Dialectical Behavior Therapy for Substance Abusers

Dialectical behavior therapy (DBT) is a well-established treatment for individuals with multiple and severe psychosocial disorders, including those who are chronically suicidal. Because many such patients have substance use disorders (SUDs), the authors developed DBT for Substance Abusers, which incorporates concepts and modalities designed to promote abstinence and to reduce the length and adverse impact of relapses. Among these are dialectical abstinence, "clear mind," and attachment strategies that include off-site counseling as well as active attempts to find patients who miss sessions. Several randomized clinical trials have found that DBT for Substance Abusers decreased substance abuse in patients with borderline personality disorder. The treatment also may be helpful for patients who have other severe disorders co-occurring with SUDs or who have not responded to other evidence-based SUD therapies.

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Developed by coauthor Dr. Marsha M. Linehan, dialectical behavior therapy (DBT) is a comprehensive treatment program whose ultimate goal is to aid patients in their efforts to build a life worth living. When DBT is successful, the patient learns to envision, articulate, pursue, and sustain goals that are independent of his or her history of out-of-control behavior, including substance abuse, and is better able to grapple with life's ordinary problems. DBT's emphasis on building a life worth living is a broader therapeutic goal than reduction in problem behaviors, symptom management, or palliative care.

The word *dialectic* refers to the synthesis of two opposites. The fundamental principle of DBT is to create a dynamic that promotes two opposed goals for patients: change and acceptance. This conceptual framing evolved in response to a dilemma that arose in the course of trying to develop an effective treatment for suicidal patients.

Dr. Linehan's basic premise for DBT was that people who wanted to be dead did not have the requisite skills to solve the problems that were causing their profound suffering and build a life worth living. However, a sole emphasis on promoting behavioral change quickly proved unworkable. Many patients were exquisitely sensitive to criticism; when prompted to change, they responded by shutting down emotionally or by exhibiting increased, sometimes overwhelming emotional arousal—for example, storming out of sessions or, occasionally, even attacking the therapist. At the same time, dropping the emphasis on change and instead encouraging patients to accept and tolerate situations and feelings that distressed them produced equally negative consequences. Patients then viewed their thera-

pist as ignoring or minimizing their suffering and responded with extreme rage or fell into a sea of hopelessness.

In short, patients experienced both promptings for acceptance and promptings for change as invalidating their needs and their experience as a whole, with predictable consequences of emotional and cognitive dysregulation and failure to process new information. To surmount this dilemma—to keep the suicidal patient in the room and working productively—DBT incorporates a dialectic that unites change and acceptance. The treatment balances the patient's desire to eliminate all painful experiences (including life itself) with a corresponding effort to accept life's inevitable pain. Without this synthesis, the patient's problems tended to converge and overwhelm both patient and therapist; with it, the patient can work on changing one set of problems while tolerating—at least temporarily—the pain evoked by other problems.

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The treatment of severe disorders requires the synthesis of many dialectical polarities, but that of acceptance and change is the most fundamental. The simultaneous embrace of acceptance and change in DBT is consistent with the philosophical approach found in Twelve-Step programs, expressed in the Serenity Prayer: "God, grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference."

The spirit of a dialectical point of view is never to accept a proposition as a final truth or indisputable fact. In the context of therapeutic dialogue, *dialectic* refers to bringing about change by persuasion and to making strategic use of oppositions that emerge within therapy and the therapeutic relationship. In the search for the validity or truth contained within each contradictory position, new meanings emerge, thus moving the patient and therapist closer to the essence of the subject under consideration. The patient and therapist regularly ask, "What haven't we considered?" or "What is the synthesis between these two positions?"

DBT OVERVIEW AND PROCEDURES

Dr. Linehan developed DBT as an application of the standard behavioral therapy of the 1970s to treat chronically suicidal individuals (Linehan, 1987, 1993*a*, 1993*b*). Subsequently, it was adapted for use with individuals with both severe substance use disorder (SUD) and borderline personality disorder (BPD), one of the most common dual diagnoses in substance abuse and mental health clinical practice. The co-occurrence of SUD and BPD causes severe emotional dysregulation, increases the probability of poor treatment outcomes, and increases the risk of suicide. DBT includes explicit strategies for overcoming some of the most difficult problems that complicate treatment of both conditions, including weak treatment engagement and retention.

