PERSONALITY DISORDERS

mhc MENTAL HEALTH CLINICIAN

CLINICAL PEARL Open Access

Dialectical behavior therapy as treatment for borderline personality disorder

Jennifer M. May, MD[1]
Toni M. Richardi, PsyD[2]
Kelly S. Barth, DO[3]

How to cite: May JM, Richardi TM, Barth KS. Dialectical behavior therapy as treatment for borderline personality disorder. Ment Health Clin [Internet]. 2016;6(2):62-7. DOI: 10.9740/mhc.2016.03.62.

Abstract

Dialectical behavior therapy (DBT) is a structured outpatient treatment developed by Dr Marsha Linehan for the treatment of borderline personality disorder (BPD). Dialectical behavior therapy is based on cognitive-behavioral principles and is currently the only empirically supported treatment for BPD. Randomized controlled trials have shown the efficacy of DBT not only in BPD but also in other psychiatric disorders, such as substance use disorders, mood disorders, posttraumatic stress disorder, and eating disorders. Traditional DBT is structured into 4 components, including skills training group, individual psychotherapy, telephone consultation, and therapist consultation team. These components work together to teach behavioral skills that target common symptoms of BPD, including an unstable sense of self, chaotic relationships, fear of abandonment, emotional lability, and impulsivity such as self-injurious behaviors. The skills include mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance. Given the often comorbid psychiatric symptoms with BPD in patients participating in DBT, psychopharmacologic interventions are oftentimes considered appropriate adjunctive care. This article aims to outline the basic principles of DBT as well as comment on the role of pharmacotherapy as adjunctive treatment for the symptoms of BPD.

Keywords: dialectical behavior therapy, borderline personality disorder, third term, psychotherapy

[1] Resident, Combined Internal Medicine and Psychiatry Program, Medical University of South Carolina, Charleston, South Carolina; [2] Postdoctoral Fellow, Department of Psychiatry, Biobehavioral Medicine Division, Medical University of South Carolina, Charleston, South Carolina; [3] (Corresponding author) Associate Professor, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, Charleston, South Carolina, stephen@musc.edu

Disclosures: The authors have no relevant financial or nonfinancial relationships to disclose.

Introduction to Dialectical Behavior Therapy

Dialectical behavior therapy (DBT) is a structured outpatient treatment based on cognitive-behavioral principles developed by Dr Marsha Linehan in the early 1990s for the treatment of parasuicidal behavior in women with borderline personality disorder (BPD).[1] Linehan defines parasuicidal behavior as "any intentional, acute self-injurious behavior with or without suicidal intent, including both suicide attempts and self-mutilative behaviors."[2] Borderline personality disorder, as outlined by the *Diagnostic and Statistical Manual, 5th Edition (DSM-5)*, is a chronic disorder that includes symptoms such as frantic efforts to avoid real or imagined abandonment, unstable relationships, identity disturbance, impulsive and dangerous behaviors, recurrent suicidal threats or self-mutilating behaviors, affective instability, feelings of emptiness, difficulties controlling anger, and/or stress-related paranoid thoughts or dissociation.[3] The lifetime prevalence of BPD is approximately 6%.[4] Borderline personality disorder accounts for significantly higher health care costs than both major depressive disorder and other personality disorders.[5] These high medical costs can be attributed to a

greater number of hospitalizations, more frequent emergency room visits, and greater use of outpatient services.[5]

The term "dialectical" means the interaction of conflicting ideas. Within DBT, "dialectical" refers to the integration of both acceptance and change as necessities for improvement.[6] Dialectical behavior therapy aims to address the symptoms of BPD by replacing maladaptive behaviors with healthier coping skills, such as mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance. It is currently the only empirically supported treatment for BPD as demonstrated by the Cochrane Collaborative Review.[7] Research has also shown it be effective in treatment of substance use disorders, mood disorders, posttraumatic stress disorder (PTSD), and eating disorders in both adults and adolescents.[8] Given the often comorbid psychiatric symptoms with BPD in patients participating in DBT, psychopharmacologic interventions are oftentimes considered appropriate adjunctive care. This article aims to outline the basic principles of DBT as well as comment on the role of pharmacotherapy as adjunctive treatment for the symptoms of BPD.

