University of North Dakota
UND Scholarly Commons

Nursing Capstones | Department of Nursing

12-12-2018

Dialectical Behavior Therapy on Borderline Personality Disorder

Alisa M. Cook

How does access to this work benefit you? Let us know!

Follow this and additional works at: https://commons.und.edu/nurs-capstones

 Part of the Nursing Commons

Recommended Citation

Cook, Alisa M., "Dialectical Behavior Therapy on Borderline Personality Disorder" (2018). *Nursing Capstones*. 242.
https://commons.und.edu/nurs-capstones/242

This Independent Study is brought to you for free and open access by the Department of Nursing at UND Scholarly Commons. It has been accepted for inclusion in Nursing Capstones by an authorized administrator of UND Scholarly Commons. For more information, please contact und.commons@library.und.edu.

DIALECTICAL BEHAVIOR THERAPY ON BORDERLINE PERSONALITY DISORDER

by

Alisa M. Cook

Bachelor of Science in Nursing, University of North Dakota, 2014

An Independent Study

Submitted to the Graduate Faculty

of the

University of North Dakota

In partial fulfillment of the requirements

for the degree of

Master of Science

Grand Forks, North Dakota

November

2018

PERMISSION

Title Dialectical Behavior Therapy on Borderline Personality Disorder

Department Nursing

Degree Master of Science

In presenting this independent study in partial fulfillment of the requirements for a graduate degree from the University of North Dakota, I agree that the College of Nursing and Professional Disciplines of this University shall make it freely available for inspection. I further agree that permission for extensive copying or electronic access for scholarly purposes may be granted by the professor who supervised my independent study work or, in her absence, by the chairperson of the department or the dean of the School of Graduate Studies. It is understood that any copying or publication or other use of this independent study or part thereof for financial gain shall not be allowed without my written permission. It is also understood that due recognition shall be given to me and to the University of North Dakota in any scholarly use which may be made of any material in my independent study.

Signature _____

Date _____

Abstract

Borderline Personality Disorder (BPD) is characterized by intense, unstable personal relationships and emotional dysregulation. Dialectical Behavior Therapy (DBT) is a type of psychotherapy frequently used to treat the symptomology of BPD. A review of Patient 1's case report provided an in vivo presentation of living with BPD. Patient 1's symptomology exhibited the mood instability and the parasuicidal behaviors characteristic of the disorder. In examining the impact of DBT on BPD, three systematic reviews and two meta-analyses were reviewed. While exerting caution when arriving at clinical implications, all five studies found a decrease in BPD's negative symptomology when treated with DBT, notably self-harm behaviors. A final review examined reports benefit from DBT for BPD, but asserts no significant difference between DBT and other specialized psychotherapy modalities for BPD. The implications for practice obtained from the literature review are large and it is recommended that DBT skill groups be implemented into most inpatient psychiatric settings. In addition, most mental health clinics should offer a regular DBT group for patients.

Dialectical Behavior Therapy on Borderline Personality Disorder

Background

According to the American Psychiatric Association[APA] (2013), borderline personality disorder (BPD) is "A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts" (p.663). The symptoms of Borderline Personality Disorder (BPD) have profound implications for a patient's quality of life and interpersonal relationships. Symptoms such as intense anger, self-mutilation and suicidal threats create enormous stress on the patient, their support system and providers alike. For psychiatric services, patients diagnosed with BPD are among the highest utilizers (Comtois & Carmel, 2016).

BPD is estimated to affect 10% of the outpatient population (APA, 2013). This case report will examine a 29-year-old female diagnosed with BPD. As part of her treatment, she has participated in a 10-week Dialectical Behavior Therapy (DBT) group. DBT is a form of cognitive therapy that is reported as a mainstay of treatment for BPD. The relationship between the emotional dysregulation of BPD and treatment modality of DBT will be examined.

Case Report

Patient 1 is a twenty-nine-year-old female who presented to an outpatient clinic in March of 2018 for medication management. Prior to her initial evaluation, she participated in a Partial Hospitalization Program (PHP) for several weeks. While at PHP, Patient 1 was diagnosed with Major Depressive Disorder (MDD), Borderline Personality Disorder (BPD), and social anxiety disorder. Her providers were attempting to rule out Bipolar spectrum and Bipolar II disorder.

