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Effectiveness of Dialectical Behavior Therapy in a Community Mental Health Center

Katherine Anne Comtois, *University of Washington, Seattle*
Lynn Elwood, *Harborview Mental Health Services, Seattle*
Laura C. Holdcraft and Wayne R. Smith, *University of Washington, Seattle*
Tracy L. Simpson, *Veterans Administration Hospital and University of Washington, Seattle*

Dialectical behavior therapy (DBT) has been shown to be effective in randomized controlled trials with women with borderline personality disorder and histories of chronic self-inflicted injury including suicide attempts. The present study is a pre-post replication of a comprehensive DBT program in a community mental health center for individuals who chronically injure themselves and/or have experienced multiple treatment failures. Twenty-four subjects were given the Treatment History Interview to obtain information regarding medically treated self-inflicted injuries and the use of crisis services. After 1 year of treatment, DBT showed a significant reduction in the number and severity of self-inflicted injuries, psychiatric-related emergency room visits, psychiatric inpatient admissions and days, and the number of crisis treatment systems engaged. Results are compared to benchmarks from 3 other clinical trials of DBT. While this pre-post comparison has threats to internal validity, it supports the feasibility of DBT when fully implemented in a community mental health clinic.

Suicide is the third leading cause of death in American youths and is among the top 12 leading causes of death for Americans of all ages, outnumbering homicides by a ratio of three to two (Goldsmith et al., 2002). Recognizing the enormity of the problem, and in response to such harrowing statistics, former Surgeon General David Satcher issued *The Surgeon General's Call to Action to Prevent Suicide* (Satcher, 1999). In this blueprint, Satcher introduced a comprehensive public health approach to increase awareness of the problem and implement specific interventions for addressing and preventing suicide. The following study addresses this call to action by providing a description and preliminary evaluation of dialectical behavior therapy (DBT) in a community mental health center. DBT is an evidence-based intervention that has been shown in randomized controlled clinical trials to decrease self-inflicted injuries, including suicide attempts in women with borderline personality disorder (Koons, Robins, & Bishop, 1998; Linehan, Armstrong, Suarez, Allmon & Heard, 1991; Linehan et al., 2006; Van den Bosch, Koeter, Stijnen, Verheul, & van den Brink, 2005).

Borderline personality disorder (BPD) is characterized by a pervasive pattern of instability in relationships, feelings of chronic emptiness, emotional lability, identity disturbance, impulsive behaviors (e.g., gambling, substance abuse, bingeing), and recurrent self-inflicted injuries or suicidal ideation (American Psychiatric Association, 1994). A self-inflicted injury is defined here as an acute, intentional self-injurious behavior, regardless of intent to die—including both suicide attempts and other self-inflicted injuries (Kreitman, 1977). Self-inflicted injury is typically present in 69% to 75% of individuals diagnosed with BPD (Clarkin, Widiger, Frances, Hurt, & Gilmore, 1983; Cowdry, Pickar, & Davies, 1985) and is an important behavior to target because it is the single best predictor of eventual suicide. In fact, 30% to 47% of suicide completers have been found to have a history of at least one self-inflicted injury (Gunnell & Frankel, 1994). The lifetime prevalence of self-inflicted injury in the general population ranges from 720 to 5,930 per 100,000 individuals, with 11 to 12 per 100,000 completing suicide (Welch, 2001), whereas the suicide rate among those with BPD is 7% to 10% (Linehan, Rizvi, Welch, & Page, 2000). Thus, treatment of individuals with BPD is an important aspect of the overall effort to reduce suicide rates.

There has also been a great need for an effective treatment of BPD. Those who suffer from BPD utilize an inordinate amount of emergency, medical, and mental health services as a result of suicidal behaviors. As can be seen by their repeated usage, these crisis services have not been effective in preventing further suicidal behavior. DBT is one of only two treatments for BPD empirically

