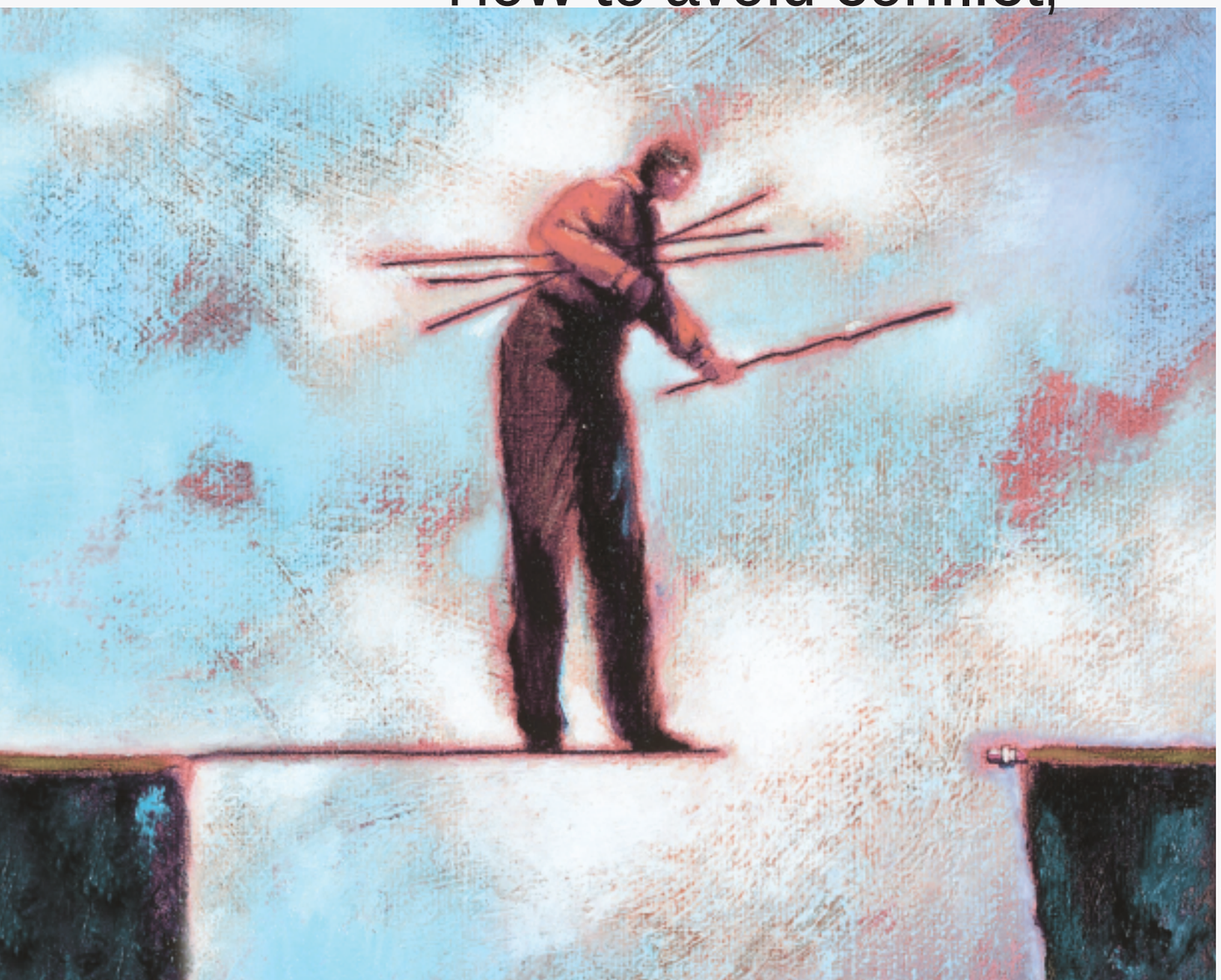
Current PSYCHIATRY

# Balanced therapy

## How to avoid conflict, help 'borderline' patients



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Dialectical behavior therapy validates patients' life difficulties, while teaching both problem-solving skills and acceptance.

**Anthony P. DuBose, PsyD**
DBT Center of Seattle, PLLC

**Marsha M. Linehan, PhD**
Professor and director
Behavioral Research and Therapy Clinics
Department of psychology
University of Washington, Seattle

Treating borderline personality disorder can seem like a no-win situation. If we try traditional cognitive-behavioral therapy (CBT) and emphasize change, patients feel unheard and invalidated; they may withdraw, quit, or even attack. But if we suggest ways to accept unhappy situations, they may feel we don't understand their suffering.

