



Treatment Failure in Dialectical Behavior Therapy

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Dialectical behavior therapy (DBT) has become a widely used treatment model for individuals with borderline personality disorder (BPD) and other individuals with significant emotion dysregulation problems. Despite its strong empirical support, DBT obviously does not have positive outcomes for all individuals. It is critical that cases of DBT nonresponse be analyzed so that further treatment development efforts can be made to enhance treatment outcomes for all individuals in DBT. Following an overview of DBT and its approach to the notion of “treatment failure,” a detailed case example of unsuccessful treatment with a woman with severe BPD is provided. Analyses of possible reasons for the treatment failure, as it applies to the specific case and other DBT cases more broadly, are offered. Research and clinical implications are discussed.

Don't be discouraged by a failure. It can be a positive experience. Failure is, in a sense, the highway to success, inasmuch as every discovery of what is false leads us to seek earnestly after what is true, and every fresh experience points out some form of error which we shall afterwards carefully avoid. —John Keats

EVERY clinician who has treated a suicidal client has likely experienced the dread of wondering if the person will make it to the next session alive and/or the sensation of entering a session feeling paralyzed by hopelessness and fear. When the suicidal client also has a diagnosis of borderline personality disorder (BPD), these feelings may be heightened by a history of extreme ups and downs in the therapeutic relationship or accompanying judgments about the person or his or her behavior and intentions. BPD is a notoriously difficult-to-treat psychological condition and has been referred to as “the virus of psychiatry” (see Simmons, 1992). Fortunately, the field has made tremendous gains in recent years toward developing efficacious psychological treatments for BPD, with or without suicidal behavior (see Zanarini, 2009).

Dialectical behavior therapy (DBT) is probably the most widely known such treatment and has received the most empirical support to date. DBT was originally developed by Marsha Linehan to treat chronically suicidal individuals with BPD (Linehan, 1993a, 1993b). It has since been adapted to treat various populations, including, but not limited to, individuals with BPD and

substance use disorders (Linehan et al., 2002), eating disorders (Telch, Agras, & Linehan, 2000), depressed elderly clients with personality disorders (Lynch, Morse, Mendelson, & Robins, 2003), and suicidal adolescents (Katz, Cox, Gunasekara, & Miller, 2004). This paper will focus specifically on the use of DBT with individuals with BPD; however, many of the issues discussed will be relevant to other DBT adaptations.

Several factors related to the treatment of BPD are important to mention in the context of describing treatment failures and impasses. First, the diagnosis of BPD is strongly associated with suicide; studies have indicated that up to 8% of individuals with the diagnosis ultimately commit suicide (see Linehan, Rizvi, Welch, & Page, 2000, for a review). Up to 75% of BPD individuals engage in nonsuicidal self-injury (Clarkin, Widiger, Frances, Hurt, & Gilmore, 1983; Grove & Tellegen, 1991; Stone, 1993), which is a significant risk factor for eventual suicide, even if there is no intent to die (Cavanagh et al., 2003; Hawton & van Heeringen, 2009). Second, individuals with BPD are high treatment utilizers. Research has found that individuals with BPD receive significantly more individual therapy, group therapy, day treatment, or psychiatric hospitalizations than individuals with major depressive disorder or other personality disorders (Bender et al., 2001). Given this high degree of utilization in the context of continued problematic behavior, it is likely that much of the services BPD individuals are receiving are not effective. Third, high dropout rates are not uncommon with this population and usually occur within the first 3 to 6 months of treatment (Kelly et al., 1992; Skodol, Buckley, & Charles, 1983; Waldinger & Gunderson, 1984). These rates are reduced in DBT studies, which demonstrate

about a 15% to 30% dropout rate across multiple studies (Linehan et al., 1991; Linehan, et al., 2006; Verheul et al., 2003). Finally, BPD is associated with a number of other behaviors that interfere with successful delivery of treatment, such as leaving sessions early or not leaving when the session is over, extreme emotion dysregulation in session, dissociation in session, no-showing appointments or showing up extremely late, not paying for therapy, and not doing homework and other assigned tasks (Linehan, 1993a; Stone, 2000). Taken together, these factors suggest that treating BPD requires significant time and effort, may not always be met with success, and calls for a focus on supporting the therapist. One of the reasons for DBT's widespread popularity among the mental health community is its explicit focus on taking care of the therapist via the emphasis on a mandatory, weekly consultation team (Fruzzetti, Waltz, & Linehan, 1997; Linehan, 1993a).

