CHAPTER TWENTY-FIVE

The Birth of Dialectical Behavior Therapy

THE GOAL OF my NIMH-funded research study was to determine whether behavior therapy would be effective in treating highly suicidal people. And, specifically, to see whether behavior therapy was *more* effective than the standard treatment of the time, which was principally psychoanalysis. Here's what happened.

The Search for the Right Balance in Therapy

There were four research goals. The first was to develop a reliable and valid measure to assess intentional self-injury and suicide attempts; this is called an outcome measure. Second, conduct a pilot study to develop the new treatment, to determine whether it has promise. Third, develop a treatment manual, a how-to guide, that I could use when conducting a randomized clinical trial and that could then be used by others treating the same population of patients. The final goal was to carry out a randomized clinical trial, based on the first three goals, to properly evaluate the new treatment.

The treatment plan was to combine problem-solving, assertiveness training, and standard behavior therapy. I would be the princi-

pal therapist in the study, working one-on-one with participants, who were mostly female, for about an hour once a week. I would talk through issues that had been bothering them in the past week, exploring what new exercises might be helpful. A fairly typical behavior therapy. Other team members would watch the therapy sessions through a one-way mirror and take notes on what worked and what didn't work. They would know it wasn't working if the patient screamed at me, walked out saying I was invalidating them, and so forth.

After each session, our team (around seven or eight people) would discuss the treatment session. I used this input to decide which procedures should be kept in the treatment and which should be dropped. The manual evolved as we went along. As far as I am aware, it was one of the first manuals—if not the first—to be written this way. That is, by observing exactly what the therapist actually does in the therapy room, rather than basing treatment instructions on theory.

Standard Behavior Therapy—a Technology of Change—Doesn't Work

Once I had my outcome measure established, I began developing and pilot-testing the treatment. I immediately found myself in uncharted territory. The client would come in, we'd talk, she would tell me about her life problems and why life did not seem worth living. We had to discover which of her many problems was driving her suicidal behaviors. It might be her believing that no one loved her, that people hated her, that she just wanted to die. I would say, "No problem. I can find a treatment for that." I went through existing behavior therapy manuals to come up with the appropriate treatment.

The next week, I would review with the client what I thought was needed to solve the problem we had focused on, what changes we

could make together. But a typical response to any attempt to change the patient's behavior was "What? Are you saying *I'm* the problem?"

They got very upset, sometimes retreating into silence, other times standing up, yelling, throwing chairs, stomping out of the room. "You're not listening to me," the client would say. "You're not hearing what I'm suffering. You're trying to change me."

Most of the clients had experienced intense suffering. They had tragic stories. In addition, they were extremely sensitive to anything that appeared to invalidate their pain, anything that suggested that they themselves needed to change. Standard behavior therapy, which is focused on helping people change, was a red flag to them.

For these clients, it was as if they didn't have emotional skin. As if they had suffered from third-degree burns all over their body. Even the lightest touch was excruciatingly painful, and they lived in environments where everyone kept poking at them. They perceived suggestions aimed at change as personal attacks or as further invalidation. It would whip them off the emotional charts.

Many Different Versions of Hell

I realized that what these people obviously needed was for me to be compassionate, to validate them, to show that the factors driving their suffering made sense to me. I had to see the world from their point of view. Before the study started, I'd had no idea how excruciatingly painful the lives of these people were. I would have to find a way for both the client and the therapist to accept the tragedies that had happened.

At the time, I didn't connect their suffering with mine. My past was so different from many of theirs. I understood pain, loneliness, rejection in general. But I didn't have to relate their experience to my past in order to understand their suffering. (That is hard to do anyway, when you are intently focused on someone else.)

When I heard and saw them, I felt with them. In a small but meaningful way, I went through what they were describing as they described it. This is not unusual among therapists. All of us have cried with our clients; all of us have felt stabbed in the chest with them. The specific thing from my life that was helpful was: I actually know what hell is, and I know how to get out. The path out of hell is hard work, a sea of misery, but I know a person can get out.

A New Focus on Acceptance: That Didn't Work, Either

So I dumped the emphasis on change and went full-bore for helping clients accept where they were in their lives. My new goal was to validate my clients' tragic lives. I knew about unconditional positive regard, a set of strategies developed by the humanistic psychologist Carl Rogers. And I knew of supportive therapy, an approach that focuses on providing a strong therapeutic alliance, where the therapist is both trusting and validating. "No problem," I thought, "acceptance is it. I am switching my strategy."

