Chapter 1

Rationale for Dialectical Behavior Therapy Skills Training

What Is DBT?

The behavioral skills training described in this manual is based on a model of treatment called Dialectical Behavior Therapy (DBT). DBT is a broad-based cognitive-behavioral treatment originally developed for chronically suicidal individuals diagnosed with borderline personality disorder (BPD). Consisting of a combination of individual psychotherapy, group skills training, telephone coaching, and a therapist consultation team, DBT was the first psychotherapy shown through controlled trials to be effective with BPD.[1] Since then, multiple clinical trials have been conducted demonstrating the effectiveness of DBT not only for BPD, but also for a wide range of other disorders and problems, including both undercontrol and overcontrol of emotions and associated cognitive and behavioral patterns. Furthermore, an increasing number of studies (summarized later in this chapter) suggest that skills training alone is a promising intervention for a variety of populations, such as persons with drinking problems, families of suicidal individuals, victims of domestic abuse, and others.

DBT, including DBT skills training, is based on a dialectical and biosocial theory of psychological disorder that emphasizes the role of difficulties in regulating emotions, both under and over control, and behavior. Emotion dysregulation has been linked to a variety of mental health problems[2] stemming from patterns of instability in emotion regulation, impulse control, interpersonal relationships, and self-image. DBT skills are aimed directly at these dysfunctional patterns. The overall goal of DBT skills training is to help individuals change behavioral, emotional, thinking, and interpersonal patterns associated with problems in living. Therefore, understanding the treatment philosophy and theoretical underpinnings of DBT as a whole is critical for effective use of this manual. Such understanding is also important because it determines therapists' attitude toward treatment and their clients. This attitude, in turn, is an important component of therapists' relationships with their clients, which are often central to effective treatment and can be particularly important with suicidal and severely dysregulated individuals.

A Look Ahead

This manual is organized into two main parts. Part I (Chapters 1–5) orients readers to DBT and to DBT skills training in particular. Part II (Chapters 6–10) contains the detailed instructions for teaching the specific skills. The client handouts and worksheets for all of the skills modules can be found at a special website for this manual. They can be printed out for distribution to clients, and modified as necessary to fit a particular setting. A separate, printed volume of handouts and worksheets, ideal for client use, which has its own website where clients can print their own forms, is also available for purchase.

In the rest of this chapter, I describe the dialectical world view underpinning the treatment, and the assumptions inherent in such a view. The biosocial model of severe emotion dysregulation (including BPD) and its development are then described, as well as how variations on the model apply to difficulties in emotion regulation in general. As noted above, the DBT skills presented in this manual are specifically designed to address emotion dysregulation and its maladaptive consequences. Chapter 1 concludes with a brief overview of the research on standard DBT (individual psychotherapy, phone

coaching, consultation team, and skills training), as well as the research on DBT skills training minus the individual therapy component. In Chapters 2–5, I discuss practical aspects of skills training: planning skills training, including ideas for different skills curricula based on client population and the setting (Chapter 2); structuring session format and starting skills training (Chapter 3); DBT skills training treatment targets and procedures (Chapter 4); and applying other DBT strategies and procedures to behavioral skills training (Chapter 5). Together, these chapters set the stage for deciding how to conduct skills training in a particular clinic or practice. A set of Appendices to Part I consists of 11 different curricula for skills training programs.

In Part II, Chapter 6 begins the formal skills training component of DBT. It covers how to introduce clients to DBT skills training and orient them to its goals. Guidelines on how to teach specific skills then follow, grouped into four skills modules: Mindfulness Skills (Chapter 7), Interpersonal Effectiveness Skills (Chapter 8), Emotion Regulation Skills (Chapter 9), and Distress Tolerance Skills (Chapter 10).

Every skill has corresponding client handouts with instructions for practicing that skill. Every handout has at least one (usually more than one) associated worksheet for clients to record their practice of the skills. Again, all of these client handouts and worksheets can be found at the special Guilford website for this manual (see above for the URL), as well as in the separate volume. Descriptions of handouts and related worksheets are given in boxes at the start of each main section within the skill modules' teaching notes (Chapters 6–10).

I should note here that all skills training in our clinical trials was conducted in groups, although we do conduct individual skills training in my clinic. Many of the treatment guidelines in this manual assume that skills training is being conducted in groups, mainly because it is easier to adapt group skills training techniques for individual clients than vice versa. (The issue of group vs. individual skills training is discussed at some length in the next chapter.)

This manual is a companion to my more complete text on DBT, *Cognitive-Behavioral Treatment of Borderline Personality Disorder*.[3] Although DBT skills are effective for disorders other than BPD, the principles underlying the treatment are still important and are discussed fully there. Because I refer to that book often throughout this manual, from here on I simply call it "the main DBT text." The scientific underpinnings and references for many of my statements and positions are fully documented in Chapters 1–3 of that text; thus I do not review or cite them here again.

The Dialectical World View and Basic Assumptions

As its name suggests, DBT is based on a dialectical world view. "Dialectics" as applied to behavior therapy has two meanings: that of the fundamental nature of reality, and that of persuasive dialogue and relationship. As a world view or philosophical position, dialectics forms the basis of DBT. Alternatively, as dialogue and relationship, dialectics refers to the treatment approach or strategies used by the therapist to effect change. These strategies are described in full in Chapter 7 of the main DBT text and are summarized in Chapter 5 of this manual.

Dialectical perspectives on the nature of reality and human behavior share three primary characteristics. First, much as dynamic systems perspectives do, dialectics stresses the fundamental interrelatedness or wholeness of reality. This means that a dialectical approach views analyses of individual parts of a system as of limited value unless the analysis clearly relates the parts to the whole. Thus dialectics directs our attention to the individual parts of a system (i.e., one specific behavior), as well as to the interrelatedness of the part to other parts (e.g., other behaviors, the environmental context) and to the larger wholes (e.g., the culture, the state of the world at the time). With respect to skills training, a therapist must take into account first the interrelatedness of skills deficits. Learning one new set of skills is extremely difficult without learning other related skills simultaneously—a task that is even more difficult. A dialectical view is also compatible with both contextual and feminist views of psychopathology. Learning behavioral skills is particularly hard when a person's immediate environment or larger culture do not support such learning. Thus the individual must learn not only self-regulation skills and skills for influencing his or her environment, but also when to regulate them.

Second, reality is not seen as static, but as made up of internal opposing forces (thesis and antithesis) out of whose synthesis evolves a new set of opposing forces. A very important dialectical idea is that all propositions contain within them their own op-

positions. As Goldberg put it, "I assume that truth is paradoxical, that each article of wisdom contains within it its own contradictions, that *truths stand side by side*" (pp. 295–296, emphasis in original).[4] Dialectics, in this sense, is compatible with psychodynamic conflict models of psychopathology. Dichotomous and extreme thinking, behavior, and emotions are viewed as dialectical failures. The individual is stuck in polarities, unable to move to syntheses. With respect to behavioral skills training, three specific polarities can make progress extremely difficult. The therapist must pay attention to each polarity and assist each client in moving toward a workable synthesis.

The first of these polarities is the dialectic between the need for clients to accept themselves as they are in the moment and the need for them to change. This particular dialectic is the most fundamental tension in any psychotherapy, and the therapist must negotiate it skillfully if change is to occur.

The second is the tension between clients' getting what they need to become more competent, and losing what they need if they become more competent. I once had a client in skills training who every week reported doing none of the behavioral homework assignments and insisted that the treatment was not working. When after 6 months I suggested that maybe this wasn't the treatment for her, she reported that she had been trying the new skills all along and they *had* helped. However, she had not let me know about it because she was afraid that if she showed any improvement, I would dismiss her from skills training.

A third very important polarity has to do with clients' maintaining personal integrity and validating their own views of their difficulties versus learning new skills that will help them emerge from their suffering. If clients get better by learning new skills, they validate their view that the problem all along was that they did not have sufficient skills to help themselves. They have not been trying to manipulate people, as others have accused them of doing. They are not motivated to hurt others, and they do not lack positive motivation. But the clients' learning new skills may also seem to validate others' opinions in other ways: It may appear to prove that others were right all along (and the client was wrong), or that the client was the problem (not the environment). Dialectics not only focuses the client's attention on these polarities, but also suggests ways out of them. (Ways out are discussed in Chapter 7 of the main DBT text.)

