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Schema Therapy in Personality Disorders and Addiction

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The most common form of dual diagnosis is personality disorder and substance abuse (Verheul, van den Bosch and Ball, 2005). Antisocial and borderline personality disorders are most prevalent in substance abuse patients, followed by Cluster C (especially avoidant personality disorder) and Cluster A (especially paranoid personality disorder) (Rounsaville *et al.*, 1998).

In Dutch addiction treatment centers, the percentage of patients with a DSM-IV diagnosis of drug dependence with one or more concomitant personality disorders varies from 44% in alcoholics, 70% in cocaine addicts, and up to 79% in heroin addicts. This concerns in particular borderline and antisocial personality disorders (Verheul, van den Brink and Hartgers, 1995). Addicts often have several personality disorders. De Jong, van den Brink, Harteveld, and van der Wielen (1993) showed that alcoholics had an average of 2.3 personality disorders and drug users an average of as many as 4.4 personality disorders.

In Dutch forensic psychiatric centers, 75–80% of the patients have one or more personality disorders. This is 4.5 times the number found in general psychiatric hospitals. These are in particular Cluster B disorders.

Antisocial, borderline, narcissistic, and paranoid personality disorders occur most frequently. Furthermore, 34% of these patients have a diagnosis of substance abuse or drug dependence. If you factor in the "intensive drug use or addiction during the criminal offense," the percentage of patients is much higher: 65–70% (Emmerik and van Brouwers, 2001).

In de Rooyse Wissel, in Venray, a Dutch forensic psychiatric center (FPC), as many as 81% of the patients have a personality disorder in addition to a diagnosis of substance abuse (1/3) or drug-dependence (2/3). More than half the patients (56%) use more than one drug. Treatment of both personality problems and addiction are very important for these patients especially as addiction is a risk factor for relapse in criminal offense behavior.

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Thus far, remarkably few studies have been carried out into the treatment of these dual diagnosis problems despite the high comorbidity. Only two so-called dual focus treatments have been described and researched (Verheul, van den Bosch and Ball, 2007): *Dialectical Behavior Therapy-Substance Abuse* (Linehan, Schmidt and Dimeff, 1999) and *Dual Focus Schema Therapy* (Ball, 1998). *Dialectical Behavior Therapy-Substance Abuse* (DBT-S) has been developed for patients with substance abuse and borderline personality disorder. For this dual focus treatment there is some evidence in borderline patients in terms of dropout and decrease in substance abuse (Linehan *et al.*, 1999).

Dual Focus Schema Therapy (DFST) is a 24-week manual-guided psychotherapy for the full range of personality disorders. It consists of a set of 16 core and 12 elective topics individualized for each patient, based on a comprehensive personality assessment and conceptualization of early maladaptive schemas and coping styles. Relapse prevention techniques are combined with coping skills training and schema-focused techniques. Ball uses schemas, and not the schema modes that were developed by Young in a later period. There is some preliminary support for DFST as a promising treatment deserving of further evaluation in a few different populations: opioid-dependent outpatients (methadone maintenance) and homeless drop-in center patients with substance abuse and personality disorders (Ball, Cobb-Richardson, Connolly, Bujosa and O'Neal, 2005; Ball, 2007).

The little research that has been done shows that it is useful to continue with the development of and research into integrated dual diagnosis treatment for personality disorders and addiction.

Ball (2007), however, following Linehan, argues that it is probably more useful to hypothesize that different personality disorders need different approaches. He also refers to the more recent study by Young, which assumes that a mode-focused approach is better for complex Cluster B patients. Furthermore, Verheul and colleagues (2007) offer a number of important guidelines, based on current scientific evidence. The most important are:

1. From the outset treatment needs to focus on both addiction and personality disorders. An integrated package of effective treatment methods for both disorders is desirable.
2. A good therapeutic alliance and intensive and long-term contact are important. The best context is long-term clinical treatment that offers sufficient structure and safety. It is desirable that such a treatment program includes training in skills and relapse-prevention.
3. Motivational interviewing is an important method within treatment. In dual diagnosis problems, often a chronic lack of motivation and difficulties with interpersonal relationships are found.

