
Dialectical Behaviour Therapy in New Zealand

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Your client won't give up her stockpile of dangerous medication as it's an "insurance policy" in case therapy doesn't work.

Your client refuses to discuss her recent overdose as she wants to talk about the argument she had with her mother.

The Struggles of treating BPD clients.

In New Zealand there is no comprehensive training for mental health professionals on the treatment of personality disorder. Yet most clinical psychologists quickly come to realise that we spend a lot of time with people with enduring interpersonal and emotional problems that cause them - and us - a great deal of impairment and suffering. These are not the discrete episodes of 'Axis I illness' between periods of healthy functioning. I'm referring to the pervasive, inflexible and unusual patterns of inner experience and behaviour that best fit what DSM would call a personality disorder (PD).

This should come as no surprise. International research (there is no adequate local research) suggests large numbers of us (the population) meet PD criteria: 10-13% of adults, over half of psychiatric outpatients and inpatients and over 70% of those inpatients with drug, alcohol, and eating disorders (de Girolamo & Dotto, 2000). About 1-2% of the population and 10-15% of community mental health clients (APA, 2001) may meet criteria for borderline

personality disorder (BPD). "Psychological autopsy" studies suggest a diagnosis of BPD could be made in more than a quarter of all completed suicides (see Paris, 2002). Those who meet criteria for BPD are noted to be some of the most challenging clients that we may care for.

We know that our standard 'Axis I' treatments are generally less effective for those with PD diagnoses. So what to do? Many of us run to the library or to supervision, look toward the "hermeneutical" psychotherapies, or try and find a way avoid seeing such people. When that doesn't work some of us leave the profession entirely

I suggest we educate ourselves about one of the newer empirically based treatments for these problems. Here I will briefly describe Dialectical Behaviour Therapy (DBT, Linehan, 1993 a & b), an empirically grounded psychotherapy particularly relevant to the skills of clinical psychologist (see Box 1).

Box 1. The Knowledge and abilities required to learn DBT.

Knowledge of:

- * functional/behavioural analysis
- * human learning research
- * behavioural/cognitive therapies

Ability to:

- * be cognitively & interpersonally flexible
- * synthesise multiple contradictory points of view
- * tolerate the risk
- * like difficult BPD clients - at least some of the time

From Fruzzetti, Waltz and Linehan (1997)

Why Learn about DBT?

I assume that at some point - or all points - in your career you will work with clients with the diagnosis of BPD. Much has been made of the problems of the term "borderline": it refers to out-dated psycho-developmental ideas, does

not describe the cause or nature of the condition and is often used as "sophisticated term of abuse" (Herman, 1992). There may be better terms around but currently this is the one most understood by our multi-disciplinary

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colleagues. Whatever we call the problem let's look at how to help.

There is clear evidence that some current psychological treatments assist with recovery from BPD. Of these treatments DBT currently has the largest number of positive empirical reports. It is beyond the current scope to review the literature for DBT but I will summarise Robins, Schmidt and Linehan (2004): With BPD persons and across multiple treatment centres and trials, DBT has been shown to reduce the frequency and severity of suicidal/self-injurious behaviour, the frequency and duration of psychiatric hospitalisation and client anger, while yielding increases in treatment retention and social/global adjustment. Adaptations of DBT have shown positive results with bulimia, substance abuse, depressed elderly, inpatient BPD and suicidal adolescents.

Recent adaptations have extended DBT to various problems of 'emotional dysregulation' such as domestic violence, forensic populations and sex offenders. DBT may now be regarded as a treatment for complex 'multi-diagnostic' and "difficult-to-treat" clients. I observe that DBT is particularly suitable to the severely emotionally dysregulated self-harming clients who frequently present within DHB services.

Non-DBT approaches of national and international interest, with varying levels of evidence, include: Stevenson and Meares' (1999) conversational model, Bateman and Fonegy's (1999, 2001) psychoanalytically informed partial hospitalisation, and adaptations of Cognitive Analytic Therapy (Ryle and Kerr, 2002) and cognitive therapy (e.g., Beck, Freeman & Davis, 2003, Young, 2003). There are no adequate comparisons of the various approaches. DBT would welcome the dialectical inevitability of different approaches and look forward to the inevitable interplay between and within them: this is how things develop. In fact we may currently be

seeing an unusual period of integration in these psychotherapies (Bateman, 2000).

