# Dialectical Behavior Therapy

Dialectical Behavior Therapy (DBT) is a cognitive-behavioral treatment approach with two key characteristics: a behavioral, problem-solving focus blended with acceptance-based strategies, and an emphasis on dialectical processes. "Dialectical" refers to the issues involved in treating patients with multiple disorders and to the type of thought processes and behavioral styles used in the treatment strategies. DBT has five components: (1) capability enhancement (skills training); (2) motivational enhancement (individual behavioral treatment plans); (3) generalization (access to therapist outside clinical setting, homework, and inclusion of family in treatment); (4) structuring of the environment (programmatic emphasis on reinforcement of adaptive behaviors); and (5) capability and motivational enhancement of therapists (therapist team consultation group). DBT emphasizes balancing behavioral change, problem-solving, and emotional regulation with validation, mindfulness, and acceptance of patients. Therapists follow a detailed procedural manual.

**Descriptive Information**

| | |
|---|---|
| **Areas of Interest** | Mental health treatment<br>Co-occurring disorders |
| **Outcomes** | **Review Date: October 2006**<br>1: Suicide attempts<br>2: Nonsuicidal self-injury (parasuicidal history)<br>3: Psychosocial adjustment<br>4: Treatment retention<br>5: Drug use<br>6: Symptoms of eating disorders |
| **Outcome Categories** | Drugs<br>Mental health<br>Social functioning<br>Suicide<br>Trauma/injuries<br>Treatment/recovery |

| | |
|---|---|
| **Ages** | 18-25 (Young adult)<br>26-55 (Adult)<br>55+ (Older adult) |
| **Genders** | Male<br>Female |
| **Races/Ethnicities** | American Indian or Alaska Native<br>Asian<br>Black or African American<br>Hispanic or Latino<br>White<br>Race/ethnicity unspecified |
| **Settings** | Inpatient<br>Outpatient<br>Other community settings |
| **Geographic Locations** | No geographic locations were identified by the developer. |
| **Implementation History** | DBT has been implemented in many therapeutic settings in Argentina, Australia, Canada, Germany, Japan, New Zealand, the Netherlands, Norway, Spain, Sweden, Switzerland, the United Kingdom, and the United States since the publication of treatment manuals in 1993. Evaluations of DBT have been conducted in Canada, Germany, the Netherlands, New Zealand, Spain, and Sweden. Some clinicians have conducted and published results from independent randomized controlled trials of DBT. |
| **NIH Funding/CER Studies** | Partially/fully funded by National Institutes of Health: Yes<br>Evaluated in comparative effectiveness research studies: Yes |
| **Adaptations** | Adaptations of DBT have been developed for:<br>• Suicidal adolescents<br>• Individuals with substance use disorders<br>• Individuals with eating disorders<br>• Individuals with comorbid HIV and substance use disorders |

| | |
|---|---|
| | • Developmentally delayed individuals<br>• Older adults with depression and one or more personality disorders<br>• Individuals with schizophrenia<br>• Families of patients<br>• Women experiencing domestic violence<br>• Violent intimate partners<br>• Individuals who stalk<br>• Inpatient and partial hospitalization settings for adolescents and adults<br>• Forensic settings for juveniles and adults |
| **Adverse Effects** | No adverse effects, concerns, or unintended consequences were identified by the developer. |
| **IOM Prevention Categories** | IOM prevention categories are not applicable. |

**Learn More** - Click on each category bar below or the buttons at the right to expand or collapse the sections.

Quality of Research

Review Date: October 2006

**Documents Reviewed**

The documents below were reviewed for Quality of Research. The research point of contact can provide information regarding the studies reviewed and the availability of additional materials, including those from more recent studies that may have been conducted.

**Study 1**

Bohus, M., Haaf, B., Simms, T., Limberger, M. F., Schmahl, C., Unckel, C., et al. (2004). Effectiveness of inpatient dialectical behavior therapy for borderline personality disorder: A controlled trial. Behaviour Research and Therapy, 42, 487-499.

**Study 2**

Linehan, M. M., Armstrong, H. E., Suarez, A., Allmon, D., & Heard, H. L. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. Archives of General Psychiatry, 48, 1060-1064.

