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Taking a Mindful Approach to Substance Abuse Treatment Through Dialectical Behavior

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Taking a Mindful Approach to Substance Abuse Treatment Through Dialectical Behavior Therapy Techniques

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Abstract

This paper will explore the use of Dialectical Behavior Therapy (DBT) with individuals seeking substance abuse treatment, including skills that allow an individual to better manage symptoms and promote a thought process that allows for a better sense of control. It will discuss DBT in comparison to evidence-based substance abuse treatments or what is referred to as Treatment-as-usual (TAU) approaches. It will also discuss applications for mental health professionals and limitations.

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Over the years there have been a variety of treatment approaches for Substance Use Disorder (SUD). Models and theories of treatment for substance use disorder have included: The moral model, the disease model, sociocultural model; twelve-step programs, motivational interviewing; and the list continues (Capuzzi & Stauffer, 2012). If you look on the Substance Abuse and Mental Health Services Administration's (SAMHSA) website at their National Registry of Evidence-based Programs and Practice for substance abuse interventions, you will find over one hundred interventions listed for substance use disorder treatment (National Registry of Evidence-based Programs and Practice, 2014). This includes Acceptance and Commitment Therapy (ACT), Brief Strategic Family Therapy (BSFT), Motivational Interviewing (MI), and Brief Strengths-Based Case Management (SBCM). What you will not find is Dialectical Behavioral Therapy (DBT).

Although controlled studies are have been limited (Linehan & Dimeff, 2008), research is showing DBT may hold an important place in today's treatment of substance use disorders. Outpatient treatment programs for substance use, such as Hiawatha Valley Mental Health Center in Winona, MN, are beginning to use DBT skills for substance abuse. Skills taught in DBT are being used to address issues of relapse, such as skills to identify triggers, controlling urges, and managing overwhelming emotions.

Literature Review

Dialectical Behavioral Therapy (DBT) was originally developed by a psychology researcher at the University of Washington by the name Marsha Linehan, PhD. Linehan's intent was to treat people with borderline personality disorder, as well as, individuals who were chronically suicidal. Today DBT has shown to be effective in cases with individuals suffering from eating disorders, mood disorders, and even traumatic brain injuries (Neacsiu, Anita, Rozvi, Linehan, 2014).

When Marsha Linehan developed DBT for patients with borderline personality disorders and a history of suicidal ideations, her main focus was on building skills that would support an individual's life worth (Linehan, 1993). The word dialectic itself means two opposing or contradictory ideas or goals that are seeking to resolve a conflict. In the case of DBT and substance abuse treatment the two opposing goals are change and acceptance (Dimeff & Linehan, 2008). Change refers to an individual working toward both abstaining from substance use and building a healthier life style. Acceptance refers primarily to accepting that relapse is a part of recovery. Acceptance could also refer to accepting the parts of one's history or environment that one cannot change or recognizing and accepting emotions that accompany sobriety. Dialectical Behavioral Therapy's goal is to find the balance between change and acceptance.

The foundation for DBT was based on the idea clients who were suicidal did not have the skill set to solve the life problem that was causing significant emotional suffering. Linehan found while approaching treatment with an emphasis of behavior change some client would respond with defensively by shutting down or becoming overly emotionally (Linehan, 1993). However, approaching treatment with less emphasis on behavior change

and more on acceptance of present life event and tolerance, clients tended to think their feelings were being minimized (Linehan, 1993). This approach also could leave a client feeling even more hopeless (Linehan, 2008). We see similar client reactions from those in chemical dependency treatment, especially when there is a co-occurring disorder present (Katz & Toner, 2013). Combining both ideas allowed clients to work toward change of a life event or dilemma while at the same time learning to accept other life pain will surface (Linehan, 2008).

DBT was developed from the Cognitive-Behavioral Theory (CBT). CBT interventions are among the most effective substance use treatments used today (Osborn, 2012) and have been proven to be effective in SUD treatment through a variety of interventions. CBT interventions primarily focus on: Social intervention, which includes social skills training, lifestyle changes, and interpersonal conflict management; emotional intervention, which includes learning how to regulate both positive and negative emotions; cognitive intervention, which includes addressing maladaptive automatic thoughts; and, physical interventions, which include introducing clients to distractions from triggers and cravings (Osborn, 2012).

