Dialectical behaviour therapy skills training compared to standard group therapy in borderline personality disorder: A 3-month randomised controlled clinical trial

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INTRODUCTION

People with borderline personality disorder (BPD) are regular users of emergency services and may often require admission to hospital. They will likely need long psychotherapies and require more medications than other personality disorder or major depression patients (Bender et al., 2006; Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004). Moreover, BPD is associated with a high prevalence of self-injurious behaviour and an incidence of completed suicide of up to 10%, a rate over 50 times higher than that in the general population. This results in a high consumption of healthcare resources (American Psychiatric Association, 2001; Lieb et al., 2004; Paris, 2002; Stone, 1998) and non-health care costs are even higher (Van Asselt, Dirksen, Arntz, & Severens, 2007).

Various psychosocial interventions have been used in the treatment of BPD and have proved to be effective in randomised clinical trials. Two of these psychological interventions are psychodynamic-oriented treatments, mentalization-based treatment (Bateman & Fonagy, 1999, 2001) and transference focused therapy (Clarkin, Kenneth, Lenzenweger, & Kernberg, 2007). The others are variations of cognitive behavioural therapy, such as schema-focused therapy (Giesen-Bloo et al., 2006), cognitive behavioural therapy (Blum et al., 2008; Davidson et al., 2006) and DBT (Koons et al., 2001; Linehan, Amstrong, Suarez, Allmon, & Heard 1991; Linehan et al., 1999, 2006; Verheul et al., 2003).

The standard DBT procedure (Linehan, 1993a, 1993b) includes four modes of intervention: group therapy, individual psychotherapy, phone calls, and consultation team meetings. The group component consists of approximately 2 h a week of skills coaching, and it aims to increase behavioural capabilities. Individual psychotherapy consists of approximately one-hour weekly session whose objective is to improve motivation to change and reduce target problem behaviours. The phone call mode focuses on generalizing skills to daily life, preserving the therapeutic relationship, and learning how to ask for help. The consultation team
meetings are attended by all the therapists using DBT and they are
held weekly. These meetings aim to provide support for therapists,
maintain motivation and adherence to the treatment model, and
help to prevent burn out.

Although several studies have introduced modifications in the
application of the original design, these adaptations have adjusted
DBT to other settings, such as BPD inpatients (Bohus et al., 2004) or
to other disorders, such as binge eating disorder (Telch, Agras, &
Linehan, 2001).

One study using this standard DBT treatment for BPD (Linde
boim, Comtois, & Linehan, 2007) focused especially on the
group component. The authors examined the type and frequency
of skills practised by patients receiving one year of standard DBT as
a part of a clinical trial (Linehan et al., 2006). This study addressed
several questions regarding the skills in standard DBT treatment. In
contrast with what is traditionally expected concerning compli-
ance in BPD patients, they reported using some skills regularly, a
minimum of at least one skill on most days. The average was
more than four skills per day during the one year of treatment. This
skills practice increased over the course of treatment, especially in
the first months of the therapy. Another finding of interest was
that patients preferred to use skills aimed at acceptance rather
than change. Although it seems clear that the group mode of DBT
in BPD may be partially responsible for the positive outcomes
reported in this setting, there is no evidence that DBT-ST treatment
is an efficacious intervention without the individual DBT therapy
mode. In a nonpublished study, Linehan et al. (Linehan, 1993a)
assigned a subgroup of BPD patients receiving non-DBT individual
treatment to DBT-ST. The results suggested that adding DBT-ST to
non-DBT individual therapy was no more effective than non-DBT
individual therapy, and less effective than individual DBT plus
DBT-ST treatment. Only one controlled study has been published
(Springer, Lohr, Buchtel, & Silk, 1996) to date. It compares content-
reduced DBT-ST to a non-psychotherapeutic discussion group.
Subjects in both groups significantly improved in most change
measures although no significant between-group differences were
found. The findings from this study are limited because treatment
was short (13 weekdays), the sample characteristics were not
homogenous (inpatients with different personality disorders),
diagnosis was made by means of a self-reported questionnaire, and
considerable modifications were introduced in the standard
course of DBT training (e.g. the Mindfulness module was not
available).