**Study 3**

Linehan, M. M., Comtois, K. A., Murray, A. M., Brown, M. Z., Gallop, R. J., Heard, H. L., et al. (n.d.). Dialectical behavior therapy versus treatment-by-experts for suicidal individuals with borderline personality disorder: One year treatment and one year follow-up. Unpublished manuscript.

**Study 4**

Linehan, M. M., Dimeff, L. A., Reynolds, S. K., Comtois, K. A., Welch, S. S., Heagerty, P., et al. (2002). Dialectical behavior therapy versus comprehensive validation therapy plus 12-Step for the treatment of opioid dependent women meeting criteria for borderline personality disorder. Drug and Alcohol Dependence, 67, 13-26.

**Study 5**

Linehan, M. M., Heard, H. L., & Armstrong, H. E. (1993). Naturalistic follow-up of a behavioral treatment for chronically parasuicidal borderline patients. Archives of General Psychiatry, 50, 971-974.

**Study 6**

Linehan, M. M., Schmidt, H., III, Dimeff, L. A., Craft, J. C., Kanter, J., & Comtois, K. A. (1999). Dialectical behavior therapy for patients with borderline personality disorder and drug-dependence. American Journal on Addictions, 8, 279-292.

**Study 7**

Linehan, M. M., Tutek, D. A., Heard, H. L., & Armstrong, H. E. (1994). Interpersonal outcome of cognitive behavioral treatment for chronically suicidal borderline patients. American Journal of Psychiatry, 151, 1771-1776.

**Study 8**

Safer, D. L., Telch, C. F., & Agras, W. S. (2001). Dialectical behavior therapy for bulimia nervosa. American Journal of Psychiatry, 158, 632-634.

**Study 9**

Telch, C. F., Agras, W. S., & Linehan, M. M. (2001). Dialectical behavior therapy for binge eating disorder. Journal of Consulting and Clinical Psychology, 69, 1061-1065.

**Study 10**

Turner, R. M. (2000). Naturalistic evaluation of dialectical behavior therapy-oriented treatment for borderline personality disorder. Cognitive and Behavioral Practice, 7, 413-419.

**Study 11**

van den Bosch, L. M., Verheul, R., Schippers, G. M., & van den Brink, W. (2002). Dialectical behavior therapy of borderline patients with and without substance use problems: Implementation and long-term effects. Addictive Behaviors, 27, 911-923.

**Study 12**

Verheul, R., van den Bosch, L. M., Koeter, M. W., De Ridder, M. A., Stijnen, T., & van den Brink, W. (2003). Dialectical behaviour therapy for women with borderline personality disorder: 12-month, randomised clinical trial in the Netherlands. British Journal of Psychiatry, 182, 135-140.

**Supplementary Materials**

Dialectical behavior therapy: Efficacy, effectiveness & feasibility [Handout]

Dimeff, L., Koerner, K., & Linehan, M. M. (2002). Summary of research on dialectical behavior therapy. Seattle, WA: Behavioral Tech, LLC.

Letters to the editor. (1993). Archives of General Psychiatry, 50, 157-158.

Linehan, M. M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford.

Linehan, M. M. (1993). Skills training manual for treating borderline personality disorder. New York: Guilford.

Robins, C. J., & Chapman, A. L. (2004). Dialectical behavior therapy: Current status, recent developments, and future directions. Journal of Personality Disorders, 18, 73-89.

**Outcomes**

| Outcome 1: Suicide attempts | |
|---|---|
| **Description of Measures** | Suicide attempts were measured by the Parasuicide History Interview (now called the Suicide Attempt Self-Injury Interview, or SASII), a semistructured interview administered by blind assessors. |
| **Key Findings** | After 1 year of care during a randomized controlled trial, 23.1% of DBT participants reported suicide attempts, compared with 46.7% of recipients of alternative expert treatment (p = .005). |
| **Studies Measuring Outcome** | Study 3 |
| **Study Designs** | Experimental |
| **Quality of Research Rating** | 3.7 (0.0-4.0 scale) |

