THE CARLAT REPORT
ADDICTION TREATMENT

A CE/CME Publication

CURRENT COVERAGE OF TOPICS IN ADDICTION MEDICINE

Joshua Sonkiss, MD
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Learning Objectives
After reading these articles, you should be able to:

1. Describe the benefits of using dialectical behavior therapy (DBT) for patients with substance use disorders. **2.** List the skills involved in DBT and how they can be applied to patients with substance use disorders. **3.** Summarize some of the current findings in the literature regarding psychiatric treatment.

Dialectical Behavior Therapy for Substance Use Disorders: A Primer

Yevgeny Botanov, PhD, and Chelsey Wilks, MS. University of Washington Department of Psychology, Seattle, WA.

Dr. Botanov has disclosed that he is employed by Behavioral Tech, LLC. Dr. Carlat has reviewed this article and has found no evidence of bias in this educational activity. Ms. Wilks has disclosed that she has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

Summary

- DBT encompasses four skill modules: mindfulness, emotion regulation, interpersonal effectiveness, and distress tolerance.
- DBT for substance use disorders includes separate attachment strategies and a set of six specific addiction skills on top of standard DBT.
- DBT has been proven effective for patients with substance abuse issues with comorbid mood or behavioral problems, or for those who don't respond to more traditional addiction treatment.

Angela is a 27-year-old woman who was just discharged from the hospital after a suicide attempt following her second arrest for DUI. She says she only drinks on the weekends, but she recently lost her third job due to

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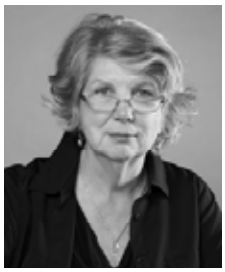
Q&A With the Expert

Applying Dialectical Behavior Therapy to Addiction
Marsha Linehan, PhD, ABPP

Dr. Linehan is a professor and director of the Behavioral Research and Therapy Clinics at the University of Washington in Seattle, WA.

Dr. Linehan has disclosed that she is a consultant for Behavioral Tech, LLC and receives book royalties from Guilford Press. Dr. Carlat has reviewed this interview and has found no evidence of bias in this educational activity.



CATR: Dialectical behavior therapy (DBT) is well-known for treating borderline personality disorder (BPD) and individuals at high risk for suicide. I'm not sure we're as familiar with it as a treatment for substance use disorders. How is DBT used in addiction treatment?
Dr. Linehan: Dialectical behavior therapy was not really designed specifically for borderline personality disorder. It is used effectively as a targeted therapy for BPD because those patients traditionally have been very difficult to treat successfully. And people with addictions—whether it is drug, alcohol, gambling, food, or so forth—also are often very difficult to treat. In general, people who have addictions have many of the other problems that are responsive to DBT, such as depression or difficulties regulating emotions.
CATR: So DBT is not just good for treating substance use disorders in people who have BPD, but really potentially anyone with a substance use disorder.
Dr. Linehan: Exactly. When we do studies on people with BPD who are highly suicidal, we often get people who have drug addiction as well. We've now done two studies on substance use disorders and found that DBT has really good outcomes in terms of reducing substance use. So we've developed a whole protocol aimed at that. It's essentially the same treatment, but with some adaptations.
CATR: Is abstinence the goal of treatment?

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Dialectical Behavior Therapy for Substance Use Disorders: A Primer

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absenteeism. She doesn't like AA, and she was kicked out of residential substance abuse treatment after the staff caught her scratching her arms with a paper clip. Her boyfriend also drinks, but she doesn't want to leave him even though the Department of Family Services took temporary custody of their children after he was accused of domestic violence while both parents were intoxicated.

Dialectical behavior therapy (DBT) is well-known as an effective treatment for individuals with personality disorders and for reducing suicidal behavior. But it's also quite effective for addictions (Linehan M et al, *Drug Alcohol Depend* 2002;67(1):13–26). In this month's expert interview, Marsha Linehan, the developer of DBT, provides a nice overview of the basics of DBT as applied to addictions. In this article, we'll discuss DBT concepts in a bit more detail and help you apply these concepts to patients with substance abuse issues.

