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Dialectical Behavior Therapy for Borderline Personality Disorders

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PERMISSION

Title Crisis Management for Patients with Borderline Personality Disorder

Department Nursing

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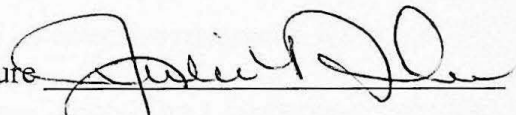
Signature 

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Abstract

Often individuals with Borderline Personality Disorder (BPD) suffer from emotion dysregulation: uncontrollable mood swings, impaired thought processes, impulsive and reckless behaviors, and chaotic relationships (National Institute of Mental Health, 2012) thus impairing their functional abilities and their quality of life. There is no known cause at this time; however, researchers suggest that genetics, abnormal brain development, and environment play a major factor the development of a BPD. Not only is the individual affected but also those who surround the patient such as families, friends, society, health care professionals, and community providers. The constant maladaptive behaviors often lead to minimal supports thus resulting in further exacerbation of the symptoms associated with BPD. Initially BPD was viewed as a non-treatable illness; however, research has proven that psychotherapy is an effective treatment. Research shows DBT is the most effective psychotherapy for BPD as evidenced by a decrease in suicides, suicidal ideations, self-injurious behaviors, symptom severity and improvement of overall functioning and quality of life. DBT entails teaching four basic behavioral skills: distress tolerance, emotional regulation, interpersonal effectiveness, and mindfulness. Not only has DBT shown to be effective for the patient, but there are also benefits for society and health care providers. DBT has proven to be effective in reducing health care utilization thus reducing healthcare costs. Lastly, DBT has shown to be effective in promoting a therapeutic relationship between the patient and mental health provider and as a result further compliance of appointments and treatment recommendations have been seen.

Dialectical Behavior Therapy for Borderline Personality Disorders

Introduction

Borderline personality disorder (BPD) affects 1-2% of the general population, 10% of persons in outpatient mental health facilities, and 20% of those in inpatient mental health facilities (National Alliance on Mental Illness [NAMI], 2011). Borderline personality disorder was added as a diagnosable disorder in the *Diagnostic and Statistical Manual for Disorder, Third Edition* (DSM) in 1980 (National Institute of Mental Health [NIMH], 2010). The exact cause of borderline personality disorder is not known. However; genetics, brain development abnormalities, absence of protective factors, and environment play a role in developing BPD (Grahol, 2007). Historically, BPD was viewed as an untreatable diagnosis but recently six different psychotherapies have been found effective in reducing some of the symptoms of BPD: cognitive-behavioral therapy, dialectical behavior therapy, psychodynamic therapy, family therapy, support groups, and psychiatric medication management (McMain, Links, Gnam, Guimond, Cardish, Korman, & Streiner, 2009).

Dialectical behavior therapy (DBT) is one of the newest therapies and was found to be one of the most researched (NAMI, 2011). A review of pertinent literature demonstrates that dialectical behavior therapy is the most effective BPD treatment and useful treatments according to individuals diagnosed with borderline personality disorder (NAMI, 2011).

Borderline personality disorder (BPD) is a mental disorder that is characterized by emotional instabilities that leads to stress and other problems interfering with the sufferer's quality of life and ability to function appropriately in social situations (Mental Health America of Franklin County, 2007).

McMain et al. (2009), report borderline personality disorder has been associated with a high morbidity and mortality rate, often leading to substantial healthcare costs. It is estimated that 69% to 80% of patients with BPD attempt suicide and an even higher percentage of those engage in non-suicidal self-injurious behaviors (SIB). According to the National Alliance on Mental Illness (2011), 75% of BPD patients self-injure and of those patients who attempt suicide, approximately 10% succeed in their suicide attempt. For this reason, implementation of DBT skills is essential for patients with BPD with chronic suicidal ideations to decrease hospitalizations and emergency room visits related to suicidal ideations. Most importantly, it is pertinent to teach DBT skills to mental health practitioners, especially county case managers, to promote a therapeutic relationship and compliance with treatment plans.

Purpose

A common problem for BPD individuals is the high probability to relapse. This is related to difficulty maintaining a therapeutic relationship with their doctors and community resources due to their noncompliance with scheduled appointments and treatment recommendations. Often they have minimal supports in their life, and community supports are all that is left due to their viscous emotional rollercoaster, reckless behavior, and suicidal ideation. The use of DBT skills will help BPD individuals gain the skills to control these self-destructive behaviors, suicidal ideations and attempts, and management of emotions to promote therapeutic relationships and gain control of their life (Linehan, 1993).

The purpose of this project is to educate mental health practitioners, especially county case managers, on the effectiveness of DBT for BPD patients with an in-depth literature review showing the success/outcomes of DBT programs. Jenni Olson, a registered nurse (RN) county case manager in central Minnesota reports that she believes BPD patients are one of the most

challenging mental health disorders to work with. She states the lack of training on how to effectively deal with the behaviors of BPD patients greatly influences her views. She reports treatment often is terminated by the patient or the case manager requests a change in case manager due to burnout (J. Olson, personal communication, February 10, 2012). As a result, an overview of a BPD diagnosis and a DBT skills training program will be developed and implemented for Douglas County mental health case managers. Teaching DBT skills will assist county case managers to work more effectively with individuals that suffer from BPD; thus, overall promoting the physical and mental health of BPD patients in the community.

Significance

Historically, individuals with borderline personality disorder have been very difficult to treat. They are often referred to as the most challenging patients in mental health because of their constant crisis, chaotic relationships, constant demands, fears of abandonment, dysfunctional behaviors, confused identities, lack of distress tolerance skills, and uncontrollable mood fluctuations (NAMI, 2011). The borderline personality disorder individual's mentality is often viewed as *black and white* or *all or nothing*. For example, a therapist is viewed as being caring and helpful when there is no difficulty in therapy or chaos in the BPD individual's life. However, if difficulty or chaos arises, the BPD individual will view the therapist as bad and uncaring (Grahol, 2007).

