Treatment of Suicidal and Deliberate Self-Harming Patients With Borderline Personality Disorder Using Dialectical Behavioral Therapy: The Patients' and the Therapists' Perceptions

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The aim was to investigate patients and therapists perception of receiving and giving dialectical behavioral therapy (DBT). Ten deliberate self-harm patients with borderline personality disorder and four DBT-therapists were interviewed. The interviews were analyzed with qualitative content analysis. The patients unanimously regard the DBT-therapy as life saving and something that has given them a bearable life situation. The patients and the therapists are concordant on the effective components of the therapy: The understanding, respect, and confirmation in combination with the cognitive and behavioral skills. The experienced effectiveness of DBT is contrasted by the patient's pronouncedly negative experiences from psychiatric care before entering DBT.

BORDERLINE PERSONALITY disorder (BPD) is a psychiatric health problem with a reputation of being difficult to deal with and to treat. Patients suffering from BPD are characterized by identity problems and unstable relations, lacking impulse control, emotional instability, and feelings of emptiness often in combination with anxiety, depression, and substance abuse (APA, 1994). To a very great extent it is younger women who are suffering from the disorder (Widiger and Weissman, 1991). Repeated, suicide attempts (intentional, acute, self-injurious behavior with suicidal intent), and acts of deliberate self-harm (intentional, acute, self-injurious behavior without suicidal intent) is very common among these patients. Long-term follow-up studies suggest that 3% to 13% die from suicide (McGlashan, 1986; Paris, 2002; Stone, 1993), and a Swedish study found BPD diagnoses behind 19 (33%) of 58 suicides, committed by adolescents and young adults (Runeson and Beskow, 1991). The literature on the epidemiology of BPD is scarce, but an American review suggests a prevalence between 0.2% and 1.8% in the general population and 15% among psychiatric outpatients (Widiger and Weissman, 1991). A Swedish study found a nearly 30% prevalence of BPD among psychiatric outpatients (Bodlund, Ekselius, Lindström, 1993).

BPD patients often evoke uneasiness and attitudes of being troublesome and manipulative

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among the staff involved in the treatment (Linehan, 1993). The treatment dropout rates are prominent, and figures as high as 40% to 50% within 6 weeks has been reported (Kelly et al., 1992). There is no specific pharmacological treatment for the disorder. Instead the medication is symptom-oriented with a great variation from patient to patient. Research focusing on medication is not extensive and the scientific quality often weak (Brinkley, 1993).

In 1991, Linehan et al (1991) published the results from a randomized controlled trial of a psychosocial intervention for BPD. The intervention in focus was a form of cognitive-behavioral therapy, called dialectical behavioral therapy (DBT). The therapy especially targets the pattern of suicide attempts and deliberate self-harm in BPD patients. The study showed that DBT resulted in significantly fewer suicide attempts and acts of deliberate self-harm, lower treatment drop out rate and fewer inpatient days compared to the control group (Linehan et al., 1991).

DBT combines intervention strategies from behavioral, cognitive, and supportive psychotherapies, and includes weekly individual and group therapy. The therapy applies a mixture of supportive techniques and directive, problem-oriented techniques (behavior skills training, exposure, contingency management, and cognitive modification). The therapy targets three phases of general treatment goals organized in the following hierarchy: (1) "Stability and security," aiming towards decreased suicidal behavior and acts of deliberate self-harm, decreased therapy-interfering behaviors and decreased quality-of-life interfering behaviors. (2) Reduction of posttraumatic stress by focusing on traumatic life events. (3) Increased self-respect and achievement of individual life goals. Both during and between sessions the therapist actively teaches and reinforces adaptive behaviors. Therapists, between sessions, have a 24-hour readiness to intervene in their patients' self-harming behavior by telephone. The treatment sessions are videotaped. The videotapes are used as a basis for supervision sessions (Linehan, 1993). Over the years DBT has made its way into practice in psychiatric health care services in several countries, the region of Lund in southern Sweden being one example. In view of positive treatment outcomes reported, i.e., decreased rates of suicide attempts, episodes of deliberate self-harm and psychiatric inpatient days (Linehan, 1991), DBT seems to be a promising outpatient treatment for self-harming BPD patients. Decreased treatment dropout rates also suggest DBT to be well accepted by the patients. However, DBT as seen from the patients' and therapists' perspective has, to our knowledge, not been investigated. The purpose of this study was to describe patients' and therapists' perception of receiving and giving DBT treatment.

SUBJECTS AND METHODS

Subjects

The respondents in the patient group were ten women aged 22-49 years (median 27 years). The sample was drawn by purposeful sampling (Sandelowsky, 1995). Patients who had been in DBT-treatment for 12 months or longer ($n = 11$), were asked to participate after having the aims and the procedures of the study explained to them. One patient resented participation (without giving any reason) and was therefore excluded. All ten respondents had a Borderline Personality Disorder according to DSM-IV, axis II (APA, 1994). Other characteristics regarding DSM-IV, axis I diagnoses, rates of suicide attempts and acts of deliberate self-harm were collected through information given by the respondents themselves. Regarding axis I diagnosis, the respondents reported that they suffered or had suffered from the following disorders; depression (nine persons), anxiety disorders (nine persons), eating disorders (three persons), social phobia (two persons). Several of the respondents also mentioned having suffered from a substance-use disorder. Regarding the respondents history of suicide attempts; five of them reported having made 10 suicide attempts or more, one respondent reported having made between five and ten and three respondents reported having made five suicide attempts or less. One respondent had not made any act that she would characterise as a suicide attempt. Regarding history of deliberate self-harm; two respondents reported having made more than 500 such acts, five respondents reported having made between 100 and 500, and three of them reported having made less than 100 acts. The respondents also reported that they have had contact with psychiatric services from 4-14 years, (median 11.5 years). Seven of them have had contact with psychiatric services since childhood.

The respondents in the therapist group were four persons, two women and two men. One of them