

# Ten Socratic Questions for Dialectical Behaviour Therapy



Avraham Santopinto, BA hons, BScN, MScN, RegN

Care providers are rarely neutral about patients who make frequent visits to emergency rooms, issue dramatic threats and place frantic telephone calls leading to distorted therapeutic alliances. These clients may be labeled with “borderline personality disorder” (BPD).

How do we bring the rigour of science to bear on new ways of structuring care with these individuals?

## ***DBT: What is it?***

Dialectical behaviour therapy (DBT) is a complex outpatient psychotherapy combining core behavioural methods with contributions from cognitive therapy to Zen philosophy.

DBT, first reported in 1987 by Linehan, consists of weekly individual and group sessions augmented by patient telephone access and therapist supervision sessions. DBT is a manualized therapy, with a training volume, videotapes and an array of approved courses.

## ***The empirical base***

The key study on DBT was a randomized, controlled trial (RCT) with 22 parasuicidal women between 18 and 45 labeled with BPD. It is still awaiting independent replication.<sup>1-3</sup>

One also finds RCTs with nonstandard populations, including depressed elders, adolescents, forensic patients and persons who misuse substances.

DBT studies have generally revealed some improvement in how clients behave, at least in the short term. However, even

### **Some features of borderline personality disorder**

- Stormy relationships
- Dramatic displays of rage
- Fears of abandonment
- Recurrent self-harm
- Chaotic, impulsive lifestyle
- Conflicted when seeking help

### **Factors deemed common to all psychotherapies**

- An articulated theoretic base
- Empathic concern or positive regard
- Boundaries concerning relationships
- Confidence in the treatment mode
- Confidence in the therapist
- Client hopes and expectations

## DBT's split assumptive base

### Zen philosophy

- My every step is on the pathway of perfection
- I am perfect just as I am
- Cause and effect are illusory
- There is no objective reality
- Engage with meditation and mindfulness

### Behaviourism

- Punishment and reward make change happen
- The client must try harder to change
- External stimuli determine the client's responses
- Client behaviour is controlled by the therapist/therapy
- Use cognitive and behavioural technologies



**Mr. Santopinto** is a casual Assistant Professor, The University of Western Ontario, and an Advanced Practice Nurse, Regional Mental Health Care-London, London, Ontario.

Linehan admits that DBT subjects are left feeling “miserable.”<sup>3</sup> Their measured life satisfaction and hopelessness remain unchanged.

## *Why the hype?*

Despite cautionary statements by Linehan, extravagant claims continue to surround DBT. It may be now at risk of becoming a “clinical cult.”<sup>4</sup> Administrators in particular tend to favour the introduction of DBT programs into their agency settings.<sup>5</sup> Despite growing interest and an emergent body of research, one encounters a surprising dearth of scholarly critique of DBT.

## *Ten Socratic questions*

Posing respectful scientific questions is both art and science. The Socratic process of hermeneutic questioning is a useful mode of inquiry.

In view of DBT's dearth of critical commentary, the following questions are posed as a springboard for reflection and dialogue:

## *Ten Socratic Questions* (cont'd on page 79)

- 1 Reviewers describe a “modest” body of DBT research supporting use with parasuicidal women 18 to 45 labeled with BPD.  
*Are uses of DBT with other populations best labeled “experimental”?*
- 2 Enthusiasm in research can be infectious.  
*To what extent may DBT study effects be attributed to research team charisma, morale and general environmental factors?*
- 3 *What are the strengths and limitations of the current research? Do sample sizes support all study conclusions? Have comparison groups been balanced to minimize type II error? Might study effects also be attributed to factors deemed common to all therapies, rather than to DBT itself?*
- 4 DBT builds on a split assumptive base—radical acceptance of each person, on the one hand, versus expectations of patient change on the other.  
*Is this split “dialectical” or is it just contradictory?*



## *Ten Socratic Questions* (cont'd from page 78)

- 5** Swenson and Linehan described DBT as a “directive” practice method.<sup>1,5</sup>  
*What patients are most likely (and least likely) to benefit from “directive” modalities grounded in behaviourism?*
- 6** A split has emerged between directive, manualized modalities and patient-driven approaches.  
*What does this split mean for therapists with relationship-oriented skill sets? Is manualized, behavioural therapy really best practice with our target population?*
- 7** DBT is a complex amalgam of diverse methods. Even advanced practitioners struggle to apply it. “Fidelity to manual” issues are now surfacing in the literature.  
*How can DBT be reliably taught to professionals with varying learning needs?*
- 8** DBT is often adapted, excluding components deemed resource-intensive.  
*When will we see dismantling studies supporting the safety and efficacy of truncated DBT? In the meantime, do adaptations of DBT compromise the balance of care elegantly described in Linehan’s manual?*
- 9** Compelling arguments for therapeutic relationship are found in Linehan’s manual; however, significant differences in therapeutic alliance have yet to be reported between treatment and control groups.  
*Why has DBT not been associated with enhanced therapeutic relationships?*
- 10** Linehan has suggested that DBT leads to only short-term change in selected target symptoms, but scores for suicidality, depression, hopelessness and reason for living remain no different from those of control groups. In addition, data suggest that even DBT’s short-term gains tend to degrade over time.  
*Why has DBT not been associated with sustained patient change?*

### *Concluding thoughts...*

Maintaining scientific rigor is a challenge when struggling with the unsettling presentations of borderline patients. But DBT's modest empirical base deserves the respect of rigorous scrutiny. As a powerful, yet respectful mode of inquiry, Socratic questioning may serve us better than the current culture of silence.

*cme*

#### References

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Further references available—contact  
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