Another dominantly used method to substance abuse treatment is the 12-step model (Bornovalova & Daughters, 2007, p. 930). The philosophy in 12-step programs sees addiction as a disease; in other words, it is seen as the primary condition as opposed to being secondary to another diagnosis such as depression or PTSD. Although programs such as Alcoholics Anonymous and the 12-steps have faced criticism over the years, along with mixed results in research studies, it remains one the most used forms of long-term

treatment for individuals suffering from substance abuse disorders (Stevens & Smith, 2009, p.293).

Although 12-step models are widely used, many outpatient treatment facilities continue to see high rates of treatment drop out, as well as, returning clients. According to a report released by the Treatment Episode Data Set (TEDS), out of 1.37million clients in outpatient treatment in 2005, only 44 percent completed treatment (The TEDS Report, 2009). According to a 2007 article, several components of DBT influence lower dropout rates for clients diagnosed with the SUD and BPD (Bornovalove and Daughters, p. 14).

Three variables seem to have the strongest influence on treatment drop out rates: motivation to engage in treatment, therapeutic alliance, and distress tolerance (Bornovalova & Daughters, 2007, p. 925). For the purpose of this paper distress tolerance refers to an individual's "unwillingness or inability to persist in goal directed behavior when experiencing emotional distress" (Linehan, 2008). Research has shown that distress tolerance is directly related to a client's history of shorter time periods in between times of relapse (Daughters, Lejuez, Kahler, Strong, & Brown, 2005, 208). According to a 2006 article, women are more likely to experience a relapse after an interpersonal conflict, such as family or marital problem (Katz & Toner, 2013).

A higher level in distress intolerance typically means a client's inability to remain in treatment consistently over a longer period of time and the inability to continue to abstain from substance use when emotions become difficult to manage. It is important to note that studies have found higher levels of distress intolerance among individuals with co-occurring disorders verses individuals with only a substance use disorder diagnosis (Bornovalova & Daughters, 2007, p. 925). Additionally, women with alcohol-dependency

are more likely to drink in response to a negative life event or stressors (Katz & Toner, 2013). The first skill of DBT's distress tolerance is to teach clients how to temporarily stop thinking about their pain and give them time to find appropriate coping skills; the second skill teaches clients how to self-sooth before facing or dealing with their distress (McKay, Wood, Brantley, 2007). For many individuals with SUD this is a needed skill to master as an alternative to their history of substance use.

Fundamental to the 12-step philosophy is the belief that abstinence from drugs or alcohol is not enough; an individual must be able to make both attitude and behavioral changes in multiple areas of life in order to have a life of abstinence (Stevens & Smith, 2009). This includes empowering individuals to address changes to their physical well-being, emotional well-being, social relationships, and spiritual health. The philosophy of the12-step program is consistent to the DBT fundamental idea of acceptance and change. A similarity can be found 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."

Many successful substance abuse treatment models focus on an individual's ability to cope with risk, or triggers, and their ability to deal with their own negative cognitive reactions. Both of which have a significant influence on the probability of relapse or continued use (Bornovalova & Daughters, 2007). For many people in recovery, relapse begins before substance use. This happens when one looses control of judgment and behavior (Gorski & Miller, 1986). Treatment then puts focus on recognizing triggers, whether it is people, actions, emotions, or environment, and skills designed to help cope in high-risk situations. Many people coming out of addiction lack the healthy coping skills to

deal with their emotions, past traumas, and daily stressor. The skills taught by DBT have the potential to teach someone coming into recovery how to both become aware of his or her triggers and emotions, as well as, how to manage them.

Many theories of recovery state that relapse is a natural part of the recovery process; however, relapse can cause clients to spiral into full use as a result of self-judgment and preconceived thought processes that state he or she must be unable to resist use. Gorski and Miller (1986) discuss what they refer to as the relapse syndrome as dysfunctional behaviors or thoughts (p.35). This can result in a chemical relapse or other maladaptive behavior. Other maladaptive behavior might include physical self-harm, harming others, or risk seeking. When relapse is dealt with openly and honestly, it becomes a learning opportunity to move forward from.

