The Dialectical Behaviour Therapy Model

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Plan of Presentation

- Present DBT’s theoretical base and model of change
- Describe DBT’s biosocial theory of pervasive emotion dysregulation
- Identify DBT’s core treatment strategies
- Review findings from our research on DBT and discuss the implications of these findings for clinical practice
How DBT Started

• In 1980’s, Linehan began by studying behaviour therapy with chronically suicidal patients
• Acceptance-based interventions were integrated into behavioural therapy to address patient sensitivity
• DBT evolved into an approach BPD
DBT in a Nutshell

- DBT is broad-based CBT treatment for severe, complex, multi-disordered patients
- Multi-modal treatment:
  - individual therapy (1 hour / week)
  - skills training group (2 hours / week)
  - phone coaching
  - therapist consultation team meetings (2 hours / week)
- Duration of standard outpatient DBT for BPD - generally one year
DBT’s Bisosocial Theory

High Emotion Vulnerability + Emotion Modulation Deficits → Problematic Behaviours (e.g. suicide, substance use)
Etiology of Pervasive Emotion Dysregulation

- Emotion Vulnerability
- Heightened Emotional Arousal
- Inaccurate/Extreme Expression
- Invalidating Responses from Others
- Pervasive History of Invalidating Responses

Fruzzetti et al., 2005
Theoretical Underpinnings

Learning Theory

Zen Philosophy

Dialectical Philosophy
DBT’s Core Strategies

- Change Strategies
- Validation Strategies
- Dialectical Strategies
Benefits of Validation

- Being understood reduces physiological arousal and increase collaboration
- Reduces avoidance of adaptive emotions and behaviours
- Helps patients recognize, accurately label and accept thoughts, emotions and behaviours
- Promotes access primary emotions associated with adaptive action tendencies
In-Session Tasks of DBT Therapist

• Keep a focus on the treatment structure and don’t get lost in the chaos
  – Stage treatment and focus
  – Use target hierarchy to guide session focus

• Monitor motivation
  – Ensure collaboration on therapy task

• Validate the patient

• Increase awareness of links between thoughts, feelings and behaviours and change these links
  – Attend to common themes across problems
  – Identify and solve obstacles to patients achieving their goals
DBT Techniques for Promoting Therapist Compassion

- Therapist consultation team
- Radical acceptance and mindfulness practice
  - Set of explicit assumptions about patients and treatment
- Prioritize focus of therapy interfering behaviours
  - Negative therapist reactions are addressed towards patients
- Emphasis on therapist genuineness and humility
Key Ideas in DBT

• Understand that the underlying nature of BPD symptoms is a problem of pervasive emotion dysregulation
• Tension in the therapy relationship is always monitored and addressed by maintaining balance
• Encourage awareness of the links between thoughts, feelings and behaviours associated with problems and look for opportunities for change
• Use validation to reduce emotional arousal and promote acceptance of experience
• Structure the treatment to guide decisions about what to focus on in any interaction
OUR RESEARCH ON DBT FOR BPD
Research on DBT for BPD: A Decade Ago

- 4 published RCT’s on DBT for BPD
  - Linehan et al. (1991), DBT vs. TAU
  - Linehan et al., (1994), DBT vs. TAU
  - Koons et al., (2001), DBT vs. TAU
  - Turner et al. (2000), DBT vs. TAU
Empirical Context for Our Research on DBT: 2002

Several critiques of the empirical base of DBT:

• Studies were underpowered
• Most RCT’s were conducted by Linehan
• No studies compared DBT to a rigorous control
• Durability of gains were not established beyond a year
• Exclusion of males
Aim of Our Canadian Study of DBT for BPD

To evaluate the clinical effectiveness and economic impact of DBT versus a strong comparator approach.
A Randomized Trial of Dialectical Behavior Therapy Versus General Psychiatric Management for Borderline Personality Disorder

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William D. Gaam, M.D.
Tim Quinlind, M.D.
Robert J. Cardisch, M.D.
Lorne Kerman, Ph.D.
David L. Streiner, Ph.D.