The Efficacy of DBT in Borderline Personality Disorder and Other Psychiatric Disorders

There have been several randomized controlled trials (RCTs) studying the efficacy of DBT in BPD. The Linehan Institute compiled a list of RCTs reviewing studies on DBT since 1991.[8] This compilation shows that DBT has been more effective than community-based treatment-as-usual in numerous areas, including reducing parasuicidal behaviors, increasing adherence to treatment, and reducing the number of hospitalizations. Dialectical behavior therapy has also been efficacious in comorbid substance use disorders, binge eating disorder, depression, and bulimia nervosa.[8] In addition, it has been studied with primary diagnoses of trichotillomania, bipolar disorder, attention-deficit hyperactivity disorder, eating disorders (eg, binge eating, bulimia nervosa, anorexia nervosa), adolescents with behavioral disorders, and PTSD.[8] Noticeably, many of the aforementioned psychiatric disorders share diagnostic criteria with BPD, such as impulsivity, labile mood, interpersonal difficulties, suicidal behaviors, and/or engagement in risky behaviors. These shared target symptoms likely contribute to DBT's efficacy across disorders.

DBT Structure

Traditional DBT consists of 4 components: skills training group, individual psychotherapy, telephone consultation, and therapist consultation team. This treatment structure was used in the RCTs validating its effectiveness; however, DBT can be modified or shortened to accommodate any treatment setting, including solo private practices or inpatient facilities.[1,6]

Skills Training Group

Linehan's DBT manual explains that the skills training group is designed to target behavioral skill deficits that are common to patients with BPD, including an unstable sense of self, chaotic relationships, fear of abandonment, emotional lability, and impulsivity. The group focuses on teaching psychosocial skills that target these deficits through 4 skills training modules: core mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance. The group typically meets weekly for approximately 2 hours, and it takes about 6 months to complete all of the modules. Individuals can choose to repeat the modules, and it is recommended that patients who are new to DBT stay in the skills training group for at least 1 year. Patients are assigned homework to reinforce skills and given diary cards to keep track of how they are using the skills outside of the group. Although patients can discuss with the group how they are using the skills, they are encouraged to process their diary cards primarily with their individual therapists.[6]

Core Mindfulness

The core mindfulness skills are central to all of the skills taught in DBT and are frequently revisited within the other 3 modules. Many of these skills have been adopted from Eastern meditation practices. The mindfulness skills are divided into "what" skills and "how" skills. The "what" skills teach patients to observe, describe, and participate fully in the present moment. These skills are meant to target the tendency of patients to participate without awareness through impulsive and emotion-driven behaviors. The "how" skills teach patients to be present in the moment with a nonjudgmental mindset, focusing on one thing at a time, and in an effective manner. These skills target the tendency of patients to idealize and devalue both themselves and other people as well as the tendency for patients to ruminate about the past or worry about the future instead of living in the present moment.[6]

Interpersonal Effectiveness

The interpersonal effectiveness module focuses on teaching and practicing social skills that are effective in relationships. Many patients with BPD have a history of childhood abuse, neglect, or other forms of invalidation that made it difficult for them to form secure attachments early in life. They therefore often experience intense, unstable relationships in which they have trouble asserting themselves. Although these patients fear abandonment, they frequently end relationships prematurely because of difficulties tolerating conflict. The interpersonal strategies teach patients how to ask for what they need, say "no" to inappropriate demands, and cope with interpersonal conflict. The focus of these strategies is in learning to

keep meaningful relationships, while also maintaining self-respect.[6]

Emotion Regulation

The emotion regulation skills are strategies for enhancing control over personal emotions. For individuals with BPD, emotions can be intense and labile. This often leads to the development of dysfunctional behaviors that are aimed at avoiding negative emotions. The emotion regulation skills first work on identifying and labeling emotions so that patients can understand how emotions can lead to behaviors affecting their overall functioning. The patients also learn to identify obstacles to changing their emotions, which often include parasuicidal and other dysfunctional behaviors that have been used by a patient for communication or validation of their experience. Patients are taught to avoid vulnerable situations that often lead to negative emotions and taught to increase events in their life that frequently lead to positive emotions. Patients are encouraged to use mindfulness techniques to accept and tolerate painful emotions in a nonjudgmental way.[6]

Distress Tolerance

The distress tolerance skills teach patients that pain and distress are an inevitable part of life, and unwillingness to accept this fact often leads to greater suffering. This module shows patients how to experience their current situation nonjudgmentally without attempting to change it. It is important to note that accepting their current situation does not mean that they must approve of their current situation. The distress tolerance skills include both crisis survival and acceptance strategies. The crisis survival skills teach patients techniques for distracting, self-soothing, and adjusting their thoughts in the moment. The acceptance skills work on transforming intolerable suffering into pain that can be tolerated.[6]

