

FIVE Dialectical Behaviour Therapy

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Historical Development of DBT

Development of the Approach

In her seminal description of dialectical behaviour therapy (DBT), Linehan (1993) articulates her early experiences in developing the treatment. She began with the application of behaviour therapy to chronically suicidal individuals, many of whom had a diagnosis of borderline personality disorder (BPD). She encountered several difficulties in these early treatment endeavours. First, clients frequently failed to complete homework tasks; second, the primary problems presented by the client at each session fluctuated dramatically; and third, clients frequently failed to attend sessions. Linehan conceptualised these problems as a result of the extreme challenge for clients with multiple and severe difficulties in a treatment exclusively focussed on change. She hypothesised that the relentless focus on change invalidated clients who believed they were incapable of change or did not deserve to improve. In response, Linehan sought to incorporate a focus on acceptance into the treatment to balance the intense focus on change. She turned to Zen philosophy and in particular mindfulness to counterbalance behavioural theory. She adopted dialectics as a philosophical context that provides a framework for synthesising these two contrasting philosophies. The resulting treatment, DBT, is a principle-driven treatment that specialises in treating high-risk behaviours, particularly suicidal and self-harm behaviours, in the context of an identified diagnostic group, most commonly BPD.

DBT was first demonstrated as an efficacious treatment for suicidal behaviour in the context of BPD in a treatment trial published in 1991 (Linehan et al., 1991), with the treatment manuals being published shortly afterwards (Linehan, 1993a; 1993b). During the last 20 years, trials confirming the initial promise of the treatment have been conducted by research groups other than Linehan's and in countries outside the USA (see later). Linehan developed a training programme for learning DBT: DBT

Intensive Training. This is a 10-day programme consisting of two 5-week blocks of teaching separated by 6–8 months of development work. The first DBT Intensive Training course was conducted in Seattle in 1993. This training programme has seeded over 500 DBT programmes in the USA (Hibbset al., 2010). DBT is also offered as a treatment in a number of European countries (Spain, Germany, Netherlands, UK) and in other parts of the English-speaking world (Australia and New Zealand).

DBT in the UK

The first DBT team from the UK trained in Seattle in 1994/95. In the ensuing years a small number of teams continued to train in the USA. In 1997, the first UK Intensive Training programme ran in the UK with the support of the Linehan Training Group, a group of specialist trainers in DBT trained by the treatment developer. Since 1997, the British Isles DBT Training Team, a team of UK practitioners trained both to adherence in the treatment and as trainers in the treatment, has trained most British teams. Recent research calculated that the British training programme has seeded 240 programmes (Swales et al., 2010). Treatment programmes report, despite positive experiences of treatment delivery, significant problems in implementation of the treatment which relate primarily to lack of organisational support for specialised treatment programmes that require significant investment of practitioner time (Taylor et al., Forthcoming).

Theoretical Underpinnings

Major Theoretical Concepts

DBT rests on three core theoretical pillars: behaviourism, Zen and dialectics. At its core, DBT is a behavioural treatment. Behaviourism influences the principles and practices of the treatment in several ways. DBT embraces a radical behaviourist philosophy in that anything an organism does – thinking, sensing, emoting, acting – constitutes behaviour. Conceptualising in this way, for example, transforms the understanding of diagnosis. From a behaviourist perspective, the diagnostic criteria are simply lists of overt and covert behaviours, more or less behaviourally defined. Thus, therapists can intervene with any behaviour engaged in by the client using principles of behaviour change. Following behaviour change, when the client no longer engages in the overt behaviours and no longer experiences the covert behaviours, the diagnosis has gone. This perspective often provides clients with a more hopeful perspective than hitherto. In addition to providing a theoretical conceptualisation of the difficulties of the client, the behavioural focus drives the central treatment strategies of DBT: problem solving. Regardless of the problem, DBT therapists spend the first part

of each session conducting behavioural analyses of clients' behaviours targeted for change. These analyses form the basis for comprehensive solution analyses of clients' difficulties (see below).

For clients with serious and multiple problems, as discussed earlier, a relentless focus on change can be difficult to tolerate. Zen philosophy, emphasising acceptance of reality as it is, provides a counterpoint to this push for change. In embracing Zen, DBT therapists accept the client as he or she is in the moment, the client's current state of progress and the status of the therapeutic relationship. In so doing, therapists model for clients how to accept themselves and reality as it is in the moment. To promote an attitude of acceptance, DBT therapists practice mindfulness themselves and teach mindfulness to clients. In contrast to other psychological treatments utilising mindfulness that focus on clients engaging in extensive practices, DBT teaches mindfulness as a series of seven skills (Linehan, 1993b), each of which is rehearsed in shorter practices. These basics of mindfulness are taught in DBT skills groups. DBT therapists strengthen and generalise these skills by noticing when clients become unmindful and coaching in how to remain more focussed in the present moment without judgement. In assisting clients to solve current problems DBT therapists balance solutions based on both acceptance-based skills and change-based skills.

Dialectical philosophy builds a bridge between acceptance and change within the treatment. As a world view, dialectics emphasises interconnect-edness and wholeness, guarding against a unipolar perspective on reality. DBT therapists recognise and welcome multiple perspectives on problems. In endeavouring to synthesise data from more than one perspective, more effective solutions may be found.