Patient 1 had a difficult childhood, reporting frequent moves and sexual abuse by her father. Her first suicide attempt was at age 9 via stabbing. At seventeen years old, she was hospitalized

for suicidal ideation. At twenty-four, she was hospitalized again after attempting to strangle herself. Her most recent inpatient hospitalization was last fall for suicidal ideation. She also reported visual hallucinations since age 16, notably “angels and demons”. History of “food issues” in adolescence, including restricting intake, bingeing and excessive exercise. Patient 1 also reported a history of social anxiety with fear of being judged by others, significant enough to interfere with daily activities. She reported difficulties leaving her home due to anxiety.

She had been married for seven years and described a positive relationship with her husband. She achieved a bachelor’s degree but has a sporadic employment history. She recently acquired a part time job as an administrative assistant, after receiving this suggestion from her therapist. She denied any substance use history, including illicit drugs and alcohol. Patient 1 reported no children and no previous pregnancies. Her support system consisted of her family and church community.

This past spring, Patient 1 presented to outpatient psychiatry for follow up after her discharge from the Partial Hospitalization Program. In her initial evaluation, Patient 1 reported fluctuating moods, chronic feelings of emptiness. Mood lability was described as frequently as “minute to minute”. Prior to her current relationship with her husband, she reports intense and unstable interpersonal relationships. Describes difficulty with controlling anger and engaged in self-harm by: “slapping myself”. Patient 1 reports frequent nightmares that greatly reduce quality sleep time. She attributes these nightmares to sexual abuse.

She has had past medication trials of Wellbutrin XL, Lamictal, Prazosin, Hydroxyzine, Celexa and Abilify. Patient 1 participates in monthly psychotherapy with a therapist at another facility. At the recommendation of her outpatient provider Patient 1 participated in her first Dialectical Behavior therapy group. Beginning about one month ago, Patient 1 attended 10

weekly 90-miute session of the Interpersonal Effectiveness module of DBT. Starting next month, she will begin the Emotional Regulation module of DBT.

Literature Review

A brief etiology of Borderline Personality disorder and development of Dialectical Behavior therapy will be provided, followed by analysis of selected studies.

Borderline Personality Disorder

Borderline Personality Disorder (BPD) frequently wreaks havoc on the lives of patients diagnosed with this disorder. Linehan (1993) supports the biosocial theory of BPD which arises from emotional vulnerability and an invalidating environment as a child. As the patient grows older, these early experiences are manifested as the symptoms of BPD, notably emotional instability and increased emotional sensitivity. Exacerbating the emotional dysregulation of BPD is rumination, which "amplifies distress, prompting impulsive attempts to escape emotions, resulting in further problems and distress" (Dixon-Gordon, Peters, Fertuck & Yen, 2017, p.428). Rumination may also lead to the intense anger that can be symptomatic of BPD.

Dialectical Behavior Therapy

Dialectical Behavior Therapy (DBT) was originally developed by Marsha Linehan in response to patients with frequent suicidality (Linehan & Wilks, 2018). In somewhat of a serendipitous manner, DBT emerged from attempts to address this population through standard behavior therapy (Linehan & Wilks, 2018). Several modifications were made to standard cognitive and behavioral therapies: acceptance and validation of current behavior, treating behaviors that may interfere with therapy, prioritizing the therapeutic relationship and dialectic processes (Linehan, 1993).

In its name, the term “Dialectics” is the balance of opposite ideas, or as Linehan (1993) describes “thesis and antithesis” (p.2). Students of DBT learn that they must accept themselves as they are, but also recognize the need to change (Linehan, 1993). Similar to standard cognitive behavioral therapy, the practice of “DBT emphasizes ongoing assessment and data collection on current behaviors; clear and precise definition of treatment targets; and a collaborative working relationship between therapist and client” (Linehan, 1993, p.5).