Often these feelings lead the BPD patients feeling more emotionally unstable and utilizing dysfunctional coping skills; for instance, they may no longer attend therapy sessions. In other cases, borderline personality disorder individuals have been viewed by health care professionals as gamey or button pushers; often leading the mental health provider to frustration or burnout (Linehan, 1993).

BPD is a severe, chronic and persisting mental illness and was initially thought of as an untreatable diagnosis until clinical trials have shown that psychotherapies: cognitive-behavioral therapy, dialectical behavior therapy, psychodynamic therapy, family therapy, support groups, and psychiatric medication management are effective in the treatment of BPD (McMain et al., 2009). Dialectical behavior therapy is the newest type of psychotherapy and is suggested to be the most effective treatment for BPD (NAMI, 2011).

DBT, a cognitive-behavioral treatment, was developed by Marsha Linehan to treat suicidal individuals as a result of multiple failures with standard cognitive behavioral therapy (CBT). She identified the following reasons for failure of CBT and added these missing items to a new therapy. The *dialectical* portion of the name DBT derived after she implemented the new modification to DBT that she believed CBT was lacking: accepting and validating the patient's capabilities and behavioral functioning. Secondly, she added two more therapy components instead of only individual psychotherapy for CBT: group and phone consulting. Lastly, she implemented a consultation team for the therapist in an attempt to increase the capabilities and motivation of the therapist (Dimeff & Linehan, 2001).

Over time, Marsha Linehan has shown DBT to be an effective treatment for individuals with BPD with multi-disorders ranging in severity and complexity period (Linehan, 1993). The goal of DBT is to help the BPD individual live a life that is worth living. The main focus of DBT is stabilization of the patient and controlling their behavior in a hierarchical order through staging (Sanderson, 2008).

The first stage focuses on transforming uncontrolled behaviors to controlled behaviors. The first and most important target is addressing self-injurious or suicidal behavior. The second target is identifying if there are any behaviors that are interfering with therapy such as coming

late, missing appointments, excessive crisis line use, and not answering or returning calls. The next target is identifying and addressing behaviors that are interfering with the individual's recovery and quality of life such as substance dependence, physiological needs, and co-morbid mental illnesses. The last and final target is learning new skills to focus on the future a without dwelling on the past, promoting development of interpersonal relationships, and emotion awareness and regulation (Sanderson, 2008).

The second stage involves the promotion of emotional wellness. It focuses on exploring ones emotions without becoming emotionally closed off. The therapist helps the individual address any history of trauma and post-traumatic stress without using dysfunctional coping mechanisms. The goal of therapy is teaching the individual to take control of their emotions and improve their life (Sanderson, 2008).

The next stage involves the removing the unhappiness and stressors of life by introducing these recently learned skills to the environment (Dimeff & Linehan, 2001). Some common life problems include marriage and work conflicts. Many patients continue with their current therapist; however others may choose to work independently on their goals (Sanderson, 2008).

Linehan added the fourth stage after individuals expressed a *spiritual dryness* or an *empty feeling inside* after completing the first three stages. Linehan found that individuals urged for meaning in life (Sanderson, 2008). Therefore, the final stage involves building a life worth living by having a secure self-identity and purpose in life (Dimeff & Linehan, 2001).

DBT is done in multiple types of therapy sessions which include individual, group, and phone coaching. Individual therapy is a client-centered approach that focuses on the patient's willingness to change, identifying problematic behaviors, and implementing new successful interventions. Group therapy is a multi-person approach that teaches the basic behavioral skills:

distress tolerance, emotional regulation, interpersonal effectiveness, and mindfulness. Lastly, phone coaching is a tactic used between the therapist and the client to implement these learned skills into the real world with verbal coaching through the phone (Linehan, 1993).

Theoretical model

This paper is guided by Kurt Lewin's Change Theory. Lewin focused the theory on the forces that influence the change process of humans. These forces can be viewed as either driving forces that promote the change process or a restraining force that hinders the change process. The goal for successful change involves moving from equilibrium or status quo by either increasing the driving forces or decreasing the restraining forces (Kaminski, 2011). Lewin identified that planned change occurs in three stages: unfreeze, change, & refreeze (Current Nursing, 2011).

The first stage is the unfreezing stage (Current Nursing, 2011). The mental health practitioner helps the patient identify that current coping mechanism or old behavioral patterns are counterproductive and detrimental to their relationships, surroundings, and self-image. The mental health practitioner's goal in this stage is helping the patient realize that change is needed, assess the patient's desire to change and identify what needs to occur for the change process to begin (Linehan, 1993).

Dr. Ryan Voigt from Douglas County Mental Health, reports that DBT is the most effective of all the treatments given than the patient wants to learn and change. Commitment to the program results in the patient being successful in the DBT program. If a patient is not willing to learn and change, general psychiatric management works best. A lot of individuals just want a quick fix with a pill; however, there is no pill for BPD (R. Voigt, personal communication, February 10, 2012).

The number one problem of BPD is emotion dysregulation: oversensitivity, over-reactive and slow baseline return which is already heightened. BPD individuals report feelings of uncontrollable anger, depression, anxiety, and emptiness that results in chaotic relationships, identity issues, and suicidal thoughts thus resulting in further crisis affecting their quality of life (Linehan, 1993).

The second stage is the change stage which involves the actual change process (Current Nursing, 2011). The patient realizes that change is better and applies the "process of change in thoughts, feelings, behavior, or all three" (Kaminski, 2011). DBT is aimed at emotion modification by increasing awareness to emotional responses that are influenced by mood. DBT teaches self-soothing techniques and refocuses attention on things other than emotions. DBT has four phases: Core Mindfulness Skills, Interpersonal Effectiveness Skills, Emotion Regulation Skills, and Distress Tolerance Skills (Linehan, 1993).

The refreezing stage is the third and last stage of the change process (Current Nursing, 2011). The final stage involves applying the change as a new habit versus using old habits. The individual takes control of their life by reducing or eliminating behaviors that affects their ability to be successful and improve their quality of life. Overall DBT teaches the patient to control their attention, emotions, and relationships thus resulting in fewer hospitalizations, fewer life-threatening behaviors, and stabilization of mental health and quality of life (Linehan, 1993).

