Dialectical Behavior Therapy for Borderline Personality Disorder

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The rate of completed suicide among individuals diagnosed with borderline personality disorder (BPD) is between 3% and 9%,1,3 comparable to the rate in other high-risk diagnostic groups such as major depression and schizophrenia. However, individuals with BPD are more likely than individuals with these other disorders to make nonlethal suicide attempts and repeated threats, to engage in nonsuicidal self-injury, and to experience chronic suicidal ideation. It is estimated that up to 75% percent of individuals with BPD have made suicide attempts, with nearly 50% making at least one severe attempt.4,5 Furthermore, approximately 80% of hospitalized patients with BPD have engaged in self-mutilation (usually cutting or burning the skin, or hitting oneself without the intention to die).6,11 The unpredictability of suicide risk within the context of other less lethal forms of self-injurious behavior causes much suffering and presents a major challenge to these individuals, their families, and the clinicians who treat them.

Dialectical behavior therapy (DBT) is a cognitive-behavioral psychotherapy treatment developed by Dr. Marsha Linehan for the treatment of BPD.12 Dialectical behavior therapy was designed as an outpatient treatment to reduce self-mutilation and suicidal behavior in the most severe subgroup of patients with BPD.

Dialectical behavior therapy aims to provide increased support for patients to stay safe on an outpatient basis, as well as support for therapists working with chronically suicidal outpatients. This is achieved through capability and motivation enhancement of both the patient and therapist. Patient capability is enhanced through the teaching of adaptive skillful behaviors, and motivation is enhanced through the reinforcement of progress and nonreinforcement of maladaptive behaviors. For the therapist, a DBT outpatient consultation team is a source of support and guidance as well as an aid to keep the therapist focused on treatment goals and format.

Dialectical behavior therapy has three stages of treatment:
- stage 1: decreasing life-threatening behaviors,
- stage 2: reducing post-traumatic stress, and
- stage 3: increasing self-respect and achieving individual goals.

Stage 1 specifically targets the reduction of life-threatening behavior and therefore has been the most researched. In addition, this first stage of treatment is of particular interest to the clinician who treats the chronic suicidality of BPD patients on an outpatient basis. Within the context of treating self-injury, other behavioral, interpersonal, cognitive, and emotional difficulties also are addressed. These include behaviors that interfere with the therapy, such as lateness and absence, as well as behaviors that interfere with the quality of life, such as interpersonal difficulties. Once a patient has control over self-injurious behaviors, he or she enters into stage 2. Because many individuals with BPD have a history of childhood

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abuse,13-15 stage 2 treatment applies behavioral principles of exposure to the healing of past trauma.16 Other quality-of-life issues, such as self-actualization in social and vocational arenas, become the target of treatment during stage 3.

This article reviews the major principles and interventions that are integral to DBT, using vignettes from a composite clinical case to illustrate the application of core DBT techniques within a stage 1 phase of treatment. Much of the description of DBT draws heavily from Linehan’s book, *Cognitive-Behavioral Treatment of Borderline Personality Disorder*,12 which can be referred to for a more complete discussion of the complexities of this treatment.

**THE DIALECTIC**

Linehan17 observed that exclusive focus on change in behavior therapy is experienced as invalidating by traumatized or rejection-sensitive individuals and can result in early dropout or resistance to change within the treatment. However, Linehan also noted that ignoring the need for change is just as invalidating in that it does not take the problems and negative consequences of the patient’s behavior seriously. This can lead to hopelessness and suicidality. Linehan therefore introduced the strategy of acceptance of whatever is valid about the patient’s current behaviors, viewing these behaviors as the patient’s best efforts to cope with unbearable pain. This acceptance and validation is balanced with change strategies. Change is achieved through the tension and resolution of this essential conflict between the acceptance of the individual as he or she is right now and demanding that the individual change. Thus, the dialectical strategy encourages cognitive restructuring from an either/or to a yes/and perspective—directly addressing the dichotomous thinking characteristic of individuals with BPD that often leads to maladaptive behaviors.17

