

COMMENTARY

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## Calling for Help? Considering Function and Meaning when Patients Drunk-Dial Psychotherapists

Kelly Serafini, Donna LaPaglia and Matthew Steinfeld\*

Yale University School of Medicine, Department of Psychiatry, New Haven, Connecticut, United States.

\*Corresponding author email: [matthew.steinfeld@yale.edu](mailto:matthew.steinfeld@yale.edu)

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**Abstract:** Drunk-dialing is a term documented in both popular culture and academic literatures to describe a behavior in which a person contacts another individual by phone while intoxicated. In our collective clinical experience we have found that clients drunk-dial their clinicians too, particularly while in substance use treatment, and yet there is a noticeable absence of research on the topic to guide clinical decision-making within a process-based understanding of these events. As the parameters within which psychotherapy takes place become increasingly technologized, a literature base to document clients' idiosyncratic use of technology will become increasingly necessary and useful. We provide a brief review of the existing research on drunk-dialing and conclude with specific questions to guide future research and practice.

**Keywords:** substance use, drunk-dialing, boundary violations, therapeutic frame, clinical process, alcohol use

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## Introduction

Clinicians that treat individuals diagnosed with substance use disorders often experience a unique set of disorder-specific presentations that typically do not occur as frequently in other forms of treatment (eg, intoxication, withdrawal). Among these is receiving voicemails from clients while they are intoxicated. Drunk-dialing is a term used in popular culture, and more recently the scientific literature, to describe a phone call placed by an intoxicated individual which he or she would typically not have made if sober.<sup>1,2</sup> We have observed in the course of our collective clinical experience that it is not uncommon for clients in substance use treatment to drunk-dial their clinicians (frequently leaving voicemail on telephone answering machines), and yet, to the best of our knowledge, there is no mention of this in the substance use and treatment literatures. We believe that one way of understanding drunk-dialing from substance-using clients is that, rather than being an action that falls outside of the parameters of treatment, it constitutes important and potentially useful strands within the fabric of the therapeutic process. The purpose of this commentary is thus intended to begin a discussion within the substance use community about this clinical event, offer ways to think about this phenomenon, and highlight the utility of future research in this area.

## Background

While there is no peer-reviewed literature on drunk-dialing in the context of psychological treatment, its presence has been well documented across varied contexts as a cultural phenomenon (in newspapers and periodicals,<sup>3-5</sup> magazines,<sup>6-8</sup> music lyrics,<sup>9-14</sup> dating columns,<sup>15-17</sup> and books).<sup>18</sup> Due to its prevalence, as well as the potential for undesirable interpersonal consequences, software companies have even developed applications for cellular devices specifically designed to decrease its occurrence.<sup>19-21</sup>

Of the little formal research that exists, the majority has focused on undergraduate populations.<sup>1,2,22</sup> In order to estimate its prevalence, one study polled 486 undergraduate students and found that 79 percent had either sent or received a drunk dial.<sup>1</sup> Another study<sup>2</sup> also found drunk-dialing to occur within a sample of 491 graduate students, establishing that it is a behavior occurring across undergraduate samples.

Reported motives for drunk-dialing vary, with one study<sup>1</sup> identifying 10 distinct drunk-dialing motives: lack of inhibition, coordination, status, boredom, social connection, homophily/reciprocity, confession of emotion, lack of accountability, entertainment, and sexual initiation. Another study<sup>2</sup> found that the top 3 reasons for drunk-dialing in their sample was an affirmative response to the following items: “Called a friend to tell them you wished she or he was partying with you”, “Called a friend to see what he or she has been up to”, and “Called a person you were romantically interested in or involved with to see if they were willing to meet you later in the evening”. In sum, the existing research suggests that drunk-dialing occurs due to a diverse set of motives.