Brief overview of DBT

Anyone who has tried to read Linehan (1993a) will know that there is a lot to it, it's not an easy read and is not easy to summarise. In a (very small) nutshell DBT seeks to (1) create a validating (not blaming) context; (2) block/extinguish "bad" behaviours while dragging good behaviour out of the patient; and (3) find a way that good behaviours are so reinforcing that the good ones continue and the bad ones stop (Linehan, 1993a, p97). It sounds so simple!

DBT assumes a biosocial theory whereby BPD arises from the interaction of a biological vulnerability to strong/intense emotions with a developmental environment that "invalidates" the person's sense of who they are and how to act skilfully

The overall goal of DBT is to build a "life worth living" - what almost all of us want. This requires staying alive and articulating recovery goals that become a "guiding star" - we strive towards these goals until we find better ones. We determine if we are acting skilfully (effectively) by whether our action takes us closer to the "star".

DBT combines behavioural, cognitive and Zen / eastern ideas within a dialectical world view. Dialectics is the logic of process with no absolute truth. Ideas/truths come and go in interplay with each other, each creating its own contradiction and each contradiction being negated by a synthesis of both preceding ideas (Robins, Schmidt & Linehan, 2004). More simply, a dialectical view is one that tries to "hold" tensions that exist in our lives between opposing yet valid truths. For instance I may be angry with a loved one yet don't want them to leave. This is the opposite of the "black and white" thinking that plagues our client's lives and much discourse in western psychology.

Box 2: The DBT treatment hierarchy.

Within any session and across all session targets are prioritised by the treatment hierarchy:

1. Decreasing suicidal and self-harm behaviour
2. Decreasing behaviours that undermine or interfere with therapy
3. Decreasing behaviours which interfere with your quality-of-life and/or lead to crisis
4. Increasing other required skills
5. Decreasing post-traumatic stress
6. Increasing respect for self
7. Achieving other individual goals

The central dialectic in DBT is the need for both acceptance and change. We need to accept clients as they are yet acceptance alone may change nothing. And to relentlessly pursue change will be invalidating (and may lead to a change of therapist). DBT pursues a dialectical synthesis of the change-oriented strategies of behavioural and cognitive therapies with more acceptance-oriented principles and strategies adapted from Zen and client-centred therapy (Robins, 2002)

DBT pursues a compassionate solving of 'here and now' problems. DBT has a range of validation strategies that affirm and celebrate what is healthy within the behaviour (and do not 'support' what is unhealthy). DBT relies heavily on learning theory, behavioural analysis, diary cards, skills coaching, and empiricism. Skills are learned and strengthened, contingencies studied and modified. Behavioural analysis pursues psychological function and contextual meaning rather than objective facts. Behavioural targets are augmented by meta-cognitive constructs so that mindfulness and acceptance become targets, skills and actions. Values become necessary parts of a meaningful life and treatment.

Standard DBT involves once-a-week psychotherapy and weekly "low emotional temperature" groups to teach skills. The four

DBT skills modules are summarised in Box 3. Groups are an efficient way to teach skills and benefit from the standard non-specific group processes. These are not process groups: they are agenda driven, highly structured and purposeful. Note there is no evidence to show (or reason to believe) that groups work by themselves or with non-DBT individual therapy.

Eliminating suicidality/self-harm is the first target of DBT as no amount of therapy is helpful if you are dead. The central dialectic around risk is to respond actively enough to block patient from actually killing herself or himself while responding in a fashion that reduces the probability of subsequent suicidal behaviour. We "talk suicide to death" with functional and solution analysis. To safely do this we need a supportive consultation team (see below), clarity about client responsibility, explicit risk management process, good documentation and crisis plans "signed off" before we need to use them. If you work with BPD clients you will need a comprehensive framework for managing risk.

Perhaps as an artefact of Linehan's research design, stage 1 DBT (largely safety and stabilisation) is said to take a year. Our experience is that for some clients a year is enough to yield clinical change but for others it is only a start.

Box 3. DBT skills training modules.

Core mindfulness - Skills to take hold of your mind with your full attention on one thing in the present moment

Distress tolerance - skills for tolerating painful emotions when you can't make things better right away

Emotion regulation - skills to help you understand emotions, reduce emotional vulnerability, decrease emotional suffering

Interpersonal effectiveness - skills for achieving your objectives, getting & keeping good relationships, keeping or improving self-respect/liking yourself.

Consult Groups

Your colleague says the client is hurt and needs extra help. You think she will learn by suffering the natural consequence of her choices.

You feel attacked when advocating a particular approach. Your team has never met the client yet again are talking "by-the-book" psychiatric mumbo jumbo.

