Contents

1

Introduction

When we first heard about borderline personality disorder (BPD), we had more questions than answers. One of us (ALC) probably first heard about BPD during my undergraduate course in abnormal psychology, while the other (KDG) read books that referred to BPD while in middle school. What stood out to both of us at the time was the image of someone who was unpredictable and out of control, with intense emotions and fears of abandonment. The term *borderline* seemed confusing, like people with BPD had some kind of mysterious or undefined syndrome. And what resonated with us was the prevailing notion that this condition may not be treatable.

A few years after my first encounter with BPD as an undergraduate, I (ALC) started working at a transitional mental health facility for patients who had been hospitalized and needed more residential support before returning home. Many of these patients had attempted suicide, harmed

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Dialectical Behavior Therapy, by A. L. Chapman and K. L. Dixon-Gordon

themselves, or experienced flare-ups of psychotic or mood symptoms. After they received some treatment in the hospital and their medications were stabilized, they stayed at the facility I worked at for a few days to a couple of weeks. I was a junior mental health clinician and knew very little about what I was dealing with, but I certainly encountered patients with BPD. As it turned out, they weren't scary or unpredictable. They were often emotionally up and down and distraught about the state of their lives, and many had seriously harmed or tried to kill themselves. At the same time, they were sensitive, empathetic, and fun to work with, and they desperately wanted help.

At the time, at least in my area, the kind of help they needed was not easy to get. People with BPD and other complex mental health problems often need a comprehensive, structured, evidence-based treatment. Not only were programs offering this kind of treatment hard to find, but clinicians often avoided patients with BPD because they either did not know how to help them or were put off by stigmatizing attitudes (i.e., the idea that BPD patients are impossible to treat, angry, unpredictable, and out of control). This combination of stigma, a lack of appropriate services, and a general unwillingness of clinicians to help those with BPD made it difficult for people to maintain hope for recovery.

Our introduction to Marsha Linehan's work indelibly shifted our views related to BPD and its treatment. I (ALC) learned about dialectical behavior therapy (DBT) during one of my graduate courses on the treatment of adult mental health problems, and later, in a course on the treatment of BPD. We had to read the main DBT text (Linehan, 1993a) and skills training manual (Linehan, 1993b), and I remember writing a paper comparing and contrasting DBT with more psychoanalytic approaches to the treatment of BPD. At around the same time, I had started to see some of my first clients, one of whom happened to have BPD. She was a bright young woman who had been harming herself for several years. I was teaching her DBT skills while another student clinician provided individual DBT weekly. I was learning DBT skills while I was teaching them to this client, so I had more homework to do each week than

she did! Over the course of a year or so, she stopped harming herself, started to improve her relationships, got back into school, and began to piece together the key ingredients of a life worth living. Throughout this process, I became fascinated with the treatment of clients with BPD and changed the direction of my research, focusing on BPD for my dissertation, completing an internship focused on DBT, ultimately working with Dr. Marsha Linehan as a postdoc for 2 years at her research and treatment center, the Behavioral Research and Therapy Clinics at the University of Washington (UW).

Likewise driven to understand this seemingly mysterious, painful, and difficult-to-treat condition, I (KDG) also wrote a paper on BPD in college. Yet it was only when I began seeking an undergraduate research experience that I learned about the work being done by Marsha Linehan to treat BPD at my very own school, UW. When I saw how behavioral principles could be harnessed to effectively treat this unfairly maligned, heartbreaking condition, I dedicated myself to the study of DBT. I was lucky enough to complete my graduate studies under the supervision of ALC. DBT and research on BPD and related problems have since been a major focus of our careers.

