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Dialectical-Behavioral Therapy for Borderline Personality Disorder

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ABSTRACT

Dialectical-behavioral therapy (DBT) has been developed as a treatment for borderline personality disorder (BPD), a disorder that afflicts approximately 10% of the outpatient population and up to 20% of inpatients. DBT conceptualizes BPD as a pervasive disorder of the emotion regulation system that arises from the transaction of a biologic predisposition to emotional vulnerability and emotional learning within an invalidating environment. As a result, individuals with BPD experience tremendous problems including interpersonal difficulties, self-injurious behaviors, and suicidal behaviors. DBT incorporates the principles of dialectical philosophy, Zen, and behavior therapy to treat these problems. DBT utilizes several modes of therapy and teaches skills in several areas to help patients who experience a tremendous amount of suffering to build a life worth living.

INTRODUCTION

Borderline personality disorder (BPD) is a pervasive problem afflicting 1% to 2% of the general population, as many as 10% of the outpatient population,[1] and up to 20% of inpatients.[2] Patients with BPD experience a tremendous amount of suffering, often to the point where they may take their own lives. Up to 10% of patients with BPD commit suicide and 75% attempt suicide.[3] Dialectical-behavioral therapy (DBT)[4,5] is a multi-modal, empirically-supported therapy that was first developed as a treatment for highly suicidal women and was subsequently refined for the treatment of BPD. DBT draws its principles from behavioral and cognitive-behavioral psychotherapy, dialectical philosophy, and Zen

Needs Assessment: Borderline personality disorder (BPD) is a pervasive disorder, particularly in psychiatric settings. Studies have established dialectical-behavioral therapy (DBT) as an empirically supported treatment for BPD. Increased familiarity with DBT as a treatment for BPD may help readers become more adept at identifying patients who may benefit from this therapy.

Learning Objectives:

- Describe the biosocial theory of BPD.
- Identify four modes of treatment involved in DBT.
- Identify the ranking of behaviors targeted in DBT.

Target Audience: Primary care physicians and psychiatrists.

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practice. The therapy focuses on helping patients find a balance between acceptance and change, with the overall goal of helping patients not only survive, but build a life worth living. In addition, DBT explicitly helps therapists to avoid getting burned out, as is often the case in treating the behaviors associated with BPD. This article will review the research on DBT for BPD and discuss some techniques and principles utilized in DBT.

RESEARCH ON DIALECTICAL-BEHAVIORAL THERAPY

Table 1[6-22] summarizes the randomized control trials of DBT to date. These studies, conducted across multiple clinical research sites, have supported that DBT is an efficacious treatment for BPD either with or without comorbid substance use disorders. In the first randomized clinical trial of the treatment of BPD, Linehan and colleagues[7] found that DBT was superior to a treatment-as-usual (TAU) condition for outcomes including percent of patients with self-inflicted injuries (including suicide attempts), number of such injuries, medical risk of injuries, treatment drop-outs, psychiatric inpatient days, anger, and social and global adjustment. Patients in both treatments had decreases in hopelessness, depression, and suicidal ideation. In a 1-year follow-up,[8] patients treated with DBT had higher global adjustment scores throughout follow-up; had better social adjustment scores, less self-injurious behavior, and less anger throughout the first 6 months of follow-up; and had fewer psychiatric inpatient days and better interviewer-rated social adjustment during the final 6 months of treatment. In a follow-up randomized control trial comparing DBT to treatment done by individuals identified as expert community psychotherapists,[18] patients treated with DBT had half as many suicide attempts, fewer psychiatric hospitalizations and psychiatric emergency room visits for suicidal behaviors, lower medical risk of self-injuries, and lower rates of treatment dropout. Patients in both conditions showed increases in reasons for living and decreases in depression and suicidal ideation. In a randomized control trial for the treatment of BPD and comorbid substance use disorder,[12] DBT was compared to TAU in the community. Patients treated in the DBT condition had less drug use, less treatment dropout, and greater global and social adjustment than community TAU.

In addition to showing efficacy, DBT also has shown evidence of cost-effectiveness. Linehan and Heard[23] compared average yearly healthcare costs of DBT to those of TAU. While outpatient DBT cost approximately $1,000 more than TAU, DBT patients had an overall savings of $9,000 compared to TAU patients when factoring in psychiatric and medical hospitalization days.