How Client Problems are Conceptualised

Primacy of Affect

Linehan proposes that the primary difficulty for clients with a diagnosis of BPD is the experience and regulation of *affect*. The central difficulty of managing affect leads to the emotional lability that is at the heart of BPD. Emotional 'dysregulation', as Linehan refers to it, drives difficulties in other systems. Thus, clients experience interpersonal dysregulation (chaotic relationships and fears of abandonment), self-dysregulation (identity disturbances and sense of inner emptiness), cognitive dysregulation (paranoid ideation and dissociative thinking) and behavioural dysregulation (suicidal and impulsive behaviours). Conceptualising the diagnosis according to these systems of dysregulation articulates a central component of DBT conceptualisation that criterion behaviours of the BPD diagnosis are either a natural consequence of being emotionally dysregulated (chaotic relationships, identity and cognitive disturbances) or represent attempts to re-regulate (suicidal and impulsive behaviours). DBT therapists, therefore, in conceptualising client problems, place a strong emphasis on affect and

understanding the relationship between the clients presenting problems and affect.

Capability and Motivational Deficits

DBT is based on a biosocial theory that explains the origins of the emotional vulnerability of BPD clients as a consequence of biological vulnerability transacting with invalidating environments. Linehan suggests that clients who develop BPD are biologically vulnerable to emotion regulation difficulties either as a result of genetic, intrauterine or neurobiological factors. Such biological predispositions will only lead to BPD in certain environmental contexts. Linehan described invalidating environments as the crucial type of environment that in concert with biological vulnerabilities transacts over time, leading to the development of BPD. Invalidation environments have three major characteristics. First, these environments fail to recognise and validate the individual's own private experiences, frequently dismissing them as inaccurate, ill-judged or indicative of major character flaws. Second, in the face of emotional escalation, invalidating environments intermittently reinforce extreme emotional displays. Third, invalidating environments oversimplify the solution of social and emotional problems. These features of invalidating environments lead to several difficulties for clients with BPD. Frequently, clients are unable to recognise and label their emotional experiences in a manner normative to the wider community. As they have not received accurate feedback about their own emotional responses to situations and the validity of their responses, they learn to distrust or to ignore their own emotional responses. For significant periods of time, invalidating environments fail to attend to emotional communications or distress but then intermittently reinforce escalations. Thus, clients learnt to oscillate between the inhibition of emotional responses and extreme behaviours, for example suicidal behaviours. As invalidating environments tend to imply that the solution to life's challenges lies in 'pulling yourself up by your own bootstraps', clients have not learnt how to solve complex problems by breaking them down into component parts and also tolerating the frustration of not having solved the problem yet. Whilst a degree of invalidation is common in all environments, development of BPD is more likely when invalidation is chronic or severe, or when the individual is highly biologically vulnerable. The transactional theory of the development of BPD, however, allows for the development of BPD in circumstances where there may be relatively minor biological vulnerability in the context of low levels of invalidation. In these circumstances, the poor fit between an individual and their environment may result in low levels of invalidation increasing the vulnerability in the child, resulting in subsequent, more intense levels of validation that further disrupt the child's capacity to emotionally regulate and, over years, lead to greater disturbance.

Consequent upon the invalidating environment that has failed to teach clients how to manage emotions, clients with BPD have significant

Table 5.1 Functions and modes of a DBT programme

Function of the DBT programme	Example modalities
Enhance client capabilities	Skills groups
Enhance client motivation	DBT individual psychotherapy
Ensure generalisation	Telephone consultation
Structure the environment:	a) Management of the DBT programme
a) Treatment	b) DBT family therapy
b) Client	
Enhance therapist capabilities and motivation	Consultation team

capability deficits in the management of emotions, relationships and behaviour and, in addition, clients have significant motivational deficits that impede effective resolution of their difficulties. Thus, DBT rests on a capability and motivational deficit model of BPD and recommends a comprehensive treatment programme to address these problems. DBT treatment programmes possess five functions, each with corresponding modalities (see Table 5.1).

Enhancing client capabilities in the realm of affect regulation, interpersonal skills and crisis management represents a core component of a DBT programme. Most programmes address this function by running DBT skills groups, which follow a core curriculum (mindfulness, interpersonal effectiveness, emotion regulation and distress tolerance) described in detail in the *Skills Training Manual* (Linehan, 1993b). DBT individual psychotherapy focuses on identifying and resolving motivational impediments to behaviour change such as problematic affects, cognitions or reinforcement contingencies. To ensure generalisation of treatment gains outside of the treatment environment, DBT programmes contain specific modalities designed to both generalise skills and also reduce suicidal crises. Most commonly, DBT programmes provide telephone consultation between the DBT individual therapist and the client between sessions to fulfil this function. In recognition of the challenge of treating clients with BPD effectively and of the complexity of the problems presented by the clients, DBT programmes also attend to enhancing the capabilities and motivation of the therapists. DBT therapists meet weekly in consultation team, during which they receive consultation and supervision on their treatment of clients. Finally, DBT programmes require modalities to assist in maintaining the structure of the treatment programme and, in some cases, to promote treatment gains within the clients' natural environments.

Behavioural Conceptualisation

Following on from the behavioural approach to diagnosis, DBT conceptualises all of the problems of the client in behavioural terms. Thus, DBT therapists, in pre-treatment, discuss with clients the primary behavioural

Table 5.2 Hierarchy of behaviours in Stage 1 of DBT**Primary targets**

Life-threatening behaviours, including:

- Suicidal behaviours
- Non-suicidal self-injury
- Homicidal behaviours
- Serious aggressive acts
- Imminently life-threatening behaviours.

Threats and urges to engage in the above.

Significant changes in suicidal/homicidal ideation.