Skills training is an essential element in DBT treatment in view of
the skills deficit underlying BPD. It can be conceptualised as a set of
abilities to manage emotional instability and has been adapted to
and tested in other diagnoses. In a controlled study that compared
an adapted 20-session DBT-ST to waiting list condition in binge
eating disorder (Telch et al., 2001), the intervention was associated
with a decrease in binge eating behaviour immediately post treat-
ment and at 6-months follow-up. Similarly, DBT-ST plus medication
and scheduled telephone coaching have been successfully adapted
to treat older depressed patients and have been associated with an
improvement in depressive symptoms compared with medication
(Lynch, Morse, Mendelson, & Robins, 2003).

Although skills training is thought to play an important role in
DBT treatment, it is frequently used by BPD patients and have
proved to be useful in other disorders such as binge eating disorder or depression, they are not adequately been tested in BPD
patients. The aim of this randomised controlled clinical trial was to
evaluate whether skills training, one of the four modes of DBT
intervention, was sufficient to induce an observable improvement
in people with BPD in comparison with standard group therapy
(SGT) administered over the same number of hours in a 3-month
period.

Method

Participants

A total of 63 patients were included (participants were recruited
from outpatient facilities and emergency service). Inclusion criteria
consisted of: 1) meeting the DSM-IV diagnostic criteria for BPD as
assessed by two semi-structured diagnostic interviews: the Struct-
tured Clinical Interview for DSM-IV Axis II Disorders (SCID-II;
Gómez-Beneyto et al., 1994) and the Revised Diagnostic Interview
for Borderlines (DIB-R; Barrachina et al., 2004); 2) age between 18
and 45 years; 3) no comorbidity with schizophrenia, drug-induced
psychosis, organic brain syndrome, alcohol or other psychoactive
substance dependence, bipolar disorder, mental retardation, or
major depressive episode in course; 4) Clinical Global Impression of
Severity (CGI-S; Guy, 1976) score > 4; 5) no current psychotherapy.

This study was approved by the clinical research ethics review
board at our centre. After giving a full description of the study,
written informed consent was obtained from all participants.

Study design and procedure

This was a single-centre, randomised, single-blind, two-group
clinical trial. Blocks of four generated using the SPSS software
program served for the randomisation to DBT-ST or SGT.

Subjects included in the study had two interview visits to
establish a pre-intervention baseline. No therapeutic intervention
was carried out in this phase. All participants were then random-
isolated to DBT-ST or SGT group psychotherapy intervention
(13 weekly sessions). During the therapy period, participants were
evaluated every 2 weeks by experienced psychiatrists. Subjects
were instructed not to disclose any information about the group
(topics, group members or therapists) to maintain blind conditions.
Both interventions, DBT-ST and SGT, consisted of thirteen psycho-
therapy sessions of 120 min each, conducted by 2 therapists (a male
and a female) for each group, in groups of 9–11 participants. During
the study, participants did not receive any other individual or group
psychotherapy. The two therapies were conducted at different
times to avoid participants meeting the members of the other
group. The DBT format used was adapted from the standard version
(Linehan, 1993a, 1993b), applying one of the four modes of inter-
vention: skills training. DBT-ST included all the original skills. These
skills can be divided into those that promote change, interpersonal
effectiveness and emotional regulation skills, and those that
promote acceptance, mindfulness and distress tolerance skills.

Interpersonal effectiveness: training in interpersonal problem
solving and assertion. It deals with learning strategies to ask for
what one needs, to say no to requests when appropriate, and to
achieve interpersonal goals, while taking care of relationships and
self-respect.

Emotion regulation: learning skills to decrease labile affect. It
includes learning to identify, label and describe emotions, using
mindfulness on emotion experience, reducing vulnerability to
negative emotions, increasing the occurrence of positive emotions,
and acting in an opposite manner to motivational tendency asso-
ciated with negative emotion.

Mindfulness: developing attentional control, nonjudgemental
awareness and sense of true self. Participants learn to simply
observe and then describe events, thoughts, emotions and body
sensations, and fully participate in their actions and experiences in
a non-evaluative manner, focusing on one thing at a time and
reorienting attention when distracted.

Distress tolerance: focusing on acceptance of painful emotions
without trying to change them. The module is divided into crisis
survival skills which are short-term strategies to tolerate a stressful
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