Definitions

The following words identified through-out this paper will be identified with definitions for a more comprehensive understanding.

Borderline personality disorder

Borderline personality disorder is a serious mental health disorder that presents with labile moods, impulsive behaviors, and unstable relationships (National Institute of Mental Health, 2010). According to DSM IV diagnosis criteria, to diagnose an individual over the age of 18 with borderline personality disorder, one must meet five of the nine criteria. The individual attempts to avoid abandonment. They have difficulty maintaining interpersonal relationships. They have a distorted self-image or a complete lack of self-identity. They report feelings of chronic emptiness. They have reckless and/or impulsive behaviors in two of the following: sex, spending, substance, driving, or eating. They have suicidal threats, attempts, or self-injurious behaviors. They experience labile moods. They have uncontrolled anger bouts. Lastly, they have paranoid thoughts or dissociation.

Diagnostic and Statistical Manual for Mental Disorders

Diagnostic and Statistical Manual (DSM) of Mental Disorders is a practice guidelines used by mental health practitioners in the United States for diagnosing mental health disorders based on signs and symptoms of the individual (American Psychiatric Association, 2012). The DSM is written by the American Psychiatric Association and used as a guide for diagnosing both adults and children with mental health disorders. The DSM includes diagnostic codes for billing, prevalence and onset of each mental health diagnosis along with treatment recommendations and outcomes (Cherry, 2013).

Dialectical behavior therapy

Dialectical behavior therapy is a cognitive-behavioral concept developed in stages to teach coping skills to control mood instability, decrease actions of self-destruction, and promote

relationships (National Institute of Mental Health 2012). DBT treatment is aimed for patients who have self-injurious behaviors or suicidal ideations (Behavioral Tech LLC, 2013).

Mental Illness

Mental illness is a condition that affects an individual's mood, thoughts, feelings, relationships, social interactions and impairs ability to function in life (NIMH, 2013). Mental illness can occur to anyone and at some point everyone's mental health is a concern (Mayo Clinic, 2013).

Self-injury or self-harm

Self-injury is also known as self-harm. It is defined as intentionally harming oneself, usually by cutting or burning. Self-injury is not a suicidal behavior; however, is considered an ineffective coping mechanism. Initially the patient may report the self-injurious behavior as a way to release anger, frustration, or pain. However, often feelings of shame and guilt follow the impulsive behavior thus it can be a vicious cycle (Mayo Clinic, 2012).

Suicide

Suicide has been defined as voluntarily and intentionally killing oneself to end their life (American Psychological Association, 2014). Suicide is often the results of the inability or difficulty to be able to cope with stressors and can be prevented (Mayo Clinic, 2014).

Suicidal Ideation or Thoughts

Suicidal ideation are thoughts of killing oneself which can range from only thoughts without a plan to making a strategic plan to complete suicide (Medical News Today, 2013).

Review of Literature

There is no accepted Food Drug Administration (FDA) medication to treat BPD. Therefore treatment is solely dependent on therapy (NAMI, 2011). DBT has proven to be

successful in reducing suicide attempts, self-injurious behaviors, and symptom severity. As a result, there was a reduction in healthcare utilization. Besides cost, DBT promotes quality of life and overall functioning in BPD individuals (Behavioral Tech, LLC, 2013). A literature search and review was conducted to gain background information to find supporting evidence for borderline personality disorder and the effectiveness of dialectical behavior therapy.

A literature search was conducted to find studies related to this topic. Search words included *dialectical behavior therapy AND borderline personality disorder* in CINAHL, PubMed with MeSH, and PsychINFO. Search engines included Google, bing, and Yahoo. Libraries included the University of North Dakota's Harley French Library and The Cochrane Library.

The Pub Med database with MeSH was searched using the terms *borderline personality disorder* AND *dialectical behavior therapy*. After including the limitations to the search which encompassed clinical trials published within the past 10 years, English language only citations, and those with full text availability, only 35 citations remained. Of those 35 citations, only nine were relevant to the topic of the project. A search of CINHAL using the same terms *borderline personality disorder* AND *dialectical behavior therapy* resulted in 13 citations with limitations of studies performed in the past 10 years and English context. After review of the abstracts, two articles were chosen for inclusion. When using *borderline personality disorder* AND *dialectical behavior therapy* in the Cochrane Library, there were two results. However, neither of these was pertinent to the topic. Lastly, a search of PsychINFO yielded 72 citations with keywords *borderline personality disorder* AND *dialectical behavior therapy.* Five of the 72 citations were relevant or new to the project. Upon searching for *borderline personality disorder* AND

dialectical behavior therapy AND *case management*, no matching criteria relevant to the topic was found.

Suicide & Self-Harm

McMain et al. (2009) completed a blind randomized controlled study comparing DBT to general psychiatric management. The study consisted of 180 BPD participants that compared psychodynamically informed therapy and symptom-targeted medication management using the quantitative approach. DBT participants had weekly one hour psychotherapy sessions, weekly two hour skills sessions, and weekly two hour phone coaching; whereas, general psychiatric management included only one hour of weekly individual psychotherapy with medication management. Of the 180 participants, 111 completed the treatment program. Thirty-five participants from DBT and 34 from general psychiatric management left the study early. There was no correlation between interventions or dropout time. The primary objective of the study was to measure the severity and frequency of suicide and self-harm using the Suicide Attempt Self-Injury Interview. Both DBT and general psychiatric management are equally effective in the treatment of BPD. This was evidenced by a 60-66% decrease in suicidal episodes and non-suicidal self-injurious episodes upon completion of 12 months of therapy (McMain et al, 2009).

McMain, Guimond, Streiner, Cardish, and Links (2012) conducted a two year follow-up study to evaluate the long-term effectiveness of receiving one year of either DBT or general psychiatric management. A survey was given at 18, 24, 30, and 36 months following completion of the initial one-year treatment regarding suicidal and non-suicidal self-harm. Of the 180 participants, 87 completed all four follow-up surveys using the Suicide Attempt Self-Injury Interview. Overall results showed a decrease in self-harm by 50% and a 98% reduction in non-suicidal self-injurious behaviors with both DBT and general psychiatric management. Therefore,

both were shown to be effective long-lasting treatments in reducing suicidal and self-injurious behaviors.

