Borderline personality disorder and DBT

Why classic CBT failed Marsha Linehan's most severe clients, and how dialectical behaviour therapy grew out of that failure

DRAFT this text has not yet been approved by the author and may change.

16 chapters ~38 min read

How solid is each fact

Proven by research | Clinical consensus | In the author's own words | Interpretation / disputed | Documented fact | Not verified

In short

- **BPD is a clinical diagnosis, not a "difficult personality".** Borderline personality disorder is lasting instability in relationships, self-image and emotions, plus impulsivity. A clinician makes the diagnosis after an assessment; an online quiz cannot.
- **Two people with BPD can look nothing alike.** DSM-5 requires 5 of 9 criteria, which gives 256 possible combinations. Any "typical borderline" portrait is a caricature.
- **Classic CBT failed these clients at first.** Marsha Linehan started with a change-focused therapy, and her clients heard it as "it's your fault". Pure acceptance sounded like "you don't care". What worked was both: acceptance **and** change.
- **DBT is a programme, not a set of worksheets.** The full model combines individual therapy, a skills group, phone coaching between sessions and a team that supports the therapists themselves.
- **DBT is the most studied therapy for BPD, but it is not a miracle.** Meta-analyses find small to moderate effects with low to moderate certainty, and other good specialist therapies do about as well.
- **DBT changes actions before thoughts.** In a meta-analysis it reduced suicidal behaviour, while the reduction in suicidal thoughts was not statistically significant.
- **BPD is not a life sentence.** Over 16 years of follow-up, almost everyone reached remission of symptoms lasting at least two years; building a stable life with work and relationships was much less common.

- **Linehan herself was never diagnosed with BPD.** At 17 she was diagnosed with schizophrenia, and she spoke publicly about her hospitalisation only in 2011, at 68.

Timeline

From a locked ward to the most studied therapy for BPD. Details and sources are in the chapters below.

1943	Marsha Linehan is born in Tulsa, Oklahoma
1961	At 17 she is admitted to the Institute of Living, a psychiatric hospital in Hartford; diagnosis: schizophrenia
1963	Discharged after 26 months
1967	A spiritual experience in Chicago, after which, in her account, she learned to bear emotional pain
1971	PhD in psychology, Loyola University Chicago
1977	Moves to the University of Washington in Seattle; her work with chronically suicidal clients starts with classic CBT
1985	Six months of Zen training: at Shasta Abbey and with a Catholic priest who was a Zen master
1991	First randomised trial of DBT
1993	Linehan's two manuals: one on treating BPD, one on skills training
2006	Trial of DBT against therapy by the community's top "experts"
2009	UK NICE guidance: consider DBT for women with BPD and repeated self-harm

2011	Linehan speaks publicly about her own hospitalisation
2015	Component analysis: which parts of DBT matter for which outcome
2018	Large trial of DBT for adolescents at high suicide risk
2020	Memoir *Building a Life Worth Living*; Cochrane review of therapies for BPD
2022	Six months of DBT turn out no worse than twelve
2024	World Psychiatry review: no specialist therapy has been shown to beat the others

How to read these notes: evidence labels

Every claim carries a label that tells you how solid it is.

The label comes first in brackets, followed by the source. **Proven by research** means randomised trials (participants are split into groups by chance and the results compared) or meta-analyses (studies that pool many trials). **Clinical consensus** means clinical guidelines such as the UK's NICE. **The author's own account** is what Linehan or her organisations say; not independently checked. **Interpretation** is a reading of the facts by reviewers, historians or the model's authors; the question may still be open. **Documented fact** covers dates, publications and institutions. **Sources disagree** means both versions are given. **Not verified** means we could not open the primary source.

Important This is education, not therapy or diagnosis. These notes discuss suicide and self-harm, without detail, but the topic can be heavy. If you are thinking about harming yourself or need support right now, go to If you need help now at the bottom of the page.

What BPD is, and what it isn't

Before talking about the therapy, it helps to know who it was built for.

Nine criteria, 256 combinations

Borderline personality disorder (BPD) is a lasting pattern of instability in relationships, self-image and emotions, with marked impulsivity. It takes shape by early adulthood and shows up across different areas of life **documented fact; Leichsenring et al., 2024**.

The American DSM-5 requires 5 of 9 criteria. In plain words **documented fact; Leichsenring et al., 2024; NIMH**:

1. Frantic efforts to avoid real or imagined abandonment.
2. Intense, unstable relationships that swing between idealising and devaluing the other person.
3. An unstable sense of self: "who am I?" is hard to answer.
4. Impulsivity in at least two potentially harmful areas, such as spending, substances, driving or binge eating.
5. Recurrent suicidal behaviour, threats or self-harm.
6. Strong mood swings lasting from a few hours to a few days.
7. Chronic feelings of emptiness.
8. Intense anger that is hard to control.
9. Brief, stress-related suspiciousness or feeling cut off from oneself and the world (dissociation).