Wheeler (2014, p. 510) summarizes DBT as: “cognitive behavioral therapy (CBT) within a Zen Buddhist worldview”. The Zen aspect of DBT is an important deviation from previous therapies because instead of changing uncomfortable feelings, clients are taught to tolerate the discomfort (Linehan & Wilks, 2018). Furthermore, Linehan (1993) asserts: “DBT goes a step further than standard cognitive-behavioral therapy in emphasizing the necessity of teaching clients to fully accept themselves and their world as they are in the moment.” (p.5)

The format of DBT is separated into four modules: mindfulness, interpersonal effectiveness, emotion regulation and distress tolerance (Linehan, 1993). Mindfulness is identified as a “core” skill of DBT, with components of this detectable in each module (Linehan & Wilks, 2018). Each module targets different areas of difficulty for patients with BPD and is surmised by Valentine, Bankoff, Poulin, Reidler & Pantalone (2014) as follows:

> (a) core mindfulness skills center on ways to strategically deploy attentional control; (b) emotion regulation skills teach clients to identify and influence emotions elicited by the environment; (c) interpersonal effectiveness skills help clients to learn to respond effectively to interpersonal demands and conflicts; and (d) distress tolerance skills teach clients to identify crisis situations and experience strong negative emotions

> while inhibiting dysfunctional behaviors that could serve to make the situation worse. (p.2).

Review of Data

Studies utilized for this literature review were obtained from PubMed, CINAHL, PsycInfo, Cochrane Database and Psychiatry Online. Keywords utilized included: "Borderline personality disorder" and "Dialectical behavior therapy". Preference was given to higher levels of evidence, including systematic reviews and meta-analysis. The evidence base for DBT in treating the symptomology of BPD is large.

Perhaps the most influential evidence is the systematic review documented in the Cohrane Database. Stoffers-Winterline, Vollm, Rucker, Timmer, Huband & Lieb (2012) examined a total of twenty-eight studies with 1,804 patients diagnosed with BPD. Meta analytic pooling was completed only for DBT due to the lack of evidence for other treatment modalities. DBT's effect on anger in BPD had a standardized mean difference of -0.83 and a confidence interval (CI) of (-1.43 to -0.22). For parasuicidality, standard mean difference was -0.54 and CI (-0.92 to -0.16). Finally, DBT was assessed for impact on mental health: standardized mean difference 0.65 and CI (0.07 to 1.24). All three outcomes measured for DBT were significant for improving the symptomology of BPD.

Another systematic review examined the effect of DBT in inpatient settings. Bloom, Woodward, Susmaras & Pantalone (2012) reviewed eleven studies. A limitation of the review was the various formats of DBT that were applied, providing a heterogeneous mix of studies and the lack of comparison groups. Bloom et al. (2012) did not pool data and no statistical analysis was conducted. Rather, this systematic review was qualitative in nature. Each study was examined for significant reduction in various symptomology domains of BPD. The results

showed reduction of self-harm, depression, anxiety and dissociation (Bloom et al., 2012). The application of DBT to inpatient settings is promising.

In another systematic review, Valentine et al. (2014) examined the effect of DBT skills only, or as the authors term it: "Stand-alone" skills. Studies with other tenets of treatment such as individual/ group therapy that form the more traditional DBT structure were not considered. Valentine et al. (2014) cite the wide variety of contexts that DBT is applied in. The "Stand-alone" skill training is more flexible for patients and settings that are unable to stick to the traditional DBT structure. No independent statistical analyses were conducted on the pool of studies. Rather, the authors evaluated individual studies and created a qualitative review of symptomology. Due to the heterogeneity of the studies, strict conclusions are difficult to draw. However, the results suggest an efficacious presence for DBT skill training (Valentine, et al., 2014). While firm conclusions cannot be made due to the variety of studies included, Valentine et al. (2018) summarize the effects of DBT: "a lack of adverse effects, low dropout rates, reported reductions in mental health symptoms and behavioral problems and improvements in overall functioning at EOT" (p.16).

Another meta-analysis examined was completed in 2014 by Panos, Jackson, Hasan & Panos. The authors examined randomized control trials (RCTs) that "assessed the efficacy of DBT in reducing suicidal attempts, parasuicidal behavior, attrition, or depressive symptomology in adult patients diagnosed with BPD". (Panos et al., 2014, p. 214). Selected studies were required to have a control group, and validated depression rating scales. Ultimately, five studies were identified to meet the criteria. Within these studies, 247 individuals were identified.

