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Is dialectical behavior therapy the right 'fit' for your patient?

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4 steps can help you choose psychotherapies that are supported by the evidence

Strong evidence for the efficacy of dialectical behavior therapy (DBT) for patients with borderline personality disorder (BPD) has brought hope to clinicians and patients alike. By including cognitive therapy, behavioral strategies, skills training, and exposure therapy, DBT addresses more than just self-harm and suicidal behavior (***Box 1***).[1-13] In fact, DBT's primary interventions—such as skills training in emotion regulation and a straightforward approach to dysfunctional behaviors—could help many people.

Because DBT is so comprehensive and practical, clinicians might be tempted to refer almost anyone who seems even slightly "borderline" for DBT. But some patients—particularly those with mood and anxiety disorders—might benefit more from other treatments. To help you make appropriate evidence-based referrals for DBT and other psychological treatments, this article recommends 4 steps:

- Know what the treatment involves.
- Consider the evidence for the treatment in patients similar to yours.
- Consider why your patient—with unique characteristics and problems—would benefit from these specific interventions.
- Communicate to the patient your reasons for the referral.

Step 1. What does DBT involve?

Difficulty with emotion regulation. DBT is based on a biosocial theory of BPD.[1] Within this frame-

work, BPD is caused by the transaction (mutual interplay) of a biologically based vulnerability to emotions with an invalidating rearing environment. The patient with BPD typically experiences strong and long-lasting emotional reactions, often to seemingly small or insignificant events such as a slight look of disappointment on someone's face or a minor daily hassle. Patients with BPD often are especially attuned to emotional reactions, particularly signs of rejection or disapproval.

Caregivers in an invalidating environment fail to provide the support a highly emotional child needs to learn to manage intense emotions. An invalidating environment:

- indiscriminately rejects the child's communication of emotions and thoughts as invalid, independent of the validity of the child's experience
- punishes emotional displays, then intermittently reinforces emotional escalation
- oversimplifies the ease of problem solving or coping.[1]

As a result, the fledgling BPD individual learns to mistrust and fear emotions and does not learn how to manage them. A patient with BPD is like a car with a powerful "emotional engine" but lacking brakes.

Team treatment. The standard DBT treatment package is an outpatient program run by a team.[1] Therapists meet weekly for consultation to help them execute DBT according to the manual, prevent burnout, and improve skills and motivation to treat patients with multiple, severe problems. The team also maintains the DBT program's integrity and functioning and ensures that all treatment components—including individual therapy and skills training—are in place.

In individual therapy, the therapist and client collaborate to help the client reduce dysfunctional behaviors, increase motivation, and work toward goals. Because persons with BPD often present with many serious life problems, the therapist organizes session time to address 3 main priorities:

- **Life-threatening behavior** (intentional self-injury or imminent threat of intentional self-injury, including suicidal crises or threats, severe suicidal ideation or urges, suicide attempts, nonsuicidal self-injury or self-injury urges, or similar behaviors).
- **Therapy-interfering behaviors** (actions by the therapist or patient that interfere with progress, such as angry outbursts, missed sessions, or tardiness).
- **Quality-of-life-interfering behavior** (behaviors or problems—such as depression, eating disorders, or substance use disorders; homelessness or financial difficulties; or serious interpersonal discord—that make it hard for the patient to establish a reasonable quality of life).

continued

Box 1

DBT: First efficacious therapy for borderline personality disorder

Marsha Linehan, PhD, developed dialectical behavior therapy (DBT) in an attempt to devise an effective protocol for highly suicidal women. Over time, she realized that many of these women met criteria for borderline personality disorder (BPD), and DBT evolved to address their emotional, interpersonal, and mental health issues.[1]

Linehan et al[2] published results from the first randomized clinical trial (RCT) of any psychological treatment for BPD. In this study, chronically parasuicidal women who met criteria for BPD received 1 year of DBT or "treatment as usual" in community settings. Those treated with DBT experienced fewer and less severe parasuicidal events, were more likely to remain in treatment, and required fewer days of inpatient care.

Findings from 9 additional RCTs have supported the efficacy of DBT for women with BPD and other populations.[3] These RCTs have examined DBT (or adapted versions of DBT) for treating:

- women with BPD and substance dependence[4,5]
- men and women with BPD in a community setting[6]
- women veterans with BPD[7]
- non-BPD women with bulimia[8] or binge-eating disorder[9]
- women with BPD in the Netherlands (53% of study subjects had a substance use disorder)[10,11]
- depressed older adults[12]
- suicidal women with BPD.[13]

Clinical Point

10 randomized clinical trials have supported the efficacy of DBT for a variety of patient populations

Right 'fit' for DBT?

