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Dialectical behavior therapy for the treatment of anger and aggressive behavior: A review

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ABSTRACT

Objective: The management of anger and aggression is a public safety issue. Dialectical behavior therapy (DBT) is a promising treatment for reducing anger and violent behavior. This mode of therapy addresses maladaptive behavior by teaching emotion regulation, distress tolerance, interpersonal effectiveness, core mindfulness, and self-management skills.
Methods: This paper reviewed DBT treatment for anger and aggressive or violent behavior. The literature search included articles from 1998 to September 2013. A total of 21 peer-reviewed articles studying the effects of DBT on anger and aggressive behavior were reviewed.
Results: Adaptations or modifications were made to standard DBT to accommodate the specific needs of the variety of populations across studies. Nine studies attempted to understand the efficacy of DBT for anger and aggressive behavior while twelve studies measured the efficacy of DBT within the context of a BPD diagnosis. There are nine randomized controlled trials (RCT) assessing DBT to reduce anger and aggressive behavior.
Conclusion: Research has shown that there are potentially clinically significant results when using DBT to treat anger and aggression in various samples. Findings from this review suggest that treatments, even when modified show a positive impact on the reduction of anger and aggressive behaviors.

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1. Introduction

Dialectical behavior therapy (DBT) is a cognitive-behavioral therapy developed by Marsha Linehan to treat women with borderline personality disorder (BPD) and self-harm or suicidal behaviors (Linehan, 1993). BPD can be understood as the product of an emotionally vulnerable individual subjected to an invalidating environment, which elicits chronic emotion dysregulation (Crowell, Beauchaine, & Linehan, 2009). DBT was designed to treat emotional dysregulation (i.e., mood disturbance, affective liability, uncontrolled anger) and the behavioral difficulties (i.e., self-harm, violent aggression) associated with chronic, severe emotion dysregulation that are characteristics of

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BPD. DBT is divided into four important therapeutic components: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness (Linehan, 1993).

Standard DBT is an outpatient therapy involving four modes of treatment, including weekly individual psychotherapy, weekly skills training groups, weekly therapist consultation team meetings (to prevent therapist burnout), and access to 24-hour per day telephone coaching from the therapist or skills group leader. DBT combines techniques from cognitive-behavioral therapy (CBT) with elements from dialectical philosophy and Zen practice (Linehan, 1993). Since Linehan's first conceptualization of DBT, the treatment approach has grown and been applied to a range of problematic behaviors. Over the past couple of decades, studies have shown the effectiveness of DBT to treat patients with emotional instability, cognitive disturbances, self-harming behavior, chronic feelings of emptiness, interpersonal problems, poor impulse control, and anger management (Bohus et al., 2004; Linehan, Heard, & Armstrong, 1993; Linehan et al., 2006; Robins & Chapman, 2004).

The management of anger and aggression is a major public safety issue, involving mental health care workers in a variety of settings including juvenile and adult detention facilities, schools, community mental health centers, and psychiatric hospitals. Cognitive-behavioral treatment approaches have received empirical support for reducing aggressive behaviors and improving coping behaviors, particularly among correctional populations (Milkman & Wanberg, 2007; Shingler, 2004; Trupin, Stewart, Beach, & Boesky, 2002). CBT has been shown to initiate changes in cognitions that affect behavior and can reduce recidivism in adult offenders (Allen, Mackenzie, & Hickman, 2001). Although DBT was originally developed to treat women diagnosed with borderline personality disorder (Linehan, 1993), it's similarity to CBT makes it a promising treatment for reducing anger and violent behavior. In addition to using CBT skills (e.g., cognitive restructuring and contingency management), DBT also addresses maladaptive behavior (such as impulsive aggression) by teaching emotion regulation, distress tolerance, interpersonal effectiveness, core mindfulness, and self-management skills.

Investigators have begun to examine DBT as a useful treatment for aggression among a variety of samples (Evershed et al., 2003; Shelton, Sampl, Kesten, Zhang, & Trestman, 2009). In addition, some have provided their own rationale and suggested modifications for the use of DBT to treat anger and aggression among domestic abuse perpetrators (Fruzzetti & Levensky, 2000) and inpatient forensic populations (McCann, Ball, & Ivanoff, 2000). McCann et al. (2000) provided five arguments for the use of DBT approaches in forensic settings for the treatment of patients with violent histories and multiple diagnoses. The authors asserted that DBT would be useful due to the incidence of personality disorders among forensic populations, the effectiveness of structured behavioral programs at reducing recidivism, the critical need to manage aggressive or life threatening behavior among patients, and the importance of using an approach that addresses staff burnout.

