

Dialectical Behavior Therapy Frequently Asked Questions

What is Dialectical Behavior Therapy?

Dialectical Behavior Therapy (DBT) is a treatment designed specifically for individuals with self-harm behaviors, such as self-cutting, suicide thoughts, urges to suicide, and suicide attempts. Many clients with these behaviors meet criteria for a disorder called borderline personality (BPD). It is not unusual for individuals diagnosed with BPD to also struggle with other problems -- depression, bipolar disorder, post-traumatic stress disorder (PTSD), anxiety, eating disorders, or alcohol and drug problems. DBT is a modification of cognitive behavioral therapy (CBT). In developing DBT, Marsha Linehan, Ph.D. (1993a) first tried applying standard CBT to people who engaged in self-injury, made suicide attempts, and struggled with out-of-control emotions. When CBT did not work as well as she thought it would, Dr. Linehan and her research team added other types of techniques until they developed a treatment that worked better. We'll go into more detail about these techniques below, but it's important to note that DBT is an "empirically-supported treatment." That means it has been researched in clinical trials, just as new medications should be researched to determine whether or not they work better than a placebo (sugar pill). While the research on DBT was conducted initially with women who were diagnosed with BPD, DBT is now being used for women who binge-eat, teenagers who are depressed and suicidal, and older clients who become depressed again and again.

Why do people engage in self-destructive behavior?

A key assumption in DBT is that self-destructive behaviors are learned coping techniques for unbearably intense and negative emotions. Negative emotions like shame, guilt, sadness, fear, and anger are a normal part of life. However, it seems that some people are particularly inclined to have very intense and frequent negative emotions. Sometimes, the human brain is simply "hard-wired" to experience stronger emotions, just like an expensive stereo is "hard-wired" to produce very complex sounds. Or, it could be that severe emotional or physical trauma causes changes in the brain to make it more vulnerable to intense feeling states. Additionally, sometimes clients have mood disorders – Major Depression or Generalized Anxiety -- that are not controlled by standard medications and thus lead to emotional suffering. Any one of these factors, or any combination of them, can lead to a problem called **emotional vulnerability**. A person who is emotionally vulnerable tends to have quick, intense, and difficult-to-control emotional reactions that make his or her life seem like a rollercoaster.

Extreme emotional vulnerability is rarely the sole cause of psychological problems. An **invalidating environment** is also a major contributing factor. What is an invalidating environment? The "environment," in this case, is usually other people. "Invalidating" refers to a failure to treat a person in a manner that conveys attention, respect, and understanding. Examples of an invalidating environment can range from mismatched personalities of children and parents (e.g., a shy child growing up in a family of extraverts who tease her about her shyness); to extremes of physical or emotional abuse. In DBT, we think that borderline personality disorder arises from the **transaction** between emotional vulnerability and the invalidating environment.

Back to the example of a shy child: If a shy child is teased by his siblings or forced to go into social situations he wants to avoid, he may learn to have tantrums to let others realize that he's scared. If his shyness is only taken seriously when he has an outburst, he learns (without being conscious of it) that tantrums work. He has not been "validated." In this case, forms of validation could have included telling the person that being shy is normal for some people, teaching him that shy people have to work harder to overcome social anxiety, or helping him learn skills for managing shyness so it does not interfere with his life.

This is a relatively benign example. Some individuals, however, grow up in situations where they are abused or neglected. They may learn more extreme ways of getting other people to take them seriously. Further, because they are in painful circumstances, they may learn to cope with emotional pain by thinking about suicide, cutting themselves, restricting their food intake, or using drugs and alcohol. A vicious cycle can get started: The person is really sad and scared, she has no one who listens to her, she is afraid to ask for help or knows no help is available, and so she tries to kill herself. Then, when her pain is treated seriously at the hospital, she learns (without being conscious of it) that when she's suicidal, other people understand how badly she feels. Repeated self-injury can result if it is seen as the only means for getting better or achieving understanding from other people.

What kind of therapy do clients receive in DBT?

Clients in standard DBT* receive three main modes of treatment – individual therapy, skills group, and phone coaching. In individual therapy, clients receive once weekly individual sessions that are typically an hour to an hour-and-a-half in length. Clients also must attend a two-hour weekly skills group for at least one year. Unlike with regular group psychotherapy, these skills groups emerge as classes during which clients learn four sets of important skills – Mindfulness, Interpersonal Effectiveness, Emotion Regulation, and Distress Tolerance. Clients are also asked to call their individual therapists for skills coaching **prior** to hurting themselves. The therapist then walks them through alternatives to self-harm or suicidal behaviors.

It should be noted that in standard DBT, it is the individual therapist who is “in charge” of the treatment. This means it is the individual therapist's job to coordinate the treatment with the other people – skills group leaders, psychiatrists, and vocational counselors. In collaboration with the client, the therapist keeps track of how the treatment is going, how things are going with everyone involved in the treatment, and whether or not the treatment is helping the client reach his or her goals.