**BORDERLINE PERSONALITY DISORDER AND THE BIOSOCIAL THEORY**

According to Linehan,12 the chronic suicidal behavior characteristic of individuals with BPD is a result of behavioral, affective, cognitive, and interpersonal dysregulation. Her biosocial theory attributes this dysregulation to a transaction between an inborn emotional vulnerability and an emotionally invalidating environment. The biologically based emotion vulnerability is characterized by an intense, quick reaction to low threshold stimuli in the environment, along with a slow return to baseline following emotional arousal. The invalidating environment consists of caretakers who may be unable to perceive, understand, and validate the individual’s emotional intensity and therefore do not provide conditions in which the individual can learn how to regulate his or her emotional experience. A transaction between these two elements, in which the emotional sensitivity leads to increased perception of threat in interpersonal situations and in which the invalidating responses from the environment exacerbate the emotion vulnerability, leads to behavioral dysregulation. Linehan also applies learning theory to explain how the emotionally vulnerable individual develops self-destructive behaviors to get a nurturing response from the invalidating environment. As the behaviors escalate, they are intermittently reinforced, making them difficult to unlearn.

The most egregious example of an invalidating environment would be one in which sexual or physical abuse or neglect were present. Besides being a clear example of invalidation of the child’s needs, the experience of childhood abuse and neglect often is characterized by inconsistency and conflict as the child experiences both nurturing and abuse/neglect from the same caretaker. Given the high prevalence of reported childhood abuse among individuals with BPD,13-15 Linehan maintains abuse cannot be ignored as contributory to the etiology of BPD. However, less explicit forms of invalidation such as repeated dismissal or denial of a child’s emotional experience and reinforcement of maladaptive coping mechanisms also can lead to severe impairment in self-regulation.12

**DIALECTICAL BEHAVIOR THERAPY ASSUMPTIONS**

The dialectical philosophy leads to the following assumptions that underlie DBT:

1. Patients are doing the best they can.
2. Patients want to improve.
3. Patients need to do better, try harder, and be more motivated to change.
4. Patients may not have caused all of their own problems but they have to solve them anyway.
(5) Patients' lives are unbearable as they are currently being lived.
(6) Patients must learn new behavior in all relevant contexts.
(7) Patients cannot fail in therapy—the treatment fails.
(8) Therapists treating patients with BPD need support.\textsuperscript{8,14}

These philosophical assumptions serve to enhance motivation and should guide the therapeutic stance at all times. For example, assumptions 1 and 2 encourage a nonjudgmental approach and discourage negative thinking on the therapist's part in the face of ongoing difficult patient behavior. Assumptions 3 and 4 validate the need for change, without blame or judgment, and promote effective problem solving. They also verbalize the belief that the therapist cannot save the patient—the patient needs to do most of the work with the help of the therapist. The fifth assumption validates the pain of the patient and leads to the conclusion that the only solution is to create a life worth living. Assumption 6 addresses the idea that patients need to learn how to function despite their extreme mood states. The therapist's role is to encourage self-care rather than to take care of the patient. If the patient fails to progress, gets worse, or drops out of treatment, assumption 7 indicates the therapy was not successful in enhancing motivation and removes blame from the patient regarding his or her lack of motivation. Assumption 8 serves to enhance therapist motivation and is operationalized through the DBT consultation team. In summary, patient motivation is enhanced through validation and a nonjudgmental stance, with emphasis on and support for problem solving. Therapist motivation is enhanced by acknowledging the responsibility of the patient as well as validating the need for therapist support.

**CLINICAL CASE COMPOSITE**

The following case is presented to illustrate the application of DBT principles and techniques.

Kim was a 28-year-old single woman living with two roommates. She came to DBT from a day program she had been attending for 3 months following hospitalization for a suicide attempt. The suicide attempt consisted of a serious overdose of her roommate's benzodiazepines, which she took impulsively after an argument with her boyfriend. She had lost consciousness, was found by one of her roommates, and taken to the emergency room where she received gastric lavage. She regained consciousness after a few hours.