With the conclusions and guidelines mentioned above as a basic principle, a proposal is made in this chapter for a schema mode-focused, integrated treatment of Cluster B personality disorders and addiction problems (i.e., substance abuse, drug-dependence, and gambling). The basic principles for this are Young's schema mode models for borderline and narcissistic personality disorders, Bernstein, Arntz and de Vos's (2007) adjusted schema modes for antisocial personality disorders and psycho-

paths in forensic settings (see Part IV, Chapter 12), and evidence-based treatment for addiction, such as motivational interviewing, self-control techniques, social and problem solving skills training, relapse-prevention training, and contingency management (Emmelkamp and Vedel, 2007).

In Practice

The prevalence of personality disorders and comorbid addiction problems in maximum security psychiatric hospitals is very high. In fact, in this setting there is even the matter of triple diagnosis problems: personality disorders, substance abuse or drug-dependence (often in combination with ADHD), and one or more serious violent offenses.

There are many variations in the nature and severity of addiction problems, in the function of substance abuse in personality disorders, and in criminal offense behavior. Therefore, it is important in treatment to conduct a thorough analysis of the connection between comorbid disorders and criminal offense behavior.

In Young's schema mode model addiction (substance abuse and gambling), is seen as an avoidant coping style. A patient can, for example, use heroin or cannabis, or start to gamble, in order to avoid emotional pain and anxiety (Detached Self-Soother or Self-Stimulator). This mechanism often occurs in borderline personality disorders. In these cases, the self-medication model or stress-reducing model of addiction is applicable.

However, clinical experience shows that substance abuse and gambling can also have other kinds of functions within the schema mode model. For example, a patient can use cocaine or ecstasy out of the need for new stimuli (novelty-seeking) and a sensitivity for reward. Impulsivity and antisocial behavior lower the threshold for using drugs. Furthermore, other patients are likely to intensify their narcissistic and antisocial schema modes by using drugs. This will in turn increase their violent and criminal behavior (e.g., the Self-Aggrandizer, Bully and Attack, or Predator mode). Finally, drugs can be used as a consequence of destructive thoughts focused on the patient himself (Punitive Parent mode).

All addictive drugs can strongly intensify schema modes because of their psychotropic effects. In summary, addictive drugs can have four types of function within schema mode models as shown in Figure 11.1: intensifying over-compensating coping modes, avoidance coping modes, child modes, and Punitive Parent mode.

In 2009, a comprehensive research study was conducted in de Rooyse Wissel, with 14 patients of the Schema Therapy study (see Part VII, Chapter 3) with dual diagnoses. The purpose was to study and test the hypothesis that substance abuse can have different functions within different Cluster B personality disorders in terms of schema modes. These 14 patients completed an addiction analysis: in 4–6 sessions, substance abuse, personality disorders (including schema modes), and criminal offense behavior are mapped out and the functions of the substances are analyzed in terms of schema modes. These addiction analyses provide the material for the qualitative analysis. In addition, the psychotherapists were interviewed to test the comorbidity patterns that were found.

All 14 patients had at least one Cluster B personality disorder and most also displayed other personality disorders. The combination of antisocial personality disorder,