The response to this was as volcanic as it had been to my focus on change. "What? You're not going to help me?" the client would say. "You're just going to leave me here, in all this pain?" More tears, more sitting mute, more walking out of the room.

As the study progressed, I began dancing back and forth, back and forth, back and forth, trying to find the right balance in the dynamic between pushing for change and offering acceptance. It was like walking on a tightrope. Too much weight on either side and over you went.

Blackmail Therapy

My students jokingly called our treatment "blackmail therapy." I would spend a lot of time at the beginning on validation, and very

little on change, other than a commitment to stay alive until the next session. Once I had a good relationship with the client, I would use it as a reinforcement, by increasing warmth toward the participant following effective behaviors or emotionally withdrawing it as a negative consequence of dysfunctional behaviors.

With suicidal clients, I would generally start by asking if they believed that they would be happier if dead. They seemed to think that their suffering would end if they killed themselves. I'd point out that there were no data proving that was true. There are religions that believe if you kill yourself you will go to hell, and others that believe you will have to live your whole life all over again. That could keep me from doing it!

The team continued to observe and offer feedback on therapy sessions. Before long we noticed a pattern. Clients had many tragedies, problems, and disorders, and they kept changing what they wanted to work on in therapy. They would say the problem from the previous week wasn't important, that some other problem was now more important. If I tried to work on one problem, the client would bring up another problem apparently even more distressing than the earlier one. "I can't stand it," "I'm going to kill myself," and so on. I realized that a core problem for my clients was their inability to tolerate distress.

Skills to Help People Tolerate Distress

I had to teach clients how to accept some suffering in the moment so that we could then focus on more important problems, such as life-threatening behaviors and dealing with interpersonal relationships. At that time, in the early 1980s, there were no protocols for teaching acceptance. No protocols for how to cope with the pain. Teaching acceptance was simply not part of the behavior therapist's repertoire.

This was the impetus for developing a series of distress tolerance

skills, of which there are more than a dozen. I told you earlier about the TIP skills (temperature, intense exercise, paced breathing, and paired muscle relaxation), which would have helped me cope better with the fire in my Washington, D.C., apartment. Half-smiling and willingness are two more examples.

Others include the STOP skills, which help you to not make a bad situation worse. They stop you from acting on your first impulse. Parents of my clients say the skills have helped them enormously in difficult situations with their kids. It helps them to not lose their temper! And, I'm sure you will agree, there are times in many people's lives (perhaps all people) when the STOP skills can be very helpful.

These are the STOP skills:

Stop the urge to act immediately.
Take a step back and detach from the situation.
Observe, so you can gather information on what is happening.
Proceed mindfully, by evaluating the most effective option to take, given the goals, and finally following that option.

I'll go into each step in more detail.

Stop:

When you feel that your emotions are about to take control, stop! Don't react. Don't move a muscle! Just freeze! It can help prevent you from doing what your emotion wants you to do—to act without thinking. Stay in control. Remember: you are the boss of your emotions. Or at least you can become the boss.

Example: If someone says something that provokes you (insulting you or saying untrue and hurtful things), you might have the urge to attack this person physically or verbally.

That, however, is probably not in your best interest. Doing that might result in your getting hurt, being jailed, getting fired, or saying something that is also untrue and hurtful. So stop, freeze, and don't act on your impulse to attack.

Take:

When you are faced with a difficult situation, it may be hard to think about how to deal with it on the spot. Give yourself time to calm down and think. Take a step back (in your mind and/or physically) from the situation. Get unstuck. Take a deep breath. Continue breathing deeply until you are back in control. Do not let your emotion control what you do. Remember: you are not your emotion. Do not let it put you over the edge.

Example: You are crossing the street and don't notice a car approaching. The driver stops the car, gets out, and starts cursing at you and physically pushes you. Your urge is to punch him in the face; however, you know that would escalate the situation and get you in trouble. So you first stop and then literally take a step back to avoid confrontation.

Observe:

Observe what is happening around you and within you. Who is involved? What are other people doing and saying? To make effective choices, it is important not to jump to conclusions. Gather the relevant facts to understand what is going on and what your options are. Try to be nonjudgmental.

Proceed Mindfully:

Ask yourself, "What do I want from this situation? What are my goals? What choice might make this situation better or worse?" Go

into wise mind (see Chapter 32 for a full explanation) and ask it how to deal with this problem. When you are calm and in control, and have some information about what is going on, you are better prepared to deal with the situation effectively, rather than make it worse.

