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MANUALIZED TREATMENT FOR SUBSTANCE ABUSERS WITH PERSONALITY DISORDERS: DUAL FOCUS SCHEMA THERAPY

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Abstract — The presence of an untreated personality disorder may be associated with worse compliance and outcome in substance abuse treatment. Therapeutic attention to the symptoms of personality disorder may reduce the severity of substance abuse and other Axis I symptoms which potentially contribute to relapse. A 24-week manual-guided individual cognitive-behavioral therapy approach has been developed that integrates relapse prevention with targeted intervention for early maladaptive schemas (enduring negative beliefs about oneself, others, and events) and coping styles. This Dual Focus Schema Therapy is being compared to 12-Step Drug Counseling for opioid-dependent individuals with personality disorders in an ongoing study funded by the National Institute on Drug Abuse. This article reviews Young's (1994) schema-focused theory and approach and summarizes the treatment manual, which integrates relapse prevention for substance abuse. © 1998 Elsevier Science Ltd

Addiction and personality disorders often co-occur (DeJong, van den Brink, Harteveld, & van der Wielen, 1993; Verheul, van den Brink, & Hartgers, 1995), and patients with these dual disorders are commonly seen in treatment programs, consume a disproportionate amount of staff time, and may be less likely to respond favorably to traditional substance abuse treatment interventions (Griggs & Tyrer, 1981; Kosten, Kosten, & Rounsaville, 1989; Nace & Davis, 1993). Personality-disordered individuals may be especially vulnerable or sensitive to negative affect and interpersonal difficulties, which are two of the most common relapse precipitants. Several research studies have emphasized the need to develop or modify existing treatments to better meet the special needs of personality-disordered substance abusers (Cacciola, Rutherford, Alterman, McKay, & Snider, 1996; Nace, Davis, & Gaspari, 1991; Rounsaville et al., 1998). Therapeutic attention to the symptoms of personality disorder may reduce the severity of substance abuse and other Axis I psychiatric problems (e.g., depression, anxiety, paranoia), which potentially contribute to relapse.

Clinical reports and single case designs suggest that cognitive-behavioral therapy is a promising approach for some personality disorders, but there are few controlled outcome studies (see review in A. T. Beck, Freeman, & Associates, 1990). With regard to addictions, alcohol-dependent individuals with greater sociopathy tend to have better outcomes with cognitive-behavioral coping skills treatment than with a less structured group therapy (Kadden, Cooney, Getter, & Litt, 1989; Longabaugh et al., 1994).

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Woody, McLellan, Luborsky, and O'Brien (1985) found that depressed antisocial opiate abusers in methadone maintenance responded better to cognitive-behavioral or supportive-expressive therapy than did nondepressed antisocials, although both did worse than non-antisocial patients.

Within the past several years, several well-defined cognitive-behavioral approaches have been developed to treat a range of personality disorders (A. T. Beck et al., 1990; J. S. Beck, 1994; Pretzer & Fleming, 1989; Young, 1994), but none have developed treatment manuals necessary for an empirical evaluation of their efficacy. The major exception to this has been Linehan's (1993) Dialectical Behavioral Therapy for Borderline Personality Disorder for which a highly detailed text, training manual, and training program exist that have been used in a few controlled trials and which is growing in popularity among clinicians. Treatment manuals and training programs allow for the specification of therapeutic ingredients, therapist behaviors, and intervention strategies so that therapists can deliver treatments as intended by the developer. No well-specified treatment manuals exist for the broader range of personality disorders, and no treatment has been developed which integrates a dual focus on substance abuse and this more diverse range of co-occurring personality disorders.

An important consideration in conducting treatment and research on personality-disordered individuals is that these individuals rarely seek psychotherapy for their personality disorder per se. Oftentimes, it is a co-occurring Axis I disorder that provides the impetus to seek help. Because of this, a treatment manual for personality disorders should be integrated with an Axis I symptom-focused approach. One of the most common comorbid Axis I conditions in personality disordered patients is substance abuse. Another important consideration is how to approach the treatment of the 10 different *DSM-IV* personality disorders seen in substance abusers. One approach has been that of Nelson-Gray, Johnson, Foyle, Daniel, and Harmon (1996) who have been developing a series of manuals based on the approach of A. T. Beck et al. (1990). Evaluating separate manuals for each disorder seems impractical in a clinical trial, especially given the substantial overlap among personality disorders and the fact that most personality disordered patients in treatment for an Axis I disorder, like substance abuse, will meet criteria for two or more Axis II disorders. A promising, alternative approach is a schema-focused cognitive therapy that focuses on a small number of core maladaptive cognitive schemas (enduring negative beliefs about oneself, others, and events) and coping styles that have been observed across all of the personality disorders (A. T. Beck et al., 1990; Freeman & Leaf, 1989; Young, 1994). Rather than using a different approach for each of the 10 personality disorders, the approach described in this article consists of a set of core topics, the specific content and delivery of which are determined by an assessment and conceptualization of the individual's maladaptive schemas and coping styles.