DBT basics

Let's start with DBT basics. DBT blends three philosophical and clinical traditions: behavioral science, Zen contemplative practices, and dialectics. The behavioral science part of DBT says that patients use ineffective behaviors, such as addictive behavior, to try and stabilize their emotions. Behavioral change strategies—think Pavlov's dog—are key to decreasing harmful behaviors and increasing healthy behaviors. Zen practices underlie DBT's mindfulness and acceptance skills, which help patients observe and understand their behaviors and emotions.

The dialectical part of DBT is the most confusing for many, in part because the jargon may cause flashbacks to college philosophy classes. Dialectics means a process in which things that seem to be opposites of one another come together to form something greater (remember your professor saying "antithesis/synthesis"?). As applied to psychotherapy, dialectics means that patients must accept themselves as they are even as they simultaneously work toward change. Acceptance and change may seem antithetical to each other, but the genius of DBT is that it synthesizes these two crucial psychological processes.

In standard DBT, individuals receive three modes of intervention: weekly individual therapy, a weekly skills training class, and between-session telephone coaching as needed. Of these three ingredients, the group skills training—taught in two cycles of a 24-week curriculum—provides crucial skills that influence therapeutic success. It is also essential for DBT practitioners to attend consultation team meetings where they confer with other DBT professionals on how to provide the most effective treatment.

For an overview of DBT for treating suicidal behavior in BPD, see *TCRBH*, September 2013 (http://goo.gl/bgFBve).

DBT-SUD

DBT for substance use disorders differs in a couple of important ways from standard DBT. First, an important part of DBT is a method of modifying patient behaviors called "contingency management." This is a fancy way of saying "taking a time out." (In DBT, contingency management is not the same as "motivational incentives," in which prizes are given for negative drug tests or other positive behavior.) For example, when working with a patient with borderline personality disorder, if the patient engages in self-harm, the therapist might interrupt the therapy—often called a "therapy vacation." This can work well in curbing self-harm.

However, this method had to be changed and adapted for addiction treatment. Why? Because it turns out that when you implement a therapy vacation with a substance user, you can inadvertently reinforce more substance use. Because of this, new strategies for substance users were created, which are called attachment strategies. For example, if Angela misses a couple of sessions, her therapist might send a dozen balloons with a note that says, "Don't fly away." (See the table on page 5 for more examples of attachment strategies.)

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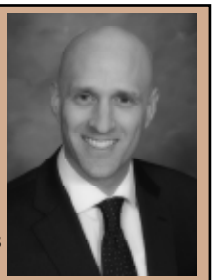
New Editor-in-Chief



We're happy to welcome Joshua Sonkiss, MD, as editor-in-chief of *The Carlat Addiction Treatment Report*. Dr. Sonkiss is a board-certified forensic psychiatrist with a wide range of experience in substance abuse treatment. He completed undergraduate training at the University of Alaska, went to medical school at McGill University in Montreal, and completed residency at the University of Utah. After his forensic training at the University of Rochester, he returned to Alaska, where he's provided psychiatric and addiction treatment in inpatient, residential, and outpatient settings as well as in some of the state's most remote, roadless communities. He is past president of the Alaska Psychiatric Association, a member of the organization's CME committee, and has received awards for teaching and advocacy. Currently he divides his time between Fairbanks Community Mental Health Services, a community mental health center; and Turning Point Counseling, a clinic specializing in substance abuse treatment. He's also an advisor to the Alaska Opioid Policy Task Force.

Dr. Sonkiss has authored several addiction-related articles for Carlat newsletters, and he's been a member of *CATR*'s Editorial Board since 2013. We're thrilled to have him step into the role of editor-in-chief!

Dialectical Behavior Therapy for Substance Use Disorders: A Primer

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Second, DBT skills training for addictions includes additional skills that are built on top of the four original skill modules. The original modules comprise mindfulness, emotion regulation, interpersonal effectiveness, and distress tolerance (Linehan M. *DBT Skills Training* 2nd ed. New York, NY: Guilford Press; 2014), which are briefly reviewed in the "DBT in Practice" table on page 4.