Individual Psychotherapy

Within the weekly individual therapy module of treatment, there are 6 main areas of focus: parasuicidal behaviors, therapy-interfering behaviors, behaviors that interfere with quality of life, behavioral skills acquisition, posttraumatic stress behaviors, and self-respect behaviors.[9] These are meant to supplement and enhance the group therapy module of treatment. Individual therapy is conducted by the patient's primary therapist on the patient's treatment team and is usually someone selected by the patient.[1]

Parasuicidal behaviors, whether those with actual suicidal intent or not, are never to be ignored in DBT. Parasuicidal behaviors are explored in detail, and emphasis is also placed on problem-solving behaviors, engaging in active coping, and using short-term distress management techniques. Previous trauma may need to be addressed if posttraumatic stress behaviors occur, as it can influence parasuicidal behaviors. However, the focus should initially be on current parasuicidal behaviors.[9]

Therapy-interfering behaviors can occur on the behalf of both therapist and patient. Patient interference includes anything that may interfere with receiving therapy or lead to therapist burnout (eg, nonadherence, inattentive behavior, breaking agreements with the therapist that are repeatedly addressed). By reducing therapy-interfering behaviors, drop-out rates can be significantly reduced.[9]

Behaviors that interfere with quality of life include any behaviors that may seriously interfere with development of an improved lifestyle for the patient. Some examples are substance abuse, high-risk sexual behaviors, financial or employment concerns, and/or any behaviors with potential legal, interpersonal, or health issues.[9]

Behavioral skills are considered those skills that will be used in the patient's daily life. These behaviors specifically address BPD traits defined in the *DSM-5*. Mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness skills are explained in further detail and applied to the patient's everyday life. In addition, new self-management skills (eg, learning/maintaining healthy behaviors, eliminating unhealthy behaviors) are taught and reinforced throughout individual therapy.[9]

Most patients, particularly those with BPD, enter therapy with a trauma history.[9] Although trauma and posttraumatic symptoms may initially remain unaddressed because of the priority of suicidal behaviors, it is important that the therapist address trauma history when the patient appears ready. This focus includes remembering the abuse (eg, validation of memories, acknowledging emotions related to abuse), reducing self-blame and stigmatization, ending denial and intrusive thoughts regarding abuse (eg, exposure techniques), and reducing polarization or dialectical view of the self and the abuser.[9]

Last, self-respect behaviors are designed to enhance the patient's ability to validate him or herself. It is important for the patient to build greater self-reliance. The therapist will need to consistently reinforce self-respect behaviors throughout the therapy process.[9]

Telephone Consultation

Telephone consultation allows the patient to contact the individual therapist for in-the-moment guidance. Phone calls are designed to teach patients how to ask for help effectively and to apply skills learned in therapy to everyday life, especially during times of crisis. Patients with BPD often do not ask for help because they feel

invalidated and instead harm themselves as a cry for help. At other times, they may ask for help in an abusive manner leaving others feeling manipulated. Phone coaching is meant to help change these dysfunctional behaviors.[1]

The strategies used for telephone consultation are designed to minimize reinforcement of parasuicidal behaviors. For that reason, patients are told at the beginning of therapy that they are expected to call their individual therapist before engaging in parasuicidal behavior. In addition, the patient is not allowed to call the therapist for 24 hours after engaging in parasuicidal behavior unless there are life-threatening injuries. The 24-hour rule is meant to encourage patients to seek help from the therapist at earlier stages of a crisis while the therapist can still offer assistance and not after the patient has already chosen maladaptive behaviors.[1]

Many therapists are fearful and overwhelmed by the idea of being available to their patients at all hours of the day and night. For this reason, many therapists limit when they are available or choose not to participate in this part of DBT treatment. Nevertheless, this part of the treatment module is strongly recommended in order to reduce parasuicidal behaviors. The length and frequency of permissible phone conversations vary for different therapists and different patients. Many therapists quickly realize that many of the patients do not utilize the phone coaching as often as they should. For patients who abuse the telephone conversations, this becomes a therapy-interfering behavior that is addressed during individual therapy sessions. When DBT is restructured in various outpatient or inpatient settings, other providers such as mental health technicians, nurses, or on-call psychiatrists may fill this role.[1]

Therapist Consultation Team

The therapist consultation team is a weekly meeting of all individual and group therapists who are currently providing DBT. Working with patients with BPD who are highly suicidal can be challenging and stressful. Significant stress can lead therapists to react in problematic ways during treatment. The therapist consultation team functions to maintain motivation and commitment among all providers in order to provide optimal treatment.[1] It can also be used to promote empathy within the therapist, focusing on accepting the patient rather than forcing change upon the patient, that will ultimately help reduce parasuicidal behaviors in the patient.[9] If a group setting is not possible, all DBT therapists are strongly encouraged to be a part of some form of consultation or supervision relationship.[1]