CORE CONSTRUCTS OF THE SCHEMA-FOCUSED THERAPY MODEL

Early maladaptive schemas

A. T. Beck et al. (1990) and Young (1994) defined maladaptive or dysfunctional schemas as enduring, unconditional, negative beliefs about oneself, others, and the environment which organize one's experiences and subsequent behaviors. These schemas are very broad, pervasive themes that are learned early in childhood and adolescence and then elaborated, reinforced, and perpetuated in adulthood. Over time,

these deep beliefs about self and others become dysfunctional to a significant degree and highly resistant to change in persons with personality disorders (Young, 1994; Young & Lindeman, 1992). In contrast to Beck's approach, Young (1994) does not connect specific schemas to each personality disorder but rather describes 18 core schemas, one or more of which is strongly present in each of the personality disorders. Early maladaptive schemas share the following characteristics: (a) develop from the interaction between temperament and repeated early experiences with parents, siblings, and peers; (b) generate high levels of affect, self-defeating consequences, or harm to others; (c) interfere with meeting core needs for autonomy, connection, and self-expression; (d) deeply entrenched, central to self, self-perpetuating, difficult to change; and (e) triggered by everyday schema-relevant events or mood states (Young, 1994; Young & Lindeman, 1992).

The 18 early maladaptive schemas (listed in parentheses) are grouped into five broader domains of: (a) Disconnection and Rejection (Abandonment/Instability, Mistrust/Abuse, Emotional Deprivation, Defectiveness/Shame, Social Isolation/Alienation), (b) Impaired Autonomy and Performance (Dependence/Incompetence, Vulnerability to Danger, Enmeshment/Undeveloped Self, Failure to Achieve), (c) Impaired Limits (Entitlement/Domination, Insufficient Self-Control/Self-Discipline), (d) Other Directedness (Subjugation, Self-Sacrifice, Approval-Seeking), and (e) Overvigilance and Inhibition (Vulnerability to Error/Negativity, Overcontrol/Emotional Inhibition, Unrelenting Standards, Punitiveness) (Schmidt, Joiner, Young, & Telch, 1995; Young, 1994).

Maladaptive coping styles

Because the experience of thoughts, feelings, and impulses associated with early maladaptive schemas is distressing to the individual or others, the individual typically develops behavioral strategies to cope. In the personality disorders, these longstanding, overlearned, usually unrecognized, cognitive, affective, interpersonal, and behavioral responses to the triggering of a schema are called maladaptive coping styles. Although these behaviors may effectively reduce the negative affect associated with schema activation, they are self-defeating and impede the meeting of basic needs and the change process (Young, 1994; Young & Lindeman, 1992).

Coping styles are categorized as schema maintenance, schema avoidance, or schema compensation. *Schema maintenance* is strictly speaking not a coping strategy, but rather represents a giving in, surrendering, or complying with the person or situation (or the associated affect) which triggers the schema. *Schema avoidance* includes various forms of escape or avoidance from people, situations, or mood states which activate the schema, for example social withdrawal, excessive autonomy, compulsive stimulation seeking, addictive self-soothing, and psychological withdrawal. *Schema compensation* involves different forms of fighting off or counterattacking the schema-triggering stimuli and includes aggression/hostility, dominance, excessive self-assertion, recognition or status-seeking, manipulation, exploitation, passive-aggressive rebellion, and excessive orderliness (Young, 1994; Young & Lindeman, 1992).

INTEGRATING A RELAPSE PREVENTION FOCUS

Cognitive-behavioral therapy, in the form of relapse prevention (Marlatt & Gordon, 1985) and coping skills therapy (Kadden et al., 1992; Monti, Abram, Kadden, & Cooney, 1989), have been evaluated in several well-controlled treatment outcome

studies and have emerged as one of the more promising treatment approaches for substance abuse (see reviews by A. T. Beck, Wright, Newman, & Liese, 1993; Carroll, 1996). Cognitive-behavioral therapy is an excellent choice for developing an integrated treatment strategy which has a dual focus on substance abuse and personality disorders. It was developed initially and found to be effective for the treatment of depression and later substance abuse which are the two most common Axis I disorders in personality-disordered patients. Cognitive-behavioral therapy can be adapted to the treatment of personality disorders and addiction by focusing on substance relapse and the processes (maladaptive schemas and coping styles) which hypothetically underlie the symptomatic expression of both disorders.