When studying traits that might lead to drunk-dialing, other researchers found that low self-control was a significant predictor of peer drunk-dialing.<sup>2</sup> Excessive alcohol use has also been identified as a predictor of intensive cell phone usage in a Spanish adolescent population.<sup>23</sup> In a similar vein, there has been some research to support substance use as a precursor to other potentially risky cell phone practices, such as “sexting” (ie, sending sexually explicit content by phone).<sup>24,25</sup>

In one of the few studies that explicitly studies the link between alcohol intoxication and cell-phone usage, researchers found that undergraduate students used drunk-dialing as a means of facilitating sexual encounters.<sup>22</sup> These drunk-dials were most likely to have occurred at the end of a drinking episode when students were most intoxicated and sometimes resulted in negative interpersonal consequences. Through interviews with those participants, a defining feature of drunk-dials in that sample was subsequent feelings of remorse, shame, or regret once the individual was sober and became aware of his/her actions.

Interestingly, while alcohol is the only substance that has been cited in our review of the literature in utilizing cellular devices (See Table 1 for a summary of the available research on drunk-dialing), it is quite plausible that any drug that facilitates behavioral disinhibition may be linked to similar occurrences. Additionally, as individuals utilize different drugs for different reasons (frequently to alter mood and thus affective state), the interaction between underlying affective state and drug of choice may be a better predictor of drunk-dialing than drug type on its own.

**Table 1.** Summary of research addressing substance use and electronic communications.

| Reference  | Description  | Population             | Sample size                   |
|--|--|------------------------|-------------------------------|
| <b>Drunk-dialing</b>                             |  |                        |                               |
| Vander Ven and Beck <sup>22</sup>                | Drunk-dialing as it relates to sexual encounters                           | Undergraduate students | 469 surveys;<br>32 interviews |
| Hollenbaugh and Ferris <sup>1</sup>              | Examined motives for drunk-dialing   | Undergraduate students | 486                           |
| Reisig and Pratt <sup>2</sup>                    | Low self-control as a predictor of drunk-dialing                           | Undergraduate students | 502                           |
| <b>Substance use and cell phones</b>             |  |                        |                               |
| Benotsch, Snipes, Martin, and Bull <sup>24</sup> | Correlation between “sexting” and substance use                            | Young adults           | 763                           |
| Dir, Cyders, and Coskunpinar <sup>25</sup>       | Alcohol use and its relationship to “sexting” and casual sexual encounters | Undergraduate students | 611                           |
| Sánchez-Martínez and Otero <sup>23</sup>         | Relationship between excessive cell phone usage and alcohol                | Adolescents            | 1, 328                        |

Many questions remain to be answered through ongoing research in this area.

However, while drunk-dialing has begun to emerge in the broader literature, to the best of our knowledge there are no studies to date that address its presence and impact on the most relevant of contexts: substance use treatment.

### Drunk-Dialing in the Context of Substance use Treatment

Within the context of substance use treatment, the vast majority of clients have access to cellular phones, despite frequently having limited financial resources. One survey found that 91 percent of clients receiving treatment from an urban substance use treatment center had access to mobile devices, despite 57 percent earning less than \$15,000 a year.<sup>26</sup> This may be due in part to newly initiated government programs aimed at providing cellular phones and services to individuals meeting need-based criteria.<sup>27</sup>

In recent years, along with increased access to technology, has come innovation in its application to the provision of psychological services. With research reporting high rates of access to technology among substance users,<sup>28</sup> a variety of phone-mediated treatments have been developed that utilize text messaging, text-based applications, and ecological momentary assessment to increase the accuracy of self-reported substance use and self-regulatory control.<sup>29–36</sup> However, despite an emerging literature proposing that the technologization of treatment has great utility, there is a noticeable absence of research on the impact that this now

technologized therapeutic landscape can have on the clinical process.<sup>37</sup>

Moreover, as clients suffering from a mood or anxiety disorder are roughly twice as likely than the general population to have a co-occurring substance use disorder,<sup>38</sup> we suggest that drunk-dials merit consideration not only for clinicians whose primary focus is the treatment of substance use disorders, but for all practitioners involved in the provision of mental health care. Why? Because an awareness of the meaning in, and function of their occurrence, can open a window into the psychology of the person calling, thus offering an opportunity for treatment engagement amidst the range of behaviors that are manifest in the sequelae of substance misuse and intoxication.