Therapy-interfering behaviours of the client and therapist

Quality-of-life interfering behaviours, including:

- Behaviours associated with other psychiatric diagnoses
- Seriously destabilising behaviours, e.g. frequent hospitalisations, violent behaviour, forensic behaviours.

Increase behavioural skills

targets for change. The specific behaviours of the client are then arranged hierarchically (see Table 5.2) according to the scheme utilised within DBT. During treatment itself, each week therapists select a specific example of one of the target behaviours that form the basis for the chain and solution analysis within the session.

DBT as a behavioural treatment is based on behavioural theory. Thus, DBT therapists apply learning theory to the problems of the client. In analysing client problems, DBT therapists seek to identify classical conditioning links in the sequence of events leading up to and operant conditioning links following target behaviours. For example, a client with a history of sexual abuse frequently dissociated at night on entering her bedroom when she saw her bed. As a child her father, just before bed, had frequently sexually abused her. For her, the bed was a cue that elicited anxiety and dissociation. This represented a classically conditioned link. Subsequent to dissociation, the client would cut herself to terminate the dissociative state which she experienced as aversive. Thus, cutting was negatively reinforced by the removal of the dissociative state. DBT therapists would then apply the appropriate intervention to treat each link. In this case, the therapist conducted an informal exposure programme to the cue of 'beds', helping the client to decrease dissociative behaviours when presented with the cue. Emotion regulation skills to manage anxiety as she approached bedtime and mindfulness enabled the client to tolerate and benefit from the exposure programme. To address the operant links, the therapist taught the client how to become 'reassociated' without cutting. Grounding skills were especially useful here, as were some cognitive restructuring of the client's beliefs that she deserved to suffer the distress of dissociation because she believed herself culpable in the abuse.

As indicated earlier, DBT applies the treatment to covert as well as overt behaviours. Thus, principles of learning theory can be applied to thoughts as well as actions. For example, many clients with a history of repeated suicidal behaviours when faced with an emotional difficulty find thinking about death soothing. Conceptually, then, the relief from distress negatively reinforces suicidal thinking. DBT therapists intervene both by providing alternative ways to experience relief other than thinking about suicide and also initiate a new learning history by challenging the client's belief that suicidal thinking is a solution to life's difficulties, that is, providing an aversive consequence to suicidal thinking.

Practical Applications

Therapeutic Relationship

DBT makes several assumptions about the therapeutic relationship: that the most caring thing a therapist can do is to help clients change in ways that bring them closer to their own goals; that principles of behaviour are universal affecting therapists as much as clients; and that therapists treating clients with BPD need support. At the start of the pre-treatment phase in DBT, therapists focus on identifying client goals and then explicitly link these to the goals of treatment. For example, a client who wants to develop better interpersonal relationships is helped to see that stopping suicidal behaviours will increase the likelihood of more mutually supportive relationships; or a client who wants to feel better is oriented to how the treatment teaches and helps to implement a range of longer-term solutions to emotional difficulties that whilst they lack the immediate affect regulatory capacity of cutting, they also lack the harmful effects on her body, her self-esteem and her family relationships. Occasionally, making these links explicit is more challenging; for example, the client who states that his or her goal in life is to be dead. In these circumstances, the DBT therapist explores what 'being dead' would do for the client. Frequently, clients will identify that being dead will relieve emotional suffering or escape intolerable life circumstances. The DBT therapist in these circumstances must build a case for the treatment to provide an alternative route to these same ends.

As principles of behaviour change are universal, the therapeutic process impacts therapists as well as clients. DBT recognises this process of reciprocal influence in the identification of therapy-interfering behaviours in the target hierarchy by explicitly stating that therapy-interfering behaviour is a 'two-way street' and that therapists may engage in behaviours that hinder client progress in therapy. DBT therapists need to practise openness in response to feedback from clients about their own behaviours and develop the capacity to scrutinise the impact of their behaviours with a willingness to modify their responses if necessary. Therapists also must remain awake to the impact of client's responses on them. Just as therapists endeavour to shape client

behaviour, clients' behaviours may shape therapists behaviour out-of-awareness and sometimes in ways that ultimately are ineffective. For example, a client who was ashamed of her suicidal behaviour became either aggressive with the therapist or mute when it was discussed. Both behaviours the therapists found a challenge to respond to. He tried a number of different interventions without success and gradually decreased his focus on the client's suicidal behaviour. The client did become more comfortable in session, but her suicidal behaviour and high risk continued unchanged. The task of the DBT consultation team is to assist therapists in both identifying and changing these problematic patterns when they arise.

In DBT the therapeutic relationship is the major source of contingent relationships for client progress. Early in the process of behaviour change clients rarely receive any direct and immediate reinforcement for their early change efforts. New emotion regulation skills rarely work with the effectiveness of suicidal and self-harming behaviours, and small changes in interpersonal style often go unremarked by the chaotic environments in which clients live. The therapist, therefore, is often the only source of reinforcement to motivate the client to remain in what is often a painful process of change. DBT therapists attend to the impact of their behaviour on clients and use their own behaviour strategically to promote change. Just as the therapist will notice and reinforce any small effort that the client makes towards using non-harming methods to manage emotions, he or she will also refrain from reinforcing problematic behaviours. So, for example, DBT therapists will take care to eliminate any increase in warmth and validation in response to suicidal communications, tending to remain matter-of-fact and reserving increases in warmth and validation for clients' non-suicidal problem-solving efforts.