| Outcome 2: Nonsuicidal self-injury (parasuicidal history) | |
|---|---|
| **Description of Measures** | Nonsuicidial self-injury (parasuicidal history) or NSSI refers to deliberate self-harm, such as self-mutilation or drug overdose, in which suicide is not intended. This outcome was measured by blind assessors using the Parasuicide History Interview (now called the Suicide Attempt Self-Injury Interview, or SASII). |
| **Key Findings** | Multiple evaluations, including randomized controlled trials and independent studies, confirmed that patients completing 1 year of DBT experienced less nonsuicidal self-injury than patients awaiting care or receiving alternative treatment ($p < .05$). In one evaluation, DBT patients averaged 0.55 incidents during the previous month compared with 9.33 incidents in a treatment-as-usual group ($p < .05$). In two other evaluations, DBT participants experienced incidents of nonsuicidal self-injury with a frequency comparable to that of recipients of alternative professional treatment. |
| **Studies Measuring Outcome** | Study 1, Study 2, Study 3, Study 5, Study 6, Study 10, Study 11, Study 12 |
| **Study Designs** | Experimental |
| **Quality of Research Rating** | 3.3 (0.0-4.0 scale) |
| **Outcome 3: Psychosocial adjustment** | |
| **Description of Measures** | Psychosocial adjustment was measured by standardized self-reports and blind assessor reports. Measures included the Social Adjustment Scale and Longitudinal Interview Follow-Up Evaluation, Global Assessment Scale, Hamilton Rating Scale for Depression, State-Trait Anger Expression Inventory, and self-reports on targeted behaviors, among others. |
| **Key Findings** | Seven randomized controlled trials found that 1 year of DBT improved at least some measures of psychological, social, or global adjustment, when compared with results for patients awaiting care or receiving alternative treatment ($p < .05$ across multiple measures). Two evaluations found sustained effects 16 and 18 months after treatment, |

| | |
|---|---|
| | respectively. One evaluation noted reduced anger among DBT participants 24 months after treatment. |
| **Studies Measuring Outcome** | Study 1, Study 3, Study 4, Study 5, Study 6, Study 7, Study 10 |
| **Study Designs** | Experimental |
| **Quality of Research Rating** | 3.4 (0.0-4.0 scale) |
| **Outcome 4: Treatment retention** | |
| **Description of Measures** | Treatment retention was measured by clinicians' records of attendance. |
| **Key Findings** | In multiple evaluations, DBT participants remained in treatment longer than patients receiving treatment as usual or alternative treatment ($p < .002$). DBT retention rates ranged from 63% to 100%, depending on the evaluation format, while retention rates for comparative treatment in the same studies ranged from 23% to 73%. |
| **Studies Measuring Outcome** | Study 2, Study 3, Study 6, Study 12 |
| **Study Designs** | Experimental |
| **Quality of Research Rating** | 3.4 (0.0-4.0 scale) |
| **Outcome 5: Drug use** | |

| | |
|---|---|
| **Description of Measures** | Drug use was measured by urine samples and structured clinical interviews. Interviews included the Timeline Followback Interview, administered by blind assessors. |
| **Key Findings** | In a randomized controlled trial, DBT participants were significantly more likely than alternative-treatment recipients to have drug-free urine screens 4 months after completing a year-long course of treatment; effect size was medium (Cohen's d = 0.75). In another evaluation, most DBT participants continued to reduce their use of opiate drugs over the course of 1 year of treatment, while alternative-treatment recipients typically increased their use during the last 4 months of treatment ($p < .05$). |
| **Studies Measuring Outcome** | Study 4, Study 6, Study 11 |
| **Study Designs** | Experimental |
| **Quality of Research Rating** | 3.3 (0.0-4.0 scale) |
| **Outcome 6: Symptoms of eating disorders** | |
| **Description of Measures** | Symptoms of eating disorders were measured by the Eating Disorders Examination, which diagnoses disorders and measures number of days and episodes of binge eating, and the Binge Eating Scale, which measures severity of eating disorder. |
| **Key Findings** | DBT participants reported significantly less binging or purging behavior than patients awaiting treatment ($p < .05$). In one evaluation, 89% of DBT participants were free of purge behavior, compared with 12.5% of patients awaiting care ($p < .001$). |
| **Studies Measuring Outcome** | Study 8, Study 9 |
| **Study Designs** | Experimental |

| | |
|---|---|
| **Quality of Research Rating** | 3.2 (0.0-4.0 scale) |

**Study Populations**

The following populations were identified in the studies reviewed for Quality of Research.