In some situations, DBT clients may also be on medications for problems like major depression bipolar disorder, are transient (short-term) psychotic episodes.

What are the top targets and goals of treatment in DBT?

The most important of the overall goals in DBT is helping clients create “lives worth living.” What makes a life worth living varies from client to client. For some clients, a life worth living is getting married and having kids. For others, it's finishing school and finding a life partner. Others might find it's joining a religious or spiritual group and buying a house near a place of worship. While all these goals will differ, all clients have in common the task of bringing problem behaviors, especially behaviors that could result in death, under control. For this reason, DBT organizes treatment into four stages with targets. Targets refer to the problems being addressed at any given time in therapy. Here are the four stages with targeted behaviors in DBT:

Stage 1: Moving from Being Out of Control of One's Behavior to Being in Control

Target 1: Reduce and then eliminate life-threatening behaviors (e.g., suicide attempts, suicidal thinking, intentional self-harm).

Target 2: Reduce and then eliminate behaviors that interfere with treatment (e.g., behavior that “burns out” people who try to help, sporadic completion of homework assignments, non-attendance of sessions, non-collaboration with therapists, etc.). This target includes reducing and then eliminating the use of hospitalization as a way to handle crises.

* “Standard” refers to outpatient DBT as it is researched and developed at Dr. Linehan's research lab.
© 1997-2003, Behavioral Tech, LLC [Sanderson, C.J.]

Target 3: Decreasing behaviors that destroy the quality of life (e.g., depression, phobias, eating disorders, non-attendance at work or school, neglect of medical problems, lack of money, substandard housing, lack of friends, etc.) and increasing behaviors that make a life worth living (e.g., going to school or having a satisfying job, having friends, having enough money to live on, living in a decent apartment, not feeling depressed and anxious all the time, etc.).

Target 4: Learn skills that help people do the following:

- a) Control their attention, so they stop worrying about the future or obsessing about the past. Also, increase awareness of the “present moment” so they learn more and more about what makes them feel good or feel bad.
- b) Start new relationships, improve current relationships, or end bad relationships.
- c) Understand what emotions are, how they function, and how to experience them in a way that is not overwhelming.
- d) Tolerate emotional pain without resorting to self-harm or self-destructive behaviors.

Stage II. Moving from Being Emotionally Shut Down to Experiencing Emotions Fully

The main target of this stage is to help clients experience feelings without having to shut down by dissociating, avoiding life, or having symptoms of post-traumatic stress disorder (PTSD). In DBT, we say that clients entering this stage are now in control of their behavior but are in “quiet desperation.” Teaching someone to suffer in silence is not the goal of treatment. In this stage, the therapist works with the client to treat PTSD and/or teaches the client to experience all of his or her emotions without shutting the emotions down and letting the emotions take the driver’s seat.

Stage III. Building an Ordinary Life, Solving Ordinary Life Problems

In Stage III, clients work on ordinary problems like marital or partner conflict, job dissatisfaction, career goals, etc. Some clients choose to continue with the same therapist to accomplish these goals. Some take a long break from therapy and work on these goals without a therapist. Some decide to take a break and then work with a different therapist in a different type of therapy.

Stage IV. Moving from Incompleteness to Completeness/Connection

Most people may struggle with “existential” problems despite having completed therapy at the end of stage III. Even if they have the lives they wanted, they may feel somewhat empty or incomplete. Some people refer to this as “spiritual dryness” or “an empty feeling inside.” Although research on this stage is lacking, Marsha Linehan added it after realizing that many clients go on to seek meaning through spiritual paths, churches, synagogues, or temples. Clients would also change their career paths or relationships.

Although these stages of treatment and target priorities are presented in order of importance, we believe they are all interconnected. If someone kills herself, she won’t get the help that she needs to change the quality of her life. Therefore, DBT focuses on life threatening behavior first. However, if the client is staying alive but is neither coming to therapy nor doing the things required in therapy, she won’t get the help needed to solve non-life threatening problems like depression or substance abuse. For that reason, treatment-interfering behaviors are the second priority in stage I. But coming to treatment is certainly not enough. A client stays alive and comes to therapy in order to solve the other problems which are making her miserable. To truly have a life worth living, the client must learn new skills, learn to experience emotions, and accomplish ordinary life goals. Therapy is not finished until all of this is accomplished.

How is DBT different from regular Cognitive Behavioral Therapy?

