Within a psychotherapy development research project, thirty male (50%) and female (50%) personality disordered outpatients receiving methadone maintenance were randomly assigned to receive one of two 6-month manual-guided individual psychotherapies, Dual Focus Schema Therapy (DFST) or 12 Step Facilitation Therapy (12FT). All participants met diagnostic criteria for at least one personality disorder with antisocial, borderline, avoidant, and dependent being the most common. There were no significant differences between the two therapies for retention, utilization, or reductions in psychiatric symptoms or psychosocial impairment. Both therapy conditions demonstrated significant reductions in various severity indicators. Participants demonstrated more rapid decreases in the frequency of their substance use over six months of DFST in comparison to 12FT. DFST also was associated with a stronger therapeutic alliance between therapists and participants. Contrary to predictions, 12FT demonstrated better reduction of dysphoric affect than did DFST. DFST shows initial promise as the first time-limited manual-guided psychotherapeutic approach for the full range of personality disorders encountered in substance abuse patients.

The most common form of dual diagnosis is personality disorder and substance abuse (Skodol, Oldham, & Gallaher, 1999; Verheul, van den Bosch, & Ball, 2005). The DSM-IV cluster B disorders (especially Antisocial and Borderline) are most common in substance abuse patients, followed in prevalence by cluster C (especially Avoidant) and cluster A (especially Paranoid) (Rounsaville et al., 1998). The co-occurrence of these psychiatric
disorders is associated with increased risk for suicide, victimization and perpetration of abuse, hospitalization, repeated treatment admissions, over-utilization of medical care, employment and legal problems, HIV infection, and other psychiatric disorders (Links, 1998; Target, 1998). A diagnosis of personality disorder in substance abuse patients is associated with greater addiction symptoms, relapse risk, and worse outcome in traditional addiction counseling (Kofoed, Kania, Walsh, & Atkinson, 1986; Kosten, Kosten, & Rounsaville, 1989; Kruegelbach, McCormick, Schulz, & Gruneich, 1993; Nace & Davis, 1993; Thomas, Melchert, & Banken, 1999).

However, several studies suggest that better addiction treatment outcomes can be achieved when personality disordered patients receive enhanced psychiatric services, intensive psychosocial treatment, or contingent behavioral incentives. For example, alcohol dependent inpatients with borderline personality disorder benefit as much as nonborderline patients when provided intensive, psychiatrically oriented services (Nace, Saxon, & Shore, 1986). Opioid dependent, antisocial patients show improvement comparable to nonpersonality disordered patients when provided individual psychotherapy, contingency management, or higher intensity psychosocial treatments (Alterman & Cacciola, 1991; Brooner, Kidolf, King, & Stoller, 1998; Cacciola, Alterman, & Rutherford, 1995; Cacciola, Rutherford, Alterman, McKay, & Snider, 1996; McKay, Alterman, Cacciola, Mulvaney, & O’Brien, 2000; Messina, Farabee, & Rawson, 2003; Silverman et al., 1998; Woody, McLellan, Luborsky, & O’Brien, 1985). Therapy approaches emphasizing cognitive, behavioral, and affect regulation coping skills also have shown promise with antisocial or borderline substance abusers (Kadden, Cooney, Getter, & Litt, 1989; Linehan et al., 1999; Longabaugh et al., 1994).