| Study | Age | Gender | Race/Ethnicity |
|---|---|---|---|
| Study 1 | 18-25 (Young adult)<br>26-55 (Adult) | 100% Female | Data not reported/available |
| Study 2 | 18-25 (Young adult)<br>26-55 (Adult) | 100% Female | Data not reported/available |
| Study 3 | 18-25 (Young adult)<br>26-55 (Adult) | 100% Female | 87% White<br>6% Race/ethnicity unspecified<br>4% Black or African American<br>2% Asian<br>1% American Indian or Alaska Native |
| Study 4 | 18-25 (Young adult)<br>26-55 (Adult) | 100% Female | 66% White<br>26% Black or African American<br>4% Race/ethnicity unspecified |
| Study 5 | 18-25 (Young adult)<br>26-55 (Adult) | 100% Female | Data not reported/available |
| Study 6 | 18-25 (Young adult)<br>26-55 (Adult) | 100% Female | 78% White<br>11% Race/ethnicity unspecified<br>7% Black or African American<br>4% Hispanic or Latino |
| Study 7 | 18-25 (Young adult)<br>26-55 (Adult) | 100% Female | Data not reported/available |
| Study 8 | 18-25 (Young adult)<br>26-55 (Adult) | 100% Female | 87.1% White<br>12.9% Race/ethnicity unspecified |

| | | | |
|---|---|---|---|
| Study 9 | 18-25 (Young adult)<br>26-55 (Adult)<br>55+ (Older adult) | 100% Female | 94% White<br>6% Race/ethnicity unspecified |
| Study 10 | 18-25 (Young adult)<br>26-55 (Adult) | 79.2% Female<br>20.8% Male | 79.2% White<br>16.7% Black or African American<br>4.2% Asian |
| Study 11 | 26-55 (Adult) | 100% Female | Data not reported/available |
| Study 12 | 26-55 (Adult) | 100% Female | Data not reported/available |

**Quality of Research Ratings by Criteria (0.0-4.0 scale)**

External reviewers independently evaluate the Quality of Research for an intervention's reported results using six criteria:

1. Reliability of measures
2. Validity of measures
3. Intervention fidelity
4. Missing data and attrition
5. Potential confounding variables
6. Appropriateness of analysis

For more information about these criteria and the meaning of the ratings, see Quality of Research.

| Outcome | Reliability of Measures | Validity of Measures | Fidelity | Missing Data/Attrition | Confounding Variables | Data Analysis | Overall Rating |
|---|---|---|---|---|---|---|---|
| **1: Suicide attempts** | 3.8 | 3.8 | 4.0 | 3.5 | 3.0 | 4.0 | **3.7** |
| **2: Nonsuicidal self-injury (parasuicidal history)** | 3.8 | 3.8 | 3.3 | 2.9 | 2.6 | 3.7 | **3.3** |
| **3: Psychosocial adjustment** | 4.0 | 4.0 | 3.0 | 3.2 | 2.7 | 3.7 | **3.4** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **4: Treatment retention** | 4.0 | 4.0 | 3.7 | 2.5 | 2.7 | 3.8 | **3.4** |
| **5: Drug use** | 3.6 | 3.6 | 3.5 | 2.8 | 2.8 | 3.5 | **3.3** |
| **6: Symptoms of eating disorders** | 3.6 | 3.6 | 3.0 | 2.3 | 2.8 | 4.0 | **3.2** |

### Study Strengths

In general, study designs were of high quality. The conservative approach used to address attrition was well founded.

### Study Weaknesses

Although the treatment is manualized, it is unclear how adherence was monitored and how deficiencies were addressed. It is also unclear how the research team addressed issues with missing data.

Readiness for Dissemination

Review Date: October 2006

### Materials Reviewed

The materials below were reviewed for Readiness for Dissemination. The implementation point of contact can provide information regarding implementation of the intervention and the availability of additional, updated, or new materials.