Objective: The authors sought to evaluate the clinical efficacy of dialectical behavior therapy compared with general psychiatric management, including a combination of pharmacotherapy, psychosocial therapy, and medication, for the treatment of borderline personality disorder. Method: This was a single-blind trial in which 19 patients diagnosed with borderline personality disorder were randomized to dialectical behavior therapy (n = 10) or general psychiatric management (n = 9) for 1 year. Results: Significant improvements were observed in self-injury, depression, and interpersonal functioning in both groups, with greater improvements in the treatment group. Conclusions: Dialectical behavior therapy is an effective treatment for borderline personality disorder.

Dialectical Behavior Therapy Compared With General Psychiatric Management for Borderline Personality Disorder: Clinical Outcomes and Functioning Over a 2-Year Follow-Up

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Robert J. Cardisch, M.D.

Objective: The authors conducted a 2-year prospective randomized controlled trial to evaluate outpatient psychiatric treatment for borderline personality disorder. Method: Patients were recruited from a community-based mental health clinic and randomized to dialectical behavior therapy (n = 30) or general psychiatric management (n = 30). Results: Both treatment groups showed significant improvements in clinical outcomes, with greater improvements in the dialectical behavior therapy group. Conclusions: Dialectical behavior therapy is an effective treatment for borderline personality disorder over a 2-year follow-up.

Both treatment groups showed significant improvements in clinical outcomes, with greater improvements in the dialectical behavior therapy group.
General Psychiatric Management

- Psychodynamic psychotherapy focused on relational elements and emotions
- Case management
- Psychopharmacotherapy
  - Targeted two algorithms –
    - Mood lability
    - Impulsivity/aggressiveness
  - Medication delivered according to predominant symptom pattern.
- Supervision group for clinicians
Results
Summary of improvements in both Treatments

- **Suicide and self harm behaviours** (Suicide and Self Harm History Interview) - 80%
- **Emergency Room Visits** (Treatment History Interview) - 50%
- **Inpatient Admissions** (Treatment History Interview) - 50%
- **Borderline Symptoms** (Zanarini BPD scale) - 50%
Treatment Effects for DBT and GPM

- **Depression**
  (Beck Depression Inventory)
  - Large

- **Anger**
  (State Trait Anger Expression Inventory)
  - Medium

- **Interpersonal Functioning**
  (Inventory of Interpersonal Problems)
  - Clinically significant change

- **Symptom Distress**
  (Symptom Checklist 90-Revised)
  - Clinically significant change
Further improvements:
- Frequency of suicidal and non-suicidal self-injurious behaviours
- Emergency room visits
- Anger, interpersonal functioning, symptom distress,
- Depression
- Overall quality of life

Maintenance of gains:
- Psychiatric hospital days, BPD symptoms, lethal risk of suicidal behaviors

No Between-Group Differences on Any Outcomes
Unemployment:
- Pre treatment: 60.3% unemployed
- 36 months: 52% (DBT=42%; GPM=60%)

Receiving Disability Benefits
- Pre treatment: 40%
- 36 months: 39% (DBT=29%; GPM=47%)
Implications of Our Findings

• Our findings provide additional compelling evidence for the effectiveness of DBT
• DBT and GPM were associated with effects on a broad range of outcomes.
• The treatment effects are durable (at 2 years postdischarge)
• There is no evidence to suggest that DBT is superior to a rigorous active comparator
Effectiveness of Psychotherapy
Cochrane Database: Stoffers et al., 2012

• A range of disorder specific treatments are effective (DBT, MBT, SFT, TFP, GPM, DDP, CAT)
• DBT supported by the most robust evidence
• Specific treatments are more effective than non-specialized treatments
• Non specific treatments showed no significant benefits
• Appropriate length: 12-18 months
Evidence Base of DBT for BPD