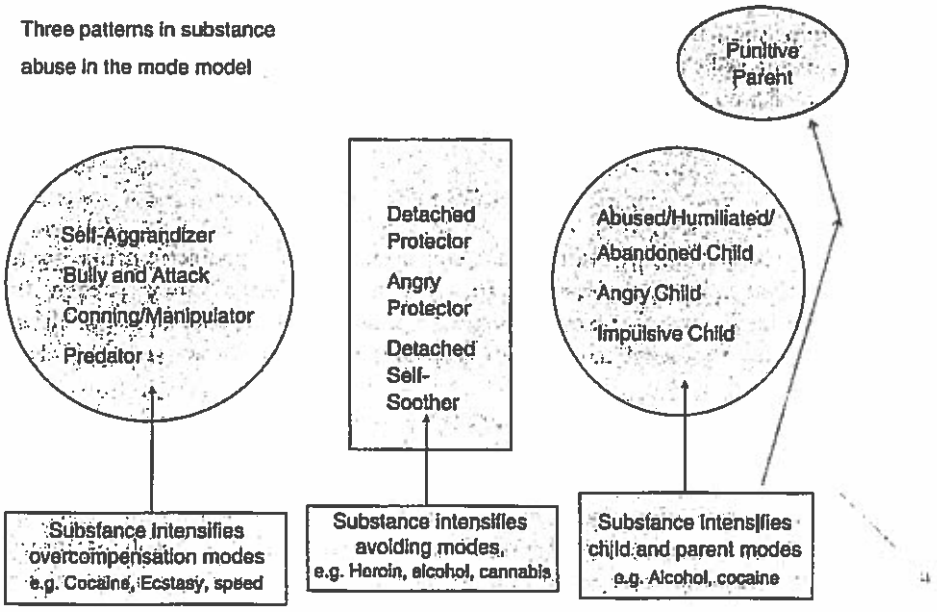

Figure 11.1 Schema modes and functions of substance abuse

borderline personality disorder, and narcissistic features occurred most frequently. In four patients, paranoid features were also diagnosed. Two patients had avoidant features and one had dependent features (Cluster C). Most patients were dependent on several drugs, which often fulfilled different functions. On Hare's Psychopathic Checklist (PCL-R), six patients scored high (>26) and eight patients scored average (15–26). Research showed the following comorbidity dynamics.

In patients with (primarily) a borderline personality disorder, there was often a mainly internalized comorbidity dynamic visible. Heroin, cannabis, and alcohol were the drugs most frequently used. The following functions were exhibited:

- Avoidance of feelings of abandonment, assault, abuse, grief (Vulnerable and Angry Child). Expression in modes as Self-Soother/Self-Stimulator or increasing the Detached Protector mode.
- Emotion regulation, self-medication: the function of creating stability and rest. In this way, substances are used to stabilize fluctuating mood swings and the rapid change of different modes.
- Substance abuse by the Angry or Impulsive Child, because of immature anger and impulsiveness.
- Extreme amounts of substances or an overdose as a way of destructive, self-injurious behavior because of the Punitive Parent mode.

In patients with (primarily) antisocial personality disorders (and in a number of cases psychopathic), there was often an external comorbidity dynamic. Substances such as

cocaine (often in combination with alcohol), ecstasy (3,4-methylenedioxymethamphetamine), and speed (methamphetamine) were used most frequently. The following functions were exhibited:

- The drive to feel superior and powerful: Self-Aggrandizer mode.
- Being capable of committing violent and sexual offenses in a calculating way, without emotion and conscience: Predator mode.
- Being capable of intimidation or attack without anxiety: Bully and Attack mode.
- Being capable of conning and cheating without any moral dilemma: Conning and Manipulative mode.
- Substance abuse by the Angry or Impulsive Child, because of a childish anger and impulsiveness (similar to borderline disorder).

In (primarily) narcissistic comorbidity dynamics, in which in particular heroin, cannabis, and cocaine were used, the following functions were exhibited:

- Increasing self-esteem: Self-Aggrandizer mode.
- Filling emptiness, loneliness, and feelings of inferiority by soothing or stimulating oneself: Self-Soother and Self-Stimulator modes.
- Substance abuse by the Spoilt or Undisciplined Child, because of a protest against rules, authority, or resistance.

Box 1:

Danny has been convicted of rape and had previous violent offenses. He has a history of emotional deprivation and physical abuse by his father. He has an antisocial personality disorder, with narcissistic, paranoid, and borderline characteristics, and he scores high on impulsivity in all cases and on the Psychopathic Check List (PCL-R, Hare, 2003). Furthermore, he abuses several substances (alcohol, cocaine, cannabis). Danny was under the influence of substances when he committed the offenses.

The substances Danny used performed different functions in (the development of) his personality problems. Cannabis originally had a social function (belonging to a group). Danny was a "follower," as he described himself (Compliant Surrender and also Conning and Manipulative mode). Furthermore, cannabis had a relaxing effect (Detached Self-Soother mode). He used cocaine in order "to be a man," initially, to be more powerful toward his father (his macho side, Self-Aggrandizer mode); later, "to be able to fight" in the criminal environment he was raised in (Bully and Attack mode and Predator mode). Danny only offended when he was under the influence of substances. If he hadn't used any substances, he never went beyond threatening language. Alcohol helped him to forget the pain of his maltreatment (Detached Self-Soother mode). However, it also made him lose self-control and had a strong aggressive dislocating effect on him (Impulsive Child mode). Alcohol and cocaine enhanced his macho side and predator side. He often used these substances at night so that he could fight in the gang he was a member of.

