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Skills Practice in Dialectical Behavior Therapy for Suicidal Women Meeting Criteria for Borderline Personality Disorder

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Dialectical Behavior Therapy (DBT) is an evidence-based practice for borderline personality disorder (BPD) and suicidal behavior that has been replicated with a variety of populations. Patients' practice of behavioral skills taught in the group skills training component of DBT may be partly responsible for the positive treatment outcomes according to the skills deficit model of BPD that underlies DBT. This study was designed to examine the type and frequency of skills practiced by DBT patients. Participants were 49 women, who met criteria for BPD and current and chronic suicidal behavior, receiving 1 year of standard DBT as part of a clinical trial. Skills were recorded on the daily diary cards completed by participants each week and reviewed by their individual therapists. Results indicated that the majority of participants reported practicing skills most days throughout treatment. Crisis survival and mindfulness skills were practiced most frequently in our sample. Hierarchical linear modeling demonstrated that skills practice increased as a function of time in therapy. Directions for future research are discussed.

Dialectical Behavior Therapy (DBT; Linehan, 1987, Linehan, 1993a,b) is the most researched treatment for borderline personality disorder (BPD). There have been seven randomized clinical trials evaluating DBT for this disorder (Koons et al., 2001; Linehan et al., 1991; Linehan et al., 1999; Linehan et al., 2002; Linehan et al., 2006a; Turner, 2000; Verheul et al., 2003). DBT has also been expanded to treat eating disorders (Safer et al., 2001; Telch et al., 2001) and depression (Lynch et al., 2003). Across these studies, results indicate that DBT is superior to a variety of nonbehavioral control conditions in reducing targeted problem behaviors including suicide attempts, nonsuicidal self-injury, substance abuse, eating binges, as well as decreasing treatment dropout, and use of psychiatric hospitalization and emergency rooms. Across a number of studies, DBT has also been shown to improve social and global adjustment and reduce suicide ideation, depression, and hopelessness.

The biosocial theory of DBT (Linehan, 1993a) conceptualizes BPD criterion behaviors as stemming from a combination of skills and motivational deficits in specific behavioral domains. Specifically, individuals who meet criteria for BPD are theorized to lack a range of self-regulation skills (primarily emotion regulation), distress tolerance (to prevent impulsive behavior), and interpersonal effectiveness skills. Standard DBT is a multimodal comprehensive treatment ordinarily including individual behavior therapy, group skills training, telephone coaching and crisis intervention, and weekly team meetings for the therapists. The DBT individual therapy component focuses on motivational issues and skills strengthening. Group skills training focuses on the acquisition and strengthening of needed behavioral skills. Telephone coaching focuses on generalization of skills and the DBT treatment team focuses on the skills and motivation of the therapists.

As in many other skills training treatments, DBT skills training (Linehan, 1993b) includes not only teaching and in-session practice of new behavioral skills, but also use of homework assignments to practice specific DBT skills. In DBT, assignments are given each week to practice the new skills taught that week, and the homework is reviewed during the first half of each subsequent skills training session. An important question, unaddressed to date, is whether BPD clients in DBT actually comply with homework assignments. BPD participants in pharmacotherapy research studies have shown high rates of treatment dropout (e.g., Kelly et al., 1992; Mazzotti et al., 2001; Palmer et al., 2003; Skodol et al., 2002) as well as poor medication compliance and medication misuse (e.g., Mazzotti et al., 2001; Waldinger and Frank, 1989). While clinical lore suggests that patient adherence to psychosocial treatment prescriptions is equally poor, only

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treatment dropout has been studied (Bateman and Fonagy, 2001; Linehan et al., 2006a; Linehan et al., 1991). Studies have shown very poor treatment compliance by BPD participants in other treatments, despite very high rates of treatment utilization (Bender et al., 2001).