Investigators have repeatedly emphasized the need to develop or modify existing treatments to address the specific needs and cognitive, behavioral, emotional, and relational problems of personality disordered substance abusers (Cacciola, Rutherford, Alterman, McKay, & Snider, 1996; Nace, Davis, & Gaspari, 1991; Rounsaville et al., 1998). The most carefully developed, widely disseminated, and scientifically promising manual-guided therapy for personality disorders is Linehan’s (1993) Dialectical Behavior Therapy that has shown its clearest effects for parasuicidal women with borderline personality disorder and has been extended to substance abuse patients with mixed results (Linehan et al., 1999). A similarly well-specified treatment model for the full range of personality disorders and their common co-occurring Axis I conditions is critically needed, especially because (with the possible exception of borderline) personality disordered individuals typically do not seek psychotherapeutic treatment for their Axis II condition. For these reasons, the author has been developing and evaluating Dual Focus Schema Therapy (DFST, Ball, 1998, 2003; Ball & Young, 2000) as the first manual-guided psychotherapy for the full range of personality disorders found in substance abusers. Using an integrative, cognitive-behavioral approach, DFST combines the Schema Therapy
model developed by Jeffrey Young (Young, 1994; Young, Klosko, & Weishaar, 2003) and Relapse Prevention first articulated by Marlatt and Gordon (1985) for alcohol abuse and subsequently manualized for drug dependence (Carroll, 1998). DFST address acute Axis I symptoms (e.g., substance abuse) and chronic, maladaptive personality functioning that heighten relapse risk and poor treatment response. It consists of a set of 16 core and 12 elective topics that are individualized for each patient based on a comprehensive personality assessment and conceptualization of early maladaptive schemas and coping styles.

Maladaptive, negative, or dysfunctional schemas have been defined (Beck, Freeman et al., 1990; Young, 1994; Young et al., 2003) as enduring and pervasive themes about oneself, others, and the world that are learned in childhood through an interaction of biologically-influenced temperaments and parenting practices. These developing mental processes are reinforced and elaborated through adolescence and adulthood (primarily through repetitive relational patterns) and are highly dysfunctional and resistant to change in persons with personality disorders. Young (1994) groups 18 core schemas into five broader domains related to themes of disconnection and rejection (e.g., Mistrust/Abuse), impaired autonomy and performance (e.g., Failure to Achieve), impaired limits (e.g., Entitlement/Domination), other directedness (e.g., Subjugation), and overvigilance and inhibition (e.g., Punitiveness). These schemas are activated by everyday events and mood states that trigger emotional distress in the individual and dysfunctional interactions with others. Early in development, the individual learns ways to cope with these negative internal and external reactions, but these methods become increasingly rigid, self-defeating, and maladaptive in adulthood. Coping styles are conceptualized as forms of schema perpetuation and include surrender, avoidance, and overcompensation. These processes impede healthy gratification of basic adult needs for autonomy and connection and block the change process (Young et al., 2003).

This study compared DFST to 12 Step Facilitation Therapy (12FT; Nowinski, Baker, & Carroll, 1992) as individual therapy enhancements for personality disordered patients in methadone maintenance to evaluate whether a therapy specifically targeting maladaptive personality provides better symptom reduction than a standard addiction therapy. 12FT is focused on addiction as a primary disease, and its major goal is the facilitation of abstinence from alcohol and illicit drugs and the development of a sober lifestyle and drug-free support network. It provides exposure to various recovery topics and tools, emphasizes the importance of self-help meetings, and is meant to approximate a standard form of counseling in many addiction treatment settings. Research to date suggests comparable efficacy of 12FT in comparison to cognitive-behavioral and motivational enhancement therapies for substance abusers (Carroll, Ball, & Martino, 2004). Because both DFST and 12FT are focused on addictive behavior, both approaches were predicted to result in significant reductions in sub-
stance use over a 6-month randomized clinical trial. Because of its specific focus on personality-related problems and symptoms, DFST was expected to be superior to 12FT in reducing psychiatric symptoms, psychosocial impairment, and affective distress. DFST's attention to individual differences and emphasis on an empathic, collaborative therapeutic style (rather than inculcation of a belief in the disease concept of addiction, faith in a higher power, and prescriptive involvement in 12 step fellowship) was expected to facilitate the development of a stronger therapeutic alliance than 12FT.

**METHOD**

**PARTICIPANTS**

The study sample for this report consisted of 30 personality disordered outpatients randomly assigned to DFST or 12FT as part of a psychotherapy development research project funded by the National Institute on Drug Abuse. A total of 78 opioid dependent patients were screened for personality disorder diagnoses after admission to a methadone maintenance program of The APT Foundation, a large publically-funded, non-profit provider of substance abuse services in the Greater New Haven (Connecticut, USA) area. Of these, 41 met criteria for a personality disorder based on the SCID-II, and their clinical characteristics have been described in a previous report (Ball & Cecero, 2001). Eleven of these 41 were treated as nonrandomized pilot or training cases for therapist certification purposes and several of these were presented as case studies in another report (Ball & Young, 2000). The remaining 30 participants are the focus of this small-scale controlled clinical trial that was conducted to evaluate the safety, feasibility, and preliminary efficacy of the newly developed DFST in comparison to a standard active reference therapy (12FT).