### Clinical Implications

One way of understanding drunk-dials, and how they affect the therapeutic relationship, is to hear them within the extensive literature on boundary violations. This phenomenon has been addressed from the psychodynamic, the cognitive-behavioral, acceptance and commitment, and dialectical behavior therapy (DBT) literatures, to name but a few.<sup>39–43</sup> Clients that use substances are perhaps more likely to transgress therapeutic boundaries because of the behavioral disinhibition that typically accompanies intoxication.<sup>44,45</sup>

Like many other boundary violations, clinical material is brought to the clinician’s attention outside of the therapy hour, but of note, drunk-dialing challenges the therapeutic frame in a unique manner: the body is absent and yet speech and emotional tone are



made readily available to the clinician. Thus, the violation of the frame is, in a sense, “disembodied”; the clinician is faced with the dilemma of what, exactly, to speak to. An absent body? A disembodied voice? There may also be discrepancies between how a patient presents in-session versus through voicemail. How the treating clinician addresses these communications is of great import, as these are opportunities that can facilitate greater psychic integration and its attendant agency.

To briefly illustrate the heterogeneous content and function of these events, the following are excerpts of drunk-dials left to voicemail machines that we have received (all identifying information has been removed and some details were disguised in order to protect patient confidentiality):

Example #1: This individual was not a client of the clinic, called a clinician to inquire about services, and left a message on their answering machine.

“Hi, I ... I knew you were going to say that. Anyways I ... I’m a real drunk and I don’t want to be a drunk anymore. So, how do we work this out? It’s not that I haven’t... been a drunk my whole life but, I’ve been sober for half of it. That still makes me a drunk. So I need help! Do I push? I want to push a button for more options ... so ... bark, bark, bark, woof, woof. So help me out, come on, I don’t want to bark so much any more, I just want to woof. Bye. I can’t explain my life any better than that. Yeah. Bark, bark, bark, woof, woof, woof.”

Example #2: This individual was enrolled in psychotherapy at the clinic and was not allowed to enter the session due to a positive breathalyzer screen for alcohol and aggressive behavior that almost necessitated calling 911. This voicemail was left to the clinician after a higher level of care was determined necessary by the treatment team.

“Look, I know ... I was sent there ... look, for drug treatment and I know this. You people [profanity] don’t understand what drug treatment is ... and I opened up ... and I opened up ... why don’t you understand human beings and listen? And see? And inject? All of you to be able to give an answer to a problem. Do you understand what I am saying? I am highly above your education. Very highly above your education and I know it. Hey look, I appreciate your sessions and all that, but I need you to understand when somebody is sent to you for drug treatment, understand it. Relate to the person. Help them out. Don’t be afraid of them. That’s what you did to me! I’m sorry, I even bothered you, but learn ... go back to college and get yourself an education in drug treatment situations, for all of you

to relate. In order for you to help somebody and not dial 911 on them. Hey look, I appreciate you listening to me off the record. I am not like that. You all don’t know your job. Bye.”

As is illustrated above, the content and function of drunk-dials can vary considerably depending on the context in which they were made and desired outcome of the call. The first example demonstrates an individual that is seeking help, while the second demonstrates a message from an individual who is sharing the complexities of someone so overcome with anger that being able to talk about it was possible only after the fact and while intoxicated. How a clinician would approach dealing with a drunk-dial would thus vary depending on the purpose of the call.

## What to do?

While there is no literature directly addressing how to treat drunk-dialing, the DBT literature offers the closest clinical insights in how to conceptualize such behaviors. DBT practitioners consider ‘treatment-interfering behaviors’ a high priority in treatment.<sup>46</sup> Disruptive drunk-dials would likely be addressed within the next therapy session with the client. DBT also utilizes coaching calls, which allow clients to contact their clinicians when they are seeking help in practicing DBT skills outside of the therapy session. From a DBT perspective, intoxication does not necessarily preclude contacting a clinician or receiving a response. The clinician must consider, rather, the function of the call. If the client is intoxicated and actively seeking help using DBT skills, the clinician may wish to continue the call. If the client is intoxicated and disrespectful, the clinician may consider ending the call due to a disruption of his/her “personal limit.”<sup>47</sup> Indeed, the DBT literature suggests that one of the most frequent errors made by clinicians utilizing telecommunication is failing to end an unproductive call.<sup>48</sup> Thus, not unlike other interactions in treatment, it is the meaning and intended function of the patient’s behaviors that is spoken to, affirming healthy recovery-oriented behaviors and attempting to extinguish countertherapeutic behaviors.