DBT is a modification of standard cognitive behavioral treatment. As briefly stated above, Marsha Linehan and her team of therapists used standard CBT techniques, such as skills training, homework assignments, symptom rating scales, and behavioral analysis in addressing clients' problems. While these worked for some people, others were put off by the constant focus on change. Clients felt the degree of their suffering was being underestimated, and that their therapists were overestimating how helpful they were being to their clients. As a result, clients dropped out of treatment, became very frustrated, shut down or all three. Linehan's research team, which videotaped all their sessions with clients, began to notice new strategies that helped clients tolerate their pain and worked to make a "life worth living." As acceptance strategies were added to the change strategies, clients felt their therapists understood them much better. They stayed in treatment instead of dropping out, felt better about their relationships with their therapists, and improved faster.

The balance between acceptance and change strategies in therapy formed the fundamental "dialectic" that resulted in the treatment's name. "Dialectic" means 'weighing and integrating contradictory facts or ideas with a view to resolving apparent contradictions.' In DBT, therapists and clients work hard to balance *change* with *acceptance*, two seemingly contradictory forces or strategies. Likewise, in life outside therapy, people struggle to have balanced actions, feelings, and thoughts. We work to integrate both passionate feelings and logical thoughts. We put effort into meeting our own needs and wants *while* meeting the needs and wants of others who are important to us. We struggle to have the right mix of work and play.

In DBT, there are treatment strategies that are specifically dialectical; these strategies help both the therapist and the client get "unstuck" from extreme positions or from emphasizing too much change or too much acceptance. These strategies keep the therapy in balance, moving back and forth between acceptance and change in a way that helps the client reach his or her ultimate goals as quickly as possible.

THE THREE FUNDAMENTALS OF DBT: CBT, ACCEPTANCE, AND DIALECTICS

1) Cognitive Behavioral Therapy

CBT and DBT therapists do not think that clients can be helped through insightful discussions, although insight can be helpful at times. *Learning new behaviors* is critical in DBT and is a focus in every individual session, skills group or phone call (for coaching). "Behavior" refers to anything a person thinks, feels, or does. Cognitive behavioral therapy uses a wide variety of techniques to help people change behaviors that inhibit a "life worth living." In DBT, as in CBT, clients are asked to change. Clients track and record their problem behaviors with a weekly diary card. They also attend skills groups, complete homework assignments and role-play new ways of interacting with people when in session with their therapist. In addition, clients work with their therapist to identify how they are rewarded for maladaptive behavior or punished for adaptive behavior. They expose themselves to feelings, thoughts or situations that they feared and avoided, and they change self-destructive ways of thinking. What we have just described in layman's terms are the four main change strategies: Skills Training, Exposure Therapy, Cognitive Therapy, and Contingency Management.

A great book on one main technique in behavior therapy – contingency management – is Karen Pryor's *Don't Shoot the Dog* (Bantam Books). Karen Pryor is a dolphin trainer who opened Hawaii's first ocean park. The principles an animal behaviorist like Pryor uses to teach animals are the same principles we can use with ourselves to change ourselves and make our relationships better. Karen Pryor's book is fun, humane, and easy to understand. Contrary to popular belief, behavior therapy is not cold and technical. Rather, at its best, it is about learning to change while treating ourselves and each other with respect and kindness. If you read this book (and it can be read in an evening), you'll know a lot more about how one of the main strategies cognitive behavioral therapy works. You can also take a lot of the techniques and apply them to your life at home, work, or school.

2) Validation (Acceptance)

As we noted in the above paragraphs, cognitive behavioral therapy techniques were not enough to help clients who were suicidal and chronically self-harming in the context of Borderline Personality Disorder (BPD). It's not that the techniques were ineffective; it's just that as stand-alone interventions, they caused clients a great deal of distress. Clients found the pushing for change *invalidating*. In a simple example, it's as if therapists were saying to someone with severe burns on the soles of their feet, "just keep walking and your feet will get stronger...try not to think about the pain," though each step was excruciatingly painful, and the patient was depressed and had no experience with keeping her mind off severe pain.

Linehan and her research team discovered that when the therapist weaved an emphasis on validation with an equal emphasis on change, clients were more likely to be collaborative and less likely to become agitated and withdrawn. So what is validation? It means a number of things. One of the things it does not mean, necessarily, is agreement. For instance, a therapist could understand that a client abuses alcohol to overcome intensive social anxiety, and yet realize that when the client is drunk, he makes impulsive decisions that may lead to self-harm. The therapist could validate that: a) her behavior makes sense as the only way she's ever gotten her anxiety to go down; b) her parents always got drunk at parties; and c) sometimes when she's drunk and does something impulsive, the impulsive behavior can be "fun." In this case, the therapist can validate that the substance abuse makes sense, given the client's history and point of view. But the therapist does not have to agree that abusing alcohol is the best approach to solving the client's anxiety.

