This is a chapter excerpt from Guilford Publications.
Treating Impulsive, Addictive, and Self-Destructive Behaviors: Mindfulness and Modification Therapy.
Peggilee Wupperman. Copyright © 2019.
Purchase this book now: www.guilford.com/p/wupperman

CHAPTER 1

Challenges of Treating Dysregulated Behavior

Copyright © 2019 The Guilford Press

If you are reading this book, you are likely a mental health professional who provides therapy to clients with dysregulated behavior. You may work in a setting that specializes in treating dysregulated behavior (e.g., a clinic targeting substance misuse or disordered eating), or you may work in a general setting but realize that dysregulated behavior is a problem for many of your clients.

Regardless, you are likely invested in conducting treatment that offers your clients the best possible outcomes. Although you and I may use different phrases to describe *best possible outcomes,* I believe we would agree that a desired outcome is one in which a client (1) overcomes any dysregulated behavior that interferes with living a valued life, and (2) takes steps to move closer to a life that feels more satisfying and fulfilling.

However, clients with dysregulated behavior often have great difficulty in treatment. They often feel as though the dysregulated behavior is impossible to resist, even while being aware of the negative consequences of the behavior. Consequently, they tend to display fluctuating motivation, difficulty with treatment engagement, and high dropout rates. Even for clients who don't drop out, therapy may be hindered by problems with attendance and home practice, risky behaviors, and disappointing outcomes (McFarlane, Olmstead, & Trottier, 2008; Miller, Walters, & Bennett, 2001). Even success in treatment may be a temporary accomplishment, as relapse rates are greater than 50% across dysregulated behaviors (McFarlane et al., 2008; McLellan, Lewis, O'Brian, & Kleber, 2000; Miller et al., 2001).

As a result, therapists treating clients with dysregulated behavior are at risk for developing emotional exhaustion and doubts about their effectiveness as clinicians (Koekkoek, van Meijel, & Hutschemaekers, 2006). Over time, these therapists may often experience feelings of disengagement and judgmental attitudes toward clients (e.g., Koekkoek, Hutschemaekers, van Meijel, & Schene, 2011). In other words, therapists who treat clients with dysregulated behavior are at risk of becoming less effective in helping the very clients they have chosen to treat.

The ultimate purpose of this book is to describe MMT, an approach that will improve the chances of positive outcomes for clients with dysregulated behavior. Secondary benefits may include decreasing your own chances of burnout, while also increasing your work satisfaction and improving your effectiveness as a therapist. By systematically integrating evidence-based clinical models and interventions, MMT offers a transdiagnostic intervention for improving client motivation, engagement, and (ultimately) outcome.

A strong word of caution before proceeding: Therapists are often busy, which means that you may feel the urge to skip the first chapters of this book and jump straight to the guidelines and handouts for the treatment sessions. (You would not be the first therapist to skip the how-to chapters of a treatment guide.) Please resist that urge! Chapters 2–7 provide important instructions on principles, strategies, techniques, and tracking that are essential in conducting MMT effectively. In MMT, the *way* you interact with the clients is every bit as vital as whether you assign the correct mindfulness practices or handouts. To phrase it more directly: If you only utilize the session handouts without reading Chapters 2–7, you will not be providing MMT to your clients. Instead, you will be providing a treatment without any backing or rationale. The results will likely be poor for your clients and discouraging for you. Thus, you are strongly encouraged to read Chapters 2–7 before moving to Chapter 8. (To facilitate this process, Chapters 2–7 were written to be as practical and direct as possible.)

Part I of this book presents an overview of MMT, as well as guidelines for conceptualizing and collaborating with clients. Part II describes five basic MMT strategies for improving motivation, engagement, and treatment outcome. These strategies are core components that are meant to be integrated throughout every MMT session. Finally, Part III contains guidelines for conducting MMT sessions, along with handouts and therapist sheets for each session topic.

Throughout the clinical chapters, handouts and therapist sheets are labeled as *H* or *TS* (respectively), followed by the letter of the relevant session and a number signifying the order in the session. For example, *H-C1* is the first handout in Session C; *TS-F3* is the third therapist sheet in Session F; and *TS-SF1* is the first therapist sheet in a semi-flex session

WHAT *IS* DYSREGULATED BEHAVIOR?

