Dialectical Behavior Therapy for Patients Dually Diagnosed With Borderline Personality Disorder and Substance Use Disorders

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With its focus on both behavior modification and mindfulness training, dialectical behavior therapy has proven quite effective in treating patients with borderline personality disorder. This article provides a primer on a modified version of this outpatient treatment for borderline patients with substance use disorders, a comorbid condition that may affect as many as two-thirds of patients with BPD.

Originally developed and empirically supported as an outpatient treatment for borderline personality disorder (BPD) (Linehan, 1993a, 1993b; Linehan et al., 1991), dialectical behavior therapy (DBT) recently has been adapted for adults with BPD and comorbid substance use disorders (SUDs) (Linehan et al., 2002, 1999). This modified treatment, DBT-SUD, has shown promise in two small randomized controlled trials and is currently being tested in a two-site study (University of Washington and Duke University Medical Center) funded by the National Institute of Drug Abuse (NIDA). The purpose of this paper is to provide a primer on the basics of DBT-SUD. For more comprehensive descriptions of DBT-SUD, the interested reader is referred to the treatment manual (Linehan 1993b), treatment outcome studies (Linehan et al., 2002, 1999), online resources for DBT-SUD training <www.behavioraltech.org> or book chapters on DBT-SUD (Rosenthal et al., 2005).

Dialectical behavior therapy for adults with BPD and comorbid SUDs was developed, in part, out of recognition that individuals with BPD often have problems with substance abuse, and that up to two-thirds of those diagnosed with SUD also meet diagnostic criteria for BPD (Dulit et al., 1990). In addition, there may be common etiological and maintaining factors across BPD and SUD, such as difficulties with the regulation of emotional experience and expression, as well as impulsivity (Bornovalova et al., 2005; Trull et al., 2001). Clinicians are faced with an enormous challenge when treating individuals with co-occurring BPD and SUD. Compared to those with BPD only, those with BPD and SUDs may show more severe psychopathology, including greater anxiety and suicide attempts (van den Bosch et al., 2001). It is unclear whether standard drug counseling approaches common in the substance abuse treatment community (e.g., 12-step) are efficacious for these difficult-to-treat patients. However, guidelines for implementing treatments for dually diagnosed patients have been articulated (Drake et al., 2001), and such treatments have been developed for individuals with both SUD and schizophrenia, antisocial personality disorder, and a history of interpersonal victimization, for example (Barrowclough et al., 2001; Drake et al., 1993; Messina et al., 1999; Najavits et al., 1998). In line with the hypothesis that a specifically tailored treatment may be appropriate for this population, and following NIDA guidelines for psychosocial treatment development, Linehan and colleagues developed DBT-SUD (unpublished data).

Like standard DBT, the modified version of this outpatient treatment is a blend of change (e.g., behavior therapy) and acceptance (e.g., mindfulness training) approaches woven together by a set of philosophical assumptions, a biosocial theory and multiple modes of treatment (e.g., individual therapy, group skills training, pharmacotherapy). On the one hand, as a behavioral treatment, DBT-SUD relentlessly pursues changing a range of maladaptive behaviors using standard behavioral principles and procedures (e.g., contingency management, shaping, stimulus control). On the other hand, as an acceptance-based treatment, DBT-SUD provides an unwavering emphasis on patient validation, mindfulness skills, and an underlying assumption, that, in some moments of life, efforts to change what inherently cannot be changed may exacerbate problems, rather than solve them. Instead of monochromatically being change- or acceptance-focused, the DBT-SUD therapist carefully integrates both behavioral change and acceptance throughout all aspects of treatment. Indeed, the ubiquitous dialectic in DBT is that of acceptance and change. Neither one alone is thought to be sufficient for all problems. Instead, the DBT-SUD therapist constantly is searching for ways to help any given problem using either, or both, change and acceptance strategies. The pragmatic goal is to
identify and implement an optimal solution to each problem that arises in a fluid context, while being completely willing to let go of any solution, as needed, in response to new problems or evidence that any one solution does not appear to be helpful. A balance between acceptance and change is important, but this does not always translate literally into an equal distribution of acceptance and change. Like a skilled athlete adjusting to the weather conditions during a game, the relative proportion of acceptance and change is a function of what appears useful in any given moment.