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford.

Linehan, M. (1993). Skills training manual for treating borderline personality disorder. New York: Guilford.

Linehan, M., & Behavioral Tech, LLC. (2006). Advanced topics in Dialectical Behavior Therapy with special emphasis on adolescents: Two-day training. Seattle, WA: Authors.

Linehan, M., & Behavioral Tech, LLC. (2006). Coping with chaos: Dialectical Behavior Therapy for the multiply disordered client. One-day training. Seattle, WA: Authors.

Linehan, M., & Behavioral Tech, LLC. (2006). Coping with chaos: Dialectical Behavior Therapy for the multiply disordered client. Two-day training. Seattle, WA: Authors.

Linehan, M., & Behavioral Tech, LLC. (2006). Dialectical Behavior Therapy applied to substance abuse. Two-day training. Seattle, WA: Authors.

Linehan, M., & Behavioral Tech, LLC. (2006). Dialectical Behavior Therapy 5-day foundational training. Seattle, WA: Authors.

Linehan, M., & Behavioral Tech, LLC. (2006). Dialectical Behavior Therapy intensive training course. Seattle, WA: Authors.

Linehan, M., & Behavioral Tech, LLC. (2006). How to be a skills trainer in Dialectical Behavior Therapy. Two-day workshop. Seattle, WA: Authors.

Linehan, M., & Behavioral Tech, LLC. (2006). Introduction to individual psychotherapy in Dialectical Behavior Therapy. Two-day workshop. Seattle, WA: Authors.

Linehan, M., & Behavioral Tech, LLC. (2006). Skills training in Dialectical Behavior Therapy. Two-day training. Seattle, WA: Authors.

Linehan, M., & Behavioral Tech, LLC. (2006). Treating the multiply disordered suicidal client. Two-day training. Seattle, WA: Authors.

**Readiness for Dissemination Ratings by Criteria (0.0-4.0 scale)**

External reviewers independently evaluate the intervention's Readiness for Dissemination using three criteria:

1. Availability of implementation materials
2. Availability of training and support resources
3. Availability of quality assurance procedures

For more information about these criteria and the meaning of the ratings, see Readiness for Dissemination.

| Implementation Materials | Training and Support Resources | Quality Assurance Procedures | Overall Rating |
|---|---|---|---|
| 4.0 | 3.0 | 2.5 | **3.2** |

**Dissemination Strengths**

An excellent range of materials is available to directly assist implementation. Materials describe the intervention as it is applied to a variety of problems. Training materials are comprehensive and vary appropriately with the topic. Online peer supervision is available. Practical and intervention-specific measures for intervention fidelity and outcomes are provided to support quality assurance.

**Dissemination Weaknesses**

Very little information is provided on how trainers are trained and selected. Little information is provided to describe how a treatment team is formed and how it functions over time, and very little attention is paid to implementation issues for administrators. There is no description of when and by whom data is collected and reported. No information is provided describing the uses of the data for improving treatment processes or program outcomes.

Costs

The cost information below was provided by the developer. Although this cost information may have been updated by the developer since the time of review, it may not reflect the current costs or availability of items

(including newly developed or discontinued items). The implementation point of contact can provide current information and discuss implementation requirements.

| Item Description | Cost | Required by Developer |
|---|---|---|
| Implementation materials, training, technical assistance/consultation, and quality assurance materials | Contact the developer | Contact the developer |

Replications

Selected citations are presented below. An asterisk indicates that the document was reviewed for Quality of Research.

For an annotated bibliography including replication citations, see:

Dimeff, L., Koerner, K., & Linehan, M. M. (2002). Summary of research on dialectical behavior therapy. Seattle, WA: Behavioral Tech, LLC. Available online at http://behavioraltech.org/downloads/dbtSummaryOfData.pdf

Contact Information

**To learn more about implementation, contact:**
Behavioral Tech, LLC
(206) 675-8588
information@behavioraltech.org

Kathryn E. Korslund, Ph.D., ABPP
(206) 616-7324
korslund@uw.edu

**To learn more about research, contact:**
Marsha M. Linehan, Ph.D., ABPP
(206) 543-9886
linehan@uw.edu