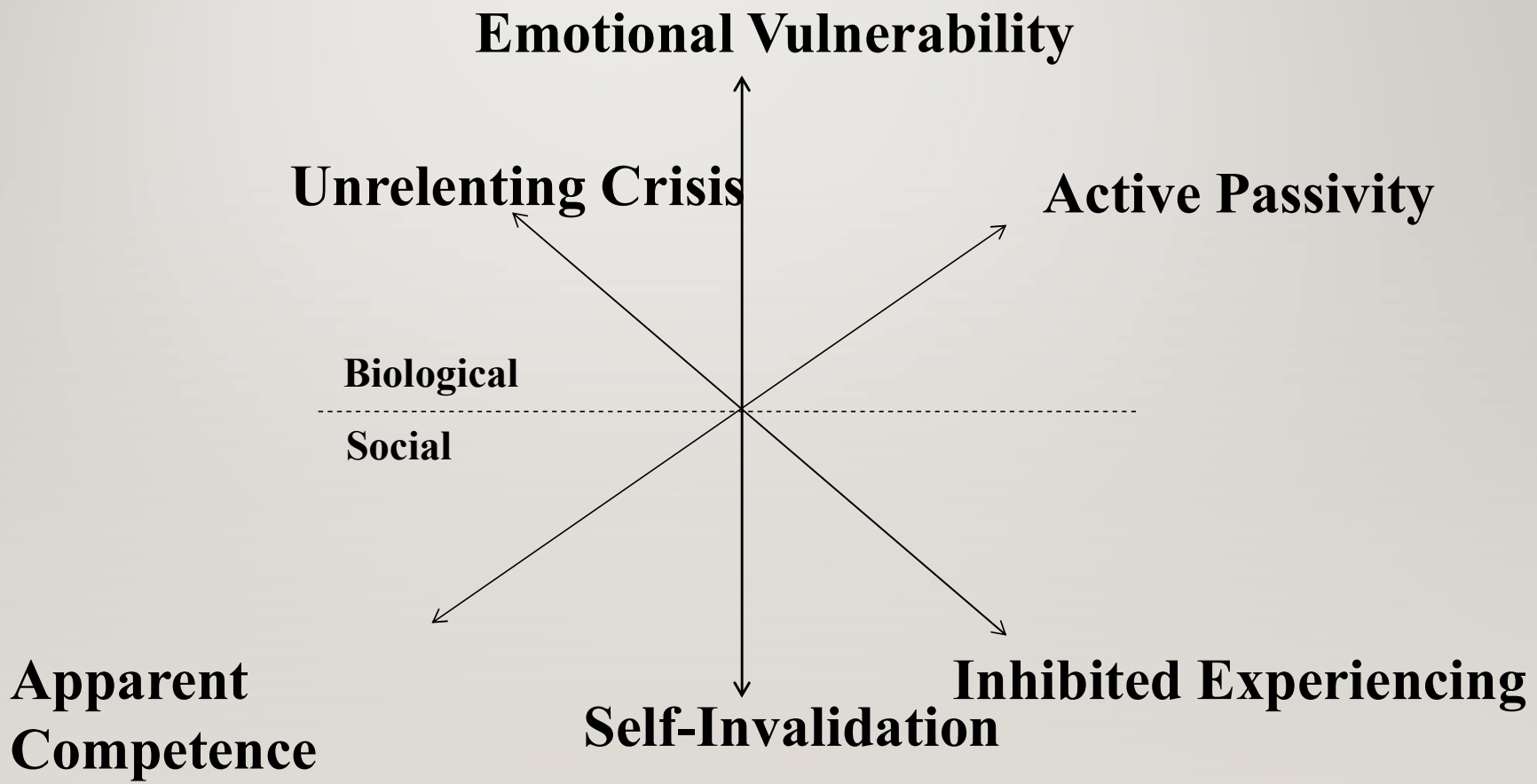
CHARACTERISTICS OF AN INVALIDATING ENVIRONMENT

1. **INDISCRIMINATELY REJECTS** communication of private experiences and self-generated behaviors
2. **PUNISHES** emotional displays and **INTERMITTENLY REINFORCES** emotional escalation
3. **OVER-SIMPLIFIES** ease of problem solving and meeting goals

AN INVALIDATING ENVIRONMENT TEACHES INDIVIDUAL TO:

1. Actively self-invalidate and search social environment for cues about how to respond
2. Oscillate between emotional inhibition and extreme emotional styles
3. Form unrealistic goals and expectations

DBT Dialectical Dilemmas



Structure Treatment Assumptions

DBT structures treatment around articulated assumptions about patients and therapy.