DBT basic skills

The skill set everyone should learn first is *mindfulness*, or being aware of the present moment without judgment. The goal of mindfulness is not to change a behavior or belief, but only to become more aware of it. For example, if Angela wanted to quit drinking, she would practice mindfulness by closely observing the sensations of consuming alcohol. Like many addictive behaviors, drinking is often performed habitually, without fully appreciating the experience. In DBT, drinkers learn to observe the taste and smell of alcoholic drinks, as well as their own bodily sensations when drinking. Often, this leads to the person noticing more aversive aspects of drinking as well—like nausea or a headache. This in turn may open the door for future behavior change.

The second skill module is *emotion regulation*, which helps reduce vulnerability to emotions. For example, individuals learn to question their assumptions about a situation and see if their emotional reaction fits the facts; this skill is termed "check the facts." We've observed that patients often use substances as coping mechanisms when they perceive a negative event has occurred. For example, Angela might believe she was slighted by a friend, and use alcohol to cope with her feelings of shame. DBT teaches her to review the facts of the situation before deciding if she was indeed slighted, or whether shame is the emotion that best fits the situation. If Angela finds her feelings don't fit the facts, she'll be less likely to take that drink.

The third module is *interpersonal effectiveness*, which teaches individuals how to interact with others effectively—in other words, how to negotiate for outcomes they want without pushing people away or losing self-respect. Interpersonal effectiveness is key for individuals with addiction, since many of their social contacts may also be users. A common example is a patient who wants to quit using drugs, but her spouse also uses and isn't ready to quit. DBT outlines a method for the patient to figure out if her chief goal is to maintain sobriety, the relationship, or her self-respect. Once these three main objectives are organized, DBT skills assist the patient in creating scripts to best achieve her goals.

The final set of skills is *distress tolerance*, or getting through crisis situations without behaving in ways that make things worse. Distress tolerance skills are a last resort—they allow patients a little more time to resist a harmful urge to drink or to use. Skills include self-soothing activities, distractions from the urge, and changing physiology in order to change emotions. For example, Angela might have an argument with her boyfriend and experience a strong desire to escape painful emotions by drinking. If she's so distressed that mindfulness and emotion regulation skills are too difficult to employ, we might suggest she change her physiology with intense exercise or activate her parasympathetic nervous system by simulating the dive response, a vagal maneuver that can slow the heart rate and calm strong emotions (Brown MZ et al, *San Diego Psychologist* 2012;26(6):14-16).

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Addiction skills

After they've learned the basic skills, we teach a special set of six addiction skills to patients with SUDs: dialectical abstinence, clear mind, community reinforcement, burning old bridges and building new ones, alternate rebellion, and adaptive denial (see the table on page 6 for examples of each of these skills).

Similar to the general DBT philosophy, *dialectical abstinence* brings together the need for behavioral change, such as abstinence, with the need for radical self-acceptance. How does this translate to clinical terms? If Angela relapses, you would encourage a non-judgmental problem-solving approach to getting back on the wagon.

Clear mind is a synthesis of addict mind and clean mind. While addict mind includes thoughts, beliefs, and actions that occur under the influence, clean mind is a self-deceiving sense of immunity to relapse that can arise during a period of sobriety. Clear mind allows Angela to remain fully aware of her potential to relapse, even while she is abstinent.

Community reinforcement includes learning how to actively seek out people, places, and activities that will reinforce non-addictive behavior. In Angela's case, the skill of community reinforcement would involve learning how to, spend time with friends, family members, and others who will reinforce her decision not to use.

Burning bridges and building new ones is a set of strategies that help patients remove triggers that cue them to use substances. These can be people, places, and/or things. There is also a set of strategies to manage cravings, such as *urge-surfing*, which employs the imagery of a wave as the urge to use is "surfed." This is an important skill for managing craving, because eventually—hopefully—the urge will peter out (Marlatt G, George W. *Relapse Prevention and the Maintenance of Optimal Health. The Handbook of Health Behavior Change.* 2nd ed. New York, NY: Springer Publishing Co; 1998).