THEORETICAL BACKGROUND OF DIALECTICAL-BEHAVIORAL THERAPY

Dialectical Philosophy

A great challenge in treating individuals with BPD is to balance pushing patients to change their current lives with acceptance and validation. In general, a dialectical tension occurs when an initial proposition or thesis is opposed by a contradictory antithesis. In the case of BPD, one of the most frequent dialectical tensions is that a behavior, such as self-injury, is both functional (it helps the patient temporarily reduce distress) and dysfunctional (the self-injury produces negative effects on health and interpersonal functioning, and is associated with risk of suicide in the long run). Both positions in a dialectical tension hold true. The dialectical tension is resolved by finding the synthesis, or rather what is being left out of the thesis and antithesis, by using skills that help the patient reduce stress and do not produce negative long-term effects. DBT helps patients find the synthesis to their behavioral dilemmas with the hope that the patient will be both validated and learn more skillful behaviors. In this manner, the key dialectical tension in DBT is that between acceptance and change. In DBT, the dialectical approach encourages patients to walk the "middle path."

Zen Tradition

The "middle path" approach of dialectics is an inherent feature of Zen. While DBT does not espouse any particular religious views, it does utilize principles of Zen and other Eastern traditions to help patients behave more effectively. DBT helps patients find the balance between a state of being caught up in emotions (ie, emotion mind) and a state of being devoid of emotions and strictly rational (ie, reasonable mind). The synthesis is termed "wise mind." Wise mind incorporates both the passion, conviction, and intuition of emotion with the logic and empiricism of rationality. A central tenet of the Zen approach is accepting reality as it is. Patients are asked to use their wise mind to perceive reality and guide their behavior. To do this, patients practice mindfulness, where they quiet themselves and become more acutely aware of the world around them. Patients and therapists alike practice exercises to observe and describe the world without judgment. DBT

tries to synthesize many of the acceptance-based strategies of the Zen approach with many of the change-based strategies of behavioral science.

Behavior Therapy

The principals of behavior therapy are key components of DBT. Dialectical-behavior therapists conceptualize patients' behaviors in terms of principles such as conditioning, reinforcement, and shaping. In DBT, therapists pay particularly close attention to the factors that maintain behaviors, such as reinforcers of self-injurious behavior, classically conditioned avoidance behavior (eg, a patient who associates being raped with specific stimuli like a type of car or a song, and avoids those stimuli), and aversive consequences of more effective behavior. Dialectical-behavior therapists utilize the theory and science of behavior therapy to define treatment targets and specify therapy interventions to help patients change

TABLE 1

SUMMARY OF RANDOMIZED CONTROLLED TRIALS OF DIALECTICAL-BEHAVIORAL THERAPY[6-22]

Treatments	Inclusion Criteria	Length of Study	Main Effects
DBT (n=24) vs. community mental health TAU (n=22)[7-10]	BPD + suicide attempt in last 8 weeks + one other in last 5 years; female	1 year	Frequency, medical risk, suicide attempts, and intentional self-injury; treatment retention; use of emergency and inpatient treatment; anger; social and global adjustment
DBT (n=12) vs. community drug abuse/mental health TAU (n=16)[11]	BPD + current drug dependence; female	1 year	Illicit drug use, social and global adjustment
DBT + LAAM (n=11) vs. comprehensive validation treatment (DBT without change strategies) + 12-step facilitation and 12-step group + LAAM (n=12)[12]	BPD + current opiate dependence; female	1 year	Opiate use
DBT-oriented (n=12) vs. patient-centered therapy (n=12)[13]	BPD + referral from emergency services for suicide attempt	1 year	Suicide attempts and self-injury, impulsiveness, anger, depression, global adjustment, use of inpatient treatment
DBT (n=10) vs. VA mental health TAU (n=10)[14]	BPD; female	6 months	Suicide attempts and self-injury frequency (trend), suicidal ideation, hopelessness, depression, anger expression
DBT (n=31) vs. community drug abuse/mental health TAU (n=33)[15-17]	BPD; female	1 year	Frequency of self-mutilation and suicide attempts (trend), treatment retention, self-damaging impulsivity
DBT (n=52) vs. community treatment by psychotherapy experts in suicide and BPD (n=51)[18]	BPD + suicide attempt or self-injury in last 8 weeks + one other in last 5 years; female	1 year	Suicide attempts, hospitalization for suicidal ideation, medical risk of suicide attempts and self-injury, treatment retention, emergency room visits, psychiatric inpatient treatment
DBT skills training + antidepressant (n=17) vs. clinical management + antidepressant (n=17)[19]	Current episode of MDD >60 years of age	28 weeks	Self-rated depression scores, dependency and adaptive coping, interviewer rated depression scores at 6-month follow-up
DBT + antidepressant (n=21) vs. medication alone (n=14)[20]	Meet full diagnostic criteria for MDD and at least one personality disorder >55 years of age	24–30 weeks	Interpersonal aggression, interpersonal sensitivity, depression remission rates (trend)
DBT individual emotion regulation skills training (n=14) vs. wait-list control (n=15)[21]	One binge/purge episode/week for previous 3 months.	20 weeks	Binge/purge incidents
DBT skills training (n=22) vs. wait-list control (n=22)[22]	Meet full research criteria for binge-eating disorder; female	20 weeks	Binge days and episodes, weight and shape concerns, eating concerns, anger