As far as we know, the current DSM-5-TR (2022) did not change the substance of these criteria **not verified: we did not open the DSM-5-TR text**.

The nine criteria can be combined in 256 ways that meet the threshold, and two people with BPD may share just one criterion **documented fact; Leichsenring et al., 2024**. There is no "typical borderline".

> Important This list is not a self-test. Strong emotions, fear of being left and impulsive decisions are common in people with no disorder at all. What matters for a diagnosis is that the pattern is lasting, shows up across areas of life and clearly gets in the way. A clinician assesses that, usually with a structured interview.

BPD in ICD-11

The WHO's ICD-11 (in force since 2022) dropped personality disorder types. Clinicians first rate severity — mild, moderate or severe personality disorder, or "personality difficulty" — and can then add the "borderline pattern" specifier (code 6D11.5), whose description closely matches the nine DSM criteria **documented fact; WHO, ICD-11; Leichsenring et al., 2024**. Formally, then, an ICD-11 diagnosis reads something like "moderate personality disorder, borderline pattern".

How common it is

According to a 2024 review, the lifetime prevalence of BPD is 0.7–2.7% of adults in the general population, about 12% of psychiatric outpatients and about 22% of psychiatric inpatients **proven by research; Leichsenring et al., 2024**.

Myth vs fact **Myth:** BPD is a "women's disorder". **What the evidence says:** clinics do see more women, about 72% of outpatients with BPD. But in a US population sample the gap almost disappears: about 3% of women and 2.4% of men **proven by research; Leichsenring et al., 2024**. The clinical skew probably reflects who seeks help and who gets this diagnosis (interpretation).

Myth vs fact **Myth:** people with BPD are manipulative. **What the evidence says:** the "manipulative" label is common even among clinicians, and reviews describe it as part of the stigma; many professionals admit they would rather avoid these patients (interpretation; Sansone & Sansone, 2013; McLaughlin et al., 2025). Linehan's model reads such behaviour differently: as an attempt to get quick relief from an emotion that feels unbearable **the author's own account; Crowell, Beauchaine & Linehan, 2009**.

Medication

No medication has consistently been shown to help the core features of BPD; drugs may help with specific severe co-occurring problems such as depression or anxiety **proven by research; Leichsenring et al., 2024**. NICE (2009) advises against prescribing drugs specifically for BPD or its individual symptoms **clinical consensus; NICE, 2009**. The main treatment is psychotherapy.

Sources for this chapter: Leichsenring et al., 2024 · NIMH · WHO, ICD-11 · Sansone & Sansone, 2013 · McLaughlin et al., 2025 · NICE, 2009

Marsha Linehan: from patient to researcher

The creator of DBT kept quiet for half a century about having been a psychiatric inpatient herself.

Everything about her own health here follows her own account — a 2011 New York Times interview and her 2020 memoir — or reviewers' readings. We deliberately leave out any detail of self-harm.

Childhood and hospital

Marsha Linehan was born on 5 May 1943 in Tulsa, Oklahoma, the third of six children in a Catholic family **documented fact; Carey, 2011; Linehan, CV**. She says she was raised to help the poor

and the suffering **the author's own account; UW Magazine**.

On 9 March 1961, aged 17, she was admitted to the Institute of Living, a psychiatric hospital in Hartford, Connecticut. She was diagnosed with schizophrenia and treated with powerful drugs, psychoanalysis and electroconvulsive therapy, and spent long stretches in a seclusion room. A discharge summary dated 31 May 1963 referred to 26 months of hospitalisation and described her as "one of the most disturbed patients in the hospital" **documented fact; Carey, 2011**.

That was when, in her words, she made a vow. "I was in hell," she said. "And I made a vow: when I get out, I'm going to come back and get others out of here" **the author's own account; Carey, 2011**. She added: "I honestly didn't realize at the time that I was dealing with myself."

In a review of her memoir, psychiatrist Awais Aftab writes that her treatment at the hospital seems to have done little good and may have made things worse (interpretation; Aftab, 2020). Linehan herself, reviewers note, writes about the people who treated her without blame (interpretation; Aftab, 2020; Simon, 2020).

