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DIALECTICAL BEHAVIOUR THERAPY (DBT)

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Definition: DBT for borderline personality disorder with suicidal and other impulsive and high-risk behaviours includes skills training, exposure, cognitive modification and contingency management balanced with acceptance by validation and mindfulness.

Elements:

In a pre-treatment phase of 4-6 weekly individual sessions, a therapist identifies client goals, orients the client to DBT, shapes commitment to its goals, and develops a target hierarchy of the order in which to address problem behaviours. If the client completes pre-treatment and agrees to DBT, the client enters Stage 1 which encompasses five functions:

1. Enhance capabilities: Clients learn skills, usually in a group, in four modules: mindfulness; distress tolerance; emotion regulation; and interpersonal effectiveness.
2. Improve motivation: In individual sessions, the therapist analyses cues for problem behaviours and reduces obstacles to more skilful behaviour by exposure, cognitive modification and contingency management.
3. Generalization: Clients can usually phone outside office hours for skills coaching.
4. Structure the environment to reward progress e.g. by offering an opportunity to extend treatment. With adolescent clients a therapist may meet their parents to advise contingency management of the target behaviours.
5. Enhance therapist skills and motivation by supervising the therapist team in a weekly meeting.

Related procedures: Cognitive restructuring, contingency management, diary-keeping, exposure, mindfulness, problem solving, role-play, social skills training.

Application: After 4-6 weeks of pre-treatment individual sessions a team of ≥4 therapists gives weekly individual and group sessions plus phone coaching usually over a year. DBT was developed for suicidal people with borderline personality disorder. Adaptations are appearing for other disorders.

1st use? Linehan M (1987)

References:

1. Linehan MM (1987) Dialectical behavior therapy: A cognitive behavioral approach to parasuicide. *Journal of Personality Disorders, 1,* 328-333.
2. Linehan MM (1993). *Skills Training Manual for treating Borderline Personality Disorder*. Guilford Press, New York & London.
3. Linehan MM (2006) Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviours and borderline personality disorder. *Archives of General Psychiatry; 63*: 757-766.

Case illustration (Stanton M, unpublished)

Julia, 32, had for 15 years repeatedly overdosed, cut her arms, misused alcohol, and been hospitalised. DBT began after a serious overdose. During 6 individual pre-treatment sessions, Julia identified goals of having a boyfriend and a job. With her

therapist, Julia developed a hierarchy of target behaviors, which were: *life threatening* (overdosing, suicide planning/actions, cutting herself, self-harming urges), *therapy interfering* (missing therapy sessions), and *quality-of-life interfering* (not applying for jobs, drinking >8 units of alcohol/week or >4 units/day).

Julia attended an open weekly 2.5-hour skills-training group with 6-8 other clients and 2 therapists. She recorded on a diary card self-harming behaviour, suicide ideas, alcohol intake, and DBT skills used. In week 1, she recorded trying mindfulness on 3 days, self-harming 5 times, and daily self-harming and suicidal urges. In weekly 1-hour individual sessions Julia chain-analysed her top target behaviour ('cut my arm on Tuesday evening') for links among thoughts, feelings and actions in order to develop more constructive behaviour for each link. The therapist, by cognitive restructuring, contingency management, skills coaching and exposure, encouraged Julia to role-play each new behavior in session. For example, Julia had argued with a friend, felt disliked by her, became angry, and drank a bottle of wine to blot this out. When that did not work, she cut her arm. The therapist validated that distress is natural after arguing with a friend, and role-played with Julia skills to talk to her friend without arguing while being mindful of her judgments. She calmed herself by deep, slow breathing and practised thinking kindly about her friend's perspective. This reduced her anger and self-harming urges.

Over the first 2 months Julia noticed that self-harming and drinking alcohol reduced distress. She became aware of her feelings, their triggers, and reasons for them. She could decide when to act on them or do something different.

Julia's frequent brief phone calls to her therapist for skills coaching diminished as her skills came automatically. She attended therapy regularly by arranging her own mobile-phone prompts. She chain-analysed target behaviours and devised helpful solutions. For example, on feeling strong self-harming urges and examining links in the chain Julia realised she felt sad because a friend was moving away and imagined this was her own fault. Julia recognised it was natural to feel sad, mindfully noticed her thoughts without involvement in them, challenged thoughts of being responsible by noting her friend was moving to be near her ill mother, and resolved to keep in email contact with her friend.

Julia began volunteer work in a plant nursery and was offered paid work. After a year of weekly outpatient individual and group sessions and telephone coaching, she began monthly 1-hour advanced-group meetings with one therapist and 4-5 DBT `graduates' for mutual support in maintaining skills. She could come as long as she kept using her skills and has attended 6 such meetings so far.