The third characteristic of dialectics is an assumption, following from the two characteristics above, that the fundamental nature of reality is change and process rather than content or structure. The most important implication here is that both the individual and the environment are undergoing continuous transition. Thus therapy does not focus on maintaining a stable, consistent environment, but rather aims to help the client become comfortable with change. An example of this is that we discourage people from sitting in exactly the same seats in a skills training group for the whole time they are in the group. Within skills training, therapists must keep aware not only of how their clients are changing, but also of how they themselves and the treatment they are applying are changing over time.

Biosocial Theory: How Emotion Dysregulation Develops*

As noted earlier, DBT was originally developed for individuals who were highly suicidal, and secondarily for individuals who met criteria for BPD. Effective treatment, however, requires a coherent theory. My first task, therefore, was to develop a theory that would let me understand the act of suicide, as well as BPD. I had three criteria for my theory: It had to (1) guide treatment implementation, (2) engender compassion, and (3) fit the research data. The biosocial theory I developed was based on the premise that both suicide and BPD are, at their core, disorders of emotion dysregulation. Suicidal behavior is a response to unbearable emotional suffering. BPD is a severe mental disorder resulting from serious dysregulation of the affective system. Individuals with BPD show a characteristic pattern of instability in affect regulation, impulse control, interpersonal relationship, and self-image.

*The ideas discussed in this section on the biosocial theory in general (and the DBT model of emotions in particular) are not only drawn from the main DBT text, but also based on the following: Neacsiu, A. D., Bohus, M., & Linehan, M. M. (2014). Dialectical behavior therapy: An intervention for emotion dysregulation. In J. J. Gross (Ed.), *Handbook of emotion regulation* (2nd ed., pp. 491–507). New York: Guilford Press; and Crowell, S. E., Beauchaine, T. P., & Linehan, M. M. (2009). A biosocial developmental model of borderline personality: Elaborating and extending Linehan's theory. *Psychological Bulletin*, *135*(3), 495–510. Neacsiu et al. discuss emotion dysregulation as central to BPD and mental disorder, and Crowell et al. present an elaboration and extension of my original biosocial theory.

Emotion dysregulation has also been related to a variety of other mental health problems. Substance use disorders, eating disorders, and many other destructive behavioral patterns often function as escapes from unbearable emotions. Theorists have proposed that major depressive disorder should be conceptualized as an emotion dysregulation disorder, based partly on a deficit in up-regulating and maintaining positive emotions.[5] Similarly, literature reviews have demonstrated that anxiety disorders, schizophrenia, and even bipolar disorders are directly linked to emotion dysregulation.[6, 7]

The DBT Model of Emotions

To understand emotion dysregulation, we have to first understand what emotions actually are. Proposing any definition of the construct "emotion," however, is fraught with difficulty, and there is rarely agreement even among emotion researchers on any one concrete definition. That being said, teaching clients about emotions and emotion regulation requires some attempt at a description of emotions, if not an exact definition. DBT in general, and DBT skills in particular, are based on the view that emotions are brief, involuntary, full-system, patterned responses to internal and external stimuli.[8] Similar to others' views, DBT emphasizes the importance of the evolutionary adaptive value of emotions in understanding them.[9] Although emotional responses are systemic responses, they can be viewed as consisting of the following interacting subsystems: (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) nonverbal and verbal expressive responses and actions; and (6) aftereffects of the initial emotional "firing," including secondary emotions. It is useful to consider the patterned actions associated with emotional responses to be part and parcel of the emotional responses rather than consequences of the emotions. By combining all these elements into one interactional system, DBT emphasizes that modifying any component of the emotional system is likely to change the functioning of the entire system. In short, if one wants to change one's own emotions, including emotional actions, it can be done by modifying any part of the system.

Emotion Dysregulation

Emotion dysregulation is the inability, even when one's best efforts are applied, to change or regulate emotional cues, experiences, actions, verbal responses, and/or nonverbal expressions under normative conditions. Pervasive emotion dysregulation is seen when the inability to regulate emotions occurs across a wide range of emotions, adaptation problems, and situational contexts. Pervasive emotion dysregulation is due to vulnerability to high emotionality, together with an inability to regulate intense emotion-linked responses. Characteristics of emotion dysregulation include an excess of painful emotional experiences; an inability to regulate intense arousal; problems turning attention away from emotional cues; cognitive distortions and failures in information processing; insufficient control of impulsive behaviors related to strong positive and negative affect; difficulties organizing and coordinating activities to achieve non-mood-dependent goals during emotional arousal; and a tendency to "freeze" or dissociate under very high stress. It can also present as emotion overcontrol and suppression, which leads to pervasive negative affect, low positive affect, an inability to up-regulate emotions, and difficulty with affective communication. Systemic dysregulation is produced by emotional vulnerability and by maladaptive and inadequate emotion modulation strategies. Emotional vulnerability is defined by these characteristics: (1) very high negative affectivity as a baseline, (2) sensitivity to emotional stimuli, (3) intense response to emotional stimuli, and (4) slow return to emotional baseline once emotional arousal has occurred.

Emotion Regulation

Emotion regulation, in contrast, is the ability to (1) inhibit impulsive and inappropriate behavior related to strong negative or positive emotions; (2) organize oneself for coordinated action in the service of an external goal (i.e., act in a way that is not mood-dependent when necessary); (3) self-soothe any physiological arousal that the strong emotion has induced; and (4) refocus attention in the presence of strong emotion. Emotion regulation can be automatic as well as consciously controlled. In DBT, the focus is first on increasing conscious control, and second on eliciting sufficient practice to overlearn skills such that they ultimately become automatic.

Biological Vulnerabilities (the "Bio" in the Biosocial Theory)[10]*

Dispositions to negative affectivity, high sensitivity to emotion cues, and impulsivity are biologically based precursors to emotion dysregulation. The biological influences include heredity, intrauterine factors, childhood or adulthood physical insults affecting the brain, and the effects of early learning experiences on both brain development and brain functioning. A dysfunction in any part of the extremely complex human emotion regulation system can provide the biological basis for initial emotional vulnerability and subsequent difficulties in emotion modulation. Thus the biological disposition may be different in different people.

Two dimensions of infant temperament, effortful control and negative affectivity, are particularly relevant here. Effortful control, which contributes to both emotional and behavioral regulation, is a general term for a number of self-regulation behaviors (including inhibiting dominant responses to engage in less dominant responses, planning, and detecting errors in behavior). Children at risk for pervasive emotion dysregulation and behavioral dyscontrol are likely to be low on effortful control and high on negative affectivity, which is characterized by discomfort, frustration, shyness, sadness, and inability to be soothed.

The Caregiving Environment (the "Social" in the Biosocial Theory)

The contributions of the social environment, particularly the family, include (1) a tendency to invalidate emotions and an inability to model appropriate expressions of emotion, (2) an interaction style that reinforces emotional arousal; and (3) a poor fit between the child's temperament and the caregivers' parenting style. This final point is emphasized here because it highlights the biology × environment transactions that shape both child and caregiver behaviors. In theory, a child with low biological vulnerability may be at risk for BPD and/or high emotion dysregulation if there is an extreme discrepancy between child and caregiver characteristics, or if the family's resources are extremely taxed (e.g., by a family member's alcoholism or a sibling with cancer). Such situations have the potential to perpetuate invalidation, because the demands of the child often exceed the ability of the environment to meet those demands.

The converse is also likely: A biologically vulnerable child may be resilient in a well-matched environment where strong family supports are in place. Such differential outcomes led me to propose three primary types of families that increase risk for BPD: the disorganized family (e.g., one that is pervasively neglectful or maltreating); the perfect family (e.g., one where expressing negative emotions is taboo), and the normal family (one characterized primarily by poorness of fit). Importantly, caregiver characteristics are not necessarily fixed or preexisting. Rather, the caregiver is also a product of complex biological, social, and psychological transactions, including evocative effects of the child on parenting style.

