

# DBT AT A GLANCE

In the late 1970s, Marsha M. Linehan (1993) attempted to apply standard Cognitive Behavior Therapy to the problems of adult women with histories of chronic suicide attempts, suicidal ideation, urges to self-harm, and self-mutilation. Trained as a behaviorist, she was interested in treating discrete behaviors; however, through consultation with colleagues, she concluded that she was treating women who met criteria for Borderline Personality Disorder (BPD). In the late 1970s, CBT had gained prominence as an effective psychotherapy for a range of serious problems. Linehan was keenly interested in investigating whether or not it would prove helpful for individuals whose suicidality was in response to extremely painful problems. As she and her research team applied standard CBT, they encountered numerous problems with its use. Three were particularly troublesome:

- 1) Clients receiving CBT found the unrelenting focus on change inherent to CBT invalidating. Clients responded by withdrawing from treatment, by becoming angry, or by vacillating between the two. This resulted in a high drop out rate. And, obviously, if clients do not attend treatment, they cannot benefit from treatment.
- 2) Clients unintentionally positively reinforced their therapists for ineffective treatment while punishing their therapists for effective therapy. In other words, therapists were unwittingly under the control of consequences outside their awareness, just as all humans are. For example, the research team noticed through its review of audio taped sessions that therapists would “back off” pushing for change of behavior when the client’s response was one of anger, or emotional withdrawal, or shame, or threatened self-harm. Similarly, clients would reward the therapist with interpersonal warmth or engagement if the therapist allowed them to change the topic of the session from one they didn’t want to discuss to one they did want to discuss.
- 3) The sheer volume and severity of problems presented by clients made it impossible to use the standard CBT format. Individual therapists simply did not have time to both address the problems presented by clients – suicide attempts, urges to self-harm, urges to quit treatment, noncompliance with homework assignments, untreated depression, anxiety disorders, etc, -- AND have session time devoted to helping the client learn and apply more adaptive skills.

***Adding Validation and Dialectics to CBT.*** In response to these key problems with standard CBT, Linehan and her research team made significant modifications to standard CBT. They added in new types of strategies and reformulated the structure of the treatment (see below, next section). In the case of new strategies, Acceptance-based interventions, frequently referred to as validation strategies, were added. Adding these communicated to the clients that they were both acceptable as they were and that their behaviors, including those that were self-harming, made real sense in some way. Further, therapists learned to highlight for clients when their thoughts, feelings, and behaviors were “perfectly normal”, helping clients discover that they had sound judgment and that they were capable of learning how and when to trust themselves. The new emphasis on acceptance did *not* occur to the exclusion of the emphasis on change: Clients also *must* change if they want to build a life worth living. Thus, the focus on acceptance did not occur to the exclusion of change based strategies; rather, the two enhanced the use of one another. In the course of weaving in acceptance with change, Linehan noticed that a third set of strategies –Dialectics --came into play. Dialectical strategies gave the therapist a means to balance acceptance and change in each session *and* served to prevent both therapist and client from becoming stuck in the rigid thoughts, feelings, and behaviors that can occur when emotions run high, as they often do in the treatment of clients diagnosed with BPD. Dialectical strategies and a dialectical world view, with its emphasis on holism and synthesis, enable the therapist to blend acceptance and change in a manner that results in *movement, speed, and flow* in individual sessions and across the entire treatment. This counters the tendency, found in treatment with clients diagnosed with BPD, to become mired in arguments, polarizing positions, and extreme positions. Thus, these three sets of strategies and the theories on which they are based from are the three foundations of DBT.

***Restructuring the Treatment.*** As noted above, very significant changes were also made to the structure of treatment in order to solve the problems encountered in the application of standard CBT. Below we discuss how DBT treatment is organized by Functions and Modes and by Stages and Targets. The treatment we are describing is the treatment that is considered to be Standard and Comprehensive DBT. It is the form of DBT that has been subject to the most rigorous research in terms of randomized clinical trials (RCTs). The variations of DBT that differ from the structure described below is being researched but has not yet been subjected to as rigorous a test as standard DBT. Thus, the reader should keep in mind that this is how comprehensive DBT is defined and that variations from this structure are *not* considered comprehensive or standard.