Among addicted individuals, substance use or relapse can be triggered by many factors, including interpersonal conflict, social pressures, negative affect states, withdrawal symptoms, and craving (Brownell, Marlatt, Lichtenstein, & Wilson, 1986). Addicted individuals with personality disorders may be especially sensitive to these relapse factors. For this dual disorder group, Dual Focus Schema Therapy (DFST; Ball & Young, 1998) hypothesizes that a substance relapse also can be triggered in one of two important ways. First, substance use can occur as a direct expression of early maladaptive schemas of Entitlement or Insufficient Self-Control or when substance-abusing relationships trigger schemas of Subjugation, Self-Sacrifice, or Approval-Seeking. These types of relapse-triggering schemas may be quite relevant for a broad range of people who abuse substances. However, clinical experience suggests that the second more potent triggering factors for personality-disordered substance abusers are maladaptive coping attempts to avoid or compensate for the activation of early maladaptive schemas of Abandonment/Instability, Mistrust/Abuse, Emotional Deprivation, Defectiveness/Shame, Social Isolation/Alienation, Dependence/Incompetence, Enmeshment/Undeveloped Self, Failure to Achieve, Overcontrol/Emotional Inhibition, Unrelenting Standards, or Punitiveness. DFST includes traditional relapse prevention techniques for interpersonal, affective, and craving factors and schema-focused techniques for the maladaptive schemas and coping styles.

Treatment interventions focused on addictive behaviors and personality disorder symptoms are integrated by a common core of techniques. For example, functional analysis is used both to understand recent episodes of substance use and craving as well as maladaptive schema and coping triggering events. Self-monitoring, problem solving, and coping skills training (e.g., for negative emotions and interpersonal conflicts and pressures) all occur for both the addiction and personality problems. Dysfunctional beliefs about substance use are conceptualized as a critically important component or expression of underlying core schemas. Most of the major cognitive-behavioral techniques used to help achieve abstinence and prevent relapse are also included in the DFST manual as separate module topics to enable a more single-focused approach to substance abuse when this is indicated for chronically relapsing patients. These manual topics include (a) functional analysis of substance use and self-monitoring of high-risk situations; (b) coping with craving and thoughts of using; (c) strategies for identifying, avoiding, and coping with environmental and internal cues for drug use; (d) lifestyle modification to promote development of constructive behavioral alternatives to substance use; and (e) working through dysfunctional cognitions such as "seemingly irrelevant decisions" (Kadden et al., 1992; Marlatt & Gordon, 1985; Monti et al., 1989). Over the course of treatment, the depth of focus and relative emphasis (e.g., substance use vs. maladaptive schemas and coping) within any one therapy session are guided by clinical judgment and an ongoing evaluation of substance use.

ASSUMPTIONS AND GOALS OF AN INTEGRATED, DUAL-FOCUS MODEL

DFST does not have the unrealistic goal of eliminating a chronic, life-defining personality disorder through a 24-week manualized treatment. The approach presented here conceptualizes "personality disorder" as resulting from an interaction of biologically based personality traits with a faulty early environment. This difficult temperament-toxic environment interaction fosters the development of strong emotional reactions, negative beliefs and assumptions about the self and others, substance use, maladaptive interpersonal strategies and other coping mechanisms that, over time, become organized as schemas. Realistic goals are necessary when treating severe personality disorders and substance dependence such as improving quality of life (e.g., self-esteem, relationships, work) and reducing symptoms through improved retention and outcome in a substance abuse treatment which explicitly addresses the personality functioning of the patient. The treatment of personality disorders is best viewed as a long-term process of controlling substance use and other coexisting Axis I disorders through the combined approaches of several psychotherapy, medication, and self-help experiences.

