For decades, patients with borderline personality disorder (BPD) have been stigmatized and providers have been left feeling hopeless and overwhelmed in the face of enormous suffering that tended to be unresponsive to traditional treatments. The idea that BPD was relatively static, pervasive, and untreatable served as the basis for the relegation of BPD to Axis II of the multiaxial diagnostic system of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM-IV-TR) and prior editions.

Marsha M. Linehan, PhD, the developer of Dialectical Behavior Therapy (DBT), drew from her own personal experience of recovery and sought to understand empirically and scientifically the elements of treatment that promote recovery from severe and complex mental illness. What came out of this vast effort from her laboratory at the University of Washington is a principled and manualized comprehensive treatment for our most difficult-to-treat patients. Positive outcomes described by her group have been replicated by other groups, and although there have been other psychotherapeutic and psychosocial treatments for BPD, DBT is the most widely studied and supported by the literature. This issue of Psychiatric Annals is meant to define and demystify DBT for psychiatric providers who may not have had an opportunity for exposure to this therapy during training.

Although there have been other psychotherapeutic treatments for BPD, DBT is the most widely studied and supported by the literature.

This issue begins with a viewpoint from the developer of this treatment, Dr. Linehan (see page 148). She discusses her thoughts about the important role of the understanding and application of learning theory in mental health care and she also describes some ways in which psychiatric prescribers can utilize elements of DBT and best partner with DBT therapists in the care of complex patients.

In order to provide a basic overview of the framework and main elements of DBT, Beverly Long, PsyD, LP, and Suzanne Witterholt, MD, describe the relevant principles and terminologies contained within this therapy (see page 152). Drs. Long and Witterholt have both been intensively trained in DBT by Dr. Linehan and have treated severely mentally ill patients together using DBT, starting in a state institutional setting. Dr. Long is a licensed psychologist and Assistant Professor of Psychiatry at the University of Minnesota and has developed a curriculum on DBT for psychiatry residents, including leading a weekly consultation and study group for trainees. Dr. Witterholt serves the State of Minnesota through her work with State Operated Services, a division of the Department of Human Services, and is the psychiatrist community liaison, consulting on diagnosis and treatment plans for some of the state’s most challenging psychiatric patients.

In the next article, Dr. Witterholt and I discuss applications of DBT from the viewpoint of the psychiatric prescriber (see page 158). Clinicians practicing outside of a DBT model often have a number of questions and concerns regarding the treatment of patients with BPD and are unsure how to best collaborate with the DBT therapist. We also discuss a pharmacotherapy session hierarchy of treatment targets with examples.
of target behaviors that correspond to each level. This article was written by psychiatrists as a means to bridge the gap between the disciplines of psychiatry and psychology.

Along with the development of DBT and evolving ideas regarding the conceptualization of BPD came the inevitable question of how to best integrate this knowledge and practice into the psychiatric residency training environment. The residency training program at Columbia University has obtained an R25 training grant from the National Institute of Mental Health (NIMH) for Education Programs of Excellence in Scientifically Validated Behavioral Treatment. Beth S. Brodsky, PhD, Barbara Stanley, PhD, and Deborah L. Cabaniss, MD, describe their approach to integrating DBT into their training curriculum (see page 162).

The Case Challenge included in this issue explores the practical aspects associated with caring for a patient with BPD in the training environment. Laurence Y. Katz, MD, FRCPC, and Sarah A. Fotti, MD, FRCPC, both psychiatrists at the University of Manitoba, describe a case in which care was provided by a resident trainee learning about DBT under the supervision of a DBT intensively trained psychiatrist (see page 172). This case also describes a positive outcome and time course for a patient with BPD having undergone DBT treatment.

The Resident Viewpoint is provided by two former residents, Aerin M. Hyun, MD, PhD, and Emily Gastelum, PhD, who trained in DBT through the Columbia University program, and Beth S. Brodsky, PhD (see page 175). This training significantly impacted their development as psychiatric providers and allowed them to feel more equipped in the treatment of complex and life-threatening disorders.

The idea that there may be hope for patients with BPD and other complex and severe psychiatric illness challenges the classic idea that these patients carry with them a poor prognosis. Ultimately, along with other longitudinal research, BPD is now considered to have a better prognosis than originally believed. This may be one of the contributing justifications for the retirement of the multiaxial diagnostic system slated for the upcoming edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Adherently practiced DBT has served as a pathway for recovery for countless individuals. Psychiatric providers may want to consider their willingness to explore their own understanding and potential applications of this treatment in order to widen potential therapeutic avenues in their care of challenging patients.

I would like to extend my sincerest appreciation to Drs. Witterholt and Dr. Long for their significant assistance in content design and collaboration in this edition of Psychiatric Annals. 

doi: 10.3928/00485713-20130403-03

about the guest editor

Katharine J. Nelson, MD, is certified by the Board of Psychiatry and Neurology and serves as Assistant Professor in the Department of Psychiatry at the University of Minnesota. Dr. Nelson is the Medical Director of the Borderline Personality Disorder (BPD) Program and was trained during residency in Dialectical Behavior Therapy (DBT). She is also the Program Director of the University of Minnesota Psychiatry Residency and has developed a curriculum to educate psychiatry residents about best practices in the assessment and treatment of patients with BPD. Dr. Nelson is an investigator for a clinical trial assessing the efficacy of n-acetylcysteine in the treatment of adolescents with nonsuicidal self-injury and is currently participating in the implementation of DBT training for psychiatric inpatient staff on an adult mood disorders unit.