As mentioned in the Introduction to Part I, the "dysregulated" behaviors that MMT targets are those that provide short-term relief or pleasure, but that cause harm over time (e.g., Mezzich et al., 1997). Individuals who routinely engage in dysregulated behavior tend to have extreme difficulty inhibiting the behavior, even when they know it is causing harm and even when they make sincere efforts to abstain or resist. Although these behaviors are often called *impulsive, addictive,* or *self-destructive* behaviors, none of these terms provide accurate descriptions of all dysregulated behaviors (e.g., Raymond et al., 1999; Wupperman et al., 2012). First, some dysregulated behaviors occur after hours of rumination and planning, so they are not consistent with the definition of *impulsive*. (A former smoker may receive a negative work review in the morning and spend the rest of the day planning how she will buy cigarettes on the way home.) Second, many behaviors do not fit the standard model of addictions. (Someone may routinely react to stress by punching walls or starting fights, but few would say that the person was

Copyright © 2019 The Guilford Press

addicted to aggressive behavior.) Third, the term *self-destructive* is problematic in that it is judgmental and also implies intent—as though the person's motive for the behavior is solely to damage or destroy her- or himself. However, most dysregulated behavior is aimed at regulating affect or decreasing urges (e.g., Goodman, 2008)—as opposed to damaging oneself. (Although damage to self and others may be one of the eventual consequences of dysregulated behavior, such damage is rarely the purpose of the behavior. Even nonsuicidal self-injury is often primarily an attempt to regulate affect or urges; Klonsky, 2007; Nixon, Cloutier, & Aggarwal, 2002). Thus, since *impulsive, addictive,* and *self-destructive* are often not accurate adjectives, this book uses the umbrella term *dysregulated behavior* (e.g., Selby et al., 2010; Wupperman et al., 2015).

MMT has been conducted with many clients who reported current suicidal ideation and/or histories of suicide attempts; however, very few MMT clients have reported *active* suicidal urges. Although those clients progressed satisfactorily, the data are limited. Considering the severity of potential consequences, the limited amount of data, and the substantial evidence supporting DBT and other evidence-based treatments for suicidality, it is recommended that any clients seeking treatment for suicidality enter a therapy with evidence for treating this specific population.

Conventional treatments for dysregulated behavior can often be stymied because these behaviors rarely occur alone. Instead, therapists are often confronted with an array of dysregulated behaviors. For example, a client who abuses alcohol or drugs has an increased likelihood of binge eating, aggression, gambling, compulsive sex, self-injury, and smoking (e.g., Bulik, Sullivan, Cotter, & Joyce, 1997; Goodman, 2008; Klonsky & Muehlenkamp, 2007; Petry, Stinson, & Grant, 2005). From another perspective, a client who engages in binge eating has an increased probability of alcohol/drug abuse, compulsive sex, compulsive spending, self-injury, and problematic anger (e.g., Allen, Byrne, Oddy, & Crosby, 2013; Goodman, 2008; Krug et al., 2008; Vansteelandt et al., 2013).

As a further challenge, clients treated for one dysregulated behavior often segue to a "replacement" behavior once the first is addressed. For example, a person may quit drinking but begin smoking; the person may then quit smoking but begin overeating (e.g., Manley & Boland, 1983). What's more, dysregulated behaviors may even interfere with therapy itself. *Therapy-interfering behavior* is any behavior that impedes treatment engagement or outcome, such as difficulty attending sessions or problems completing home practice assignments.

As a result of the above, therapists often feel they are treating a moving target. They may become overwhelmed and uncertain when facing multiple target behaviors, transitions from one dysregulated behavior to another, and/or an array of therapy-interfering behaviors.

Why MMT?

Therapists treating clients with dysregulated behavior need (1) a transdiagnostic treatment that includes (2) a systematic integration of therapy components with evidence for treating dysregulated behaviors. This treatment should be able to target multiple dysregulated behaviors, while also allowing customization for each client's specific behavior(s).