Alternate rebellion helps patients find skillful and non-destructive ways to rebel against society that don't involve substance use. This skill is particularly appropriate for individuals whose identity as an addict functions as a way to be different or unique. Alternative rebellion examples include dyeing your hair a wacky color or buying a controversial bumper sticker.

Finally, *adaptive denial* is a means to deal with cravings and urges to use. Instead of denying outright that she's craving a drink, Angela tells herself she's craving mineral water or a good workout instead. Adaptive denial turns Angela's self-deception into an asset (Dimeff L, Koerner K. *Dialectical Behavior Therapy in Clinical Practice: Applications Across Disorders and Settings.* New York, NY: Guilford Press; 2007).

DBT-SUD effectiveness

Does DBT work for SUDs? DBT researchers relentlessly seek empirical evidence to back up treatment claims, and so far they've found quite a bit of it. Several RCTs for DBT have been completed. Among patients with treatment resistant polysubstance dependence, those who received DBT were much more likely to attend a higher number of treatment sessions, to remain

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Expert Interview

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Dr. Linehan: Abstinence is the desired outcome for drug users, but not necessarily for alcohol users. We're all for abstinence, but with alcohol we don't insist on it because the research says if you tell people they have to be abstinent, it sometimes leads to a worse outcome. That's the reason we have a skill called "wise mind decisions," which is all about going to wise mind, determining what is the best outcome for you, and having a wise approach to that.

CATR: Are you saying the desired outcome depends on the client's orientation, and what they want to get out of treatment?

Dr. Linehan: Yes, for an alcoholic. The idea is not that alcoholics shouldn't be abstinent. A lot of alcoholics need to have abstinence—for example, those who have one drink and it's over, and they just can't stop. But the research now is that mandating abstinence isn't always the best approach for everyone. In our view, the decision has to be made by the client. When it comes to drug addiction, on the other hand, because drugs are illegal and if you get caught with drugs you can end up in prison, you can't say to someone it's reasonable to be using drugs—at least for drugs that are illegal. The outcomes are too big to take those risks. For illegal drug users, we have a skill related to this called "dialectical abstinence."

"Dialectical abstinence boils down to teaching people how to be abstinent, but at the same time teaching what to do if they fall off the wagon…In DBT you are either abstaining, or when you're not, you're recovering and coming back."

Marsha Linehan, PhD, ABPP

CATR: What about for marijuana, which is more and more in kind of a gray area as the public and lawmakers move toward a more permissive stance?

Dr. Linehan: When it's legal, which it is where I live, we treat it like we treat alcohol. It boils down to having an honest look at the positives and negatives of using it. And it may be legal, but for a lot of people it actually is quite harmful. If it's harmful, we say, "Okay you've either got to cut it way down or go to abstinence." We try to help the client make a wise decision about what their outcome should be, basically.

CATR: I'm curious about the protocol. Do you treat patients with addiction issues with a modified form of DBT, or is it the same treatment with some adaptations for substance abuse?

Dr. Linehan: We teach everyone the same skills. We start with the mindfulness skills, then we go through the emotional regulation ones, then the interpersonal skills, and finally distress tolerance. (See table below for more information on the DBT skills.) Within the DBT skills, they are going to learn about reasonable mind, emotion mind, and wise mind. The only real difference in skills for substance abuse or similar patients is adding the addiction skills.

CATR: Tell us about the addiction skills.

Dr. Linehan: Well, we start with the main DBT skills, beginning with mindfulness and going in the order that they are presented in the book (Linehan M. *DBT Skills Training.* 2nd ed. New York, NY: Guilford Press; 2014). We tell clients addiction skills are coming after that. We have several addiction skills, but the main one is *dialectical abstinence.* Dialectical abstinence boils down to teaching people how to be abstinent, but at the same time teaching what to do if they fall off the wagon. The idea is that you're going all out to abstain, but you're not going to go berserk if you slip or relapse. In DBT you are either abstaining, or

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DBT in Practice

Goal: To learn how to change the patient's behaviors, emotions, and thoughts that are linked to problems in living and are causing misery and distress.