With the above view in mind, DFST makes several important therapeutic assumptions. First, it assumes that targeted intervention into the most problematic areas of functioning (especially substance use) may lead to greater change by disrupting the behavioral and interpersonal chain of events which help perpetuate the dual disorder in adulthood. This perspective hypothesizes that a broad range of the patient's difficulties can be subsumed by a single or few maladaptive schemas and coping styles and that targeted change in substance use and core schemas can have a significant impact on a relatively broad range of behaviors. Second, the therapist's ability to effect cognitive-behavioral change and substance abuse symptom reduction depends on an empathetic understanding (of the origins and reasons for maladaptivity) and confrontation of the patient's addiction and personality (schemas, coping) and the quality of the therapeutic relationship (Linehan, 1993; Young, 1994). Any attempt to cognitively dispute a personality disordered person or push for rapid behavior change will be ineffective if it fails to appreciate the historical origins of these problems, the reasons why certain coping styles developed, and the "rationality" of the self-defeating behavioral cycle which forms the core of personality pathology and the resistance to change. A therapist can push for significant behavior change and recovery after the patient feels that their resistance to change is emphatically understood.

TREATMENT STAGES AND STRATEGIES

DFST occurs in two stages. First, the therapist integrates early relapse prevention work with an identification and education about early maladaptive schemas and coping styles and their association with substance use and other presenting life problems. Once the therapist completes this complex assessment and develops a detailed, empathetic appreciation and conceptualization of the history of the patient's current life problems, then the stage is set for changing the maladaptive schemas and coping styles that underlie both the personality and addiction problems.

Relapse prevention and schema assessment and education

Therapy begins with a discussion and analysis of the patient's presenting problems and life patterns, particularly as they are related to substance dependence. Maladap-

tive schemas and coping styles are assessed through the completion of four questionnaires developed by Young and associates to measure schemas, parental origins, avoidance, and compensation. Reactions to homework readings, in-session discussions of schemas, imagery exercises, and the nature of the therapy relationship provide additional information to confirm which schemas and coping styles are central to the patient. As such, the assessment process is complex, ongoing, and relies on several different sources of data. This educational stage is meant to accomplish at least three important goals: initiate abstinence or significantly reduced substance use, establish a strong therapeutic alliance, and develop a detailed case conceptualization. The development of a strong therapeutic alliance is dependent on both the patient's experience of the therapist's limit setting and focused attention on addictive behaviors as well as the therapist's interest in understanding the patient's personality and its origins. Patients develop a sense of trust and collaboration through the therapist's interest in obtaining and providing information about the patient's schemas and coping styles and developing a highly individualized conceptualization of their past and current problems. The theoretically based, individualized case conceptualization that emerges then guides the delivery of an integrated series of therapeutic techniques designed to reduce the intensity of substance abuse and other Axis I symptoms, life problems, schemas, and coping styles (Young, 1994).

Schema change techniques

Based on the case conceptualization, detailed change strategies for each schema are developed. Typically, change strategies are grouped into four areas that correspond roughly to the order with which they are implemented (Young, 1994): (a) Cognitive (schema validity, disputes, and dialogues; flashcards for healthier internal voice; reframe past to create distance; identify and confront validity of schemas and usefulness of coping style; substance abuse as avoidant coping); (b) Experiential (imagery and inner child work; role play; ventilation about past and toward caregivers; work on schema origins; letter writing); (c) Behavioral (change self-defeating behaviors maintaining the schemas; identify life change and overcoming avoidance; in-session rehearsal; graded task assignment; individualized schema/coping relevant coping skills training; empathic confrontation); and (d) Therapy Relationship (confront in-session schemas and coping styles; limited re-parenting).

Relapse prevention modules

Although work on initiating and maintaining abstinence from substances is continually integrated within the framework of the schema-focused approach, therapists may shift to a primary focus on relapse prevention when clinically indicated. This work includes identification of intrapersonal and interpersonal relapse precipitants, coping skills training for high-risk situations, resisting social pressures to use, assertive communication, coping with cravings, and developing pleasurable activities.

Schema mode and special problem modules

Special problems often occur in the treatment of personality-disordered individuals. When avoidance of the therapeutic work persists, the therapist may shift to a focus on *schema modes*. A mode may consist of several linked early maladaptive schemas combined with a predominant affect and coping style and is experienced and expressed as broader (typically unintegrated) components or sides of the patient's personality (i.e., similar to an ego state). In this work, the various sides or modes of the patient are

identified and labeled (e.g., Detached Protector, Vulnerable Child, Punitive Parent), and their origin and functions are explored and targeted for change through cognitive disputes, empathic confrontation, imagery, and empty chair techniques. Mode work is especially useful when working with borderline or highly avoidant, overcompensating, or self-critical patients. The concept of modes seems to be easily grasped by addicted individuals who may have split off an "addictive, antisocial, acting out" personality from a "recovering, vulnerable, emotional" personality. Other elective module session topics are used to address boundary violations and limit setting in the therapeutic relationship, working with traumatic memories of abuse, managing suicidal crises and self injurious behavior.