The patient's individual therapist is the primary treatment provider in DBT. He or she takes ultimate responsibility for developing and maintaining the treatment plan for the patient.

The treatment includes five essential functions:

- improving patient motivation to change,
- enhancing patient capabilities,
- generalizing new behaviors,
- structuring the environment, and
- enhancing therapist capability and motivation.

In outpatient therapy, these functions are delivered via four treatment modes: individual therapy, group skills training, telephone consultation, and therapy for the therapist.

Like other behavioral approaches, DBT classifies behavioral targets hierarchically. The DBT target hierarchy is to decrease behaviors that are imminently life-threatening (e.g., suicidal or homicidal); reduce behaviors that interfere with therapy (e.g., arriving late or not attending therapy, being inattentive or intoxicated during the session, or dissociating during the session); reduce behaviors with consequences that degrade the quality of life (e.g., homelessness, probation, Axis I behavioral problems, or domestic violence); and increase behavioral skills. In any given session, a DBT therapist will pursue a number of these targets but will place the greatest emphasis on the highest order problem behavior manifested by the patient during the past week.

For substance-dependent individuals, substance abuse is the highest order DBT target within the category of behaviors that interfere with quality of life. DBT's substance-abuse–specific behavioral targets include:

- decreasing abuse of substances, including illicit drugs and legally prescribed drugs taken in a manner not prescribed;
- alleviating physical discomfort associated with abstinence and/or withdrawal;
- diminishing urges, cravings, and temptations to abuse;
- avoiding opportunities and cues to abuse, for example by burning bridges to persons, places, and things associated with drug abuse and by destroying the telephone numbers of drug contacts, getting a new telephone number, and throwing away drug paraphernalia;

- reducing behaviors conducive to drug abuse, such as momentarily giving up the goal to get off drugs and instead functioning as if the use of drugs cannot be avoided; and
- increasing community reinforcement of healthy behaviors, such as fostering the development of new friends, rekindling old friendships, pursuing social/vocational activities, and seeking environments that support abstinence and punish behaviors related to drug abuse.

THE DIALECTICAL APPROACH TO ABSTINENCE

In the quest for abstinence, the DBT dialectic takes the form of pushing for immediate and permanent cessation of drug abuse (i.e., change), while also inculcating the fact that a relapse, should it occur, does not mean that the patient or the therapy cannot achieve the desired result (i.e., acceptance). The dialectical approach therefore joins unrelenting insistence on total abstinence with nonjudgmental, problem-solving responses to relapse that include techniques to reduce the dangers of overdose, infection, and other adverse consequences.

Establishing Abstinence Through Promoting Change

The therapist communicates the expectation of abstinence in the very first DBT session by asking the patient to commit to stop using drugs immediately. Because a lifetime of abstinence may seem out of reach, the therapist encourages the patient to commit to a length of abstinence that the patient feels certain is attainable—a day, a month, or just 5 minutes. At the end of this period, the patient renews the commitment, again for a sure interval. Ultimately, he or she achieves long-term, stable abstinence by piecing together successive delimited drug-free periods. The Twelve Steps slogan, "Just for Today," invokes the same cognitive strategy to reach the same goal—a lifetime of abstinence achieved moment by moment.

A second absolute abstinence strategy teaches patients to "cope ahead" (Linehan, in press). The patient learns the behavioral skill of anticipating potential cues in the coming moments, hours, and days, and then proactively preparing responses to high-risk situations that otherwise might imperil abstinence. Additionally, the therapist presses the patient to burn the bridges to his or her drug-abusing past—for example, to get a new telephone number, tell drug-abusing friends that he or she is off drugs, and throw out drug paraphernalia. Woven throughout the absolute abstinence pole of the dialectic is the clear message that the use of drugs would be disastrous and must be avoided.