The Role of the Invalidating Environment

The role of invalidation in the development of emotion dysregulation makes a lot of sense, once you realize that a primary function of emotions in humans (as well as other mammals) is to serve as a rapid communication system. Invalidation of emotions sends the message that the communication was not received. When the message is important, the sender understandably escalates the communication by escalating the emotion. When the receiver does not "get" the communication or disbelieves it, he or she understandably increases efforts to stop the communication, usually by some means of invalidation. And so it goes, around and around, escalating on both sides until one side backs down. It is often the receiver who finally stops and listens or gives in to the demands of the highly emotional sender. Ergo, escalation has been reinforced. When this continues intermittently, the pattern of escalated emotion dysregulation is cemented.

Such an environment is particularly damaging for a child who begins life with high emotional vulnerability. The emotionally vulnerable and reactive individual elicits invalidation from an environment that might have otherwise been supportive. A defining characteristic of an invalidating environment is the

*The "Biological Vulnerabilities (the "Bio" in the Biosocial Theory)" section is adapted from Crowell, S. E., Beauchaine, T. P., & Linehan, M. M. (2009). A biosocial developmental model of borderline personality: Elaborating and extending Linehan's theory. *Psychological Bulletin*, *135*(3), 495–510. Copyright 2009 by the American Psychological Association. Adapted by permission.

tendency to respond erratically and inappropriately to private experience (e.g., beliefs, thoughts, feelings, sensations), and in particular to be insensitive to private experience that does not have public accompaniments. Invalidating environments also tend to respond in an extreme fashion (i.e., to over- or underreact) to private experiences that do have public accompaniments. Phenomenological, physiological, and cognitive components of emotions are prototypic private experiences that lead to invalidation in these settings. To clarify the invalidating environment's contribution to emotionally dysregulated behavioral patterns, let us contrast it to environments that foster more adaptive emotion regulation skills.

In the optimal family, public validation of private experience is given frequently. For example, when a child says, "I'm thirsty," parents give him or her a drink (rather than saying, "No, you're not. You just had a drink"). When a child cries, parents soothe the child or attempt to find out what is wrong (rather than saying, "Stop being a crybaby!"). When a child expresses anger or frustration, family members take it seriously (rather than dismissing it as unimportant). When the child says, "I did my best," the parent agrees (rather than saying, "No, you didn't"). And so on. In the optimal family, the child's preferences (e.g., for color of room, activities, or clothes) are taken into account; the child's beliefs and thoughts are elicited and responded to seriously; and the child's emotions are viewed as important communications. Successful communication of private experience in such a family is followed by changes in other family members' behavior. These changes increase the probability that the child's needs will be met and decrease the probability of negative consequences. Parental responding that is attuned and is not aversive results in children who are better able to discriminate their own and others' emotions.

By contrast, an invalidating family is problematic because the people in it respond to the communication of preferences, thoughts, and emotions with nonattuned responses—specifically, with either nonresponsiveness or extreme consequences. This leads to an intensification of the differences between an emotionally vulnerable child's private experience and the experience the social environment actually supports and responds to. Persistent discrepancies between a child's private experience and what others in the environment describe as the child's experience provide the fundamental learning environment necessary for many of the behavioral problems associated with emotion dysregulation.

In addition to early failures to respond optimally, an invalidating environment more generally emphasizes controlling emotional expressiveness, especially the expression of negative affect. Painful experiences are often trivialized and attributed to negative traits, such as lack of motivation, lack of discipline, and failure to adopt a positive attitude. Strong positive emotions and associated preferences may be attributed to other negative traits, such as lack of judgment and reflection or impulsivity. Other characteristics of the invalidating environment include restricting the demands a child may make upon the environment, discriminating against the child on the basis of gender or other arbitrary characteristics, and using punishment (from criticism up to physical and sexual abuse) to control behavior.

The invalidating environment contributes to emotion dysregulation by failing to teach the child to label and modulate arousal, to tolerate distress, or to trust his or her own emotional responses as valid interpretations of events. It also actively teaches the child to invalidate his or her own experiences by making it necessary for the child to scan the environment for cues about how to act and feel. By oversimplifying the ease of solving life's problems, it fails to teach the child how to set realistic goals. Moreover, by punishing the expression of negative emotion and erratically reinforcing emotional communication only after escalation by the child, the family shapes an emotional expression style that vacillates between extreme inhibition and extreme disinhibition. In other words, the family's usual response to emotion cuts off the communicative function of ordinary emotions.

Emotional invalidation, particularly of negative emotions, is an interaction style characteristic of societies that put a premium on individualism, including individual self-control and individual achievement. Thus, it is quite characteristic of Western culture in general. A certain amount of invalidation is, of course, necessary in raising a child and teaching self-control. Not all communications of emotions, preferences, or beliefs can be responded to in a positive fashion. The child who is highly emotional and who has difficulty controlling emotional behaviors will elicit from the environment (especially parents, but also friends and teachers) the greatest efforts to control the emotionality from the outside. Invalidation can be quite effective at temporarily inhibiting emotional expression. Invalidating environments, however, have different effects on different children. The emotion control strategies used in invalidating

families may have little negative impact on children who are physiologically well equipped to regulate their emotions, or may even be useful to some such children. However, such strategies are hypothesized to have a devastating impact on emotionally vulnerable children.

This transactional view of the development of pervasive emotion dysregulation generally should not be used to diminish the importance of trauma in the etiology of BPD and emotion dysregulation. Researchers have estimated that up to 60–75% of individuals with BPD have histories of childhood trauma,[11, 12] and many continue to experience further trauma during adulthood.[13, 14] In one study, researchers found that 90% of inpatients with BPD reported some experience of adult verbal, emotional, physical, and/or sexual abuse, and that these rates of adult abuse were significantly higher than those reported by comparison participants with Axis II disorders other than BPD.[14] It is unclear, however, whether the trauma in and of itself facilitates the development of BPD and of high emotion dysregulation patterns, or whether the trauma and the development of the disorder both result from the extant familial dysfunction and invalidation. In other words, the occurrence of victimization and emotion regulation problems may arise from the same set of developmental circumstances.

Development of Emotion Dysregulation: Summary

Emotion dysregulation in general, as well as the dysregulation encountered in BPD specifically, is an outcome of biological disposition, environmental context, and the transaction between the two during development. The biosocial developmental model proposes the following: (1) The development of extreme emotional lability is based on characteristics of the child (e.g., baseline emotional sensitivity, impulsivity), in transaction with a social context that shapes and maintains the lability; (2) reciprocal reinforcing transactions between biological vulnerabilities and environmental risk factors increase emotion dysregulation and behavioral dyscontrol, which contribute to negative cognitive and social outcomes; (3) a constellation of identifiable features and maladaptive coping strategies develops over time; and (4) these traits and behaviors may exacerbate risk for pervasive emotion dysregulation across development, due to evocative effects on interpersonal relationships and social functioning, and via interference with healthy emotional development. This model is illustrated in Figure 1.1.

The Consequences of Emotion Dysregulation

Maccoby has argued that the inhibition of action is the basis for the organization of all behavior.[15] The development of self-regulatory repertoires (as in effortful control, described above), especially the ability to inhibit and control affect, is one of the most important aspects of a child's development. The ability to regulate the experience and expression of emotion is crucial, because its absence leads to the disruption of behavior, especially goal-directed behavior and other prosocial behavior. Alternatively, strong emotion reorganizes or redirects behavior, preparing the individual for actions that compete with the nonemotionally or less emotionally driven behavioral repertoire.