Myth vs fact **Myth:** Linehan created DBT because she had BPD. **What the evidence says:** she was never diagnosed with it; in 1961 she was diagnosed with schizophrenia **documented fact; Carey, 2011**. The NYT describes BPD as "a diagnosis that she would have given her young self" **the author's own account; Carey, 2011**, and Aftab calls the nature of her condition partly a mystery (interpretation; Aftab, 2020). The accurate wording: by her own account, what she went through as a young woman resembled what her future clients lived with.

1967: "I love myself"

Leaving hospital was not a cure. The turning point, in her account, came in 1967 in Chicago: while praying in a chapel, she had a vivid spiritual experience and said to herself, "I love myself" **the author's own account; Carey, 2011**. Sources differ on where: the NYT names the chapel of the Cenacle Retreat Center in Chicago, while a reviewer of the memoir places it in a chapel at Loyola University **sources disagree; Carey, 2011; González-Blanch, 2021**.

According to the NYT, when she later tried to understand why she had wanted to die again and again, she arrived at an idea that became the heart of her therapy: hopelessness came from the gap between who she wanted to be and who she was. The way out was to accept herself as she was and still keep working to change **the author's own account; Carey, 2011**.

Into research

Linehan studied at Loyola University Chicago: a BS in psychology in 1968, an MA in 1970 and a PhD in 1971. Then came an internship at a suicide prevention and crisis service in Buffalo and a postdoctoral fellowship in behaviour modification at Stony Brook. From 1977 she worked at the University of Washington in Seattle, as full professor from 1989; she became professor emerita in 2019 **documented fact; Linehan, CV**. Her aim had not changed: to help people who want to die.

Sources for this chapter: Carey, 2011 · Linehan, CV, 2020 · UW Magazine · Aftab, 2020 · Simon, 2020 · González-Blanch, 2021

Why classic CBT didn't work

A therapy that helps many people with depression and anxiety sounded like an accusation to Linehan's clients.

A technology of change

By the late 1970s, CBT — cognitive behavioural therapy, the subject of the earlier episodes in this series — was seen as the most scientific psychotherapy. Linehan called it a "technology of change": therapist and client find problem thoughts and behaviours and agree on what to change **the author's own account; UW Magazine**. Later she admitted: "It didn't actually occur to me that the treatment wouldn't work" **the author's own account; Joseph, 2004**.

Her clients were women with chronic suicidal behaviour, most of whom had BPD. In her account, the classic approach ran into four problems **the author's own account; UW Magazine; Joseph, 2004**:

- **Change sounded like blame.** A focus on what needed fixing came across as "something is wrong with you, it's your fault" — something many of them had heard all their lives. They felt their suffering was being dismissed and turned against the therapy.
- **Too many crises.** As soon as the therapist focused on one problem, a suicide threat over another came up.
- **Missing skills.** Clients lacked the skills to carry out even their own plans.
- **Dropping out.** They missed sessions and left therapy over small things.

Acceptance without change doesn't work either

So Linehan tried the opposite: more acceptance and support. Clients heard that as "you don't care that I'm suffering" **the author's own account; Joseph, 2004**. Her team watched her sessions through a one-way mirror and gave feedback; by trial and error she concluded that both halves were needed **the author's own account; UW Magazine**. "Over time, I figured out that I had to synthesize the two approaches," she said **the author's own account; Joseph, 2004**.

In philosophy, a synthesis of opposites is called dialectics. Hence the name: dialectical behaviour therapy, DBT.

Example After a clash with her boss, a friend says: "I'm awful, I ruined everything." "Let's go through what you did wrong" will probably land as criticism right now. "Oh come on, you're great" will land as brushing her off. A DBT-style reply holds both: "No wonder you feel terrible — it happened in front of everyone. Let's think about what you can do tomorrow."

Taking the Zen out of Zen

Where would acceptance come from? In 1985 Linehan took a sabbatical: three months at Shasta Abbey, a Zen monastery in California, and three more with a Catholic priest who was a Zen master **documented fact; UW Magazine**. She later became a Zen teacher herself **documented fact; Wikipedia, Marsha M. Linehan**.

But her clients were not going to meditate for hours, and they held all kinds of views on religion. So, in her words, she had to "take the Zen out of Zen": keep the practice of attention and acceptance and drop the religious form **the author's own account; UW Magazine**. That is how mindfulness became one of the first acceptance practices built into a behaviour therapy.

Myth vs fact **Myth:** DBT is a Buddhist therapy. **What the evidence says:** its core is behaviour therapy — behavioural analysis, problem solving, managing the consequences of behaviour, exposure. Zen contributed acceptance and mindfulness practices in a secular form **documented fact; UW Magazine; Sonkiss, 2013**.

Linehan framed the goal not as a ban but as a purpose: "We're not a suicide prevention program. We're a 'life worth living' program" **the author's own account; Joseph, 2004**.