Kim was currently taking art courses and looking for an office job of some kind. In the past, after graduating from college, she had worked as an administrative assistant at a bank for about 2 years until she became depressed and angry, and either would not show up to work or would get into altercations with coworkers. As she described it, "I stopped going to work because I felt as if my boss was deliberately trying to give me a hard time."

She was referred to DBT because she had been diagnosed with BPD and was intermittently suicidal. She experienced suicidal ideation and occasionally would engage in self-mutilation consisting of making cuts on her inner arm without intent to die. Her mood fluctuated from depression to anger to feelings of emptiness, and she had interpersonal difficulties due to increased guardedness and suspiciousness when she was under stress.

Kim reported a history of severe repeated sexual abuse at the hands of her stepfather when she was 8 to 12 years old. When drunk, her stepfather would go into her room at night, frighten her into having intercourse, and force her to remain quiet about it. This abuse ended when her mother and stepfather divorced. Kim suspected her mother knew about the abuse, but she was not certain her mother knew. This resulted in an inability to trust her own perceptions, as well as a conflicted relationship with her mother, whom she perceived as weak and needing protection.

**COMMITMENT STRATEGIES AND HIERARCHY OF GOALS**

The following nonnegotiable hierarchy of goals is built into stage 1 DBT:

(1) Reduction of life-threatening and self-injurious behaviors.
(2) Reduction of therapy-interfering behaviors, such as lateness, missed sessions (individual and skills group), failure to keep a diary card (described below), and any other behavior on
the part of the patient or therapist that interferes with the therapy.

(3) Reduction of behaviors interfering with quality of life, such as interpersonal difficulties.

The first task of the clinician is to establish a commitment from the patient to accept this hierarchy of goals, particularly the primary one of reducing self-injury. The sessions in which this commitment is negotiated are considered the pretreatment phase.

Linehan\textsuperscript{18} has devised what she terms “commitment strategies” that lay the foundation for the course of stage 1 DBT treatment. These strategies incorporate cognitive-behavioral techniques for motivation enhancement,\textsuperscript{19} as well as compliance techniques based on the social psychological concepts of “foot in the door” and “door in the face.”\textsuperscript{19,20} First, the therapist gets the foot in the door by educating patients about BPD and the potential usefulness of DBT for their problems. This involves reviewing the DSM criteria for BPD and encouraging patients to consider which characteristics seem to describe their experiences. The therapist then describes how DBT targets exactly the types of problems patients are experiencing. This often has the effect of reassuring and drawing patients in by giving a name to what they are experiencing and providing a therapy designed to address their specific difficulties. The matter-of-fact, didactic approach also communicates respect for patients and sets the tone for a collaborative effort between therapists and patients to objectively look at patients’ difficulties and find solutions.

Once the foot is effectively in the door, and it has been established DBT may be useful for patients’ particular problems, the therapist switches gears and uses the devil’s advocate “door-in-the-face” strategy. This might take the form of questioning whether this is an appropriate time to begin DBT treatment. After all, as much as chronic suicidality is problematic for patients, they have been this way for a very long time. Self-injurious behaviors, although disturbing, are an effective short-term solution for managing unbearable pain. What makes patients think they are ready to give up this behavior? And why now? Patients are encouraged to convince the therapist they feel ready to proceed with DBT.

These pretreatment commitment phase strategies lay the foundation for the entire treatment by enhancing patient motivation and compliance from the beginning. There are many times throughout the course of DBT therapy when patients appear to lose interest or motivation in working toward the goal they originally committed to. In these cases, the therapist reminds patients of the commitment they made. The commitment phase is revisited as many times as necessary to keep the therapy on track toward the goal of reducing self-injury.

A summary of Kim’s pretreatment commitment phase follows:

The main challenge was to obtain Kim’s commitment to the goal of reducing self-injury. From Kim’s perspective, the self-injury was not problematic. She would vacillate between feeling that “having to live with the horrible feelings and memories is just too much to bear and suicide feels like the only way out” and “I don’t think I will do something stupid like that [overdosing on pills] again, I’m not suicidal anymore.” Her stated goal for treatment was to work through her childhood trauma, which was the main cause of her unhappiness and hopelessness.