Regarding parasuicidal behaviors, three of the five studies utilized psychological scales. The other two studies utilized suicide attempt rates. For the studies using psychological scales,

Hedge's *g* value was -0.636 and 95% CI (-1.382 to +0.111). The results from this cohort were not significant in reducing parasuicdal behaviors. In contrast the remaining studies that examined the suicide attempt rate reported a Hedge's *g* value of -0.622 and CI (-0.983 to -0.260). These results demonstrate that DBT reduces parasuicidal behaviors. Panos et al. (2014) estimates through their analysis that suicide attempts were reduced by 2/3 through application of DBT.

A meta-analysis by DeCou, Comtois & Lands (2018) reviewed eighteen studies that measured the effect of DBT on the following outcomes: self-harm, suicidal ideation and accessing crisis resources. DeCou et al. (2018) report a significant difference reduction in self-directed violence with DBT. Specifically, the weighted mean effect size, or *d*, =-.324 and CI (-.471 to -.176). Like the effect on self-harm, DeCou et al. (2018) also found a significant decrease in accessing emergency psychiatric services with *d*=-.379 and CI (-.581 to -.176). While the previous measures showed significant results, DBT did not reduce suicidal ideation in the pooled studies. DeCou et al. (2018) report *d*=-.229 and CI (-.473 to 0.16).

An article by Levy, McMain, Bateman & Clouthier (2018) examined the overarching treatment of BPD. Research of several modalities of treatment, such as DBT, mentalization-based therapy, and transference-focused psychotherapy were compared. Regarding the efficacy of BPD the authors state: "…DBT is consistently superior to nonspecific comparators in reducing suicidal and self-harm behavior, health care utilization" (Levy, et al., 2018).

Furthermore, Levy et al (2018) dispute the role of DBT as the only therapy effective for BPD. In fact, the authors assert there is no significant difference amongst DBT and other specific forms of therapy in treating symptomology of BPD. The authors state: "As such, it would be shortsighted to think that one treatment is best for all presentations" (Levy, et al., 2018, p.722).

Implications for Practice

In examining the effect of dialectical behavior therapy, multiple systematic reviews and meta-analyses have found a reduction in several negative symptoms of BPD. Specifically, five of the studies reported a reduction in self-harm. Other significant symptom reductions reported by the studies included: anger, accessing crisis resources and suicide attempts.

Considering the large body of evidence, including several systematic reviews, the link between dialectical behavior therapy and reduction of emotional dysregulation in borderline personality disorder can be confirmed. Considering the consequences of BPD on functioning and the high utilization of psychiatric services (Comtois & Carmel, 2016), the need for a treatment that addresses the theoretical underpinnings of BPD is essential. DBT addresses the invalidation and emotional vulnerability of the patient with modules tailored to this symptomology.

According to Coyle, Shaver & Linehan (2018), the number of psychiatric ER visits and inpatient admissions may place a patient at higher risk for subsequent suicide attempts. Furthermore, Coyle et al. (2018) found that DBT reduced the number of psychiatric ER visits and suicidal behavior. This further supports the rationale for utilizing DBT. In preventing the number of crisis utilization services by a patient, we can also reduce the incidence of suicidal behavior as well.

The results reviewed have also suggested that the format of DBT is not essential to the reduction of self-harm behaviors. Thus, the need for highly structured groups or interventions is not a factor to consider when engaging patients in DBT. The ease and relative low financial burden to which DBT can be utilized is reassuring to providers.

According to the DSM-5, the prevalence of Borderline personality disorder in a primary care setting, mental health setting and inpatient psychiatric facility is 6%, 10% and 20%, respectively

(APA, 2013). Coupled with the destructive consequences of emergency room and inpatient admissions, the need for efficacious treatment is present. Dialectical behavior therapy meets the need with few, if any adverse events (Stoffers-Winterline, Vollm, Rucker, Timmer, Huband & Lieb, 2012).

