

An overview of recent adaptations to Dialectical Behaviour Therapy

Georgina Knott, Christy Pitfield & Thomas Richardson

Dialectical Behaviour Therapy (DBT) is a treatment model, developed by Marsha Linehan, incorporating Cognitive Behavioural Therapy (CBT), assertiveness training and Eastern meditative practices (Linehan, 1993). Originally formulated to reduce suicidality and deliberate self-harming behaviour in those diagnosed with Borderline Personality Disorder (BPD), it became the first empirically supported treatment for this complex clinical population (Linehan et al., 1991). Since first conceptualised, this treatment model has been adopted and adapted across diverse settings and populations. This article evolved from a need to evaluate the evidence base in order to ensure that the authors were promoting evidence-based practice within their clinical practice at an adult acute inpatient unit. Specifically, it was aimed to assist with reviewing the content of a current transdiagnostic ward-based 'Living Skills' group that was incorporating elements of the original DBT model.

An introduction to Dialectical Behavioural Therapy

THE DEVELOPMENT OF DBT stemmed from Linehan's recognition that traditional CBT approaches were not sufficiently addressing the emotional instability underpinning BPD. Linehan (1993) opined that a treatment which fundamentally focused on change left patients feeling invalidated and disparaged and increased the likelihood of them disengaging from therapy. Therefore, the principle dialectic in DBT involves therapists balancing the act of validating and accepting a client as they present, whilst simultaneously assisting them to recognise and change their maladaptive behaviours (Dimeff & Linehan, 2001). A substantial evidence base has emerged to suggest that the model is superior to CBT and consequently is considered the treatment of choice for adults with BPD (National Institute of Clinical Excellence, 2009).

The fundamental methodology of DBT is targeting key difficulties associated with BPD such as emotional instability, impulsivity, interpersonal difficulties and identity disturbance. DBT is offered by a team of mental health professionals, ideally with experience

of CBT, who have completed an accredited two-week intensive training programme. It follows a highly structured protocol, prioritising problems impacting on a client's safety and quality of life, as well as working on 'therapy interfering behaviours' such as cancelling sessions (Linehan, 1993). DBT uses four different modes of treatment; group skills training, individual psychotherapy, telephone coaching and therapist consultation meetings. Group skills training consists of four taught modules of mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness. Weekly individual psychotherapy allows the monitoring of targeted behaviours to be reviewed. It also provides a forum for 'chain analyses' to be constructed which outline the sequence of events leading up to a target behaviour and the generation of solutions for similar situations that could be utilised in the future. Telephone coaching is used to assist clients in the use of these skills outside of therapy and group settings.

The desire to innovate the DBT model has resulted from the needs of clients, thera-

pists and services that may be incompatible with the traditional protocol (Koerner, Dimeff & Swenson, 2007). In some settings, group skills training programmes are prioritised over weekly individual psychotherapy, in what is perceived to be the most cost effective solution (Robins & Chapman, 2004). In an acute psychiatric hospital, where the length of stay is usually brief, it is not possible to teach all the DBT skills. Consequently, modules may be shortened or removed according to identified goals (Kroger et al., 2013). McQuillan et al. (2005) developed a shortened intensive DBT package for patients with BPD, conducting sessions for four hours a day for four days. This was found to reduce depression, hopelessness and hospitalisation, however, suicidal behaviours were not measured and there was no control group.

Adapting DBT to other client groups

It has been noted that chronic difficulties with emotional regulation and impulse control are not exclusive to BPD (Linehan et al., 1999). Therefore, attention has been given to adapting developments of DBT to other client groups. The areas below focus on research with adults. For a recent review on DBT adapted for adolescents please refer to Groves et al. (2012).

Eating disorders

It has been suggested that food restriction and bingeing may be a dysfunctional attempt to regulate emotions (Linehan & Chen, 2005; McCabe, LaVia & Marcus, 2004). Since binge eating can fulfill one of the diagnostic criteria for BPD and is associated with emotional dysregulation, it was suggested that some elements from DBT may be effective with this client group (Bankoff et al., 2012).

Telch, Agras and Linehan (2000) conducted a DBT-based skills group for 11 women with Binge Eating Disorder (BED), finding that 82 per cent ceased binge eating six months post-therapy. There were also improvements in mood regulation and

emotional eating. A later Randomised Controlled Trial (RCT) (Telch, Agras & Linehan, 2001), with 18 women in the DBT group found 89 per cent had stopped binge eating compared to 12.5 per cent of the control group at the end of treatment, though this reduced to 56 per cent at the six-month follow-up. DBT also led to a reduction in urges to eat when angry, though there was no difference compared to the control group for weight loss, depression or anxiety. Safer and Jo (2010) conducted an RCT with 101 men and women with BED. This compared DBT to an active control to see whether skills training was beneficial over non-specific therapeutic factors. This found significantly greater reductions in binge frequency and abstinence in the DBT based treatment group which was maintained at 12-month follow-up. However, there was no difference between groups in emotion regulation.