An Overview of DBT

Standard DBT is a cognitive-behavioral treatment that includes four modes designed to address different functions of comprehensive treatment. The modes are individual therapy, skills training often in the form of group, as-needed telephone coaching, and therapist consultation meeting. The five functions of treatment are to increase motivation (largely addressed in individual therapy), enhance capabilities (addressed in skills training), generalize to the larger environment (addressed primarily through phone coaching), structure the environment (addressed through individual therapy or bringing friends and family members in to sessions), and increase therapist motivation and competence (therapist consultation team).

The overarching goal in DBT is to help the client with BPD build "a life worth living." This goal is met by balancing standard change strategies from CBT with acceptance strategies. The central "dialectic" in DBT exists in the tension between accepting the client exactly as he or she is in that moment and simultaneously pushing the client toward changing maladaptive behavioral patterns. The three theories that inform DBT result in a principle-driven treatment (as opposed to a protocol-driven treatment). These theories are the biosocial theory for the etiology of BPD, behavior theory, and a dialectical philosophy.

The biosocial theory is used to explain the development of pervasive emotion dysregulation considered the primary feature of BPD. It suggests that this pervasive emotion dysregulation develops from the transaction between a biologically based vulnerability to emotions and an invalidating environment. This dysregulation takes the form of greater sensitivity to emotional stimuli, greater intensity of emotional experiences, and slower return to baseline (Lynch, Chapman, Rosenthal, Kuo, &

Linehan, 2006). DBT seeks to address this dysregulation by both emphasizing the use of validation strategies (to counter a long history of invalidation by others and the self; Linehan, 1997) and teaching emotion-regulation skills so the individual can develop new ways of responding or strengthen preexisting adaptive responses.

The second theory, behavior theory, is used to explain the development and maintenance of problematic behavior. DBT adopts a broad view of "behavior" to refer to everything an organism does, including thinking, talking, feeling, and overt action. Behavior is conceptualized according to principles of classical and operant conditioning and/or observational learning (modeling). Furthermore, because principles of behavior are universal, it is assumed that therapists' behavior are under the same influence of antecedents and consequences as clients' behavior. In DBT, behavioral theory informs the entire treatment, including problem definition, assessment, case formulation, and solution generation. Problematic behavior is viewed as the result of one or more of the following: skills deficit, cued responding, reinforcement of maladaptive behavior or punishment of adaptive behavior, or cognitive factors. Thus, the primary DBT interventions are skills training, exposure, contingency management, and cognitive restructuring.

The third theory that informs DBT, dialectical theory, is used to help both the therapist and the client adopt a worldview that emphasizes the nature of reality as interrelated and connected and continually in a process of change (see Linehan & Schmidt, 1995, for more detail on the dialectics of DBT). From a dialectical perspective, opposing forces (thesis-antithesis) exist simultaneously. Thus, tension and conflict are inevitable and not to be avoided. In fact, tension is often the prerequisite for change. DBT therapists search for the synthesis between opposing forces and teach their clients to attempt to do the same. Dialectical thinking in the therapist emphasizes finding the "middle path" in contrast to rigid, black-and-white styles of thinking. The primary dialectic that informs all aspects of DBT is *change versus acceptance*. Thus, interventions include both change- and acceptance-oriented techniques and clients are taught skills for both changing and accepting themselves and reality as it is.

Based on these theories, DBT is organized hierarchically into stages and each stage is associated with specific targets for intervention (Linehan, 1993a). Following a pretreatment stage in which the goal is to obtain the client's commitment to treatment, Stage I consists of working toward behavioral control by targeting hierarchically: first, suicidal, homicidal, and self-injurious behavior (life-threatening behaviors); second, behaviors on the part of the therapist or client that interfere with successful delivery of treatment (therapy-interfering behaviors); and third, quality-of-life interfering behaviors, which are often

severe Axis I disorders, as well as other significant psychosocial problems that interfere with a person's ability to maintain a reasonable quality of life (e.g., homelessness, job maintenance, and severe relationship impairments). Other stages and targets for each stage are discussed more thoroughly in Linehan (1999).