Copyright © 2019 The Guilford Press

An Integrated Intervention Specifically Designed to Target Behavior Dysregulation

To address this need, MMT was designed by integrating key strategies and principles from six evidence-based treatments: motivational interviewing (MI), mindfulness-based relapse prevention (MBRP), dialectical behavior therapy (DBT), acceptance and commitment therapy (ACT), cognitive-behavioral therapy (CBT), and mentalization-based psychotherapy (MBP). Strategies and procedures from each of these treatments were identified, systematically integrated, and targeted toward the aim of decreasing dysregulated behavior.

MMT is a threefold intervention. It consists of explicit evidence-based methods for addressing (1) multiple dysregulated behaviors, (2) "replacement" dysregulated behaviors, and (3) broad constructs that underlie and contribute to this spectrum of behaviors. MMT also specifically targets the related clinical issues of low motivation, problems with engagement, and frequent dropout, as well as high relapse rates.

MMT is a partially manualized treatment that includes general session templates, guidelines, and principles, while also allowing the therapist to customize the treatment to fit each client's specific needs and behaviors. In implementing MMT, clinical judgment and skills are not just important; they are essential. As a therapist, you will have substantial opportunity to creatively tailor the treatment within the general MMT framework. The ultimate goals of MMT are to help each client move past dysregulated behavior and begin to move toward a life that feels more satisfying and fulfilling.

Copyright © 2019 The Guilford Press

Mindfulness in the Treatment of Dysregulated Behavior

Dysregulated behaviors are commonly conceptualized as attempts to avoid or regulate negative affect and urges (Baker, Piper, McCarthy, Majeskie, & Fiore, 2004; Cooper, Frone, Russell, & Mudar, 1995; Williams, Fennell, Barnhofer, Crane, & Silverton, 2015; Witkiewitz & Bowen, 2010). In this conceptualization, negative affect can include emotions such as sadness, anxiety, or boredom, but it can also include *dissatisfaction* with the current state of being. For example, a person may think she should feel happier than she does after receiving a promotion, so she uses drugs to feel happier. Or a person may want to feel confident around friends, so he drinks to seem more confident. In both cases, the individuals did not necessarily feel *unhappy* or *unconfident* initially; instead they just didn't feel *as* happy or *as* confident as they thought they *should* feel. They were dissatisfied with what they were experiencing.

However, despite research supporting dysregulated behaviors as efforts to avoid or change negative affect and urges, the negative affect and urges may not be the primary drivers of the behaviors. After all, we all experience negative affect on a fairly regular basis, but we do not all routinely engage in harmful dysregulated behaviors. Instead, a primary problem that often underlies such behaviors is *the perceived inability to experience and tolerate* (and thus adaptively cope with) the negative affect and urges. In other words, the problem may be difficulties with mindfulness.

Mindfulness involves being aware of, attentive to, and accepting of the present moment, without feeling the need to avoid or suppress one's experiences (Kabat-Zinn, 1982). Consistently, mindfulness is negatively related to a wide variety of dysregulated behaviors (Borders, Earleywine, & Jajodia, 2010; Lavender, Jardin, & Anderson, 2009; Lundh, Karim, & Quilisch, 2007; Spinella, Martino, & Ferri, 2013; Wupperman, Fickling, Klemanski, Berking, & Whitman,

2013). Mindfulness is also associated with enhancements in neural pathways related to self-regulation (e.g., Holzel et al., 2011; Witkiewitz, Lustyk, & Bowen, 2013).

The mindfulness practices in MMT were designed to address a central construct underlying dysregulated behaviors. By integrating mindfulness with other empirically supported methods, MMT helps clients process and habituate to negative emotions and urges, thus reducing the perceived need to avoid the emotions or to act on the urges (Wupperman et al., 2012, 2015). MMT's mindfulness practices are also designed to help clients (1) become aware of conditioned reactions, and (2) tolerate their affect long enough to choose adaptive strategies for regulating emotions and behaviors—instead of responding automatically with habitual reactions (e.g., Berking & Whitely, 2014; Bowen et al., 2014; Witkiewitz et al., 2013; Wupperman, Neumann, & Axelrod, 2008). In addition, mindfulness is integrated with techniques designed to decrease interpersonal conflict and increase awareness of positive emotions (e.g., Wupperman et al., 2015)—which may also reduce the perceived need to engage in dysregulated behaviors.