Supporting Abstinence by Encouraging Acceptance

DBT treats a lapse into substance abuse as a problem to solve, rather than as evidence of patient inadequacy or treatment failure. When a patient does slip, the therapist shifts rapidly to helping the patient *fail well*—that is, the therapist guides the patient in making a behavioral analysis of the events that led to and followed drug use, and gleaning all that can be learned and applied

PREVALENCE AND CONSEQUENCES OF SUD-BPD COMORBIDITY

In studies published between 1986 and 1997, reported rates of borderline personality disorder (BPD) among patients seeking treatment for substance use disorders (SUDs) ranged widely, from 5 to 65 percent (Trull et al., 2000). More recently, Darke and colleagues (2004) documented a 42 percent prevalence of BPD among 615 heroin abusers in Sydney, Australia. Conversely, in Trull's review, the prevalence of current SUDs among patients receiving treatment for BPD ranged from approximately 26 to 84 percent.

That SUD and BPD should frequently co-occur stands to reason, because substance abuse is one of the potentially self-damaging impulsive behaviors that constitute diagnostic criteria for the personality disorder. However, this overlap in criteria cannot account for the full extent of the comorbidity. For example, Dulit and colleagues (1990) found that, among study participants with SUDs, 85 percent of those who also met the criteria for BPD would still have done so because of symptoms unrelated to substance abuse.

Individuals with SUD and BPD are among the most difficult patients to treat for either condition, and they have more problems than those with only one or the other (Links et al., 1995). For example, rates of suicide and suicide attempts, already high among substance abusers (Beautrais, Joyce, and Mulder, 1999; Links et al., 1995; Rossow and Lauritzen, 1999) and individuals with BPD (Frances, Fyer, and Clarkin, 1986; Stone, Hurt, and Stone, 1987), are even higher for those with both disorders (Rossow and Lauritzen, 1999). Substance-abusing patients have significantly more behavioral, legal, and medical problems, including alcoholism and depression, and are more extensively involved in substance abuse if they also have a personality disorder (Cacciola et al., 1995, 2001; McKay et al., 2000; Nace, Davis, and Gaspari, 1991; Rutherford, Cacciola, and Alterman, 1994). Results from one study suggest, further, that patients with BPD have more severe psychiatric problems than patients with other personality disorders (Kosten, Kosten, and Rounsaville, 1989). In a 6-year study with 290 BPD patients, Zanarini and colleagues (2004) found that the co-occurrence of an SUD was the factor most closely associated with poor treatment outcomes.

to future situations. Additionally, the therapist helps the patient make a quick recovery from the lapse. This stance and procedure correspond to Marlatt's paradigm of "prolapse" to alleviate the abstinence violation effect (AVE; Marlatt and Donovan, 2005) by mitigating the intense negative emotions and thoughts that many patients feel after a lapse and that can hinder reestablishing abstinence ("What's the point? I've already blown it. I might as well really go for it.").

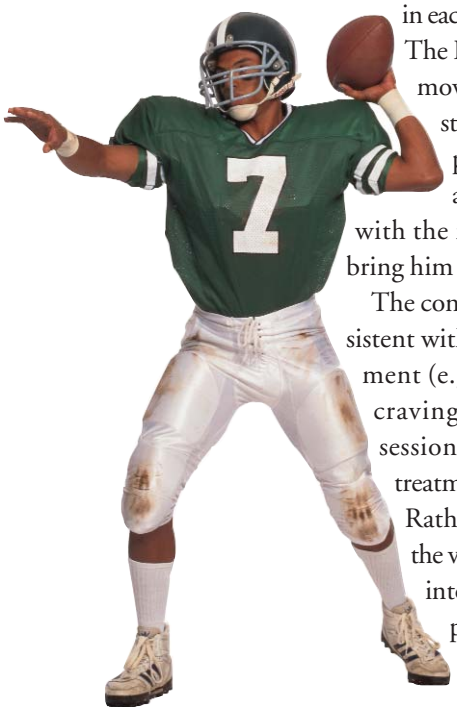
The idea of failing well also involves repairing the harm done to oneself and others during the lapse. This concept is similar to making amends in Steps Eight and Nine of Twelve Steps (Alcoholics Anonymous, 2006) and serves two functions:

- increasing awareness and memory of the negative consequences when the person uses drugs, and
- directly treating a component of AVE, namely, justified guilt.

Once the individual has resumed abstinence, the therapist moves back to the opposite (absolute abstinence) pole. Failing well may be particularly important for individuals who have BPD as well as SUD, given their susceptibility to dysregulated emotion.