CASE EXAMPLE

To understand the problems DBT aims to solve, consider the case of "Mandy." Mandy is a 25-year-old Caucasian woman who lives off and on with her partner. She currently works at a local coffee shop while taking some classes at the community college and wishes to eventually go into social work. Mandy grew up in a large city in the Northeast, with her parents and two older brothers. She described her upbringing as "difficult." When asked to elaborate, she became tearful and eventually disclosed that she had always felt like the black sheep in the family. Unlike her older brothers, who were straightlaced, into sports, and seemed to take everything in stride, she was always the emotional one. Her family called her "moody Mandy," as she had so many ups and downs. She was

also a little on the impulsive side, had difficulty focusing at school, and gravitated toward rougher crowds from a fairly young age—kids who smoked, drank, and experimented with drugs as early as junior high school. Mandy reported that her parents were very caring but often seemed fed up with her and her problems (emotional ups and downs, getting in trouble at school, and so forth). In her early teens, she started to experience depressive episodes following an attempted sexual assault by an acquaintance, and she began to drink more, experiment with drugs, and engage in risky sex. Over the next couple of years, Mandy became increasingly depressed, started self-injuring, and was hospitalized for the first time following a suicide attempt at age 15. She attempted suicide two or three more times following the index attempt and continued to self-injure. Throughout high school, Mandy often seemed to be in a crisis of some sort. Her relationships with friends were up and down, she seemed to choose the wrong guys to date, and she often skipped classes and failed to prepare for tests or complete assignments. Mandy was very bright, but she had tremendous difficulty organizing herself, and her emotional ups and downs made it nearly impossible to function consistently. Eventually, she dropped out of school, later receiving her high school equivalency and beginning college in her early 20s. Before she came to treatment, Mandy already had seen five or six other therapists. She reported that some of her previous therapists were very helpful but that she tended to get overly attached, had difficulty keeping up with therapy (often missing sessions or dropping out prematurely), and regrets some of the things she said or did during past therapy sessions. In the month before her intake, she had withdrawn from her courses for the semester and made a serious suicide attempt, following which she was hospitalized for a week. Mandy desperately wants help and wishes her life could be different. She wants to finish college, work as a social worker helping underserved and disenfranchised clients, have a stable and happy relationship, and mend fences with her family (from whom she is currently alienated). She has told her therapist that she is going to give therapy "one last chance" before she packs it in and decides life isn't worth the constant struggling and suffering.

DIALECTICAL BEHAVIOR THERAPY

"Mandy" is fairly representative of the types of complex suicidal clients that Dr. Marsha Linehan (whom we will periodically refer to as Marsha throughout this book, as we know her well) set out to help when she began developing DBT (Linehan, 1993a) in the late 1970s and early 80s. Marsha's primary goal in developing DBT was to find a way to help highly suicidal individuals learn how to build lives that were worth living. In Mandy's case, a life worth living would involve better relationships with her family, at least one close, supportive relationship with a friend or romantic partner, and meaningful work helping others. Despite her many strengths, her extreme emotional ups and downs, difficulty with impulse control, and sensitivity in relationships kept getting in her way. She often became demoralized and began to believe that it was impossible to achieve her goals, as she just couldn't trust her "incredibly emotional brain" to stop dragging her down time and time again.

Through challenges in her work applying standard cognitive behavior therapy (CBT) with clients like Mandy, Marsha quickly realized that something new was needed. One challenge that emerged was that many of the clients she was treating had BPD, with its accompanying instability in emotions, relationships, cognition and identity (American Psychiatric Association, 2013). Forming effective therapy relationships with clients whose emotions were often dysregulated and who vacillated between loving and hating their therapists was sometimes a daunting task. Standard cognitive therapy strategies were hard to employ, given intense emotional ups and downs that made it difficult for clients to reflect on and change their thinking patterns. In addition, like Mandy, clients often presented with myriad difficulties, and therapists needed to find a way to structure and address many treatment targets at once. The co-occurrence of many clinical problem areas made it challenging to use any specific CBT protocol. When applying treatment for panic, for example, other problems such as self-injury, substance use or disordered eating often rose to the top of the priority list, taking therapy in another direction. The solution to this problem was to develop a structured way to organize and prioritize problem areas, discussed in detail in Chapter 4.