Pharmacologic Considerations for Treatment of BPD

In general, psychotherapy is the treatment of choice for BPD over psychotropic medications.[10] In fact, the National Institute of Health and Clinical Excellence (NICE) has published guidelines that medication should not be used specifically for BPD or symptoms associated with BPD.[11] However, patients with personality disorders are prescribed medications more frequently than any other diagnostic group,[12] and the American Psychiatric Association declared pharmacotherapy as having an important "adjunctive role" in treatment of personality disorders.[13]

In a 2012 multicenter study in the United Kingdom, researchers showed that within a sample of 161 patients with BPD, approximately 45% were prescribed second-generation antipsychotics (other than clozapine), 40% were prescribed mood stabilizers, and 20% were prescribed clozapine. Polypharmacy (including antidepressants, mood stabilizers, antipsychotics, benzodiazepines, and "other" medications) was also shown to be common, with approximately 62% of patients on 2 or more medications and approximately 24% on 3 or more medications. In this study, approximately 80% of patients with BPD had past or current comorbid psychiatric disorders, including schizophrenia, PTSD, depression, bipolar disorder, and/or anxiety. Additionally, approximately 60% of the 14 "consultants" involved in management of these subjects with BPD disagreed with the NICE guidelines, and none completely agreed with the guidelines.[10]

In the scientific literature, there appears to be mixed evidence on the efficacy of medications for the management of BPD, and psychopharmacologic interventions usually have nonspecific results.[14] A 2011 meta-analysis evaluated the effectiveness of medications in treating impulsivity, aggression, depression, anxiety, anger, and suicidal behavior in patients with BPD, and concluded the following: (1) selective serotonin reuptake inhibitors (SSRIs) can improve impulsivity and aggression but have little effect on other symptoms; (2) mood stabilizers and anticonvulsants have a moderate effect on depression and can improve aggression and impulsivity; (3) first-generation antipsychotics can reduce anger and suicidal behavior in patients with BPD but have little effect on psychosis and anxiety; and (4) second-generation antipsychotics can have an effect on aggression, but there are mixed results for other symptoms.[12] Benzodiazepine use by patients with BPD has been greatly discouraged, as it may be abused (ie, used to self-medicate intrapersonal issues) and exacerbate BPD symptoms.[12] Other research has supported this finding, as 87% of psychiatrists interviewed cited medication misuse, including overdose, as a common problem among their BPD patients.[15] Despite

continued use of pharmacotherapy, researchers have concluded that conservative use should be considered best practice, given potential lethality of most medications, with the exception of SSRIs.[14]

There is some evidence that DBT is effective in lowering psychotropic medication use in patients. One study noticed significant decrease in psychotropic medication use among college students with parasuicidal behaviors following DBT treatment.[16] One particular study focusing on adolescent DBT during long-term inpatient therapy also found a reduction in psychotropic medications prescribed.[17] However, there were no comparison group results with which to run a statistical analysis on the significance in the DBT group's reduction in medication. This is an area that deserves further consideration, given the mixed evidence for medication effectiveness, medication side effects, and potential for misuse of psychotropic medications.

There are several overall implications of medication in the treatment of BPD. While medications may be helpful for some comorbid psychiatric symptoms in patients with BPD, their efficacy for treatment of BPD should not be assumed.[18] For example, research shows that SSRIs may show improvement in depression or anxiety on a variety of self-report measures in patients with BPD; however, these measures are not designed to assess changes in symptoms of BPD, as depression and anxiety are comorbid issues.[18] In addition, medications in BPD often create more problems than they solve owing to the potential for adverse side effects, addiction, and lethal overdose.[14] Therefore, it is recommended to use caution when prescribing medications to this population. When medications are prescribed, they should only be used in conjunction with psychotherapy.[19] In general, DBT is first-line treatment for BPD and has been shown to reduce the need for medications and medical care by up to 90%.[8,19]

Conclusion

Although medications can provide adjunctive treatment in patients with BPD and comorbid psychiatric symptoms, DBT is currently the only empirically supported treatment for BPD. For that reason, it is important that all patient providers understand when a patient could potentially benefit from DBT. Pharmacists, in particular, have the unique opportunity to speak to patients and providers in both formal contexts (eg, medication management appointments, medication reconciliation and education, inpatient consultation, medical rounds) and informal contexts (eg, conversation while a patient pays for a prescription, patient chart review in a medical setting). Within these contexts, a patient provider may discover behaviors consistent with those of BPD, including impulsivity, affective instability, interpersonal or intrapersonal conflict, parasuicidal behaviors, substance abuse (alcohol, prescription drugs, or illicit drugs), or polypharmacy. If a pharmacist notices any of these symptoms, it would be beneficial to provide the patient with a referral to a local community mental health center for DBT in addition to providing direct services such as assessing current medication efficacy or safety concerns, reducing unnecessary polypharmacy, and/or addressing prescription drug abuse concerns.