Sources for this chapter: UW Magazine · Joseph, 2004 · Sonkiss, 2013 · Wikipedia, Marsha M. Linehan

Where BPD comes from: the biosocial model

Linehan explained BPD as a sensitive temperament meeting an environment that doesn't teach how to handle emotions.

Two ingredients

DBT sees BPD first and foremost as a disorder of emotion regulation — difficulty managing how intense emotional reactions get and how long they last

the author's own account; Crowell, Beauchaine & Linehan, 2009. The biosocial model explains how this develops through two ingredients (interpretation; Crowell, Beauchaine & Linehan, 2009):

- **Emotional vulnerability.** Some people are more sensitive by nature: emotions rise faster, hit harder and take longer to settle. Think of skin without its protective layer: what barely registers for someone else hurts.
- **An invalidating environment.** This means surroundings that dismiss a child's inner experience, especially when there is no obvious outside reason for it: "you're imagining it", "stop crying", "others have it worse". Such an environment is also inconsistent — sometimes punishing emotions, sometimes finally responding when the child "explodes". The child never learns to name, understand and tolerate emotions and swings between bottling them up and big outbursts.

This leads to another idea in the model: self-harm and other risky behaviour can serve a function — bringing quick, if short-lived, relief from an unbearable emotion. The relief reinforces the behaviour, so it repeats (interpretation; Crowell, Beauchaine & Linehan, 2009). This is an explanation, not an excuse: it shows where a replacement is needed.

Not about blaming parents

It is easy to read the model as "the parents are to blame", but that is not how it works. It is transactional: child and environment shape each other in a loop. A child's temperament affects the parents as much as the parents affect the child; a sensitive child in a family that suits them can do well, while a less sensitive child can be at risk in an overstretched family (interpretation; Crowell, Beauchaine & Linehan, 2009). Trauma is common in the histories of people with BPD, but according to the authors it is neither necessary nor sufficient (interpretation; Crowell, Beauchaine & Linehan, 2009).

There is a biological side too: a Swedish population study puts the heritability of BPD at about 46% proven by research; Leichsenring et al., 2024.

How well supported is it?

Honestly: the model is plausible and testable, but not proven. Most data come from adults and older adolescents, and studies that follow children over years are scarce (interpretation; Crowell, Beauchaine & Linehan, 2009).

Sources for this chapter: Crowell, Beauchaine & Linehan, 2009 · Leichsenring et al., 2024

Dialectics and validation: the core of the method

DBT's central pair is acceptance and change, at the same time.

"And", not "but"

Dialectics is a philosophical frame in which truth emerges from a synthesis of opposites. DBT's central pair is acceptance and change **the author's own account; UW Magazine**. For the therapist, it means fully accepting the client as they are while firmly pushing for change. For the client, it means moving from all-or-nothing thinking to "both".

For example: "I'm doing the best I can, **and** I need to do better." With "but", the second half cancels the first; with "and", both stay true.

Validation is not approval

Validation means communicating that a person's feelings and behaviour make sense in their situation, even when they are harmful **documented fact; Sonkiss, 2013**. Validating does not mean agreeing that the behaviour was right.

> Example A colleague gets torn apart at a team meeting and slams the door on the way out. Validation: "No wonder you're furious — that was in front of everyone." That is not "you were right to slam the door". The door can wait until the person feels understood.

Bluntness as a tool

DBT's communication style combines warm reciprocity with what it calls irreverent communication — unexpected bluntness that knocks a person out of a stuck line of thought **the author's own account; UW Magazine**. The aim is not to sting but to move a conversation that has stalled.

Sources for this chapter: UW Magazine · Sonkiss, 2013

How DBT works: four modes and a target hierarchy

Full DBT is not one session a week but several parts working together.

Four modes

Standard, or comprehensive, DBT has four modes **documented fact; DBT-LBC; Sonkiss, 2013**:

Mode	How often	Why
Individual therapy	weekly	motivation, working through specific episodes and target behaviours
Skills training group	weekly, about 2–2.5 hours	teaching skills, like a class with homework
Phone coaching	between sessions, as needed	using a skill in a hard moment — before a crisis, not after
Therapist consultation team	weekly	supporting the therapists, preventing burnout, staying true to the model

The last one is distinctive. Work with people in such despair is hard, and the model holds that nobody should do it alone; within DBT the team is called "therapy for the therapists" **documented fact; DBT-LBC; UW Magazine**.

In the early trials therapy lasted 12 months **documented fact; Linehan et al., 2006**. Programmes with only a skills group are called skills-only, and those using individual elements are called DBT-informed. The evidence applies mainly to the full model **clinical consensus; Behavioral Tech; DBT-LBC**.