The heavy focus on cognitive and behavioral change in standard CBT also did not fit well with these clients. The message of standard CBT was that clients needed to change their thinking and behavior and learn new coping skills, and this was probably true. Marsha discovered, however, that clients needed therapists who were able to deftly balance acceptance of the client with efforts to help the client make difficult changes (e.g., face painful emotions, learn how to navigate relationships differently). She also discovered that clients needed to learn how to accept themselves before they were able to change. Mandy, for example, needed to accept that she was a sensitive person who had an emotional system that was fairly turbulent and complex. Rather than engage in futile efforts to suppress or numb her emotions, or punish herself for feeling at all, what Mandy needed to do was to learn how to navigate her own brain, recognize and manage her emotions, and curb impulses that often led her astray. In this way, DBT evolved into a "dialectical" treatment, involving the balance and synthesis of acceptance and change, with the acceptance end of the dialectic including a nonjudgmental and validating therapeutic stance that often runs counter to prevailing pejorative and stigmatizing views of clients with BPD.

Additionally, through her work with clients like Mandy, Marsha learned that complex, highly suicidal clients did not have many of the skills they needed to improve their lives. Through a combination of having a highly emotional temperament and growing up in an environment that invalidated their emotions, highly suicidal clients with BPD had not learned how to understand and manage their emotions. They often had difficulty tolerating overwhelming emotions without engaging in harmful behavior (e.g., self-injury, suicidal behavior, and other reckless or risky behaviors) and getting their needs met while maintaining healthy relationships. Clients needed concrete, practical tools that they could use to attend to the present moment (i.e., what was happening both inside and outside of them), recognize and manage emotions, deal with other people in ways that maintained or enhanced their relationships, tolerate distress, and avoid behaviors that made things worse. DBT, therefore, evolved into a skills-oriented therapy. Standard DBT consists

of a combination of individual treatment, structured skills training, telephone consultation (geared toward helping clients transfer skills they are learning in therapy to their everyday lives), and a therapist consultation team.

Regarding the team, Marsha recognized that clinicians seeing complex, often suicidal clients needed support and help maintaining their skills and motivation. DBT includes a consultation team consisting of therapists who meet weekly to help one another maintain the skills and motivation needed to help their clients build lives worth living. Each team member takes some responsibility both for the well-being of their teammates and that of all clients seen on the team. In this way, DBT is best considered a community of therapists treating a community of clients.

OVERVIEW OF THIS BOOK

Our aim in writing this book is to provide a clear and concise description of the theory, research, and practice of DBT. Our hope is that seasoned clinicians and students alike will find this book to be a helpful resource, whether they are practicing full, standard DBT, or simply trying to incorporate some DBT principles, strategies, or skills into their everyday practice. As with other books in the Theories of Psychotherapy Series, this book includes chapters on the history of the approach, the theoretical foundations of DBT, the treatment's structure and primary interventions, research evidence, and mechanisms of change, or how and why DBT might work. Clinicians who wish to make DBT a focus of their practice will still need to be familiar with the original DBT text (Linehan, 1993a) and the DBT skills training handouts (Linehan, 2015a) and manual (Linehan, 2015b) and should ideally seek additional training through clinical workshops, and possibly ongoing supervision or consultation. Next, we briefly describe the focus of each chapter.

Chapter 2 provides a discussion of the history of DBT. In this chapter, we expand the discussion we began in this chapter to illustrate how Dr. Marsha Linehan developed DBT, why it is called "dialectical"

behavior therapy, and how the struggles of applying standard CBT to complex clients formed the impetus for the development of a comprehensive treatment program. We also discuss issues related to training and dissemination, some elements of the evolution of the research on DBT (although this is discussed much more thoroughly in Chapter 5), and how DBT has changed, adapted, and expanded to populations other than suicidal individuals with BPD.