The behavioral characteristics of individuals meeting criteria for a wide range of emotional disorders, can be conceptualized as the effects of emotion dysregulation and maladaptive emotion regulation strategies. Impulsive behavior, and especially self-injurious and suicidal behaviors, can be thought of as maladaptive but highly effective emotion regulation strategies. For example, overdosing usually leads to long periods of sleep, which in turn reduce susceptibility to emotion dysregulation. Although the mechanism by which self-mutilation exerts affect-regulating properties is not clear, it is very common for individuals engaging in such behavior to report substantial relief from anxiety and other intense negative emotional states following such acts. Suicidal behavior is also very effective in eliciting helping behaviors from the environment, which may be effective in avoiding or changing situations that elicit emotional pain. For example, suicidal behavior is generally the most effective way for a nonpsychotic individual to be admitted to an inpatient psychiatric unit. Suicide ideation, suicide planning, and imagining dying from suicide, when accompanied with a belief that pain will end with death, can bring an intense sense of relief. Finally, planning suicide, imagining suicide, and engaging in a self-injurious act (and its aftereffects if it becomes public) can reduce painful emotions by providing a compelling distraction.

The inability to regulate emotional arousal also interferes with the development and maintenance

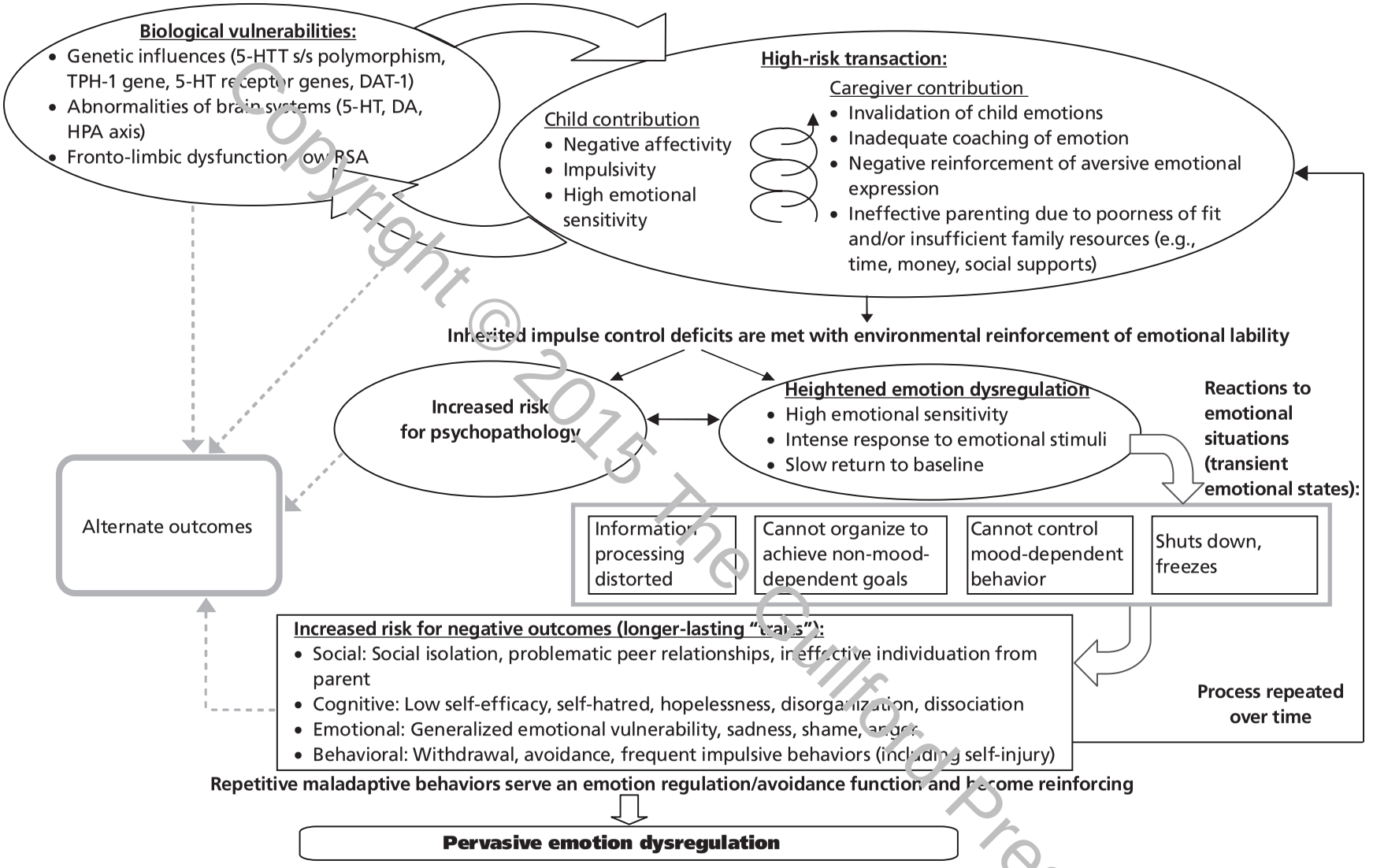

FIGURE 1.1. Illustration of the biosocial developmental model of BPD. 5-HT, serotonin; 5-HTT, serotonin transporter; TPH-1, tryptophan hydroxylase 1; DA, dopamine; DAT-1, dopamine transporter 1; HPA, hypothalamic–pituitary–adrenocortical; RSA, respiratory sinus arrhythmia. Adapted from Crowell, S. E., Beauchaine, T. P., & Lenzenweger, M. F. (2008). The development of borderline personality and self-injurious behavior. In T. P. Beauchaine & S. Hinshaw (Eds.), *Child psychopathology* (p. 528). Hoboken, NJ: Wiley. Copyright 2008 by John Wiley & Sons, Inc. Adapted by permission.

of a sense of self. Generally, one's sense of self is formed by observations of oneself and of others' reactions to one's actions. Emotional consistency and predictability, across time and similar situations, are prerequisites of identity development. Unpredictable emotional lability leads to unpredictable behavior and cognitive inconsistency, and consequently interferes with identity development. The tendency of dysregulated individuals to try to inhibit emotional responses may also contribute to an absence of a strong sense of identity. The numbness associated with inhibited affect is often experienced as emptiness, further contributing to an inadequate and at times completely absent sense of self. Similarly, if an individual's sense of events is never "correct" or is unpredictably "correct"—the situation in an invalidating environment—then the individual may be expected to develop an overdependence on others.

Effective interpersonal relationships depend on both a stable sense of self and a capacity for spontaneity in emotional expression. Successful relationships also require a capacity for self-regulation of emotions and tolerance of emotionally painful stimuli. Without such capabilities, it is understandable that individuals develop chaotic relationships. When emotion dysregulation is pervasive or severe, it interferes with a stable sense of self and with normal emotional expression. Difficulties controlling impulsive behaviors and expressions of extreme negative emotions can wreak havoc on relationships in many ways; in particular, difficulties with anger and anger expression preclude the maintenance of stable relationships.

Relationship of Emotion Dysregulation to DBT Skills Training[16]

As noted above, many mental disorders can be conceptualized as disorders of emotion regulation, with deficits in both up- and down-regulation. Once you realize that emotions include both actions and action tendencies, you can see the link between emotion dysregulation and many disorders defined as behavior dyscontrol (e.g., substance use disorders). DBT skills are aimed directly at these dysfunctional patterns.

First, dysregulation of the sense of self is common in individuals with severe emotion dysregulation. In both depression and BPD, for example, it is not unusual for individuals to report having no sense of a self at all, feeling empty, and not knowing who they are. Feelings of being disconnected from others, of contempt for self, and of invalidity or worthlessness are also common. In addition, individuals with high emotion dysregulation often view reality through the lens of their emotions, rather than the light of reality as it is. Thus both judgmental responses and distorted inferences, assumptions, and beliefs are common sequelae. To address such dysregulation of the sense of self, the first DBT skills training module (Chapter 7) aims to teach a core set of "mindfulness" skills—that is, skills having to do with the ability to consciously experience and observe oneself and surrounding events with curiosity and without judgment; to see and articulate reality as it is; and to participate in the flow of the present moment effectively. To address the impact of high emotionality, mindfulness skills also focuses on observing and accurately describing internal and external present events without judgment or distortion of reality. Mindfulness skills are core to all subsequent skills, and thus are reviewed at the beginning of each subsequent skills module.