All participants were required to be adults on a stable dose of methadone (i.e., 50–110 mg) for at least one month and have used an illicit drug in the prior 30 days. Other psychiatric inclusion criteria were a current opioid dependence diagnosis and a lifetime personality disorder diagnosis. Psychiatric exclusion criteria included current suicidal or homicidal plans or active intent, lifetime schizophrenia, current major mood disorder, and history of traumatic brain injury. Other exclusion criteria included illiteracy, pending legal incarceration or treatment detoxification, and concurrent participation in individual psychotherapy or use of psychotropic medications.

**ASSESSMENTS**

*Structured Clinical Interview for DSM-IV- Axis II* (First, Spitzer, Gibbon, Williams, & Benjamin, 1994). The SCID-II is a semi-structured interview that assessed personality disorders upon entry into the study. A self-report instrument was first completed in which participants rated each of
the 117 dichotomous items corresponding to the Axis II diagnostic criteria. The interviewer then queried the persistence, pervasiveness, and maladaptivity of “yes” responses for those disorders with sufficient endorsed items to yield potential diagnoses. The interviewer had five years experience with the SCID-II from a prior diagnostic study, particularly with the procedures for rendering personality diagnoses independent of the acute and chronic effects of substances (Rounsaville et al., 1998). Videotapes were reviewed regularly in supervision with the author.

**Substance Use Time-Line Calendar** (derived from Miller & DelBoca, 1994). This instrument assesses substance use on a day-to-day basis to provide a weekly estimate of the amount and frequency of opiate, cocaine, alcohol, marijuana, benzodiazepine, and other drug use. These participant reports were collected by therapists at their weekly sessions and were confirmed by weekly urine tests collected by a research assistant blind to assigned treatment conditions.

**Addiction Severity Index** (ASI; McLellan, et al., 1992). This structured interview assesses the severity of substance abuse-related psychosocial impairment in the areas of medical, employment, alcohol abuse, drug abuse, legal, family/social, and psychiatric functioning. This information was collected at baseline and at each monthly appointment by the research assistant and provided data necessary to compute ASI composites as the primary measures of change in psychosocial impairment and as an independent measure (from the therapist generated time line calendar) of substance frequency and amount over the 6-month treatment.

**Brief Symptom Inventory** (BSI; Derogatis, 1993). The BSI is a 53-item self-report inventory of psychiatric symptoms that asks participants to rate items on a five-point scale of distress. Collected at baseline and at each month of treatment, it yields nine primary symptom dimensions and three composite summaries, of which the Global Severity Index was analyzed for this study as a measure of change in psychiatric symptom severity.

**Multiple Affect Adjective Checklist-Revised** (MAACL-R; Zuckerman & Lubin, 1985). The MAACL-R is a 132 adjective checklist providing state and trait measures of affects. The baseline and monthly summary score rating of Dysphoria (Anxiety, Depression, and Hostility subscales combined) was used as the measure of change in negative affect state ratings.

**Working Alliance Inventory** (Horvath & Greenberg, 1986). The WAI is 36-item self-report inventory that measures agreement on goals, tasks, and bonds between client and patient. Both client and therapist versions of this form were collected at each monthly assessment and the global alliance was a measure of change.

**TREATMENT PROCEDURES**

DFST and 12FT were compared as therapy enhancements to an existing methadone maintenance program that focused primarily on the stabilization of addictive behavior with improved psychosocial functioning ex-
pected as a likely consequence of agonist medication. This program provided very limited supportive individual counseling, and group counseling was provided 1–4 times per month. Thus, the study therapies were not redundant with services offered. Post-study analyses of the amount of services received within the methadone clinic or outside programs were evaluated using the Treatment Services Review (McLellan, Alterman, Cacciola, Metzger, & O’Brien, 1992). There were no differences between the two therapy conditions (e.g., DFST, mean = 4.3 group and 1.5 individual sessions vs. 12FT, mean = 3.2 group and 1.0 individual sessions over the entire six month period), and attendance at ancillary medical, psychiatric, vocational, 12 step, and criminal justice meetings were also very minimal and similar.

