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Dialectical behaviour therapy skills training compared to standard group therapy in borderline personality disorder: A 3-month randomised controlled clinical trial

Joaquim Soler [a,c,*], Juan Carlos Pascual [a,c], Thaïs Tiana [a,c], Anabel Cebrià [a,c], Judith Barrachina [a,c], M. Josefa Campins [a,c], Ignasi Gich [b,c], Enrique Alvarez [a,c], Víctor Pérez [a,c]

[a] Department of Psychiatry, Santa Creu i Sant Pau Hospital, Centro de Investigación Biomédica en Red de Salud Mental, CIBERSAM, St. Antoni M. Claret, 167, 08025 Barcelona, Spain
[b] Department of Epidemiology, Santa Creu i Sant Pau Hospital, St. Antoni M. Claret, 167, 08025 Barcelona, Spain
[c] Universitat Autònoma de Barcelona, Barcelona 08025, Spain

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ABSTRACT

Dialectical behaviour therapy (DBT) has proven to be an effective treatment in borderline personality disorder (BPD). However, the effectiveness in BPD of DBT skills training (DBT-ST) alone is not known. This study aimed at comparing the efficacy of DBT-ST and standard group therapy (SGT) for outpatients with BPD. Sixty patients meeting the DSM-IV diagnostic criteria for BPD, as assessed by two semi-structured diagnostic interviews, were included in a 3-month, single-blind randomised controlled trial. A total of 13 weekly group psychotherapy sessions of 120 min of either SGT or DBT-ST were conducted. Assessments were carried out every 2 weeks by two blinded evaluators. Observer-rater, self-report scales and behavioural reports were used as outcome measures. DBT-ST was associated with lower dropout rates, 34.5% compared to 63.4% with SGT. It was superior to SGT in improving several mood and emotion areas, such as: depression, anxiety, irritability, anger and affect instability. A reduction in general psychiatric symptoms was also observed. Three-months weekly DBT-ST proved useful. This therapy was associated with greater clinical improvements and lower dropout rates than SGT. DBT-ST seems to play a role in the overall improvement of BPD seen with standard DBT intervention. It allows straightforward implementation in a wide range of mental health settings and provides the additional advantage that it is cost effective.

Introduction

People with borderline personality disorder (BPD) are regular users of emergency services and may often require admission to hospital. They will likely need long psychotherapies and require more medications than other personality disorder or major depression patients (Bender et al., 2006; Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004). Moreover, BPD is associated with a high prevalence of self-injurious behaviour and an incidence of completed suicide of up to 10%, a rate over 50 times higher than that in the general population. This results in a high consumption of healthcare resources (American Psychiatric Association, 2001; Lieb et al., 2004; Paris, 2002; Stone, 1998) and non-health care costs are even higher (Van Asselt, Dirksen, Arntz, & Severens, 2007).

Various psychosocial interventions have been used in the treatment of BPD and have proved to be effective in randomised clinical trials. Two of these psychological interventions are psychodynamic-oriented treatments, mentalization-based treatment (Bateman & Fonagy, 1999, 2001) and transference focused therapy (Clarkin, Kenneth, Lenzenweger, & Kernberg, 2007). The others are variations of cognitive behavioural therapy, such as schema-focused therapy (Giesen-Bloo et al., 2006), cognitive behavioural therapy (Blum et al., 2008; Davidson et al., 2006) and DBT (Koons et al., 2001; Linehan, Amstrong, Suarez, Allmon, & Heard 1991; Linehan et al., 1999, 2006; Verheul et al., 2003).

The standard DBT procedure (Linehan, 1993a, 1993b) includes four modes of intervention: group therapy, individual psychotherapy, phone calls, and consultation team meetings. The group component consists of approximately 2 h a week of skills coaching, and it aims to increase behavioural capabilities. Individual psychotherapy consists of approximately one-hour weekly session whose objective is to improve motivation to change and reduce target problem behaviours. The phone call mode focuses on generalizing skills to daily life, preserving the therapeutic relationship, and learning how to ask for help. The consultation team

* Corresponding author. Department of Psychiatry, Santa Creu i Sant Pau Hospital, Centro de Investigación Biomédica en Red de Salud Mental, CIBERSAM, St. Antoni M. Claret, 167, 08025 Barcelona, Spain. Tel.: +34 932919185; fax: +34 2919399.
E-mail address: jsolerri@santpau.cat (J. Soler).

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meetings are attended by all the therapists using DBT and they are held weekly. These meetings aim to provide support for therapists, maintain motivation and adherence to the treatment model, and help to prevent burn out.

Although several studies have introduced modifications in the application of the original design, these adaptations have adjusted DBT to other settings, such as BPD inpatients (Bohus et al., 2004) or to other disorders, such as binge eating disorder (Telch, Agras, & Linehan, 2001).