DBT therapists participate in a weekly consultation team that assist therapists to stay motivated and within the treatment frame. The DBT consult group "does DBT" on itself. It starts with mindfulness, sets an agenda (prioritised by the treatment hierarchy), and pursues a compassionate, dialectical understanding and solutions to the problems of clients and group alike. A therapist who is burning out (a therapy interfering behaviour) has a responsibility to identify, understand and change whatever is threatening their ability to provide the treatment. The consult group has the responsibility to assist, validate, cheerlead, challenge, coach and whatever else is required to ensure the therapist survives. Consult teams enact a dialectical agreement which we remind ourselves of at each meeting.

A good DBT consult group is great. In 2002 I surveyed 27 DBT practitioners working in 3 North Island DHBs. Consult teams were rated as the most important source of support in sustaining motivation and effectiveness in work with BPD clients. (Managers and the extended mental health service were rated as the least supporting and sustaining.)

Sometimes getting a functioning consult group can be tricky. Most DBT therapists start out as some other kind of therapist. So when problems inevitably arise they naturally drift toward solutions from their native framework. This can be very problematic. Solving the problems of a DBT consult group through, say, psychodynamic therapy methods would be as sensible and effective as solving the problems of a psychodynamic group by DBT methods. In DBT we try not to argue over who is right - we affirm our dialectical agreement and accept difference as it inevitably occurs. We try not to ventilate our rage - we may need to tolerate our distress, use

interpersonal effectiveness skills and "half-smile" towards accepting reality as it currently is. If our colleague is upset we are empathic yet don't treat them as fragile. When we readily agree on something complicated we try to look for what we are all missing.

Your client misses two consecutive sessions then phone is a crisis. She is angry that you can't see her that day.

Observing Limits

If we "burnout" in DBT we will be of no use to anyone: it would be a therapy interfering behaviour. So we are required to observe our own limits to remain engaged and effective. We "observe" what we find our personal limits to be rather than "set" limits that may be more arbitrary or less personally relevant. Consult team members may have different limits and, while staying within the DBT framework, we agree not to impose our limits of each other. So if my colleague is comfortable with loud angry outbursts they are free have stormy volatile sessions. But if I am more genteel I may ask my client to moderate their behaviour and even insist that we find a way to change if I am to remain their therapist.

DBT in NZ

Currently the five most northern DHBs (Northland, Waitemata, Auckland, Counties-Manukau and Waikato) all provide some form of DBT programme complete with intensively trained individual therapists, skills groups and consult teams. Te Whare Mahana is a rural NGO residential service that provides DBT care in Takaka. Some other DHB and NGO providers have attempted some level of DBT provision but I am not aware of other "by-the-book" DBT treatments being currently offered.

DBT texts (Linehan 1993a) assume the therapist is available for crisis coaching calls. This has been an unpopular idea in New Zealand DHBs so we have had to look towards systemic implementations by relying on appropriately trained crisis teams for after-hours cover. DHB implementations require more relationship building and staff training. They should develop clinical pathways to define the service expectations and responses. Private

providers to severe BPD clients will have to develop and maintain functioning relationships with DHB crisis teams whether they adopt a DBT or other approach.