Chapter 3 details the theoretical underpinnings of DBT. Within this chapter, we discuss the dialectical world view underlying DBT and the influence of Zen practice on the treatment. As DBT, at its core, is a behavioral treatment, we also discuss behavioral principles for understanding the causes and maintaining factors for human behavior. Additionally in Chapter 3, we describe the biosocial developmental theory (Crowell, Beauchaine, & Linehan, 2009; Linehan, 1993a) of the development of BPD. These theoretical elements come together to inform a treatment that (a) balances acceptance and change in terms of therapeutic style, core interventions, and skills training; (b) focuses on the function or purpose of client behavior and the need to ameliorate skill deficits in key areas; and (c) emphasizes the role of dysregulation in the emotion system in the many behavioral problems that often accompany BPD and other complex mental health difficulties (e.g., suicidal behavior, self-injury, drug and alcohol use, other harmful behaviors).

In Chapter 4, we describe the goals, structure, and process of DBT. DBT is a comprehensive, cognitive–behavioral treatment program with several key aims, including (a) improving client skills and capabilities, (b) improving client motivation to change, (c) ensuring that clients generalize what they learn in therapy to their everyday lives, (d) structuring the treatment environment and the client's natural environment to promote positive change, and (e) maintaining therapist skill and motivation. Standard DBT accomplishes these aims through weekly individual therapy, group skills training, telephone consultation, and a therapist consultation team. DBT also occurs in stages, with different types of treatment targets emphasized in each stage. Additionally, as DBT was developed with clients who often had difficulty navigating

therapy relationships and getting the most out of their treatment, DBT also includes principles and strategies to address problems that interfere with therapy. Clinicians who are wondering what DBT looks like, what to focus on in the initial stages of therapy, how to navigate the flow of activities in an individual therapy session, the focus and importance of a therapist consultation team, the role of telephone consultation in DBT, and how to structure skills training, will find this chapter to be a helpful, concise resource.

In Chapter 5, our focus is on the research supporting the efficacy and effectiveness of DBT. This chapter provides a contemporary, thorough snapshot of the state of the research on DBT, recognizing, of course, that the research is always evolving. From the beginning, when a small randomized trial showed that highly suicidal clients with BPD could be treated effectively (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991), research on DBT has proliferated, expanding well beyond its the initial focus. Although the strongest evidence for DBT still has to do with the treatment of problems characteristic of BPD, growing evidence suggests that DBT and its elements (e.g., DBT skills training) are probably helpful for a range of clinical problems. When people ask us whether they should consider using DBT with their clients, we often tell them that it may be most helpful with clients who (a) are multiproblem and multidiagnostic, (b) are suicidal or self-injurious, (c) have BPD or significant BPD features, or (d) present with significant emotion dysregulation and risky or harmful behaviors. We discuss these and other important points about the application of DBT in Chapter 5 and in various places in other chapters in this book.

Having established in Chapter 5 that DBT works, our emphasis in Chapter 6 is on mechanisms of change, or how and why DBT works. In this chapter, we focus broadly on (a) treatment elements that may be essential to the effectiveness of DBT, and (b) changes in the client that may account for the effects of DBT. Although much research remains to be done to understand the precise mechanisms of change in DBT, findings have emphasized the importance of skills training as a key element of the treatment, skills practice as a potential mediator of treatment

outcome, and changes in brain regions related to emotions and emotion regulation as potentially important within-client mechanisms of change. We also illustrate how these mechanisms may play out in therapy, using illustrative clinical examples.

Finally, in Chapter 7, we pull together what we have presented in the previous chapters to provide a summary of DBT. In this chapter, we return to the case example of Mandy to briefly illustrate the theoretical underpinnings of DBT, the structure and process of treatment from start to finish, and some of the core interventions and skills used in DBT. We also discuss future directions for the development and practice of DBT.