The target hierarchy

Remember how multiple crises derailed classic CBT? DBT answers with a strict order of priorities **documented fact; Sonkiss, 2013; DBT-LBC**:

1. **Life-threatening behaviour:** suicidal behaviour, self-harm, suicidal thoughts and urges.
2. **Therapy-interfering behaviour:** missed or late sessions, skipped homework — on the therapist's side as well as the client's.
3. **Quality-of-life-interfering behaviour:** addictions, problems with housing, money or work, co-occurring disorders.
4. **Building skills.**

A session starts with whatever is highest on the list. The therapist no longer chases the problem of the week.

Stages and tools

Treatment begins with a pre-treatment stage in which the client learns how the programme works and agrees on goals and rules with the therapist **documented fact; Sonkiss, 2013**. Stage 1 is behavioural control: staying alive and staying in therapy. Later stages address trauma and

painful emotions, then ordinary life problems and, finally, a sense of a full life **the author's own account; Knowlton, 1999**.

Two main working tools **documented fact; Sonkiss, 2013**:

- **The diary card** — a daily record of emotions, urges, target behaviours and skills used; it sets the session agenda.
- **Chain analysis** — a detailed walk through how one link led to the next: vulnerability, trigger, thoughts, emotions, sensations, urges, action, consequences. The aim is to find the link where a skill could fit in. When the behaviour is self-harm, this is done only with a therapist.

A DBT therapist also coaches clients to deal with other professionals themselves rather than doing it for them **documented fact; Sonkiss, 2013**.

Sources for this chapter: DBT-LBC · Sonkiss, 2013 · Knowlton, 1999 · UW Magazine · Behavioral Tech · Linehan et al., 2006

The four skills modules

The skills are described here in our own words: the programme materials are copyrighted and designed for use with a therapist.

This is how it works in therapy: the group teaches four modules, with mindfulness as the foundation for the rest **documented fact; Sonkiss, 2013; UW Magazine**.

Module	What it is for	An example idea
Mindfulness	noticing what is happening before the automatic reaction kicks in	"wise mind"
Distress tolerance	getting through a crisis without making it worse when the situation can't be changed right now	radical acceptance
Emotion regulation	understanding emotions, lowering vulnerability to them and changing them	opposite action
Interpersonal effectiveness	asking, saying no, keeping relationships and self-respect	choosing a priority for a conversation

Mindfulness

DBT talks about three states of mind: emotion mind, reasonable mind and "wise mind", which brings the first two together with intuitive knowing **documented fact; Sonkiss, 2013**. Wise mind is the moment when you feel hurt, see the facts and know what to do, all at once. To get there, people learn to observe, describe and fully participate — non-judgementally, one thing at a time and with an eye on what works **documented fact; Sonkiss, 2013**.

Distress tolerance

These are skills for moments when the main goal is not to make things worse: distracting yourself, soothing yourself, weighing the pros and cons of acting on an urge **documented fact; Sonkiss, 2013**. This module also includes radical acceptance — fully acknowledging a fact that is pointless to fight **the author's own account; Simon, 2020**. Your flight is cancelled: you can spend an hour fuming at the departures board, or accept it and look for another flight. Acceptance here is not resignation; it is what makes action possible.

Some of the crisis techniques in this module have medical contraindications, so they are chosen with a therapist, not from a video.

Emotion regulation

This module teaches people to name emotions and understand what they are for. Another part is lowering vulnerability by looking after the body: treating illness, sleeping, eating, moving, avoiding substances and doing something every day that builds a sense of competence **documented fact; Sonkiss, 2013**. When you are tired and hungry, every emotion hits harder.

The module's best-known skill is opposite action. When an emotion doesn't fit the facts, or acting on it won't help, you do the opposite of what it urges **documented fact; Carey, 2011**. Scared to make a phone call that is objectively safe? Make it instead of putting it off. In effect this is exposure (deliberately facing what you fear) in everyday form (interpretation).

Interpersonal effectiveness

How to ask and how to say no. Before a conversation it helps to decide what matters most right now: getting what you want, keeping the relationship or keeping your self-respect **documented fact; Sonkiss, 2013**. That choice shapes how you handle it.

Adolescents and families also get a "walking the middle path" module: dialectics in family conflict, validation and principles of behaviour change **documented fact; DBT-LBC**.

Sources for this chapter: Sonkiss, 2013 · UW Magazine · Simon, 2020 · Carey, 2011 · DBT-LBC

Does DBT work? Trials and meta-analyses

DBT is the most studied approach to BPD. But most studied does not mean most effective.