Every time Kim was asked to commit to the goal of reducing her self-injury, she would respond, “You just don’t get it.” She would start crying and withdraw from interaction. Kim was experiencing the focus on changing her behavior as invalidation of her trauma history. Thus, the “foot-in-the-door” rather than the “door-in-the-face” technique was implemented. This required a major focus on validation—of the pain and hopelessness, of the horror of her childhood abuse.

The use of validation strategies over a number of sessions allowed Kim to feel I understood the disruption her trauma history caused in all areas of her life, despite my insistence on focusing on reduction of her self-injury. I explained to her I was very interested in working with her on healing from the trauma. However, she needed first to be able to control the life-threatening behaviors and increase her adaptive coping strategies for dealing with the painful feelings surrounding the trauma.

Kim and I eventually made a commitment to work together to reduce her self-injury. We identified
consistent attendance as a second goal of treatment. Finding employment would be a quality-of-life goal that we would work toward in the absence of self-injury or therapy-interfering behavior. While Kim agreed to focus on reduction of self-injury as the primary goal, I agreed to balance this with understanding the suicidal feelings and self-injury were validations of Kim’s pain. Several times during the course of Kim’s treatment she would miss a session, only to return and insist she needed to focus on the trauma and not on the reduction of her self-injury. Later analysis revealed she had felt invalidated by too strong an emphasis on change in the previous session. At these times, the commitment needed to be revisited on both sides—Kim’s commitment to reducing her behaviors and my commitment to balancing change with validation.

Kim’s desire to focus on the trauma rather than the self-destructive behaviors is a common scenario faced by the therapist in stage 1 DBT treatment, in which reduction of life-threatening behavior is the primary goal. An alternative common theme of the commitment phase is illustrated by the patient who is quick to agree to reducing self-injury. In this case, the commitment strategies need to focus more on the “door-in-the-face” strategies. Anticipating the difficulty of stopping the behaviors is helpful in enhancing motivation to work toward that goal. The therapist acknowledges the distress associated with the behaviors, but also emphasizes their effectiveness in reducing unbearable pain. The therapist gently anticipates how difficult it will be for patients to stop the behaviors. As patients make the commitment to reduce self-injury, the therapist makes the commitment to help patients tolerate the pain and to be available to coach them in learning new skills for managing their emotions and behaviors.

### SKILLS TRAINING

The teaching of skillful behaviors with which to replace the maladaptive ones is a major component of capacity enhancement in DBT. A weekly skills training group in which skills are taught within a didactic framework, preferably by a therapist other than the individual therapist, is an essential component of the treatment.

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The group serves to introduce and teach the concepts of skills and provides an opportunity to interact with other patients who also are learning skills. A skills training manual describes the skills and how to teach them, and also contains worksheets and homework assignments to facilitate learning.

The four modules of skills target the four areas of dysregulation of BPD: mindfulness skills for cognitive dysregulation, distress tolerance skills for behavioral dysregulation, interpersonal effectiveness skills, and emotion regulation skills (Table).

**Mindfulness Skills**

Mindfulness skills are based on Eastern Zen Buddhist principles. Patients are taught techniques for focusing their thoughts and attention on the present, and coupling awareness with non-judgmental thinking.

**Distress Tolerance Skills**

These skills focus on how to live through a crisis situation without engaging in destructive behaviors. Crisis survival strategies include distracting and self-soothing techniques, pro and con analyses, and strategies for accepting reality rather than fighting it.
Interpersonal Effectiveness Skills

Interpersonal effectiveness skills incorporate assertiveness training techniques with cognitive restructuring. Patients are encouraged and taught to challenge distorted cognitions related to interpersonal interactions and how to identify and stay mindful of their goals within these interactions. They learn techniques for effectively making requests or saying no to unwanted demands and balancing their objectives with maintaining relationships and self-esteem.