Empirical Standing of DBT

DBT has been the subject of multiple randomized controlled trials and numerous other quasi-experimental studies (see Lynch, Trost, Salsman, & Linehan, 2007, for a review). These studies have suggested that DBT is effective for that which it intends to target, i.e. DBT reduces suicidal and self-injurious behavior in trials of individuals chosen for a history of suicidal behavior, DBT reduces drug use in studies of individuals selected for drug dependence, etc. Further, as discussed earlier, DBT is more effective at keeping individuals in treatment than control conditions. However, as with any treatment, DBT has its limitations. Many individuals continue to engage in problematic behaviors following a year of DBT, suggesting that further efforts must be made to better understand and treat the core problems in BPD. For example, in one study, 35% of individuals in DBT reported at least one episode of intentional self-injury in the last 6 months of a 1-year treatment, though this was significantly less than the 57% in the control condition (Verheul et al., 2003). In another study, nearly 20% of individuals in DBT were hospitalized for a psychiatric reason during the treatment year (compared to nearly 50% in the control condition; Linehan et al., 2006). In a study on DBT for opiate-dependent individuals with BPD, 35% of the small sample had positive urinalyses during the last 4 months of treatment (Linehan et al., 2002).

Although these isolated statistics from three studies do not provide the full picture for every individual enrolled in a DBT program, they do illustrate that many individuals likely continue to suffer from BPD and related problems even after a year of treatment. Given the severity of the disorder, this is likely not that surprising. However, the emphasis on demonstrating one treatment is more effective than another (so called "horse race studies"), which has dominated the research on DBT, unfortunately does not address the needs of individuals who do not respond to any treatment. More research that documents the experience of individuals who do not respond to DBT treatment is sorely needed.

There is also a surprising dearth of studies on predictors of treatment response in DBT. In their 1-year study of individuals with BPD, Verheul and colleagues (2003) found a trend toward greater effectiveness of DBT for individuals who were more severe at baseline (defined as a median split based on lifetime number of self-injurious acts). Ongoing studies examining mechanisms

of change in DBT as well as dismantling studies that examine the relative effectiveness of different components of DBT will hopefully address this deficit (Lynch et al., 2007).

Defining Treatment "Failure" in DBT

Determining treatment success or failure for BPD can actually be quite nebulous, as there are few outcome measures designed specifically for the disorder. This is in contrast to many discrete Axis I disorders that have popular psychometrically sound outcome measures that are gold standards in the field and are used in most, if not all, treatment outcome research. For example, the Beck Depression Inventory (BDI; Beck, Steer, & Brown, 1996) or Hamilton Rating Scale for Depression (HAMD; Hamilton, 1960) are both widely used as measures of treatment outcome for depression or dysthymia. Many researchers use standards to determine when someone is considered a responder to treatment or is no longer depressed (e.g., a score less than 11 on the BDI). By comparison, treatment research with BPD individuals lacks a standardized, widely agreed upon set of measures, which makes defining success more difficult. Most clinicians would agree that the absence of suicidal or self-inflicted injurious behavior is a desired outcome, but for how long should a person be abstinent before being considered a success? Does this length of time differ for a person who used to self-injure every day compared to a person who "only" self-injured every few months? These questions are similar for any problematic behavior one hopes to reduce within the context of therapy for BPD (e.g., drug use, premature "quitting behavior," risky sexual behavior, relationship conflict).

The idea of treatment success in BPD is even more murky when one considers measuring "urges" rather than discrete behaviors. If an individual with BPD has stopped cutting but still experiences extremely high urges to cut when faced with a stressful situation, is that more or less successful than someone who very rarely experiences urges but cuts when he does? Similarly, how to assess success in a person with chronic suicide ideation, but no action, is also complicated. In DBT, these urges are constantly monitored via a daily diary card that the client completes and shares with the individual therapist each session. Although primarily used as a clinical tool to help the therapist determine treatment targets for each particular session, the diary card can also be used as an outcome data measure. Therapists can chart urges over time, as they relate to particular interventions used, and by so doing, create a more standardized tool for assessing change.

A further complexity in measuring success or failure in DBT is the premise that the core feature of BPD in the DBT model is emotion dysregulation. Emotion

dysregulation is broadly defined and not easily measured. A growing number of self-report measures for emotion regulation have been developed; however, it is unclear as to how well these measures assess change vis-à-vis treatment. Moreover, there are no widely accepted standards for interpreting scores on such measures, so there is no consensus on what constitutes a “normal/adaptive” level of emotion dysregulation versus an “abnormal/maladaptive” level. All of these factors contribute to the premise that measuring success and failure in the treatment of BPD is far from uniform and open to a great deal of interpretation.

