

# **The Dialectical Behavior Therapy Primer**

How DBT Can Inform  
Clinical Practice

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## Chapter 1

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# Introduction

### For whom is this book intended?

In this volume, we hope to provide (a) an accessible, easy-to-understand primer for clinicians wanting to adopt Dialectical Behavior Therapy (DBT) as their treatment approach; (b) guidance, tools, and, more importantly, a way of thinking about treating borderline personality disorder (BPD) for clinicians who want to incorporate aspects of DBT principles and techniques into their practice but do not wish to adopt the entire model and (c) an introduction to DBT for the patients and their families and friends who want to learn the basics of this treatment approach. While becoming proficient in DBT requires intensive training, supervision, and feedback on therapeutic performance, there are many DBT principles, strategies, and techniques that can be understood and utilized by clinicians using other therapeutic modalities and models. For example, psychopharmacologists who have knowledge of DBT may better understand and manage their BPD patients' medication requests and suicidal behavior. Furthermore, their clinical approach to patients with BPD may be enhanced by a better understanding of the importance of validation (a central DBT concept) with this population. While we recommend utilizing DBT as developed since that is what has the empirical support behind it, we recognize that not all clinicians will choose to do so. And we believe that, whatever the treatment approach, clinicians can benefit from incorporating aspects of DBT into their practice. Thus, the primary purpose of this book is to provide a clinically oriented, user-friendly guide to understanding and utilizing the principles and techniques of DBT.

### The challenge of treating Borderline Personality Disorder and disorders of emotion dysregulation

Individuals with BPD and disorders in which there is pervasive emotion dysregulation generally present many challenges in psychotherapeutic treatment for even the most trained and dedicated clinicians. The BPD diagnosis is one of the most stigmatized of the mental illnesses, notorious for treatment resistance [1], high treatment utilization [2],

high dropout rates, high comorbidity with other diagnoses [3], and recurrent suicidal and non-suicidal self-injurious (NSSI) behaviors [1]. Therapist burnout with this population is common. The severity and chronicity of BPD symptoms cause individuals with the disorder and those involved with them a great deal of anguish and frustration. The clinicians treating those with the disorder are not immune to this sense of frustration and, consequently, act in ways that they find uncharacteristic and, ultimately, not helpful, despite initial and perhaps long-sustained intentions to help. Why?

More specifically, we ask, *“Why do mental health clinicians who are ordinarily empathic and who have chosen the helping profession as their career become exasperated, off balance, or unwilling to continue trying to help certain patients? Why may they resort to measures they would not take with their other patients?”*

Most psychotherapists have a story to tell regarding their most “difficult” patient. Chances are this patient was either clearly diagnosed with BPD or was given multiple Axis I diagnoses that shifted over time and, in retrospect, was best understood as BPD. What is it about BPD that individuals with this disorder are experienced as “difficult” and even as the *most* difficult patients to treat? Are their problems more severe than those diagnosed with schizophrenia or bipolar disorder? We do not think so.

Is it the fact that their problems are often manifest in the interpersonal domain that creates the difficulties?

Is it that their triggers to extreme emotional dysregulation may seem trivial and unpredictable to the therapist?

Is it that the emotional dysregulation itself is experienced as so extreme by the clinician that it is difficult to tolerate?

We think that all three factors contribute to the problems clinicians report in working with patients with BPD and severe emotion dysregulation problems. Clinicians become “burned out” and discouraged by the difficult symptomatology presented by borderline patients. These patients experience intense anger, sometimes directed at therapists and at any other person to whom they become emotionally attached. They engage in disturbing and frightening self-destructive behaviors including suicide attempts, nonsuicidal self-injury, and substance abuse. These behaviors are often triggered by interpersonal interactions, including even well-intentioned therapeutic interventions.