Eating disorders and co-morbid substance use

There is an increasing recognition of a high level of co-morbidity between eating disorders and substance misuse (Wolfe & Maisto, 2000). It has been suggested that a desire for emotional reward and poor impulse control may underlie both eating disorders and substance use (Dawe & Loxton, 2004; Stewart et al., 2006;).

Courbasson, Nishikawa and Dixon (2012) conducted a RCT with 25 female outpatients with an eating disorder and substance use disorder. The DBT was largely similar to the original model, but included elements of DBT adapted for those with BPD and substance use (Linehan & Dimeff, 1997). Courbasson et al. (2012) also added motivational interviewing and relapse prevention techniques. Reductions were found in mood dysregulation, binge eating frequency, concerns about weight and substance use frequency. However, due to small sample size this could not be compared to a control group. Interestingly, an increase in the participants' perceived

ability to cope with negative emotional states was associated with a decrease in emotional eating and greater confidence in resisting urges to misuse substances.

Forensic inpatients

McCann, Ball and Ivanoff (2000) proposed various arguments for the application of DBT in a forensic inpatient setting. These included the importance of managing aggressive and life threatening behaviour to maintain a safe environment for staff and patients as well as the recognition that there is a high proportion of personality disorders including BPD, Narcissistic and most notably Antisocial Personality Disorder (APD) within this population (Berzin & Trestman, 2004). McCann et al. (2000) suggest that whilst those with BPD suffer from emotional dysregulation, those with APD are insensitive to emotions and unempathic (McCann et al., 2000).

McCann et al. (2007) adapted DBT for APD on this basis. This includes the four standard DBT modules, but significant changes have been made to the emotion regulation module, namely trying to increase emotional attachment to others through the development of empathy, understanding the consequences of ones actions on others and practising altruistic acts of kindness. A 'graduate group' for successful completers supported clients to develop a chain analysis of their crimes before working on a relapse prevention plan incorporating specific DBT skills. McCann et al. (2007) compared the effects of this programme with Treatment as Usual (TAU) with DBT and reported improvements in depression, paranoia, hostile behaviour and interpersonal coping styles amongst those completing the intervention as well as reduced staff burn-out (McCann et al., 2007). The authors suggest this adapted DBT could reduce violence and subsequent re-offending, but no research has yet confirmed this.

Whilst McCann et al. (2007) support the use of adapted group skills training along-

side other modes of DBT, Gordon and Hover (1998) reported a decrease in impulsivity in sex offenders who had only attended DBT-based group skills and did not have individual sessions or telephone coaching. This conflicts with Linehan's assertion that skills group training without the other modes of DBT does not have a significant impact (Linehan, 1993).

Depression

Almost all adapted DBT has been with patients experiencing emotion dysregulation or impulse control (Robins & Chapman, 2004), in contrast to the restricted behaviour and decreased emotional experience characteristic of depression. However, Lynch (2000) states that by adapting the focus of DBT to behaviours related to the rigid, maladaptive coping styles involved in the maintenance of depression it can become an appropriate treatment model to this client group.

Feldman et al. (2009) compared the effectiveness of DBT to a waiting list control group in 24 participants with treatment resistant depression. The original four modules were used but were shortened, with a greater emphasis on mindfulness and acceptance. Reduced symptoms of depression were only noted in the DBT group, however both groups experienced an increase in emotional processing.

It has been suggested that skills-based learning may allow individuals to learn how to relate to their negative emotions differently so that they experience less distress, whereas exposure without these emotion regulation skills may increase the symptoms of depression (Feldman et al., 2009). Feldman et al. (2009) consider whether mindfulness practice helps prevent people with depression from feeling overwhelmed by negative feelings by reducing rumination.