With all these limiting factors in mind, treatment failure in DBT is obviously a very real, and not infrequent, occurrence. DBT has a particular, and perhaps unique, position about treatment failure, which is part of the overarching set of assumptions about treatment. The position states that although DBT therapists can fail and DBT itself can fail, the client in DBT cannot fail (Linehan, 1993a). Therapists can fail by not applying the treatment according to the protocol. DBT as a treatment can fail if it does not achieve its desired outcomes for a particular client, even when applied adherently. Of course, we know that no treatment is 100% successful and it is this lack of uniform success that will continue to drive necessary further treatment development efforts in the field. From a DBT perspective, the idea that a client can fail in treatment is antithetical to other treatment assumptions like “the client is doing the best that he can” and “the client wants to improve.” As Linehan (1993a) writes, the idea of attributing failure to the therapist or the therapy instead of the client “contrasts with the assumption of many therapists that when patients drop out or fail to improve, it can be attributed to a deficit in their motivation. Even if this assumption is true, the job of therapy is to enhance motivation sufficiently for the patients to progress” (p.108). Thus, the responsibility of improving treatment success lies with the therapist, the treatment team, and treatment developers.

Case Illustration¹

Barbara was a 28-year-old, single Caucasian woman who, as part of a larger study, was assigned to receive 6 months of treatment with this author. Prior to starting treatment, Barbara underwent a comprehensive diagnostic evaluation. In addition to BPD, she was diagnosed with severe major depression, subthreshold posttraumatic stress disorder, and social anxiety disorder. Her GAF score was 38. Barbara grew up with both parents and a brother. She reported being physically and emotionally abused by her father from a very young age and had

ceased to communicate with him since early adulthood. She also reported a very strained relationship with her mother. Barbara stated that she held her mother primarily responsible for the abuse she endured by her father since, in her view, her mother knew and did nothing to stop it. Barbara reported very few friends and acquaintances, and spent nearly all her time alone. She stated she had tremendous difficulty interacting and connecting with others. For many years, she had held a job as a night janitor at a local school which was almost entirely solitary, except for the occasional interactions with her supervisor. Prior to enrolling in this treatment study, her past treatment history consisted of seeing a female therapist when she was 20. After about 4 months of treatment, she and the therapist became romantic partners and lived together for 3 years before a volatile breakup.

In terms of DBT target behaviors, Barbara had a history of two suicide attempts during her teenage years. In both attempts, she had overdosed on a variety of prescribed and over-the-counter medication and in both cases, she woke up after several hours and never sought medical help. She reported a chronic low level of suicide ideation that would spike to high levels periodically when she was under a great deal of stress. She had cut herself intentionally once but reported no urges to continue to do so. Barbara also had significant problems with anger, which was considered a target within quality-of-life-interfering behaviors. Barbara's anger problems largely centered around interactions with her work supervisor. She stated that she tried to avoid him as much as possible but, based on the nature of her work, had to occasionally interact with him. At those times, she stated that he would “purposely try to piss [her] off” by criticizing her work. Although she had screaming matches with him on more than one occasion, she was never written up and her job did not appear to be in jeopardy. Other quality-of-life-interfering behaviors included extreme isolation and a high degree of anxiety and depression. Barbara was clearly in Stage I of DBT.

Observationally, Barbara presented with some odd behaviors and mannerisms, many of which became therapy-interfering behaviors. During her three assessment sessions (conducted by a clinical assessor, not the therapist) and her first few therapy sessions, she would wear very baggy clothing and a baseball cap pulled low on her face so that her eyes were all but obscured. When sitting in her chair, she would often rock back and forth in a highly agitated manner. She would rarely make eye contact, and when she did, her expression appeared quite angry and accusatory. She had developed an attachment to the clinical assessor, which is not that unusual an occurrence, but this attachment was also accompanied by behaviors that made the assessor feel uncomfortable, such

¹ Details about the case have been modified to protect the identity of the client.

as asking personal questions about where she lived and what she liked to do, and writing her intimate notes. The director of the assessment team stepped in and asked Barbara to cease this behavior, at which point she did, stating that she also felt humiliated by her own behavior. As part of my training experience, she was assigned to me as my first DBT client. She would also receive weekly group skills training with two other DBT therapists as skills trainers.

Therapy with Barbara was extremely difficult and exhausting from the very first moment. It is hard to describe in words the experience of sitting across the room from her. Every attempt that I made to ask a question was met with either silence, anger, or a return question that was usually off-topic and personal (e.g., “Where did you grow up?” “What music do you listen to?”). Furthermore, she was quite agitated during most of her sessions, either rocking back and forth or shaking her legs vigorously. Attempts to determine the source of her agitation were responded to similarly. Many of the sessions had huge gaps of silences.