Participants were referred to the research study by the methadone treatment staff or responded to flyers posted in the clinic waiting area that offered individual therapy for current substance use, emotional, and relationship problems. The research assistant conducted eligibility screening, informed consent, and all assessments. Participants were not paid for treatment but received a total of $150 (US) for completing baseline, monthly, and termination research assessments. Thirty substance using personality disordered patients were randomly assigned to either DFST or 12FT for six months (180 day individual therapy window from baseline to termination assessment) that was delivered twice weekly for the first month (to facilitate a connection to therapy and abstinence focus) and then weekly thereafter.

Dual Focus Schema Therapy (DFST). DFST is a structured, manual-guided treatment for substance abuse and personality dysfunction using a modified, integrative cognitive-behavioral approach. The goals and stages of DFST and its conceptualization of addictive and personality psychopathology are described in detail elsewhere (Ball, 1998, 2003; Ball & Young, 2000). Briefly, DFST assumes that problems are best addressed through targeted interventions for a limited number of early maladaptive schemas and coping styles. The first stage (months 1–2) involves an integration of relapse prevention work with an assessment and psychoeducation about schemas and coping styles and their relation to substance abuse and other life problems. Based on a detailed, personality-focused case conceptualization, specific change strategies are selected for each schema and coping style from the following four areas (Young, 1994): (a) Cognitive (e.g., disputing validity of schemas and usefulness of coping style); (b) Experiential (e.g., imagery); (c) Behavioral (e.g., new coping skills); and (d) Therapy Relationship (e.g., addressing schemas and coping activation in sessions). In addition to these core topics, elective session may be used to address treatment interfering substance use, other forms of extreme avoidance, boundary violations, intrusive traumatic memories, suicidal/self-injury crises, and maladaptive schema modes.

12 Step Facilitation Therapy (12FT). Participants randomized to this condition received a manual-guided therapy based on NIAAA Project MATCH’s 12FT (Nowinski et al., 1992), modified for use with patients on methadone
maintenance. This treatment emphasizes the disease concept of addiction using a 12-step philosophy and steps as themes for session topics. The therapist's roles are both educator (e.g., explaining 12-step model, advocating self-help meetings) and facilitator (e.g., exploring resistance and encouraging attendance at self-help meeting, pointing out denial). Each session emphasizes complete abstinence, compliance with agonist medication, gradually increasing involvement in 12-step fellowship, completion of recovery tasks (e.g., journaling, reading, meeting commitments, connection to sponsor), and developing a recovery support system.

Therapist Training and Fidelity. Six licensed doctoral-level clinical psychologists (three for each condition) received separate 3-day trainings by the developers of the treatment models on which the study manuals were based: Jeffrey Young provided training for schema therapy (Young et al., 2003) and Stuart Baker for 12FT (Nowinski et al., 1992). The author provided additional training on the use of the manuals for patients with dual disorders in methadone maintenance. Training methods included didactic lectures and discussion, handouts and reading, review of videotapes, illustration of techniques, and role-plays. Immediately after training, all therapists completed a certification case and began weekly small group supervision with the author. All therapy appointments were videotaped, and the author reviewed one session weekly from each condition for supervision that continued through the duration of the study. Therapists completed a self-assessment of their own adherence to the manuals after each session as an informal method to help maintain integrity and prevent drift.

Therapist adherence and competence was formally evaluated through independent videotape raters using a tape rating system modified from the Yale Adherence Competence Rating System (Carroll et al., 2000) with item content relevant to DFST and 12FT. Four raters were selected for training who were highly experienced masters-level clinicians with specific training and clinical practice in one of the two approaches (two each from the two models), but who were blind to the specific comparison condition and the specific aims of the study. Multiple sessions were rated for each participant to insure a representative sample of sessions over the 6-month course of both therapies. t-tests of averaged expert ratings indicated that DFST therapists used significantly more DFST interventions than did 12FT therapists, \( t(234) = 15.4, p < .0001 \), and did so with greater skill level, \( t(116) = 3.68, p < .001 \). Likewise, 12FT therapists used more 12FT interventions than did DFST therapists, \( t(234) = 21.6, p < .0001 \), and did so with greater skill level, \( t(145) = 3.16, p < .002 \).

