Linehan, M.M., et al., 1991. Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry* 48(12):1060-1064.

Linehan, M.M., et al., 1999. Dialectical behavior therapy for patients with borderline personality disorder and drug-dependence. *American Journal on Addictions* 8(4):279-292.

Linehan, M.M., et al., 2002. Dialectical behavior therapy versus comprehensive validation therapy plus 12-step for the treatment of opioid dependent women meeting criteria for borderline personality disorder. *Drug and Alcohol Dependence* 67(1):13-26.

Linehan, M.M., et al., 2006. Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. *Archives of General Psychiatry* 63(7):757-766.

Linehan, M.M.; Dimeff, L.A.; and Sayrs, J.H.R., in press. *Dialectical Behavior Therapy for Substance Use Disorder.* New York: Guilford Press.

Linehan, M.M., and Heard, H.L., 1999. Borderline personality disorder: Costs, course, and treatment outcomes. In: N. Miller and K. Magruder (Eds.), *The Cost Effectiveness of Psychotherapy: A Guide for Practitioners*. New York: Oxford University Press, pp. 291-305.

Linehan, M.M.; Heard, H.L.; and Armstrong, H.E., 1993. Naturalistic follow-up of a behavioral treatment for chronically parasuicidal borderline patients. *Archives of General Psychiatry* 50(12):971-974.

Links, P.S., et al., 1995. Borderline personality disorder and substance abuse: Consequences of comorbidity. *Canadian Journal of Psychiatry* 40(1):9-14.

Lynch, T.R., et al., 2003. Dialectical behavior therapy for depressed older adults: A randomized pilot study. *American Journal of Geriatric Psychiatry* 11(1):33-45.

Marlatt, G.A., and Donovan, D.M., 2005. *Relapse Prevention: Maintenance Strategies in the Treatment of Relapse Prevention.* New York: Guilford Press.

McKay, J.R., et al., 2000. Prognostic significance of antisocial personality disorder in cocaine-dependent patients entering continuing care. *Journal of Nervous and Mental Disease* 188(5):287-296.

Nace, E.P.; Davis, C.W.; and Gaspari, J.P., 1991. Axis II comorbidity in substance abusers. *American Journal of Psychiatry* 148(1):118-120.

Rossow, I., and Lauritzen, G., 1999. Balancing on the edge of death: Suicide attempts and life-threatening overdoses among drug addicts. *Addiction* 94(2):209-219.

Rutherford, M.J.; Cacciola, J.S.; and Alterman, A.I., 1994. Relationships of personality disorders with problem severity in methadone patients. *Drug and Alcohol Dependence* 35(1):69-76.

Safer, D.L.; Telch, C.F.; and Agras, W.S., 2001. Dialectical behavior therapy for bulimia nervosa. *American Journal of Psychiatry* 158(4):632-634.

Stone, M.H.; Hurt, S.W.; and Stone, D.K., 1987. The PI 500: Long-term follow-up of borderline inpatients meeting DSM-III criteria. I: Global Outcome. *Journal of Personality Disorders* 1:291-298.

Telch, C.F.; Agras, W.S.; and Linehan, M.M., 2001. Dialectical behavior therapy for binge eating disorder. *Journal of Consulting and Clinical Psychology* 69(6):1061-1065.

Trull, T.J., et al., 2000. Borderline personality disorder and substance use disorders: A review and integration. *Clinical Psychology Review* 20(2):235-253.

van den Bosch, L.M., et al, 2005. Sustained efficacy of dialectical behaviour therapy for borderline personality disorder. *Behaviour Research and Therapy* 43(9):1231-1241.

Verheul, R., et al., 2003. Dialectical behaviour therapy for women with borderline personality disorder: 12-month, randomised clinical trial in The Netherlands. *British Journal of Psychiatry* 182:135-140.

Zanarini, M.C., et al., 2004. Axis I comorbidity in patients with borderline personality disorder: 6-year follow-up and prediction of time to remission. *American Journal of Psychiatry* 161(11):2108-2114.

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 curricula 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

front. The counselor acknowledges right at the start that dropouts happen and problem-solves with patients to prevent it, in part by planning with patients to contact them if they don't show up for a session.

The DBT focus on teaching patients to tolerate pain and discomfort is similar to conventional coaching of clients to ride out their urges to use drugs, but it goes further. I think this could be very helpful with engagement and retention, particularly in early abstinence. Among stimulant abusers, for example, overwhelming psychological discomfort is among the problems that lead to high dropout rates.

The terms "addict mind," "clean mind," and "clear mind" are consistent with traditional concepts in recovery and could be particularly useful in helping clients to understand their stages of recovery. I would like to see the authors articulate these terms further, with a list of changes and behaviors that clients can use to assess their progress. Clients could then say, "Well, I see that I am feeling so-and-so, and that tells me I'm in clean mind" or "I just did such and such, so I know I'm in clear mind."

Gavriel: The central concept of dialectical abstinence is another good example of DBT putting a new spin on treatment issues and practices. Although it is not earth-shatteringly new, it merges the concept of abstinence-based therapy and the attitude of learning from relapse in a novel, useful way. Similarly, getting client locator information up front and seeking out no-show patients is not unique to DBT. However, it has not become embedded in practice, and the emphasis that DBT puts on it is unique.