While there is overall research support for the use of homework assignments in psychotherapy in terms of its acceptability for clients and therapists as well as its association with positive therapeutic outcomes (e.g., Burns and Spangler, 2000; Coon and Thompson, 2003; Gonzalez et al., 2006; Kazantzis et al., 2000), no published study to date has evaluated homework with BPD participants. Indeed, homework has not traditionally been a part of established treatments for this population until the recent development of DBT. In a related study, Miller et al. (2000) examined client perceptions of the usefulness of the DBT skills as part of a quasi-experimental treatment study of DBT with suicidal adolescents with BPD features. On a 5-point scale ranging from 1 (*not at all helpful*) to 5 (*extremely helpful*), mean client ratings of the 19 specific skills ranged from 3.00 to 4.27, indicating high overall perceived utility of DBT skills in that sample. However, this study did not examine actual use of skills.

The current study adds to the literature on DBT and homework practice by evaluating the use of DBT skills homework among chronically suicidal women who met BPD criteria in a large randomized controlled trial of DBT. Three research questions were addressed. The primary aim was to examine compliance with homework; that is, to what extent did participants report practicing the skills between group sessions? Our second question was whether practice varied across specific skills. That is, were certain skills used more frequently than others? Third, we evaluated whether skills practice increased over time in treatment. We predicted that practice would increase as participants incorporated more skills into their behavioral repertoire.

Method

Participants

All participants were seeking treatment as part of a large randomized clinical trial of Dialectical Behavior Therapy vs. Treatment by Community Experts (Linehan et al., 2006a). For study inclusion, participants were required to be women between the ages of 18 and 45 who met criteria for BPD on two structured interviews: the International Personality Disorder Examination (IPDE; Loranger, 1995) and the Structured Clinical Interview for the *DSM-IV* (SCID-II; First et al., 1996). They were also required to have had at least two incidents of a suicide attempt or nonsuicidal self-injury in the last 5 years, one of which had to occur during the 8 weeks prior to intake. Exclusion criteria were a diagnosis of schizophrenia, bipolar disorder, seizure disorder, mental retardation, or the need for primary treatment for another debilitating condition. Potential participants were screened via telephone, and those eligible signed informed consent to participate in the study. Of the 101 women who met criteria at screening, completed pretreatment interviews, and entered therapy, 52 were randomized to the DBT condition. Three participants dropped out of treatment before skills training data were collected, and were dropped from the analyses in the current study, forming a sample of 49 participants. All procedures were approved by the University of Washington human subjects review board.

Sample Characteristics

Mean age of the sample was 29 years (±7.4). The majority of the sample was Caucasian (85.7%), followed by African American (4.1%), Asian American (2.0%), Native American (2.0%), and Latino (2.0%). Two participants classified themselves as "other ethnicity" (4.1%). The majority of the sample (65.3%) was never married; 18.4% were divorced, 4.1% were separated, and 12.2% were married. A substantial portion of the sample was living below the poverty line, largely on some form of public assistance or disability payments: 29.2% had an annual income of less than $5,000, 77.1% of the participants had an income less than $15,000, and only 18.7% of the participants had an annual income higher than $20,000. By contrast, 10.2% of the sample had at least some graduate or professional education, 12.2% had completed college, 44.9% had at least some college, and 4.1% had business or technical school education. Only 18.4% had no more than a high-school diploma or GED and 10.2% did not complete high school or its equivalent.

In addition to the diagnosis of BPD, participants also met criteria for an average of 2.9 comorbid Axis I diagnoses. At intake, 80% met criteria for a mood disorder (98% met criteria at some point during their lifetime) and 84% had a current anxiety disorder (92% lifetime). The mean Global Assessment of Functioning (GAF; *DSM-IV*, 1994) was 40 (*SD*=1.3), indicating severe impairment. Nearly two-thirds (65%) made at least one suicide attempt in the last year before entering the study. The median number of suicide attempts in the pretreatment year was 1.0 (IQR 0 – 3) and nonsuicidal self-injury was 11 (IQR 2.5 – 50).

Treatment

All participants received up to 1 year of standard DBT. The DBT skills group met once weekly for 2.5 hours and followed a set curriculum that included standard techniques such as lecture, modeling, behavioral rehearsal, feedback, coaching, and homework assignments. Homework assigned the previous week was reviewed during the

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