Dialectical Behavior Therapy: Current Indications and Unique Elements

ABSTRACT

Dialectical behavior therapy (DBT) is a comprehensive, evidence-based treatment for borderline personality disorder (BPD). The patient populations for which DBT has the most empirical support include parasuicidal women with borderline personality disorder (BPD), but there have been promising findings for patients with BPD and substance use disorders (SUDs), persons who meet criteria for binge-eating disorder, and depressed elderly patients. Although DBT has many similarities with other cognitive-behavioral approaches, several critical and unique elements must be in place for the treatment to constitute DBT. Some of these elements include (a) serving the five functions of treatment, (b) the biosocial theory and focusing on emotions in treatment, (c) a consistent dialectical philosophy, and (d) mindfulness and acceptance-oriented interventions.
INTRODUCTION

Dialectical behavior therapy (DBT) evolved from Marsha Linehan’s efforts to create a treatment for multiproblematic, suicidal women. Linehan combed through the literature on efficacious psychosocial treatments for other disorders, such as anxiety disorders, depression, and other emotion-related difficulties, and assembled a package of evidence-based, cognitive-behavioral interventions that directly targeted suicidal behavior. Initially, these interventions were so focused on changing cognitions and behaviors that many patients felt criticized, misunderstood, and invalidated, and consequently dropped out of treatment altogether.

Through an interplay of science and practice, clinical experiences with multiproblematic, suicidal patients sparked further research and treatment development. Most notably, Linehan weaved into the treatment interventions designed to convey acceptance of the patient and to help the patient accept herself, her emotions, thoughts, the world, and others. As such, DBT came to rest on a foundation of dialectical philosophy, whereby therapists strive to continually balance and synthesize acceptance and change-oriented strategies.

Ultimately, this work culminated in a comprehensive, evidence-based, cognitive-behavioral treatment for borderline personality disorder (BPD). The standard DBT treatment package consists of weekly individual therapy sessions (approximately 1 hour), a weekly group skills training session (approximately 1.5–2.5 hours), and a therapist consultation team meeting (approximately 1–2 hours). At present, eight published, well-controlled, randomized, clinical trials (RCTs) have demonstrated that DBT is an efficacious and specific treatment for BPD and related problems.

This article highlights several key aspects of DBT and is organized around central questions that practitioners may have in deciding whether and how to implement the treatment. In so doing, this article primarily highlights aspects of the theory and practice of DBT that set this treatment apart from other approaches, who the suitable patient populations are, and critical and unique elements of DBT that must be in place for any given patient.

WHEN TO APPLY DBT: USING THE RESEARCH EVIDENCE AS A GUIDE

In deciding whether to use DBT or other treatments for a particular patient, one key deciding factor is the research data on the treatment with patients that are similar in terms of problem areas, diagnoses, or characteristics to the patient in question. Researchers and treatment developers have applied DBT to a variety of patient populations, but the preponderance of RCTs has focused on persons (mainly women) with BPD. The following section includes a brief review of the well-controlled RCTs that have evaluated DBT.

Parasuicidal patients with BPD. For parasuicidal BPD patients, the most consistent finding is that DBT results in superior reductions in parasuicidal behavior compared with control conditions. The first RCT of DBT (N=44 parasuicidal women with BPD) found that DBT outperformed a control condition consisting of treatment as it usually is conducted in the community (TAU, or treatment-as-usual) in reducing the frequency and medical severity of parasuicide, inpatient hospitalization days, trait anger, and social functioning. Through the first six months of the 12-month follow-up period, DBT patients demonstrated less parasuicidal behavior and anger and better social adjustment.

Findings regarding better social adjustment persisted throughout the final six months of the follow-up period, and DBT patients also had fewer inpatient psychiatric days during this period.

The most recent and largest RCT of DBT (N=101) replicated the first study with a more rigorous control condition consisting of treatment by community practitioners designated as experts in treating BPD (treatment-by-community experts, or TBCE). This study found that DBT patients had greater reductions in suicide attempts, psychiatric hospitalization, medical risk of parasuicidal behavior, angry behavior, and emergency room visits, compared with TBCE patients’ across the 12-month treatment and the 12-month follow-up period.

A couple of studies have examined DBT for women with BPD in community settings, such as a community mental health center and a VA hospital. In a community mental health setting, Turner compared a modified version of DBT that only included individual therapy to a client-centered therapy control condition. Patients in the DBT condition had greater reductions in suicide attempts, deliberate self-harm, inpatient days, suicidal ideation, impulsivity, anger, and global mental health problems. In addition, a study of women veterans with BPD found that DBT patients had greater reductions in suicidal ideation, hopelessness, depression, and anger experienced than did TAU patients. Follow-up data for these two studies are not available.