Example: You get home really late from work because you had a flat tire on the way. Your partner starts to yell at you, accusing you of cheating on him and calling you names. You get really angry, and your first impulse is to yell and call him names back. However, you want to deal with the situation skillfully. So you stop and then take a step back from your partner. You observe that there are a lot of empty beer bottles in the kitchen and realize that your partner has probably had a little too much to drink. You know that when he's drunk, there's no point in arguing, and he is likely to apologize in the morning. So you proceed mindfully by explaining the flat tire, pacifying your partner, and going to bed. You postpone a full discussion till the next morning.

I am sure that you won't have a lot of trouble thinking back to a situation in which, had you used the STOP skills, you wouldn't have gotten yourself into a situation you later regretted.

Is This Something New?

Within a couple of years, I had an embryonic version of what eventually would be called Dialectical Behavior Therapy. It was wildly incomplete and still lacked some of the major innovations that make DBT so very effective (balancing acceptance and change, providing a set of behavioral skills, requiring that all therapists work within a team). My major question at that point, though, was this: Is DBT something new and different?

I wrote to a few trusted colleagues and described what I was doing. I'd ask the straightforward question "Is this something novel, or is it simply a version of standard behavior therapy?"

Terry Wilson is now professor of psychology at Rutgers. When I wrote to him back in the early eighties, he had recently served as president of the Association for Advancement of Behavior Therapy. Terry said something to the effect of "Your emphasis on distress tolerance and acceptance is unique, and not part of behavior therapy." As it turned out, acceptance was a key difference.

Movement, Speed, and Flow

Throughout the development of DBT, I had to be prepared to go where my clients wanted to go. At other times, I had to guide them where I wanted them to go. It required a spaciousness of mind, dancing with what I call "movement, speed, and flow." Both the client and the therapist are moving forward into a new place, smoothly and quickly. It became a mantra for us. Knowing when to push. Knowing when to support. Going back and forth, an organic and loosely scripted flow. It's not easy to explain this process.

Beatriz Aramburu, a former student, has a different angle on it: "Marsha has a deep, deep blend of warmth and caring for her clients, and she couples that with telling them, 'That's not all right—stop doing that. I understand why you do it, and I know it comes from pain and is difficult to stop. Now knock it off.' Marsha has a very good clinical sense of getting into the client's mind."

This new therapy we were developing was more demanding than standard behavior therapy, not least because the client population the therapist works with are highly emotionally volatile and present the very real threat that they might kill themselves. You can imagine how emotionally draining that could be. The therapist needs to be compassionate without getting drawn into the horrors of her client's current crisis. In addition, clients are free to call their therapist

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at any time of day or night. Again, the therapist has to be compassionate, but completely focused on directing the client to the DBT skills that are relevant to the current crisis. DBT practitioners have to be willing to reveal themselves to some degree. It's not surprising, then, that there is a high burnout rate among DBT practitioners. Many therapists have to move on to other avenues of work after three years or so. At the same time, DBT is more liberating. "It is a treatment that allows me to be me, to use me, the person, as a therapist, as opposed to just supporting the client," says Beatriz.

Another student of mine, Anita Lungu, echoes this. "To be good at this therapy, you have to know the treatment components extremely well," she says. "Yet at the same time, it allows me to be who I am. I don't need to put on a therapist's hat and assume a different persona, because I am in the role of therapist. I can be who I am, very genuine, very straightforward, say what I think. And at the same time, having the treatments in my mind to guide my decisions. I don't have to become a different person to be a therapist."

The Role of Irreverence

One of the defining techniques is irreverence. I am naturally irreverent, saying what is on my mind, not censoring myself, calling a spade a spade. It's gotten me in trouble more than once. But the students noticed that my irreverence often had beneficial effects, getting the therapy unstuck after it had jammed.

Being irreverent is saying the unexpected. Research shows that unexpected information is processed more deeply than expected information. It gets the client's attention, maybe jolts them out of their mental rut—hating therapy, for example, or being consumed with self-loathing. An example might be:

CLIENT: I'm quitting therapy!
THERAPIST: Oh. Would you like a referral?

It is not being cold and unemotional. It has to be in a context of warmth and validation, letting the client know that you understand that they are miserable and why they are miserable. The population of people I work with often have a rather direct and intense way of communicating, and they often respond positively to equally direct communication.

CLIENT: My life is so horrible. I am so miserable. I just want to be dead, to escape all this pain!
THERAPIST: You know, there is absolutely no evidence that you will feel better when you are dead. Why take the risk?