DATA ANALYSIS

The principal analyses for the effects of study therapies were: (a) analysis of variance for continuous outcome variables at 6-month termination (e.g., % days abstinence, number of therapy sessions, symptom measures); and (b) random effects regression or hierarchical linear modeling (HLM; Bryk
for the following five continuous dependent variable domains measured at six monthly intervals during treatment: (a) substance use amount and frequency (both from weekly therapist timeline calendar and monthly research assistant ASI); (b) psychosocial severity (ASI composite ratings for medical, employment, alcohol, drug, legal, family, psychological); (c) psychiatric symptoms (BSI Global Severity Index); (d) negative affect (MAACL-R Dysphoria); and (e) therapeutic alliance (WAI global alliance rating). In addition to Therapy main effects (ANOVA at month 6 only, HLM across months 1 through 6), Time main effects (for symptom changes regardless of therapy assigned), and Therapy × Time interactions were evaluated using HLM to determine whether the slope (rate of change) in DFST differed from the slope of 12FT. Given the small sample size and the impact of even small amounts of missing data at each monthly time point, an important advantage of HLM is its ability to provide estimates without dropping or imputing values for missing assessment time points. An intercept and slope is estimated for each participant iteratively based on all available data for the participant, augmented by data from the whole sample. These random effects, along with the fixed effects of Therapy were included in the regression equation to predict values for the five dependent variables domains listed above across Time Factor. Using the subject-specific intercept and slope from the model, missing observations were estimable by plotting the regression line through the model parameter estimates.

RESULTS
SAMPLE CHARACTERISTICS

The sample consisted of an equal number of men (n = 15) and women (n = 15) who were predominantly unmarried (43% single; 37% separated/divorced; 17% married; 3% widowed), Caucasian (80%; 17% African American; 3% Hispanic) with a mean age of 37.0 (SD = 6.1). The ASI indicated that most (70%) were high school educated (mean = 12.0, SD = 2.5 years) and unemployed currently (only 20% received income for more than ten days in the past month) and chronically (only 30% employed in past three years). Participants met structured interview criteria for an average of 3.2 (SD = 1.3) personality disorders with Antisocial being the most common diagnosis (63%) followed closely by Borderline (57%) and Avoidant (53%). Dependent (23%) personality disorder was present in several cases, but the remaining Axis II disorders were not common (7% each for Paranoid, Schizoid, Schizotypal, Narcissistic, Obsessive-Compulsive, and no cases of Histrionic). At the time of baseline assessment, many in the sample reported significant current (ASI) symptoms of depression (30%), anxiety (50%), violence (23%), and suicidal ideation (30%). The majority had experienced such symptoms in their lifetime (87% serious depression, 90% serious anxiety; 50% violence; 73% suicidal ideation, and 50% attempts).
The majority (90%) also reported experiencing past emotional abuse and many reported past physical (53%) and sexual (33%) abuse.

The ASI indicated that half of the participants (56%) identified heroin (intravenous 63%; intranasal 33%; oral 3%) as their current drug of choice while cocaine (23%), alcohol (10%), and benzodiazepines (10%) were primary for the remainder of the sample. Participants reported an average of almost 12 years of regular use of their primary substance (mean = 139.9 months, \( SD = 94.7 \)) and had used drugs on about half of the days (mean = 11.2, \( SD = 10.6 \)) during the month prior to baseline assessment. Half of the sample reported using heroin in the prior 30 days (37% used alcohol, 43% cocaine, 27% tranquilizer, 7% cannabis). Participants reported high levels of prior treatment for substance abuse (mean = 8.3, \( SD = 7.3 \)), mental health (mean = 6.0, \( SD = 12.1 \)), extensive criminal justice involvement, including arrests (mean = 17.8, \( SD = 20.2 \)), and periods of incarcerations (mean = 27.4 months; \( SD = 55.1 \)). The early maladaptive schemas, coping styles, interpersonal problems, negative affect, and personality traits of this sample are described in detail in Ball and Cecero (2001).