In DBT, there are several levels and types of validation. The most basic level is staying alert to the other person. This means being respectful to what she is saying, feeling, and doing. Other levels of validation involve helping the client regain confidence both by assuming that her behavior makes perfect sense (e.g. of course you're angry at the store manager because he tried to overcharge you and then lied about it) and by treating the other person as an equal (i.e., as opposed to treating her like a fragile mental patient).

In DBT, just as clients are taught to use cognitive behavioral strategies, they are also taught and encouraged to use validation. In treatment and in life, it is important to know what about ourselves we can change and what about ourselves we must accept (whether short term or the long term). For that reason, acceptance and validation skills are taught in the skills modules as well.

There are four skills modules all together - two emphasize change and two emphasize acceptance. For example, it is extremely important that clients who self-harm learn to accept the experience of pain instead of turning to self-destructive behavior to solve their problems. Likewise, clients who cut themselves, binge and purge, abuse alcohol and drugs, dissociate, etc., must learn to simply "be with" reality, as painful as it may be at any given moment, in order to learn that they "can stand it." DBT teaches a host of skills so that clients can learn to stand still instead of running away. DBT also teaches clients how to work to understand why their lives are so hard.

3) Dialectics

"Dialectics" is a complex concept that has its roots in philosophy and science. We won't go into its background here but we will attempt to explain what we mean by dialectics and give examples of thinking dialectically.

"Dialectics" involves several assumptions about the nature of reality: 1) every thing is connected to everything else; 2) change is constant and inevitable; and 3) opposites can be integrated to form a closer approximation to the truth (which is always evolving). Here's a brief example about how these assumptions would come into play in a DBT program. Suppose you are silent in groups. The other group members are affected by your silence and they try to get you to talk. You affect them and they affect you. Perhaps the group pushes you so hard that you feel like quitting and you talk even less. Then the other members get tired of your silence and withdraw. Paradoxically, this makes you feel better and causes you to talk a bit more. As you become a true member of the group, the leaders shift the way they run the group in order to manage the tension between you and the other members. In other words, you are all interconnected, influencing each other in each moment.

As time passes in the group, there are inevitable changes. Perhaps the group becomes more skilled at getting you to talk. Perhaps you take some risks and talk more. Maybe a new member enters the group while an older

member of the community transitions out and the group struggles to adjust to the new arrangement. You also may become aware that your thoughts and feelings change throughout the group, as does every other group member's. You notice that the group is constantly evolving, constantly readjusting itself. Thinking dialectically means recognizing that all points of view—yours, the other members – have validity and yet all may also be wrong-headed at the same time. If the group is working together dialectically, the group leaders and the members are in constant flux, looking at how opposing points of view can be in play and yet be synthesized. In short, the group is always balancing change and acceptance. Throughout, the group leader and the members would try to hold on to the idea that everyone is doing the best he or she can AND that everyone has got to do better.

DBT also involves specific dialectical strategies to help clients get “unstuck” from rigid ways of thinking or viewing the world. Some of these are traditional Western therapy interventions and others draw on Eastern ways of viewing life. If you read Linehan's (1993a) text, you can read about these strategies in chapter seven and review the examples she gives. But here are two examples. Suppose a client makes a strong initial commitment to do a year's worth of DBT. Rather than simply saying “Hey, that's terrific!” the therapist would gently turn the tables on the client by asking, “Are you sure you want to? It's going to be very hard work.” This strategy, called “Devil's advocate,” causes the client to argue in favor of why and how she will complete the therapy and not drop out. In this case, the therapist guides the client to strengthen her (the client's) arguments for being accepted into treatment, rather than the therapist trying to convince her to stay. “Making Lemonade out of Lemons,” another strategy, also helps the clinician handle similarly tough situations. For instance, a client may complain that she absolutely hates her group therapist and wants to switch skills groups. The therapist might respond with an opposing suggestion: This can be seen as a learning opportunity in handling intense negative emotions towards authority. The therapist could then show the similarity between the client's group therapist and other persons of authority (teachers, bosses, supervisors), and demonstrate this as a chance to tolerate a person one can't stand but has to work with. As these examples illustrate, the point of all dialectical strategies is to provide movement, speed, and flow so that therapist and client do not become stuck in “I will not do that” vs. “Oh, yes you will!”

Suggested Reading

Linehan, M.M. (1993a). Cognitive behavioral therapy for Borderline Personality Disorder. New York: Guilford Press. *This is the published treatment manual for the entire treatment. Many lay-people say this is a difficult read, though very helpful. For that reason, many start by reading the skills manual listed next.*

Linehan, M. M. (1993b). Skills Training Manual for Treating Borderline Personality Disorder. New York: Guilford Press. *This manual gives an excellent overview of DBT and the skills-training in the program.*

Pryor, K. (1993). Don't Shoot the Dog! New York: Bantam Doubleday Dell Pub. *This is a great introduction to principles of learning and behaviorism by a dolphin trainer. Her techniques apply to all of us.*