



Dialectical behaviour therapy-informed skills training for deliberate self-harm: A controlled trial with 3-month follow-up data



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ABSTRACT

Dialectical Behaviour Therapy (DBT) has been shown to be an effective treatment for deliberate self-harm (DSH) and emerging evidence suggests DBT skills training alone may be a useful adaptation of the treatment. DBT skills are presumed to reduce maladaptive efforts to regulate emotional distress, such as DSH, by teaching adaptive methods of emotion regulation. However, the impact of DBT skills training on DSH and emotion regulation remains unclear.

This study examined the Living Through Distress (LTD) programme, a DBT-informed skills group provided in an inpatient setting. Eighty-two adults presenting with DSH or Borderline Personality Disorder (BPD) were offered places in LTD, in addition to their usual care. A further 21 clients on the waiting list for LTD were recruited as a treatment-as-usual (TAU) group. DSH, anxiety, depression, and emotion regulation were assessed at baseline and either post-intervention or 6 week follow-up.

Greater reductions in the frequency of DSH and improvements in some aspects of emotion regulation were associated with completion of LTD, as compared with TAU. Improvements in DSH were maintained at 3 month follow-up. This suggests providing a brief intensive DBT-informed skills group may be a useful intervention for DSH.

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Individuals who engage in deliberate self-harm (DSH) are considered among the most complex and difficult to treat client groups (Slee, Arensman, Garnefski, & Spinhoven, 2007). This population typically present with a range of psychological difficulties including Borderline Personality Disorder (BPD), depression, eating disorders, and substance abuse (Nock & Kessler, 2006). While several treatment models have been shown to be effective for DSH (Klonsky & Muehlenkamp, 2007), Dialectical Behaviour Therapy (DBT) has been the most extensively researched (Lynch, Trost, Salsman, & Linehan, 2007). Research examining DBT first emerged over twenty years ago, when the treatment was shown to be effective in reducing self-harm behaviours among individuals with BPD (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991). Since then, several modified versions of the treatment have been developed including adaptations for other treatment settings, such as inpatient settings (Robins & Chapman, 2004).

DSH has been defined as the intentional repetitive destruction or alteration of body tissue, severe enough to cause harm, but without conscious suicidal intent (Gratz, 2003). It includes a broad range of behaviours such as cutting, burning, and biting, and has serious physical and psychological consequences for individuals (Kerr, Muehlenkamp, & Turner, 2010; Messer & Fremouw, 2008). For example, the risk of suicide for those who engage in DSH has been shown to be over 60 times greater than the general population (Hawton, Zahl, & Weatherall, 2003). For these reasons the provision of effective treatment for DSH is a priority for mental health services.

DBT is a structured psychotherapy incorporating individual therapy, skills training groups, telephone support, and a consultation group for therapists (Linehan, 1993). Numerous studies, including several RCTs, have shown that DBT is associated with greater reductions in DSH than treatment-as-usual (Lynch et al., 2007). The effectiveness of DBT in reducing DSH has been further supported by a recent meta-analytic review of treatment studies (Kliem, Kroger, & Kosfelder, 2010). The biosocial model that underlies DBT proposes that acquiring skills to regulate intense emotional distress will lead to reductions in DSH (Linehan, 1993).

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This is consistent with research indicating that DSH may function to provide relief from overwhelming emotions (Klonsky, 2007).

As the full DBT programme requires considerable time and resources to implement (Pitman & Tyrer, 2008), shorter and less intensive versions of the treatment have begun to be examined (Linehan, Bohus, & Lynch, 2009). Most notably, researchers have examined the effectiveness of the DBT skills training group, when provided without other aspects of the treatment. The DBT skills group incorporates mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness skills (Linehan, 1993). Initial studies found shortened versions of the DBT skills group, provided without individual therapy, were associated with reductions in the use of mental health services and improvements on measures of depression, hopelessness, and anger (Koons et al., 2006; Sambrook, Abba, & Chadwick, 2006). However, these studies did not measure DSH and the absence of control groups limits the conclusions that can be drawn. A more recent study found greater improvements in depression, anger, and affect instability for individuals with BPD who attended a DBT skills group as compared to standard group therapy (Soler et al., 2009). However, no improvements in DSH were found for either group (Soler et al., 2009). While the DBT skills training group seems to have several beneficial effects, it remains unclear whether it is a useful treatment for DSH.