Of course, mindfulness is not a magic cure for dysregulated behavior. (*Considering some of the recent hype about mindfulness, this point cannot be stressed enough.*) Clients who struggle with dysregulated behavior tend to have problems coping in a variety of areas and require more than just mindfulness to be treated effectively. Mindfulness practice also does not immediately address the difficulties with therapy alliance, motivation, homework completion, retention, and communication often experienced by such clients. Thus, although a mindfulness component may be beneficial in treating dysregulated behavior, it is not sufficient on its own. Instead, MMT strategically integrates mindfulness with other evidence-based components for addressing dysregulated behavior.

Copyright © 2019 The Guilford Press

MMT: An Integrated Intervention for Behavior Dysregulation

Despite growing research supporting the potential utility of mindfulness in treatment for behavior dysregulation (e.g., Bowen et al., 2014; de Souza et al., 2015; Fix & Fix, 2013; Godfrey, Gallo, & Afari, 2015), there is still a need for a transdiagnostic treatment that can target a variety of dysregulated behaviors, including treatment-interfering behaviors. Conventional mindfulness interventions have shown great promise for treating specific areas of dysregulation (e.g., mindfulness-based eating awareness training; Kristeller, 2015) and/or targeting relapse prevention in clients no longer actively engaging in the behavior (e.g., MBRP for addictive behaviors; Bowen et al., 2010). In contrast, although MMT draws on core elements of conventional mindfulness treatments, it was designed to be transdiagnostic and to focus on individuals who are actively engaging in dysregulated behavior(s) at intake. For example, MMT (1) targets general behavior dysregulation, while also tailoring sessions and practices for specific behaviors; (2) stresses the therapy relationship; (3) includes methods for addressing motivational issues; and (4) includes methods for targeting problems with attendance and homework completion. MMT can also be customized for each client's overall goals and values, and when compared to most mindfulness-based treatments, MMT contains a greater range of skills (including mindful emotion regulation and communication skills that are specifically relevant to dysregulated behavior).

Accordingly, conventional mindfulness treatments may be more beneficial for (1) settings in which a more didactic style is needed; (2) situations in which a brief, concentrated treatment is appropriate; (3) larger groups; and/or (4) situations in which clients have already stopped the

behavior but need relapse prevention skills. In contrast, MMT may be more beneficial for clients who (1) are currently engaging in the dysregulated behavior, (2) need a more individualized approach, (3) have trouble with treatment engagement, and/or (4) have multiple dysregulated behaviors (and/or the potential for multiple behaviors).

MMT also incorporates key principles and techniques of DBT and ACT (a balance of acceptance and change, as well as a focus on long-term values); however, MMT is also distinct from these treatments. MMT is a focused treatment specifically aimed at reducing dysregulated behaviors that interfere with clients' lives. All sessions and exercises involve mindfulness, and the brief added focus on mindful emotion regulation and communication is aimed primarily at decreasing dysregulated behaviors and relapse. Further, MMT includes formal, audio-guided mindfulness practices (as opposed to informal practices in DBT and ACT), a simpler range of skills and processes, and more structured home assignments.

In contrast, DBT and ACT are both comprehensive treatments. DBT was developed to alleviate suicidal behaviors and other symptoms related to borderline personality disorder. Although DBT has been adapted to target additional dysregulated behaviors (Dimeff & Koerner, 2007), these adaptations are largely comprehensive treatments that include individual therapy, group therapy, between-session coaching calls, and therapists' consultation groups. Further, DBT skills training spends equal time on mindfulness, distress tolerance, emotion regulation, and interpersonal skills. ACT is also a comprehensive treatment that has been used to treat full diagnoses or spectrums of dysfunction. It involves six interconnected therapeutic processes (the hexaflex) and is based on a theory of the relation of language to acquired stimuli.