DBT Skill[1]	Definition	Goal	Core Components[2]
Mindfulness	• Intentionally living with awareness in the present moment • Not judging or rejecting the moment • Not experiencing attachment to the moment	• Reduce suffering and increase happiness • Increase control of mind • Experience reality as it is	• States of mind: wise mind, reasonable mind, emotion mind • What skills (observe, describe, participate) • How skills (non-judgmentally, one-mindfully, effectively)
Interpersonal effectiveness	• Balancing acceptance and change ie, "walking the middle path" • Thinking and acting dialectically	• Be skillful in getting what you want and need from others • Build relationships and end destructive ones • Walk the middle path	• Clarifying priorities • Skills for objectives effectiveness (DEAR MAN), relationship effectiveness (GIVE), and self-respect effectiveness (FAST)
Emotion regulation	• Managing negative and overwhelming emotions while increasing positive experiences	• Recognize and name primary and secondary emotions • Decrease the frequency of unwanted emotions and suffering • Reduce emotional vulnerability	• Changing emotional responses by checking the facts, using opposite action and problem solving skills • Reducing vulnerability to emotion mind both in short and long term (ABC PLEASE)
Distress tolerance	• Learning strategies to accept life in the moment and to tolerate crisis without engaging in problem behaviors	• Survive crisis situations • Accept and tolerate reality • Avoid acting on unhealthy desires and urges during intense emotional moments	• Tolerating painful events, urges, and emotions using STOP, pros and cons, TIP skills, distraction (wise mind ACCEPTS) • Practicing radical acceptance

Source: *DBT Skills Training Handouts and Worksheets*, Second Edition, by Marsha M. Linehan. ©2015.

[1]DBT skills ©2016 Marsha M. Linehan.

[2]The acronyms in this column refer to specific skill sets. For more information on these skills, consult the DBT skills training book referenced for this table.

Dialectical Behavior Therapy for Substance Use Disorders: A Primer

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in treatment (64% versus 27%), and to achieve greater reductions in drug abuse throughout treatment (Linehan M et al, *Am J Addict*. 1999;8(4):279–292). In another RCT, BPD patients with opioid use disorder who received DBT and methadone replacement therapy maintained more urinalysis-confirmed reductions in opiate abuse during the last four months of treatment than controls who received methadone replacement plus treatment as usual (Linehan M et al, *Drug Alcohol Depend* 2002;67(1):13–26).

After six months of DBT, Angela has reduced her drinking to less than once per month. She found a new job and has been meeting the terms of her probation. Her boyfriend continues to drink, but they are getting along better after he agreed not to drink at home. She feels less emotionally reactive, and she hasn't self-harmed in over three months.

Could your patients benefit from DBT? Maybe. It's important to understand that DBT isn't designed for any single diagnosis. Rather, it's intended to be transdiagnostic and effective for patients who have severe difficulty regulating emotions and behavior. Since this applies to most addicts, DBT can be a good option for substance-abusing patients with comorbid mood or behavioral problems, or for patients who don't respond to more traditional addiction treatment. For more information about DBT-SUD, read "Dialectical behavior therapy for substance abusers (Dimeff L and Linehan M, *Addict Sci Clin Pract* 2008;4(2):39–47).

CATR VERDICT: DBT is a promising treatment that is grounded in philosophy and behavioral theory, is supported by RCTs, and offers hope for patients with comorbid or refractory addiction.

Attachment Strategies

Strategy	Action
Establish a just-in-case plan	Make a list of all the places you should look and people you should call if your patient becomes "lost."
Increase contact during the first several months of treatment	Schedule check-in phone calls; exchange voice or email messages.
Shorten or lengthen therapy sessions	Adjust to suit your patient's needs.
Bring therapy to the patient	Meet at a park, a diner, or some other location away from the office.
Keep in touch	Send birthday or holiday cards; think of creative ways to stay connected.