Emotion Regulation Skills

These skills include observing and identifying emotional states, and validating and accepting one’s emotional reactions. There are also techniques for avoiding vulnerability to negative emotions and increasing the experience of positive emotions.21

INDIVIDUAL SESSIONS

In addition to the skills training group, patients attend at least one or two individual therapy sessions of 1 to 1½ hours each week. The individual therapy session is structured by a number of behavioral techniques. First, patients are required to keep a daily record of behaviors, level of misery, and suicidal ideation on what is called a diary card.21 The diary card is reviewed by both therapist and patient, and is used to create an agenda for the session. If patients engaged in self-injury, a behavioral analysis (described below) is required. In the absence of self-destructive behavior, any therapy-interfering behavior also is highlighted and subject to a behavioral analysis. In the absence of either self-injury or therapy-interfering behavior, patients can choose a quality-of-life issue to address in the session.

A major change technique used in the individual session is the step-by-step behavioral analysis of self-injurious or therapy-interfering behavior. The dialectical approach to behavioral analysis is unique to DBT. This involves identifying the vulnerability patients bring to the situation, the precipitating event, and the reinforcing consequences of the self-injurious behavior. The positive consequences for patients, such as immediate relief from unbearable emotional pain, is highlighted and validated. The patient and therapist then collaborate in reconstructing the series of events (thoughts, feelings, actions, and environmental events) that led to the self-injury. The therapist asks for as much detail as possible and weaves solutions or alternative skillful behaviors patients might have used into the thread of the analysis. The following is an excerpt from one of Kim's behavioral analyses:

Analysis of Events

I was staying at my parents’ home. I had insomnia the whole night. My mother got up at 6:30 am and saw that I was still awake. She started questioning if I was OK enough to go to the funeral. My sister woke up. She started telling me not to go, not to feel bad. She said, “You never take care of yourself.” My mother then said to my sister, “Do you know she didn’t sleep the whole night?” I got more upset, and I started feeling a lot of shame because they were noticing I wasn’t doing well. I started to yell, “If I didn’t think I could handle, it it I wouldn’t go!” The urge to cut myself started right at this point. I think it was because I was confused and feeling ashamed. I wanted to be able to go, but I also knew they were right—I wasn’t really up to it. “I’m going—end of story.”

They left me alone. My mother went back into her room, and my sister took a shower. I was feeling self-hate, thinking “I’m not able to do anything. I’m a parasite, totally dependent and not good for anything.” A lot of confusion and thoughts were racing through my head. I was sitting in the living room, crying, thinking, “It’s so early in the day, I’ll have to fight the urge the whole day; why should I?” I tried to fight it, though—I put my hands in cold water. I thought to myself, “This is not going to work.” I said forget it and started cutting myself.

Vulnerability Factors

The night before I didn’t sleep well. I woke up feeling tired and unable to face the day.

Precipitating Event in the Environment

A cousin of mine died, and my family was telling me I was looking unstable and I should stay home and not go to the funeral.

Major Problem Behavior

Cutting myself.
Consequences of the Behavior

Thoughts and confusion left my head—I felt relieved. A few hours later, I started to feel disappointed.

Different Solutions

Emotion Regulation Skills. Address insomnia so that I’m not so emotionally vulnerable.

Mindfulness Skills. Use some mindfulness skills to address the judgmental thinking and also challenge my expectation that I’ll be feeling the urge to cut the whole day.

Distress Tolerance Skills. Try some other substitute actions once the urge to cut is present—ice water, breathing, exercise, asking someone for help. Is there any other way to get relief from the confusion and pain? Do a pro and con analysis, and try to remember how disappointed I feel after I cut myself.

Behavioral analysis is a useful tool for gaining understanding into the emotional and behavioral events that lead to an unwanted behavior and for generating specific solutions. It also is built into DBT as an aversive consequence of the maladaptive behavior. The expectation of spending a good portion of the next therapy session involved in a painstaking analysis of a self-injurious act often serves as a deterrent.

In Vivo Skills Coaching

The individual therapy session and relationship is also where patients are given direct guidance in how to incorporate skills into their lives. As seen in the behavioral analysis, patient and therapist engage in solution analysis by identifying skills the patient can use in the next crisis situation.