Second, individuals with emotion dysregulation often experience interpersonal dysregulation. For example, they may have chaotic and intense relationships marked with difficulties. Nevertheless, they may find it extremely hard to let go of such relationships; instead, they may engage in intense and frantic efforts to keep significant individuals from leaving them. More so than most, these individuals seem to do well when they are in stable, positive relationships and to do poorly when they are not in such relationships. Problems with anger and jealousy can ruin intimate relationships and friendships; envy and shame can lead to avoidance of others. A highly anxious individual may need to have a partner around all the time as a safety behavior. In contrast, severe depression may cause difficulties connecting or engaging in relationships. Thus another DBT skills training module (Chapter 8) aims to teach interpersonal effectiveness skills.

Third, difficulties with emotion dysregulation are common in many disorders. These difficulties include problems with recognizing emotions, with describing and labeling emotions, with emotional avoidance, and with knowing what to do when an emotion is on the scene. Therefore, a third DBT skills training module (Chapter 9) aims to teach these and other emotion regulation skills.

Fourth, individuals with high emotion dysregulation often have patterns of behavior dysregulation, such as substance misuse, attempts to injure or kill

themselves, and other problematic impulsive behaviors. Impulsive and suicidal behaviors are viewed in DBT as maladaptive problem-solving behaviors resulting from an individual's inability to tolerate emotional distress long enough to pursue potentially more effective solutions. To counter these maladaptive problem-solving and distress tolerance behaviors, a fourth DBT skills training module (Chapter 10) aims to teach effective, adaptive distress tolerance skills.

Table 1.1 lists the specific skills in each of these modules.

TABLE 1.1. Overview of Specific DBT Skills by Module

Mindfulness Skills

- Core mindfulness skills
  - Wise mind (states of mind)
  - "What" skills (observe, describe, participate)
  - "How" skills (nonjudgmentally, one-mindfully, effectively)
- Other Perspectives on Mindfulness
  - Mindfulness practice: A spiritual perspective (including wise mind and practicing loving kindness)
  - Skillful means: Balancing doing mind and being mind
  - Wise mind: Walking the middle path

Interpersonal Effectiveness Skills

- Obtaining objectives skillfully
  - Clarifying priorities
  - Objectives effectiveness
    - DEAR MAN (Describe, Express, Assert, Reinforce; stay Mindful, Appear confident, Negotiate)
  - Relationship effectiveness
    - GIVE (be Gentle, act Interested, Validate, use an Easy manner)
  - Self-respect effectiveness
    - FAST (be Fair, no Apologies, Stick to values, be Truthful)
  - Whether and how intensely to ask or say no
- Supplementary interpersonal effectiveness skills
  - Building relationships and ending destructive ones
    - Skills for finding potential friends
    - Mindfulness of others
    - How to end relationships
  - Walking the middle path skills
- Dialectics
- Validation
- Behavior change strategies

Emotion Regulation Skills

- Understanding and naming emotions
- Changing emotional responses
  - Checking the facts
  - Opposite action
  - Problem solving
- Reducing vulnerability to emotion mind
  - ABC PLEASE (Accumulate positive emotions, Build mastery, Cope ahead; treat PhysicaL illness, Balance Eating, avoid mood-Altering substances, balance Sleep, get Exercise)
- Managing really difficult emotions
  - Mindfulness of current emotions
  - Managing extreme emotions

Distress Tolerance Skills

- Crisis survival skills
  - STOP skill
  - Pros and cons
  - TIP body chemistry
    - (Temperature, Intense exercise, Paced breathing, Paired muscle relaxation)
  - Distracting with wise mind ACCEPTS
    - (Activities, Contributing, Comparisons, Emotions, Pushing away, Thoughts, Sensations)
  - Self-soothing through the senses
    - (vision, hearing, smell, taste, touch; body scan)
  - IMPROVE the moment
    - (Imagery, Meaning, Prayer, Relaxation, One thing in the moment, Vacation, Encouragement)
- Reality acceptance skills
  - Radical acceptance
  - Turning the mind
  - Willingness
  - Half-smiling
  - Willing hands
  - Mindfulness of current thoughts
- Supplementary distress tolerance skills when the crisis is addiction:
  - Dialectical abstinence
  - Clear mind
  - Community reinforcement
  - Burning bridges and building new ones
  - Alternative Rebellion and adaptive denial

The Standard DBT Treatment Program

DBT was originally created for high-risk, multiple-diagnosis clients with pervasive, severe emotion dysregulation; the clinical problems presented by these clients were complicated. It was clear from the beginning that treatment had to be flexible and based on principles, rather than tightly scripted with one protocol to fit all clients. To give some clarity and structure to the inherent flexibility built into the treatment, DBT was constructed as a modular intervention, with components that can be dropped in and pulled out as the needs of each client and the structure of the treatment dictate.

Treatment Functions

DBT clearly articulates the functions of treatment that it is designed: (1) to enhance an individual's capability by increasing skillful behavior; (2) to improve and maintain the client's motivation to change and to engage with treatment; (3) to ensure that generalization of change occurs through treatment; (4) to enhance a therapist's motivation to deliver effective treatment; and (5) to assist the individual in restructuring or changing his or her environment in such a way that it supports and maintains progress and advancement toward goals (see Figure 1.2).

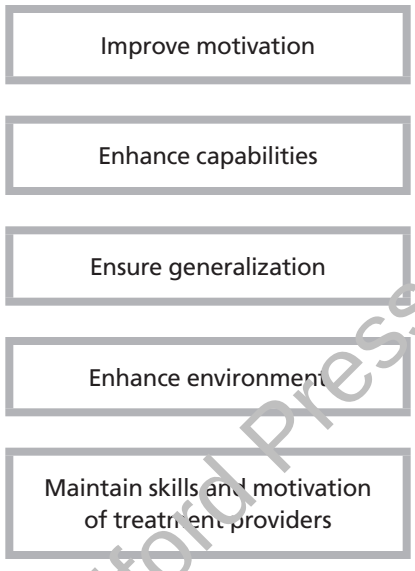

FIGURE 1.2. Functions of comprehensive treatment. Adapted from Lungu, A., & Linehan, M. M. (2015). Dialectical behaviour therapy: A comprehensive multi- and trans-diagnostic intervention. In A. Nezu & C. Nezu (Eds.), *The Oxford handbook of cognitive behavioural therapies*. New York: Oxford University Press. Copyright 2014 by The Guilford Press. Adapted by permission of The Guilford Press and Oxford University Press.

Treatment Modes

To accomplish these functions effectively, treatment is spread among a variety of modes: individual therapy or case management, group or individual skills training, between-session skills coaching, and a therapist consultation team (see Figure 1.3). Each of the modes has different treatment targets, and also different strategies available for reaching those targets. It is not the mode itself that is critical, but its ability to address a particular function. For example, ensuring that new capabilities are generalized from therapy to a client's everyday life might be accomplished in various ways, depending on the setting. In a milieu setting, the entire staff might be taught to model, coach, and reinforce use of skills; in an outpatient setting, generalization usually occurs through telephone coaching. The individual therapist (who is always the primary therapist in standard DBT), together with the client, is respon-

FIGURE 1.3. Modularity of treatment modes. Adapted from Lungu, A., & Linehan, M. M. (2015). Dialectical behaviour therapy: A comprehensive multi- and trans-diagnostic intervention. In A. Nezu & C. Nezu (Eds.), *The Oxford handbook of cognitive behavioural therapies*. New York: Oxford University Press. Copyright 2014 by The Guilford Press. Adapted by permission of The Guilford Press and Oxford University Press.

sible for organizing the treatment so that all functions are met.

