The Course and Evolution of Dialectical Behavior Therapy

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Dialectical behavior therapy was originally developed from early efforts to apply standard behavior therapy to treat individuals who were highly suicidal. Its development was a trial and error effort driven primarily from clinical experience.

Dialectical behavior therapy is a modular and hierarchical treatment consisting of a combination of individual psychotherapy, group skills, training, telephone coaching, and a therapist consultation team. The inherent modularity and hierarchical structure of DBT has allowed for relative ease in adapting and applying the treatment to other populations and settings. New skills have been developed and/or modified due to clinical need and/or advancement in research such as treatment outcomes or mechanisms. There has been an effort to implement DBT skills as a standalone treatment. More research is needed to assess how DBT skills work and for whom. As DBT broadens its reach, the treatment will continue to grow and adapt to meet demands of an evolving clinical landscape.

KEYWORDS: Dialectical behavior therapy, suicide, borderline personality disorder, evidence-based treatments.

HISTORY OF DBT

Dialectical behavior therapy (DBT) emerged from attempts to apply standard behavior therapy to the treatment of highly suicidal individuals. In essence, DBT was a trial-and-error clinical effort based on the application of behavioral principles (Bandura, 1969) and social learning theory (Staats & Staats, 1963; Staats, 1975) to suicidal behaviors (Linehan, 1981). In the first randomized controlled trial (RCT), Linehan and colleagues actively recruited the most severe, highly suicidal clients from local area hospitals (Linehan et al., 1991). From the beginning the focus of DBT has

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been to build a "life worth living." The first complete draft of the treatment manual focused primarily on ameliorating suicidal behaviors; however, federal grant funding required that treatment outcome research identify a mental disorder diagnosis. As a result, the first clinical trials conducted were focused on treating chronically suicidal who also met criteria for borderline personality disorder (BPD), a population known for being at risk for suicide (Leichsenring, Leibing, Kruse, New, & Leweke, 2011).

Initially, treatment focused on teaching clients effective problem-solving strategies. However, treating such a high-risk and complex population moved the therapists to apply treatment strategies that required clients to make very difficult life changes. This focus on problem solving was experienced as extremely invalidating by clients. Often, clients responded with hostility by lashing out, often at their therapist, or dropping out of treatment altogether. In response, treatment shifted dramatically to focus on warmth and acceptance. Clients were equally frustrated by this treatment, saying it was not doing enough to solve their problems. It became clear was that there was a need for new therapist strategies that could encompass a synthesis of

a) a technology of change and a technology of acceptance,
b) spaciousness of the therapist's mind to "dance" with movement, speed and flow,
c) radical acceptance by the therapist of the client as is, with slow and episodic rate of progress and the constant risk of suicide, and
d) therapist humility to see the transactional nature of the enterprise.

This led to a synthesis of both acceptance and change—accepting clients where they are while pushing for progress and combining a range of change strategies aimed at problem solutions and acceptance strategies with a core emphasis on validation.

However, this synthesis of acceptance and change was troubling for clients as well. Given the complexity of the clients' problems, asking them to temporarily tolerate distressing experiences to focus on other treatment goals proved difficult if not impossible. For many clients, the pain from the past was intolerable and elicited dysfunctional behaviors. What was needed was a new set of client targets that focused on teaching

a) radical acceptance of what each of us has to accept; our past, the present and realistic limitations on the future and
b) skills to tolerate distress without impulsively or destructively reducing it.

Evolution of DBT

Dialectical behavior therapy is rooted in behaviorism, and at the time DBT was created, behavioral treatments focused primarily on changing distressing experiences rather than on temporally tolerating them. This prompted an alteration to traditional behavioral treatment.