References

1. Linehan MM. Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press; 1993.
2. Linehan MM. Cognitive-behavioral treatment of chronically parasuicidal borderline patients. Arch Gen Psychiatry. 1991; 48(12):1060-4. DOI: 10.1001/archpsyc.1991.01810360024003.
3. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Washington: American Psychiatric Association; 2013.
4. Grant BF, Chou SP, Goldstein RB, Huang B, Stinson FS, Saha TD, et al. Prevalence, correlates, disability, and comorbidity of DSM-IV borderline personality disorder: results from the Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions. J Clin Psychiatry. 2008;69(4):533-45. PubMed PMID: 18426259.
5. Bender DS, Dolan RT, Skodol AE, Sanislow CA, Dyck IR, McGlashan TH, et al. Treatment utilization by patients with personality disorders. Am J Psychiatry. 2001;158(2):295-302. DOI: 10.1176/appi.ajp.158.2.295.
6. Linehan MM. Skills training manual for treating borderline personality disorder. New York: Guilford Press; 1993.
7. Stoffers JM, Völlm BA, Rücker G, Timmer A, Huband N, Lieb K. Psychological therapies for people with borderline personality disorder (review). Cochrane Database Syst Rev. 2012;8: CD005652. DOI: 10.1002/14651858.CD005652.pub2.
8. Linehan MM, Dimeff L, Koerner K, Miga EM. Research on dialectical behavior therapy: summary of the data to date. 2014. Available from: http://behavioraltech.org/downloads/research-on-dbt_summary-of-data-to-date.pdf
9. Shearin EN, Linehan MM. Dialectical behavior therapy for borderline personality disorder: treatment goals, strategies, and empirical support. In: Paris J, editor. Borderline personality disorder: etiology and treatment. Washington: American Psychiatric Press; 1993. p. 285-318.
10. Völlm BA, Chadwick K, Abdelrazek T, Smith J. Prescribing of psychotropic medication for personality disordered patients in secure forensic settings. J Forens Psychiatry Psychol. 2012;23(2): 200-16. DOI: 10.1080/14789949.2012.655764.
11. National Institute for Health and Clinical Excellence. Borderline personality disorder: treatment and management. National Clinical Practice Guideline Number 78. London: National Institute of Health and Clinical Excellence; 2009.
12. Ripoll LH, Triebwasser J, Siever LJ. Evidence-based pharmacotherapy for personality disorders. Int J Neuropsychopharmacol. 2011;14(9):1257-88. DOI: 10.1017/S1461145711000071. PubMed PMID: 21320390.
13. American Psychiatric Association. Practice guideline for the treatment of patients with personality disorder. Am J Psychiatry. 2001;158(10 Suppl):1-52. PubMed PMID: 11665545.
14. Dimeff LA, McDavid J, Linehan MM. Pharmacotherapy for borderline personality disorder: a review of the literature and

recommendations for treatment. J Clin Psychol Med Settings. 1999;6(1):113-38.
15. Waldinger RJ, Frank AF. Clinicians' experiences in combining medication and psychotherapy in the treatment of borderline patients. Hosp Community Psychiatry. 1989;40(7):712-8. PubMed PMID: 2777227.
16. Pistorello J, Fruzzetti AE, MacLane C, Gallop R, Iverson KM. Dialectical behavior therapy (DBT) applied to college students: a randomized clinical trial. J Consult Clin Psychol. 2012;80(6):982-94. DOI: 10.1037/a0029096.
17. McDonnell MG, Tarantino J, Dubose AP, Matestic P, Steinmetz K, Galbreath H, et al. A pilot evaluation of dialectical behavioural therapy in adolescent long-term inpatient care. Child Adolesc Ment Health. 2010;15(4):193-6. DOI: 10.1111/j.475-3588.2010.00569.x.
18. Biskin RS, Paris J. Management of borderline personality disorder. CMAJ. 2012;184(17):1897-902. DOI: 10.1503/cmaj.112055.
19. Gunderson JG. Clinical practice: borderline personality disorder. N Engl J Med. 2011;364(21):2037-42.