In addition, in vivo skills coaching is conducted by the individual therapist to provide the necessary support for the learning of new behaviors in the moment. Patients are encouraged to call or page individual therapists between sessions when they are fighting urges to injure themselves and require help in implementing a substitute skillful behavior. During these phone contacts, the therapist and patient decide on a number of skillful ways of handling the current stressful situation.

Rather than resulting in constant calling or boundary violation by patients, the in vivo skills coaching is conducted in such a way as to enhance therapist capability and motivation. First, phone contacts are focused and limited to skills coaching and relationship repair. If a patient calls but is not really interested in problem solving, the therapist indicates he or she is available when the patient is interested in skills coaching, and quickly ends the contact. If skills coaching is agreed on, therapist and patient quickly review which skills the patient has already tried, and the therapist helps the patient generate a plan to try new skills. The therapist praises the patient for calling and validates the difficulty of tolerating the pain and trying a new behavior. These contacts should not exceed 10 minutes and often result in the prevention of self-injury, and therefore are positively reinforcing for the therapist (if not the patient).

The 24-hour rule of DBT, built in as an aversive consequence for self-injury, states that patients cannot call the therapist for 24 hours after they have engaged in self-injury. If a patient calls his or her therapist after the fact, the therapist, once ascertaining the patient is safe from further self-harm, expresses regret that he or she cannot speak to the patient for the next 24 hours. The therapist wishes out loud the patient would have called sooner for skills coaching and support. The therapist then expresses the desire to hear from the patient as soon as the 24-hour period is over. Thus, the patient is encouraged to call before engaging in self-injurious behavior, giving the therapist a chance to intervene.

In the event that a patient uses between-session contact inappropriately and the therapist begins to burn out, it is addressed as therapy-interfering behavior. This includes conducting behavioral analyses, generating solutions, and applying skills to the reduction of the behavior.

Managing Suicidal Behavior on an Outpatient Basis

An underlying assumption of DBT is that patients need to create a life worth living. Recurrent hospitalization is disruptive of whatever progress patients are making toward various life goals (eg, relationships, vocational functioning, and self-esteem) and therefore is avoided as much
as possible. Consultation to third-party treaters, such as emergency room staff, is a DBT strategy for changing contingencies in the environment so that hospitalization is a less reinforcing option as illustrated by the following example:

About 6 months into Kim’s treatment, she paged me on a Sunday morning after she had taken a “handful” of pills, maybe 5 to 12 pills, to help her calm down after being upset by her boyfriend. He had called her at the last minute the previous evening to cancel their plans; he had wanted to see a friend first and then go over later to Kim’s apartment. Kim became very angry with him and told him not to bother coming at all. She then felt very lonely and guilty that she had yelled at him. She became agitated, lying awake all night thinking that he would leave her. She then took the pills to help her get to sleep.

I encouraged Kim to go to the emergency room to get a medical evaluation. Kim expressed a desire to go to the hospital, saying she was tired and needed a rest. She said she did not really want to kill herself, but wasn’t sure she could prevent herself from taking pills again. I validated her feelings of wanting a rest, but also reminded her of all that we had been working on and expressed my wish that Kim would stay out of the hospital so we could have our outpatient appointment the next day. I offered to do whatever I could to help her tolerate staying out of hospital. I reminded her it was her choice—she could present herself to the emergency room as needing hospitalization or not. I encouraged her to call me from the emergency room so I could either coach her to stay out of the hospital or engage the emergency room staff to make hospitalization seem more aversive.

Kim called from the emergency room. She had been medically cleared but still wanted to be hospitalized. I asked to speak with the emergency room staff and asked them to evaluate her suicidalitv since clearly her judgment was impaired, but also informed them I would be willing to see Kim the next day and work with her to keep her safe as an outpatient. Kim called later that day, complaining the emergency room staff had made her wait 10 hours and she just wanted to go home. I told her I was looking forward to seeing her the next day.