Individuals with BPD can be very dependent on those around them for self-definition and self-esteem [4]. They often develop an intense need for concrete contact with people important to them. This need for contact can be experienced as overwhelming and impossible to satisfy. Furthermore, the functioning of individuals with BPD is highly mood-dependent, can fluctuate dramatically, and can depend on the “emotional valence” of the situation. For example, individuals with BPD can do extremely well in work or school settings where they meet with success and positive feedback. Their underlying vulnerability may not be seen or provoked. To those who do not fully appreciate the nature of the disorder, this can create the impression that individuals with BPD are capable of high functioning in all circumstances and are deliberately behaving in a “helpless, manipulative” manner when their functioning is compromised by their emotional state or by the nature of their interpersonal relationships. So, the same individual

who can produce a high-quality well-researched legal brief may fall apart when her boyfriend cancels a date at the last minute because of work commitments. On a very basic level, it does not seem possible that the dysfunctional behaviors are genuine. But they are.

These are some direct quotes from therapists with whom we have consulted or supervised.

*My patient with BPD is so unbelievably manipulative. She gets great grades at that Ivy League college she attends and does independent research for one of her professors that draws great praise. Yet she gets distraught and can't function if her boyfriend doesn't call her or if I'm a few minutes late for our appointment. She's so melodramatic and self-centered. I find myself continually annoyed with her.*

*I have a really "bad borderline" who keeps calling me and I can't stand to take her calls any more. She never has a good reason for the calls. Everything is an emergency to her.*

*I'm sick and tired of my borderline patient's repeated suicide gestures and the inevitable calls from the ER in the middle of the night. Next time she does it, I'm going to tell the ER that she has been terminated from my care.*

This type of clinician response is not an infrequent occurrence when the patient is diagnosed with BPD. We have been suicide researchers and clinicians for many years and experienced a sense of our own limitations as we began to do psychotherapy with suicidal and self-injuring individuals who had BPD. We were both trained in a traditional psychodynamic model which we found did not provide the tools or a useful framework to help our patients manage their suicidal urges, their self-injury, their out-of-control emotions, and their relationships. Many clinicians who have sought our advice and consultation in working with their BPD patients have echoed this experience.

Why are we focusing on the clinician's reactions here instead of the enormous suffering of individuals with BPD? Because we recognize that BPD is a very common disorder and many individuals with BPD are desperately in need of treatment, and, therefore, most clinicians are likely to be asked to treat individuals with BPD. Some clinicians choose (when they have the option) not to treat this population or are not as helpful as they might be. By helping clinicians feel and, in fact, be more capable in working with individuals with BPD, we hope to decrease the suffering of the patients afflicted with this disorder who seek treatment. Are there approaches in which clinicians can better maintain a sense of balance and perspective while being understanding of and helpful to their patients with BPD? DBT offers one such approach.

## What is DBT?

DBT is a treatment for individuals with pervasive emotion dysregulation and has quickly become a psychotherapeutic treatment of choice for individuals with BPD, particularly for those with suicidal and self-injurious behaviors, the population for whom the treatment was originally developed [5]. It was not until Marsha Linehan, the treatment developer, worked

with patients with chronic self-injury and suicidal behavior that she concluded that her patients had the diagnosis of BPD in common. And, thus, DBT became a treatment for BPD, and more recently is being more broadly considered to be a treatment for severe emotional dysregulation, a core feature of the BPD diagnosis [6]. But its focus on self-harm behaviors lent it to adaptations for similar problems in which there is a pattern of self-destructive behaviors, such as substance abuse and eating disorders. Furthermore, in clinical practice, DBT has been extended for use with individuals who have a broad range of difficulties with regulation of emotions.

The beauty of DBT is that, through its structure, it provides a *road map* for clinicians (and their patients) to navigate the path toward improving the lives of multiproblem patients with chaotic, crisis-driven, and often self-destructive patterns of living. The structure of DBT focuses therapists and patients on crucial problems that must be addressed (e.g., suicidal behavior and self-injury), helps them stay on track, and prevents detours that can easily be taken when the patient has a crisis-driven life. This road map keeps the therapeutic dyad moving toward mutually agreed upon goals.