Women with BPD and substance use disorders. The second patient group for which DBT has demonstrated promising data consists of women with BPD and a substance use disorder (SUD). The first study in this area compared DBT to TAU for women who met criteria for BPD and SUD and found that DBT patients...

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showed greater reductions in drug use during the 12-month treatment and through the four-month follow-up period and had lower drop-out rates during treatment. For a second study conducted by Linehan’s group, opiate-dependent women with BPD were randomly assigned to two conditions: DBT or a rigorous control condition, called Comprehensive Validation Treatment with 12-step (CVT-12S). In both conditions, participants also received LAAM (levomethadyl acetate hydrochloride), an opiate replacement medication. CVT-12S consisted of a stripped down version of DBT that only involved acceptance-oriented interventions designed to control for time of access to treatment, academic treatment setting, and therapist experience and commitment. Participants in both DBT and CVT-12S showed significant reduction in opiate use during the 12-month treatment, but DBT patients had greater sustained abstinence from opiate use at the 16-month follow-up.9

A couple of RCTs conducted outside of the US also have examined DBT for substance abusers with BPD. A recent study conducted at the Centre for Addiction and Mental Health (CAMH) in Canada compared standard DBT to treatment-as-usual (TAU) for women with BPD and a substance use disorder (N=27).10 DBT patients demonstrated greater reductions in suicidal and parasuicidal behaviors and alcohol use, but not other drug use. A study conducted in the Netherlands included BPD patients, 53 percent of whom met criteria for a substance use disorder (SUD). Findings indicated that DBT patients had greater reductions in parasuicidal behavior and impulse-control problem behaviors (including binging, gambling, and reckless driving, but not substance abuse), compared with TAU patients. DBT patients continued to demonstrate less parasuicidal behavior, impulsive behaviors, and alcohol use throughout the six-month follow-up period.

**Other clinical populations and problems.** Additionally, some research has examined DBT-oriented treatments for other clinical problems, including eating disorders and depression in elderly patients. Telch and colleagues compared a 20-week DBT-based skills training group to a wait list control condition for women with binge-eating disorder and found that DBT patients had greater improvements in binging, body image, eating concerns, and anger.

**PEOPLE WHO MAY BENEFIT FROM DBT**

- Parasuicidal patients with BPD
- Female patients with BPD and SUD
- Patients with eating disorders
- Elderly patients with depression and personality disorders

**DBT: dialectical behavior therapy**

**BPD: borderline personality disorder**

**SUD: substance use disorder**

Although 86 percent of DBT participants had stopped binging by the end of treatment, this number declined to 56 percent during the six-month follow-up period. A second study compared a modified version of individual DBT that included skills training to a wait list condition. DBT patients had greater reductions in binging and purging.11 No follow-up data are currently available for this latter study.

In a study of depressed elderly patients who met criteria for a personality disorder, investigators compared an adapted version of DBT plus antidepressant medications to medications only. Findings indicated that a larger proportion of DBT patients were in remission from depression at post-treatment and at the six-month follow-up period.

**Summary.** In summary, the patients for whom DBT has the strongest and most consistent empirical support include parasuicidal women with BPD. There also are some promising data on DBT for women with BPD who struggle with substance use problems. Preliminary data suggest that DBT may have promise in reducing binge-eating and other eating-disordered behaviors. On the one hand, the most conservative clinical choice would be to limit DBT to women with BPD. On the other hand, DBT is a comprehensive treatment that includes elements of several evidence-based, cognitive-behavioral interventions for other clinical problems. As such, DBT often is applied in clinical settings to multiproblematic patients in general, including those patients who have comorbid Axis I and II disorders, and/or who are suicidal or self-injurious; however, caution is important in applying a treatment beyond the patients with whom it has been evaluated in the research.

**CRITICAL AND UNIQUE ELEMENTS OF DBT**

The following section involves a discussion of some of the critical and unique elements of DBT. DBT is a comprehensive treatment that includes many aspects of other cognitive-behavioral approaches, such as behavior therapy (i.e., exposure, contingency management, problem solving, and stimulus control), cognitive restructuring, and other such interventions. As many of these interventions are very similar to those found in other treatments, the emphasis here is on those essential aspects of treatment that are relatively specific and unique to DBT, including (a) five functions of treatment, (b) biosocial theory and focusing on emotions in treatment, (c) dialectical philosophy, and (d) acceptance and mindfulness.

**Five functions of treatment.** DBT is a comprehensive program