Interestingly, despite the long silences in session and the seeming lack of collaboration or attachment to me when we were together, Barbara paged me frequently from the very beginning. Between the first and second session, she called me in crisis as a result of a blowup with her boss, stating that she was having thoughts of killing herself so that she could “end [her] misery forever.” This phone call, and most of the other phone calls we had, was filled with loud and constant crying on her part, which resulted in me not being able to understand her and having to ask repeatedly what was happening so I could be helpful. As a novice therapist, I knew that phone calls in DBT were primarily to be used to provide brief *in vivo* skills coaching and that these phone calls were lasting too long (probably on average more than 20 minutes) and occurring too frequently (almost every day, if not several times in one day). However, despite this knowledge, I felt too nervous ending them earlier if I didn't have a sense of what was happening, for fear that she might kill herself or do something else reckless.

Clearly there were a number of therapy-interfering behaviors to attend to, in addition to the life-threatening behaviors of suicide ideation and suicide threats. These included, but were not limited to: noncollaborative behaviors in session (shutting down, not speaking, angry responses), excessive and nonproductive phone calls, and other behaviors that pushed my personal limits, such as repeatedly asking me personal questions. Unfortunately, my attempts to gain commitment to work on *any* of these behaviors seemed futile. Moreover, it seemed like any progress made was met with a huge setback. For example, Barbara was intermittently missing her group skills training. She said that she had trouble relating to other

people in the group and reported that she sometimes found the skills trainers to be “patronizing.” During one individual therapy session, I worked to gain her commitment to attend group the following week. My primary rationale was (in addition to lessening the risk that she might get dropped from the program if she were to miss four in a row) that she needed the skills that they were teaching to help reach her goals and reduce her severe emotion dysregulation. She agreed to attend the next group (a not-so-minor victory) but when she showed up, she was visibly intoxicated and was asked to leave the group by the co-leader, as per the guidelines of the group. Barbara stated that she drank so that she would be more relaxed during group and interpreted this episode as rejection as well as “unfair” and called me in an extremely dysregulated state to complain.

Unfortunately, the worst was yet to come. I was feeling completely ineffectual in my treatment with Barbara, which, in retrospect, was leading me to become more and more rigid in my approach. I would attempt to follow “the rules” of DBT—ask for the diary card, conduct a chain analysis on the highest target behavior, identify problematic links and offer skillful replacements—and then get deeply frustrated and punitive when the session didn't go the way I wanted. After she had been in therapy about 3 months, Barbara began to repeatedly ask the question, “So have you figured out what my problem is yet?” in various forms. I first attempted to understand what she meant by this question, to no avail. She would simply repeat the question verbatim without clarifying. I then decided to take the question at face value and attempted to address the question by providing didactic information about the diagnosis of BPD, its associated problems and features, and the other diagnoses that had been yielded by her comprehensive assessment. When I did this, Barbara would either sit back and smirk at me or get deeply upset and tell me that I “obviously didn't have a clue as to what was going on.” I would implore her to “give me a clue” but she would refuse. Finally, perhaps out of desperation, I decided to extinguish this behavior by not responding to the question. This approach had moderate success.

Over the course of the 6-month treatment, Barbara's level of suicidal ideation and number of suicide threats far exceeded what was expected based on her initial evaluation. It was never clear whether she had minimized her suicidal intent either deliberately or whether she became significantly worse in this area upon entering treatment. However, from the first between-session phone call, it was clear that Barbara presented a much greater suicide risk than initially believed. Her plans to kill herself often centered around hanging herself. During one session, she admitted to having a noose in her car. We spent the entire session working to get her agreement to

give me the noose before she left, and then I followed her out to her car to retrieve it. One time she called me as she was walking around a local gun store saying that she planned to purchase one so that she could shoot herself immediately. Another time, when she was intensely angry with me, she told me that she planned to hang herself on the tree outside my office and pin a note to her chest stating that I was responsible for her suicide. All of these calls left me with frayed nerves, a newly formed conditioned anxiety response to the sound of my pager, and a greatly reduced sense of efficacy.

