

Dialectical behaviour therapy in the treatment of borderline personality disorder

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Dialectical behaviour therapy was developed by Marsha Linehan, a clinical psychologist, to address the treatment needs of individuals with a diagnosis of borderline personality disorder and a history of parasuicidal behaviour (Linehan, 1993a,b). Linehan's original randomised controlled trial demonstrated efficacy for this form of therapy compared with treatment as usual in reducing the frequency of parasuicidal behaviour, in retaining patients in therapy and in reducing in-patient bed-days (Linehan *et al*, 1991). In a further randomised controlled trial (Linehan *et al*, 1999), dialectical behaviour therapy was shown to be more effective than treatment as usual in reducing drug misuse in a group of patients with borderline personality disorder. The first replication study by an independent group, although only a small pilot study, provided further support for the efficacy of the model (Koons *et al*, 2001). A further important development was the publication of a randomised 1-year clinical trial, again with positive findings, showing that the approach could be replicated in a European setting (Verheul *et al*, 2003). Factors contributing to the relative prominence of dialectical behaviour therapy include the availability of a treatment manual and workbook (Linehan, 1993a,b), the spread of training workshops in the USA and Europe, and support for the model from managed care companies in the USA (Gunderson, 2001). The therapy has also been recommended as a specific treatment for borderline personality disorder by the American Psychiatric Association (2001). It is therefore timely to consider the treatment model and its clinical applications and limitations.

TREATMENT MODEL

Dialectical behaviour therapy integrates proven techniques from cognitive and

behavioural therapies within a philosophical and theoretical framework for understanding borderline pathology. Its theory and practice borrow from four different orientations: biological, social, cognitive-behavioural and spiritual (Linehan, 1993a). Central to the theory is a dialectical perspective both of the experiences of individuals with borderline personality disorder and of effective therapeutic intervention. In this view, every experience contains simultaneously valid polarities, with the tension between them offering the possibility of change. The fundamental dialectic in this therapy is between validation and acceptance of the patients as they are, within the context of simultaneously helping them to change. The components of standard out-patient dialectical behaviour therapy are once-weekly individual psychotherapy, coordinated with a weekly skills training group and telephone consultations between sessions with the primary therapist with the aim of preventing emergencies by providing skills coaching and/or relationship repair with the therapist. The fourth component is a weekly consultation session for the therapy team members to ensure adherence to the model and to keep them motivated in the face of the difficulties that arise in the treatment of individuals with borderline personality disorder.

Dialectical behaviour therapy is a four-stage treatment. In stage 1, the primary focus is on stabilising the patient and achieving behavioural control. The target behaviours are:

- (a) decreasing life-threatening suicidal behaviours;
- (b) decreasing therapy interfering behaviours;
- (c) decreasing quality-of-life interfering behaviours;
- (d) increasing behavioural skills.

Stage 1 is expected to take at least a year. In stage 2 the focus is on

treating problems related to past trauma. In stage 3 the emphasis is on the development of self-esteem and the effective management of problems of daily living. Stage 4 sees the individual as seeking to develop the capacity for optimum experiencing.

CLINICAL APPLICATIONS

The most consistent observation from research published to date is that the application of standard out-patient dialectical behaviour therapy (stage 1) reduces the rate of suicidal behaviour compared with treatment as usual. Further positive findings have been reported in respect of decreased rates of psychiatric hospitalisation and increased patient retention in therapy. The approach has also demonstrated efficacy for patients with borderline personality disorder regardless of the presence of substance use disorders (Linehan *et al*, 1999; Verheul *et al*, 2003). The obvious cost benefits related to reduced length of in-patient stay and the efficacy data have provided the impetus for the development of clinical programmes devoted to providing dialectical behaviour therapy, particularly in the USA (Fox, 1998; Gunderson, 2001).

Similar positive findings in the treatment of borderline personality disorder have been demonstrated for psychoanalytically oriented partial hospitalisation: Bateman & Fonagy (1999) reported a decrease in parasuicidal behaviour and fewer psychiatric in-patient days, accompanied by an improvement in depressive symptoms and better social and interpersonal functioning which continued to the end of the 18-month treatment period. A follow-up study also reported positive findings (Bateman & Fonagy, 2001) and a cost-effectiveness study (Bateman & Fonagy, 2003) showed this treatment to be competitive with the cost of general psychiatric care. The original study has yet to be replicated, and the absence of a treatment manual is likely to make this difficult.