DBT ASSUMPTIONS ABOUT PATIENTS

- Patients are doing the best they can
- Patients want to improve
- Patients need to do better, try harder, and/or be more motivated to change
- Patients must learn new behaviors in all relevant contexts
- Patients cannot fail in DBT
- Patients may not have caused all of their own problems, but they have to solve them anyway
- The lives of suicidal, BPD individuals are unbearable as they are currently being lived

DBT ASSUMPTIONS ABOUT THERAPISTS AND THERAPY

- The most caring thing a therapist can do is help patients change in ways that bring them closer to their own ultimate goals
- Clarity, precision, and compassion are of the utmost importance in the conduct of DBT
- The therapeutic relationship is a real relationship between equals
- Principles of behavior are universal, affecting therapists no less than patients
- DBT therapists can fail
- DBT can fail even when therapists do not
- Therapists treating BPD patients need support

Structure the Comprehensiveness of Treatment

DBT structures treatment by Functions.

5 FUNCTIONS OF ALL COMPREHENSIVE TREATMENTS

- Improve motivational factors
- Enhance capabilities
- Assure generalization to natural environment
- Structure the environment
- Enhance therapist capabilities and motivation to treat effectively

STANDARD DBT MODES

- Outpatient Individual Psychotherapy
- Outpatient Group Skills Training
- Telephone Consultation
- Therapists' Consultation Team
- Uncontrolled Ancillary Treatments
  - Pharmacotherapy
  - Acute-Inpatient Psychiatric

DBT FUNCTIONS AND STANDARD MODES COMBINED

Improve client motivation	via	**Outpatient Individual Psychotherapy**
	via	
Assure generalization to natural environment	via	**Telephone Consultation**
	via	
Enhance therapist capabilities and motivation to treat effectively	via	**Therapists' Consultation Meeting**

CONSULTATION TEAM AGREEMENT

- To accept a dialectical philosophy
- To consult with the client on how to interact with other therapist and not to tell other therapists how to interact with the client
- That consistency of therapists even with the same client is not expected.

CONSULTATION TEAM AGREEMENT

- That all therapists are to observe their own limits without fear of judgmental reactions form other team members
- To search for non-pejorative, phenomenologically empathic interpretations of client's behavior
- That all therapists are fallible

ADAPTATIONS OF DBT

- Inpatient settings
- Partial hospital
- Day Hospital
- Forensic settings
- Adolescents
- Older adults with depression
- Substance Abuse
- Eating Disorders….

Structure the Primary Targets of Treatment

DBT arranges targets hierarchically by importance and grouped by level of patient disorder.