## Future Directions

While there is scattered literature identifying drunk-dialing as a negative consequence of substance use, there are empirical questions that warrant answers addressing the frequency of its occurrence across



varied clinical settings, the clinical impact on the therapeutic process within substance use treatment, and how to speak to these events when they do occur. To address this gap in the literature, we propose the following questions to guide future research:

- What are the prevalence rates of drunk-dialing across clinical settings (eg, addiction treatment, general mental health, private practice, primary care)?
- Are there specific demographic characteristics that correlate with drunk-dialing (eg, gender, age)?
- How might drunk-dialing (which implies alcohol use) differ from drug-induced communications, such as marijuana, cocaine, and other illicit drugs? And is there an interaction between substance type and underlying affective state?
- How might alcohol use affect other communications (eg, text-messaging, emailing)? Are there meaningful distinctions and consequences between different modes of substance-induced communications?
- How is one to understand the multiplicity of meaning present in a drunk-dial? Does it represent a cry for help? A demonstration of antisocial behavior? Is it indicative of a patient's early attachment patterns (eg, a disorganized 'approach' gesture through a call, coupled with a withdrawal of body)?
- Is drunk-dialing correlated with severity and/or pattern of substance use?
- What is the relationship between the content and function of the communication?
- How should clinicians intervene if they encounter a drunk-dial? Should they return the phone call? Should they wait to discuss the drunk-dial within the treatment session? How will they address the drunk-dial with the client?
- Should a clinician play the intoxicated voicemail back to the patient in the next session?

Because everyone who makes a drunk-dial has access to a phone, the majority of which are increasingly mobile devices, drunk-dialers may be especially likely to utilize a technologized intervention as an adjunct to psychotherapy. Having preliminary answers to the above questions would be of use in guiding who receives these interventions, and across which technologized platforms. For instance, research that determined the relationship between the number

of alcoholic beverages consumed and consequences of subsequent alcohol-induced communications (eg, the recipient of the drunk-dial, duration of call, purpose of call, content of call, outcomes of call), could identify patients for whom, given the severity of their substance using behaviors, a phone-based intervention would be of great utility. By studying the correlates of drunk-dialing further, broader treatment recommendations may emerge with implications relevant to the maintenance of the therapeutic frame and how to maximize treatment engagement when clinicians are drunk-dialed by their clients.

As is readily apparent, and as is the case with most any event that takes place on either side of the treatment frame, there is a vast number of ways to interpret drunk-dials in the context of a person's psychology, as well as to leverage that interpretation in the service of motivation and change.

## Conclusion

In our collective clinical experience, drunk-dialing is a relatively common occurrence within substance-using populations and thus warrants further study. A variety of factors may contribute to its occurrence in this population, including patient characteristics of decreased inhibitory-control, increased impulsivity, developmental histories of disrupted social attachments, use of mood altering substances, and an increase in cellular phone usage as a main mode of communication. However, despite the high likelihood of drunk-dialing occurring in the psychotherapy of substance users and the emotional salience of these encounters, there is a noticeable absence in the substance abuse treatment literature to guide therapeutic interventions. We propose that future research should both seek to better understand the correlates of drunk-dialing within substance use treatment and to use that understanding to develop interventions to guide clinical practice. As our society, field, and treatments begin to utilize more and more technology, it is of import that our consideration of the effects of technology on clinical practice keeps pace.

## Author Contributions

Conceived the concepts: KS, MS. Analyzed the Data: KS. Wrote the first draft of the manuscript: KS, MS. Contributed to the writing of the manuscript: KS, DL, MS. Agree with manuscript results and conclusions:



KS, DL, MS. Jointly developed the structure and arguments for the paper: KS, DL, MS. Made critical revisions and approved final version: KS, DL, MS. All authors reviewed and approved of the final manuscript.

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