Thus, DBT or ACT may be the clear choices when a therapist's primary goal is to provide comprehensive treatment for suicidal behaviors, borderline personality disorder, or the disorders targeted in ACT treatment manuals (e.g., anxiety, depression, chronic pain, etc.). In contrast, MMT may offer advantages when targeting dysregulated behavior is a primary goal. MMT focuses on core interventions specifically designed to target dysregulated behavior. Compared to DBT and ACT, these core interventions can be less costly, less time-consuming, and more accessible for therapists to learn and gain expertise. Treatment implementation can also be more time and cost efficient, and MMT's less complex skills were designed to be simpler for clients to learn and master. (For further information comparing MMT to mindfulness-based treatments, DBT, and ACT, see Wupperman et al., 2012, 2015.)

Copyright © 2019 The Guilford Press

> This book is written for mental health professionals, regardless of whether they describe themselves as psychologists, therapists, counselors, clinicians, social workers, psychiatrists, or any other mental-health-related label. Although this book uses the term *therapist,* feel free to mentally substitute the label with which you identify, and feel free to mentally substitute *counseling* for *therapy* if that term feels more relevant to you.

Basic Description of MMT

MMT helps clients (1) clarify life values and (2) develop the capability to experience the moment—including negative emotions, thoughts, and urges—without engaging in dysregulated behaviors. MMT also targets risk factors for dysregulated behavior, such as difficulty living

according to personal values, lack of pleasurable/fulfilling life experiences, difficulty with basic regulation of emotions, and problems with relationships/lack of social support.

The primary evidence for MMT is the simple fact that it systematically integrates relevant components from evidence-supported interventions for dysregulated behavior. MMT thus allows therapists to implement evidence-based principles and techniques in a cohesive protocol that is strategic, efficient, and focused.

In addition, preliminary studies of MMT's systematic integration have been conducted in four small trials and in multiple case studies. Results have shown significant decreases in a range of dysregulated behaviors. Trials have focused on (1) women court-referred for alcohol abuse and aggression (Wupperman et al., 2012), (2) adults self-referred for drug/alcohol problems and anger issues (Wupperman et al., 2015), (3) community and college adults self-referred for binge eating and depressive symptoms (Wupperman, Burns, Edwards, Pugach, & Spada, 2019a), and (4) adults with mild psychotic and/or manic features who were self-referred for opioid addiction (Wupperman, Burns, Pugach, & Edwards, 2019b). All effect sizes were large, and retention rates were consistently greater than 80%. In addition, clinical case studies of MMT for men and women of varied socioeconomic backgrounds have shown decreases in combinations of trichotillomania, smoking, bulimic episodes, compulsive checking behavior, shopping/spending, alcohol abuse, anger outbursts, computer gaming, general avoidant behaviors, and obsessively texting romantic interests (Wupperman, Burns, Spada, Pugach, & Shapiro, 2018). Thus, although the studies have been small and have not yet included a randomized controlled trial, these results—combined with MMT's integration of empirically supported methods—provide a promising evidence base. Additionally, larger trials are also scheduled.

Finally, clients in all studies tended to rate MMT as highly helpful (average ratings of 8.67–9.62 on a scale of 1–10) and reported more than 80% confidence that they would continue practicing at least some of the skills after treatment ended.

Although MMT has most often been conducted in weekly individual sessions, the frequency and format of sessions can be customized based on needs of clients and clinics. Initial sessions focus on building rapport, enhancing motivation, identifying the client's values, and improving the client's ability to mindfully experience neutral stimuli (e.g., physical sensations) without reacting to them reflexively. In later sessions, clients visualize upsetting situations and purposely experience the resulting emotions, thoughts, and urges without engaging in habitual reactions.

Ensuing sessions continue to include these elements, while also targeting issues relevant to individuals with dysregulated behaviors, including (1) mindful regulation of emotions; (2) mindful communication, understanding of others, and refusal skills; and (3) integration and generalization. After the first five sessions, therapists are encouraged to modify the order of session topics to best meet the needs of the client.

Mindfulness and related skills are taught and practiced in every session; in addition, home assignments include:

- Guided audio practices (6–15 minutes; 5 times weekly),
- Daily informal practice (average 2–3 minutes),
- Daily Log of emotions, urges, and dysregulated behaviors, and
- Further assignments that broaden daily practices.