- DBT for BPD has been evaluated in 13 randomized trials
- DBT has been evaluated independently of the treatment developer in RCT’s conducted across 9 sites in 6 countries
- DBT has been evaluated in a large study of large sample, with long term follow-up and with a balance of allegiance to type of treatment (McMain et al., 2009; 2012)
- DBT has been evaluated against meaningful comparison groups and the evidence for the superiority of DBT is mixed (Clarkin et al., 2004; Linehan et al., 2006; McMain et al., 2009; 2012)
DBT Is Effective Across A Broad Range of Outcomes

- Suicidal attempts
- Non suicidal self-harm
- Psychiatric hospital days/admissions
- Anger
- Impulsivity
- Substance Use
- Depression
- Interpersonal problems
- Social adjustment
- PTSD Symptoms
- Dissociation
- General psychopathology
- Anxiety
DBT for BPD has a Robust Evidence Base

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Access to specialized treatments such as DBT remains too limited given the demand for these services.
Possible Solutions

• Invest in further development of specialized services for BPD by increasing training more health care providers to deliver DBT
• Ensure that all health providers are knowledgeable in principles and practice of BPD-informed care
• Improve efficiencies in the delivery of specialized treatments such as DBT
Brief Treatment Models
<table>
<thead>
<tr>
<th>Treatment</th>
<th>Length</th>
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<tbody>
<tr>
<td>Blum et al. 2008</td>
<td>STEPPS</td>
</tr>
<tr>
<td>Farrell et al. 2009</td>
<td>Group schema therapy + Individual</td>
</tr>
<tr>
<td>Soler et al., 2009</td>
<td>DBT skills</td>
</tr>
<tr>
<td>Bos et al., 2010</td>
<td>STEPPS + Individual</td>
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Recently Completed RCT to Evaluate the Effectiveness of DBT Skills (McMain, Guimond, & Streiner)

**Patients:** BPD + Suicidal/Self harm (n=84)

**Interventions:** DBT skills (20 weeks) vs. Wait list (both groups: unrestricted treatment as usual)

**Outcomes:** Suicide/self harm, impulsivity, anger, health care utilization, symptom distress, distress tolerance, mindfulness, emotion regulation

**Duration:** 20 weeks + 3 month follow-up
Summary of Findings

Between group differences favoring DBT:
- Frequency of suicidal and non suicidal self harm
- Anger
- BPD symptoms (at post treatment only)
- Depression (at post treatment only)
- Mindfulness
- Emotion Regulation
- Distress Tolerance

Within group differences:
- DBT group showed significant improvement on impulsivity
Comparison of Outcomes Following DBT Skills vs Standard DBT

<table>
<thead>
<tr>
<th>Outcome</th>
<th>DBT skills only</th>
<th>Standard 1 year DBT</th>
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<tr>
<td></td>
<td>Baseline</td>
<td>20 wks</td>
</tr>
<tr>
<td>Suicide and self-harm†</td>
<td>14.74</td>
<td>(22.24)</td>
</tr>
<tr>
<td>SCL - GSI</td>
<td>1.91</td>
<td>(.61)</td>
</tr>
<tr>
<td>Expressed Anger</td>
<td>37.98</td>
<td>(9.94)</td>
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<tr>
<td>Depression (BDI)</td>
<td>32.41</td>
<td>(10.64)</td>
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†These scores were scaled by the estimated overdispersion stemming from observational heterogeneity
Clinical Implications

- DBT skills training showed an ability to achieve behavioural control and improvements in effective coping skills among chronically self harming individuals with BPD.
- BPD patients show meaningful benefits from this brief intervention and treatment gains were sustained postdischarge.
- There was no evidence that the effectiveness of this intervention for high risk suicidal and self harming patients was associated with increased risk or emotional suffering.
Thank you!