Depression in older adults

Lynch Morse, Mendelson and Robins (2003) randomly assigned 34 chronically depressed participants over the age of 60 to either

receive 28 weeks of antidepressant medication without any psychological support or to receive the course of medication alongside attending DBT-based treatment. The adapted DBT consisted of a weekly two-hour skills training group involving aspects of the four standard modules presented twice on a 14-week sequence. It also included a weekly 30-minute telephone call with a trained therapist to review diary cards and discuss problem solving strategies. Providing scheduled telephone therapy had the advantages of not needing transport, which can be difficult for physically frail older adults with a consequent cost reduction. Post-treatment, 71 per cent of participants receiving DBT-based treatment were in remission, compared to 47 per cent of control participants. Six months later this had increased to 75 per cent versus 31 per cent. It appears that participants in the DBT augmented condition not only learnt skills that benefited them after treatment had ended, but that they also protected them against relapse. Additionally DBT led to an increase in adaptive coping styles, and a non-significant trend in reduced hopelessness.

Lynch and Cheavens (2007) similarly reported that standard DBT was effective in reducing depressive symptoms in adults over the age of 55 years with a diagnosis of both depression and a personality disorder. There has been increasing research to suggest that intense emotional dysregulation is less of a problem amongst older adults (McConatha & Huba 1999; Morse & Lynch, 2004). Consequently, Lynch et al. (2007) modified the standard DBT model with an emphasis on teaching skills relating to cognitive and behavioural flexibility. The mindfulness module is substantially changed, incorporating the concept of 'fluid', 'fixed' and 'fresh' states of mind, which assist older adults to develop a synthesis between what they know to be true based on past experiences with current information. A fifth module called radical openness was created to tackle rigidity, increase willingness towards novel experiences, reduce bitterness

and enhance compassion to self and others. An RCT has not yet been conducted on this, though a case study of its application has been published (Lynch & Cheavens, 2008).

Conclusions and future directions

There is an ongoing dialectic in the practice of DBT; namely an ethical concern that if clinicians fail to adhere to the standardised DBT approach, treatment may be less effective or even harmful. However, there is a need to balance this with innovation to promote new ways of working and generate practice-based evidence (Koerner et al., 2007). The studies reviewed suggest that there is benefit to developing adaptations of DBT according to patient needs and settings, particularly when difficulties are related to emotional dysregulation. It appears that the most common adaptations involve modifying the skills group both in terms of its duration and content. Many retain the four original modules, but some amend the sessions on emotion regulation to fit the patient group (McCann et al., 2000) or emphasise the mindfulness module (Feldman et al., 2009; Lynch et al., 2007; McQuillan et al., 2005,). Other clinicians have created additional modules relevant to specific difficulties (Berzins & Trestman, 2004; Lynch et al., 2007; McCann et al., 2000). As well as the improvements in symptoms described previously, a distinct advantage of DBT appears to be the low number of dropouts (Kroger et al., 2013; Telch et al., 2000). This may be the result of the specific focus on addressing behaviours that interfere with therapy, such as non-attendance.

There continues to be a need to build on the existing evidence base before firm conclusions can be reached in terms of the efficacy for adaptations of DBT. Studies to date have tended to be preliminary, with small, gender biased sample sizes and relatively short follow-up periods. Additionally, the effectiveness of adapted DBT in comparison to other therapies is less clear. Future research may help to identify more precisely the key ingredients for successful treatment

and predict the type of patient who will benefit from DBT-based treatment (Robins & Chapman, 2004).

Whilst research in the field of adapting DBT is still in its infancy, continued effort is placed in replicating these initial findings and expanding its use with other populations experiencing some emotional dysregulation. For example, adapted DBT with adults with Attention Deficit Hyperactivity Disorder (Hesslinger et al., 2012) and trichotillomania (Keuthen et al., 2012) have shown encouraging results. There have also been studies suggesting benefits of group skills training for carers (Drossel, Fisher & Mercer, 2011; Supulveda et al., 2008). Furthermore, evaluating the use of modern technology such as Skype for skills-based learning or using smartphone apps for diary cards will no doubt allow DBT-based treatment to reach a wider audience (Matta, 2012). Overall, it is hoped that ongoing studies will help demonstrate how adapted DBT may be beneficial for a range of problems outside of the BPD populations for which it was originally developed.

The Authors

Georgina Knott

Trainee Clinical Psychologist,
Professional Training Unit,
School of Psychology,
University of Southampton.

Christy Pitfield

Assistant Psychologist,
Antelope House, Brintons Terrace,
Southern Health NHS Trust,
Southampton.

Thomas Richardson

Clinical Psychologist,
Mental Health Recovery Team South,
St. Mary's Community Health Campus,
Solent NHS Trust,
Portsmouth.

Correspondence

Georgina Knott

Professional Training Unit,
School of Psychology,
University of Southampton.
Email: gik2u11@soton.ac.uk



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