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Evaluation of DBT Emotional Coping Skills Groups for People with Parasuicidal Behaviours

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Abstract. Five 18 week skills training groups based on Dialectical Behaviour Therapy (DBT) were provided for 34 participants with parasuicidal behaviours; 26 participants completed the programme. Monthly support/education groups for their keyworkers were also provided. Inpatient admissions decreased by 30% and out-patient appointments for those without admission by 61% over the 18 months from the initial pre-group formulation meeting, compared with the preceding 18 months. Statistical analysis ($N = 17$) showed significant reduction in CORE scores over the intervention period, and a similar effect in scores on the Work and Social Adjustment Scale. User satisfaction was high and drop out low (23.5%). Results indicate DBT skills group might be a useful service where full DBT is unavailable.

Keywords: Borderline personality disorder, self-harm, DBT skills, service use.

Introduction

People with Borderline Personality Disorder (BPD) present with severe, chronic and persistent self-injury, suicide attempts, impulsive risky behaviours and emotional dysregulation leading to depression and anxiety. Approximately 10% commit suicide; service costs are high through inpatient beds, community support and crisis interventions, and in staff "burn out" (National Institute for Mental Health in England, 2003). Dialectical Behaviour Therapy (DBT) has been developed for people with BPD. A randomized controlled trial of DBT versus treatment as usual found people receiving DBT had fewer suicides, inpatient days, emergency admissions, and both fewer and less severe parasuicidal behaviour (Linehan, Armstrong, Suarez, Allmon and Heard, 1991). DBT comprises at least a year of individual therapy, group skills training, telephone consultation and a staff consultation group. Research has begun to show therapeutic impact for combinations of some but not all components (e.g. Davidson and Tyrer, 1996). We present data from five, 18-week Emotional Coping Skills (ECS) groups, supplemented by a monthly consultation group for staff key-working those clients. The primary outcome measure was days spent in hospital over the 18 months prior to participation, compared with the subsequent 18 months. Secondary data on well being, symptoms, risk, social functioning and satisfaction were gathered.

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Method

Participants

Thirty-four people with parasuicidal behaviours (e.g. cutting, burning, frequent overdosing) in the last 6 months began an ECS group, of whom 26 "completers" attended over 50% of the sessions (range 56–100%). Groups 1–4 were all female, Group 5 included two men. Ages ranged from 20–53.

Measures

The primary outcome was the number of days spent as an in-patient, or for those without admissions, the number of outpatient appointments. The latter was chosen as a way of representing service use, where higher levels of outpatient appointments indicate increases in crisis. Data were collected for the 18 months prior to beginning a group, and the subsequent 18 months. Secondary data were gathered using the CORE, a 34-item self-rated questionnaire designed specifically as an outcome measure for psychotherapy (Barkham et al., 1998), assessing subjective well-being, problems/symptoms (ratings of both anxiety and depression), life functioning (perceived coping) and risk (both to self and others). The Work and Social Adjustment Scale (SAS; Marks, 1986) asks participants to rate (scale 0, not at all – 8, very severely) how much their problems impact on work, home management, private and social leisure activities, and family relationships (range 0–40). Satisfaction was measured using a questionnaire developed for evaluation of CBT services. Seven statements are listed (e.g. "my therapist treated me with respect") and rated on the scale disagree strongly (0), disagree slightly (1), unsure (2), agree slightly (3), agree strongly (4).

Procedure

Individualized formulation. A group facilitator met each group member to: (1) explain the skills-training purpose of the group, with written handouts; (2) formulate the individual's self-harm behaviour; (3) assess level of risk to self and others; (4) discuss alternatives to self-harm; (5) instil hope; (6) emphasize commitment to the group; and (7) plan for difficult times. The mean time interval between these meetings and the start of the group was 3 weeks.

Emotional Coping Skills (ECS) groups. Groups comprised 18 weekly sessions of 2 hours, and were facilitated by two clinical psychologists trained in DBT. The groups balanced change and acceptance. Sessions were divided into reflection on use of current skills (pre-break), and teaching of new skills (post-break). Sessions comprised: Introductions and surviving crises (2 weeks); Introduction to mindfulness (2 weeks); Understanding emotions (2 weeks); Regulating emotions (2 weeks); Tolerating distress (3 weeks); Building skills into everyday life (1 week); Problem solving (1 week); Assertiveness (4 weeks); Preventing relapse (1 week).

Keyworker group. Twelve clients had keyworkers, who received monthly support, comprising updates of progress in client group, and supervision for their work with clients.

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Results

During the data collection period (18 months either side of the pre-group formulation) 17 people were admitted to the acute inpatient ward. Two were excluded as there were no pre-group data available. For the remaining 15 people, a total of 1540 bed days were recorded prior to the group and 1080 post group, a decrease of 460 days in total (30%). One person accounted for 37% (398) of the total post-group bed days. Four members had increased bed use post group (a total of 89 days); the remainder decreased on average by 85 days per person (range 1–210). For the 9 participants with no admission during the 3 years, outpatient appointments fell from 54 (18 months pre) to 21 (subsequent 18 months), a reduction of 61%. All 9 participants showed a decrease in their outpatient appointments.

An initial Friedman's analysis showed a significant interaction between CORE scores and passage of time across formulation, start and end of ECS group ($df = 3$, $p = .02$). Wilcoxon pairwise analyses revealed a significant fall only between formulation and end of group ($z = -2.84$; $p = .003$). There was a decrease between SAS scores over time, but subsequent pairwise comparisons showed this to only approach significance between formulation and the end of group ($z = -1.909\, p = .056$). Twenty participants completed satisfaction questionnaires. The mean total satisfaction score was 23.7 ($n = 20$, possible range 0–28).

Discussion

The fall in hospital days (30%), out-patient appointments (61%) and CORE score (significant at 5%) are encouraging. Lack of experimental control renders these findings preliminary. Client satisfaction was high, and drop out was low (23.5%). The study suggests that the coping skills component of DBT might be sufficiently powerful to benefit people with BPD even without concurrent individual therapy. Linehan conceives of therapy being in stages: stage 1 seeks behavioural and emotional control (Linehan, 1993); stage 2 addresses underlying issues (e.g. post traumatic stress). The present findings raise the possibility that stage 1 might occur in groups. Future research might also measure episodes of self-harm, although this behaviour can serve a range of functions and even be adaptive (i.e. an alternative to suicide). The approach is not intended to replace DBT, but rather to use its therapeutic potential in services unable to offer full DBT.

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