DBT=dialectical-behavioral therapy; vs.=versus; TAU=treatment-as-usual; BPD=borderline personality disorder; LAAM=levro-a-acetylmethadol; VA=Veteran's Administration; MDD=major depressive disorder.

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their behavior. Concurrently, therapists balance the change focus of behavior therapy with principles of acceptance woven in through mindfulness practice and validation.

THE BIOSOCIAL THEORY OF BORDERLINE PERSONALITY DISORDER

According to the biosocial theory of BPD, dysfunctions arise from a transactional relationship between biologic emotional vulnerability within the context of an invalidating environment. DBT reorganizes the diagnostic criteria of BPD into five categories of dysfunction. These categories are emotion dysregulation, including affective lability and problems with anger; interpersonal dysregulation, including chaotic relationships and fears of abandonment; self dysregulation, including identity disturbance, difficulties with a sense of self, and sense of emptiness; behavioral dysregulation, including suicidal behavior and impulsive behavior; and cognitive dysregulation including dissociative responses and narrow, rigid thinking. Arising from this transaction, BPD is conceptualized as a pervasive disorder of the emotion regulation system.

The first component of the biosocial transaction is a biologic emotional vulnerability. Patients with BPD are characterized by having high emotional sensitivity, high reactivity and extreme reactions, and a slow return to baseline. In other words, they are predisposed to be at the higher end of the emotion vulnerability spectrum. Research has indicated differences among control participants and patients with BPD in volume and activation of the amygdala and hippocampus (ie, brain regions associated with emotions).[24,25] However, biosocial theory suggests that the presence of a biologic predisposition to emotional vulnerability alone is not sufficient to cause BPD.

The second component of the biosocial transaction in BPD is an invalidating environment. An invalidating environment consistently and pervasively dismisses or rejects the behavior of a person regardless of whether or not this behavior is valid, punishes emotional displays and intermittently reinforces emotional escalation, and over-simplifies the ease of problem solving. People who persistently experience these invalidating responses do not learn how to trust their own reactions as valid, appropriately label their own experiences, or effectively regulate emotions. Instead, they are conditioned to self-invalidate and depend on the social environment for cues on how to respond. Again, biosocial theory suggests that an invalidating environment is insufficient in forming BPD. There must be a transaction between the invalidating environment and the biologic dysfunction in the emotion regulation system.

The transaction of emotional vulnerability within an invalidating environment often leads to negative consequences. Within the context of pervasive dismissiveness or rejection, people do not learn how to label emotions, regulate emotions, or validate themselves. Behavioral research has shown that behaviors that are intermittently reinforced (ie, reinforced on some occasions but not on others) are among the most difficult to extinguish. When people are intermittently reinforced for extreme emotional expression, it becomes more likely that they will engage in and escalate these behaviors in the future. People raised in invalidating environments with intermittent reinforcement often fail to learn how to communicate pain effectively and how to accurately express emotion. Instead, they learn to alternate between inhibiting emotions and engaging in extreme emotional behaviors. Another characteristic of the invalidating environment is an oversimplification of the process of problem solving. There is often a lack of coaching skillful behavior in an invalidating environment. Due to this, individuals fail to learn distress tolerance and problem solving skills. Instead, individuals learn to hold themselves to perfectionistic standards, develop unrealistic goals, and have high negative arousal in response to failure.