A conservative view is that standard out-patient dialectical behaviour therapy may be superior to psychiatric treatment as usual in reducing parasuicidal behaviour in patients with borderline personality disorder – the primary target of stage 1 treatment.

LIMITATIONS

A comprehensive critique of dialectical behaviour therapy has been made by Scheel (2000). The promising findings are acknowledged but significant methodological difficulties in the available studies are outlined. In particular, all studies have had small numbers of participants, who have largely been severely dysfunctional parasuicidal women with borderline personality disorder, and selection criteria have placed restrictions on multiple diagnoses. Borderline personality disorder is a heterogeneous condition with significant differences in individual symptom patterns, and commonly overlaps with other Axis I and Axis II disorders. An important issue for further research is whether this therapy is effective for the entire range of clients with borderline personality disorder or whether it is primarily a treatment for parasuicide. The lack of evidence that it is efficacious for other core features of borderline personality disorder, such as interpersonal instability, chronic feelings of emptiness and boredom and identity disturbance, has led to the suggestion that dialectical behaviour therapy might be the treatment of choice for people with severe, life-threatening impulse control disorders rather than for borderline personality disorder *per se* (Verheul *et al*, 2003).

Dialectical behaviour therapy is a multifaceted treatment requiring significant theoretical knowledge and clinical skills for its application. Many of the individual therapists in the studies to date were doctoral-level professionals who had been personally trained by Linehan. The finding therefore that this therapy can be effectively learned by mental health professionals outside academic research centres and from a broad range of training backgrounds (Hawkins & Sinha, 1998; Verheul *et al*, 2003) is important in regard to the clinical usefulness of the treatment. None the less, the difficulties of translating such a model to community mental health settings, where there is often a shortage of suitably trained staff, are obvious. In this regard, a pilot study using a brief manual-based treatment, which contained elements of dialectical behaviour therapy, achieved promising results in reducing parasuicidal behaviour (Evans *et al*, 1999).

Concern also arises as to how long the gains of standard 1-year out-patient dialectical behaviour therapy programmes may last, given that the outcomes in patients

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given dialectical behaviour therapy and a control group were similar a year after the discontinuation of treatment (Linehan *et al*, 1993). Research on the later stages of this therapy is awaited. In addition, it has not yet been established that standard outpatient dialectical behaviour therapy is more effective across the range of outcome variables than any other comparatively consistent form of treatment (Scheel, 2000).

It is not clear at present how the individual elements of the therapy contribute to treatment outcome. The addition of a dialectical behaviour therapy skills training group to non-dialectical individual therapy has not been shown to be of benefit (Linehan, 1993a). It is of interest to note that dialectical behaviour therapy and Bateman & Fonagy's partial hospitalisation model have many characteristics in common:

- (a) an intensive, relationship-focused treatment approach;
- (b) a highly structured theoretically coherent model;
- (c) ease of access to therapists;
- (d) a multimodal approach, with several therapists for each person;
- (e) regular therapist peer group supervision.

These similarities lend support to Tyrer's robust critique of the American Psychiatric Association practice guidelines for the treatment of borderline personality disorder, in which he proposes that the ability to integrate a common team approach to such patients is the successful ingredient of treatment (Tyrer, 2002).

CONCLUSIONS

Linehan and her colleagues have made an important contribution to research in the area of treatment of borderline personality disorder; Gunderson (2001) described it as 'since 1987, the single most remarkable entry in therapeutic strategies for borderline

patients'. None the less, given the limited resources in many psychiatric settings, allied to the intensive nature of the programme and debate as to the generalisability of the research findings, further development of dialectical behaviour therapy is likely to be limited to specialist settings. Perhaps Linehan's most important achievement with this therapy has been to instil a sense of hope in people with borderline personality disorder – and their therapists – that a life worth living may be an achievable goal.

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