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## 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-

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apist 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.

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 through-

## 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.

out 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 gleaned all that can be learned and applied

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 "pro-lapse" 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 anti-craving medications, attendance at sessions, continued participation in treatment) contingent on abstinence.

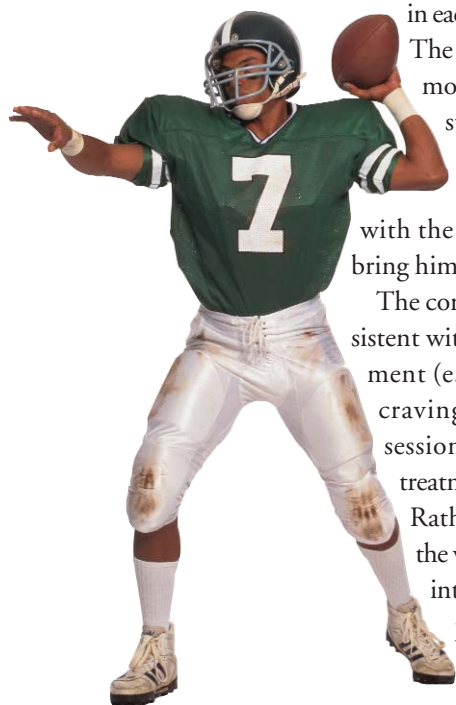
Rather than punishing patients for the very problems that brought them into treatment, DBT assumes that patients are doing the best they can and must continue working to achieve their goals.

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.

## CLINICAL TRIALS OF DBT

The adaptation of DBT to patients with SUD and BPD represents a natural extension of the therapy, in light of the comorbidity's frequent and often synergistic threat to life (see *Prevalence and Consequences of SUD-BPD Comorbidity*). The adaptation was designed for a population of individuals with SUD that is largely heteroge-



neous across drugs of abuse and demographic variables.

To date, nine published randomized controlled trials (RCTs) conducted across five research institutions have evaluated DBT. The results support DBT's efficacy in reducing a number of behavioral problems, including suicide attempts and self-injurious behaviors (Koons et al., 2001; Linehan et al., 1991, 2006; Linehan, Heard, and Armstrong, 1993; van den Bosch et al.,



2005; Verheul et al., 2003), substance abuse (Linehan et al., 1999, 2002), bulimia (Safer, Telch, and Agras, 2001), binge eating (Telch, Agras, and Linehan, 2001), and depression in the elderly (Lynch et al., 2003). These and other studies have also demonstrated that DBT is

### IS DBT APPROPRIATE FOR PATIENTS WITH SUD BUT NOT BPD?

Pending clinical efficacy trials, we suggest considering a few basic principles in deciding whether to intervene with dialectical behavioral therapy (DBT) when substance-abusing patients do not have comorbid borderline personality disorder (BPD). First, be guided by what is known from the empirical literature. Is there a treatment already proven for the patient's particular problem or problems? Second, be parsimonious. All things being equal, consider beginning with a less complex and comprehensive treatment than DBT. Although DBT contains elements that doubtless will be therapeutic for most patients, it is also likely to be considerably more extensive than most patients with a substance use disorder (SUD) require. Third, consider the extent to which emotional dysregulation plays a role in the individual's continued use of drugs. As DBT was developed specifically for individuals with pervasive emotional dysregulation, DBT may be a good fit for people whose use of drugs is associated with affective dyscontrol. DBT may be ineffective for individuals with whom emotions play little, if any, role in their sustained use of drugs.

On the other hand, given that DBT was developed for a population of difficult-to-treat patients with multiple Axis I and Axis II problems, it may be a reasonable approach for the non-BPD multidagnostic SUD patient who has failed on multiple occasions in other evidence-based SUD therapies. DBT may also be a reasonable first-line treatment for individuals who are substance dependent and chronically suicidal but do not meet criteria for BPD.