**Empirical Support**

Two randomized trials examining DBT-SUD have been conducted. In the first study, 28 women diagnosed with BPD and/or SUD were randomly assigned to receive one year of DBT-SUD or treatment as usual (TAU) in the community (Linehan et al., 1999). After treatment, patients receiving DBT-SUD attended significantly more individual psychotherapy sessions, dropped out of treatment less often and had significantly less substance use, as measured via structured interviews and urinary analyses. At 16-month follow-up, patients receiving DBT-SUD reported higher global and social adjustment compared to those receiving TAU.

In the second study, 23 adults with BPD and opioid dependence (all heroin) were randomly assigned to receive either one year of DBT-SUD or a comprehensive treatment that included 12-step meetings (e.g., Narcotics Anonymous/Alcoholics Anonymous) plus individual therapy sessions using a manualized approach based purely in acceptance without direct emphasis on behavioral change (comprehensive validation therapy) (Linehan et al., 2002). All patients concurrently received levomethadyl (Orlaam) as an opiate replacement medication. Patients in both treatment conditions evidenced decreases in drug use and improvements in social and general adjustment following treatment. However, in the last four months of treatment, patients receiving DBT-SUD continued to maintain previous treatment gains, whereas those receiving comprehensive validation had an increase in opiate use. Although a larger follow-up study currently is being conducted to replicate and extend these findings, these preliminary studies taken together suggest that DBT-SUD holds promise as a treatment for substance users with BPD.

**The Basics of DBT**

*Philosophy.* Dialectics in DBT-SUD refers broadly to both a worldview and a process of change. Using a dialectical worldview, the disease, disorder and symptoms are not treated. Instead, patients are considered as whole individuals whose problem behaviors occur in specific contexts. Accordingly, an ongoing and often moving target for the DBT-SUD therapist is to understand the relevant context in which drug use and other problem behavior occurs, in order to better predict and control these behaviors. As a process of change, dialectics refers to the practice of arriving at a working truth for any given moment. For every point (thesis) that is made a counterpoint (antithesis) can be taken, until a synthesis between these oppositional positions emerges that appears to be effective. The synthesis is then examined for what is left out, what may not actually be useful or for likely barriers to implementation.

For example, a patient may state their desire not to talk about a recent lapse in drug use, with a corresponding preference to talk about an event from the past week that is upsetting. If the therapist rigidly insists on talking about the lapse, the patient and therapist may be at an impasse. Instead, the DBT-SUD therapist may look for ways to discuss both the recent lapse and the upsetting event, by searching for threads that connect the two seemingly disparate topics.

Another example of a dialectic is the stance taken in DBT-SUD about whether the best model for substance use is abstinence or harm reduction. Arguably, there are pros and cons to each approach. Rather than uniformly adopting one of these two apparently contradicting models, however, DBT-SUD includes elements of both abstinence and harm reduction approaches, a stance called dialectical abstinence. This refers to the complete and total emphasis on abstinence on the one hand, with, on the other hand, a planned approach in the event of lapse or relapse that is designed to mitigate harm and resume abstinence.