DIALECTICAL-BEHAVIORAL THERAPY AS A COMPREHENSIVE TREATMENT

Dialectical-Behavioral Therapy Assumptions About Patients and Therapists

Dialectical-behavior therapists bring specific assumptions about patients and therapists into therapy (Table 2). These assumptions indicate that the onus for success is on the therapist and the therapy. DBT deemphasizes views of patients being manipulative or working against change. Instead they are viewed as experiencing extreme suffering and doing the best they can. These assumptions help dialectical-behavior therapists be compassionate with their patients and may reduce the likelihood of burnout.

Five Functions of Dialectical-Behavioral Therapy

DBT as a comprehensive treatment is designed to serve five functions (Table 3). Capability enhancement is based on the idea that one of the major difficulties for individuals with BPD is a deficit in behavioral skills. Treatment is designed to remediate these deficits by helping patients to acquire

affective, cognitive, physiologic, and behavioral response repertoires for effective performance. DBT seeks to accomplish this through modeling and behavioral rehearsal of effective behavior, psychoeducation, coaching and feedback, and homework assignments.

DBT utilizes motivational enhancement to reinforce therapeutic progress and remove factors that may interfere with effective behavior. Motivational enhancement is necessary as effective behaviors are often blocked by over-learned emotional responses, behavioral and cognitive patterns, or environmental contingencies that discourage effective behavior or encourage dysfunctional behavior. Methods to increase motivation include cognitive modification, contingency management, and exposure-based strategies.

The goal of enhancing generalization is to ensure that skillful responses developed in therapy are transferred to patients' lives in the world outside of therapy. Therapy interventions for enhancing generalization include phone and E-mail consultation, homework practice, in vivo interventions, and patient review of therapy tapes outside of sessions. Through the use of these methods, a therapist may increase the chances that a behavioral pattern that typically leads to self-injurious behavior is interrupted and changed by a more skillful response.

Structuring the environment is often necessary to help the patient create environments that will maximize therapy gains. The DBT treatment program as a whole is structured to reinforce treatment progress and not dysfunctional behavior. In addition, DBT may intervene within the patient's community to further facilitate the reinforcement of treatment gains. Interventions for structuring the environment may include interactions between the patient and the clinic director or other administrators, case management, and family or marital interventions.

DBT seeks to treat problems often seen in therapists treating patients with BPD, such as burnout, by enhancing therapist capabilities and motivation. An isolated therapist may have difficulties constantly facing patient problems such as unrelenting crises and extreme emotionality. Methods to enhance therapist motivation include supervision, continuing education, treatment manuals, staff incentives, and a weekly consultation team meeting. The five targets of DBT are addressed throughout the different modes of DBT.

TABLE 2
DBT ASSUMPTIONS ABOUT PATIENTS AND THERAPISTS

Assumptions About Patients
1. Patients are doing the best they can
2. Patients want to improve
3. Patients need to do better, try harder, and be more motivated to change
4. Patients must learn new behaviors in all relevant contexts
5. Patients cannot fail in DBT
6. Patients may not have caused all of their own problems, but they have to solve them anyway
7. The lives of suicidal BPD patients are unbearable as they are currently being lived
Assumptions About Therapists
1. The most caring thing a therapist can do is help patients change in ways that bring them closer to their own ultimate goals
2. Clarity, precision, and compassion are of the utmost importance in the conduct of DBT
3. The therapeutic relationship is a real relationship between equals
4. Principles of behavior are universal affecting therapists no less than patients
5. Dialectical-behavioral therapists can fail
6. DBT can fail even when therapists do not
7. Therapists treating BPD patients need support

DBT=dialectical-behavioral therapy; BPD=borderline personality disorder.