Research has shown that individuals with co-occurring disorders are prone to abusing substances as a means of avoidance or escape as a coping strategy (Bornovalova & Daughters, 2007). Signs of relapse syndrome should be seen as warning signs. It is important for someone in recovery to be aware of his or her warning signs. One of the key pieces of DBT is teaching how to stop engaging in self-destructive behavior (Linehan, 1993). According to Gorski and Miller (1986), during the chronic stage of addiction an individual's thinking becomes both irrational and delusional (p. 47). This stage comes gradually and the individual begins to become unaware of identifying harmful behavior. Many individuals abusing substances do so as a means of coping with physical or emotional pain. Some individuals use self-destructive behavior to avoid physical or emotional pain through other natural highs, such as, sex, self-abuse, or danger. Other unhealthy coping skills include: thinking about past mistakes, thinking about possible future mistakes,

isolating self to avoid possible distressing situation, taking feelings out on others, engage in dangerous behavior such as self harm.

Pain or negative emotions cannot be avoided in life; however, fixating on those emotions and therefore trapping our selves in a state of suffering over a long period of time can be. Individuals who suffer from substance abuse have a shown to "suffer" from emotional pain longer (Gorski & Miller, 1986) Distress tolerance skills in DBT focus on distracting yourself from harmful thoughts, learning how to relax or self-sooth, and then coping with the distress while in a calmer, clearer state of mind.

Many addictions can last for years, even decades. It can be overwhelming for someone who is in the early stages of recovery to take on facing the damage their addiction has caused; learn how to cope with emotions without the escape of substance use; and, begin to identify triggers.

Skills taught in DBT do seem to support the needed foundations of substance abuse treatment: motivation for change, motivation to continue in treatment, and becoming mindful of high-risk situations. Additionally, DBT focused on a person's maladaptive behaviors, such as substance abuse, as a function to regulate or relieve overwhelming or unwanted emotions during time of distress. Linehan (2008) lists five essential functions of treatment: improving patient motivation to change, enhancing patient capabilities, generalizing new behaviors, structuring the environment, and enhancing therapist capability and motivation.

As of 2008 there have been nine randomized control trials on DBT published, conducted across five research institutions on DBT (Linehan & Dimeff, 2008). Two of the trials focused on DBT's efficacy in reducing substance use (Linehan & Dimeff, 2008). "The

two randomized controlled trials of DBT, supported by grants from the National Institute of Mental Health and the National Institute of Drug Abuse, have indicated that DBT is more effective than Treatment-As-Usual (TAU) in treatment of BPD and treatment of BPD and co-morbid diagnosis of substance abuse" (Evidence Based Practices for Substance Use, 2014, http://lib.adai.washington.edu). However, both of the trails were conducted using clients diagnosed with Borderline Personality disorder, as well as, poly-substance dependent with a history of unsuccessful attempts to abstain from use (Linehan & Dimeff, 2008).

Application for professionals

Dialectical Behavioral Therapy over all focuses on clients learning tools and skills that can empower them to be as effective as they can be in their own lives. These are skills that can be applied in everyday life and in most situations.

Dialectic Behavior Therapy has shown to be the most effective when it is used with in individual therapy with the primary therapist being responsible for developing and maintaining the treatment plan (Linehan, 2008). A strong relationship from the first session has been linked to higher retention rates. Before beginning treatment, clients are asked to make three commitments: to stay alive for one year, to work on behaviors that may interfere with therapy or treatment, and participate to the best of their ability in DBT skills (Linehan, 1993).

According to Linehan (2008), treatment is approached by targeting behaviors as a hierarchy: "decrease behaviors that are life threatening; reduce behaviors that interfere with therapy (late, not attending, intoxicated); reduce behaviors with consequences that degrade the quality of life (homeless, probation, domestic violence); and increase behavioral skills". In an outpatient treatment setting, DBT is delivered via four treatment

modalities: individual therapy, group skills training, telephone consultation, and therapy for the therapist (Freedman & Duckworth, 2013). As discussed earlier, the first skill, distress tolerance, helps clients cope better with painful events without the need for substance use by building up their resiliency and provides new ways to soften the effects of upsetting circumstances.

The first of the two distress tolerance skills teaches clients how to temporarily stop thinking about one's pain and give time to find appropriate coping skills. It is important during treatment that there is a distinction made between temporarily stop thinking of one's pain and avoiding it. The second distress tolerance skill teaches an individual how to self-sooth. Linehan (2008) states that it is necessary for many individuals to self-sooth before facing an argument, rejection, challenge, or a painful event (p. #). This is an important skill because it gives an individual the chance to become calm from anxiety, calm from anger, or gain strength.