The case of "Lucy" illustrates the kind of non-BPD patient who may benefit from DBT. An opiate-dependent woman in her mid-30s, Lucy has been repeatedly discharged from a community methadone maintenance program because of drug-positive urinalyses and problems with attendance. In addition to meeting criteria for opiate dependence, Lucy has had multiple episodes of major depression and is currently living with an abusive partner who is not interested in quitting his own use of drugs. A careful behavioral analysis highlights the central role of emotional dyscontrol resulting in her frequent use of drugs (often before having sex with her boyfriend; after an argument with him; or as a way to escape negative emotions, including sadness). Although Lucy does not meet the full criteria for treatment with BPD, the intervention may still be warranted because many of her problems are rooted in emotional dyscontrol.

more cost-effective than treatment as usual in reducing the medical severity of suicide attempts, hospitalization, emergency room visits, and utilization of crisis/respite beds (American Psychiatric Association, 1998; Linehan and Heard, 1999).

Two of the RCTs focused specifically on the application of DBT for individuals with SUD and BPD. Both were conducted by Dr. Linehan and colleagues at the University of Washington (Linehan et al., 1999, 2002).

The majority of participants were polysubstance-dependent with extensive histories of substance abuse and unsuccessful attempts at abstaining from drugs prior to beginning DBT. Comprehensive DBT that included all modes and functions was provided in both trials across a 12-month course of treatment. In each trial, the assessment phase spanned a total of 24 months, from pretreatment through a year following treatment completion. The initial RCT compared DBT ( $n = 12$ ) with community-based treatment as usual ( $n = 16$ ) among polysubstance-dependent women with BPD (Linehan et al., 1999). Those who received DBT were significantly more likely to remain in treatment (64 versus 27 percent), achieved greater reductions in drug abuse as measured by structured interviews and urinalyses throughout the treatment year, and attended more individual therapy sessions than subjects receiving treatment as usual. Additionally, although trial participants in both conditions improved in social and global adjustment during the treatment year, only DBT subjects sustained these improvements at the 16-month followup.

The second trial involved 23 opiate-dependent individuals with BPD and used a more rigorous control condition, comprehensive validation therapy with Twelve Steps (CVT+12). This CVT + Twelve Steps is a manualized approach that includes the major acceptance-based strategies used in DBT in combination with participation in a Twelve-Step program, such as that used in Narcotics Anonymous (NA). Therapists focused on validating the patient in a warm and supportive atmosphere—providing, of course, that the behavior was effective in terms of the patient's long-term goals. Subjects in the CVT +12 arm of the study were required to attend at least one NA meeting weekly, conducted at the treatment clinic and facilitated by the therapists, both of whom were members of NA. All subjects took levomethadyl (ORLAAM, which is no longer available in Europe or the United States), an opiate replacement medication, throughout the treatment year and continued to receive it post-treatment.

Three major findings emerged from this study. First, although both treatments were associated with urinalysis-confirmed reductions in opiate abuse, only DBT subjects maintained these reductions during the last 4 months of treatment. Second, both treatments retained subjects in treatment, but CVT + 12 was exceptionally effective in doing so (100 versus 64 percent in DBT). Finally, both post-treatment and at the 16-month followup assessment, subjects in both treatment conditions

showed overall reductions in levels of psychopathology relative to baseline.

Clearly, further studies are required to confirm the efficacy of DBT for individuals with SUD and BPD. However, the data thus far are promising, and additional research/clinical trials are under way.

To date, no clinical trials have evaluated DBT for patients with SUD but not BPD. However, we believe that certain circumstances and considerations may justify its use for the treatment of SUD patients who have other severe co-occurring psychosocial problems and/or have failed to respond to other SUD therapies (see *Is DBT Appropriate for Patients With SUD But Not BPD?*).