Upon further exploration comparing DBT to general psychiatric management, Links, Kolla, Guimond, and McMain (2013) completed a cohort study with 180 BPD participants. Participants were randomly placed in either DBT or general psychiatric management. DBT and general psychiatric management both showed a significant reduction in the severity and frequency of suicidal and non-suicidal behaviors; however, there was no clinically significant difference between the two treatments (Links et al., 2013).

Verheul et al. (2003) conducted a randomized controlled quantitative trial and compared DBT to treatments as usual. The study included 58 women with BPD. The participants were randomly assigned to either 12 months of DBT or usual treatment. Twenty-seven were assigned to DBT and 31 to treatment as usual. DBT therapy included weekly therapy visits, weekly skill training for two hours, and weekly supervision and consultation for the therapist; whereas, and treatment as usual participants received clinical management no more than twice monthly from a psychologist, psychiatrist, or social worker. DBT resulted in better retention rates and greater reductions of self-mutilating and self-damaging impulsive behaviors compared to usual treatment, especially those with history of frequent self-mutilation. DBT was found to be superior to treatment as usual in reducing high-risk behaviors in patients with BPD (Verheul et al., 2003).

Feigenbaum et al. (2011) completed a randomized control trial study comparing DBT to treatment as usual (TAU) and similar results were concluded. The study consisted of 42 participants, both men and women, with a diagnosis of BPD between the ages of 18-65 years. Exclusions included forensic history with risk to self or others, diagnosis of schizophrenia,

bipolar, substance abuse, or severe cognitive impairment. There was a more significant decrease in suicidal behaviors in the TAU group versus DBT; however, DBT showed less suicidality (Feigenbaum et al., 2011).

On the other hand, a study done by Carter, Willcox, Lewin, Conrad, and Bendit (2010), completed a randomized controlled trial of 73 borderline women comparing DBT with TAU. Both groups resulted in a reduction of self-harm from baseline; however, there was no significant difference between the two groups indicating that DBT has more potency (Carter et al., 2010).

Linehan et al. (2006) completed a randomized controlled quantitative trial compared DBT with treatment offered by non-behavioral psychotherapy experts-community treatment by experts. The study was 101 women with BPD. The participants were randomly assigned to either 12 months of DBT or community treatment by experts (CTBE). DBT therapy included weekly one hour therapy visits, weekly two hours of skill training, telephone consultation as needed, and weekly consultation for the therapist; whereas, CTBE participants received clinical management no more than twice monthly from a psychologist, psychiatrist, or social worker. DBT had better outcomes in the intent-to-treat than CTBE in most target areas with two years of treatment and follow-up. DBT participants were half likely to attempted suicide, hospitalizations for suicide ideation were decreased, and risk for suicide attempts and self-injurious acts were lowered (Linehan et al., 2006).

To further test the hypothesis, Neacsiu, Rizvi, and Linehan (2010) compared DBT group to three different control groups. The study consisted of 108 BPD women with the following exclusions: psychotic disorder, seizure disorders requiring anticonvulsants, or other medical conditions interfering with their ability to participate in the study. Participants were randomly assigned to a treatment group. Participants in the DBT group were three times more likely to use

their DBT skills versus using maladaptive behaviors. As a result, a decrease in suicide attempts and non-injurious self-harm was seen (Neacsiu et al., 2010).

Comparing transference-focused psychotherapy (TFP) and DBT, Clarkin, Levy, Lenzewger, and Kernberg (2007) conducted a blind randomized controlled quantitative trial that compared transference-focused psychotherapy (TFP), dialectical behavior therapy, and dynamic supportive treatment. The study included 90 participants with BPD. The participants were randomly assigned to TFP, DBT, or supportive treatment and medications as needed. TFP focused on the relationship between the participant and the therapist, DBT focused on learning emotion regulation skill, and supportive treatment focused on emotional support on daily occurring problems. Both showed a significant association with improvement in suicide rates. However, the study did not prove DBT to have more efficacy than TFP or dynamic supportive treatment in decreasing the prevalence of suicide (Clarkin et al., 2007).

Since most of the studies consisted of individuals with BPD being age 18 and older, Hjalmarsson, Kaver, Perseius, Cederberg, and Ghaderi (2008) completed a study on the effectiveness of DBT on adolescents and young adults; however, 63% of those participants were over age 18. Exclusions included psychosis, severe eating disorders, and drug addictions. DBT treatment consisted of one hour of individual therapy a week and three hours of group skills training weekly. A total of 16 out of 21 participants with BPD completed the pre-test, five month, and 12 month self-questionnaires successfully. Parasuicidal behaviors were reduced by 65% in six months of DBT and 89% in one year of DBT (Hjalmarsson et al., 2008).

Individuals with BPD characteristically have difficulty maintaining relationships, including those with mental health providers, often resulting in premature discontinuation of therapy or services. It is essential for a positive therapeutic alliance between the therapist and the

patient for DBT to be most effective. Bedics, Atkins, Comtois, and Linehan (2011) completed a randomized two year study comparing the therapeutic relationship of DBT and community treatment by experts (CTBE) of 101 women with a diagnosis of BPD ages 18-45 years of age. DBT participants self-reported less non-suicidal self-injury due to therapist's emotional supports and feelings of being protected. CBTE participants showed less improvement compared to DBT, thus indicating that DBT not only improves borderline personality disorder symptoms but also promotes a therapeutic relationship (Bedics et al., 2011).

DBT can be done in multiple types of therapy sessions including: individual, group, and phone coaching. In an attempt to see if individual DBT is superior to combined group/individual therapy, a study was completed by Andion et al. (2012). The study consisted of 51 women with a diagnosis of BPD. Upon completion of the study, there was no significant difference between individual DBT and combined individual/group DBT. However, group DBT is more cost effective (Andion et al., 2012).