The implications for practice are broad for DBT in the treatment of BPD. To target the high prevalence of inpatient cases, and the negative effects of recurrent hospitalizations (Coyle et al. 2018), it is prudent for a psychiatric nurse practitioner to recommend the application of DBT to inpatient therapy. As the systematic review conducted by Valentine et al. (2014) concluded, the benefit of "stand-alone" skills show promise that DBT is effective outside of the standard infrastructure. Inpatient psychiatric units should offer DBT focused therapy sessions to all patients admitted. Offering at least one daily session provides the opportunity for DBT introduction. On discharge, patients should have the option to continue DBT on an outpatient basis.

Mental health clinics should strive to offer regular DBT therapy sessions, both in a group and individual format. A psychiatric nurse practitioner has the educational background to obtain training in DBT to offer this to patients. An outpatient setting would afford the more traditional application of DBT, such as follow up phone calls. Psychiatric nurse practitioners conducting DBT in an outpatient setting would allow patient's more time to practice skills and receive feedback from group/therapy facilitators.

Borderline personality disorder has the potential to wreak havoc on an individual's personal life and the resources of psychiatric crisis services. In examining the summative effect of dialectical behavior therapy, psychiatric nurse practitioners can confidently treat patients

diagnosed with BPD, and encourage patient referrals to clinicians that can provide this type of counseling.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th ed.).* Arlington, VA: American psychiatric association publishing.

Bloom, J.M., Woodward, E.N., Susmaras, T., Pantalone, D.W. (2012). Use of dialectical behavior therapy in inpatient treatment of borderline personality disorder: A systematic review. *Psychiatric Service, 63* (9), 881-888. Doi: 10.1176/appi.ps.201100311

Comtois, K.A. & Carmel, A. (2016). Borderline personality disorder and high utilization of inpatient psychiatric hospitalization: concordance between research and clinical diagnosis. *Journal of Behavioral Health Services & Research, 43*(2), 272-280.

Coyle, T.N., Shaver, J.A. & Linehan, M.M. (2018). On the potential for iatrogenic effects of psychiatric crisis services: The example of dialectical behavior therapy for adult women with borderline personality disorder. *Journal of Consulting and Clinical Psychology, 86*(2), 116-124.

DeCou, C. R., Comtois, K. A., & Landes, S. J. (2018). Dialectical behavior therapy is effective for the treatment of suicidal behavior: A meta-analysis. *Behavior Therapy*. https://doi-org.ezproxylr.med.und.edu/10.1016/j.beth.2018.03.009

Dixon-Gordon, K.L., Peters, J.R., Fertuck, E.A. & Yen, S. (2017). Emotional processes in borderline personality disorder: An update for clinical practice. *Journal of Psychotherapy Integration, 27*(4), 425-438.

Levy, K.N., McMain, S., Bateman, A., Clouthier, T. (2018). Treatment of borderline personality disorder. *Psychiatric Clinics of North America, 41*(4), 711-728.

Linehan, M.M. & Wilks, C.R. (2015) The course and evolution of dialectical behavior therapy. *American Journal of Psychotherapy, 69* (2), 97-110.

Linehan, M.M. (1993). *Skills training manual for treating borderline personality disorder*. New York, NY: The Guilford Press.

Panos, P.T., Jackson, J.W., Hasan, O. & Panos, A. (2014). Meta-analysis and systematic review assessing the efficacy of dialectical behavior therapy (DBT). *Research on Social Work Practice, 24*(2), 213-223.

Stoffers-Winterling, J.M., Vollm, B.A., Rucker, G., Timmer, A., Huband, N & Lieb, K. (2012). Psychological therapies for people with borderline personality disorder. *Cochrane Database of Systematic Reviews,* (8).

Swales, M.A. (2009). Dialectical behavior therapy: Description, research and future directions. *International Journal of Behavioral Consultation and Therapy, 5*(2), 164-177.

Valentine, S.E., Bankoff, S.M., Poulin, R.M., Reidler, E.B. & Pantalone, D.W. (2015). The use of dialectical behavior therapy skills as a stand-alone treatment: A systematic review of the treatment outcome literature. *Journal of Clinical Psychology, 71*(1), 1-20.

Wheeler, K. (2014). *Psychotherapy for the advanced practice psychiatric nurse: A how-to guide for evidence-based practice* (2nd ed.). New York, NY: Springer Publishing Company, LLC.