Copyright © 2019 The Guilford Press

Daily Logs and other assignments are reviewed at the beginning of each session. If necessary, the therapist nonjudgmentally helps the client recognize antecedents to lapse(s), recommit to treatment goals, and rehearse future coping. Along with the focus on mindfulness and skills training, MMT also includes a strong focus on the therapeutic relationship, with active reflection and affirmation throughout treatment.

Suggested Session Structure: Brief Outline

The following suggested structure applies to the second session and forward. The timelines can be somewhat flexible to allow you to modify sessions based on the client's needs.

- First 20 minutes: Greet the client and review the previous week.
  - Listen to the client's experiences and concerns; show the client that you are interested in him or her as a human being.
  - Review and discuss the Daily Log and home practice.
  - Address any issues with home practice and/or target behavior.
- Next 20–25 minutes: Introduce and discuss the current session topic.
  - Customize your explanation to fit the client's needs, values, and concerns.
  - Conduct relevant mindfulness/experiential exercise.
  - Discuss the client's understanding of and reactions to the topic.
  - Assign the home practice for the upcoming week.
- Last 5 minutes: Conduct any additional planning for the upcoming week and wrap up the session.

This book is written to be practice-focused and selectively manualized. It offers a framework for treatment, while also providing guidance on how you can tailor MMT to fit the needs of your clients and settings. In other words, MMT is not a cookie-cutter therapy. Your clinical skills and expertise are not just important; they are essential.

Depending on need, MMT can be:

1. Delivered on its own for clients who primarily need help decreasing dysregulated behavior,
2. Delivered as a "first step" treatment to decrease dysregulated (and treatment-interfering) behaviors prior to further treatment (e.g., for trauma), or
3. Integrated with treatments for disorders comorbid with dysregulated behavior (e.g., social anxiety), which might decrease co-occurring and future dysregulated behaviors.

Upcoming chapters guide you in selecting and implementing MMT components in order to customize the treatment for the specific dysregulated behavior(s), values, and needs of each client. You will also be instructed on delivering MMT in individual or group sessions.

Copyright © 2019 The Guilford Press

This book provides:

1. Several hypothetical case examples and vignettes, as well as examples of dialogues from therapy sessions that cover common experiences (e.g., what to say when a client doesn't complete home practice).
2. Weekly therapist guidelines and client handouts/worksheets. The handouts/worksheets are also available on the publisher's website to download and print (see the box at the end of the table of contents). Since MMT is transdiagnostic, the handouts/worksheets use the term *target behavior* for the dysregulated behaviors. You are encouraged to download and customize the documents to fit each client's specific behavior.
3. Audios for all guided mindfulness practices, with instructions on sharing the files with your clients (see the box at the end of the table of contents).

Important note: If you are a mental health professional, you are probably pressed for time, so you may feel tempted to skim through this book as fast as possible. *Please remember that it is crucial for you to read Chapters 2–7 (on the basic MMT strategies and general guidelines) before moving to the detailed session descriptions that begin in Chapter 8.* (Thank you for your patience in reading these reminders.)

Chapter Summary

- Dysregulated behaviors provide short-term relief or pleasure, but lead to negative consequences over time. Persons who routinely engage in dysregulated behavior tend to have extreme difficulty resisting the behavior, even when they know it is causing harm.
- MMT is a transdiagnostic therapy that integrates evidence-supported methods for addressing (1) multiple dysregulated behaviors, (2) "replacement" dysregulated behaviors, and (3) broad constructs that underlie and contribute to this spectrum of behaviors. MMT also specifically targets the related clinical issues of low motivation, problems with engagement, and frequent dropout, as well as high relapse rates.
- The overriding purpose of MMT is to help each client (1) take steps toward a life that feels more satisfying and fulfilling, and (2) overcome any dysregulated behavior that interferes with moving toward such a life.

Copyright © 2019 The Guilford Press

Copyright © 2019 The Guilford Press.
No part of this text may be reproduced, translated, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, microfilming, recording, or otherwise, without written permission from the publisher.
Purchase this book now: www.guilford.com/p/wupperman

Guilford Publications
370 Seventh Avenue
New York, NY 10001
212-431-9800
800-365-7006
www.guilford.com