**Dialectical Behavior Therapy Team**

As stated earlier, a unique component of DBT is the outpatient therapist team. In addition to providing support in times of crisis, the DBT consultation team meets on a weekly basis and is composed of individual therapists, skills therapists, and sometimes psychiatrists involved in psychopharmacologic treatment of the patient. The consultation team meeting provides an opportunity for each therapist to present individual DBT patients and to receive consultation. The team performs a number of functions in promoting the individual DBT therapy. A primary goal is to support the therapist to remain in the therapeutic relationship. Second, the consultants assist the therapist in maintaining an optimum balance between validation and change in relation to the patient. Third, the team provides the context within which the treatment is conducted. The following interactions highlight the benefits of the DBT consultation team:

A few weeks into treatment, Kim would arrive for her session and then sit across from me in complete silence. After a few weeks of this, I became increasingly angry at Kim and began to accuse her of trying to make me angry. When I presented this in DBT consultation team, a member suggested Kim was doing her best to show up, which must be really difficult for her. During the next session, I shared this observation with Kim, who lifted her head, made eye contact for the first time in weeks, and nodded. I then acknowledged I had missed this completely and praised Kim for showing up even though it was so difficult for her. We were able to proceed.

A few weeks later, Kim paged me to let me know she was feeling suicidal and was not sure she could control her urge to go to the office building of her new job and jump from the window of her office on the 12th floor. I responded by praising her for calling and asked Kim if she would be willing to work with me to stay safe. Kim said, “I’m not sure I can, but I guess if I called you I want to try.” I asked Kim to briefly describe why she was having such a
strong urge to kill herself. I validated her distress, and we then strategized about skills she could use to stay safe. We agreed she would use some self-soothing strategies such as taking a bath and trying to take a nap until she could contact her boyfriend and ask him to come over. She expected him to call her within a few hours. She felt she could do this and promised to page me again if she felt she could not follow through on this plan.

After Kim’s call, I called a team member for consultation, because I did not know Kim very well and was feeling unsure about whether I could rely on her to follow through. The team member suggested I call Kim back for two reasons—first to ask Kim to call me back in a few hours either way, and second for me to assess whether Kim was feeling connected enough to me and to the plan to stay safe. I reached Kim, who had just gotten out of the bath and was feeling better. She agreed to call me again in 2 hours.

**DIALECTICAL BEHAVIOR THERAPY EFFICACY**

A number of studies have documented the efficacy of outpatient DBT. A randomized clinical trial consisting of 1 year of DBT treatment compared with “treatment as usual” in the community showed significant effects in three areas: (1) significantly decreased parasuicidal behavior (suicidal and nonsuicidal self-injury), (2) decreased treatment dropout rate (84% remaining in DBT treatment), and (3) decreased number of days of inpatient hospitalization. There were, however, no differences between DBT and treatment as usual on measures of depression, hopelessness, suicidal ideation, or reasons for living. On 1-year follow-up of this study, Linehan et al. found individuals with DBT had significantly fewer suicidal and self-mutilating behaviors, less anger, fewer psychiatric inpatient days, and better social adjustment than individuals who underwent treatment as usual.

Dialectical behavior therapy also has been adapted for inpatient settings. Barley et al. conducted a partial replication of Linehan’s study in a pre-post design by showing a reduction in rates of suicidal behavior and self-mutilation incidents with DBT. Monthly rates of self-destructive behavior on an inpatient unit were compared before and after the introduction of DBT with rates on a similar general adult inpatient unit using a non-DBT treatment. Mean monthly rates of self-injurious behavior on the DBT unit were significantly lower after the introduction of DBT whereas rates on the non-DBT unit were not significantly altered during the same time period. Therefore, DBT appears to be effective in treating the more serious behavioral aspects of BPD, namely suicidal behavior and self-mutilation. Further treatment outcome studies comparing DBT with other forms of psychotherapy and psychopharmacologic treatment are currently under way. Scheel offers a comprehensive, critical review of the empirical findings regarding DBT.

**CONCLUSION**

Dialectical behavior therapy is a promising psychotherapeutic approach to the treatment of suicidality and self-injury in BPD. Additional studies are needed to identify the effective components of DBT and the ability of DBT to affect subjective feelings and quality-of-life issues. However, the dialectical philosophy clearly represents a paradigmatic shift in thinking regarding this patient population, resulting in pragmatic interventions as well as increased hope for these patients and their therapists.

**REFERENCES**