Health Care Utilization

DBT has proven to reduce the use of more costly health care services. McMain et al. (2009; 2012) did two studies showing the effects of 12 months of DBT with long-term outcomes of treatment compared to general psychiatric management. The DBT group's baseline emergency room visits was 1.99 and their days in hospital was 10.52. Following completion of 12 months of DBT, that number was reduced to 0.93 for emergency room visits and 3.73 for hospital days. The 36 month follow-up resulted in lower results, emergency room visits were 0.68 and 2.76 hospital days. In comparison to DBT, general psychiatric management also showed a reduction in both groups. The group's baseline was 2.08 in emergency room visits with a reduction to 1.00 following 12 month of treatment with a lower incidence of 0.67 at the 36

month follow-up. Similar, hospital day's baseline was 8.90 and after 12 months of general psychiatric therapy that number was reduced to 2.23. After 36 months, unlike DBT, there was a slight increase in hospital days of 3.03 (McMain et al., 2012).

Compliance with treatment is a huge factor with BPD. Often BPD individuals don't follow through with treatment thus resulting in returning to maladaptive behaviors. In two separate studies similar results were found. DBT participants were less likely to drop out of treatment resulting fewer psychiatric ER visits and hospitalizations (Linehan et al. 2006). In a study completed by Carter et al. (2010), there was a significant reduction in hospital admission and days stayed in the hospital with just six months of either DBT or TAU versus one year of treatment DBT. However, the study showed no significant difference when comparing DBT and TAU in reducing health care utilization (Carter et al, 2010).

BPD is one of the most expensive psychiatric disorders due to mortality and morbidity. Amner (2012) completed a study in the United Kingdom of 21 participants with BPD symptoms of emotional dysregulation and history of self-harm. A cost analysis was completed prior to starting DBT and then again following the duration of one, two and three years post DBT treatment. Research showed a cost saving of $36,000 following one year of DBT in out-patient appointments, in-patient day bed, day care, nursing, psychotherapy, and DBT (Amner, 2012).

Symptom Severity

In an attempt to research the question and compare the outcomes of symptom severity, Clarkin et al. (2007) study showed all three treatments groups showed significant positive change in depression, anxiety, and social adjustment across one year of treatment. Only TFP & DBT showed improvement in impulsivity and only TFP was associated with change in irritability and verbal/direct assault (Clarkin et al, 2007).

In another study, Kroeger, Harbeck, Armburst, and Kliem (2013) completed a self-rating study comparing pre and post DBT treatment for 4,323 BPD individuals in an inpatient setting for three months. The study showed an overall Borderline Symptom List (BSL) reduction in the following: self-perception, affect regulation, self-destruction, dysphoria, loneliness, intrusions, & hostility (Kroeger et al, 2013).

Similarly, in the study completed by McMain et al. (2009), symptom severity was reduced at each four month interval during the one year treatment of DBT. The Beck Depression Inventory was used to assess depression. Results yielded a decrease in depression each quarter. Likewise, using the State-Trait Anger Expression Inventory, participants reported lessened anger (McMain et al., 2009).

Lastly, when comparing DBT to three controlled groups, the DBT participants reported a decrease in depression and increase in anger control. Individuals in the DBT group were three times more likely to use skills versus the control groups (Neacsiu et al., 2010).

Since impulsivity and inattentions is a known factor in BPD. Soler et al. (2011) recruited 60 patients with BPD to experiment on the effectiveness of DBT-mindfulness (DBT-M) with impulsivity and inattention. Fifty-nine of those participants were either assigned to either general psychiatric management or DBT-M with general psychiatric management. In an effort to ensure robust findings, the DBT-M group had double the participants. As a result, the DBT-M group had a significant improvement in attention and impulsivity versus general psychiatric management (Soler et al, 2011).

Quality of Life & Overall Functioning

Research shows that DBT promotes behavior changes resulting in an improvement in overall functioning and personality changes. Davenport, Bore, and Campbell (2010) indicated

there was little research showing the mechanism of change. The study consisted of 17 DBT participants that were either placed in a control group or DBT group. The control group consisted of participants who were on a waiting list for psychotherapy and had not completed DBT training. Upon completion of DBT treatment, self-reported questionnaires reflected an improvement in self-control, agreeableness, and consciousness when compared to pre-treatment.

In the study by McMain el al. (2009), quality of life improved in both the DBT group and general psychiatric management. Both groups showed a reduction in personal problems using the EQ-5D, a tool used to measure one's quality of life determinates such as self-care, activities, pain, and anxiety/depression. However, high employment rates and dependence on disability benefits indicates that there is still some functional impairment.

Carter et al. (2010) compared DBT to TAU. DBT was considered to be superior to TAU. Likewise in a study by Feigenbaum et al. (2012), DBT was superior to TAU in risk, functioning, well-being, and problems.

Brassington and Krawtiz (2006) completed a six month trial for the efficacy of DBT prior to implementing DBT into their new standard of mental health care in New Zealand. Ten participants with a diagnosis of BPD were recruited from TAU group. Treatment consisted of 60-90 minutes of individual therapy, two hours of group skills training, and 90 minutes of phone consultations weekly. All 10 participants remain in the study for the duration of the study and all 10 participants reported a significant improvement in overall functioning (Brassington et al., 2006).

Lastly a non-controlled and nonrandomized study completed by Stepp, Epler, Jahng, and Trull (2008) wanted to see if the use of DBT skills increased during the duration of DBT treatment and the overall results. Participants consisted of 27 individuals, age 16 to 61, with a

BPD diagnosis consisted of majority women. Treatment consisted of individual therapy, weekly skills training, telephone consultation, and team consultation. The therapists had each participant complete weekly diaries that showed the utilization of DBT skills in the past week. Following completion of the study, mindfulness was the most frequently used DBT skill followed by distress tolerance, emotional regulation, and interpersonal effectiveness. On average, participants reported using seven skills per week. Overall, an increase utilization of DBT skills resulted in an overall improvement of BPD features (Stepp et al., 2008).

Results

In the studies performed, there was a mutual conclusion that DBT is an effective treatment for BPD. All criteria for the studies were the same. The studies were open to participants with a DMS-IV borderline personality disorder diagnosis, aged 18 to 65, and with two episodes of suicidal or non-suicidal self-injurious behavior within the past two to five years and one within the past three months. Exclusions included psychotic disorder, bipolar, delirium, dementia, mental retardation, schizophrenia, and substance abuse. Some studies included other exclusions related to living arrangement and plan to stay in the area until the study was completed.