The problem was where to find an acceptance-based practice that did not focus on change. Acceptance-based treatments (e.g. client centered therapy; Rogers, 1946) used positive acknowledgement as a vehicle to enact change, and thus were ultimately change focused. A search for practices that were purely acceptance based, and for individuals who could teach acceptance without linking it to change, led to the study of both Eastern (Zen) and Western contemplative practices (Aitken, 1982; Jager, 2005). Fundamental to these practices is the concept of radical acceptance of the present moment without attempts to change it. Integrating Zen and contemplative practices into behavioral therapy also created challenges. Both Zen and contemplative prayer spring from spiritual practices, and clients presented from the entire spectrum from no spirituality to intense spirituality and religious convictions. An inclusive approach had to be developed. Many individuals struggled with meditating in silence and focusing their attention on their breath and inner sensations. At the time, meditation did not exist in psychotherapy. The idea of meditation was viewed as weird, threatening, and out of reach to individuals whose avoidance of emotions and inner sensations was a strong pattern. Thus, basic Zen practices, along with aspects of other contemplative practices, were translated into a set of behavioral skills that could be taught to both clients and therapists. The spiritual and religious overtones in Zen had to be parceled out as well, at least at first pass. Thus, the term mindfulness was used to describe the skills translated from Zen. The term was adopted from the work of both Ellen Langer (1989) and Thich Nhat Hanh (1976). The skills translating contemplative practices were labeled "reality acceptance skills" and drew heavily from the work of Gerald May (1987).

Another problem to solve was to develop a model for BPD. Such a model would have to be capable of guiding effective therapy, non-pejorative for the client, and compatible with current research data. Thus, the model that was developed was the biosocial theory, which states that BPD is a pervasive disorder of the emotion regulation system. Taken further, BPD criterion behaviors function to regulate emotions or are a natural consequence of emotion dysregulation (Linehan, 1993).

Dialectical behavior therapy required a theoretical framework that could integrate the principles of Zen and other contemplative practices with behaviorism. That framework emerged with a chance encounter with

the philosophical concept of dialectics, which highlights the process of synthesizing oppositions. After dialectics was adopted, the treatment was scrutinized to insure that it was consistent with the underlying philosophy and the treatment manual was published (Linehan, 1993a; Linehan, 1993b). Dialectics continues to provide a framework from which the treatment evolves; continual tensions between theory and research versus clinical experience and between Western psychology versus Eastern practice drives the evolution that is consistent with the theoretical integration model described by psychotherapy integration researchers (Arkowitz, 1989; Arkowitz, 1992; Prochaska & Diclemente, 2005; Ryle, 2005; Norcross & Goldfried, 2005).

Stages of Treatment

Clients coming into treatment ordinarily met criteria for BPD, were at high risk for suicide, had a wide range of co-occuring axis I disorders (e.g., depression, multiple anxiety disorders, eating disorders, substance abuse disorders, etc.), had a difficult time managing negative emotions, and were engaged in behaviors antithetical to treatment (e.g., avoidance of appointments, poor time management skills), all of which made conducting effective therapy difficult. At the time there were no guidelines on how to treat clients with severe multiple disorders and high-risk behaviors, and therapists needed guidance on what and how to prioritize problems within sessions. To organize treatment, a set of priorities were developed based on the concept of level of disorder, which included imminent life threatening risk, severity, pervasiveness, and complexity of disorder and, disability.

The guidelines provide a hierarchy of what to treat and when to treat it for a particular client. It also enables the clinician to treat individuals with varying complexities and problems. Targets can be grouped into recommended stages of treatment. In stage 1, the focus of treatment is to stabilize the client and achieve behavioral control. Stage 1 is broken into the following behavioral targets: to decrease imminent life interfering behaviors (e.g. suicide attempts, non-suicidal self-injury), reduce therapy interfering behaviors (e.g. missing treatment, behaviors that are burning out the therapist, refusal to collaborate with necessary steps for desired change), decrease client-guided, quality-of-life interfering behaviors (e.g. substance use, unemployment, homelessness), and increase skillful behaviors to replace dysfunctional behaviors (this is called DBT skills training). Stage 2 is called the stage of "quiet desperation." Action is controlled but emotional suffering is not. In stage 2, the goal of treatment is for the client to experience to full range of emotions; also PTSD is treated in stage 2.