Source: Dimeff L and Linehan M, *Addict Sci Clin Pract* 2008;4(2):39–47.

Expert Interview

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when you're not, you're recovering and coming back. And that's really a lot based on Alan Marlatt's work. After dialectical abstinence, we teach a whole set of skills for what to do in case you do fall off and relapse.

CATR: Like what?

Dr. Linehan: Well, the second skill is called *clear mind*. Clear mind is a skill that basically says it's very easy to think that you're safe when you've quit. So you've quit, but now you start thinking that you're safe when in reality you're never safe. The person who doesn't have a clear mind is the one thinks, "Well, I've been off alcohol for a long time and I don't have to worry about it. I heard there's a really good bar down the street that has great hamburgers, so I think I'll go down there and eat." This is when you go down there and, of course, instead of having a hamburger you end up drinking. So clear mind is designed to address that.

CATR: Fascinating. What comes after clear mind?

Dr. Linehan: The final set of skills is called *alternate rebellion*. Those are things like if you're doing all this to rebel, let us give you a whole bunch of other ideas of how you can rebel without getting in lots of trouble. It is sort of like saying, "Drop that and do this." Alternate rebellion has become pretty popular on the internet, and if patients look it up they can get all kinds of ideas of things to do. For example, they could dye their hair blue.

CATR: Those sound like skills people can have some fun with. How does DBT fit in with 12-step groups and the recovery movement as a whole? Are they compatible?

Dr. Linehan: DBT is very supportive of 12-step groups. The only real conflict point is that some of the groups are 100% abstinence-based, whereas for alcohol DBT really isn't. But if clients attend AA groups that are 100% abstinence based, we don't tell them that they should not be abstinent. If they choose to be abstinent, then that's what they should do. Beyond that, we generally try to help the person use wise mind decisions. In most other areas, DBT is very compatible with the 12 steps. In fact, some of the 12 steps have similar origins and applications to DBT mindfulness skills.

CATR: DBT therapists provide off-hours telephone coaching to clients who are having trouble regulating their emotions or behavior. Can addiction clients call their therapist any time of day or night and say, "I just walked past a bar and I have this terrible craving?" If so, how does this differ from the role of a 12-step sponsor?

Dr. Linehan: My understanding is that 12-step sponsors do not want to be psychotherapists. I've treated lots of people who have alcohol addiction who have an AA sponsor, but they also have me. In those cases, clients can call whichever one of us they're most comfortable with at that moment. It is often helpful to have both because 12-step participants can burn out their sponsors and clients can burn out their therapists. I've had clients who call their sponsors a lot, and I'm really happy that they do because that means they're not calling me! I don't tell them to call their sponsor, but I do say, "Look, pay attention to what they're telling

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Research Updates

Bret A. Moore, Psy.D, ABPP

Dr. Moore has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

ANTICONVULSANTS

Reports of Gabapentin Misuse and Abuse Appear to Be True
(Smith R et al, *Addiction* 2016;111: 1160–1174)

Gabapentin is FDA-approved for seizures and neuropathic pain, but it's commonly used off-label for a variety of psychiatric and physical conditions, including anxiety, insomnia, borderline personality disorder, alcohol use disorders, and multiple pain disorders. Another aspect of gabapentin use that has come to light in recent years is a seemingly pervasive pattern of misuse and abuse. This has perplexed clinicians and researchers alike as gabapentin has long been considered to have no abuse potential (while the DEA has classified pregabalin as a Schedule V substance, gabapentin is not a scheduled drug). In order to understand the magnitude of and reasons behind the misuse and abuse of gabapentin, University of Kentucky researchers did a systematic review on the issue.

Multiple databases were mined for peer-reviewed articles on the misuse of gabapentin, which was defined as taking medication without a prescription or at a higher dose than prescribed. The final analysis included 47 case studies and 11 epidemiological reports from around the world. Here's what the researchers found.