DBT resulted in a significant decrease in reported suicidal ideation, hospitalizations, and emergency room visits. All studies used the same protocol for DBT comparing with other treatments. All of but two of the studies were level II and randomized controlled quantitative studies, therefore, the studies were equivalent in the hierarchy of evidence.

In all of the studies, the participants were voluntary. This allowed individuals to also be able to drop out of the studies. As a result, there was dropout seen in all of the studies with no

patterns. However, dropout was seen in all therapies and was linked patient-therapist relationships or the participant moving out of the study area.

While all these studies show DBT to be equivalent or superior for BPD, all the studies are subject to responder bias. Due to the use of interviews, outcomes were restricted to self-report.

Another concern is the studies were predominantly female. Therefore, there is a lack of data for men and makes the reader question the validity for males.

The target audience was patients diagnosed with borderline personality disorder according to DSM IV diagnosis criteria with a history of suicide attempts. Patients were not excluded based on their age, race, or gender.

Implication for Nursing

Overall, DBT has been found to be effective in treating BPD and has been effective as a treatment regimen. Individuals with BPD seek mental health services on a regular basis. Each case of BPD is different and starting DBT varies from individual to individual. The therapist and the individual must agree when and if the individual is ready to participate in DBT. The individual must develop an open an honest relationship with their therapist and be compliant with their treatment regimen and appointments.

Stabilization of BPD is not only in the hands of mental health practitioners but also county case managers who help maintain community living by providing the resources needed to stay out of hospitals and emergency rooms. County case managers assist with goal development, implementation of needed services, and coordination of services to meet recovery goals (NAMI, 2014).

It is just as important that county mental health case managers be taught the basic DBT skills to help redirect maladaptive behaviors. As a result, the county mental health case manager

will help the individual utilize their new learned skill to promote a therapeutic relationship in an effort to prevent early termination of services by the patient or burn out of the case manager.

Summary

The PowerPoint presentation (see appendix) provided a basic overview of BPD along with a background history of DBT and the basic skills training. County mental health case managers, five registered nurses and six social workers, in the county were present. Prior to the training, the five registered nurses had reported no trainings in BPD or DBT. The registered nurses self-reported burnout and frustration and viewed the BPD individual as being gamey and manipulative. They reported frequent termination of county case management by the BPD individual as a result. The social workers reported that they have had BPD training but lacked DBT training. Upon completion of the PowerPoint presentation, the county case managers reported that they had a better understanding of the diagnosis of BPD and how DBT works. They believed knowing the basic DBT skills would help them promote a therapeutic working relationship and an overall better working relationship thus resulting in more compliance with their services and recommendations. A three month follow-up was completed with the county case managers. They reported better working relationships with the BPD individual, less termination of county case management, decreased healthcare utilization, and increased compliance by the BPD individual.

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Appendix

Refer to PowerPoint Presentation attached.

3/26/2014

Dialectical Behavioral Therapy Skills for Borderline Personality Disorder

Julie Nohre
University of North Dakota

Borderline Personality Disorder

- 1-1 6% general population, 10% outpatient, 20% inpatient (NAMI, 2011).
- Increased prevalence in the United States (Perese, 2012).
  - Maladaptive parent-child relationships
    - Rapid industrialization
    - Changing roles for men & women
    - Increase divorce
    - Poor role models in media
    - Increased availability of illegal drugs
  - Diminished power of formerly protective institutions
    - Schools
    - Religious institutions
    - Absence of nurturing surrogates
    - Scattering of extended family
- #1 problem of BPD is emotion dysregulation that results in further crisis affecting their quality of life
  - Oversensitivity
  - Over-reactive
  - Slow baseline return (baseline is higher already)

Etiology

- Genetic influence-69%
- Abnormalities of brain development present at birth
- Poor fit between the child's temperament & parent's ability to meet their child's needs
- Adverse childhood experience (neglect/abuse)
- Unstable early environments
- Parent psychopathology
- Absence of protective factors

- Higher incidence in women in clinic settings; however, equal in the community
  - However, men usually dx with NPD or ASPD

DSM V diagnosis criteria

- Pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked by impulsivity, beginning by early adulthood (5 or more):
  - Frantic efforts to avoid real or imagined abandonment
  - Pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
  - Identity disturbance: markedly and persistently unstable self-image or sense of self
  - Impulsivity in at least two areas that are potentially self-damaging: spending, sex, substance abuse, reckless driving, or binge eating
  - Recurrent suicidal behaviors, gestures, or threats, or self-mutilating behaviors
  - Affective instability due to a marked reactivity of mood (intense episodic dysphoria, irritability, anxiety usually lasting a few hours and only rarely for more than a few days)
  - Chronic feelings of emptiness
  - Inappropriate, intense anger or difficulty controlling anger (frequent displays of anger, constant anger, recurrent fights
  - Transient, stress-related paranoid ideation or severe dissociative symptoms

American Psychiatric Association, 2013

Treatment

- 6 psychotherapies are effective in reducing some of the symptoms of BPD.
  - cognitive-behavioral therapy
  - dialectical behavior therapy
  - psychodynamic therapy
  - family therapy
  - support groups
  - psychiatric medication management.
- Emotion modification
  - Prevent inappropriate responses to negative/positive emotions
  - Try not to react with mood/emotions
  - Self-soothe emotional responses
  - Refocus attention away from emotional response
- DBT is one of the newest psychotherapies yet according to studies/literature reviews, DBT is the most effective treatment for BPD

Studies used for Presentation

- Amner (2012)
- Bedics et al. (2011)
- Brassington & Krawitz (2006)
- Carter et al. (2010)
- Clarkin et al. (2007)
- Davenport et al. (2010)
- Feigenbaum et al. (2012)
- Hjalmarsson et al. (2008)
- Kroeger et al. (2013)
- Linehan et al. (2006)
- McMain et al. (2009)
- McMain et al. (2012)
- Neacsui et al. (2010)
- Soler et al. (2011)
- Stepp et al. (2008)
- Verheul et al. (2003)