A more effective approach is dialectical behavior therapy (DBT), first developed to treat highly suicidal persons with borderline personality disorder and used with other populations that have difficulty regulating their emotions.

This article describes how invalidating environments may damage emotional health and suggests how psychiatrists can use DBT's methods when treating borderline personality disorder.

### BIOLOGY PLUS ENVIRONMENT

For the patient, borderline personality disorder's behavior clusters *(Table 1)*:

- function to regulate emotions
- or result from emotion dysregulation.

DBT theory identifies emotion dysregulation

Table 1

## Diagnostic criteria for borderline personality disorder

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. **Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
3. Identity disturbance: markedly and persistently unstable self-image or sense of self
4. Impulsivity in at least two areas that are potentially self-damaging (eg, spending, sex, substance abuse, reckless driving, binge eating) **Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
6. Affective instability due to a marked reactivity of mood (eg, intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and rarely more than a few days)
7. Chronic feelings of emptiness
8. Inappropriate, intense anger or difficulty controlling anger (eg, frequent displays of temper, constant anger, recurrent physical fights)
9. Transient, stress-related paranoid ideation or severe dissociative symptoms

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as the primary deficit in borderline personality disorder. Biologically based emotional vulnerability is seen as interacting with an inability to modulate emotions because of a skills deficit.

**Emotional vulnerability.** Three characteristics—high sensitivity, high reactivity, and slow return to baseline emotional state—define high emotional vulnerability:

**High sensitivity.** The person reacts more quickly and to more things than do others in emotion-provoking situations. When walking, for example, they may pass someone who doesn't say hello. Most people would shrug this off, but persons with high emotional sensitivity may quickly notice, assume there is a problem, feel they have done something wrong, then feel shame and anger.

**High reactivity.** Their emotional reactions are large, and the high arousal dysregulates cognitive processing.

**Slow return to baseline.** Events stack up because emotional reactions are long-lasting for persons with high emotional vulnerability. They don't have time to get over one thing before something else happens.

DBT postulates that, over time, borderline personality disorder results from the transaction of biological emotional vulnerability and an invalidating environment. This therapeutic model asserts that biology and the environment are flexible, and interventions may influence both.

**Invalidating environment.** DBT acknowledges that invalidation occurs in all environments, even nurturing ones. It becomes detrimental when a vulnerable person is exposed to pervasive invalidation that is not related to the validity of the person's behavior or to the person's expressed emotions or thoughts.

An invalidating environment has three characteristic patterns. One is indiscriminate rejection of communication of private experiences and self-generated behaviors.

**Case examples.** Mary, age 8, says she's been teased and it hurt her feelings. Her mother tells her she is making too much of the incident. Mary questions herself and searches the social environment for cues about how to respond to similar situations in the future.

Robbie, age 4, completes a drawing and shows it to his father with delight. His father points out some "sloppy" coloring. If his father repeatedly finds fault with his work, Robbie is likely to not show him his work or stop drawing, and his expres-

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Table 2

## Strategies used in dialectical behavioral therapy

| | |
|---|---|
| **Structural strategies** | Organization of sessions, attending to the treatment hierarchy, reviewing progress, checking on other modes of therapy |
| **Problem-assessment strategies** | Defining problems with specificity, conducting chain analyses, developing and testing hypotheses |
| **Problem solving strategies** | Providing didactic information, generating and evaluating solutions, teaching skills and coaching on use of skills, generalizing skills to the real-world environment |
| **Contingency management** | Use of reinforcement, extinction, aversive contingencies, and principles of shaping. |
| **Exposure-based procedures** | Both formal and informal |
| **Cognitive strategies** | Contingency clarification, observation and description of cognitions, cognitive modification |
| **Validation strategies** | Appearing interested, accurately reflecting, correctly articulating things that have not been fully expressed, explaining behavior in terms of learning history or biological factors, acknowledging the validity of responses in terms of current events, interacting in a manner that is radically genuine, communicating believing in the patient |
| **Reciprocal communication strategies** | Being responsive, expressing warm engagement, being nonjudgmental, using self-disclosure, maintaining a reasonable power equilibrium |
| **Irreverent strategies** | Engaging in a matter-of-fact manner, directly confronting dysfunctional behavior, using unexpected, irreverent or humorous responses |
| **Dialectical strategies** | Using a balanced style, balancing acceptance-oriented strategies with change-oriented strategies, magnifying tension, using metaphor, modeling dialectical thinking and behaviors, moving with speed and flow. |
| **Case-management strategies** | Following a model of consultation to the patient when long-term out come is more important than short-term outcome; intervening in the patient's environment when short-term outcome is more important than long-term outcome |