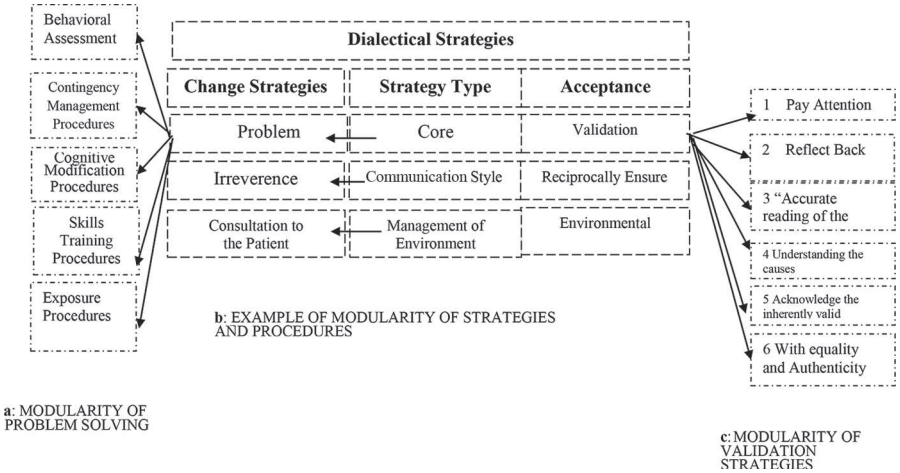

Figure 1

Stage 3 is to reduce ordinary problems in living. Stage 4 is designed to increase a sense of completeness, to find joy, and/or achieve transcendence.

Modularity

As previously mentioned, DBT was developed for clients with complex, multi-diagnostic, high-risk disorders, and resultantly, the clinical problems that emerged were very complicated. It was clear that in order for DBT to be effective, treatment had to be flexible and based on principles rather than on highly structured protocols. Strategies for approaching and resolving complex problems are modularity and hierarchy. Modularity can be used to separate the functions of a treatment/intervention into independent modules such that each module contains everything necessary to carry out one specific aspect of the desired treatment. This inherent modularity to DBT enables various aspects of disorder-specific protocols to be included or withdrawn from the treatment as needed. Hierarchy is built into the treatment by having predetermined levels of disorder, which are addressed in order from most to least severe.

Dialectical behavior therapy was developed for individuals entering stage 1 of treatment. However, DBT has a modular and flexible structure, which allows for the treatment to be scaled to treat clients with simpler clinical presentations. Disorders are treated depending on a treatment hierarchy with protocols within DBT or protocols brought in from other treatments for specific problems (for example, formal exposure for specific phobias).

Team as a Part of Treatment

Dialectical behavior therapy was developed and applied initially within a graduate training program that evolved into a research environment. After completion of formal DBT training and supervision, all research therapists attended a weekly consultation team meeting to insure the maintenance of fidelity to the model during the study. Because this was and is the model used in all of the early DBT studies it, the treatment, when defined, included this focus on team consultation as part of the treatment. The primary functions of consultation team are to focus on therapist treatment fidelity, manage burnout, and provide support to those treating clients at imminent suicide risk and/or engaging in significantly more dysfunctional behavior. In DBT, the emphasis of consultation team reinforced and/or shaped therapist behavior, with the aim to improve fidelity and treatment. The essence of team is to prioritize topics based on severity and acuity. Therapists are also encouraged to cheerlead and validate each other and to maintain a non-judgmental tone. Consequently, DBT is defined as the treatment of a community of clients by a community of therapists, and the treatment of the therapists by the community of therapists.

Between-Session Coaching

The primary rationales for providing between-session telephone coaching is that 1) suicidal individuals often need more contact than weekly individual sessions, especially during crises, and 2) allowing phone calls *only* when suicidal is likely to reinforce suicidality for many clients. Another reason for phone coaching between sessions is that most clients desperately needed to learn how to interact with people in ways that make others want to help them rather than making others angry or frustrated. Thus a focus of phone calls is to teach clients phone skills and to provide effective consequences for dysfunctional social interactions. Phone skill coaching is used to aid in skill generalization in different contexts and environments. Lastly, phone coaching can be used to repair damage done to the therapeutic relationship when having to wait until the next session is unnecessarily painful.