DBT Skills Modules

The skills taught to clients reflect a key dialectic described earlier—the need for clients to accept themselves as they are, and the need for them to change. Hence there are sets of acceptance skills as well as change skills. For any problem encountered, effective approaches can include acceptance as well as change (see Figure 1.4). Skills are further divided into the four skills modules by the topics they address: mindfulness, emotion regulation, interpersonal effectiveness, and distress tolerance. Each skills module is further divided into a series of sections, and then further divided into a series of separate skills that are ordinarily taught in sequence but can also be pulled out separately for teaching and review. Clients can work on a single skill or set of skills at a time; this helps keep them from being overwhelmed by all the things they need to learn and change. Once clients have made progress in a set of skills, they can incorporate those skills into work on a new skills module. Some of the more complex skills, such as the interpersonal assertiveness skills (i.e., the "DEAR MAN" skills described in Chapter 8), are also made up of smaller parts to increase comprehension and accessibility.

Roles of Skills Trainer and Individual Therapist

As described earlier in this chapter, the theoretical model on which DBT is based posits that a combination of capability deficits and motivational problems underlies emotion dysregulation. First, individuals with severe and pervasive emotion dysregulation, including those with BPD, lack important self-regulation, interpersonal, and distress tolerance skills. In particular, they are unable to inhibit maladaptive mood-dependent behaviors, or to initiate behaviors that are independent of current mood and necessary to meet long-range goals. Second, the strong emotions and associated dysfunctional beliefs learned in the original invalidating environment, together with current invalidating environments, form a motivational context that inhibits the use of any behavioral skills a person does have. The person is also often reinforced for inappropriate and dysfunctional behaviors. Therefore, attention needs to be paid to increasing both a person's repertoire of skills and his or her motivation to employ those skills. However, as my colleagues and I developed this treatment approach, it quickly became apparent that (1) behavioral skills training to the extent we believe necessary is extraordinarily difficult, if not impossible, within the context of a therapy oriented to reducing the motivation to die and/or act in a highly

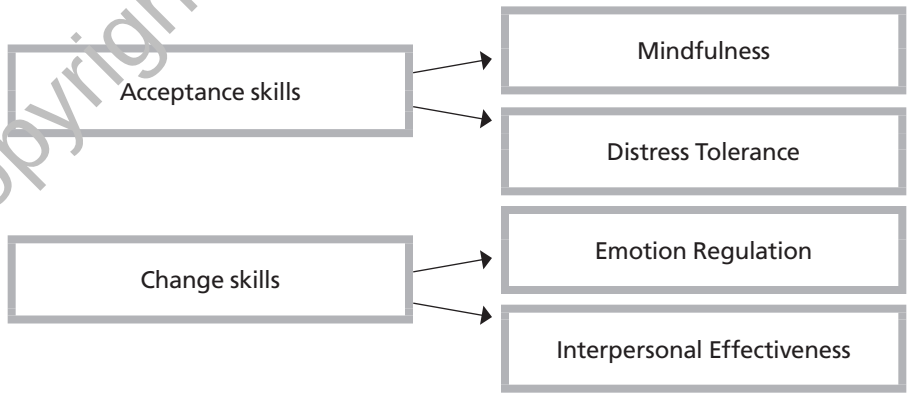

FIGURE 1.4. Modularity of acceptance and change skills. Adapted from Lungu, A., & Linehan, M. M. (2015). Dialectical behaviour therapy: A comprehensive multi- and trans-diagnostic intervention. In A. Nezu & C. Nezu (Eds.), *The Oxford handbook of cognitive behavioural therapies*. New York: Oxford University Press. Copyright 2014 by The Guilford Press. Adapted by permission of The Guilford Press and Oxford University Press.

emotionally reactive fashion; and (2) sufficient attention to motivational issues cannot be given in a treatment with the rigorously controlled therapy agenda needed for skills training. From this dilemma was born the idea of splitting the therapy into two components: one that focuses primarily on behavioral skills training, and one that focuses primarily on motivational issues (including the motivation to stay alive, to replace dysfunctional behaviors with skillful behaviors, and to build a life worth living).

The role of the skills trainer in standard outpatient DBT with severely dysregulated clients is to increase clients' abilities by teaching DBT skills and eliciting practice. The role of the individual therapist is to manage crises and help a client to apply the skills he or she is learning to replace dysfunctional behaviors. The individual therapist provides telephone coaching of skills to the client as needed. Furthermore, as noted above and in Figure 1.3, an integral component of standard DBT is the therapist consultation team: Skills trainers and individual therapists meet on a regular basis not only to support each other, but also to provide a dialectical balance for each other in their interactions with clients.

Individual therapy for chronically suicidal individuals and others with severe disorders may be needed for several reasons. First, with a group of serious and imminently suicidal clients, it can at times be extraordinarily difficult for the skills trainers to handle the crisis calls that might be needed. The caseload is simply too large. Second, in a skills-oriented group that meets only once a week, there is not much time to attend to individual process issues that may come up. Nor is there time to adequately help each individual integrate the skills into his or her life. Some clients need much more time than others do on particular skills, and the need to adjust the pace to the average needs makes it very likely that without outside attention, individuals will fail to learn at least some of the skills.

What kind of individual psychotherapy works best with skills training? Our research findings to date are mixed. In our first study on the topic, we found that skills training plus DBT individual therapy is superior to skills training plus non-DBT individual therapy.[17] In a second study, we tested skills training plus a version of intensive case management that may also be effective for some clients, whereas for others standard DBT with DBT individual therapy may be better.[18] In DBT, "case management" refers to helping the client manage his or her physical and social environment so that overall life functioning and well-being are enhanced, progress toward life goals is facilitated, and treatment progress is expedited.[3] Clients' individual therapists often can serve as case managers, helping the clients to interact with other professionals or agencies, as well as to cope with problems of survival in the everyday world. In this study, however, case management replaced individual DBT therapy. In this version of case management, caseloads were very small (six clients). Case managers met weekly with their teams; used the DBT Suicidal Behavior Strategies Checklist (see Chapter 5, Table 5.2); were available for phone coaching of clients during work hours, and had access to a community crisis line at other times; and applied many of the acceptance elements of DBT (validation, environmental intervention) that balanced the change focus of many DBT skills.

Therapists conducting skills training, however, may not always have control over the type of individual psychotherapy their clients get. This is especially likely in community mental health settings and inpatient or residential units. In settings where DBT is just being introduced, there may not be enough DBT individual therapists to go around. Or a unit may be trying to integrate different approaches to treatment. For example, a number of psychiatric inpatient units have attempted an integration of DBT skills training with individual psychodynamic therapy. Acute inpatient units may structure psychosocial treatment primarily around milieu and skills training, with individual therapy consisting of supportive therapy as an adjunct to pharmacotherapy. The next chapter discusses issues for skills trainers in managing non-DBT individual therapists.

Modifications of Cognitive and Behavior Therapy Strategies in DBT

DBT as a whole and DBT skills training in particular apply a broad array of cognitive and behavior therapy strategies. Like standard cognitive-behavioral therapy (CBT) programs, DBT emphasizes ongoing assessment and data collection on current behaviors; clear and precise definition of treatment targets; and active collaboration between the therapist and the client, including attention to orienting the client to the intervention and obtaining mutual commitment to treatment goals. Many components of DBT (e.g., problem solving, skills training, contingency management, exposure, and cognitive modification) have been prominent in cognitive and behavior therapies for years.

Although DBT borrows many principles and procedures from standard cognitive and behavioral therapies, the development and evolution of DBT over time came about as I tried—and in many ways failed—to get standard CBT to work with the population of clients I was treating. Each modification I made came about as I was trying to solve specific problems I could not solve with the standard CBT interventions available at the time. These modifications have led to DBT's emphasizing 10 areas that, though not new, had not previously received as much attention in traditional CBT applications. The treatment components that DBT has added to CBT are listed below. Many, if not most, of these are now common in many CBT interventions.

1. Synthesis of acceptance with change.
2. Inclusion of mindfulness as a practice for therapists and as a core skill for clients.
3. Emphasis on treating therapy-interfering behaviors of both client and therapist.
4. Emphasis on the therapeutic relationship and therapist self-disclosure as essential to therapy.
5. Emphasis on dialectical processes.
6. Emphasis on stages of treatment, and on targeting behaviors according to severity and threat.
7. Inclusion of a specific suicide risk assessment and management protocol.
8. Inclusion of behavioral skills drawn primarily from other evidence-based interventions.
9. The treatment team as an integral component of therapy.
10. Focus on continual assessment of multiple outcomes via diary cards.