Table 3

## Modes of therapy in outpatient DBT

| Function | Mode |
|---|---|
| To improve motivational factors | Individual psychotherapy |
| Enhance capabilities | Skills training |
| Assure generalization to natural environment | Between-session consultation |
| Enhance therapist capabilities and motivation to treat effectively | Therapist consultation team |
| Structure the environment | Consultation to the patient |

DBT: dialectical behavioral therapy

sions of delight are likely to decrease.

Invalidating environments may also punish emotional displays and intermittently reinforce emotional escalation. Someone may show disapproval for or ignore a person's genuine sadness or fear but attend to angry outbursts that result when the person feels ignored.

The third invalidating pattern is to oversimplify the ease of problem-solving and meeting goals.

**Case example.** As a child, when Susan asked for help, her mother would say "just do it," without considering the skills her daughter needed to accomplish tasks. When Susan became frustrated, her mother demanded that she "just stop crying," even though no person could modulate his or her emotions that quickly. As an adult, Susan now sets unrealistic goals and expectations for herself and despairs when she is unable to solve problems in her life.

These three invalidating patterns cause persons to search the social environment for cues about how to respond to situations. They may question themselves, their identity, and the appropriateness of any emotional expression. As a result, they may oscillate between emotional inhibition and extreme emotional styles, set unrealistic goals and expectations for themselves, and eventually despair of being able to solve their problems.

Specific to borderline personality disorder is that the environment ignores genuine emotional expression, and the individual's emotions escalate. This pattern is reinforced when the listener finally rewards emotionally extreme behavior with attention or desired changes.

As the pattern is repeated over time, extreme emotional reactions become the norm rather than the exception, and the emotional chaos can make the person wish to die. Acting on that desire when past expressions of desperation have been ignored or invalidated can provide attention or interventions that would never happen after simple emotional expressions.

Thus, an environment that does not recognize or validate genuine emotional expression can reinforce suicidality.

### SOLVING NO-WIN THERAPY

**Pitfalls with emphasizing change.** Therapy that emphasizes solving problems and getting things to change typically triggers high arousal in persons with borderline personality disorder. Feeling out of control, they respond by trying to get in control, including attempts to control the therapist.

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Similarly, they see attempts to get them to change their behavior as invalidating their experiences or, worse, who they are. Intense emotions aroused by the message they hear—that *they* are the source of their problems—impair learning and intensify their efforts to gain control. In a battle for control, collaboration and therapy cannot occur.

**Case example.** Ms. K wants you to understand how difficult her life is because of difficulties with her boss. You start talking about what Ms. K can do to change the situation, without acknowledging how difficult it is to deal with her boss.

Ms. K feels upset and says you don't understand. For her, the interaction has led to emotion dysregulation and impaired cognitive processing.

**Pitfalls with emphasizing acceptance.** Most persons who come to therapy very distressed want something in their lives to change. If your primary message is acceptance instead of change, they may lose confidence in you.

**Case example.** Ms. K wants help dealing with her boss, who is making life quite difficult. As her therapist, you respond with warmth and acceptance but offer no suggestions as to how she might change the situation. Ms. K likes the way you listen to her but abandons therapy after several sessions.

At first, patients with borderline personality disorder may like the warmth of client-centered acceptance approaches. Over time, however, they may feel their therapy sessions are out of control. They may think the therapist doesn't understand the situation, doesn't know how to help, or that situations that are troubling them cannot be changed.

**Balanced therapy.** DBT solves the change-or-acceptance dilemma by attempting to help patients with borderline personality disorder change themselves and their lives while offering strategies for accepting themselves and their situations.[1,2] DBT includes problem-solving and acceptance strategies *(Table 2)*.

## DBT'S 4 THERAPY STAGES

DBT is a comprehensive treatment. The original outpatient model for borderline personality disorder *(Table 3)* has been adapted to different settings and applied to other populations.

Outpatients meet weekly in individual psychotherapy and a skills training group.[3] Therapists also meet weekly in a consultation team viewed as "therapy for the therapist."