The second skill of DBT is Mindfulness. This teaches clients how to experience more fully the present moment while focusing less on painful experiences from the past or frightening possibilities in the future. Mindfulness also provides tools to over come habitual, negative judgments about self and others are considered one of the core skills of DBT (Linehan, 1993). Studies have shown that mindfulness skills have also been shown to be effective in reducing reoccurring episodes of major depression (Teasdale, 2000) and increase skills to cope with difficult situations (Baer, 2003). Research has shown mindful-base relapse prevention increases awareness of triggers, automatic responses, and habitual patterns, as well as, bring awareness to a range of choices before taking action (Felver, 2012).

Mindfulness teaches a nonjudgmental awareness of experiences as they occur in the here and now. Mindfulness teaches clients how to recognize that their internal experiences are temporary and subjective projections, rather than permanent and accurate depictions of reality (Felver, 2012). In other words, clients are taught to be aware of internal and external experiences without judgment of themselves or their own feelings. Additionally mindfulness teaches awareness of unnecessary automatic responses to these experiences or internal feelings.

Thought suppression is one trait that seems to be connected to substance relapse. Individuals who have higher rates of thought suppression also have higher rates of continue substance use and relapse (Katz & Toner, 2012). Learning how to be mindfulness allows a client to become aware of urges. From there, the clients begin to recognize that urges, as well as negative emotions, are temporary and will pass. Mindfulness skills allows client to react more thoughtfully and feel more in control.

The third skill is Emotional Regulation. This skill helps an individual to recognize more clearly what they are feeling and then to observe each emotion without getting overwhelmed by it. The overall goal is to adjust your feelings without behaving in reactive, destructive ways based solely on your emotions. In substance abuse treatment, mindfulness skills focuses on dealing with the past and the planning for the future while being present in the here and now. This parallels the AA philology of living in recovery one day at a time (Stevens & Smith, 2009). Clients are empowered by their counselor to build impulse control and tolerance for varying emotions. One technique is to teach clients to feel a strong emotion or impulse is not the same as acting on it. Once a client learns to not act

on an emotion, the counselor provides positive reinforcement (McKay, Wood, & Brantley, 2007, p. 122).

The forth and final set of skills thought is Interpersonal Effectiveness. Interpersonal Effectiveness is a tool designed to help a client express his or her beliefs and needs, set limits, and negotiate solutions to problems (McKay, Wood, Brantley, 2007). By becoming more functional in their relationship clients may find less of a need for substance use. This is done all while protecting the person's relationships and treating others with respect.

Many people who are entering into recovery are dealing with physical, psychological, and social damage in their life caused by their addiction, behavior, or outside forces, sometimes for the first time. Living in recovery does not simply mean the absence of substance use. It is learning to live a healthy and meaningful life without the need for drugs or alcohol (Gorski & Miller 1986). One key aspect of Dialectical Behavioral Therapy is to teach individuals how to control emotions. DBT puts into practice the above four primary skills that are designed to teach an individual how to reduce the size of the emotion and help keep balance when emotions become overwhelming.

First goal is to get the patient to commit to abstain from using drugs. It is during drug free periods that a patient works on additional skills. In addition the client is asked to work toward abstaining or avoiding any behavior or lifestyle choices that might interfere with treatment (Bornovalova & Daughters, 2006, p.926)

In substance abuse treatment it is important for clients to begin to recognize when to anticipate a relapse (Linehan, 2008). This consists of recognizing specific behaviors, feelings, or thought patterns that in the past have lead up to a relapse in sobriety. This might also be referred to as what is called a dry drunk or the relapse syndrome. According

to Gorski and Miller (1986), “it is possible to interrupt the relapse syndrome before serious consequences occur by bringing the warning signs of relapse that you are experiencing into conscious awareness” (p. 35). Typically in SUD treatment, this is the beginning of relapse prevention planning.