The basic components of DBT include individual psychotherapy (conducted in a fairly structured manner); skills training, which typically takes place in a weekly seminar-type format and during which skills are taught to help individuals with severe emotion regulation problems; intersession patient coaching; and clinician team consultation to provide support to fellow therapists and to help each other stay on track in their work with this multiproblem population. These components are described to the patient in the initial sessions (pretreatment phase) so that the patient's agreement to be in DBT is with full knowledge of the treatment components and expectations for each of these components. There is misunderstanding by some in the field that DBT is only about teaching skills in a group format. And while the skills component is crucial, it is only one component. There are no studies yet that demonstrate that skills alone or added to other forms of treatment are effective. However, in our clinical work, we have certainly seen where it has been beneficial for patients who are struggling in other forms of therapy but do not wish to leave that treatment, to add a skills training group to their therapeutic experience. Interestingly, the recommendation for a DBT skills group often comes from the primary therapist who adheres to a model other than DBT. In order for this arrangement to be helpful to the patient, the primary therapist must be open to helping the patient apply the skills.

*Why the name DBT?* The B (behavior) in DBT is easy to understand. DBT is rooted in principles of behavior therapy with an emphasis on the application of learning principles, including operant and classical conditioning. And while it is a form of cognitive behavioral therapy (CBT), most adaptations of CBT place an emphasis, while not excluding the other, on either the cognitive or behavioral aspects of a CBT model and can be described as emphasizing the cognitions or behaviors, that is, big C (CbT) versus big B (cBT) approaches. The orientation of DBT is cBT, whereas Aaron Beck's approach is CbT [7]. These differences are more than an academic distinction because they determine the route these approaches take to change. The term "dialectical" in DBT requires more clarification. Dialectics is a philosophical concept that includes several assumptions: (a) all things are connected; (b) change is inevitable and continual; and (c) opposites can be integrated to develop a closer approximation of the truth. It is

this last point that it is stressed in DBT and is at the core of the ongoing and continual explicit balance of acceptance and change that we will describe as present throughout the treatment [7].

As clinicians and researchers who have taken a particular interest in understanding and improving treatment efficacy for individuals with BPD, we have been inspired and informed by DBT. In particular, we have come to see that the philosophical assumptions underlying DBT serve to both orient and maintain morale in the clinician, a major aspect of improving treatment for individuals with BPD. As one patient put it, “Oh yes, I was in DBT therapy. It helped me but it also helped the therapist feel better about working with me.”

Helping therapists feel better about treating individuals with BPD is no small feat. Of course, therapists would not “feel better” unless they were able to experience a sense of increased efficacy – their patients showed up for sessions, stayed in treatment, and improved. We believe that the theoretical stance inherent in DBT, as well as the specific interventions, effectively targets both the clinician and the patient.

The usual clinical training can leave clinicians ill-equipped to accurately interpret and intervene, and, therefore, be effective in the face of the severity and multitude of problems experienced by individuals with BPD. Notably, many standard approaches do not have protocols for treating and managing suicidal behaviors and nonsuicidal self-injury. In fact, some training programs refrain from exposing their trainees to suicidal patients with BPD because it is felt that they are too “difficult.” We maintain that this is the ideal time because of the available support and structure. However, there has been little guidance for clinicians in tolerating and minimizing the emotional toll of frantic calls for help, the seemingly “bottomless pit” of dependency needs, the emotional intensity, lability, unpredictability, and genuine extreme sensitivity of these individuals. Conventional ideas regarding boundaries and limit setting do not prepare clinicians for finding the appropriate balance between autonomy and dependence in BPD patients. Nor are they particularly effective.

Many individuals with BPD experience therapeutic “neutrality” as uncaring and this, in turn, can breed resentment in a clinician who feels that their well-meaning efforts are being willfully misinterpreted. Furthermore, in BPD, what is neutral clinician behavior can be misread as “rejecting,” “angry,” “disinterested,” or worse, as tacit approval of maladaptive and self-destructive behavior. While it is important for those with BPD to learn that they have a tendency to misread, they may experience this as too upsetting early on in treatment and withdraw before they have the opportunity to address this.

Toward this end, we present a clear, comprehensive summary of DBT principles and techniques illustrated with rich clinical vignettes. It should be noted that while we have tried to stay as true as possible here to the DBT model as developed by Linehan, our writing is inevitably affected by our training and our experience in applying the model. Thus, we also include DBT-informed conceptualizations and interventions that we have developed based on our experience over the years of conducting DBT in both research and clinical settings with individuals at risk for self-harm behaviors. We try to state explicitly where our thinking is informed by the DBT model but is an expansion of it.