Throughout treatment, it had always been clear that despite our high level of conflict, Barbara was deeply attached to me. In fact, her efforts to gain personal information about me were, in my formulation, indicative of her desire to get closer to me and feel more understood. I also recognized that her learning history played a large role in this pattern. Her previous therapy had turned into a romantic relationship and although Barbara never wanted to discuss this, I was confident that asking personal questions was reinforced by the previous therapist. I discussed this issue extensively with my team. Although I am, in a manner consistent with a DBT approach, comfortable sharing a great deal of information about myself with my clients, there was something about the way Barbara asked the questions and seemed to relish the answers that made me nervous in a way I hadn't felt before.

Toward the end of our 6 months in therapy, I contemplated our future together. In spite of everything, a part of me did not want to accept failure and there was a strong desire to continue to work with her. Of course, another part of me wanted to close this chapter of my life and not have the constant fear for her life and dread that came from each phone call. In significant consultation with my team, I decided it was for the best that I not continue with Barbara. She hadn't made significant progress over the previous 6 months and there was a possibility in my mind that her condition had worsened. We spent the majority of our last 4 weeks working toward termination. Of course, standard with the DBT model, we had discussed termination from the very beginning of treatment. Barbara continued to ask me pointed questions and also continued to try to "test" me on my knowledge of her. In the very last session, she said to me: "I'm going to tell you my diagnosis—what I've had all this time that you never figured out. I'm going to write it on this piece of a paper and then leave it here. I don't want you to look at it until after I leave." I was taken aback by this whole situation, stymied about what the "right" response might be, and let her do as she asked. We said goodbye, she left a piece of paper in my office and walked out. I took a deep breath, opened the paper, and saw that she had written "Body Dysmorphic Disorder."

At her final assessment, Barbara's scores on several outcome measures were virtually unchanged from her baseline assessment 6 months earlier. Her BDI score had gone from a 35 at pretreatment to a 28 at posttreatment, both indicating severe levels of depression. Similarly, her score on the HAMD decreased ever so slightly from a 28 to a 26. Her scores on the five anger scales that constitute the State Trait Anger Expression Inventory (STAXI; Spielberger & Sydeman, 1994) had only changed by 2 to 4 points each, sometimes in the reverse direction. Despite the problems inherent in measuring success in treatment for BPD discussed earlier, it was clear by all accounts that this was an example of treatment failure.

Reflections

It has been several years since my treatment with Barbara, yet I continue to explore the case as an opportunity for learning and further treatment development efforts. Although it is easy to look back with a "hindsight is 20/20" perspective, I also try to recognize the extreme difficulties of the case that would have impaired my ability to be effective, no matter what my degree of knowledge. However, I believe that treatment "failed" with Barbara for the following reasons: objective measures of psychopathology did not change, subjective reports of distress did not change, and we were no closer to a life worth living at the end of treatment than we were at the start. According to the DBT assumptions, this failure was a result of either the therapist not adhering to the model of DBT and/or the treatment of DBT being insufficient.

DBT can be an incredibly difficult treatment to implement. It requires a thorough knowledge of and competence in behavior therapy. Added to that are the myriad of validation, dialectical, and other core strategies that round out the treatment. In the history of the development of DBT, Linehan describes adding validation and dialectical strategies because standard behavior therapy did not work with an extremely emotionally dysregulated population such as BPD. Thus, the complexity of the treatment matches the complexity of the population. For a novice therapist, the number of treatment elements to keep in mind at once can seem overwhelming.

In retrospect, one overarching problem in my delivery of DBT with Barbara was the lack of consistency regarding treatment targets. The model requires that first, life-threatening behavior, and second, therapy-interfering behavior be addressed before focusing on any other behavior or problem. This system often means delaying everything the client wants to work on or talk about until other higher-order topics are addressed (e.g., the client may say, "I don't want to talk about suicide ideation or not going to group last week, I want to talk about how to get

me less depressed!”). In Barbara's case, I believe I would have been more effective if I was more insistent and consistent with addressing her suicide ideation and threats and her extreme therapy-interfering behavior. Instead, I often got distracted onto other topics. Usually, if I noticed that Barbara was more collaborative one day, I would myself become avoidant of bringing up more unpleasant topics for fear that Barbara would shut down and/or become angry. However, because I didn't bring them up during those times, we missed opportunities to problem solve for the future and the patterns kept repeating.

Because every interaction with a client provides an opportunity for contingency management, I am also quite sure that I inadvertently reinforced dysfunctional behavior and punished functional behavior throughout the course of treatment. Some of these instances were probably too subtle for me to even recognize in hindsight, though it is important for all clinicians to remember that contingencies are always operating, whether we are planful about them or not. However, there are obvious examples as well. In particular, I believe from the beginning, I reinforced excessive and dysfunctional phone call behavior in that I would take phone calls at all hours, return them promptly no matter what I was doing, and stay on the phone past the point at which I could be helpful and despite extremely maladaptive behavior on Barbara's part. Most of this was done out of my own fear that she would kill herself if I did not respond promptly or stay on the phone with her.