Dialectical Behavior Therapy

- Founded by Marsha Linehan after attempts with CBT that resulted in failure. DBT's goal: learn new skills to change dysfunctional behaviors, emotions, & thinking:
- Dialectics: philosophy of change
- Focus: acceptance-> change
- Decrease
  - Interpersonal chaos
  - Labile affect, moods, & emotions
  - Impulsiveness
  - Confusion about self, cognitive dysregulation
- Increase
  - Interpersonal effective skills
  - Emotion regulation skills
  - Distress tolerance skills
  - Core mindful skills

Dialectical Behavior Therapy

- Emotional Dysregulation
  - Teach emotion regulation skills
- Interpersonal Dysregulation
  - Teach interpersonal effectiveness skills
- Behavioral Dysregulation
  - Teach distress tolerance skills
- Sense of self Dysregulation
  - Teach "mindfulness skills"
- Therapy Options
  - Individual
  - Skills training group
  - Telephone consultation
  - Therapist consultation

Importance of DBT skills

- According to NAMI, 75% of BPD patients self-injure and of those patients who attempt suicide, approximately 10% succeed in their suicide attempt
- High morbidity & mortality rate resulting in substantial healthcare costs
- DBT is key to decrease hospitalizations and emergency visits related to suicidal ideations/acts
- High probability to relapse related to difficulty maintaining a therapeutic relationships with their doctors and community resources due to their noncompliance with scheduled appointments and treatment recommendations
  - Teach DBT skills to county case managers to promote a therapeutic relationship and compliance with treatment plans
  - DBT skills will help the client gain the skills to control these self-destructive behaviors, suicidal ideations and attempts, and management of emotions to promote therapeutic relationships and gain control of their life

Stage I: Out of Control to In Control

- **Stabilization**
  - 1: Reduce/eliminate the life-threatening behavior
  - 2: Reduce/eliminate behavior impeding treatment being successful & hospitalizations
  - 3: Reduce/eliminate behaviors that affect one's quality of life yet promoting what does improve one's quality of life
  - 4: Learn skills to control the following:
    - Attention
    - Relationships
    - Emotion regulation
- **Phases of DBT**
  - 1. Core mindfulness skills
  - 2. Distress tolerance skills
  - 3. Emotion regulation skills
  - 4. Distress tolerance skills

Phase One:

Core Mindfulness Skills

"Reasonable mind" + "Emotion mind" = "Wise mind"

Thinks rationally & logical, attends to facts, focuses attention, "cool" in approach, & plan behavioral response	Difficult to think rationally or logical, facts are distorted or amplified, "hot" in approach, & behavior matches emotions. BPD individuals use emotion mind prior to DBT	Integration of reasonable mind & emotional mind. Allow intuition- find it in the belly, the center of your head, or by following your breath

Take Control With "What" & "How" Skills

"What" skills
- Observe
- Describe
- Participate

"How" skills
- Non-judgmental Stance
- One-mindfully
- Effectively

"What": Observe

- Learning to observe, describe & participate with awareness
  - Just notice the experience
    - Don't react to the experience, just observe
  - Have Teflon mind
    - Watch thoughts/emotions come & go
  - Control your attention, cling to nothing
  - Be alert to thoughts, emotions, & actions
  - Step inside & Observe
    - Notice each feeling (rising and falling) and your response
  - Notice what flows through your senses

"What": Describe

- Puts words on the experience
  - Notice emotion/thought= acknowledge it!
    - "Stomach muscles tightening"
    - "A thought 'I can't do this' has come into my mind"
- Put experiences into words
  - Tell yourself what is going on
  - Put a name on your feelings

"What": Participate

- Become one with your experience, completely forgetting yourself
  - Get involved in the moment
  - Let go of ruminating
- Act intuitively with a "wise" mind
  - Act skillfully with in the given situations
  - Do what needs to be done
- Practice skills
  - Removing from harmful situations
  - Removing harmful responses to experiences
  - Accept self and the experience as is!

"How": Non-judgmental Stance

- Don't evaluate
  - Utilize just the facts
  - Be aware but don't evaluate
    - Good versus bad
    - Should have or should not have
- Unglue your opinions from facts
  - Sort options from facts
- Accept
  - Accept each moment
- Acknowledge
  - Acknowledge the helpful & harmful
- Don't judge your judging

"How": One-Mindfully

- Just do one thing at a time
  - Do each thing with all your attention
- Let go of distractions
  - Go back to the moment
- Concentrate your mind
  - If you find yourself doing two again, go back to doing ONE!

ONE-MINDFULLY:
In The Moment

"How": Effectively

- Focus on what works & needs to be done
  - No:
    - Right versus wrong
    - Fair versus unfair
- Play by the rules
  - consider the context
- Act skillfully
- Keep an eye on your objectives
  - Focus on what needs to be done to meet your objectives
- Let go of:
  - Vengeance, useless anger, & righteousness

Interpersonal Effectiveness Skills: Building Mastery & Self-respect

- *GOAL: Keep or improve liking self*
- Stand up for yourself
- Be competent & effective
- *FAST*
- Fair to yourself and the other person
- Apology dramatization is not allowed
  - Being alive
  - Requests
  - Opinions or disagreeing
- Stick to your values
  - Beliefs
  - Morals
- Truthful
  - Don't be dishonest, act helpless, exaggerate, or use excuses

Emotion Regulation Skills: Goals of Emotion Regulation Training

- Understand Emotions You Experience
  - Observe & describe one's emotions
  - Understand what emotions do for oneself
- Reduce Emotional Vulnerability
  - Decrease vulnerability to the "emotion mind"
  - Increase positive emotions
- Decrease Emotional Suffering
  - Let go of painful emotions through "mindfullness"
  - Change painful emotions through doing the opposite

Emotion Regulation Skills: Put a Name on the Emotion

- Love Words
  - Love, compassion, longing, adoration, desire, lust, affection, enchantment, passion, arousal , fondness, sentimentality, attraction, infatuation, sympathy, caring, kindness, tenderness, charmed, liking, & warm
- Joy Words
  - Joy, enjoyment, glee, pride, amusement, enthrallment, happiness, rapture, bliss, enthusiasm, hope, relief, cheerfulness, euphoria, jolliness, satisfaction, contentment, excitement, joviality, thrill, delight, exhilaration, jubilation, triumph, eagerness, gaiety, optimism, zaniness, ecstasy, gladness, pleasure, zest, elation, & zeal
- Anger Words
  - Anger, disgust, grumpiness, rage, aggravation, dislike, hate, resentment, agitation, envy, hostility, revulsion, annoyance, exasperation, irritation, scorn, bitterness, ferocity, jealousy, spite, contempt, frustration, loathing, mean spiritedness, vengefulness, destructiveness, grouchiness, outrage, & wrath.