### TREATMENT FIDELITY AND CLINICAL OUTCOMES

To date, two published studies have evaluated the relationship of DBT fidelity to treatment outcome; both confirm the importance of program fidelity and clinical adherence to the treatment manual. The first study (Linehan, 1993a) was an RCT designed to address the question: Can DBT skills training, when separated from the other modes and functions of DBT, be beneficial? Chronically suicidal individuals with BPD receiving outpatient non-DBT individual therapy were randomly assigned to receive either DBT skills training ( $n = 11$ ) or a wait list control ( $n = 8$ ). After 12 months of treatment, while subjects in both conditions improved over time, no significant differences between conditions were detected in any outcome variables, including suicidal and nonsuicidal self-injurious behavior, lethality of suicide attempts, emergency room visits, and inpatient hospital admissions. Additionally, the analysis did not suggest that the failure to detect a difference between conditions was due to the small sample size.

Although subjects from this sample were not substance-dependent, there is no reason to expect the findings would differ among those who are. This study clearly indicates that providing pieces of DBT separated from the comprehensive model does not improve clinical outcomes for chronically suicidal BPD patients already engaged in non-DBT therapy. What is not known is whether DBT skills training alone, when compared with no treatment or less treatment (e.g., periodic case management), would be of benefit. Given the strength of current data on comprehensive DBT for patients with severe BPD, the absence of data supporting a “lighter” version of DBT, and the high-risk nature of the patient

population, it is advisable to preserve the treatment’s integrity.

A second RCT by Dr. Linehan and colleagues (2002) examined the relationship of DBT treatment adherence to a key clinical outcome—drug-free urinalyses—in substance-dependent individuals with BPD. In comparison with patients assigned to non-DBT-adherent therapists ( $n = 3$ ), patients of therapists who adhered to the treatment manual ( $n = 4$ ) had significantly more drug-free urinalyses throughout the treatment year ( $F = 5.71$ ;  $P > 0.038$ ) and at the 12-month post-treatment assessment ( $F = 9.6$ ;  $P > 0.018$ ). In other words, sticking to the manual (adhering to the treatment at all turns) improves clinical outcomes.

### COST-EFFECTIVENESS OF DBT

The highest health care costs associated with BPD are the result of lengthy and repeated psychiatric hospitalizations (Linehan and Heard, 1999). Two studies have been published to date demonstrating that outpatient DBT can yield considerable cost savings for public sector systems (American Psychiatric Association, 1998). In the first RCT of DBT for chronically suicidal patients with BPD, Dr. Linehan and Dr. Heard (1999) found that the treatment saved \$9,000 per patient during the initial treatment year over the cost of treatment as usual. Data from the Mental Health Center of Greater Manchester in New Hampshire also demonstrated significant cost savings and improvements in clinical outcomes in chronically suicidal individuals with BPD (American Psychiatric Association, 1998). Comparison of the psychiatric services used in the year before therapy with those used in the year following therapy by patients ( $n = 14$ ) who completed a year of DBT showed significant decreases in psychiatric service utilization: 77 percent in hospitalization days, 76 percent in partial hospitalization days, 56 percent in crisis beds, and 80 percent in emergency room contacts. Total service costs also fell dramatically: from \$645,000 to \$273,000. We know of no separate studies to date that evaluate cost savings of DBT for a comorbid SUD and BPD patient population.

### DBT MANUALS AND TRAINING

Dr. Linehan’s (1993a) *Cognitive-Behavioral Treatment of Borderline Personality Disorder* provides a comprehensive description of the treatment. *Skills Training Manual for Treating Borderline Personality Disorder* (Linehan, 1993b) describes the skills, strategies for teaching

Data on the efficacy of dialectical behavior therapy for individuals with substance use disorders and borderline personality disorder are promising.

Trainings range from a 2-day introductory workshop to a 10-day intensive program.

them, and topics to discuss in DBT skills training groups. It includes extensive handouts and homework sheets to reproduce for use in the DBT skills training. A forthcoming third manual focuses specifically on the modifications of DBT for substance-dependent individuals with BPD (Linehan, Dimeff, and Sayrs, in press).