## **“Top 10 questions” therapists ask about working with individuals who have BPD**

We have identified the “top 10” most frequently asked questions about how to effectively intervene with borderline patients. While we set the questions in a neutral format, they are often asked with a great deal of anger, worry, and judgmental tone. We note the questions here and will demonstrate throughout the book how DBT effectively addresses each of these questions.

- 1 How can clinicians maintain empathy for their borderline patients?
- 2 What can clinicians do to help patients who are extremely sensitive to criticism tolerate change interventions and not leave prematurely in response to a change-oriented intervention?
- 3 How do clinicians help patients manage their chronic suicidal ideation, threats, and gestures in an outpatient setting without becoming dysregulated themselves? How can clinicians refrain from becoming either overly anxious and overreactive or disinterested and immune to suicide ideation and behaviors?
- 4 Are there effective therapeutic techniques for directly treating nonsuicidal self-injury and other destructive behaviors?
- 5 How do practitioners maintain limits when they fear it will trigger suicidal behavior and how do they refrain from inadvertently reinforcing suicidal behavior?
- 6 How do clinicians offer availability while placing manageable limits on between-session phone calls and requests for contact? In other words, how can clinicians expand their boundaries when appropriate without stretching them too far and how do clinicians keep from stretching them further and further and then abruptly ending the relationship?
- 7 How do clinicians handle emotionally dysregulated patients’ angry and frantic requests for help in an effective manner?
- 8 When should an individual with BPD be hospitalized and how can clinicians avoid unhelpful, repeated hospitalizations?
- 9 What are the ways of effectively managing behaviors that are referred to as “splitting” in treatments where there are multiple clinicians?
- 10 How do practitioners assess capability in BPD patients and help patients set realistic goals and achieve a good quality of life?

## **How does DBT help the clinician?**

By tackling these and other questions, we encourage clinicians to learn to view the BPD diagnosis and its treatment from within the framework of DBT. While DBT is a method of treatment based in CBT, it is also firmly embedded in a theoretical perspective about the nature of the disorder. In our experience, a DBT perspective particularly helps clinicians to see, from the patient’s perspective, what it is like to suffer with the disorder. It removes pejorative expressions about the “badness” of a patient (e.g., manipulative or provocative) and discusses problems in a descriptive, nonjudgmental manner. In so doing, DBT immediately helps clinicians change their emotional reaction to patients.



DBT challenges and requires a relearning of certain basic conventions regarding the nature of doing therapy. For example, the term “treatment resistance” is absent from the DBT model. “Treatment resistance” is a concept from psychodynamic psychotherapy and a term that has become ubiquitous in therapeutic parlance to describe what the patient is doing to oppose the process of therapy. From a psychodynamic perspective, resistance is considered to be both conscious and unconscious, stemming from an individual’s reluctance toward and defense against thinking about or facing certain feelings or experiences [8]. But the absence of this terminology in DBT does not mean that difficulties in the therapeutic relationship go unaddressed. Quite to the contrary, they are inquired about and addressed explicitly in each and every session. However, these difficulties are described as “therapy-interfering behaviors,” a term that, in our opinion, carries a more neutral tone. In DBT, both the patient’s and therapist’s behaviors can be therapy-interfering, and both are the subject for discussion and resolution in sessions.

Through discussion of our experiences and those of the clinicians with whom we have consulted and supervised, we share how we have come to understand the emotional and behavioral world of individuals with BPD. We suggest that the nature of the disorder can transact with particular assumptions underlying the practice of some other forms of psychotherapy to exacerbate symptoms, and contribute to demoralization and clinician burnout. Our perspective is that, in order to retain these individuals in treatment, to reduce symptoms, and to increase capacity for positive life experience, clinicians need to carefully consider their assumptions and interpretations, and to assume greater responsibility for treatment failure. At the same time, they also need to engage the patient in taking shared responsibility for their treatment and for staying safe. The dialectic worldview, when applied to the treatment of BPD, provides clinicians with a viable theoretical approach. We take pains to illustrate how the dialectic philosophy underlies each DBT intervention, and how integral this way of thinking is to the effective practice of DBT.