DBT Skills

In developing the treatment it became apparent that it was extraordinarily difficult, if not impossible, in 60 minutes to focus simultaneously on problem solving a range of crises, dysfunctional behaviors, emotional distress and high emotion dysregulations while teaching a set of behavioral skills that required practice to be useful. Accordingly, treatment was

separated into two parts serving differing roles, one that focused primarily on skill training and one that focused primarily on solving current problems and motivational issues, (e.g. staying alive, abstaining from drug use, reducing depression and/or stay in therapy). In DBT skills the primary emphasis is to help clients learn behaviors that can be used in place of ineffective or maladaptive behavior. Some attention to motivational issues occurs in DBT skills training, particularly with the weekly skills practice homework assignments, but the fundamental emphasis in DBT skills training is on acquiring and strengthening skills.

Skills training is didactically focused, with a heavy emphasis on skills training procedures, including modeling, instructions, stories, behavioral rehearsal, feedback and coaching, and homework assignments. Skills for each module are transcribed on handouts, and various worksheets are provided for each skill. There are four skills modules

1) mindfulness,
2) interpersonal effectiveness,
3) emotional regulation, and
4) distress tolerance.

Skills are separated into "change skills" (interpersonal effectiveness and emotion regulation) and "acceptance skills" (mindfulness and distress tolerance). The inherent modularity of DBT allows for skills to be added, modified, or deleted depending on the curriculum or need. Many of the DBT skills are developed from research in social psychology, spiritual teachings, or are adaptations of instructions given to clients in various evidence-based treatments targeting specific problems. The original skills package was developed for individuals who were highly suicidal and diagnosed with BPD; since then, DBT has been implemented with differing populations and with individuals presenting with differing problem behaviors. New skills have been developed and/or modified due to clinical need and/or advancement in research such as treatment outcomes or mechanisms. Further, the development of DBT was and continues to be an iterative process—as new research comes in, skills will naturally adapt to improve treatment or address new challenges.

Mindfulness is central to DBT, and thus mindfulness skills are labeled the "core" skills. These skills (going within to wise mind, wordless observing, describing what is observed, participating, being non-judgmental, one mindfulness, and effectiveness) are behavioral translations of common instructions given across Eastern and Western contemplative practices. Each skills module has at least one mindfulness skill, e.g., mindfulness of others in interpersonal skills, mindfulness of current emo-

tions in emotion regulation, and mindfulness of current thoughts in distress tolerance. The mindfulness skills of "observe and describe" are part of every worksheet.

Emotion regulation training teaches a range of behavioral and cognitive strategies for reducing unwanted emotional responses and increasing desired emotions. Skills focus on teaching how to identify and describe emotions, how to change emotional responses, how to reduce vulnerability to negative emotions, and how to manage difficult emotions. Dialectical behavior therapy emotion regulation skills training first teaches that emotions are brief, involuntary, full-system, patterned responses to internal and external stimuli (Eckman & Davidson, 1994). Also emphasized in skills training is the importance of the evolutionary adaptive value of emotions in understanding them (Tooby & Cosmides, 1990). The first task of emotion regulation skills training is presenting the model of emotion which identifies

1) emotional vulnerability to cues,
2) internal and/or external events that, when attended to, serve as emotional cues (e.g., prompting events),
3) appraisal and interpretations of the cues,
4) response tendencies, including neurochemical and physiological responses, experiential responses and action urges,
5) non-verbal and verbal expressive responses and actions, and
6) after-effects of the initial emotional "firing" which can include secondary emotions.

Many DBT skills target specific components of the emotional system because we believe that if someone wants to change her emotions, including emotional actions, it can be done by targeting any part of the system of emotions. Once a model is formed, skills to change emotions largely come from existing treatment manuals. Exposure based procedures are found in the skill of "Opposite Action," where clients explicitly do the opposite of what their emotions and/or action urges dictate (e.g. approach a feared stimulus). Since the original publication of the skills manual (Linehan 1993b), new research emerged for the treatment of depression (e.g. behavioral activation [BA]; Dimidjian et al., 2006) and post-traumatic stress disorder (e.g. prolonged Exposure [PE]; Foa, Hembree, & Rothbaum, 2007). Subsequent research trials on BA and PE provided further research support for opposite action for emotions like sadness or fear respectively. New emotion regulation skills emerged to target specific aspects of the model of emotions. For example, Nezu, Nezu, and Perri's (1989) problem solving therapy was repurposed to "Problem Solving,"