A significant component of the role of the DBT therapist is to be both a teacher and a consultant to the client. In skills training groups, therapists explicitly teach skills and indeed the format of the class is more that of an educational class than a therapy group. In individual therapy, therapists may help clients acquire new skills, but primarily they focus on assisting clients to strengthen new skills. DBT is entirely open with clients about its philosophy and its proposed methods of action. DBT therapists therefore orient clients to therapeutic strategies, especially to the four change procedures (skills training, cognitive modification, exposure and contingency management), to promote clients' capacity to manage their own behaviour.

Whilst DBT therapists actively teach, model and demonstrate to clients and take an active problem-solving stance throughout therapy, their primary stance for solution implementation is consultation to the patient. Thus, rather than the therapist intervening to solve problems on behalf of the client with other professionals or other parts of the treatment system, the DBT therapist coaches the client on how to approach and solve whatever problems he or she is experiencing with others.

Strategies of Treatment

Within DBT all treatment techniques and strategies are arranged on the dialectic of acceptance and change. The core treatment strategies are *problem solving*, representing the change pole, and *validation*, representing the acceptance pole.

Problem Solving

Central to DBT is problem solving; standard CBT problem solving with a few novel twists. Each therapy session, the DBT therapist selects the most high-priority target behaviour that the client has engaged in the preceding week for analysis. First, the therapist obtains a precise definition of the topography and severity of the target behaviour before conducting a behavioural analysis of all the links in the sequence of events that led up to and followed the behaviour. In conducting the chain analysis the therapist seeks to identify and distinguish affective, cognitive and overt behavioural links and to clarify which of the links in the sequence of events are dysfunctional, and which of them are controlling variables with respect to the target behaviour.

The therapist uses the behavioural analysis as a basis for the solution analysis. If the therapist assesses that the problematic link occurred as a result of a skills deficit, then, if the client does not yet know the skill, the therapist teaches a new skill, or, if the client has acquired the basics of the skill in the skills training group, then the therapist strengthens the skill and assists the client to generalise the skill to the new context. If the problematic link is an unwarranted affect, or where the affect is warranted but the intensity of affect is unwarranted, the therapist may use exposure as a solution. When problematic cognitions interfere with skilful behaviour, then the therapist will use cognitive modification procedures. When more skilful behaviour is within the client's repertoire of behaviours but is low down in the response hierarchy, or where more dysfunctional behaviours are higher in the response hierarchy, then the therapist utilises contingency management procedures to modify client responses.

Once the therapist has selected a solution or range of solutions to address the target behaviour, the therapist rehearses the new behaviours with the client in session. Rehearsal provides the therapist with an opportunity to identify any problems in understanding or implementing the new behaviour and also to shape successive approximations to more skilful behaviour. Finally, the therapist considers with the client the detailed practicalities of implementing the new solutions outside the therapy session and troubleshoots any potential problems in generalising the new behaviours.

Validation

Balancing the problem-solving focus, DBT therapist distils from the myriad responses of the client – emotions, cognitions and behaviours – those which are valid, and feeds this back to the client. The therapist

thus provides a counterpoint to the invalidating environment by modelling and then teaching clients how to validate their own responses. Dialectically, therapists simultaneously validate the valid aspects of the client's responses whilst invalidating their invalid aspects. For example, a client may repeatedly cut herself in order to relieve anxiety. Cutting is, therefore, valid both because it relieves anxiety and because most people seek methods to reduce unpleasant levels of anxiety. The behaviour is invalid, however, in that it reduces the likelihood that the client will reach his or her ultimate goal of feeling better and enhancing his or her self-esteem.

Whilst many treatments more or less explicitly incorporate validation, DBT articulates a series of levels of validation, some of which are especially characteristic of the treatment. The lower levels of validation (staying awake to the client's responses moment-by-moment in the session; reflecting accurately the client's responses; mind-reading that which is unspoken; validating the client's behaviour in terms of their past learning history) are more typical of a wider range of therapies. The two higher levels, validation in terms of present context and radical genuineness, are particularly distinctive features of DBT. Validation in terms of present context requires the therapist to identify those aspects of a client's responses that are valid in the present context or are indicative of normative functioning. For example, a client with an abuse history agreed to work with a female therapist although she would have preferred a male therapist because female family members had persistently failed to rescue her from abusive situations. The client struggled to disclose matters of significance to the therapist. The therapist validated this in terms of normative functioning by saying 'It makes sense to me why you have difficulty trusting me as you've only just met me and don't know yet whether I can be trusted'. This was more effective with this client in promoting engagement with the therapist than a more traditional validation of her learning history, for example 'It makes sense why you don't trust me yet as women have often let you down.'

In using radical genuineness, the DBT therapist responds to the client in the way that he or she would to a family member or a colleague. In other words, the therapist 'tells it like it is', treating the client as another human being robust enough to hear the truth. For example, a client had broken a vase in the therapy room during an aggressive outburst and was immediately apologetic, saying 'I shouldn't have done that', hiding her face away from the therapist. The therapist responded 'You're right, it was totally inappropriate - how are you going to put it right?', validating the warranted shame, matter-of-factly. The client relaxed slightly in her posture, looked up at the therapist and was then able to discuss appropriate reparation. This example indicates a key characteristic of validation: it involves finding the validity or accuracy in the client's response and does not necessarily involve saying something positive.