Given that DBT has been shown to be an encouraging option for treating anger and aggression, it is clinically relevant to determine the state of the empirical literature in this relatively new area. There appear to be discrepant findings for the efficacy of DBT to treat anger in the literature. By closely examining the existing literature, we can begin to credibly evaluate the validity of DBT for treating aggressive behavior. The literature appears to lack a comprehensive or systematic review that evaluates the published research on DBT for anger and aggressive behavior. Aims of the present review include comprehensively identifying, summarizing, and critically evaluating the existing literature to draw conclusions and make recommendations about the use of DBT to treat anger and aggressive behaviors, including those occurring in the context of BPD.

2. Methods: primary data sources

This review aims to include all relevant content featuring any form of DBT treatment for anger and aggressive or violent behavior, outside of, and within, the context of BPD. The literature search was completed using the electronic databases PsychInfo, Pubmed/MEDLINE, and ScienceDirect from January 1998 through September 2013 using various combinations of the search terms (a) *DBT* or *dialectical behavioral therapy*, and (b) *aggressive behavior*, *anger*, *aggression*, or *violence*. The search yielded 60 results.

2.1. Inclusion criteria

From the abstracts, only English-language peer-reviewed journal articles presenting original empirical research and using self-reported anger or behavioral ratings of aggression as dependent variables were selected. Two of the articles were single-case studies, 13 were doctoral dissertations, and 24 of the articles were descriptive, theoretical, or review papers and hence, all were excluded. The relevant journal articles ($N = 21$) are discussed below and summarized in detail in Table 1.

3. Results

Twenty-one peer-reviewed articles assessing the effects of DBT on anger and aggressive behavior outside of and within the context of BPD were reviewed. Many of the articles describe adaptations or modifications of DBT for use with specific populations (Brown, Brown, & Dibiasio, 2013; Evershed et al., 2003; Linehan, McDavid, Brown, Sayrs, & Gallop, 2008; Long, Fulton, Dolley, & Hollin, 2011; Nelson-Gray et al., 2006; Shelton, Kesten, Zhang, & Trestman, 2011; Shelton et al., 2009) and some detail studies that experimentally assess the use of DBT for treatment of anger or aggression as compared with a controlled sample (Koons et al., 2001; Lynch et al., 2007; McMain et al., 2009; Neacsiu, Rizvi, & Linehan, 2010). However, the majority of studies used a pre-post study design (Gutteling, Montagne, Nijs, & van den Bosch, 2012; Koons et al., 2006; Long et al., 2011; Nelson-Gray et al., 2006).

3.1. Modifications to DBT

Adaptations or modifications were made to standard DBT as described by Linehan (1993) to accommodate the specific needs of the variety of populations included in this review. Changes included the removal of individual sessions altogether (Shelton et al., 2011; Soler et al., 2009; Woodbury & Popenoe, 2008), while others included traditional DBT skills training and "DBT group therapy," described as including the tasks carried out in individual therapy sessions (i.e., reviewing diary card) (Gutteling et al., 2012; Koons et al., 2006). Other changes include modification of language and format to accommodate individuals with intellectual disabilities (Brown et al., 2013) and the addition of violent behaviors to "therapy-interfering behavior," omission of telephone consultation, and inclusion of relevant material for incarcerated populations (Evershed et al., 2003; Shelton et al., 2009, 2011). Nelson-Gray et al. (2006) modified the training modules to be age appropriate for young adolescents with Oppositional Defiant Disorder. Other DBT modifications were implemented to specifically address aggressive behavior as a target behavior for treatment (Linehan et al., 2008).

3.2. Efficacy of DBT to treat anger/aggression

The efficacy of DBT for anger and aggressive behavior was evaluated through a review of nine studies. These studies assessed the impact of DBT on measures of anger and aggression among participants with a variety of diagnoses. Some of the participants in these studies met the criteria for a personality disorder (including some with BPD); however, the aim of these investigations was not to examine a reduction in anger among BPD patients specifically. These included seven uncontrolled (most of which used pre–post test design) and two randomized controlled studies (both included follow-up data). Of the nine reports, eight found that DBT interventions significantly reduced overall scores