***Functions and Modes.*** Briefly, Linehan (1993) hypothesizes that any comprehensive psychotherapy must meet five critical functions. The therapy must: a) enhance and maintain the client's motivation to change; b) enhance the client's capabilities; c) ensure that the client's new capabilities are generalized to all relevant environments; d) enhance the therapist's motivation to treat clients while also enhancing the therapist's capabilities; and, e) structure the environment so that treatment can take place. Due to space considerations, we will not review every possible mode (method) that can meet these functions. Rather, we offer the most common examples of how these functions are met in standard outpatient DBT. It is typically the individual therapist who maintains the client's motivation for treatment, since the individual therapist is the most salient individual for the client. Skills are acquired, strengthened, and generalized through the combination of skills groups, phone coaching (clients are instructed to call therapists for coaching prior to engaging in self harm), *in vivo* coaching, and homework assignments. Therapists' capabilities are enhanced and burnout prevented through weekly consultation team meetings. The consultation team helps the therapist stay balanced in his or her approach to the client, while supporting and cheerleading the therapist in applying effective interventions. (In DBT, a therapist is not considered to be meeting the requirements of the treatment unless he or she meets weekly in a DBT consultation team). Finally, the environment can be structured in a variety of ways, say by the client and therapist meeting with family members to ensure that the client is not being reinforced for maladaptive behaviors or punished for effective behaviors in the home.

***Stages and Targets.*** DBT also organizes treatment into stages and targets and, with very few exceptions, adheres strictly to the order in which problems are addressed. The organization of the treatment into stages and targets prevents DBT being a treatment that, week after week, addresses the crisis of the moment. Further, it has a logical progression that first addresses behaviors that could lead to the client's death, then behaviors that could lead to premature termination, to behaviors that destroy the quality of life, to the need for alternative skills. In other words, the first goal is to insure the client stays alive, so that the second goal (staying in therapy), results in meeting the third goal (building a better quality of life), partly through the acquisition of new behaviors (skills). In short, we have just described the targets found in Stage I. To repeat, the first stage of treatment focuses, in order, on decreasing life threatening behaviors, behaviors that interfere with therapy, quality of life threatening behaviors and increasing skills that will replace ineffective coping behaviors. The goal of Stage I DBT is for the client to move from behavioral dyscontrol to behavioral control so that there is a normal life expectancy. In Stage II, DBT addresses the client's inhibited emotional experiencing. It is thought that the client's behavior is now under control but the client is suffering "in silence". The goal of Stage II is to help the client move from a state of quiet desperation to one of full emotional experiencing. This is the stage in which post-traumatic stress disorder (PTSD) would be treated. Stage III DBT focuses on problems in living, with the goal being that the client has a life of ordinary happiness and unhappiness. Linehan has posited a Stage IV specifically for those clients for whom a life of ordinary happiness and unhappiness fails to meet a further goal of spiritual fulfillment or a sense of connectedness of a greater whole. In this stage, the goal of treatment is for the client to move from a sense of incompleteness towards a life that involves an ongoing capacity for experiences of joy and freedom.

## Research on DBT

Two randomized controlled trials (RCTs) 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 (Linehan, Armstrong, Suarez, Allmon & Heard, 1991; Linehan, Schmidt, Dimeff, Craft, Kanter & Comtois, 1999). Clients receiving DBT, compared to TAU, were significantly less likely to drop out of therapy, were significantly less likely to engage in parasuicide, reported significantly fewer parasuicidal behaviors and, when engaging in parasuicidal behaviors, had less medically severe behaviors. Further, clients receiving DBT were less likely to be hospitalized, had fewer days in hospital, and had higher scores on global and social adjustment. Likewise, in the RCT conducted on DBT for women with co-morbid substance abuse, in addition to similar findings to the original study regarding improvement in BPD criterion behaviors, DBT was more effective than TAU at reducing drug abuse. Follow up indicated that subjects who had received DBT also had greater gains in global and social adjustment. DBT has also been the subject of RCTs conducted independently of Linehan's research clinic at the University of Washington. Koons, Robins, Tweed & Lynch (2001) randomly assigned 20 women veterans diagnosed with BPD to either DBT or TAU. Unlike Linehan's, et al. (1991, 1993) original studies, subjects were not required to have a recent history of parasuicide. However, subjects enrolled in DBT showed statistically significant reductions in suicidal ideation, depression, hopelessness, and anger compared to subjects enrolled in TAU. Verheul, Van Den Bosch, Koeter, De Ridder, Stijnen & Van Den Brink (2003) conducted an RCT in the Netherlands, again comparing DBT to TAU. Their findings are consistent with the earlier studies: Subjects enrolled in DBT had greater treatment retention, reduced suicidality, reduced episodes of self harm and self-mutilation. DBT continues to be the subject of randomized controlled trials. At present, Linehan (personal communication, 2003) is completing a randomized controlled trial of DBT v. Treatment- By-Expert (TBE). Other studies are ongoing regarding the use of DBT with eating disorders, DBT with BPD and co-morbid substance abuse, as well as the utility of DBT in other than outpatient settings.

### References:

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