Whether these differences between DBT and standard CBT approaches are fundamentally important is, of course, an empirical question. In any event, CBT interventions have expanded their scope since DBT first appeared, and components of DBT have made their way into many standard interventions. The differences between them and DBT have eroded. This is most clearly evident in the increasing attention to the synthesis of acceptance and change and to the inclusion of mindfulness in many current treatments (e.g., Mindfulness-Based Cognitive Therapy, Acceptance and Commitment Therapy); it can also be seen in the emphasis on attending to in-session behaviors, particularly to therapy-interfering behaviors (e.g., Functional Analytic Psychotherapy). Although researchers to date have not found that the therapeutic relationship necessarily mediates outcomes in behavior therapy, the field as a whole nonetheless puts a greater emphasis now on developing and maintaining a collaborative interpersonal relationship. Chapters 4 and 5 discuss the DBT strategies listed above, as well as how to apply CBT strategies within DBT's skills training context.

Effectiveness of Standard DBT

An overview of randomized controlled trials (RCTs) examining the effectiveness of standard DBT is presented in Table 1.2. As noted previously, standard DBT includes individual DBT therapy, DBT skills training, between-session coaching, and DBT team. For updates on research go to the Linehan Institute (*www.linehaninstitute.org/resources/fromMarsha*).

Standard DBT as a Treatment for BPD

There have now been a large number of studies evaluating the effectiveness of standard DBT as a treatment for high-risk individuals with severe and complex mental disorders. Most but not all of this research has focused on individuals meeting criteria for BPD—primarily because individuals with BPD have high rates of suicide and pervasive emotion dysregulation, and ordinarily present with a complex range of serious out-of-control behaviors. It is just the complexity that arises from such dysregulation that DBT was originally designed to treat. At present DBT is the only treatment with enough high-quality research to be evaluated as effective for this population by the Cochrane Database of Systematic Reviews, a highly regarded independent review group in Great Britain.[19]

Standard DBT as a Treatment for Suicidal Behaviors

In adults diagnosed with BPD and at risk for suicide, standard DBT has yielded significantly higher improvements on measures of anger outbursts, hopelessness, suicidal ideation, and suicidal behavior, as well as reduced admissions to emergency departments and inpatient units for suicidality, when compared to treatment as usual (TAU)[1, 17, 20, 21, 22, 23, 24] and to treatment by community experts.[23, 25] In the latter study, the expert therapists were nominated by mental health leaders in Seattle as the best

TABLE 1.2. RCTs of Standard DBT

Treatment/diagnosis/study population	Comparison group	Significant outcomes
DBT for BPD: **44** females	Treatment as usual (TAU)	**DBT decreased** risk for suicidal behavior, use of services, dropout **DBT and TAU decreased** suicidal ideation, depression, hopelessness[1, 17, 65]
DBT for BPD: **58** females	TAU	**DBT decreased** suicide attempts **DBT decreased** nonsuicidal self-injury (NSSI); **TAU increased** NSSI **DBT and TAU decreased** substance use[2, 3]
DBT for BPD: **101** females	Community treatment by experts (CTBE)	**DBT decreased** suicide attempts, emergency department and inpatient admissions for suicidality, dropout **DBT produced** significant reduction in substance use disorders; significant changes in self-affirmation, self-loving, and self-protecting; and less self-attacking throughout treatment and follow-up **DBT and CTBE decreased** suicidal ideation, depression **DBT and CTBE increased** remission from major depression, anxiety, and eating disorders **CTBE produced** significant treatment interaction for therapist affirmation/therapist projection **DBT increased** introject affiliation[42]
DBT for BPD: **73** females	TAU + wait list	**DBT and TAU decreased** NSSI, hospital admissions or length of stay in hospital, quality of life, disability[64]
DBT for veterans with BPD: **20** females	TAU	**DBT decreased** NSSI, hospitalizations, suicidal ideation, dissociation, hopelessness, depression, anger suppression/expression[22]
DBT for veterans with BPD: **20** females	TAU	**DBT decreased** NSSI, suicidal ideation, depression (self-report), hopelessness, anger expression **DBT and TAU decreased** service use, depression, anxiety, anger suppression[23]
DBT for BPD with current drug dependence: **28** females	TAU	**DBT decreased** substance abuse **DBT and TAU decreased** anger outcomes[34]
DBT + levo-alpha-acetyl-methadol (LAAM; an opioid agonist medication) for BPD with current opiate dependence: **23** females	Comprehensive validation therapy with 12-Step group (CVT-12s) + LAAM	**DBT and CVT-12s decreased** psychopathology, opiate use; however, participants in CVT-12s increased their use of opiates in last 4 months[35]
DBT for Cluster B personality disorders: **42** adults	TAU	**DBT decreased** self-reported risk behavior **DBT and TAU decreased** NSSI reductions, use of services, aggression anger expression, depression, irritability[24]
DBT + medication for at least one personality disorder, high depression score: **35** adults	Medication only	**DBT produced faster** remission from major depressive disorder[37]
DBT for BPD: **180** adults	General psychiatric management (GPM)	**DBT and GPM decreased** suicidal behavior, use of crisis services, depression, anger, distress symptoms[66]

(*cont.*)

TABLE 1.2 (*cont.*)

Treatment/diagnosis/study population	Comparison group	Significant outcomes
DBT for 18- to 25-year-old college students with current suicidal ideation: **63** individuals	Supervision by experts in psychodynamic treatment (SBE)	**DBT decreased** NSSI, use of psychotropic medication, suicidality, self-reported depression **DBT increased** life satisfaction[31]
Inpatient DBT for PTSD: **74** females	TAU + wait list	**DBT increased** PTSD remission[32]
Inpatient DBT for BPD: **60** females	TAU + wait list	**DBT increased** abstinence from NSSI, decreased depression and anxiety **DBT and TAU decreased** anger[26]
DBT for any eating disorder and substance abuse/dependence: **21** females	TAU	**DBT decreased** dropout rate, dysfunctional eating behaviors/attitudes and severity of use of substances at post compared to pre **DBT increased** ability to cope and regulate negative emotions at post compared to pre[33]

Note. Data from Neacsiu, A. D., & Linehan, M. M. (2014). Borderline personality disorder. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders* (5th ed., pp. 394–461). New York: Guilford Press.

(nonbehavioral) therapists in the area. The aim of the research was to find out whether DBT works because of its own unique characteristics or because it is just a standard good therapy. In other words, the question was "Are all treatments equal?" The answer was "No." In comparison to treatment by community experts, DBT cut suicide attempts by half, admissions to hospital emergency departments for suicidality by half, and inpatient admissions for suicidality by 73%. Bohus and colleagues obtained similar findings for a 12-week inpatient DBT adaptation for females with BPD and a history of suicidal behavior.[26] More patients receiving DBT abstained from self-injurious behaviors at posttreatment than patients receiving TAU (62% vs. 31%).

Standard DBT as a Treatment for Mood and Other Disorders

Among individuals meeting criteria for BPD, outcomes across DBT studies indicate that DBT is an effective treatment for a number of disorders other than BPD. During 1 year of treatment, those in DBT have improved significantly in reductions of depression, with remission rates from major depression and substance dependence as good as those found in evidence-based CBT and pharmacological interventions.[27] DBT participants also reported significant improvements in developing a more positive inner object (a psychodynamic construct we measured to test the view that DBT only treats symptoms). Those in DBT developed significantly greater self-affirmation, self-love, and self-protection, as well as less self-attack, during the course of treatment; they maintained these gains at a 1-year follow-up.[42]

DBT as a treatment for suicidality is not limited to adults. Research with suicidal adolescents[28, 29, 30] and suicidal college students[31] has also found significant reductions in use of psychotropic medications, depression, and suicidal behaviors, as well as increases in life satisfaction, when DBT is compared to control conditions.