For Charles Swenson, who was the first person outside the clinic whom I trained in the new therapy, in the late 1980s, it was a challenge. He had had psychoanalytic training, so he was stepping into very different territory. I'll let him tell his story.

Marsha supervised me in the beginning. I would videotape a session, send it to her, and she would talk about it with me over the phone. She'd always start by saying, "Okay, I've watched the tape. Do you want the good news or the bad news?" I said, "Let's start with the good news." She said, "You are unbelievably validating. I think your psychoanalytic training probably helped with that. You have a million ideas. I think your psychoanalytic training helped there, too."

I then said, "So what is the bad news?" She said, "Are you ever funny? You aren't in your sessions. You are like you are in church. That has to change. Do you have irreverence in you? Next week, I want you, at least once, to speak without thinking. Just speak. See what comes out." She was right. I thought too much. It was my psychoanalytic training.

I eventually figured it out. There was an adolescent boy I was working with, and adolescent boys can be very dark. He said to me, "Why should I do anything in therapy with an adult? Have you looked at the world lately? Have you seen how fucked up the

world is now? Who has done that? Have children done that? No! Adults have fucked up the entire world, and they do that every day, and I am supposed to be in therapy with an *adult*?" My response was "I know what you are saying. But you are wrong. It is way worse than you are saying. It is worse than you can imagine. I can't even tell you how bad it is." The kid said, "Really?" It got his attention. I said, "Yes, but I can't go down that road or we'll both end up dead." That's pretty irreverent, because it's not what he was expecting to hear. He really turned around.

Most people are very serious when they talk about suicide. It is a serious matter, of course. But being serious all the time is not the answer. The occasional irreverent statement, spoken with humor, warmth, and support, can be an effective tool. It can produce fireworks, sometimes when you least expect them. It's all in the timing. A client might get angry, for instance, and scream at me that a friend will take care of her dog when she's dead. I would say, "Well, I am going to tell them not to. So if you want your dog to live, you have to stay alive."

Acceptance: For Both the Client and the Therapist

One of the reasons I developed a therapy that was out of the mainstream was likely because my academic training was in science and the methodology of scientific research. I hadn't formally trained as a clinician, dealing with clients. I was saved from "therapy-ese"—the approach to treatment that is highly rule-bound, overly "fragilizing" of clients, with oh-so-soft voices on the one hand, treating them as damaged human beings in need of coddling, and judgmental invalidation on the other. I learned to apply science-based treatment at Stony Brook, but I had arrived there with an already developed philosophy of treatment. That philosophy, of compassion and love, later drove my development of DBT.

You could say there were two realizations that set me on the path to DBT. First, I had to accept clients for who they were, as well as accept the tragedy of their lives. Second, clients *also* had to accept the tragedy of their lives. I had to accept the slow pace of change, the attacks and anger from clients, the refusal to do what I wanted them to do. I also had to accept the real risk that he or she might die; I could even be sued. I saw what was needed—acceptance—but I didn't know how to do it myself, and I didn't know how to teach it.

Therapist Teams

Working with highly suicidal people is extremely challenging. Your emotions pull you in different directions. At one extreme is trying to take control of the patient's life, to save them from themselves. At the other is wallowing in compassion and empathy, sharing in the patient's misery and despair. Neither response is helpful. Therapists who work with highly suicidal people need emotional support themselves. This was why I developed the requirement for therapist teams.

Teams have two main responsibilities: first, to keep therapists effective and in compliance with DBT therapy, and second, to provide support to reduce therapist burnout. Teams are like therapy for the therapist. They are coaches and consultants to one another. Therapist teams also agree that all therapists are responsible for all clients. If a client commits suicide, and a therapist on the treatment team is later asked, "Have you ever had a client commit suicide?" the therapist has to say yes, even if he or she did not personally treat the client. This is no small responsibility.

Six Rules to Guide Therapists

I developed a set of six consultation agreements for therapists. Of the six, my favorite is the Fallibility Agreement. No one therapist is perfect, or can be. This rule, then, is that we have to accept that all therapists are fallible and can make mistakes that cause clients pain and suffering. "Therapists are all jerks," as we express it in the agreement. This rule, which is called the Fallibility Agreement, and the five others* are vital for providing support for every therapist on the team.

We were making good progress at this point (the early eighties), and I was encouraged by our direction. The combination of change skills and acceptance skills was new to psychotherapy. Now we needed a name for this new therapy.

* The others are the Dialectical Agreement, the Consultation-to-the-Patient Agreement, the Consistency Agreement, the Observing-Limits Agreement, and the Phenomenological Agreement.