Approach

There are more factors that play a part in the development and continuation of addiction. In the analysis that is described above, the focus was mainly on the original triggers and functions of substance abuse. As soon as (excessive) substance abuse crosses over into addiction it becomes an autonomous process in which the original functions of substances become less visible.

As previously mentioned, most patients in this research study had several personality disorders, and the substances used also performed different functions. An example of a patient (see Box 1) and the functions that different substances accomplished for him.

Danny had undergone four years ST and was monitored for three more years. Two or three times a year he had a follow-up session with the Schema Therapist. More than a year ago, the court ended his detention in a maximum security psychiatric hospital because it didn't consider Danny in danger of re-offending. Untill now Danny didn't relapse in drug abuse and agression. He found a women and became father last year. ST was a difficult therapeutic process. His motivation to undergo therapy was mainly based on external factors (parole, the need to make amends in relation to his mother, the need for a relationship with a woman). In his therapy, limited reparenting, empathic confrontation, and setting limits were the focus. At first, the Self-Aggrandizer, Bully and Attack, Paranoid Over-Controller, Angry Protector, and Angry Child modes were present during the sessions. On the ward, they often saw the Predator, the Conning and Manipulative, and Bully and Attack modes, especially when Danny felt offended. In ST, the Vulnerable Child mode gradually came to the fore, especially when discussing maltreatment by his father, feelings of guilt toward his mother, and shame and blame because of the rape.

At first, Danny was not willing to do imagery exercises regarding to his past (Paranoid Over-Controller), the maltreatment by his father, or the rape. He also refused chair work and role-play. He found these techniques too mysterious, not 'genuine'. Two reasons for refusing imagery exercises became apparent. He was afraid of feeling pain and anger toward his father. Furthermore, he was afraid to be confronted with a strong craving for substances again, and as a consequence he would feel the need to start using them again. The Vulnerable Child and substance abuse as a coping mode (Detached Self-Soother) proved to be strongly linked. There was an extended focus on inclination and how to deal with this by "mindsurfing" and by training in alternative coping. Expressing emotions in conversations and undertaking employment (cleaning) proved to be good behavior alternatives. Finally, as Danny gained more confidences in the therapist, he agreed to do a few imagery exercise in relation to the maltreatment by his father. During these imageries, he was very emotional, his craving for drugs was strong, but he could stand it and could wait untill the craving diminished during the imagery. It was an important exercise in self-control.

The rescripting also went well. However, Danny thought that the imagery was unprofitable and was determined to draw a line under his youth. He hadn't been able to cope with it since.

ST was completed three years ago, because most of the maladaptive schema modes had decreased considerably and Healthy Adult behavior had increased. Mistrust, impulsivity, and antisocial behavior were markedly less significant. Danny reported that he felt calmer, he had dealt with the pain of his past, and that wasn't "triggered" so quickly. During the evaluation, he also mentioned that he had started to appreciate another kind of music: instead of aggressive, hardcore music, he now preferred calm, romantic music. The change was also clearly visible in the treatment department. Psychiatric therapists noticed that Danny was more open, less mistrustfull, and was better at waiting and frustration tolerance.

For the first time in years, he no longer caused incidents, he didn't use any substances, and he was better at keeping appointments. He became more and more realistic in setting goals and taking decisions. This process continued when Danny entered a rehabilitation project, started work, and began a relationship with a woman. Danny himself reported that ST had been very useful for him.

Personality pathology (psychopathy) was Danny's most prevalent problem. The psychopath schema modes (Predator and Self-Aggrandizer modes) and Impulsive Child mode are the most important risk schema modes. Under the influence of mainly cocaine and alcohol these modes are intensified, and as a result a direct danger of offending arises.

All this shows that it is very important to make a thorough analysis of the relationship between personality pathology, addiction, and criminal offense to be able to give a personalized treatment. An analysis of the function of substances in terms of schema modes proved to be valuable. Furthermore, there is the added value of a dual focus during the treatment. Partly due to experiences in a number of dual-focus treatments, a set-up for individualized, integrated treatment of dual diagnosis problems has been developed. This consists of the following phases and parts.