where solutions are generated to solve problems causing justified emotional distress. Cognitive modification (e.g. Meichenbaum, 1979) became the new skill of "check the facts" where unjustified emotions are challenged and events are reinterpretated to fit the facts. Imaginal rehearsal was repurposed into "Cope Ahead," where individuals imagine coping effectively to a feared and/or distressing situation. Imaginal rehearsal is also applied in the nightmare protocol (Krakow et al., 2001). In addition to changing emotional response, emotion regulation skills also teach clients to reduce vulnerability to negative emotions. Dialectical behavior therapy is referred as a treatment that helps clients build a "life worth living." To emphasize that point, skills were added that taught accumulating positives in both the short-term (e.g. adding pleasant events) and in the long-term (e.g. developing goals that fit one's values). Both skills fit within the behavioral activation treatment model for depression and are also similar to the emphasis on values in acceptance and commitment therapy ([ACT] Hayes, Strosahl, & Wilson, 1999).

Individuals with difficulty regulating their emotions often experience difficulties in interpersonal relationships; for example, jealousy and anger can damage close relationships, fear and shame can lead to avoidance of interpersonal contact, and even depression can inhibit efforts to interact with others. Thus interpersonal effectiveness training is a collection of skills that teach individuals to manage interpersonal conflict, develop new friendships and/or end destructive ones, and reinforce the environment effectively. Many of the interpersonal effectiveness skills came from research in assertiveness training (Linehan & Egan, 1979); for example, the skill of DEARMAN (see figure 2) teaches individuals how to make requests effectively. This is balanced by skills on how/when to effectively say no. Interpersonal effectiveness skills have broadened to include skills in dialectics, validation, and contingency management procedures. These skills were added to address different interpersonal dynamics. For example, "Walking the Middle Path," was originally designed for family skills training with adolescents and their care givers. In walking the middle path, individuals are taught dialectics, more in depth validation (see Linehan 1997), and behavior change procedures. This includes a skill on behaviorism, which teaches clients how positive and negative reinforcement can be strategically implemented to shape goal directed behavior.

When DBT was developed, there were no existing treatment manuals that targeted temporarily tolerating distressing events or circumstances. Available behavioral treatment focused on changing behavior, while distress tolerance teaches clients to accept, find meaning, and tolerate distress.

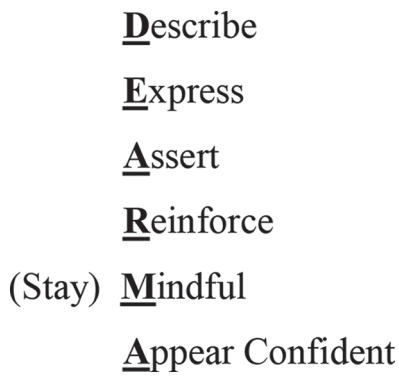

Figure 2
DEARMAN ACRONYM FROM INTERPERSONAL EFFECTIVENESS MODULE

Distress tolerance training teaches a number of "delay of gratification" and self-soothing techniques aimed at surviving crises without making things worse (e.g. avoiding using drugs, attempting suicide, or engaging in other dysfunctional behavior). For example, the *TIP* skill (see figure 3) was developed by translating research on how to activate the body's physiological nervous system for decreasing arousal either through temperature (Jay, Christensen, & White, 2006 & Foster & Sheel, 2005), exercise (Tate & Petruzzello, 1995), effective breathing , and muscle relaxation (Linehan, 2005). Also, in distress tolerance are a set of skills focused on reality acceptance, which aim to reduce suffering and increase freedom when painful facts cannot be changed immediately (if ever). The skill of "radical acceptance," for example emerged from the extensive literature on survivors of Nazi concentration camps, particularly the work by Viktor Frankl (1985). Luck plus radical acceptance of the facts of the present moment were essential to survival.

