DBT: 'wastebasket' patients' salvation

Why BPD patients are the way they are is accepted. DBT sees this as irrelevant. Helping such distressed people achieve calmness is what matters

Mental health

Malcolm Falconer

Dialectical behaviour therapy (DBT) is a skills-based, therapeutic relationship-focused therapy developed by Marsha Linehan.

The US psychologist is director of the behavioural research and therapy clinics at the University of Washington. Her focus has been on achieving behavioural change using DBT to address suicidal behaviours, drug abuse and borderline personality disorder (BPD). *Psychology Today* recently reported that she had made a courageous public confession: she has suffered from what she believes to be BPD all her adult life.

DBT is a version – or evolution – of cognitive behaviour therapy (CBT) that has been adapted for patients diagnosed with BPD. It combines behavioural science with the concepts of acceptance and mindfulness derived from both Eastern and Western contemplative practices.

Mindfulness has lately become the in-word in therapy, and "Gucci-Buddhists" now abound in acceptance and commitment therapy (ACT), emotion-focused therapy (EFT), alcohol and other drug (AOD) treatment, and other therapies. The recommended reading in many DBT programmes is the Dalai Llama's *The Art of Happiness.*

Embracing change the Greek way

The term "dialectical" has its origins in Greek philosophy and was made popular by Plato in the Socratic dialogues. It involves a discussion between two or more people who hold different points of view about a subject and who want to establish the truth of the matter by using dialogue, with reasoned arguments as opposed to simple debate.

Using DBT, the polarities (thesis *versus* antithesis) that exist for the person with BPD mean that to reach a helpful solution the person must synthesise these different polarities. Put simply, in DBT, people have to accept the way things are and themselves along with their unhelpful behaviours, and embrace the need to change these.

Many years ago I attended a DBT training course facilitated by a Marsha Linehan trainer, Liz Simpson. I asked her why people with BPD, or any disorder associated with high levels of distress, seem to make good progress in therapy and then, just when things appear to be going well, self-sabotage by self-harming or engaging in impulsive acts involving drugs or alcohol, or wreck their relationships etc.

Dr Simpson totally refuted my assessment. She said there wasn't an organism on the planet that "self-sabotaged". Such behaviours, no matter how harmful they might appear, aim to reduce tension, relieve pressure and avoid pain, ie, survival is the imperative. The person self-harming, binge-drinking or taking drugs, or walking out on a good relationship does so because of a belief that his or her survival is compromised.

The behaviour, however unhelpful the consequences, is what the person has learnt is necessary to survive. The fact that it has unintended harmful consequences is not incorporated in this decision making. To ask the person to stop such behaviour is to threaten the person's survival. Furthermore, to suggest a new behaviour in place of the unhelpful one is to ask the person to try something that has not been tested as a survival skill, ie, it is new and therefore risky.

So, the dialectical challenge for the patient is to let go of what he or she knows and find out what is not known, which involves embracing change. The dialectical issue becomes: "I cannot change and stay the same, or I cannot distrust people and have a helpful therapeutic relationship. I hate living, but dying is not a good choice."

Toxic experiences cause of the problem

Most BPD patients developed their disorder as a result of actual or perceived invalidation of their emotional states. Typically, this involves a history of toxic life experiences, eg, sexual abuse, abandonment, deprivation, neglect and poor attachment. Prior to the development of DBT, therapy for these patients often involved catharsis – the "relived-relieved" notion that extinguishing the emotional state involves revisiting what has happened.

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Whether this was done using psychodrama, CBT, empty chair work or visualisation, the unintended outcome, more often than not, was retraumatisation and deterioration, with worsening symptoms. DBT doesn't go there. Why BPD patients are the way they are is accepted. But, in terms of therapy, it is irrelevant. What to do about it is all that matters. So, visiting the past or lifting the lid on overwhelming emotional states is not the focus.

