Skills use and common treatment processes in dialectical behaviour therapy for borderline personality disorder

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ABSTRACT

Background and Objectives: Dialectical behaviour therapy (DBT) trains participants to use behavioural skills for managing their emotions. The study aimed to evaluate whether skills use is associated with positive treatment outcomes independently of treatment processes that are common across different therapeutic models.
Method: Use of the DBT skills and three common treatment processes (therapeutic alliance, treatment credibility and self-efficacy) were assessed every 2 months for a year in 70 individuals with borderline personality disorder receiving DBT. Mixed-multilevel modelling was used to determine the association of these factors with frequency of self-harm and with treatment dropout.
Results: Participants who used the skills less often at any timepoint were more likely to drop out of DBT in the subsequent two months, independently of their self-efficacy, therapeutic alliance or perceived treatment credibility. More frequent use of the DBT skills and higher self-efficacy were each independently associated with less frequent concurrent self-harm. Treatment credibility and the alliance were not independently associated with self-harm or treatment dropout.
Limitations: The skills use measure could not be applied to a control group who did not receive DBT. The sample size was insufficient for structural equation modelling.
Conclusion: Practising the DBT skills and building an increased sense of self-efficacy may be important and partially independent treatment processes in dialectical behaviour therapy. However, the direction of the association between these variables and self-harm requires further evaluation.

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1. Introduction

Despite growing evidence for the effectiveness of a number of different psychological treatments for borderline personality disorder (BPD) (Stoffers et al. 2012), evidence on treatment processes is minimal. Dialectical behaviour therapy (DBT) is one of the most commonly used treatment models for BPD (Rizvi et al., 2013; Swales, Taylor, & Hibbs, 2012) and has been tested in numerous randomised controlled trials. Meta-analysis of these trials suggests a medium effect size favouring DBT over treatment as usual, for reducing suicide and self-injury, and for improving global outcomes (Kliem, Kröger, & Kosfelder, 2010). DBT is based on the biosocial theory of BPD. A major premise is that BPD develops when emotionally sensitive individuals encounter invalidating environments that ignore, suppress or punish their emotions, which further compounds their emotional sensitivity and prevents development of the behavioural and cognitive skills required to self-regulate emotions (Linehan, 1993a). DBT therefore has five essential functions: 1) to teach skills for more effective emotional and behavioural regulation, 2) to enhance client motivation to use these skills, 3) to ensure clients can use the skills in a wide variety of situations, 4) to help shape an environment that reinforces skill use and 5) to enhance the therapist's own skills and motivation to keep working effectively with the client (Linehan, 1993a, 1993b).

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Other treatment models for borderline personality disorder, such as mentalization based therapy, schema-focussed therapy and transference focussed therapy, achieve comparable outcomes, despite each taking a different approach to treating BPD (Bateman & Fonagy, 2009; Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Farrell, Shae, & Webber, 2009; Giesen-Bloo et al. 2006). It is possible that each of these treatment models operates via different specific treatment mechanisms that offer different routes to the same outcome. It is also feasible that the techniques used in one model can activate the therapeutic processes specified in another model. Moreover, the effectiveness of different treatment models may suggest the importance of considering treatment processes that are common to multiple models of therapy. Frank and Frank (1991) and Wampold (2001) theorise that key treatment processes common across all effective psychotherapy models include treatment credibility (the client's perception that their treatment is a credible means of improving their mental health), the therapeutic alliance (the development of a bond and a working alliance between client and therapist), and self-efficacy (the client's belief that they can perform difficult tasks or cope with challenges in various domains of their lives).

