

Dialectical Behavior Therapy

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Description

Dialectical Behavior Therapy (DBT) is a successful therapeutic approach originally developed to treat suicidal patients. Well-supported by many studies, DBT has also been found to be effective with a number of other mental health issues, including borderline personality disorders, eating disorders, psychosocial rehab, post-traumatic stress, multiple disorders, co-occurring and so on. The term 'dialectic' means 'conversation,' and in DBT refers to the process of point, counterpoint, and understanding or acceptance of the other position (i.e., the therapist's position). DBT could be described as rational emotive or cognitive restructuring therapy with Zen Buddhism concepts added in.

DBT is based on acceptance and change. The patient learns to accept their dysfunctions, the limitations they cause in their life and the patterns that maintain or promote their dysfunctions. A key component for the success of DBT is the patient's willingness to change as part of therapy. This willingness to actively engage in change is taught, coaxed and motivated throughout the course of DBT.

DBT is comprised of two components individual sessions and group therapy sessions. In the individual sessions, usually occurring once per week, the patient & therapist discuss the various issues that have arisen during the week. Suicide and self-injurious behaviors and behaviors that might interfere with the therapy attendance and compliance are addressed. For the remainder of the session, the patient and therapist discuss real life issues that have occurred since the previous session, looking at how the situations caused undesirable emotional responses, the emotional and cognitive processes that formed the reactions and the outcomes and consequences. The patient and therapist then look at ways the patient could have accepted the situation, responded better to the stressor, controlled their emotions and remained calm. These same skills are then practiced during the group sessions.

The group sessions focus on the development of interpersonal problem solving skills and emotional control skills. During discussion and group interaction, the patients practice four key skills: core mindfulness, interpersonal effectiveness, emotional regulation and distress tolerance.

- *Core mindfulness skills* address living in the moment without rumination on the past or dread of the future. Based in part on Zen Buddhist concepts, core mindfulness skills include being nonjudgmental, acceptance of the stressful moments of life, natural emotion reactions, etc. The intent is to help the patient learn how to find and hold a calm, centered mind in the face of their particular distressors. A non-religious form of meditation is used to reduce the strength of emotional reactions to stressors, perhaps akin to systematic desensitization or progressive relaxation techniques.
- *Interpersonal effectiveness skills* teach assertiveness, social and interpersonal problem-solving skills. The goal is to teach the patient new ways to interact and achieve their goals in socially acceptable ways.
- *Emotional regulation skills* are a systematic approach to monitoring and controlling emotions, especially anger and anxiety. The DBT patient learns to gain increased mindfulness of their current emotions, to identify and label emotions, to control their emotional responses to stressors, and to reduce their susceptibility to strong emotions, such as anger. The DBT patient

also learns to ways to increase the number and perception of positive emotional events, when and how to take the opposite action from the first impulse, and how to apply distress tolerance techniques.

- *Distress tolerance skills* are skills focused on helping the patient accept, understand and tolerate distressing events by accepting life as it is in the moment. The understanding gained gives person a chance to think calmly about what to do, how to react, etc., as an alternative to reacting negatively or overemotionally. Instead, they learn that they can tolerate and survive crises. Specific cognitive strategies/tools taught and practiced in DBT include self-distraction, self-soothing, improving on the moment, thinking of pros and cons, accepting things as they are, and the finding the willingness to work with bad situations instead of trying to control them.

DBT has been tested and found to be a successful intervention well beyond suicidal adults. Populations that DBT has worked well with include:

- Suicidal adolescents
- Individuals with substance use disorders
- Individuals with eating disorders
- Individuals with co-morbid HIV and substance use disorders
- Developmentally delayed individuals
- Older adults with depression and one or more personality disorders
- Individuals with schizophrenia
- Families of patients
- Women experiencing domestic violence
- Inpatient and partial hospitalization settings for adolescents and adults
- Violent intimate partners
- Individuals who stalk
- Forensic settings for juveniles and adults

Characteristics

- Population
 - Gender – male and female
 - Ages – Adults: 18-25 (Young adult), 26-55 (Adult), 55+ (Older adult)
 - Races – American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, White
- Risk, Protective & Causal Factors
 - Previous suicide attempts (R)
 - Non-suicidal self harm (R)
 - Lack of psychosocial adjustment (R)
 - Substance Use (R)
 - Unmanaged mental health disorders (R)
 - Skills & capability training (P)
 - Comprehensive monitoring and feedback system (P)
- IOM Category (level of care)
 - Indicated – adults with specific risk factors for suicide or self-harm