Major Treatment Techniques

Stylistic Strategies

DBT therapists deliver problem solving and validation using two dialectically opposing styles: reciprocal and irreverent communication. Reciprocal communication is a fairly typical communication style in psychotherapy, consisting of warmth and genuineness. DBT therapists, in addition, use self-disclosure. In modelling self-disclosure, the therapist discloses personal examples of where they have encountered similar challenges to the client but have utilised skills or strategies from the treatment to solve the problem. Effective modelling self-disclosure uses a coping rather than a mastery model of skill use. Therapists also only disclose resolved or uncontentious problems from their own lives, ensuring that the focus of the session remains on the resolution of clients' difficulties. In self-involving self-disclosures, DBT therapists communicate directly to clients their own response to clients' behaviours, emotions and thoughts. For example, a client frequently said, without consideration, 'That won't work' to all of her therapist's suggestions, whilst demanding that her therapist provided her with help. The therapist responded to the client, 'When you demand my help and dismiss all my suggestions without detailed consideration, my motivation to help you decreases'. The client was surprised by this information as it had not been her intention to elicit this response in the therapist, rather her summary dismissals stemmed from an anxiety that she would be unable to change her behaviour. Disclosing her response to the client facilitated problem solving of how the therapist could more effectively make suggestions for change and what the client could do to manage her anxiety.

DBT therapists use irreverent communication when the client is entrenched or stuck with the aim of increasing engagement and shaking up established ways of thinking, feeling and acting. Irreverent strategies, however, just like reciprocal strategies, must also come from a position of compassion for the client. At its most basic, irreverence involves using a matter-of-fact or confrontational tone to discuss subjects that often are not discussed or skirted around. Most commonly, DBT therapists use this style in the discussion of suicidal behaviour. For example, in pre-treatment a client described her only goal in life was to die. The therapist said 'So what would dying do for you?' The client immediately looked up at the therapist and became more engaged in the discussion. The client then described that she thought that death would provide an escape from life's difficulties. The therapist then increased the intensity of irreverence using the strategy of 'plunging in where angels fear to tread' and asking what no-one else would ask. The therapist enquired 'So why not die now?' The client was surprised by the directness of the question and then listed a number of reasons, one of which was that she wanted to wait until her daughter had left home. The therapist was then able to explore why the client killing herself was likely to have an impact on the client's daughter whatever age and wherever she

lived, facilitating negotiation of commitment to the treatment. Combined with these irreverent interventions, the therapist was simultaneously validating of the extreme difficulties in the client's life and the need to develop effective, alternative-to-death, solutions for them.

Dialectical Strategies

Dialectics permeates the whole of the treatment. Balancing acceptance of the client in the moment with a push for change, moving between validating the valid and invalidating the invalid, considering multiple perspectives on the same problem and how solutions for one problem impinge upon another, dialectics drives the movement and speed of the therapeutic interaction. The primary dialectical strategy is the continual movement and balancing of problem solving and validation, weaving the different styles seamlessly together.

In addition to the movement between different styles and strategies, DBT has a number of strategies (use of metaphor, devil's advocate, making lemonade out of lemons, extending, activating wise mind) that embrace aspects of change and acceptance within them. For example, DBT therapists frequently use metaphor to encapsulate aspects of the client's current situation yet also indicating how to change. With the client in the case example below, Renee, the therapist used metaphor to help her understand the treatment stance on reducing suicidal and self-harm behaviours prior to addressing past trauma. The therapist described therapy as akin to climbing a mountain, and that in climbing a mountain you need to be properly prepared with the appropriate equipment, provisions and skills, particularly as this particular mountain is challenging and experiences frequent adverse weather conditions. DBT treatment is the stage of developing mountain-climbing skills, acquiring all the necessary provisions and practising withstanding adverse weather conditions. Describing the task in this way not only validated the difficulty of the task and the client's desire to do it – the sense of achievement, the view from the top will transform how you see the future – but also indicated what the client needed to do to be successful.

Overcoming Obstacles to Client Progress

Two aspects of the treatment assist DBT therapists in solving obstacles to client progress: the first is the inclusion of therapy interfering behaviours on the target hierarchy, and the second is the team focus of the treatment. If during the week prior to the therapy session there have been no suicidal behaviours, then therapy-interfering behaviour takes priority for behavioural and solution analyses. Therapists use the same principles and strategies to analyse therapy interfering behaviours as they do for suicidal behaviours. Behaviours engaged in during the therapy session itself may also interfere with the conduct of therapy. In these circumstances, the therapist may do a brief 'detour' to analyse the links in the chain leading up to and following

the in-session behaviour and rehearse solutions with the client before returning to the analysis of the out-of-session behaviour. This movement between in-session and out-of-session behaviour is also characteristic of DBT.

Clients with BPD experience multiple complex problems and frequently live in environments characterised by high levels of adversity. Consequently, progress is often slow and solving client problems a significant challenge. Therapists may become demotivated and risk burn-out in these circumstances. DBT assumes, therefore, that therapists delivering the treatment need support in order to maintain a therapeutic stance with clients who are in a lot of emotional pain and where progress is slow. Thus, DBT is a team treatment; an individual therapist alone cannot deliver DBT. The DBT team meets weekly to provide consultation and supervision to the therapists on the team. DBT consultation teams focus on enhancing therapists' capabilities and motivation to treat effectively. Therapists may seek to learn about how to more effectively implement strategies of the treatment from their colleagues and also ask for assistance in increasing motivation for treating the clients. Team members utilise the same treatment strategies and solutions on themselves that they are teaching to clients. So, for example, a team might teach a therapist the key principles of exposure therapy; have a therapist role-play an interaction from therapy that did not go well and provide feedback; validate the struggles of the therapists in helping a client experiencing a traumatic court case; generate new solutions for a therapist to try with a client for whom no solutions seem to have worked so far. Therapists on a DBT team need to be willing, therefore, to apply all skills and strategies that they use with clients to themselves.