*Biosocial theory.* As is standard DBT, the theoretical model underpinning DBT-SUD includes three primary factors: temperamental emotional vulnerability, the history and/or presence of an invalidating environment(s), and problems with emotional dysregulation. According to Linehan (1993a), individuals with BPD are hypothesized to suffer from biologically mediated (e.g., temperament) problems with emotional vulnerability, whereby these patients respond quickly to a wide range of stimuli (sensitivity). The magnitude of such reactions is high (reactivity), and, once emotionally aroused, it takes a long time to return to previous levels of emotional arousal (slow return to baseline). In addition, individuals with BPD frequently report growing up in and/or currently living in social environments characterized by physical and sexual abuse/neglect, as well as invalidation of internal experiences, such as emotions and thoughts. The biosocial theoretical framework underpinning DBT suggests that the reciprocal and transactional influence of emotional
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Adequate food, housing and employment, case management can be added to DBT-SUD. Unlike DBT-SUD case management choice of medications is guided by controlled efficacy studies. Finally, speed of improvement is specific symptoms are targeted first, rather than general problems, such as impulsivity. Fourth, problems with side effects and drug interactions, both of which can interfere with treatment. Third, small supply of take-home medications. Second, simple medication regimens are used to mitigate pharmacotherapist may observe the medication being ingested, but also may consider providing a tele consultation may not easily generalize into all relevant contexts outside the therapy office. Consultation team meetings provide much of the impetus for the necessary motivation to continue working with these patients for a long period of time. Telephone consultation. Treatment once a week may be insufficient for patients with BPD and SUDs. Because crises can be unrelenting between weekly appointments, and in light of the myriad treatment target that are evident in any single session, DBT-SUD includes a heavy emphasis on the use of the telephone to communicate with patients. A primary function of telephone consultation is to generalize previously acquired skills into the natural environment and to help directly implement skills plans made during sessions. As a behavioral treatment, this component of DBT-SUD is considered essential, as cognitive and behavioral skills trained during group and individual sessions may not easily generalize into all relevant contexts outside the therapy office. Consultation team. Individuals with co-occurring BPD and SUDs are difficult to treat. When considering the common lapses, numerous treatment targets and frequent therapy-interfering behavior (e.g., late or missed appointments), clinicians can feel acutely frustrated, demoralized and hopeless. As in standard DBT, in DBT-SUD a key component is a weekly clinician consultation team. The primary purposes of these meetings are remoralization and prevention of clinician burnout. Consultation team members help each other better assess problem behavior, identify creative solutions to ongoing problems, enhance phenomenological empathy and provide validation to each other to reinforce hard work and effective clinician behavior. Although no component studies have examined whether the consultation team is an essential element of DBT, it is possible that consultation team meetings provide much of the impetus for the necessary motivation to continue working with these patients for a long period of time. Pharmacotherapy. There are several principles that organize the management of psychotropic medications in DBT-SUD. First, and most importantly, safe and non-lethal medications are prescribed after careful assessment. For those with a history of medication abuse, the DBT-SUD pharmacotherapist may observe the medication being ingested, but also may consider providing a small supply of take-home medications. Second, simple medication regimens are used to mitigate problems with side effects and drug interactions, both of which can interfere with treatment. Third, specific symptoms are targeted first, rather than general problems, such as impulsivity. Fourth, choice of medications is guided by controlled efficacy studies. Finally, speed of improvement is important, with, for example, opiate replacement rapidly induced to a maintenance dose. DBT-SUD case management. Because substance users with BPD often have problems maintaining adequate food, housing and employment, case management can be added to DBT-SUD. Unlike
standard case management that commonly intervenes in the environment (e.g., making a phone call on behalf of a client), DBT-SUD case management strongly emphasizes coaching patients to intervene on their own behalf. The case manager is utilized, as needed, by the individual therapist as a resource to the therapist for referrals or advice, to provide information or referrals directly to the client, or to provide in vivo skills coaching in the patient's natural environment. **Attachment Problems**

Several new skills have been added to DBT-SUD that are geared directly toward problems experienced by individuals with BPD and SUD (unpublished data). One important adaptation is the inclusion of attachment strategies. Because individuals with BPD and SUDs may attend treatment sessions inconsistently, arrive late for session or not at all, or more generally appear "nonattached" to the treatment or therapist, in DBT-SUD there are a number of ways in which efforts are made to increase patient attachment to the therapist and treatment. For example, to develop rapport, the first several sessions include a large amount of therapist validation, with less emphasis on immediate change and/or aversive contingencies than in standard DBT. Other attachment strategies include orienting the patient to this problem, increasing contact with patients toward the beginning of treatment, frequent contacts with patients via voice mail, in vivo therapy sessions, decreasing or increasing session length as needed, family and friends network meetings, calling patients when they appear to be avoiding treatment, and finding them when they repeatedly fail to show up for appointments and do not respond to telephone calls. **Summary**

Overall, DBT-SUD is a principle-driven and flexible treatment approach for individuals with BPD and co-occurring SUD that is comprehensive, in that the treatment modalities include: 1) individual therapy to enhance patient motivation and develop strategies for targeting problem behavior; 2) group skills training to enhance acquisition of behavioral and cognitive skills; 3) telephone consultation to promote generalization of skills to the patient's natural environment; 4) therapist consultation team to reduce therapist burnout; 5) pharmacotherapy approaches; and 6) case management strategies.

**References:**


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