Effectiveness

Compared to non-DBT groups of suicidal adults, adults who completed one year of DBT:

- reported significantly fewer suicide attempts (23.1% vs. 46.7% in an alternative care group)

- reported significantly fewer intentional self-injury incidents than similar adults waiting for treatment or in an alternative care group (0.55 events in 30 days prior compared with 9.33 incidents)
- had less severe intentional self-injury episodes
- reported improvement in psychological, social, or general mental functioning adjustments (e.g., anger management). Some of the gains were evident at 16 – 24 month follow-up assessments
- had a significantly higher rate of clean urine analyses four months after the conclusion of one year of DBT
- remained in mental health treatment longer than usual care or alternative treatment programs (63%-100% retention for DBT vs. 23%-73% across a number of studies)

Program delivery

DBT is designed to be delivered in a standard mental health environment using a combination of individual and group therapy sessions. While an individual could function solely as a DBT therapist, the typical DBT practitioner will likely be a credentialed therapist who has added DBT as a tool to their skill set.

DBT describes the intervention as a one year treatment period, with the patient working individually with the therapist once per week and participating in ongoing group therapy sessions. In the individual sessions, the patient and therapist monitor for increased suicidality, obstacles to continuing with and completing DBT, and daily life issues. During the review of the patient's interactions with the world since the previous session, the patient and therapist examine undesirable or stressful situations and the patient's emotional and behavioral responses. They then re-examine the situations for different ways the patient could have responded using DBT skills and concepts.

In the group therapy sessions, the patients use ordinary group therapy processes to practice the DBT skills, with an increased focus on remaining balanced and centered while under emotional turmoil, using new interpersonal and emotional management skills, and on using the distress tolerance techniques to distract or ride out unavoidable emotional or unpleasant interpersonal conflicts.

Considerations for use in Idaho

DBT is a well-researched, widely used and recognized successful intervention for suicide and a host of other mental health issues. DBT can be implemented in existing mental health services agencies with little or no expense beyond the initial training. A branch of therapy in its own right, DBT is a tool that can be added to many mental health workers skill set. There are many qualified trainers and training organizations available as well as a relatively inexpensive web-based training. The program itself is designed to fit into an ordinary mental health service environment and only requires space for individual counseling and group therapy sessions.

Perhaps the two biggest limitations for DBT in Idaho are the lack of mental health services in many rural areas and the cost of the recommended full year of weekly individual therapy sessions. This cost may limit the availability in rural and frontier areas and for impoverished or state funded patients, and that in turn, may lower the interest of small mental health offices in becoming credentialed in DBT. A further difficulty, common with other group based approaches to suicide prevention in Idaho is that rural areas may not have enough people in simultaneous suicide crises to be able fill the group sessions, although this will probably not be an issue for urban areas.

Training & costs

A variety of training methods and costs for DBT are available. The least expensive is to be trained by a colleague who has been certified in DBT. While not specifically addressed by the DBT developer, this opens the door to trainers of trainers, a training model that works well in a resource limited state such as Idaho. In recent years, graduate courses in DBT have become available, making it attractive and accessible to those completing their education as therapists (<http://depts.washington.edu/brtc/training/other>).

The DBT developer offers trainings in a number of levels and formats, including at their training facility, at national training events, and through web-based instruction. The following gives an idea of the types and costs of training available. For full details of the different levels and costs, visit the DBT training website (<http://behavioraltech.org/training/>).

- half-day or 1- or 2-day training on campus (\$125-\$140 per day)
- web-based training (\$450-\$550, cf. http://www.behavioraltech.org/ol/details_chain.cfm)
- 10-day DBT intensive training (\$2,400 per team member)
- full-scale system implementation trainings are available at a cost of about \$21,000 per eight-member team

In addition, there are many organizations beyond the program developer that provide training for DBT. A Google search using the terms *dialectic behavior therapy training suicide* returned over 20,000 entries.

Dissemination & support

There are a wide variety of DBT trainers and implementation materials available. The program developer's basic treatment manuals are available on Amazon.com <http://depts.washington.edu/brtc/sharing/treatment-manuals>, with other manuals, materials and assessment tools available through the program vendor. There is also a large body of independent trainers and consultants (<http://behavioraltech.org/training/trainers.cfm>).

Contact information

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Phone: (206) 675-8588

E-mail: information@behavioraltech.org

Website: <http://www.behavioraltech.org>

Website: <http://www.brtc.psych.washington.edu/>

Other program synopses

- NREPP: http://nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=72

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