Between sessions, therapists consult with patients by telephone to:

- decrease suicide crisis behaviors
- increase generalization of behavioral skills
- decrease patients' feelings of conflict, alienation, or distance with the therapist.

**Four stages.** DBT follows four stages. For persons with borderline personality disorder, researchers have evaluated the efficacy of stage-1 therapy. Studies on stage-3 DBT have been conducted with nonborderline-personality individuals with eating disorders. The goals at each stage are:

**Stage 1.** Move from severe behavioral dyscontrol to behavioral control. Decrease suicidal and other life-threatening behaviors and those that interfere with therapy and quality of life. Increase mindfulness, tolerance for distress, interpersonal effectiveness, and emotion regulation.

**Stage 2.** Move from quiet desperation to emotional experiencing.

**Stage 3.** Address problems in living, and move toward ordinary happiness/unhappiness.

**Stage 4.** Move from incompleteness to capacity for joy and freedom.

Seven randomized controlled trials have shown that DBT can be useful in treating borderline personality disorder.[4-10] The initial trial by Linehan et al[4] included 47 women ages 18 to 45 who met criteria for borderline personality disorder and had at least two parasuicide incidents in the previous 5 years, with one in the previous 8 weeks. Treatment lasted 1 year, and subjects agreed to stop other individual psychotherapy if

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assigned to DBT.

Subjects were then randomly assigned to either DBT or "treatment as usual" in the community. In the various DBT studies, treatment-as-usual has included community therapists, Department of Veterans Affairs outpatient treatment, client-centered therapy, and treatment by persons identified by their peers as experts in their communities.

Subjects were assessed every 4 months while in treatment and for 1 year thereafter. DBT was more effective than usual treatment in:

- reducing suicide attempts and self-injury
- decreasing premature dropout from therapy
- reducing emergency room admissions and length of psychiatric hospitalization
- reducing drug abuse, depression, hopelessness, and anger.

## RECOMMENDATIONS

Some psychiatrists may find "borderline patients" frustrating and unpleasant to treat. DBT therapists, however, make two assumptions that can help anyone working with individuals with borderline personality disorder. To avoid falling into the trap of polarization with these patients, assume that:

- they are doing the best they can
- their efforts are insufficient to meet their needs.

They therefore need to do better, and the therapist's job is to help them do so. Also assume that if you try to help a patient with borderline personality disorder, you will need help, too. We require DBT therapists to participate in consultation teams.

**Training.** DBT is a comprehensive program that requires familiarity with the manuals mentioned in this article (see *Related resources*). Some teams have learned DBT through self-study and consultation with other teams.

If you plan to offer DBT to patients with borderline personality disorder, we recommend that you be:

- trained in behavior therapy and CBT
- familiar with research on emotions and processes involved in emotion regulation.

If you have not had CBT training, find a behavior therapist to join your team or get consultation from a behavior therapist.

An intensive training course in DBT—with 2 weeks of instruction and case consultation and several months of consultation with someone well-versed in DBT—is an efficient way to become familiar with the most critical principles of the treatment. If you cannot train toward adherent delivery of the individual therapy, we recommend referring patients to someone trained in DBT.

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5. Linehan MM, Schmidt HI, Dimeff LA, et al. Dialectical behavior therapy for patients with border-line personality disorder and drug-dependence. *Am J Addict* 1999; 8:279–92.
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**Bottom Line**

**D**ialectical behavioral therapy is an evidence-based, comprehensive treatment for highly suicidal persons not responding well to standard CBT. It recognizes the suffering caused by emotional dysregulation in persons with borderline personality disorder and emphasizes clarity, precision, and compassion.

## Balanced therapy for 'borderline' patients

### Related resources

- Lieb K, Zanarini MC, Schmahl C, et al. Borderline personality disorder. *Lancet* 2004;364(9432):453-61.
- University of Washington, Behavioral Research and Therapy Clinics. www.brtc.psych.washington.edu/frameResearch.htm; www.brtc.psych.washington.edu/framePublications.htm
- Behavioral Tech, LLC. Consultation and training in dialectical behavioral therapy. www.behavioraltech.org.

DISCLOSURE

Dr. DuBose is president and CEO/co-owner of DBT Center of Seattle, PLLC, and a speaker for Behavioral Tech, LLC.

Dr. Linehan is a shareholder in Behavioral Tech Research, Inc., which develops computerized training for DBT, a DBT trainer for Behavioral Tech, LLC, and the author of two books on DBT. She also receives research grants from the National Institute of Mental Health and National Institute on Drug Abuse.


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