**THERAPY EFFECTS**

There were no baseline differences between patients assigned to the two therapy conditions for the major variables of relevance to this study (e.g., demographics, personality disorder symptoms, various ASI severity ratings, BSI psychiatric symptoms, MAACL affect ratings, or substance use indicators). There were no treatment retention or utilization (number of weeks, sessions, or missed appointments of therapy) differences between the two conditions. The mean number of session weeks completed was 13.5 for DFST and 14.7 for 12FT, indicating that both conditions received comparable doses of treatment. ANOVAs at the 6-month termination assessment indicated no treatment main effects for the substance use measures (percent of urines positive, percent days used, monthly amounts, consecutive abstinence weeks) or for termination (i.e., month 6) measures of ASI psychosocial impairment, BSI psychiatric symptoms, or MAACL-R dysphoria symptoms. Similarly, HLM indicated no significant main effect treatment differences across months 1 through 6 of therapy.

**TIME EFFECTS**

In the random regression analyses (HLM), there were several Time main effects for ASI alcohol (estimate = -.01, SE = .00, \( z = -2.15, p < .03 \)), family (estimate = -.03, SE = .01, \( z = -3.55, p < .001 \)), and psychological (estimate = -.04, SE = .01, \( z = -4.74, p < .001 \)) composite severity. ASI current psychiatric symptoms (estimate = -.19, SE = .05, \( z = -3.61, p < .0001 \)), BSI global severity (estimate = -.08, SE = .02, \( z = -3.61, p < .001 \)), and MAACL Dysphoria (estimate = -.99, SE = .28, \( z = -3.55, p < .0001 \)). All of these effects indicated a reduction in severity of psychosocial and psychi-
bacric symptoms over six months in both treatment conditions. Participants also reported feeling less bothered by their substance use (estimate = −.17, SE = .06, z = −2.81, p < .005) and psychological (estimate = −.29, SE = .06, z = −5.05, p < .0001) problems over time on the monthly ASI.

THERAPY X TIME EFFECTS

Substance Use Amount and Frequency. A significant Therapy × Time HLM effect was found for the monthly average days/week primary substance use as assessed by the therapist weekly calendar, estimate = −.06, SE = .02, z = −2.25, p < .005. In addition a significant HLM effect indicated better substance use reduction based on the timeline calendar, estimate = .20, SE = .09, z = 2.17, p < .03. Both effects indicated that participants assigned to DFST reduced their substance use frequency more rapidly over the 6-month treatment than did participants assigned to 12FT (see Figure 1). This effect was marginally significant when the independent research assistant monthly ASI percent of days/month of primary substance use index was analyzed, estimate = −.22, SE = .12, z = −1.83, p = .068. In both effects, the regression lines indicated a difference favoring DFST over 12FT beginning to emerge at month three. This corresponded to a point in treatment when the therapeutic focus of DFST was shifting from assessment/education to cognitive and behavioral change techniques.

Psychosocial Impairment. There were no interactions for ASI composite scores.

Psychiatric Symptoms. There were no interactions for the BSI global severity index score.

Negative Affect States. A significant Therapy × Time HLM effect was found for MAACL-R Dysphoria. Analyses of the slopes indicated that participants treated with 12FT exhibited steady decreases in negative affect

![FIGURE 1. Time (baseline through termination) × Therapy (DFST vs. 12FT) interaction for average days/week substance use frequency.](image-url)
OPIOID DEPENDENT PATIENTS

FIGURE 2. Time (baseline through termination) × Therapy (DFST vs. 12FT) interaction for MAACL Dysphoria scale.

over time. In contrast, DFST demonstrated no decrease in Dysphoria over six months, estimate = 1.34, SE = .42, z = 3.24, p < .001 (see Figure 2).