Based on a study of 1,500 people in the U.K., it's estimated that gabapentin is abused by a tad over 1% of the general population. Not surprisingly, the groups most at risk of gabapentin misuse are those with a history of alcohol, illicit drug, or opioid abuse or dependence. People mostly misuse the medication in order to get high, self-medicate, and harm themselves. And they aren't using it in isolation. Gabapentin is commonly combined with alcohol, benzodiazepines, and opioids. Regarding the latter, upwards of 22% of opioid abusers in the U.S. and U.K. are believed to also abuse gabapentin. Interestingly, those who misuse gabapentin report subjective sensory and psychological experiences similar to benzodiazepines, opioids, and psychedelics. The range of doses being abused varies and falls within the standard therapeutic range of 900–3,600 mg/day. But, when euphoria is the goal of the abuser, gabapentin may be crushed to powder and inhaled. In some cases of misuse, doses of up to 12,000 mg have been seen, but 4,800 mg seems to be the upper limit if the intent is to create a sense of sedation or relaxation. With abrupt discontinuation of doses greater than 3,600 mg/day, some have experienced withdrawal symptoms, including confusion, tremor, agitation, and sweating.

But, as noted above, gabapentin is typically not used in isolation. Abusers can achieve feelings of euphoria and calmness at much lower doses when gabapentin is combined with other medications like buprenorphine, methadone, baclofen, and quetiapine. The street value of gabapentin also supports the anecdotal reports of its abuse potential, particularly when it comes to recreational use. Several studies from the U.S. and U.K. found that gabapentin was often traded for illicit drugs and commanded up to $7 per pill on the street.

CATR's Take: It appears there is validity to the anecdotal reports we all hear about the misuse and abuse of gabapentin. Therefore, we should prescribe it conservatively, especially to those using benzodiazepines and opioids, individuals battling alcohol and drug addiction, or patients already taking psychiatric medications that can potentiate the abusive properties of the medication.

DBT Addiction Skills

Skill	Description
Dialectical abstinence	Striving for abstinence while being prepared or ready for occasional lapses.
Clear mind	The synthesis between *addict mind*, which is fully engaging in your addictive behavior, and *clean mind*, which is pretending addiction is not a problem for you. *Clear mind* is essentially being fully aware that you can slip back into addiction.
Contingency management	Identifying people, places, and activities that can reinforce non-addictive behavior.
Burning bridges and building new ones	Identifying people, places, and activities that trigger substance use and getting rid of them; learning strategies to manage cravings.
Alternative rebellion	Finding alternative ways to rebel if drug use functions as a way for you to rebel against society.
Adaptive denial	Denying cravings and urges to use, and telling yourself instead you are craving something benign like lemonade or a bubble bath.

Source: Linehan M. *DBT Skills Training.* 2nd ed. New York, NY: Guilford Press; 2014.

CE/CME Post-Test

This CME test is only available to active subscribers and it must be taken by August 31, 2017. If your subscription expires before that date, you will not have access to the test until your subscription is renewed. To earn CME or CE credit, you must read the articles and then take the post-test at www.TheCarlatReport.com. You must answer at least four questions correctly to earn credit. You will be given two attempts to pass the test. As a subscriber to *TCPR*, you already have a username and password to log onto www.TheCarlatReport.com. To obtain your username and password, please email info@thecarlatreport.com or call 978-499-0583.

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Below are the questions for this month's CE/CME post-test. This page is intended as a study guide. Please complete the test online at www.carlataddictiontreatment.com. Note: Learning objectives are listed on page 1.

1. Distress tolerance is a dialectical behavior therapy (DBT) skill that helps patients: (Learning Objective #1)
   [ ] a. Apply self-soothing strategies to get through a crisis situation
   [ ] b. Interact with others effectively
   [ ] c. Reduce vulnerability to emotions by "checking the facts"
   [ ] d. Be aware of the present moment without judgment

2. According to the DBT model of treatment, alcohol users should become completely abstinent, but illicit drug users may use drugs in moderation. (LO #2)
   [ ] a. True [ ] b. False