STAGE 1 PRIMARY TARGETS FOR INDIVIDUAL THERAPY: DIALECTICAL SYNTHESIS

Severe Behavioral Dyscontrol ▶ Behavioral Control

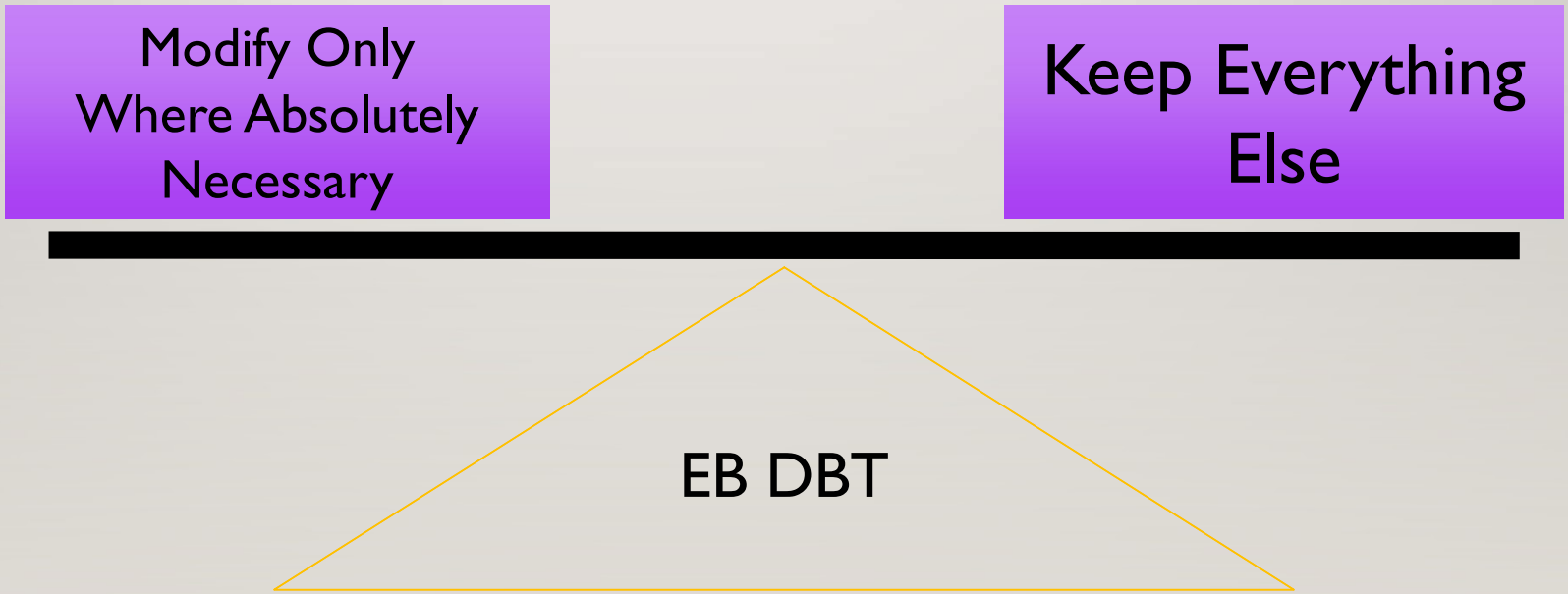
- Life-threatening Behaviors
- Therapy-interfering Behaviors
- Quality-of-life Interfering Behaviors

Decrease Behavioral Dyscontrol

Increase Behavioral Skills

- Core Mindfulness
- Distress Tolerance
- Interpersonal Effectiveness
- Emotion Regulation
- Self-Management

Solution: STRETCH DBT Without Changing It to Non-DBT



Suicidal Patients	Drug-Addicted Patients
Reinforced by extra sessions	Reinforced by canceling a session
Mental health community their community	Drug users their community
Therapists anxious to get them back in treatment	Therapists decide they aren't ready for treatment
Regulate emotions by cutting/SA	Regulate emotions by quick acting drugs
Motivational interviewing is not appropriate for deciding on suicide	Motivational interviewing is appropriate for deciding on stopping drug use

DBT FOR DRUG ADDICTION: PRIMARY ADDITIONS

- Dialectical abstinence
- SUD target specificity
- Attachment strategies
- Skills for addictions
- Drug replacement

WHAT REMAINS THE SAME

1. Dialectical, Behavioral, Zen Principles
2. Bio-social Model
3. Assumptions
4. Functions
5. Life threatening & Therapy Interfering targets
6. DBT Skills
7. Dialectical, Core, Stylistic, Case Management Strategies
8. Change Procedures

OBSERVED DIFFERENCES

Drug-Addicted People with BPD

- Compared to -

Suicidal People with BPD

- Drug-Addicted People with 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 to rely on

DĚKUJI

AMY.GAGLIA@GMAIL.COM