Therapeutic Alliance. A significant Therapy × Time HLM effects was found for the global client WAI measure. Participants in both conditions rated the therapeutic alliance as “good” by the end of the first month of treatment. Whereas 12FT participants reported no further increase beyond this initial rating, participants receiving DFST demonstrated continuing increases over the subsequent five months, ending at a very strong therapeutic alliance, estimate = .13, SE = .06, z = 2.09, p < .037 (see Figure 3). This finding was consistent with the main effect for Therapist WAI rating indicating that DFST therapists reported feeling a stronger working
alliance over the course of treatment with participants than did 12FT therapists, estimate = .83, SE = .33, z = 2.48, p < .013.

DISCUSSION
DFST is the first highly detailed, manual-guided psychotherapeutic approach for the full range of personality disorders encountered in substance abusers. The study findings provide very preliminary support for DFST as a promising treatment deserving further evaluation. Personality disordered opioid dependent outpatients demonstrated more rapid decreases in the frequency of their substance abuse over six months of DFST in comparison to 12FT. Given that both DFST and 12FT focus on promoting abstinence from substances, a difference on this outcome was not predicted and was encouraging for this new treatment especially in comparison to a standard addiction treatment with empirical support (12FT). DFST was predicted to yield better reductions in psychosocial impairment, psychiatric symptoms, and negative affect. However, neither ANOVAs of symptoms at 6-month termination nor HLMs of symptom reduction over the 6-month time period supported this prediction. In fact, 12FT demonstrated better reduction of dysphoric affect than did DFST. Despite this apparent failure, DFST seemed to promote a stronger bond between therapists and participants as both groups independently reported a strengthening therapeutic alliance over the course of DFST in comparison to 12FT. The maintenance of mild to moderate dysphoria in DFST could be due to its ongoing cognitive and affective processing of painful past and current themes while also reducing substance use as a dominant method of avoidant coping. This sustained dysphoria did not relate to relapse or drop out risk, in fact, substance abuse symptoms decreased and the working alliance strengthened despite this persistent negative affect. The relation between client and patient perspectives on alliance, treatment approach (i.e., highly collaborative vs. highly directive), and symptom changes in different domains is likely to be highly complex, interactive, and deserving of future careful study in a larger sample.

The limitations of a 6-month manual-guided treatment for very long-term addiction and personality problems must be acknowledged. DFST addresses presenting problems by targeting a few early maladaptive schemas and coping styles with the goal of reducing symptoms and self-defeating behaviors. Symptom reduction is a necessary but not sufficient condition for changing personality disorders. Verheul et al. (2000) found that the successful reduction of substance abuse was associated with remission of mood and anxiety disorder symptoms, but not with significant changes in personality disorder symptoms. DFST does not treat complex, chronic dual diagnosis patients with an unrealistic goal of full remission. Instead, it focuses on achievable goals such as improving self-esteem, relationships, work/school functioning, retention, and exposure to substance abuse or mental health services that provide ongoing care. For a science
of personality disorder treatment to continue its development, improve-
ments in focal life problems (e.g., DBT’s focus on hospitalization and sui-
cidality) should be the major outcome of interest rather than structural or
syndromal changes in personality disorder.

The individual therapy model described in this paper and elsewhere
(Ball, 1998, 2003; Ball & Young, 2000) is one of a growing number of
promising, research-informed treatments for personality disorders, and
one of only a few that is being subjected to a series of controlled compari-
sions with other active treatments. Although the current study was small
in sample size and narrow in behavioral targets, it was the first controlled
clinical trial evaluating the efficacy of DFST for personality disordered sub-
stance abusers. Through this work, all of the major tasks of psychotherapy
development (Rounsaville, Carroll, & Onken, 2001) have been accom-
plished, including the development of a treatment manual, evaluating
safety and acceptability to patients (i.e., comparable levels of adverse
events, retention, and patient satisfaction with a standard treatment),
training therapists, pilot efficacy testing, and evaluating treatment fidelity.
There are now two other small, randomized clinical trials evaluating DFST
and one larger trial nearing completion. DFST has been compared to stan-
dard group drug counseling for 53 homeless drop-in center clients with
substance abuse and personality disorders, and analyses indicate better
utilization of DFST (Ball, Cobb-Richardson, Connolly, Bujosa, & O’Neall,
2005). In an exploratory NIMH-funded treatment development project,
DFST has been modified for 35 depressed women with histories of child-
hood sexual abuse (many of whom have borderline personality disorder)
and compared to pharmacotherapy and clinical management (Zlotnick,
personal communication). On a larger efficacy testing scale, follow-up as-
sessments are currently being completed on 105 adult and adolescent sub-
stance abusers in a long-term residential therapeutic community who were
randomly assigned to either DFST or manual-guided Individual Drug Coun-
seling (Mercer & Woody, 1999) as methods to improve retention, psychiatric
symptoms, and psychosocial functioning. Confident conclusions about the
efficacy of DFST must await this and other larger sample studies.