Key trials

1991: the first trial. Women with BPD and recent self-harm or a suicide attempt received a year of DBT or usual community treatment. The DBT group had fewer and medically less severe self-harm episodes, stayed in therapy better and spent fewer days in hospital **proven by research; Linehan et al., 1991**. The sample size is reported differently: the developers' summary lists 24 people in DBT and 23 in usual care, while popular accounts say 44 women **sources disagree; Behavioral Tech, 2016**. For a group considered untreatable, this was a landmark.

2006: against the best. Critics could argue that usual care is often weak. So DBT was compared with therapists whom the professional community had named as the best at working with difficult patients (none of them were CBT therapists). The trial involved 101 women, a year of treatment and a year of follow-up. During the treatment year, 23.1% of the DBT group made a suicide attempt versus 46.7%; 25% versus 59% left their assigned therapist; 19.6% versus 48.9% had a psychiatric hospitalisation **proven by research; Linehan et al., 2006; NIMH, 2006**.

2009: against good general care. A Canadian trial of 180 adults compared DBT with general psychiatric management, a structured approach based on American Psychiatric Association guidance. Both groups improved substantially, with no difference on any outcome **proven by research; McMain et al., 2009**. The good news: more than one method can help.

2015: what actually works. 99 women with BPD and high suicide risk received full DBT, a skills group with case management only, or individual DBT without skills. Suicide attempts fell in all three conditions with no significant difference. The conditions that included skills reduced non-suicidal self-harm and depression more; 48% dropped out of the no-skills condition versus 24% of full DBT **proven by research; Linehan et al., 2015**. The authors concluded that skills training is a necessary component.

2022: shorter, not worse. In a trial of 240 adults, six months of comprehensive DBT was no worse than twelve for self-harm **proven by research; McMain et al., 2022**.

What the reviews say

- **A 2017 meta-analysis** (33 trials, 2,256 participants): psychotherapies had small effects on BPD symptoms, self-harm and suicidality (g = 0.32–0.40; g is a standardised effect size where 0 means no difference). At follow-up only DBT (g = 0.34) and psychodynamic approaches (g = 0.41) beat controls. The effects are inflated by risk of bias and publication bias **proven by research; Cristea et al., 2017**.

- **The 2020 Cochrane review** (75 trials, 4,507 participants): compared with usual care, DBT reduced BPD severity (SMD −0.60) and self-harm (−0.28) and improved functioning (−0.36), but the certainty of all these findings is low. Only the difference in BPD severity reached clinical significance **proven by research; Storebø et al., 2020**.
- **A 2019 meta-analysis** (18 trials): DBT reduced self-directed violence (suicidal behaviour and self-harm; d = −0.32) and use of crisis services (d = −0.38). The reduction in suicidal thoughts (d = −0.23) was not statistically significant. The authors link this to DBT prioritising behaviour over thoughts **proven by research; DeCou, Comtois & Landes, 2019**.
- **A 2024 review:** DBT, mentalisation-based therapy, transference-focused therapy and schema therapy are all supported by trials; none has been shown to be superior; the effect over usual care is moderate (0.50–0.65), and almost half of patients do not respond well enough **proven by research; Leichsenring et al., 2024**.

Myth vs fact **Myth:** DBT is the best therapy for BPD. **What the evidence says:** it is the most studied, but in head-to-head comparisons it does not beat good general psychiatric management or other specialist therapies **proven by research; McMain et al., 2009; Leichsenring et al., 2024**. Comparing approaches is the subject of the next episode.

Adolescents

The evidence is strongest for adolescents with repeated self-harm. In a 2018 US trial of 173 adolescents aged 12–18, all with a past suicide attempt and repeated self-harm, six months of DBT for adolescents with parent involvement was compared with supportive therapy. Right after treatment, 90.3% versus 78.9% had made no suicide attempt and 54.2% versus 36.9% had no self-harm at all; by 12 months the difference was no longer significant. 94.8% of participants were girls **proven by research; McCauley et al., 2018**.

A 2021 Cochrane review: after DBT for adolescents, 30% repeated self-harm versus 43% with other treatment (4 trials, 270 participants), rated as high-certainty evidence, though the trials are few and small **proven by research; Witt et al., 2021**. A meta-analysis the same year also found reductions in self-harm and suicidal thoughts but flagged a high risk of bias in many studies **proven by research; Kothgassner et al., 2021**.