Case Example: Renee

Renee is 25 years old, unemployed and lives alone in supported housing. She has a history of suicidal and self-harming behaviours that began when she was 10 years old. These behaviours have increased in intensity in recent years. Renee cuts herself three to four times per week, mainly with box cutters. Her wounds are frequently sutured, but she will also often treat them herself as she dislikes attending A&E. Renee has a history of taking overdoses, primarily with paracetamol, but also of fluoxetine that she takes for her depressed mood. She has taken five overdoses in the last 18 months. She has had frequent admissions to hospital, commencing with a 1-year stay in an adolescent unit at the age of 16. In the last year she has had two brief admissions. Her consultant psychiatrist is reluctant to admit her as she usually deteriorates during admission, becoming more suicidal during the admission and increasing the difficulty of discharging her. She has had one episode of attempted hanging on the inpatient unit. She frequently expresses the wish to die and to escape her unending emotional turmoil. In addition to her suicidal

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behaviour, Renee meets criteria for BPD, post-traumatic stress disorder (PTSD) and substance abuse disorder (alcohol).

Renee was sexually abused by her biological father and one of her mother's subsequent partners. Neither man was successfully prosecuted. Her mother is dependent on alcohol and was dependent throughout Renee's childhood. Renee describes caring for her mother when she was drunk and that her own physical and emotional needs were not addressed. Current contact with her family remains fraught with tension.

Renee has had experience of psychological treatments before. She was treated for her PTSD during her adolescence with an exposure-based treatment that resulted in a worsening of her suicidal and self-injurious behaviours. She was referred for psychodynamic therapy but was judged too unstable to benefit and she dropped out of a course of CBT after five sessions. She intermittently attends scheduled appointments with her community psychiatric nurse (CPN) and consultant psychiatrist, but presents frequently in crisis at evenings and weekends.

Conceptualisation of Renee's problems

During pre-treatment, Renee described her primary goal for treatment as decreasing the extreme emotional distress in her life. Renee described frequent and intense symptoms of PTSD, especially flashbacks and dissociation, high levels of shame and avoidance of ordinary social situations that often triggered these symptoms. The therapist's initial conceptualisation of suicidal and self-harming behaviours as well as her alcohol misuse as attempted solutions to her problems resonated with Renee. Suicidal behaviours provided her with a sense of escape from her problems, whilst self-harm behaviours and alcohol misuse serviced to release tension, stop flashbacks and dissociation and significantly reduced high levels of emotion. As treatment progressed, the therapist's behavioural conceptualisation about Renee's problems became more comprehensive (see Table 5.4).

Therapeutic Relationship

As is typical in DBT, Renee's therapist employed validation and reciprocal communication strategies balanced with challenge and confrontation (irreverent strategies) to build the relationship. Primarily, the therapist validated the wisdom of Renee's ultimate goal of reducing distress in her life. More irreverently, however, the therapist validated how effective suicidal and self-harm behaviours were in achieving this goal by suggesting that she (the therapist) could be in favour of them if it was not for their longer-term negative effects. This intervention caught Renee's attention, leading to a more thoughtful evaluation of the costs and benefits for Renee of retaining suicidal behaviours as a solution to her difficulties. Following this discussion, Renee made a provisional commitment to treatment. The therapist shaped this commitment by employing the 'devil's advocate' strategy, one of the dialectical strategies in the treatment. The therapist emphasised the difficulty of therapy and wondered why Renee would want to attempt something so challenging when she had dropped out of other therapies before. In response, Renee articulated some of

Table 5.3 Renee's preliminary target hierarchy

Life-threatening behaviours to decrease:

- Hanging
- Overdoses
- Cutting
- Threats to self-harm
- Urges to self-harm

Therapy-interfering behaviours to decrease:

- Non-attendance
- Not phoning the therapist
- Saying 'I can't' repeatedly

Quality-of-life interfering behaviours:

- PTSD
 - Decrease dissociation
 - Decrease flashbacks
- Substance abuse
 - Decrease alcohol use to <10 units a week
- Increase structured activity during the day

Increase behavioural skills

her own scepticism about therapy and with some problem solving from the therapist committed to working on those behaviours that might interfere with therapy. Renee reported that she found the therapist's directness about the likely difficulties refreshing and helpful. Following orientation to the treatment programme and to the telephone consultation modality in particular, Renee was willing to commit to relinquishing suicidal and self-harm behaviours for the year-long contract. Renee's target hierarchy, drawn up at the end of pre-treatment, is shown in Table 5.3.

Application of Treatment Strategies and Techniques

The early part of Renee's treatment focused on analysing and developing comprehensive solution analyses for her suicidal behaviour. During the first 10 weeks of treatment, the most frequent behaviour in the top category was cutting. An example, of one of the chain analyses of cutting, is shown in Table 5.4. The left-hand column describes Renee's therapist's conceptualisation of the chain, where, affective, cognitive and behavioural links and reinforcing and punishing consequences are clearly distinguished. Identification of links in this way facilitates a more accurate and comprehensive solution analysis. The central column describes the links in the chain. The right-hand column outlines potential solutions to each of the links.