Although DFST appears to be a promising approach meriting further
evaluation, several important questions should be addressed to provide a
more definitive test of the boundaries of its efficacy. Meta-analytic reviews
(Perry, Banon, & Ianni, 1999; Sanislow & McGlashan, 1998) suggest that
symptomatic improvements must be measured over a long follow-up pe-
riod when evaluating change in a chronic condition like personality disor-
ders (and substance dependence). Thus, longer periods of follow-up will
be necessary before concluding that DFST is an effective treatment. In ad-
dition, the originator of cognitive therapy for personality disorders (A.T.
Beck et al., 1990) and the theorist and investigator of the only empirically-
validated behavioral therapy for a specific personality disorder (Linehan,
1993), both have argued that separate approaches are needed for different
DSM-IV personality disorders. In fact, Young et al. (2003) now believes
that his original schema therapy model may be less appropriate for some personality disorders (e.g., borderline, narcissistic, and highly avoidant patients) than a mode-focused approach. As argued previously (Ball, 1998), the evaluation of different models for specific diagnoses seems unjustifiable, inefficient, and impractical to advance the science of personality disorder treatment, particularly given the limited reliability and validity of the current DSM-IV Axis II diagnostic constructs. DFST focuses on treatment targets (schemas, coping styles) believed to underlie the symptomatic expression of all personality disorders. However, it remains an empirical question whether this approach can be applied with equal effectiveness to the diverse Axis II disorders, and the current sample (consisting primarily of antisocial, borderline, avoidant, and dependent) was too small to permit an analysis of outcome as a function of categorical diagnosis. Future research will evaluate this question.

In the current study and three subsequent studies, DFST was evaluated in comparison to an active, protocol-driven reference therapy as enhancements to standard treatment services. This decision reflects the author's belief that any innovative psychotherapy for personality disorder should be held to a high standard of proof for its benefit relative to: (a) relevant individual, group, or family treatment models already in practice, and; (b) standard services currently accessed by these patients. Complex forms of psychotherapy for personality disorders should demonstrate their efficacy against a standard, active reference comparison treatment that is delivered at an equal level of specification, fidelity, and intensity. To be accepted as an evidence-based therapy that justifies the extra costs associated with intensive training and continuous supervision, DFST should be expected to demonstrate its superiority over more easily implemented counseling methods (e.g., Individual Drug Counseling or 12 Step Facilitation) for personality disordered substance abusers. Although most outcome findings were not different between the conditions, this pilot efficacy study provided preliminary evidence for a more rapid reduction of substance use in DFST and a more rapid reduction of dysphoria in 12FT. Future research involving larger samples should evaluate whether DFST results in robust changes in symptoms and functioning above and beyond standard care. In this regard, DFST is currently conceptualized, not as a stand-alone intervention, but as time-limited in its delivery within the context of a more chronic care model (Ball, 2003). Although such longer-term treatment contexts provide essential symptom and crisis management and facilitate sufficient retention, the demonstration of individual therapy efficacy above and beyond standard services is a rigorous challenge and also raises potential confounds for determining efficacy of an approach. Nonetheless, these kinds of comparisons seem most relevant for psychotherapies for severe personality disorder as these patients most often access treatment for an Axis I disorder, and therapies being developed must balance the priorities of acute symptom management, establishing a strong therapeutic alliance, and addressing core life problems.
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