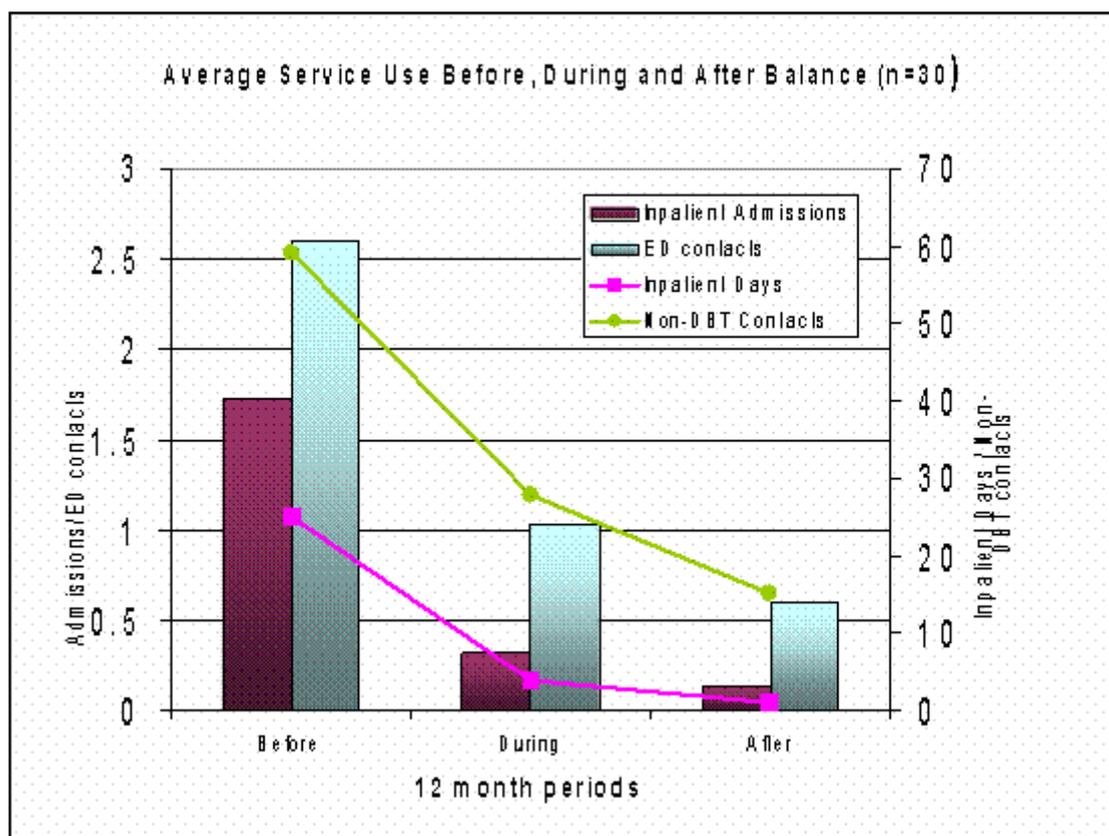
The Auckland DHB Balance Programme is the most established NZ DBT provider, offering community based DBT treatment since 1998. The Balance programme runs across four community mental health centres, has three consult teams, up to four skills groups and at any one time about 30 BPD clients. Balance is affiliated with the Segar House residential programme that is run in partnership with Richmond fellowship. Since 2000 Segar House has offered an intensive DBT-based residential programme to northern regional DHB clients with severe and complex psychological disorders. Auckland DHB Child and Family Services have recently re-launched

their DBT programme for adolescents and their families.

An uncontrolled evaluation of 30 Balance clients compared service levels for the 12 month periods before, during and after Balance (Moudgil, 2004). The data (figure 1) showed a large reduction in inpatient admissions/days, emergency department contacts, and non-DBT community contacts. Respite and crisis contacts increased while in treatment reflecting appropriate help seeking behaviour before self-harm. The pilot Waikato DBT endeavour demonstrated a positive change on a range of psychological measures (Brassington, 2002).

While these reports have their obvious limitations, they do suggest that DBT can be successfully applied within New Zealand.

Figure 1. Service Use Before/During/After Balance



Developing DBT at your place

The treatment of personality disorder has a flourishing literature and is attracting growing interest within New Zealand health funders and providers. Within the public sector the DHB-based National Personality Disorder Advisory

Group has been meeting over the past few years to promote and develop effective and compassionate treatment of those with PD, especially BPD diagnoses. Almost all of the DHBs are represented. Recently the Ministry of Health / Health Research Committee

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Workforce Development group has sought expressions of interest from organisations able to provide DBT training. Intensive DBT is currently only available from Behavior Tech LLC, the US based training company associated with Linehan. It is extensive and expensive.

As psychologists we are likely to be seeing BPD clients already and we have the established skill sets most needed in this work. Soon we may be expected by our multidisciplinary colleagues to be competent in this area. While most of us can't access full DBT training we can extend our reading and form a study group. DBT is probably 80% made up of skills and methods familiar to most of us. We need to develop our understanding of dialectics and mindfulness and then build the necessary structures. Starting a consult group may be as easy as knocking on the door of your long suffering colleague in the next office. Or a lunchtime meeting at the private practice. Self study groups can grow into consult groups. They can be a great way of learning DBT and coping with Linehan's unique writing style. There are recent texts on developing DBT within private practice settings (Marra, 2005).

We should also bear in mind that the evidence for DBT only relates to full programmes. Naming patchy efforts as "DBT" may 'inoculate' clients against "DBT proper" should they meet it in their future. One study suggests that too little training can leave practitioners unaware of treatment subtleties and punitive in their action. Still, for the competent clinical psychologist who practices within their limits there are clear benefits to becoming more informed. I have worked in our DBT programme for over 7 years and found the treatment and the clients to be personally rewarding. It can be great fun and is never boring.

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