Clinical Point

You might consider DBT for patients who self-injure, even if they do not have borderline personality disorder

Table 1

Candidates for DBT: An evidence-based referral priority list*

Most supporting evidence	***Women with BPD who are suicidal or who self-harm*** (without bipolar disorder, a psychotic disorder, or mental retardation). One randomized clinical trial with suicidal individuals with BPD included men. Two studies excluded participants with substance dependence, but the most recent, largest study[13] did not.
	Women with BPD and substance use problems (without bipolar disorder, a psychotic disorder, or cognitive impairment)
	Women with bulimia nervosa or binge-eating disorder (without substance abuse, psychotic disorder, or suicidal ideation). Other empirically supported treatments exist for these patients (*Table 2, page 64*).
	Depressed older adults (age ≥60, without bipolar disorder, a psychotic disorder, or cognitive impairment). Investigated treatments included group DBT skills training, telephone consultation, selective serotonin reuptake inhibitor medications, and psychiatric clinical management.[12]
	Suicidal and nonsuicidal adolescents with oppositional defiant disorder or bipolar disorder
	Incarcerated men and women with or without BPD, in high- and low-security forensic settings
Least supporting evidence	***Couples and families where 1 member has BPD*** or where domestic violence occurs in an intimate relationship

*Persons at the top of the list are the ones for whom the most solid, rigorous research has demonstrated the efficacy of DBT. Fewer rigorous studies of DBT have been conducted in persons further down the list.
BPD: borderline personality disorder; DBT: dialectical behavior therapy
Source: References 3,12,13

Additional priorities include skills deficits and secondary targets.[1] Each week, the client monitors his or her behaviors, emotions, and actions using a diary card. The therapist uses this information to collaboratively prioritize the focus of each individual therapy session.

Skills training typically occurs weekly in group sessions of 1.5 to 2.5 hours with 1 or 2 therapists. This structured, psychoeducational training focuses on skills that persons with BPD often lack:

- mindfulness (paying attention to the experience of the present moment)
- emotion regulation (regulating or managing distressing emotions)
- distress tolerance (averting crises, tolerating or accepting distressing situations or emotions)
- interpersonal effectiveness (maintaining relationships and asserting needs or wishes).

Therapists often use the first half of group sessions to review each patient's homework and to provide feedback and coaching on effective skill use. The remaining time is spent teaching new skills. The therapist then assigns homework to practice new skills and closes with a wind-down exercise, often involving relaxation training.

Step 2. Consider the evidence

Before you make a referral for DBT (or any psychological treatment), know what the research says about who is likely to benefit from it. For women with BPD, DBT is the only treatment that can be considered "well-established."[3,14] The literature on DBT includes 10 randomized controlled trials (as well as many uncontrolled trials), and the strongest research supports its use in women with BPD.[2,4-13]

Based on a detailed review of the literature on DBT, I recommend a basic, evidence-based priority list for referrals (***Table 1***).[3,12,13] Patient groups at the top are most likely to benefit from DBT—according to the most solid, rigorous research—and deserve your strongest consideration for referral. Patient groups further down the list—with fewer rigorous studies of DBT—merit less consideration of DBT as the treatment of

choice. Of course to use this list, an accurate diagnosis of your patient's problems is essential.

DBT's treatment strategies—exposure therapy, skills training, cognitive therapy, emotion regulation training, and mindfulness—can work for other types of patients. I have noticed, however, that some clinicians refer patients with depression, anxiety disorders, or even bipolar disorder for DBT. Despite DBT's intuitive appeal, sufficient evidence does not yet support its use in patients with these disorders. Other evidence-based treatments may be more suitable for patients with uncomplicated mood and anxiety disorders (***Table 2, page 64***).[3]

Step 3: Would this patient benefit?

Would your patient, with unique struggles and characteristics, benefit from DBT? Consider to what degree DBT's interventions would solve some of your patient's problems and whether DBT fits your patient's needs.

DBT's target problems. In controlled trials, DBT's pragmatic approach outperforms comparator treatments in reducing suicidal behaviors and self-injury, and DBT therapists monitor and target these behaviors. Thus, because few treatments reduce self-injury,[15,16] you might consider DBT for patients who self-injure even if they do not have BPD.

DBT also includes a strong focus on emotions and emotion regulation. Therefore, if difficulty managing emotions is among your patient's primary problems, DBT may offer some benefit. DBT also includes structured interpersonal skills training that might be useful for patients who lack assertiveness.

Finally, if you have a patient with multiple diagnoses and severe problems—but not psychosis—the DBT approach to organizing and prioritizing treatment targets may be beneficial. Some multi-diagnosis patients may struggle with aspects of DBT (such as learning new skills), but DBT is set up to incorporate other empirically supported treatment protocols for co-occurring Axis I and II disorders.