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supported in randomized controlled trials to prevent further self-inflicted injuries: DBT (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan, Heard, & Armstrong, 1993; Linehan, Tutek, Heard, & Armstrong, 1994) and partial hospitalization (Bateman and Fonagy, 1999, 2001). DBT has several advantages over partial hospitalization, including a treatment manual (Linehan, 1993a, 1993b); replication in six randomized clinical trials in four independent laboratories (Koons et al., 1998; Linehan et al., 2006; Linehan et al., 2002; Linehan et al., 1999; Turner, 2000; Van den Bosch et al., 2005; Verheul et al., 2003; for view see Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004); and is shorter, with fewer sessions per week. DBT has also been evaluated in randomized controlled trials for eating disorders (Safer, Telch, & Agras, 2001; Telch, Agras, and Linehan, 2001) and older adults with depression (Lynch, Morse, Mendelson, and Robins, 2003) as well as in a number of quasi-experimental evaluations (Bohus et al., 2004; Dimeff, Rizvi, Brown, & Linehan, 2000; Katz, Cox, Gunasekara, & Miller, 2004; Rathus & Miller, 2002) and recognized adaptations (Award, 1998, 2004).

To our knowledge, a study has yet to be published or presented that examines the effectiveness of a comprehensive DBT program for individuals with BPD receiving outpatient care in a community mental health center. Since anecdotal evidence indicated that the Harborview Mental Health Services DBT program might be as effective as DBT provided in Linehan's tightly controlled university clinic setting, we believed it would be useful to more rigorously evaluate the program within a quality assurance framework. This paper presents pre-post treatment outcomes for self-inflicted injury and use of crisis services and compares these outcomes with the benchmarks of DBT randomized controlled trials conducted by Linehan and colleagues (Linehan et al., 1991; Linehan et al., in press) and van den Bosch and colleagues (Van den Bosch et al., 2005).

Method

Subjects

Setting and referral process. Harborview Mental Health Services (HMHS) is a large outpatient community mental health center in Seattle, Washington, that is affiliated with Harborview Medical Center, a major medical facility in downtown Seattle managed by the University of Washington as both the county hospital and a research and training facility. Harborview's mission is the control of illness and the promotion and restoration of health,with priority care given to the individuals of King County who are incarcerated, mentally ill, substance abusers, indigent, and non-English-speaking poor.

Thirty-eight English-speaking outpatients were enrolled in the HMHS DBT program for at least 4 months during this program evaluation. Nine clients refused to participate in the program evaluation or dropped out in the first 4 months and were not followed for assessments, 4 individuals who relocated were unable to be contacted for assessment, and 1 client is not included in this analysis because she completed only 6 months of the first year before progressing to the advanced program.

One client died before the completion of the first year of treatment. The medical examiner recorded her death as "undetermined cause." The client had not expressed increased suicidal ideation or plan in her final sessions so her death may have been the result of an accidental overdose. However, as suicide was considered a possibility by the DBT clinical team and the client's family, these analyses took a conservative approach and considered her death a suicide for the categorical self-inflicted injury and dropout analyses. This client is not included in the continuous self-inflicted injury and health services analyses because the client died before the year 1 interview and we therefore cannot determine the total number of suicidal behaviors and health services that occurred and would have occurred during that year.

At intake, the participants ranged in age from 19 to 54 with a mean age of 34 years. Ninety-six percent were women and Caucasian, 52% single, never married, 31% divorced, and 17% cohabitating with a partner. Eighty-two percent were unemployed, 9% were working sporadically, and 9% were working part-time.

The team psychiatrist used a clinical interview to make Axis I and II diagnoses. Findings were that 96% of the clients met criteria for BPD, 87% had a primary *DSM-IV* Axis I disorder of depression or dysthymia, 4% had a primary diagnosis of schizoaffective disorder, 4% bipolar disorder, and 4% schizotypal disorder. In addition to their primary diagnosis, 52% met criteria for an eating disorder, 65% met criteria for an anxiety disorder, 43% met criteria for substance abuse or dependence, and 91% had a history of self-inflicted injury including at least one suicide attempt.

Treatment

The treatment provided in the HMHS DBT program during the period studied was very similar to the treatment described by the DBT manuals (Linehan, 1993a, 1993b) and evaluated in the randomized clinical trials for suicidal behavior (Linehan et al., 1991; Linehan et al., in press; Van den Bosch et al., 2005), which will be referred to as "standard DBT." However, some adaptations were made (see Table 1 for comparison of DBT functions and modes of treatment).

Screening and pretreatment. Clients were referred to the HMHS DBT program from hospital inpatient units,

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