An array of DBT educational products and instructor-led training programs are available for the beginner, intermediate, and advanced levels. The trainings range from 2-day introductory workshops to a team-based 10-day intensive program that is conducted in two parts, each 5 days in length, over 6 to 9 months. Developed by Dr. Linehan, the DBT intensive training format provides in-depth knowledge of the content in the first 5 days. Extensive individual and team homework is assigned upon completion of Part I and is intended to guide DBT teams in applying and building a DBT program within their unique settings. During Part II, teams present their DBT program, provide a thorough case presentation, and conduct a role play of work with the patient. Presentations are then critiqued by the trainers for clinical adherence and program fidelity.

A number of self-training methods have been generated to date by Dr. Linehan, Dr. Linda A. Dimeff, and their colleagues. These include five videos/DVDs featuring Dr. Linehan teaching DBT skills to patients, as well as more than 25 hours of in-depth online training in the core DBT curriculum, including DBT skills, behavioral chain analysis, and validation. Information about workshops, intensive training, online training, and other educational products for patients and therapists can be obtained through Behavioral Tech, LLC ([www.behavioraltech.org](http://www.behavioraltech.org)).

## CONCLUSION

The co-occurrence of substance dependence in patients with BPD poses a unique set of risks and challenges for patients and their clinicians. DBT, a treatment originally developed by Dr. Linehan that is efficacious for chronically suicidal patients with BPD, has been adapted for this patient population. Features of the adapted intervention include drug-specific behavioral targets for treatment of problem drug use, a set of attachment strategies for fostering and building a strong therapeutic relationship, and dialectical abstinence—a synthesis of two polar opposite methods for addressing drug abuse. DBT and its adaptation may also be effective for SUD patients with multiple, complex problems rooted in emotional dyscontrol who have not responded to other evidence-based approaches.

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## RESPONSE: INNOVATIONS AND IMPLEMENTATION

Mardell Gavriel, Psy.D.; Suzette Glasner-Edwards, Ph.D.; and Helen Sackler, Ph.D.

**Mardell Gavriel:** At Walden House, we use dialectical behavior therapy (DBT) skills training and strategies with a wide range of clients, although we don't implement the whole package. As we practice it, embracing a dialectic way of thinking means avoiding rigid notions, understanding that it's all right to feel more than one way about something, and being cognitively fluid and creative in one's thinking. The clinician may help the patient connect to both poles of his ambivalence about drugs. On one hand, the client wants recovery and recognizes that drugs have been problematic in his life, and on the other, he has real urges to use because drugs have been his survival strategy for a long time. Both of those rationales are equally true; what the dialectic recognizes is that both can yield useful insights.

**Helen Sackler:** The authors' football analogy illustrating the dialectic (Dimeff and Linehan, 2008) is similar to the way we routinely talk to substance abusers. In the analogy, the quarterback always has the goal of scoring, but he knows he can't score on every play. On most plays, he just has to try to push the ball downfield. To our patients, we say, "What's going to make your life worth living a year, 2 years, 5 years down the road? Keep your eyes on the prize, but work a day at a time."

**Gavriel:** One reason the DBT model has been fairly easy to implement in substance abuse treatment is that, philosophically, it integrates well with other existing models. To a great extent, the DBT skills are the same ones that underlie many of the cur-

ricula that are traditionally taught in substance abuse treatment—stress tolerance, emotional regulation, relapse prevention, and so on. Staffers find that DBT training reinforces and promotes their ability to do what they are already aiming for, which is to try to maintain a balance between accepting each client where he or she is and pushing for change.

**Suzette Glasner-Edwards:** DBT overlaps greatly with other cognitive-behavioral and relapse prevention therapeutic approaches. Where it stands out and is innovative is in its conceptual framing and the emphasis it puts on some issues. DBT's handling of engagement issues and treatment dropouts seems fairly intuitive, for example, but it is distinctive because it is so direct and up



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