Providing skills for identifying the emotional states, dealing with the distress these evoke and surviving the feelings until they pass is the focus of DBT. So, acceptance of suffering, ie, being mindful of the fluctuations in one's internal state, describing these states and then taking healthy action in the face of this suffering is what DBT is all about – as well as resisting the impulse to act out in the old harmful ways.

Finding the best time to challenge the patient

The therapy dilemma is always when to challenge unhelpful behaviours and thinking, and when to accept and support the patient. In DBT both occur simultaneously. The therapist must develop trust and empathy, and validate the patient, or nothing will change. Once trust has been established, then challenges and the possibility of alternative behaviour can be introduced. DBT is usually an outpatient programme involving an hour a week of individual therapy plus two-and-a-half hours of group therapy for a year.

Linehan says BPD patients, because of their toxic upbringing, and possible biological factors, respond abnormally to emotional stimulation. Their level of arousal escalates quicker, peaks at higher levels and takes longer to return to normal. The harmful behaviours, eg, self-harming, impulsive sexual acting out and substance abuse etc are the result of a lack of coping and problem-solving skills in dealing with these surges and peaks of emotionality.

Without going into the "how to", which would require more space than this article permits, DBT targets these problem behaviours and offers more adaptive alternatives. Patients examine, in detail, the chain of events leading up to the behaviours and develop the ability to be mindful of their internal states and of the physiological indicators that precipitate their acting out. They then learn skills to regulate their emotions, tolerate distress, develop trust and intimacy, and be more effective in their interactions and relationships with others.

DBT in New Zealand – long but obscure history

DBT was first introduced in New Zealand by Waitemata Health 25 years ago by psychiatrist Roy Krawitz and his team. The service was aimed at those with the poorest outcomes from the mental health services, ie, those with cluster B personality disorders, most notably BPD, who were often regarded as "wastebasket" patients.

The service mainly dealt with those women with BPD who were the highest users of crisis team services, had high acute unit usage and consumed vast amounts of the pharmaceutical budget but with little result.

Keith Crump, a highly regarded mental health pharmacist, was pharmacist for Waitemata DHB at the time. Having seen first-hand the benefits of DBT, he is a big advocate. Several studies show a reduction in medication use, crisis team involvement and acute unit bed demand from those who have completed a DBT programme.

Most DHB mental health services run DBT-based distress tolerance or "balance" groups. Segar House in Auckland has a regional service that runs several programmes. And Te Whare Mahana in Takaka runs an inpatient residential DBT programme. This evidence-based therapy is now the treatment of choice for BPD sufferers and for many other disorders where emotional distress is a problem.

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Key points

- Dialectical behaviour therapy (DBT) helps in identifying emotional states and dealing with the distress these can evoke.
- The "relived–relieved" notion that patients must revisit the past is now seen as wrong as it retraumatises them.
- Acceptance of suffering and taking healthy action in the face of it are part of DBT.
- Because of their toxic upbringing, BPD patients respond abnormally to emotional stimulation.
- DBT was introduced as a way of dealing with "wastebasket" patients – but it worked.

Further reading

- Diamond S. Linehan and Jung as Wounded Healers: Two Dialectically Different Approaches to Dealing With Inner Demons. *Psychology Today* Dec 30, 2011.
- Krawitz R, Jackson W. *Borderline Personality Disorder.* New York: Oxford University Press; 2008.
- Linehan M. *Skills Training Manual for Treating Borderline Personality Disorder.* New York: Guilford Press; 1993.

Practice Quiz Answers

SPORTS MEDICINE
1. True. **2.** True. **3.** False.

MENTAL HEALTH
1. True. **2.** True. **3.** True.

ELDER HEALTH
1. False. **2.** True. **3.** True

DERMATOLOGY
1. False. **2.** False. **3.** True.

FIRST TIME
1. True. **2.** False.

MEDICOLEGAL
1. False. **2.** True. **3.** False.