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TABLE 3
FIVE FUNCTIONS OF DIALECTICAL-BEHAVIORAL THERAPY

Function	Example Methods for Providing the Function
1. Enhance capabilities	Behavioral skills training including modeling, behavioral rehearsal, psychoeducation, coaching and feedback, homework
2. Enhance motivation	Individual therapy including behavioral assessment, chain analysis, contingency management, exposure-based strategies, cognitive modification
3. Assure generalization to the natural environment	Phone and E-mail consultation, homework, in vivo interventions, patient review of therapy tapes
4. Structure the environment	Case management, family or marital interventions
5. Enhance therapist capabilities and motivation to treat effectively	Weekly consultation team meeting, treatment manuals, supervision, continuing education

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MODES OF DIALECTICAL-BEHAVIORAL THERAPY

Individual Therapy

Each patient has one individual therapist who is the "point person" in the treatment of a patient. The individual therapist is responsible for treatment planning, monitoring, and ensuring progress toward all DBT targets; integration of all modes of therapy; consulting to the patient on how to have effective interactions with other treatment providers; and the management of all life-threatening behaviors and crises. In addition, the individual therapist must strike a balance between validation of a patient's behavior and changing behavior to become more effective. If the therapist focuses too heavily on changing a patient's behaviors, then the therapist might become part of an invalidating environment. Patients typically attend 1 hour of individual therapy per week.

Dialectical-Behavioral Therapy Orientation Phase

DBT individual therapists utilize the first several sessions of therapy as a trial orientation phase. One of the key components of this phase is commitment to uphold therapy agreements. Both therapist and patient must agree that goals for therapy are in accordance with the targets of treatment. That is, ending life-threatening behavior must be the highest priority. The individual therapist and patient must reach an agreement to work toward ending these behaviors before therapy can proceed. Therapists will use techniques developed in social psychology research, including foot-in-the-door (ie, getting a larger commitment by obtaining a series of small consecutive commitments), door-in-the-face (ie, asking for a larger commitment than expected and then asking for subsequently smaller commitments), and devil's advocate (ie, the therapist pulls the patient to argue for the side of the commitment, rather than against committing) to obtain and strengthen a commitment.

Individual Therapy Targets

In individual DBT, the therapists have an explicit ranking of behaviors to target in treatment. The highest priority behaviors are life-threatening behaviors. These include suicide attempts, intentional self-injury, and urges for these behaviors. During a session, discussion of these behaviors takes precedence over any other behaviors. Any time these behaviors occur, the individual therapist will do a detailed behavioral analysis of the precipitating events and results of these behaviors in the following therapy session. The goal of behavioral analysis is to precisely identify moments when the patient can engage in more effective and skillful behavior. Therapists use behavior analyses to determine the contingencies and prompting events that operate around the behavior. Subsequently, therapists engage patients in rehearsing new and more adaptive behavior in response to prompting events.

The second highest target in individual therapy is to eliminate therapy-interfering behaviors on the part of the patient or the therapist. The principle behind this target is to eliminate those behaviors that may impede therapy from proceeding, such as behaviors that increase the likelihood of therapist burnout or of the patient dropping out. Behaviors targeted at this level may include not attending individual or group sessions, not doing homework, or the therapist or patient being late to sessions. In the absence of any life-threatening behavior, therapy-interfering behaviors will take precedence over all else.

The third highest target is quality-of-life interfering behaviors. These behaviors may include interpersonal dysfunction, criminal behaviors, homelessness, or high-risk sexual behavior. Often, patients want help with quality-of-life problems and may view them as a top priority. Therefore, patients may be reinforced with additional therapy time and focus when they do not engage in life-threatening or therapy-interfering behavior.

Dialectical-Behavioral Therapy Diary Card

Each week patients are given a DBT diary card to fill out daily. The diary card is a daily record that tracks self-injurious and suicidal behaviors and urges, drug use, daily emotions, and skills use. The card can be tailored to track the most important behaviors for a particular patient. Therapists typically scan the card at the beginning of each session to determine what will be discussed in therapy.

Group Skills Training

Since the individual therapist is the "point person" for the patient, the targets of group therapy differ from those of individual therapy. The top target is to decrease any behaviors that may destroy the group, the second is to increase skill acquisition, and the third is to decrease therapy-interfering behavior. These targets are in place to maximize the chances that group members will learn skills. Beyond any behavior that may destroy the group, such as patient violence during group, the top priority is to teach skills. A typical format for skills group is to meet for 2.5 hours, with the first half of group dedicated to skills homework review and the second half dedicated to teaching new skills.