While DBT was originally developed and evaluated in community settings, research has begun to examine adaptations of DBT for inpatient settings. For example, Bohus et al. (2004) provided an inpatient adaptation of DBT that involved three and a half hours of individual therapy and four hours of DBT skills groups per week over a three month period. Greater improvements in DSH, depression, anxiety, and interpersonal problems were reported for the DBT group compared to TAU in the community (Bohus et al., 2004). Similarly, Kroger et al. (2006) examined an inpatient version of DBT, involving five hours of the skills group and one hour of the individual therapy per week over three months. They found significant reductions in overall symptoms of mental health difficulties at post-treatment and 15 month follow-up for clients with BPD and multiple co-morbid mental health problems (Kroger et al., 2006). These studies indicate that offering a more intensive form of DBT, over a reduced treatment period, may be an effective adaptation of the treatment. However, further research is needed to determine whether a DBT skills training group alone is a beneficial intervention for those who require inpatient treatment. Of note most previous research on group interventions for DSH has tended to exclude individuals who require inpatient care (e.g. Gratz & Gunderson, 2006; Slee, Garnefski, van der Leeden, Arensman, & Spinhoven, 2008).

Another avenue of research on DSH interventions has begun to explore potential mechanisms of change within these treatments. In line with the biosocial model, improvements in emotion regulation have been identified as a potential mechanism of change within DBT (Linehan, 1993). An initial study found significant improvements in emotion regulation difficulties and DSH for individuals who attended an integrative skills group, as compared to TAU (Gratz & Gunderson, 2006). The treatment included elements of DBT, Emotion-Focused Therapy, and Acceptance and Commitment Therapy (Gratz & Gunderson, 2006). The results indicated improvements in emotion regulation may have been related to improvements in DSH. However, given the combination of treatment models used it was unclear which aspects of the treatment may have contributed to these positive outcomes. A more recent study showed improvements in emotion regulation skills mediated changes in DSH following a short-term individual CBT intervention (Slee, Garnefski, Van der Leeden, et al., 2008). Reductions in DSH were partially attributed to improvements in two aspects of

emotion regulation difficulties, namely impulse control and ability to engage in goal-directed behaviours when distressed (Slee, Garnefski, Van der Leeden, et al., 2008). This indicates that improvements in emotion regulation are likely to be a mechanism of change within treatments for DSH. This is important as identifying mechanisms of change can lead to refinement of treatments and allows the theoretical models underlying the treatments to be tested (Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006). At present the role of emotion regulation in DBT-informed interventions remains unclear and appears worthy of further research.

The current study examined the Living Through Distress (LTD) programme, a DBT-informed skills group for individuals with DSH in an inpatient setting. It is an intensive intervention providing one hour of skills training four days a week over a 6 week period. LTD aims to provide clients with skills they can implement when they experience intense emotional distress, in an effort to reduce their self-harm behaviour. Learning to regulate emotional distress and developing behavioural control are identified as initial treatment goals for individuals with emotion regulation difficulties (Linehan, 1993). It was hoped that the LTD programme may be valuable as an early stage of therapy for clients presenting with DSH.

An initial study found significant reductions in DSH, improvements in distress tolerance, and a reduction in inpatient days for individuals who completed the LTD programme in addition to treatment-as-usual (Booth, Keogh, Doyle, & Davies, 2014). To the best of our knowledge this was the first study of a DBT-informed skills group to report improvements in DSH. However, the absence of any control group limits the interpretation of these positive findings.

The primary aim of this controlled trial was to examine whether the addition of DBT-informed skills training to TAU was associated with any improved outcomes for individuals presenting with DSH, as compared to TAU only. The outcomes examined were frequency of DSH and two indicators of emotional distress, namely depression and anxiety. The secondary aim was to examine possible changes in emotion regulation associated with DBT-informed skills training as compared to TAU. Based on the biosocial model it was hypothesised there would be greater improvements in emotion regulation for the DBT-informed skills training group than the TAU group.

Method

Participants

One hundred and three clients (aged 18–60 years) of an independent, not for profit mental health hospital were recruited. Inclusion criteria for participants were to be over 18 years of age and to have engaged in DSH during the 6 weeks prior to the intervention and/or to meet diagnostic criteria for BPD. Exclusion criteria were kept to a minimum to increase the extent the results can be generalised to similar samples. Only clients currently receiving treatment within the secure unit of the hospital were excluded as they were not permitted to leave the ward. Participants had a broad range of psychiatric diagnoses, as assessed by their multidisciplinary teams. With regard to the inclusion criteria, 84% of participants reported a recent history of DSH behaviours and 73% participants met criteria for BPD, as assessed at study intake. See Table 1 for further information regarding other psychiatric diagnoses.

Study design and procedure

This was a single-centre, non-randomised clinical trial. The study was granted ethical approval by the relevant committees and

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