These two factors, therapist avoidance and therapist fear, are likely critical to most instances of treatment failure in DBT, as well as other treatments. Not only was I inconsistent with my application of the treatment more broadly, I was likely also avoidant of bringing up key issues to discuss in my weekly consultation team. The DBT consultation team is a critical component of the treatment and operates to enhance the capabilities and increase motivation for all therapists on the team. However, it also usually works on an “honor system” in that it is up to the individual therapist in most cases to initiate a conversation about a treatment that is going poorly. There are many factors that may interfere with a therapist doing this, some of which were present in my treatment of Barbara. First, therapists may not recognize a problem as it is occurring, and therefore do not think there is anything worth mentioning at the team meeting. Second, therapists may be too embarrassed or ashamed to bring up instances of their own lack of skill or clinical scenarios in which they feel they did poorly. Third, therapists may feel guilty for using too much of the team's time or because the team feels imbalanced. Fourth, there may be power differentials present on the team such that a trainee may not want to bring up something in team if it means she or he would

be evaluated poorly. In my treatment with Barbara, I believe I was partially influenced by not wanting to seem incompetent, or less competent, to my peers as well as feeling guilty for needing more time than an even share given the complexity of the case.

Of course, there are no steadfast rules as to how long any one team member should have the floor in the consultation meeting, but generally, if a client is exhibiting life-threatening behaviors or is at risk of being dropped from the treatment program (because of four misses in a row or another egregious therapy-destroying behavior), the clinician should bring this up on team. The model of DBT is that it is a community of therapists treating a community of clients. From this perspective, all therapists on a consultation team are responsible for each and every client being treated. The entire team failed to treat Barbara effectively.

The other possible reason why DBT did not “work” for Barbara is that it was insufficient as a treatment. No treatment is 100% effective for all clients. This fact drives continuing treatment development efforts. Given that DBT is a principle-based, rather than protocol-based, treatment, it is more difficult to isolate the particular ways in which the treatment itself was substandard. One possibility with regard to the treatment with Barbara is, given the complexity and severity of her disordered behavior, more treatment than was provided in the comprehensive outpatient model was needed. Perhaps an even more structured treatment would have been more effective, such as partial hospitalization or day treatment. A limitation to those methods of treatment, however, is that they take the client out of her natural environment. Despite the problems with her boss, Barbara was able to hold down a job for many years and paid all her bills on time. I was worried that placing her in a higher order of care would, in effect, turn her occupation into that of “full-time mental patient,” which might have more negative long-term consequences. I may have been wrong about this. Deciding what level of care is needed for suicidal clients is far from a perfect science. In fact, there are no data indicating that hospitalization is effective for decreasing suicide rates in BPD, compared to outpatient models (Paris, 2004). This is an area in dire need of empirical research. A valid model that provides help with clinical decision making regarding what level of care would be most effective for reducing suicidal behavior would be an extraordinary contribution to the field.

The fact that Barbara believed herself to have body dysmorphic disorder (BDD) and that no one on the treatment or assessment team had a suspicion about it, speaks to the limitations of structured assessments and clinical impression. Although she underwent a comprehensive diagnostic assessment, which included screening

questions for somatoform disorders, her symptoms slipped through the cracks and never came to light. In this scenario, it is easy to fall into a line of thinking that blames the client: "She should have just told us earlier so that we could have helped her." Although I believe that would have been the more effective thing for Barbara to do, given her short- and long-term goals, the dialectical perspective also teaches me to search for another perspective and to move away from rigid thinking. Given the characteristics of the disorder, it is likely that Barbara felt deep shame about her BDD and the particular body feature that was the cause of her distress. She probably believed this feature to be so apparently hideous that anyone, including her therapist, should have seen it and helped her with it. The fact that I didn't could have led her to see me as clueless and incompetent. At the same time, I was one of the few people in her life that expressed any form of caring toward her and thus she was caught in a dilemma of wanting to be close to me but also feeling quite misunderstood. This experience with Barbara highlighted the consequences of extreme shame and provided inspiration for future work on developing DBT interventions for maladaptive shame (Rizvi & Linehan, 2005).