DBT explicitly addresses skills deficits by systematically teaching four sets of skills labelled mindfulness, interpersonal effectiveness, emotional regulation, and distress tolerance. Self-regulation skills are woven into all areas of skills training.

Mindfulness skills involve observing, describing, and fully participating in a non-judgmental manner, fully focusing on one thing at a time, and focusing on being effective. Interpersonal effectiveness skills are designed to help patients be successful in reaching their goals (eg, obtaining their objectives, improving or maintaining relationships, or maintaining self-respect) in interactions. Emotion regulation skills involve teaching patients to decrease unwanted or ineffective emotional responses and increase positive emotions. Distress tolerance is a set of skills specifically designed to help patients survive crises as well as accept a life with many unwanted characteristics.

Telephone Consultation

Dialectical-behavior therapists are available to patients for phone consultation. The purpose of consultation is to have a brief discussion to help the patient engage in effective behavior rather than dysfunctional behavior. The telephone consultation approach in DBT is different from many therapy approaches in that it provides greater access to the therapist than is typical in some other psychosocial approaches. Some therapists may have a degree of uncertainty about providing patients with this level of access. However, research indicates that consultation access may not lead to a greatly increased burden on the therapist and may lead to better outcomes. Linehan and Heard[10] found no significant difference between the number of phone calls in the DBT condition and in the TAU condition. They found that phone calls in DBT had no significant correlation with the number of self-injurious episodes, while phone calls in the TAU condition were correlated with increased self-inflicted injuries. This result was interpreted as confirmation that the goal of DBT is to reduce the contingency between suicidal behavior and telephone contact. That is, DBT patients are encouraged to contact their therapist before engaging in parasuicidal behaviors and therefore do not have to become suicidal to gain access to the clinician.

Therapist Consultation Team

Dialectical-behavior therapists participate in a consultation team where they help each other acquire, integrate, and generalize effective therapeutic behaviors. One of the problems cited with working with BPD is that therapists often become burned out with the behavior of the patients. Therapists reinforce the effective behavior of each other and work to reduce responses that interfere with effective treatment, thus helping one another be as effective as possible. The role of the team is to help the therapist plan and trouble-shoot effective therapy interventions, to reduce personal characteristics interfering with therapy, to help the therapist adhere to the principles of DBT and progress toward a level of competence, to consult to the therapist on how to be effective with the mental health network, and to provide support.

The Role of Pharmacotherapy in Dialectical-Behavioral Therapy

DBT advocates the use of evidence-based pharmacotherapy for treating targeted problems, although pharmacotherapy is not a required part of treatment. A patient's pharmacotherapist may or may not be part of the DBT team. The DBT individual therapist consults with the patient on how to effectively interact with the pharmacotherapist.

FOUR STAGES OF DIALECTICAL-BEHAVIORAL THERAPY

DBT is a flexible treatment that varies in its approach depending on the patient's initial level of disorder. If a patient enters DBT with problems involving severe behavioral dyscontrol, such as suicidal behaviors or heroin addiction, then the patient enters the first stage of treatment. The target of stage 1 of therapy is to eliminate problematic behaviors that lead to an imminent threat to the patient and/or lead to a high level of disability. In addition, first-stage work targets increasing mindfulness, interpersonal effectiveness, emotion regulation, and distress-tolerance skills. If behavioral dysfunction is under control, patients move to stage 2 of treatment, which focuses on shifting from quiet desperation to emotional experiencing. Stage 3 addresses problems in living such as uncomplicated Axis I disorders, career problems, and marital problems. Finally, stage 4 involves helping the patient eliminate incompleteness and develop the capacity for freedom and joy. Treatment targets in stage 4 may include emptiness and loneliness.

CONCLUSION

DBT is a comprehensive treatment that has been shown to be effective in the treatment of BPD. This therapy incorporates principles from dialectical philosophy, Zen practice, and behavioral science. DBT counteracts the etiologic factors of BPD, including a biologic predisposition to emotion vulnerability and an invalidating environment, by balancing acceptance strategies and change strategies in therapy. The modes of therapy include individual therapy, group therapy, phone consultation, and team consultation. In many cases, DBT offers a unique perspective in approaching BPD. Dismantling studies currently underway may reveal more about the mechanisms of change in DBT. ***PP***

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