Sackler: There is one valuable innovation in DBT that I think is brand new. It's the idea that patients should immediately make amends for the harm they have done, rather than—as in Alcoholics Anonymous—waiting until Step 8.

Gavriel: For all its compatibility with current practices, DBT does challenge some common ideas in the field. For example, we tend to say, when clients engage in inconsistent help-seeking, that they are not yet motivated enough for treatment and need to bottom out and come back. DBT says, instead, that we should try to maintain therapeutic relationships—and go find them.

Sackler: I think this is a great direction for substance abuse treatment to take.

Glasner-Edwards: Yes, so do I, particularly for its approaches to overcoming some of the problems of treatment engagement and retention.

Jumping in versus wading in

Glasner-Edwards: As to the feasibility of jumping in with a program like this, it will depend on what the funding priorities are and whether dealing with comorbidities is a strong agenda item for decision makers. In most cases, I imagine it will be very difficult to get the necessary support to fully implement DBT, given the cost and labor associated with it—for training, ongoing supervision, fidelity monitoring, and the intensity of the clinical services provided both in and out of the clinic setting. Think just of the staff resources needed for community outreach—counseling becomes more than a 9 to 5 job, as therapists are essentially on call all the time.

Gavriel: San Francisco's community behavioral health services have made a large commitment to DBT. One main reason was the promise of reducing costs. Large portions of the dollars for community care were going to small numbers of clients, many of whom had been diagnosed with borderline personality disorder (BPD) and were frequent users of expensive emergency and stabilization services throughout the city. Of course, a lot of money is taken up not only by BPD, but by substance abuse in general, because the recidivism rate is so high. Thus, funders sought an approach that would help to sustain these clients outside of these emergency structures. DBT has the potential to teach more skillful living and thus maintain the client outside the hospital.

In 2003, the Linehan group gave a weeklong training to 200 providers from city- and county-affiliated clinics. Today the model is still going strong at some facilities and has dwindled away at others, mostly because trained staffers leave and it's hard to keep up the training of new hires.

The city is trying to revive the initiative and increase consistency. Its goals include crisis care services that are calibrated on the DBT model and a referral system wherein clients who move between providers or levels of care consistently encounter DBT. The range of issues involved is tremendous, including practical ones like team meetings. Those hours affect clinic productivity and must be billable.

Despite all that, I think it behooves us to invest in best-practice initiatives and strategies like DBT, because there are areas where our whole field needs to improve. We fail with a lot of clients. I don't believe DBT or any one model has all the answers, but I think we should keep trying to raise our game and so be open to implementing new approaches, even if they are difficult and take resources.

Glasner-Edwards: I think it would make sense to introduce DBT gradually. A program or a system might start with some of the basic components and move in a stepwise fashion toward full implementation. Perhaps it would focus first on seeing whether it's feasible to train community providers and supervise them in the use of these skills.

Sackler: Drs. Dimeff and Linehan report that a partial version of DBT was not effective in trials, but I struggle with this conclusion. In my experience in various clinics and research settings providing treatment for substance abusers, I have found that some of these techniques do work when used independently of this model. For example, the

Community Reinforcement Approach of the University of Vermont (Budney and Higgins, 1998) sends staff out into the community to re-engage patients and has found doing so to be very effective.

Glasner-Edwards: The Linehan group's findings regarding the importance of maintaining the integrity of the full DBT treatment came from studies of people with BPD, one of which involved a small number of individuals with comorbid substance abuse. I'm not surprised that the researchers concluded that DBT skills and training aren't efficacious in themselves, because BPD patients probably benefit from the structure that's provided by the full model. It would be interesting to compare the efficacy of a full versus an à la carte approach for other populations. You might not need the whole package with less suicidal populations or substance-abusing populations who have less severe psychiatric impairment.

Gavriel: In our agency, with the benefit of intensive training from the Linehan group, we're sometimes able to offer DBT-informed therapy to a small percentage of our clients. We try to make it available to our clients with BPD. We have implemented the curriculum of DBT skills training very broadly, however.

The burning question for us is: Can skills training alone, without the rest of the model, be effective for clients who do not have BPD, but have primary substance use disorder and may also have less severe psychiatric conditions, such as depression? We may get some answers from a study that we are now doing in collaboration with the University of California at Los Angeles. The study takes place in a large Walden House substance abuse prison program, where clients in one yard receive DBT skills training and clients in another receive treatment as usual.

Glasner-Edwards: I think it would be very interesting to isolate the component of upfront planning for potential dropout and test whether it makes any difference.

Sackler: You could apply the dialectic to the issue of implementation. The long-term, ultimate goal is to realize the benefits of these comprehensive programs, but we need to set out from where we are now and painstakingly put the pieces together.

I do think that comprehensive programs are ultimately doable. If we have to start piecemeal to get people up to speed and to develop their skills, and only later implement the full-package DBT or some other comprehensive program, so be it. I think it's acceptable to work toward long-term implementation in a series of small short-term steps.

REFERENCES

Budney, A.J., and Higgins, S.T., 1998. *A Community Reinforcement Plus Vouchers Approach: Treating Cocaine Addiction. NIDA Therapy Manuals for Drug Addiction, Manual 2.* NIH Publication No. 98-4309. Rockville, MD: National Institute on Drug Abuse.

Dimeff, L.A., and Linehan, M.M., 2008. Dialectical behavior therapy for substance abusers. *Addiction Science & Clinical Practice* 4(2):39-47