A caution: skills for everyone

In Australia, an eight-session DBT-based programme (WISE Teens) was run for every Year 8–9 student in four Sydney schools (1,071 adolescents, not randomly allocated). Straight after the programme, results on several emotional well-being measures were worse than with regular lessons: more emotional difficulties, slightly higher depression and anxiety symptoms, poorer relationships with parents; six months later most differences had faded, except relationships with parents (proven by research, with limits: a non-randomised trial; Harvey et al., 2023, from

the abstract and a PsyPost summary). The lesson matters: what helps people in severe distress is not necessarily useful to everyone as a class.

Sources for this chapter: Linehan et al., 1991 · Linehan et al., 2006 · NIMH, 2006 · McMain et al., 2009 · Linehan et al., 2015 · McMain et al., 2022 · Cristea et al., 2017 · Storebø et al., 2020 · DeCou et al., 2019 · Leichsenring et al., 2024 · McCauley et al., 2018 · Witt et al., 2021 · Kothgassner et al., 2021 · Harvey et al., 2023 · Behavioral Tech, 2016

Outlook: BPD is not a life sentence

The most hopeful study on BPD is not about any one therapy but about how people are doing years later.

BPD carries a markedly higher risk of suicide **proven by research; Leichsenring et al., 2024**, which is why life-threatening behaviour sits at the top of DBT's hierarchy. Yet the long-term outlook is far better than its reputation.

Mary Zanarini's study at McLean Hospital (Harvard) followed 290 former inpatients with BPD, assessing them every two years **proven by research; Zanarini et al., 2010, 2012**:

Follow-up	Symptomatic remission	Recovery
10 years	93% — remission lasting at least 2 years; 86% — at least 4 years	50%
16 years	99% — remission lasting at least 2 years; 78% — at least 8 years	60% for 2 years; 40% for 8 years

Remission means symptoms fall below the diagnostic threshold. Recovery means remission plus good social and vocational functioning: work or study, close relationships. The authors conclude that sustained remission is substantially more common than sustained recovery **proven by research; Zanarini et al., 2012**. At the 10-year mark, 34% of those who had recovered later lost their recovery **proven by research; Zanarini et al., 2010**.

An important caveat: participants received all kinds of treatment, so this shows the natural course of BPD, not the effect of DBT (interpretation). Therapy probably speeds up and stabilises improvement rather than creating it from scratch (interpretation).

Myth vs fact **Myth:** BPD is forever. **What the evidence says:** for most people symptoms drop below the diagnostic threshold over time. Building a life — work, relationships — is

harder, and that is where people need support **proven by research; Zanarini et al., 2010, 2012**. That is exactly what Linehan's phrase "a life worth living" is about.

Sources for this chapter: Zanarini et al., 2010 · Zanarini et al., 2012 · Leichsenring et al., 2024

DBT beyond BPD, and its critics

From a therapy for one group of clients, DBT grew into a family of programmes — and drew its share of criticism.

Adaptations

- **DBT for adolescents** — parents join the skills group, plus the "middle path" module **documented fact; McCauley et al., 2018; DBT-LBC**.
- **DBT with prolonged exposure for PTSD** (Melanie Harned's protocol) — trauma work begins once behaviour is under control. In a pilot trial of 26 women, 80% of completers reached PTSD remission versus 40% in standard DBT **proven by research, pilot trial; Harned, Korslund & Linehan, 2014**.
- **DBT-PTSD** (Martin Bohus, Germany) — for women with PTSD after childhood abuse; in a trial of 193 women it outperformed cognitive processing therapy **proven by research; Bohus et al., 2020**.
- **Radically open DBT** (RO DBT, Thomas Lynch) — for the opposite problem, overcontrol: people who don't explode but suppress emotions and stay rigid. In a UK trial in treatment-resistant depression (250 adults), the benefit seen at 7 months was no longer significant at 12 and 18 months **proven by research; Lynch et al., 2020**.
- **Skills only** — small trials in binge eating, bulimia, adult ADHD and other conditions **proven by research, small samples; Behavioral Tech, 2016**.

Criticism

- **Smaller than the legend.** Small effects, publication bias, unstable follow-up results and low Cochrane certainty **proven by research; Cristea et al., 2017; Storebø et al., 2020**.
- **Researcher allegiance.** Many early trials were run by the method's own team, and such studies tend to produce results more favourable to the method (interpretation).
- **Almost only women.** In adolescent trials up to 95% of participants are girls; data on men are scarce **documented fact; McCauley et al., 2018; Kothgassner et al., 2021**.
- **Demanding and costly.** It needs individual sessions, a group, coaching and a trained team, which is a barrier in many towns and countries (interpretation).
- **Commercial infrastructure.** Training and certification run through organisations Linehan founded (Behavioral Tech, the Linehan Institute, the DBT-Linehan Board of Certification)

documented fact; Linehan, CV. How to judge that is a matter of opinion (interpretation).