Clinical Implications

From this one illustration of a treatment failure in DBT, there are many lessons that can be applied more broadly. First and foremost, the role and value of the DBT consultation team cannot be underestimated. A healthy DBT consultation team is one in which conflict or tension is tolerated and therapists feel comfortable with disclosing vulnerabilities. In addition, it is the role of other team members to actively seek information if one member has been quiet for several weeks or fails to bring up topics related to a particular difficult case. One implication from learning from unsuccessful treatment cases is that it would be helpful for DBT clinicians to conduct periodic team assessments in which the attributes of the team are openly discussed and efforts are made to repair any problems within the team. These assessments offer the opportunity to evaluate how the team is functioning as a whole and also check in on each individual team member. It would also provide the opportunity to discuss treatment outcome for all the individuals being treated by members of the team. This attention to ongoing treatment outcome monitoring is consistent with the CBT model (see, for example, Persons, 2008) and can serve as a reminder that DBT is an outcome-oriented treatment.

In addition, a helpful rule of thumb when treatment is not advancing is to return to the treatment manual (Linehan, 1993a). Similar to team assessment, clinicians are encouraged to do a self-assessment periodically (or a team assessment) in which certain questions are asked

and answered based on recent clinical interactions. These questions can include, though are not limited to:

Is the therapist balanced in terms of acceptance and change strategies, or is the therapist leaning too much in one direction?

Have the therapist and client become polarized?

Are dialectical strategies being used regularly, and especially in moments of polarization?

Is the target hierarchy being adhered to during each session?

Is the therapist offering DBT skills as solutions to problems?

Video or audiotaping sessions, with the client's permission of course, and then watching clips during team, or with a supervisor, is also a very important strategy for ensuring fidelity to the model and also adding a level of transparency to the treatment. Transparency of the treatment is actually encouraged in DBT and also aids in developing a more collaborative therapeutic relationship (Rizvi, 2011).

Research Implications

There are many research implications that can be drawn from this one case example. There are certain therapist and treatment variables that may be important to examine in terms of identifying concrete ways to improve treatment response. Although a DBT adherence measure exists (Linehan & Korslund, 2003), it has so far been used in outcome studies to determine whether a therapist is adherent or not to the treatment (i.e., as a broad categorical variable). However, it would be useful to know, for example, the relative merits of therapist executions of dialectical, behavioral, and validation strategies for helping a client with severe BPD. In terms of therapist training, it would be helpful to determine how one can effectively learn a treatment with so many different components and with such difficult clients. Currently, there is no research that can guide us on this question. While some supervisors/trainers, such as mine, might prefer the "trial by fire" approach whereby a novice therapist learns the treatment in the context of treating an extraordinarily complex case, others might suggest that starting with a lower severity client would be preferable. To date, we do not have any data to suggest one approach is more effective than the other. It would be interesting, and quite informative for developing appropriate training methods, to conduct research on different methods of training for individuals new to DBT. The role of therapist emotions, such as fear, and behaviors, such as avoidance, that hindered my work with Barbara would be important to study to determine their effects on therapist adherence and client outcome. We can aspire toward developing

“evidence-based training” to improve the quality of the therapists who are attempting to use evidence-based treatments, such as DBT, in their work with clients.

It is also important to examine each case of treatment failure as an opportunity to develop greater awareness of the obstacles that prevented treatment from being more effective and to explore ways in which the treatment could be enhanced for subsets of individuals who do not readily benefit from the standard model. As mentioned, there is a dearth of studies on predictors of successful or unsuccessful treatment outcome in DBT. This limitation needs to be overcome in order for there to be advancement in DBT. As of now, we have very little to inform our decision as to who may be a good fit for DBT. More work also needs to be done with individuals classified as DBT nonresponders. Developing a standard set of criteria for response and nonresponse that is widely accepted by the research community would be a practical first step. Following this, creating long-term studies that develop and test innovative therapeutic approaches with individuals classified as nonresponders would aid in reducing the number of individuals who suffer from severe emotion dysregulation and its consequences.

The dialectical philosophy that serves as the backbone for DBT suggests that change is an inevitable and welcome part of life. As DBT clinicians, we cannot allow ourselves to be too rigid or too loose in our application of DBT. Rather, we must apply the treatment to the best of our ability, in a manner most consistent with the overall model. If that does not work, for a variety of reasons detailed throughout this article, we must find the positive experience in failure. Therapists can use the failure as an opportunity to grow as a clinician, learn from mistakes, and constantly strive toward helping each and every client get closer to his or her ideal “life worth living.”

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