- Sadness Words
  - Sadness, despair, grief, misery, agony, disappointment, homesickness, neglect, alienation, discontentment, hopelessness, pity, anguish, dismay, hurt, rejection, crushed, displeasure, insecurity, sorrow, defeat, distraught, isolation, suffering, dejection, gloom, loneliness, unhappiness, depression, glumness, melancholy, & woe
- Fear Words
  - Fear, apprehension, fright, panic, horror, shock, anxiety, hysteria, tenseness, distress, jumpiness, terror, dread, nervousness, uneasiness, edginess, overwhelmed, & worry
- Shame Words
  - Shame, discomposure, humiliation, mortification, contrition, embarrassment, insult, regret, culpability, guilt, invalidation, & remorse
- Other Emotion Words
  - Interest, excitement, curiosity, intrigue, weariness, dissatisfaction, disinclination, shyness, fragility, reserve, bashfulness, coyness, reticence, cautiousness, reluctance, suspiciousness, caginess, caginess, surprise, amazement, astonishment, awe, startle, wonder, boldness, bravery, courage, determination, powerfulness, a sense of competence, capability, mastery, dubiousness, skepticism, doubtfulness, apathy, boredom, dullness, ennui, fidgetiness, impatience, indifference, & listlessness.

Emotion Regulation Skills: What Good Are Emotions?

- Emotions Communicate to others
  - Facial expressions are hard-wired. Facial expression speaks louder than words
  - Hard to change emotions when communicating if it is important to us
  - Communication of emotions influence others
- Emotions Organize & Motivate Action
  - Emotions= actions (motivating)
  - Emotions save the time of thinking
  - Strong emotions help overcome obstacles
- Emotion is Self-Validating
  - Emotions can be signals or alarms
  - Extreme emotions are treated as facts
    - "If I am afraid, it is threatening"

Emotion Regulation Skills: Reduce Vulnerability

"PLEASE MASTER"

- Treat Physical Illness, take care of the body
- Balance Eating- good nutrition & not meal skipping
- Avoid Mood-altering drugs & take meds as prescribed
- Balance Sleep that leaves you rested & vibrant
- Get Exercise daily
- Build MASTERy
  - Try to do one thing a day to make yourself feel competent and in control
  - Can be something you're good at or something you want to be good at
    - Drawing
    - Coloring
    - Journaling
    - Mentally
    - "I am going to practice listening today"

Emotion Regulation Skills: Increase Positive Emotions

- Build Positive Experiences
  - Short-term: do pleasant things that are possible now
    - Events cause positive emotions
    - One positive thing each day
  - Long-term: make changes in life; therefore, more positives occur
    - Accumulate positives
      - Make a list of positive events you want
    - Attend to relationships
    - Avoid avoiding
- Mindful of Positive Experiences:
  - Focus on positive events
  - Refocus when thinking of negative events
- Unmindful of Worries
  - Don't think about when the positive event will end
  - Don't think about whether deserving
  - Don't think about expectations

Emotion Regulation Skills: Mindful of Current Emotion

- Observe Your Emotion
  - Note presence
  - Step back
  - Get unstuck
- Experience Your Emotion
  - View emotion as a wave- comes and goes
  - Don't block, suppress, push, or rid of emotions
  - Don't keep or hold onto emotions
  - Don't amplify
- **REMEMBER:** You Are Not Your Emotion
  - Don't act on emotions
  - Remember the positive times
- Practice Loving Your Emotion
  - Don't judge emotions
  - Accept emotions
  - Practice willingness

Emotion Regulation Skills: Act Opposite of Current Emotions

- Fear
  - Overcome fears with repetition
  - Confront fears
    - Events, places, people, or activities
  - Maintain control & mastery
  - List small steps towards overall goal & take that first step
- Guilt or Shame
  - Apologize
  - Make things better- do something nice
  - Commit not to do again
  - Accept and let it go
- Sadness or Depression
  - Be active and approach! Don't avoid!
  - Do things that make you feel confident & competent
- Anger
  - Avoid person rather than attack
  - Be Nice versus mean or attacking
  - Try sympathy & empathy versus blame

Distress Tolerance Skills

- Distract with ACCEPT
  - Activities
    - engage in exercise, hobbies, or social activities
  - Contributing
    - Contribute to someone or volunteer your time/work
  - Comparisons
    - Compare yourself with those who are coping same or less than you
  - Emotions
    - Choose things that 'bring on' the desired emotion
  - Pushing away
    - Build imaginary walls between self and the situation
  - Thoughts
    - Count to 10, read, watch tv
  - Sensation
    - Hold ice in your hand, squeeze a rubber ball, or put rubber band on wrist

Distress Tolerance Skills

- Self-Soothe
- Using your senses
  - Vision
    - Be mindful of each sight that passes in front of you
  - Hearing
    - Being mindful of sounds that come your way
    - Allow to come in ear and out the other
  - Smell
    - Be mindful of the smells that you breathe
  - Taste
    - Be mindful of the time needed to taste your food
  - Touch
    - Be mindful of what you are touching & considered soothing

Distress Tolerance Skills

- IMPROVE the Moment
  - Imagery
    - Relaxing place, safe place
  - Meaning
    - Create purpose, meaning, or value in the pain
  - Prayer
    - Open your wise mind, look to higher power
  - Relaxation
    - Relaxation techniques; breathe deeply
  - One thing in a Moment
    - Focus attention on what you are doing right now
  - Vacation
    - Activities and do for a limited time
  - Encouragement
    - Cheerlead yourself