DFST treatment manual

Core and elective session topics and their goals and methods have been developed (Ball & Young, 1998) and are currently being evaluated in a NIDA-funded, 24-week manualized therapy for substance-dependent personality-disordered patients in methadone maintenance. A small randomized trial is nearing completion comparing DFST to a 12-Step Drug Counseling—two active treatments with very different mechanisms of action. Both weekly individual therapies are provided by doctoral-level clinical psychologists trained by the originators of the two respective approaches (S. Baker from NIAAA Project MATCH 12-Step Facilitation; J. Young for schema-focused therapy). Therapist adherence and competence in delivering the distinct treatment conditions are assessed though weekly supervision and independent ratings of videotaped sessions. Treatment outcomes include substance abuse, treatment retention, psychiatric symptoms, working alliance, AIDS risk, methadone clinic outcomes, affective experiences, interpersonal problems, cognitive schemas, and coping styles.

CONCLUSIONS

Substance abuse and personality disorders frequently co-occur in clinical populations (DeJong et al., 1993; Verheul et al., 1995). The presence of a personality disorder may lead to higher relapse rates, noncompliance, and poor outcome in substance abuse treatment programs (Griggs & Tyrer, 1981; Kosten et al., 1989; Nace & Davis, 1993), although Verheul, Ball, and van den Brink's (1998) recent review suggests that this may not be the case. Little research has been conducted on how the treatment of substance use disorders may be altered by the presence of a personality disorder, and no integrated treatments of the two disorders have been systematically evaluated. This article presents DFST, a manualized individual cognitive-behavioral therapy which integrates a schema-focused approach (Young, 1994) with a symptom-focused relapse prevention coping skills approach (Kadden et al., 1992; Marlatt & Gordon, 1985; Monti et al., 1989) to treat the interrelated symptoms of substance abuse and personality disorders. A NIDA-funded study is currently comparing DFST with 12-Step Drug Counseling on measures of treatment retention and outcome in methadone-maintained patients with personality disorders.

Linehan (1993) developed Dialectical Behavior Therapy for substance abusers with borderline personality disorder. This article describes a first attempt to develop an integrated approach for the full range of personality disorders seen in addicted individuals. The author believes that the development of empirically tested treatments for these dual disorders will be an enormously complicated, time-consuming task if different treatment approaches are needed for each specific personality disorder. For this

reason, the current approach focuses on theoretical constructs with treatment implications that cut across and below the surface of the symptom-focused *DSM* system. Although the clinical conceptualization (e.g., schemas, coping styles) necessarily varies from case to case, use of a common core of cognitive, experiential, relational, and behavioral techniques for all disorders will facilitate a more efficient evaluation of the therapy's effectiveness by other investigators within the substance abuse field as well as for other Axis I disorders commonly seen in personality-disordered individuals (e.g., depressive, anxiety, eating, somatoform, trauma-related disorders).

Although an integrated therapy approach to research may be more efficient than studying *DSM* Axis II disorders one at a time, this area of research still contends with important practical considerations. Although therapist training for Axis I disorders requires time and effort, appropriate training for personality disorder treatment models such as those developed by Young (1994), Linehan (1993), or Benjamin (1993) can be best described as burdensome. Developing treatment manuals greatly facilitates the process of working with very challenging patients, but it cannot substitute for an intensive training period followed by close supervision of some ongoing cases. It also remains to be seen whether these highly complex models of psychotherapy can be implemented effectively by clinicians without formal training in advanced theories of psychopathology, psychotherapeutic techniques, and specifically addiction psychotherapy. Another problem is the treatment time frame. Current treatment research funding and behavioral health care priorities, at least in the United States, are biased against therapies longer than 3–6 months (Benjamin, 1997). From the standpoint of personality disorder treatment, even 12 months is probably an unrealistically short period of time for addressing longstanding, maladaptive patterns of viewing self and relating to others and severe addiction.

Finally, the practical consideration of where one recruits personality-disordered individuals for psychotherapy has important implications for treatment planning, manual development, and generalizability of research findings. Because this group of individuals rarely presents for treatment for their personality disorder per se, researchers invariably study and treat these disorders in the context of alleviating a presenting Axis I disorder or symptoms or significant pressure within the patient's environment. The advantage of the model presented here is that it combines a core set of schema-focused manual topics, which may be useful for a wide range of patients with challenging Axis I and II psychopathology, with an Axis I relapse module for substance abuse that might be easily modified for other co-occurring Axis I disorders.

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