Standard DBT as a General Treatment

Although DBT was originally developed for high-risk, out-of-control individuals with complex difficulties, the modular makeup of the treatment allows therapists to "rev up" or "rev down" the number of components actively used in treatment at a given time. To date, adaptations of DBT have been shown to be effective for posttraumatic stress disorder (PTSD) due to childhood sexual abuse;[32] eating disorders comorbid with substance abuse;[33] drug dependence comorbid with BPD; [34, 35, 36] eating disorders alone; [39, 40] Cluster B personality disorders;[24] PTSD with and without comorbid BPD;[41] and depression in older adults.[37, 38] Taken as a whole, these

studies suggest that DBT is a broadly efficacious treatment.

This modular flexibility also allows us to bring into the treatment new interventions and strategies to replace old strategies that are less effective. Thus, as time goes on, it is likely that the utility of DBT will expand as the research base expands.

DBT Skills Training as a Stand-Alone Treatment

DBT skills training is rapidly emerging as a stand-alone treatment. Although the majority of research on DBT efficacy consists of clinical trials on standard DBT, many sites over the years have provided DBT skills alone, usually because of insufficient resources to provide the entire treatment. As these programs multiplied, research to determine whether such programs provided effective treatment got started. This growing area of research is suggesting that skills training alone can be very effective in many situations.

Evidence for the Effectiveness of DBT Skills as a Stand-Alone Treatment

An overview of RCTs examining the effectiveness of DBT skills training without individual therapy is presented in Table 1.3. Additional non-RCT studies examining the effectiveness of DBT skills alone are presented in Table 1.4.

As can be seen in Table 1.3, in clinical RCTs, DBT skills training without concurrent individual therapy has been found effective in a number of areas. It was found to reduce depression in nine separate studies;[38, 42, 45, 47, 48, 49, 51, 52, 54] anger in four studies;[43, 46, 52, 53] and emotion dysregulation,[38, 51] including affective instability[43] and emotional intensity,[44] in four studies. Adaptations of DBT skills have also been found to be an effective treatment for eating disorders in three studies,[39, 45, 46] as well as for drinking-related problems[51] and attention-deficit/hyperactivity disorder (ADHD).[50] Among incarcerated women, DBT skills have been effective at reducing PTSD symptoms, depression, and interpersonal problems.[54] Among men and women in correctional facilities, DBT skills have been shown to decrease aggression, impulsivity, and psychopathology.[55] Skills have also reduced intimate partner violence potential and anger expression among those with histories of such violence. Among individuals in vocational rehabilitation with severe mental disorders, DBT skills have decreased depression, hopelessness, and anger, and have increased number of hours working as well as job satisfaction.[52]

As can be seen in Table 1.4, studies of DBT skills training in pre–post research designs (where there is no control condition to which to compare outcomes) have findings similar to the RCTs. These studies have shown decreased depression [57, 58, 60, 61, 62] and ADHD symptoms,[61] as well as increased global functioning[60] and social adjustment coping.[62] Three studies have been conducted of DBT skills training with families of troubled individuals,[56, 57, 58] and all three showed reduction in grief and a sense of burden. Very few studies have been published of skills training for children, however, in the case of children with oppositional defiant disorder (ODD), DBT skills training was associated with reductions in externalizing and internalizing depression, a reduction in problematic behaviors, and an increase in positive behaviors.[60]

The majority of these studies offered only the skills training component of DBT. Two exceptions were presented by Lynch and colleagues.[37] In the first study, DBT skills and DBT phone coaching were added to antidepressants and compared to antidepressants alone for an elderly, depressed sample. In the second study, standard DBT with medication was compared to medication alone for an elderly, depressed sample with comorbid personality disorders. In both studies, the authors found that the depression remitted much faster when individuals were treated with DBT and medication than when they were treated with medication alone

The eating disorder studies used skills-only adaptations of DBT. Several of these studies did not report which DBT skills they used, making it difficult to determine which skills were important in bringing about clinical change. Although skills training has been linked to the reduction of emotion dysregulation in general,[63] we will need more research to determine exactly which skills are necessary and which can be discarded.

The next chapter addresses key issues in planning to conduct skills training, including suggestions for planning a skills training curriculum.

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TABLE 1.3. RCTs of DBT Skills Training Only

Diagnosis/study population	Comparison group	Significant outcomes
BPD: **49** women, 11 men	Standard group therapy	**DBT skills decreased** depression, anxiety, irritability, anger, affective instability, treatment drop-out[43]
BPD: **29** women, **1** man	Control video	**DBT skills increased** DBT skills knowledge, confidence in skills **DBT skills decreased** in emotional intensity[44]
Bulimia nervosa: **14** women	Wait-list control	**DBT skills decreased** bingeing/purging behavior, depression[45]
Binge eating disorder: **101** men and women	Active comparison group therapy	**DBT skills decreased** binge eating[46]
Binge-eating disorder: **22** women	Wait-list control	**DBT skills decreased** anger, weight, shape and eating concerns **DBT skills increased** abstinence from bingeing behavior[46]
Major depressive disorder: **24** men and women	Control condition	**DBT skills decreased** scores on depression **DBT skills increased** emotion processing[47]
Major depressive disorder: **29** women and **5** men over **60**	DBT + medication management vs. medication management only	**DBT skills decreased** self-rated depression scores **DBT skills increased** full remission of depressive symptoms/dependency, adaptive coping[38]
Major depressive disorder: **18** women, **6** men	Wait-list control	**DBT skills increased** emotional processing associated with **decreases** in depression[48]
Bipolar disorder: **26** adults	Wait-list control	**DBT skills decreased** depression, fear toward reward **DBT skills increased** mindful awareness, emotion regulation[49]
ADHD: **51** adults	Loosely structured discussion group	**DBT skills decreased** ADHD symptoms[50]
Problem drinking: **87** women, **58** men (all college age)	BASICS[a]; control	**DBT skills decreased** depression, drinking-related problems **DBT skills increased** emotion regulation, positive mood[51]
Vocational rehab for severe mental illness: **12** adults	TAU	**DBT skills decreased** depression, hopelessness, anger **DBT skills increased** in job satisfaction, number of hours worked[52]
Intimate partner violence: **55** men	Anger management program	**DBT skills decreased** intimate partner violence potential, anger expression[53]
Incarcerated women with histories of trauma: **24** women	No-contact comparison	**DBT skills decreased** PTSD, depression, and problems in interpersonal functioning[54]
Correctional facility inmates: **18** women, **45** men	Case management	**DBT skills decreased** aggression, impulsivity, and psychopathology **DBT skills increased** coping[55]

[a]Brief Alcohol Screening and Intervention for College Students (a harm reduction approach).

TABLE 1.4. Non-RCTs of DBT Skills Training Only

Diagnosis/study population	Comparison group	Significant outcomes
Family members of individuals with BPD: **44** men and women	No comparison group; pre–post design	**DBT skills decreased** grief, burden **DBT skills increased** mastery Changes greater in women[56]
Family members of suicide attempters: **13** men and women	Pre–post design	**DBT skills decreased** anxiety, perceived family member burden, emotional overinvolvement **DBT skills increased** global psychiatric health[57]
Self-injurious behavior: **32** women, **2** men	Pre–post design	**DBT skills decreased** number of inpatient hospitalizations, outpatient appointments, general psychopathology[58]
Convicted offenders with diagnosed intellectual disability: **7** women and men	Pre–post design	**DBT skills decreased** dynamic risk **DBT skills increased** relative strengths, coping skills, and global functioning[59]
ODD: **54** male and female adolescents	Pre–post design	**DBT skills decreased** depression, negative behaviors **DBT skills increased** positive behaviors (e.g., productive behaviors)[60]
ADHD: **8** male and female adults?	Pre–post design	**DBT decreased** ADHD symptoms and depression[61]
Victims of interpersonal violence: **31** women	Pre–post design	**DBT skills decreased** depression, hopelessness, general distress **DBT skills increased** in social adjustment[62]

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