Poor therapeutic alliance is one of the most consistent predictors of poor clinical outcomes in psychotherapy for BPD (Barnicot et al. 2012), including DBT (Leerer, 1997; Turner, 2000; Bedics et al. 2015), and has been shown to predict dropout from schema-focussed therapy and transference-focussed therapy (Spinhoven, Giesen-Bloo, van Dyck, Kooiman, & Arntz, 2007). However, the association of treatment credibility and self-efficacy with treatment outcome in BPD has not been studied. Two studies of dialectical behaviour therapy have shown that patients who use the DBT skills more often achieve greater reductions in BPD symptoms and self-harm (Neacsiu, Rizvi, & Linehan, 2010; Stepp, Epler, Jahng, & Trull, 2008). Furthermore, Neascui and colleagues also assessed skills use in a control group receiving other forms of psychological treatment, and found that skills use was 3 times higher in the DBT condition by the end of treatment, and that skills use fully mediated the effect of DBT on decreasing suicide attempts, depression and anger, and partially mediated the reduction in self-harm (Neacsiu, Rizvi, & Linehan, 2010). Whilst there were no significant differences between DBT and the control condition in participants' expectations of positive outcomes or therapeutic alliance (Bedics et al. 2015; Linehan et al. 2006b), the interrelationship between skills use and common treatment processes was not assessed. It is likely that participants who use the DBT skills more also have a stronger sense of self-efficacy, find their treatment more credible and have a stronger therapeutic alliance. Therefore, any observed positive effect of DBT skills use on outcome could be confounded by these common treatment processes. It is therefore important to determine the interrelationship between DBT skills use and common treatment processes, and to determine whether DBT skills use is associated with positive treatment outcomes independently of common treatment processes.

The present study therefore aimed to evaluate the following research questions:

1) Is more frequent use of the DBT skills associated with more positive perceptions of treatment credibility, the therapeutic alliance and self-efficacy, and vice versa?
2) Are DBT skills use, treatment credibility, the therapeutic alliance and self-efficacy independently associated with a lower rate of self-harm?
3) Are DBT skills use, treatment credibility, the therapeutic alliance and self-efficacy independently associated with a lower probability of dropping out of treatment in the subsequent two months?

2. Method

2.1. Design

This was a longitudinal study in a cohort of participants receiving DBT for BPD with self-harm.

2.2. Inclusion and exclusion criteria

Participants were included if they:

1) Had a diagnosis of borderline personality disorder
2) Had self-harmed in the 12 months prior to recruitment
3) Entered into a dialectical behaviour therapy programme
4) Attended at least one DBT skills group session and completed at least one assessment of skills use.

The only exclusion criteria were learning or English language difficulties of sufficient severity to prevent completion of study questionnaires.

2.3. Study setting

The study took place in a community personality disorder service in the United Kingdom, in an inner city area with high levels of socioeconomic deprivation and ethnic diversity. The service was initiated in 2003 and offers a twelve month course of DBT (one hour individual therapy a week, two hours group skills training a week, out of hours telephone skills coaching). In addition, the service provides care coordination according to the care programme approach (CPA; Department of Health, 2008), including consultant responsibility and medication management. All therapists were trained by the treatment developer's official training provider (Behaviour Tech), some receive supervision from DBT experts, and trained adherence raters have assessed both group and individual sessions as adherent to the DBT model (Priebe et al., 2012). The service implements Linehan's attendance requirements — namely, that therapy is discontinued if a service-user misses more than 3 consecutive individual or group sessions (Linehan, 1993a).

2.4. Procedure

All participants were recruited between May 2008 and March 2011. Some participants (N = 52 of the final analysis sample) were concurrently participating in a randomised controlled trial of DBT versus treatment as usual (Priebe et al., 2012). The remainder were recruited from referrals to the DBT service after RCT recruitment had ceased. The flow of participants through the present study is summarised in Fig. 1.

The clinical DBT team assessed eligibility for the present study, following which researchers obtained informed consent, conducted a baseline interview and then arranged to interview participants every two months for a year in order to collect process and outcome data, including assessments of all of the skills and common factor treatment processes and self-harm. Interviews were conducted face-to-face wherever possible but in a few instances were conducted over the phone following repeated non-attendance of face-to-face appointments. All study procedures were approved and monitored by the Camden and Islington Community Research Ethics Committee, London, United Kingdom.

2.5. Measures

2.5.1. Baseline measures
The Structured Clinical Interview for DSM-IV, Axis II (SCID-II)