3. According to recent studies, patients with chronic, treatment resistant polysubstance dependence who received DBT had what type of outcome? (LO #1)
   [ ] a. Less likely to take a therapy vacation during treatment
   [ ] b. No change in drug abuse throughout treatment
   [ ] c. More likely to apply the addiction skills versus the traditional DBT skills
   [ ] d. More likely to remain in treatment

4. _____ is a DBT addiction skill that emphasizes substituting certain activities for substance abuse. (LO #2)
   [ ] a. Dialectical abstinence [ ] b. Clear mind [ ] c. Alternate rebellion [ ] d. Emotional mind

5. According to a recent study, what percentage of opioid abusers in the U.S. and U.K. are estimated to abuse gabapentin as well? (LO #3)
   [ ] a. 2% [ ] b. 12% [ ] c. 22% [ ] d. 32%

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Expert Interview

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you. Do what they're telling you to do." I've been very impressed with sponsors, to be honest with you. They give good advice.

CATR: Interesting. It sounds like there's potentially a lot of overlap there.

Dr. Linehan: There is, but sponsors aren't the ones to call when clients are feeling suicidal. A lot of my clients also have their sponsors say, "Look, you can't keep calling me; I'm not your therapist." So the therapist has an important role. On the other hand, what a psychotherapist can't duplicate is a meeting. I try to get my clients to go to as many meetings as possible.

CATR: What about motivational interviewing (MI), which as you know is very non-confrontational? Does it jibe with DBT's more directive approach?

Dr. Linehan: People think DBT therapists are always pushing people into things, but DBT and MI are not that different. Both start out with, "What are your goals?" The job of a DBT therapist is to help clients figure out and reach their goals. Help them reach their goals. That's not different from MI. The only goal we are not willing to help them with is killing themselves. That is the only thing we are really pretty strong on. And I'm pretty sure anybody else would do the same thing—would not agree that it's reasonable to decide to kill yourself. DBT has a whole set of skills on values because most of the people we deal with, if you ask them what their values were, they'd be ashamed because they wouldn't be able to tell you. They can tell you what they want out of therapy, but they can't really tell you what's important to them in life in general. So we have a whole list of possible values, and we have them go through it and check off everything important to them. And then we have a whole strategy on how to make these values become part of their lives, to build their lives according to their values. But we are not interested in anything else about their values except for the fact that we are not going to help them kill themselves.

CATR: And I gather you are not going to help them use drugs or alcohol either.

Dr. Linehan: I'm not going to help them use, but I'm not going to tell them not to. What we do is try to help clients see the pros and cons, then they decide what they want to do. We try to help clients figure out for themselves what is the best outcome, then we teach them the skills to help achieve those outcomes. We know which skills work for what, but it's up to clients to pick out which skills to use.

CATR: DBT famously favors "skills over pills," but we know many patients are on methadone, buprenorphine,

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This Month's Focus:
Dialectical Behavior Therapy in Addiction
Next month: Addiction in Health Care Professionals

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naltrexone, and other medical treatments to help them maintain abstinence. How do those medicines fit into the DBT substance abuse treatment model?
Dr. Linehan: Trading skills for pills comes into play when people come in on a whole bunch of mood-altering drugs that are far outside of evidence-based treatment. But I believe in better living through chemicals, and I'm in favor of opioid replacement therapy. It's critical for heroin addiction. In fact, we had incredibly good outcomes on a study where we had the primary therapist giving them replacement drugs the same as a family member would do—we had special permission for the therapists to actually hand-dispense methadone. We had great retention because there was a real reinforcement for coming to see the therapist! We are also in favor of medications that reduce cravings.
CATR: Is there anything else you'd like to tell us?
Dr. Linehan: One thing I think is really important is that if you have a waiting list, put people in a skills group while they are waiting. You only need one or two people to teach a whole group, and a motivated teacher can learn the skills from reading the skills manual (Linehan M. *DBT Skills Training.* 2nd ed. New York, NY: Guilford Press; 2014). My other advice is to start at the beginning and learn all the skills—DBT and addiction skills—in the order they are presented in the book, because that's what the research supports. There's no research to support using the addiction skills by themselves.
CATR: Thank you for your time, Dr. Linehan.