Discussion

Through my research what I have found is that there is no one single treatment approach that will work for all clients in the area of substance abuse treatment. It is most important to tailor a treatment plan for an individual client based on evidence-based practices. Additionally in order to best meet the needs of an individual client, counseling professions should be aware of a variety of evidence based approaches. Although DBT itself is still being researched as a best practice for the treatment of addiction, the skills taught provide clients with a foundation for managing their overwhelming emotions. For people struggling with sobriety it is their inability to manage these types of emotions that lead them to relapse. This does not always include negative emotions. Some individuals struggle with the positive attention they receive when they begin to structure a healthier lifestyle. Although their primary emotion might be pride or joy, the feeling of pressure or anxiety to "stay the course" can become overwhelming and turning back to escape through use may seem more appealing.

Other clients may judge their primary emotion because they may feel they do not deserve to feel proud after a history of unhealthy behaviors. Through DBT skills, such as emotional regulation, clients can learn how to prevent a secondary emotion from influencing a client's behavior or prevent the unhealthy secondary emotion from occurring at all. Additionally mindfulness skill can teach a client to be aware of a positive, or negative, primary emotion without judgment or action.

Many substance abuse counselors still practice under the disease model for treatment that sees addiction as a chronic, progressive, involuntary, irreversible, and potentially as a fatal illness (Osborn, 2012). The foundation of this model sees addiction,

dominantly alcohol dependency, as an individual's loss of control to manage the addiction. This again is fitting to the foundation of Alcoholics Anonymous (AA). Although AA has historically shown to be effective for many working toward abstaining from use, this model does overlook other explanations for addiction. DBT primary focus is on emotional regulation and finding healthy means of coping with overwhelming emotions verses self-medicating or escaping through drug or alcohol use. DBT may work best with clients who abuse substances as a way to cope with unwelcome or overwhelming emotions. Studies have shown that women tend to have preexisting mood and anxiety disorders prior to developing substance use disorders (Katz & Toner, 2013).

DBT is designed for clients with multiple Axis I and Axis II problems (Moonshine, 2012) and my work best with clients whom substance use is tied to their inability to control manage emotions in a healthy manor. DBT is extensive. Articles published suggest DBT would be better suited for clients whom have not had success in the past in treatment or those with an emotional disorder (Bornovalova & Daughters, 2007) and be implemented by counselors who have been trained (Linehan & Dimeff, 2008).

When deciding whether DBT is appropriate for a treatment program, it is important to first look at other programs that have been shown to be effective. Although DBT contains elements that that have the ability to be therapeutic for most clients, it may be more extensive for most patients with SUD (Dimeff & Linehan, 2008). However, for clients that have a history of relapse and unsuccessful completion in TAU programs, DBT has the potential to help clients be successful.

Limitations

Much of the literature on the effectiveness of DBT in substance abuse treatment is specific to treating individuals with a Borderline Personality Disorder as their primary diagnosis. DBT has been shown to reduce substance abuse drop out rates in individuals with co-occurring disorders such as Borderline Personality Disorder (Bornovalova & Daughters, 2007). However, more research on individuals with other co-occurring diagnosis or Substance Use Disorder as a primary diagnosis is needed. According to Bornovalova and Daughters' (2007) findings, the effectiveness of DBT protocol used therapy will have limited outcomes when the therapist has minimal or limited training in DBT skills (p.925). One reason trails on how effective DBT is among specific groups, such as substance abuse users, are limited is the costly nature of therapy (Bornovalova & Daughters, 2007, p. 925). Clients are required to attend multiple therapy sessions, both group and individual, per week.

Although evidence does suggest that mindfulness techniques alone promise positive intervention in the treatment for substance use disorder (Price, Wells, Donovan, & Brooks, 2012), more research is needed in its success with none BPD patients. According to Linehan and Dimeff (2008), DBT as a treatment for substance use disorder may be more extensive then needed as compared to traditional substance use treatment. Training should be extensive. DBT provides an abundance of information and counselor's who choose to implement it should be trained. Although DBT contains elements that that have the ability to be therapeutic for most clients, it may be more extensive for most patients with SUD (Dimeff & Linehan, 2008). Linehan (2008) suggests that in the treatment of SUD, DBT would most likely be most effective with clients whose substance use is associated with

affective disorders such as major depressive disorder, anxiety disorders, or schizoaffective disorder. Clients who, along with SUD, have a history of suicidal or homicidal ideations, clients that have a history of relapse and unsuccessful completion in TAU programs, DBT has the potential to help clients be successful (Linehan, 2008).

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