1. Diagnostic phase

Through questionnaires (e.g., the YSQ), tests and observation tools such as the Mode Observation Scale (MOS; Bernstein, de Vos and van den Broek, 2009) diagnostic analysis referring to addiction and personality problems is conducted, and DSM-IV classification is determined. Schemas and modes are diagnosed.

2. Crime scene and addiction analysis

Case conceptualization. During the crime scene, the case conceptualization and mode models are set up in cooperation with the patient; addiction problems are included.

Addiction analysis. An addiction analysis is made, an analysis of the functional relations of (personality) problems, addiction, and offense (holistic theory and functional analyses) of schema modes.

3. Criminal chain group and addiction care program

All patients participate in an criminal chain group, in which cognitive, emotional, behavioral, and situational factors are mapped out preceding, during, and after the offense. Schema modes and the role of substance abuse within them are included in the offense sequence (risk schema modes and risk substances).

Dual diagnosis patients will start with two addiction modules during this phase: the substance info module (information and motivation), followed by the substances and coping modules (dealing with craving, behavior alternatives).

In the rehabilitation phase, patients participate in the Relapse Management Module (dealing with risk situations and relapse).

4. Individual dual focus treatment

Parallel to or after the completion of the offense sequence group, individual ST will start, including interventions focused on addiction problems. The treatment consists of the following phases and elements:

- building up therapeutic reparenting alliance, patient education about Schema Therapy and addiction;
- training in self-control techniques (cognitive and behavior conventions) related to craving and/or substance abuse;
- experiential techniques (imagery, chairwork) to work on internal provokers of addiction (e.g., traumatic memories), a focus on dealing with craving at the same time;
- motivational interviewing in relation to setting targets for each substance: total abstinence or controlled use;
- training relapse management techniques, especially in the rehabilitation phase;
- in addition to psychotherapy, art therapy and psychomotor therapy can also play an important role in dual focus treatment.

Pitfalls and Tips

"Addiction is no longer a problem"

Because of the 'forced remission' of alcohol and drugs in the maximum security psychiatric hospital, many patients think that they no longer have an addiction problem because they don't experience craving and they have been abstinent for years. They think they won't have any problems when they are released. However, relapse always remains a danger, as becomes clear when patients reach the rehabilitation phase. During parole outside the clinic, when patients are exposed to external provocations, they realize that their addiction is still there. Tip: keep addiction and

craving on the agenda during the entire period in the maximum security hospital and pay continuous attention to it. Focus on internal triggers of craving and substance abuse (e.g., humiliation, loneliness, restlessness, grief – the Vulnerable Child modes) through experiential techniques in the inpatient phase. In the rehabilitation phase, it is important to focus on dealing with external triggers, especially relapse prevention and management techniques (behavioral and cognitive techniques).

"I don't believe in the imagery"

Several antisocial patients with a strong Paranoid Over-Controller mode (primal compensating mode for the abused/maltreated child) refuse imagery exercises and don't believe in rescripting. They think it's "fake" and only do things when they can see the point. Tip: first, use other techniques then, when time is right, try to negotiate with the patient about a few "test" sessions.

"You are the predator now"

Diagnosing schema modes can stigmatize or intensify a mode, especially in the case of an antisocial schema mode. For example, referring to the Predator mode when the patient is in that mode might increase the cold aggression, and this is therefore risky. Tip: care and especially good timing are essential when referring to and discussing behavior in terms of antisocial schema modes. Limit setting is indicated in the case of predator and bully and attack modes.

The Future

This chapter reports of the first phase in the development of a dual-focused treatment in which Schema Therapy and addiction treatment are combined. This treatment still has to be developed and described further. The intention is to describe specific methods and techniques in as much detail as possible in guidelines or protocols. The main focus is to describe how ST techniques and cognitive behavior techniques for addiction can be integrated in such a way that treatment is effective on personality disorders and addiction. Our clinical experiences with this treatment is promising. Experiential techniques appear to be have a strong effect on the internal triggers of addiction, the schema's of the vulnerable child mode. The next step will be implementation of this dual focused treatment and an effectiveness study.

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