- **The memoir.** Kirkus suggests readers may find DBT less revolutionary than its author presents it (interpretation; Kirkus Reviews, 2020).

Sources for this chapter: McCauley et al., 2018 · Harned et al., 2014 · Bohus et al., 2020 · Lynch et al., 2020 · Behavioral Tech, 2016 · Cristea et al., 2017 · Storebø et al., 2020 · Kothgassner et al., 2021 · Linehan, CV · Kirkus Reviews, 2020

What you can try yourself, and what needs a professional

Some DBT ideas are useful in everyday life. DBT as treatment, though, is a clinical programme.

Ideas you can try in everyday life

- Dialectics: "and" instead of "but".
- Validating yourself and others: "it makes sense that I react this way" — before deciding what to change.
- Noticing and naming an emotion and how strong it is.
- Remembering that sleep, food, illness and alcohol change how vulnerable you are to emotions.
- Opposite action in everyday situations: making the phone call you dread when it is actually safe.

Only with a professional

Self-harm, suicidal thoughts or attempts, and years of severe emotional crises call for a trained professional, not a video or a worksheet from the internet. If there is immediate danger, get emergency help (see If you need help now).

If a service says "we do DBT", it is fair to ask: is there individual therapy, a skills group, coaching between sessions and a team? Where did the therapists train? Certification by the DBT-Linehan Board of Certification requires, among other things, DBT training, a year on a consultation team, an exam and rated session recordings documented fact; Behavioral Tech; DBT-LBC. Without the full model, "DBT-informed" is the more accurate term.

Supporting someone close

Here is what validation looks like in practice (interpretation; Sonkiss, 2013):

Usually helps	Usually hurts
"I can see this is really hard for you right now"	"You're being dramatic again"
"I get why that upset you"	"Calm down"
"Do you want me to listen, or help you solve it?"	"You're being manipulative"
"I'm here" — with clear limits on behaviour	"That's just your BPD talking"

Validating feelings and holding firm limits on behaviour go together — that is dialectics. If someone close talks about wanting to die, take it seriously, ask directly and help them reach support. People close to someone with BPD need support too.

A one-minute exercise: "...and I can..."

This is not a technique from DBT worksheets and not therapy; it simply illustrates the idea of dialectics.

1. Think of something that is worrying or annoying you right now and name the emotion in one word.
2. Rate its strength from 0 to 10.
3. Finish a two-part sentence: "Right now I feel ***, and I can*** ". The first half is acceptance ("right now I feel really hurt"); the second is a small step ("and I can step out for five minutes before I reply").

Not "but" — "and": both halves are true at once. If instead of hurt or anger you notice thoughts of harming yourself, this is not a moment for an exercise — it is a moment to reach out for help.

Wrap-up: check yourself and key takeaways

Check yourself

1. **How many criteria does DSM-5 require for BPD, and why is there no "typical borderline"?** Five of nine; there are 256 possible combinations, and two people with BPD may share only one criterion.
2. **Why didn't classic CBT help Linehan's clients?** They heard the focus on change as blame; there were too many crises, skills were missing and clients dropped out. Pure acceptance sounded like indifference.
3. **What are the two parts of the biosocial model, and why isn't it about blaming parents?** Emotional vulnerability and an invalidating environment; the model is transactional —

child and environment shape each other, and trauma is not required.

4. **What are the four modes of full DBT?** Individual therapy, skills group, phone coaching and the therapist consultation team.
5. **What did DBT change in the meta-analysis, and what not?** It reduced suicidal behaviour and crisis service use; the drop in suicidal thoughts was not significant.

Key takeaways

- Acceptance and change are not opposites but two halves of the same work.
- To validate is to acknowledge that a reaction makes sense, not to approve of an action.
- DBT is well studied, but its effects are modest and other specialist therapies do about as well.
- For most people BPD symptoms fade over time; building a life is harder, and that is the focus of therapy — "a life worth living".
- Linehan was diagnosed with schizophrenia, not BPD. She went public 50 years later, after a patient asked whether she was "one of us" and explained: "Because if you were, it would give all of us so much hope." Linehan said of her decision, "I cannot die a coward," and of herself today, "I'm a very happy person now" **the author's own account; Carey, 2011**.
- BPD and schema therapy, and a comparison of approaches, come in episode 12; another branch of acceptance, ACT, in episode 13.

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If you need help now

If your life is in danger, call your local emergency number: 112 in most of Europe, 911 in the US and Canada, 999 in the UK, 000 in Australia. For support lines by country, see **Help now**.

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