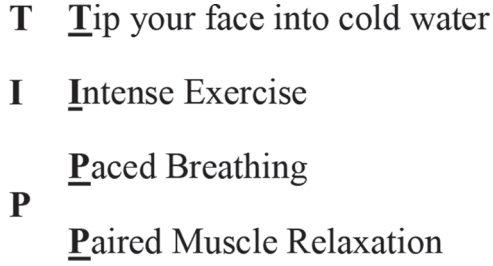

Figure 3
TIP ACRONYM FROM DISTRESS TOLERANCE MODULE

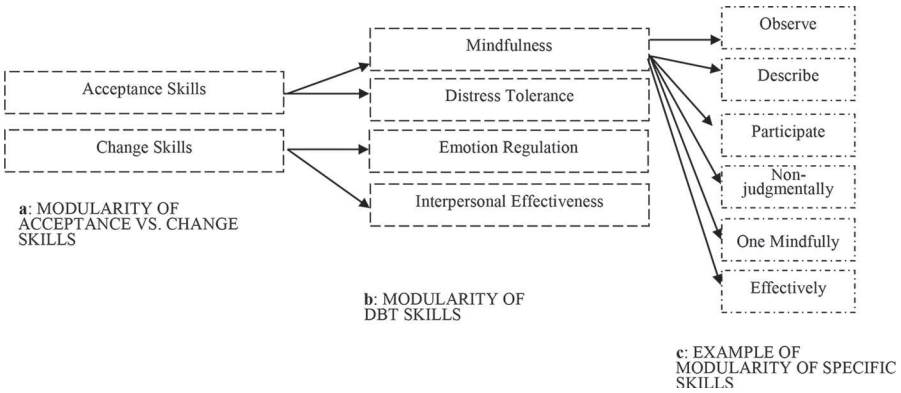

Figure 4

The skill of willingness, contrasted with willfulness, was taken from Gerald May's (1982) book and it teaches clients to be wholeheartedly ready to respond to life's challenges, doing what is necessary, and throwing one's self into the community as a whole. Among the reality acceptance skills are ones that are accepting reality with the body—these are half smiling and willing hands. Half smiling came from research that showed that emotions are influenced by facial expressions (Ekman et al., 1987 & Ekman, 1993). For the treatment of substance abuse, a new set of skills that highlighted drug addiction were added to the distress tolerance module. These skills integrate community reinforcement, alternative rebellion, and the concept of "dialectical abstinence," which is a synthesis of an abstinence approach with a harm reduction approach. Very recently, the *TIP* skill within the distress tolerance module was modified to include a skill called "paired muscle relaxation." Adapted from stress management for collegiate and professional athletes (Smith, 1980), paced muscle relaxation pairs induced affect, cognitive modification, and relaxation.

Future Directions

Beyond treating clients with BPD, DBT has demonstrated efficacy with different conditions, such as eating disorders (Safer & Jo, 2010; Safer & Joyce, 2011), depression in older adults (Lynch et al., 2007; Lynch Morse, Mendelson, & Robins, 2003), and a cluster B personality disorder (Feigenbaum et al., 2011). In addition, there has been an effort to implement DBT skills as a stand-alone treatment. A number of articles have identified that the DBT skills component alone (without the individual therapy) to be efficacious for a variety of populations including incarcerated women with histories of trauma (Bradley & Follingstad, 2003), ADHD (Hirvikoski

et al., 2011), and for intimate partner violence (Iverson, Shenk, & Fruzzetti, 2009) among others. More research is needed to identify which skills are effective for which problem area and for whom; though, DBT skill use as a whole has been found to be effective at reducing emotion dysregulation (Neacsiu, Rizvi, & Linehan, 2010). Dialectical behavior therapy skills training has been applied to focus on building resilience and it can be applied across work or school settings; for example, DBT skills lesson plans are now being used in school systems to teach middle and high school students (Mazza, Mazza, Murphy, Miller, & Rathus, in press). A relative recent advance to psychotherapy is the integration of technology to psychotherapy. For example, computerized psychotherapy treatments have been found to reduce depression (Richards & Richardson, 2012; Proudfoot et al., 2003) and anxiety (Marks, Kenwright, McDonough, Whittaker, & Mataix-Cols, 2004). In some cases, the computerized interventions have been found to be as efficacious as face-to-face interventions (Selmi, Klein, Greist, Sorrell, & Erdman, 1990). Dialectical behavior therapy, with its established efficacy in face-to-face interventions for a variety of clinical problems and populations and its structured skills training format, is an ideal candidate for dissemination as a computerized intervention.

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