## Overview of the book

This book has two main parts. The first part, Chapters 2–7, lays the theoretical foundation and presents the empirical evidence for how DBT informs our understanding of the phenomenology of BPD and self-harm behaviors. The second part, Chapters 8–18, provides a clinical guide to incorporating DBT interventions into clinical thinking and practice.

In accord with these aims, in Chapter 2 we describe who (patients and clinicians) should consider doing DBT. We also discuss the qualities needed in therapists to work with individuals who grapple with chronic suicide ideation. We review the empirical basis for the efficacy of DBT with various diagnostic populations. We present the experiences of trainees from all mental health disciplines regarding the value of learning DBT. We also make recommendations to guide clinicians in performing an honest assessment regarding whether they are ready, willing, able, and open to “turn their minds” to the DBT way of thinking and intervening.

Chapter 3 explores the history and myth of BPD untreatability and the modifications that make DBT more effective in treating this population. Chapter 4 describes the stigma

that has developed around the BPD diagnosis, by highlighting the historical aspects of the BPD diagnosis that relate to our current understanding of the disorder and treatment response. We describe and illustrate the subjective experience of the individual with BPD, informed by the theoretical perspective of DBT.

Chapter 5 provides a comprehensive review of what we currently know about the phenomenology of suicidal and nonsuicidal self-injury in BPD, including a DBT-informed conceptualization for understanding self-harm behaviors in BPD.

Chapters 6 and 7 provide an overview of DBT. In Chapter 6, we review the ABC's of DBT theory, describing what it means to take a dialectic therapeutic approach, and reviewing the assumptions underlying DBT theory and interventions. We elucidate the role of explicit validation in DBT, and describe the learning theories integral to DBT change interventions. In Chapter 7, we review the ABC's of DBT interventions, reviewing the four stages of DBT and the four modalities of DBT – individual psychotherapy sessions, group skills training, between-session coaching, and the DBT consultation team. We provide a clinical vignette to illustrate the multipronged DBT approach.

Chapters 8 through 18 provide step-by-step guidelines for using DBT techniques. Chapter 8 reviews the initial stages of DBT treatment strategies for making a commitment to and establishing goals for treatment. Chapter 9 describes the structure of an individual therapy session and the use of the diary card, agenda setting, and behavioral chain analysis to target treatment goals. Stylistic and dialectical strategies such as self-disclosure, irreverence, and use of metaphor are reviewed and illustrated. Chapters 10 and 11 describe the skills training component of DBT and how non-DBT individual therapists can enhance the learning of skills in their patients. Chapter 12 addresses between-session contact, in vivo skills coaching, and the DBT approach to observing boundaries. Chapter 13 provides guidelines for managing suicidal behavior from a DBT perspective and how to balance the emphasis on building a “life worth living” while guarding patient safety. Chapter 14 reviews the Safety Planning Intervention (SPI) developed by Barbara Stanley and Dr. Gregory K. Brown. Chapter 15 addresses the DBT approach to collaboration with colleagues, including consultation with third-party treaters, the DBT approach to “splitting,” and how therapists who treat individuals with BPD can find support. In Chapter 16, we present the guidelines for conceptualizing a case from the DBT perspective and present case material to illustrate how case conceptualization informs treatment planning. In Chapter 17, we review a DBT-informed approach to the treatment of behaviors other than self-harm behaviors. For example, we illustrate DBT approaches to addressing therapy-interfering behaviors such as lateness and medication non adherence. We propose a DBT-informed way of thinking about how to assess and set realistic quality-of-life goals for individuals with BPD, in the face of their severe fluctuations in level of functioning. In our concluding Chapter 18, we discuss the various DBT ways of thinking about the end of treatment, including issues related to highly lethal suicide attempts and suicide.

We invite clinicians and individuals who care about someone with BPD to be open to viewing BPD from a perspective that can increase empathy for their plight, while at the same time feel more equipped to not become overwhelmed by it. Or, to use DBT language, we invite readers to take a dialectical stance, to be willing to validate the difficulty and pain of individuals with BPD, to view them and their behavior without judgment, while at the same time observing their personal natural (nonarbitrary) limits.

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