The solution analysis demonstrates several hallmarks of DBT. First, the therapist used solutions from more than one set of change procedures (skills, exposure, contingency management and cognitive restructuring) and recommends a balance of acceptance-based (mindfulness and distress tolerance skills) and change-based skills (acting opposite to emotion and interpersonal skills).

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*(Continued)***Table 5.4 Chain and solution analysis of cutting behaviour**

Conceptualisation	Links in the chain	Potential solutions
Vulnerability factors	Low mood. Poor sleep.	
Prompting event	Argument with sister when Renee refuses to attend family event.	Interpersonal effectiveness skills: how to say 'No' more effectively.
Affective link	Anger.	Emotion regulation skills: unclench hands, sit down calmly, do not stomp about, validate why her sister may want her to attend the event.
Cognitive links	'She's never understood.' 'It was different for her.' 'She doesn't really believe what happened.'	Mindfulness. Self-validation.
Behavioural link	Tears up a drawing she was doing.	Emotion regulation: Acting opposite to the emotion: continue to be creative. Distress tolerance: self-soothe.
Affective link Behavioural link	Anger decreases. Curls up on sofa.	Acting opposite: go for a walk, remain seated upright, distraction.
Affective link	Sadness. Urge to withdraw.	Behavioural activation: text friend. Exposure to sadness as a cue that frequently elicits shame.
Cognitive link	'I shouldn't destroy things.'	Cognitive restructuring of the judgement. 'Destroying things doesn't help me.' Mindfulness of the judgement 'I'm just noticing that I am judging myself for tearing the drawing'.
Affective link Cognitive link	Sadness increases. 'It's all my fault.' 'I damage things and people.'	Mindfulness. Cognitive restructuring: 'I have hurt people in the past, I'm working on changing that.' 'I've been hurt in the past too.' 'I'm not totally responsible for all the difficulties in my family.'
Affective link	Shame	Act opposite to urge to hide away: reach out – call therapist or friend.
Cognitive link	Flashback to past emotional abuse by Mum.	Grounding skills: Mindfully describe room and current context.

Conceptualisation	Links in the chain	Potential solutions
Behavioural link	Rocking to and fro with hands over her ears.	Sit in upright posture in the chair and ...
Affective link	Shame increases.	... mindfully follow the breathing. Practice self-soothe.
Behavioural link	Goes to kitchen. Picks up box cutters from draw.	Avoid kitchen – go for walk. Remove box cutters from the house or lock away so harder to access. Crisis survival skills: review cons of self-harm behaviours as a solution.
Behavioural link	Cuts herself four times with box cutters on upper thigh.	
Negative reinforcement	Shame decreases.	
Positive reinforcement	'I've punished myself.'	Psychoeducation that cutting is reinforced by the consequences, not punished.
Behavioural link	Steri-strips on cut	
Positive reinforcement	Soothed.	Use alternative strategies to soothe self earlier in the chain.
Positive reinforcement	Texts friend who is sympathetic and comes over.	Contingency management: text friend before cutting, not after. Write out own chain and solution analysis (positive punishment).

Second, in approaching cognitive links, the therapist used mindfulness, in particular noticing and letting go of judgements, as well as traditional cognitive restructuring. One of the challenges for the therapist in working with Renee was that many of her most distressing cognitions were not inaccurate, that is, she frequently destroyed things and had often caused distress and upset to others. In DBT, the therapist, in a radically genuine way, will not avoid confirming the validity of some of these thoughts, although the therapist will ensure that the client sticks with the facts of the situation without adding interpretations or judgements. For example, in this chain the therapist did validate that many of Renee's friends had been hurt by her at various times but challenged the belief that her friends had been 'damaged' as there was no evidence that this was the case. The therapist also validated that Renee had at times damaged property. The movement between 'validating the valid' and promoting restructuring of the invalid components demonstrates dialectics in action.

Third, the therapist observed over a number of behavioural analyses that when Renee experienced sadness, this frequently elicited shame and thoughts that she was to blame for her sadness. This sequence was, in part, related to her history of

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her mother berating her when anything went wrong in the family. Thus, the link between sadness and shame was classically conditioned. In DBT, when faced either with affects that are unwarranted by the situation or where the affect may be warranted but the intensity is not, as in this case, DBT therapists will use exposure as a solution. The therapist, therefore, asked Renee to imagine tearing up the drawing and the experience of sadness elicited by her actions. As Renee did this, her sense of shame began to rise. The therapist encouraged Renee to re-focus mindfully on her sadness, without judging herself or the behaviour, coaching her to say 'I have torn up my drawing. I notice my sadness that I did that. I notice the thought that I wish I hadn't done that'. The therapist also blocked any of Renee's typical shame behaviours, for example curling up and saying 'Everything is my fault'. By remaining more mindful of the sadness, less judgemental and more upright, Renee experienced a gradual reduction in shame, and sadness was less likely to trigger shame.

Fourth, the therapist developed contingency management strategies. For Renee, cutting primarily functioned to decrease shame. Blocking this immediately negatively reinforcing effect of self-harming behaviours is almost impossible, so the task of the therapist was to identify the function of the self-harm and find alternative behaviours to fulfil this same function. So in addition to decreasing the likelihood that she would experience shame, the therapist worked on decreasing shame when it arose, using skills, primarily acting opposite and reaching out to others, and countering cognitions associated with shame, such as Renee reminding herself that she was not solely responsible for the problems in her family. The therapist noticed, again over several chains, that Renee was more likely to call her one good friend after she had harmed herself. As the friend was very supportive and validating at these times and often justified Renee's self-harm behaviour, the therapist and Renee agreed that she, Renee, would approach her friend prior to but not after harming herself. The therapist also introduced a positive punishment for self-harm behaviours: if Renee did self-harm, she was to complete her own chain and solution analysis. In keeping with the stance of the treatment that teaches clients to know as much about the principles of behaviour change as therapists, the therapist explained the principles of contingency management to Renee and together they negotiated how to implement the solutions.

