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# Evaluation of inpatient Dialectical-Behavioral Therapy for Borderline Personality Disorder — a prospective study

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## Abstract

Dialectical-Behavioral Therapy for Borderline Personality Disorder (DBT) developed by M. Linehan is specifically designed for the outpatient treatment of chronically suicidal patients with borderline personality disorder. Research on DBT therapy, its course and its results has focused to date on treatments in an outpatient setting.

Hypothesizing that the course of therapy could be accelerated and improved by an inpatient setting at the beginning of outpatient DBT, we developed a treatment program of inpatient therapy for this patient group according to the guidelines of DBT. It consists of a three-month inpatient treatment prior to long-term outpatient therapy. In this pilot study 24 female patients were compared at admission to the hospital, and at one month after discharge with respect to psychopathology and frequency of self-injuries. Significant improvements in ratings of depression, dissociation, anxiety and global stress were found. A highly significant decrease in the number of parasuicidal acts was also reported. Analysis of the average effect sizes shows a strong effect which prompts the development of a randomized controlled design. © 2000 Elsevier Science Ltd. All rights reserved.

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## 1. Introduction

DBT is a cognitive-behavioral therapy, developed by M. Linehan originally for the outpatient treatment of chronically suicidal patients with borderline personality disorder. As

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with standard behavior therapies, DBT presumes that attention to both skills acquisition and behavioral motivation is essential for change. Taking into account the characteristic features of patients with borderline personality disorder, several modifications to standard behavioral therapy were made (Linehan, 1993). First, a number of treatment strategies that reflect acceptance and validation of the patients' current capacities and behavioral functioning were gathered and added to the treatment. The dialectical emphasis of the treatment ensures the balance of acceptance and change within the treatment as a whole and within each individual interaction. Second, treatment of the patient was split into three components: one that focuses primarily on skill acquisition, one that focuses primarily on motivational issues and skills strengthening, and one designed explicitly to foster generalization of skills to everyday life outside the treatment context. Third, a consultation-team-meeting with specific guidelines for keeping the therapist within the treatment frame was added. In standard outpatient DBT, treatment consists of structured psychosocial individual or group therapy (for skills training), individual psychotherapy (addressing motivational and skills strengthening), telephone contact with the individual therapist (addressing generalization), and peer supervision meetings (to monitor the therapist). DBT is further characterized by a clear hierarchy of treatment targets (the behavior identified for change), and a set of treatment strategy groups (tactics and procedures of the therapist used to achieve change). In contrast to many behavioral approaches, DBT also places great emphasis on the therapeutic relationship.

Reliable data are available for an outpatient treatment period of one year. During this period and in the framework of a controlled randomized study, DBT proved to be superior with regard to several factors compared to experienced therapists following an unspecified 'treatment as usual' approach. Frequency and severity of parasuicidal acts were significantly reduced in the group of patients treated according to DBT; the same is true for the frequency of premature treatment termination, as well as for the frequency and length of stays in psychiatric hospitals (Linehan, Armstrong, Suarez, Allmon & Heard, 1991; Linehan, Heard & Armstrong, 1993). Meanwhile, data from replication studies are available (Koons, 1998).

As discussed above, DBT was originally developed as a form of outpatient therapy and emphasizes the potential risk of nonspecific inpatient treatment. One of the main risk factors seems to be the (unintended) reinforcement of dysfunctional patterns of behavior such as self-injury, suicide attempts, and/or suicide communications by the therapeutic milieu. This notion is similar to the views of numerous depth psychology-oriented authors who particularly emphasize the distinct tendency towards 'regression' on the part of borderline inpatients, as well as 'manipulatory behavior' and difficult transference and counter-transference phenomena. A deterioration of the symptoms and a tendency towards long-term hospitalization are the most frequent results (Nurnberg & Suh, 1978; Rosenbluth & Silver, 1992).

Nonetheless, several reasons speak for the development of a specific module of inpatient treatment according to the guidelines of DBT. First, the number of patients who meet the criteria for borderline personality disorder is estimated at 30% of all inpatients worldwide who are treated for personality disorders, thus ranking in first place (Loranger et al., 1994). Second, the probability of requiring psychiatric or psychosomatic inpatient treatment at some point in one's lifetime is unusually great for persons with a borderline disorder. We studied a representative population of 40 female patients in Germany with borderline

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