Further Comments on Dialectical Abstinence

The process of dialectical abstinence can be compared to the actions of a quarterback in football. The quarterback focuses constantly on the ultimate goal of scoring a touchdown, even if only a few yards are gained in each play and even if ground is lost. The DBT therapist, likewise, always moves the patient toward the goal, stops only long enough to get the patient back on his or her feet after a fall, and is always ready with the next play that will eventually bring him or her to the goal line.



The conceptual basis of DBT is inconsistent with making the benefits of treatment (e.g., receipt of prescribed anticraving medications, attendance at sessions, continued participation in treatment) contingent on abstinence. Rather than punishing patients for the very problems that brought them into treatment, DBT assumes that patients are doing the best they can and must continue working to achieve their goals.

A common misunderstanding involves the scope of abstinence required in DBT. Many Twelve-Step programs require complete abstinence from all psychoactive substances—not only illicit and misused addictive substances or alcohol, but also prescribed medications. In DBT, the counselor determines the scope of abstinence appropriate for each patient based on a thorough assessment and three ruling principles:

- Target the primary drug(s) of abuse—that is, those that are causing the most significant problems for the patient, as determined by the patient's history of abuse, and diagnostic and behavioral assessments.
- Target other drugs that appear to reliably precipitate use of the primary drug of abuse—for example, some patients may not use marijuana frequently but may end up injecting their primary drug of abuse, heroin, every time they do.
- Make sure that the treatment goals are, in fact, attainable.

With regard to the third principle, patients with SUD and BPD typically have myriad problem behaviors, including self-injurious and suicidal behaviors, in addition to those associated with drug abuse. Pragmatically, there is only so much that a severely disordered patient can be expected to change at one time. For example, DBT may not target a patient's drinking, even if consumption of alcohol exceeds recommended guidelines, unless (i) the patient states an explicit interest in stopping alcohol use; (ii) alcohol is the primary drug causing the individual's problems; or (iii) alcohol is reliably associated with use of the primary drug of choice or another higher order target—for example, if the patient attempts suicide only when drunk.

Patients with SUD typically begin DBT in a mental and behavioral state that we call "addict mind." Their thoughts, beliefs, actions, and emotions are under the control of drugs. As they achieve increasingly lengthy abstinence, they typically develop an outlook that we call "clean mind." In this state, they are off drugs but seemingly feel immune from future problems—a lack of vigilance that can set the stage for lapses. The alternation between addict mind and clean mind constitutes a dialectic that leads to the emergence, during the process of dialectical abstinence seeking, of a third state called "clear mind." Now, the individual enjoys abstinence while remaining fully aware of the nearness and tendencies of that addict mind; he or she is vigilant and takes measures to avoid or cope with the circumstances that can—in a moment—restore addict mind.

DBT STRATEGIES FOR ATTACHMENT

Drug-abusing individuals are often difficult to draw into treatment. Although some attach easily to their treatment providers, others behave like butterflies, flying frequently into and out of the therapist's hand and departing just at the very moment when the therapist believes they have landed for good (Linehan, 1993*a*). Common butterfly problems include episodic engagement in therapy, failure to return telephone calls or participate in sessions, and ultimately early termination from treatment. Additionally, the therapist has relatively little power to persuade butterfly patients to do things they prefer not to do.

DBT employs a number of strategies to engage treatment butterflies. These strategies increase the positive valence of therapy and the therapist, re-engage "lost" patients, and prevent the deleterious consequences that commonly occur during periods when patients fall out of contact with their therapist. Until an attachment is secured and the substance-dependent individual is out of significant danger of relapse, DBT therapists are active in finding lost patients and re-engaging them in treatment.

Beginning in the first therapy session, the therapist orients the patient to the butterfly attachment problem, and the two discuss the likelihood that the patient may fall out of contact with the therapist during the course of treatment. A "just in case" plan is established: The patient makes a list of all the places the therapist might look should the patient become lost (e.g., addresses and telephone numbers for drug-abusing friends, places where the patient goes to abuse drugs), as well as supportive family and friends who can be counted on to help the therapist and patient in this event. Other strategies include increasing contact with the patient during the first several months of treatment (e.g., scheduling check-in telephone calls between sessions, exchanging voice mail or e-mail messages); bringing therapy to the patient—that is, conducting sessions at his or her home, in a park, in a car, or at a diner; and shortening or lengthening therapy sessions.