Learning to do chain analyses and developing the attentional and memory capacities to recall relevant events is a skill in itself and takes time to learn. Early chains from Renee were sketchy but still provided sufficient material to work on. Renee's very first chain consisted of Renee saying 'I felt crap and I cut myself - what else do you need to know?' The therapist expanded this to the following sequence: 'I was at home, felt lonely, sad I'm alone. Thought "it's all my fault", cut self, sadness decreased'. The therapist in this session chose skills to reduce sadness and reviewing the pros and cons of cutting as a solution to emotional problems.

Sixteen weeks into treatment, Renee's suicidal behaviour was significantly reduced. Therapy sessions were then directed at Renee's quality-of-life interfering behaviours. As a direct consequence of working on links leading to self-harm, Renee had already acquired some basic skills in re-grounding herself and the reduction of shame. Once flashbacks became a target in their own right, Renee and the therapist

developed a hierarchy of cues that elicited flashbacks, for example any contact with men, visiting cafés, shopping, and implemented an exposure programme based on this. Gradually Renee's confidence increased and she began attending an evening class. Working on managing cues that elicited flashbacks helped to further decrease suicidal thinking, but also impacted on Renee's alcohol use as the primary function of drinking was to decrease painful memories from the past. Additional links addressed in reducing Renee's alcohol use involved her reducing the frequency of contact with her mother and also cognitively restructuring of her self-blame beliefs about the abusive events of her childhood. As Renee made progress in managing her PTSD and alcohol misuse she reported that she no longer felt the earnest desire to discuss her past trauma that she had experienced at the start of therapy. She decided instead to join the graduate DBT skills training group, which focused on more autonomous problem solving, and to gradually increase her time in education.

Overcoming Obstacles in Therapy: Solving Therapy-Interfering Behaviours

In the early phase of therapy Renee frequently missed group skills training. Analysing Renee's decision not to attend group sessions revealed two important links. First, she felt ashamed of her self-harm behaviours and believed that other group members were judging her for this; these thoughts increased her urges not to attend. Second, she had often spent her bus fare on alcohol so that even when she was more motivated to come she lacked the financial wherewithal to travel to the group. For the first link the therapist helped Renee practise mindfulness of her judgements and cognitive restructuring focussing on Renee reminding herself of the primary focus of the skills group – to learn new skills. For the second link, the therapist devised a plan with Renee for keeping 'emergency' bus fare in a locked tin which had alternative strategies to alcohol use taped to the lid, but also worked out a walking route to the group if this failed. The therapist was clear in her expectation that Renee should attend the group even if she had to walk. This changed the contingencies for Renee sufficiently to motivate her not to raid her emergency bus money for alcohol.

Three months into therapy, Renee experienced a significant suicidal crisis. At this time her collaboration in therapy diminished and she frequently demanded hospital admission. The therapist was adamantly opposed to this course of action given Renee's previously unsuccessful hospital admissions. The therapist's frequent outlining of her reasons why she believed this would be unhelpful rapidly escalated a therapeutic impasse. The therapist's DBT consultation team recognised that the therapist had lost her capacity to remain dialectical and worked with the therapist to help her decrease negative value judgements about hospitalisation, to help her analyse the function of Renee's requests for hospitalisation and to promote her ability to validate Renee's requests. Implementing these changes increased the therapist's effectiveness in developing solutions that honoured both Renee's sense that she was at the limit of her capacity to cope and the therapist's view that hospital admission may have some deleterious effects. Renee and her therapist, therefore, arranged more frequent contact during the difficult period and discussed the possibility of a short time-limited admission with clear goals with Renee's psychiatrist.

Research Status

Since the first RCT published in 1991 (Linehan et al., 1991), DBT has become one of the most evaluated treatments for BPD. There are now five further treatment trials on the efficacy of the treatment for clients with the original diagnostic profile (Linehan et al, 2006; Koons et al., 2001; Verheul et al., 2003; Clarkin et al., 2007; McMain et al., 2009). Generally, these studies demonstrate that DBT is efficacious in decreasing suicidal behaviours, medical seriousness of suicidal and non-suicidal self-injurious behaviours, inpatient days and increasing global and social functioning. Strength of findings was greatest in studies with less robust control procedures. On the basis of this evidence, the National Institute of Health and Clinical Excellence recommends that clinicians consider using DBT for women with BPD and chronic suicidal behaviour where reduction in self-harm is a clinical priority (NICE, 2009).

DBT has been applied to diagnostic groups other than clients with BPD and suicidal behaviour and to clients in different settings. Two small trials of DBT for substance-dependent, BPD women indicated benefits in decreasing the use of psychoactive substances and demonstrated higher rates of treatment retention than is typical in most treatments for this client group (Linehan et al., 1999; Linehan et al., 2002). RCT data is also available to support the use of DBT in for the treatment of older adults with co-morbid depression and personality disorder (Lynch et al., 2003; Lynch et al., 2007) and the treatment of adult women with a diagnosis of binge-eating disorder (Telch et al., 2001). Controlled trial data also supports using DBT in inpatient settings for adults with a BPD diagnosis (Bohus et al., 2004).

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