Does DBT 'fit' your patient? DBT is very structured and involves direct discussions of maladaptive behaviors. If your patient prefers or would benefit from a structured approach, you might consider a referral for DBT.

continued

Right 'fit' for DBT?

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DBT may offer some benefit if difficulty managing emotions is among your patient's primary problems

Table 2

When not to refer a patient for DBT: Evidence is stronger for alternate treatments

Diagnosis	Treatments with empirical support
Major depressive disorder	CBT, behavioral activation, interpersonal therapy, antidepressant medication, mindfulness-based cognitive therapy for depressive relapse
Panic disorder/panic disorder with agoraphobia	CBT involving cognitive therapy and exposure-based interventions
Posttraumatic stress disorder	Prolonged exposure therapy, cognitive therapy, EMDR
Bulimia nervosa	CBT, interpersonal therapy
Primary substance use disorders	CBT, motivational enhancement/motivational interviewing, community reinforcement approach
Psychotic disorders	Medication management, social skills training, family-based interventions

CBT: cognitive-behavioral therapy; DBT: dialectical behavior therapy; EMDR: eye movement desensitization and reprocessing therapy
Source: Reference 3

Box 2

Communicating a DBT referral to your patient: A sample explanation

Based on my initial assessment, you seem to meet criteria for a diagnosis of borderline personality disorder, or BPD. A diagnosis is a category for different symptoms or experiences. To receive a BPD diagnosis, a person has to have at least 5 of 9 symptoms, and you seem to have about 6 of them. From what you have said, the main problems you struggle with are roller-coaster emotions and moods, problems with relationships with other people, and self-harm.

A lot of people recover from BPD, and there's no reason to think you will have these problems for the rest of your life. In fact, there is a very effective treatment for BPD. This treatment is called dialectical behavior therapy, or DBT. I think you're a great candidate for DBT. Of course, there's no guarantee that DBT is the ideal treatment for you, but several studies have shown that DBT helps people learn how to manage their emotions, reduce self-harm, and improve their functioning in life.

DBT includes a couple of different things: meeting once a week with a therapist on an individual basis, then meeting once a week with a group. In the group, you will learn how to manage your emotions, pay attention to the present moment, deal with other people, and tolerate being upset without getting into a crisis.

I know some people in town who provide DBT. Is this something you think you might be interested in? If so, what questions do you have?

DBT is an outpatient behavioral treatment that focuses on the here and now. DBT might not be the best fit if your patient:

- views his or her problems as resulting primarily from childhood experiences or relationships with parents
- would prefer insight-oriented therapy.

If, however, your patient would like a practical approach focused on problem-solving, DBT could be an effective choice.

DBT is based in part on a dialectical philosophy, and DBT therapists often seek to bring together or synthesize polarized thinking. If your patient struggles with "black or white" thinking, this dialectical philosophy might be helpful. On the other hand, DBT might not be the best fit if your patient is particularly rigid in thinking or seems to require cognitive therapy to address his or her thought patterns.

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DBT is not the treatment of choice for all personality disorders. Most of the evidence examines its use for BPD, and few studies have looked at any other personality disorder. Also, keep in mind that being interpersonally "difficult" does not mean that a patient is "borderline" or needs DBT.

Step 4: Communicate reasons for referral to your patient

Finally, communicate to your patient the reasons you are referring him or her for DBT. Patients often walk into my office for DBT, confused about why they are there. If patients understand why they have been referred for DBT and how it may help them, they may be more likely to follow through and realize its benefits.

A sample explanation of referral that I offer to guide this communication (***Box 2, page 64***) includes 3 main points:

- my diagnosis or conceptualization of the patient's clinical problems
- a brief description of DBT
- a rationale for why DBT would be a good fit, and what kinds of benefits the patient might receive.

Related Resources

- Chapman AL, Gratz KL. *The borderline personality disorder survival guide: everything you need to know about living with BPD*. Oakland, CA: New Harbinger Publications; 2007.
- National Education Alliance for Borderline Personality Disorder. Information for professionals, patients, and families. www.neabpd.org.
- Behavioral Tech, LLC, founded by Marsha Linehan, PhD. DBT training and resources, including a directory of DBT therapists. www.behavioraltech.org.
- Dialectical Behaviour Therapy Centre of Vancouver. www.dbtvancouver.com.

Disclosure

The author reports no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

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Clinical Point

DBT might not fit patients who believe their problems stem primarily from childhood experiences

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Bottom Line

Consider the evidence when referring patients for dialectical behavior therapy. DBT appears most effective for women with borderline personality disorder who struggle with suicidality and self-harm, but its structure may be useful for other patients' needs. Decide if the evidence supports using DBT to treat your patient's problems and if DBT would be a good 'fit.' If both of these criteria are met, clearly communicate to the patient your reasons for referring her or him for DBT.