One study using this standard DBT treatment for BPD (Lindenboim, Comtois, & Linehan, 2007) focused especially on the group component. The authors examined the type and frequency of skills practised by patients receiving one year of standard DBT as a part of a clinical trial (Linehan et al., 2006). This study addressed several questions regarding the skills in standard DBT treatment. In contrast with what is traditionally expected concerning compliance in BPD patients, they reported using some skills regularly, a minimum of at least one skill on most days. The average was more than four skills per day during the one year of treatment. This skills practice increased over the course of treatment, especially in the first months of the therapy. Another finding of interest was that patients preferred to use skills aimed at acceptance rather than change. Although it seems clear that the group mode of DBT in BPD may be partially responsible for the positive outcomes reported in this setting, there is no evidence that DBT-ST treatment is an efficacious intervention without the individual DBT therapy mode. In a nonpublished study, Linehan et al. (Linehan, 1993a) assigned a subgroup of BPD patients receiving non-DBT individual therapy to DBT-ST. The results suggested that adding DBT-ST to non-DBT individual therapy was no more effective than non-DBT individual therapy, and less effective than individual DBT plus DBT-ST treatment. Only one controlled study has been published (Springer, Lohr, Buchtel, & Silk, 1996) to date. It compares content-reduced DBT-ST to a non-psychotherapeutic discussion group. Subjects in both groups significantly improved in most change measures although no significant between-group differences were found. The findings from this study are limited because treatment was short (13 weekdays), the sample characteristics were not homogenous (inpatients with different personality disorders), diagnosis was made by means of a self-reported questionnaire, and considerable modifications were introduced in the standard content of DBT skills training (e.g. the Mindfulness module was not taught).

Skills training is an essential element in DBT treatment in view of the skills deficit underlying BPD. It can be conceptualised as a set of abilities to manage emotional instability and has been adapted to and tested in other diagnoses. In a controlled study that compared an adapted 20-session DBT-ST to waiting list condition in binge eating disorder (Telch et al., 2001), the intervention was associated with a decrease in binge eating behaviour immediately post treatment and at 6-months follow-up. Similarly, DBT-ST plus medication and scheduled telephone coaching have been successfully adapted to treat older depressed patients and have been associated with an improvement in depressive symptoms compared with medication (Lynch, Morse, Mendelson, & Robins, 2003).

Although skills training is thought to play an important role in DBT treatment, is frequently used by BPD patients and have proved to be useful in other disorders such as binge eating disorder or depression, they are not adequately been tested in BPD patients. The aim of this randomised controlled clinical trial was to evaluate whether skills training, one of the four modes of DBT intervention, was sufficient to induce an observable improvement in people with BPD in comparison with standard group therapy (SGT) administered over the same number of hours in a 3-month period.

Method

Participants

A total of 63 patients were included (participants were recruited from outpatient facilities and emergency service). Inclusion criteria consisted of: 1) meeting the DSM-IV diagnostic criteria for BPD as assessed by two semi-structured diagnostic interviews: the Structured Clinical Interview for DSM-IV Axis II Disorders (SCID-II; Gómez-Beneyto et al., 1994) and the Revised Diagnostic Interview for Borderlines (DIB-R; Barrachina et al., 2004); 2) age between 18 and 45 years; 3) no comorbidity with schizophrenia, drug-induced psychosis, organic brain syndrome, alcohol or other psychoactive substance dependence, bipolar disorder, mental retardation, or major depressive episode in course; 4) Clinical Global Impression of Severity (CGI-S; Guy, 1976) score ≥ 4; 5) no current psychotherapy.

This study was approved by the clinical research ethics review board at our centre. After giving a full description of the study, written informed consent was obtained from all participants.

Study design and procedure

This was a single-centre, randomised, single-blind, two-group clinical trial. Blocks of four generated using the SPSS software program served for the randomisation to DBT-ST or SGT.

Subjects included in the study had two interview visits to establish a pre-intervention baseline. No therapeutic intervention was carried out in this phase. All participants were then randomised to DBT-ST or SGT group psychotherapy intervention (13 weekly sessions). During the therapy period, participants were evaluated every 2 weeks by experienced psychiatrists. Subjects were instructed not to disclose any information about the group (topics, group members or therapists) to maintain blind conditions. Both interventions, DBT-ST and SGT, consisted of thirteen psychotherapy sessions of 120 min each, conducted by 2 therapists (a male and a female) for each group, in groups of 9–11 participants. During the study, participants did not receive any other individual or group psychotherapy. The two therapies were conducted at different times to avoid participants meeting the members of the other group. The DBT format used was adapted from the standard version (Linehan, 1993a, 1993b), applying one of the four modes of intervention: skills training. DBT-ST included all the original skills. These skills can be divided into those that promote change, interpersonal effectiveness and emotional regulation skills, and those that promote acceptance, mindfulness and distress tolerance skills.

Interpersonal effectiveness: training in interpersonal problem solving and assertion. It deals with learning strategies to ask for what one needs, to say no to requests when appropriate, and to achieve interpersonal goals, while taking care of relationships and self-respect.

Emotion regulation: learning skills to decrease labile affect. It includes learning to identify, label and describe emotions, using mindfulness on emotion experience, reducing vulnerability to negative emotions, increasing the occurrence of positive emotions, and acting in an opposite manner to motivational tendency associated with negative emotion.

Mindfulness: developing attentional control, nonjudgemental awareness and sense of true self. Participants learn to simply observe and then describe events, thoughts, emotions and body sensations, and fully participate in their actions and experiences in a non-evaluative manner, focusing on one thing at a time and reorienting attention when distracted.

Distress tolerance: focusing on acceptance of painful emotions without trying to change them. The module is divided into crisis survival skills which are short-term strategies to tolerate a stressful