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Dialectical behaviour therapy for men and boys: A systematic review

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Abstract

Background: Dialectical behaviour therapy (DBT) is a popular treatment that targets emotional dysregulation, a key feature associated with borderline personality disorder (BPD). The majority of available literature exploring the effectiveness of DBT is based on research concerning female samples. Therefore, the application and efficacy of DBT as a treatment intervention for men and boys remains unclear.

Methods: Multiple research databases were searched using a systematic review process for articles that reported on the use of DBT with male samples across any outcome measure and included pre- and post-treatment symptom scores.

Results: Nineteen studies met the inclusion criteria. Studies indicated that the application of DBT to male samples varies. Vast differences were found in treatment length, use of DBT modes and population settings. Most studies identified some benefits of DBT; however, the sample sizes were small and there was large heterogeneity across the studies.

Conclusions: There is preliminary evidence supporting the use of DBT for males, specifically targeting anger and violence as well as emotional dysregulation and suicidality. Despite this, the limitations and heterogeneity from the current studies preclude the current review from drawing any definitive conclusions about the overall efficacy of the treatment in this population.

KEYWORDS
boys, DBT, dialectical behaviour therapy, men

1 | INTRODUCTION

Dialectical behaviour therapy (DBT) is a comprehensive cognitive behavioural therapy developed by Marsha Linehan (1993), initially for the treatment of problems associated with borderline personality disorder (BPD), a presentation characterised by difficulty regulating emotions, thoughts, behaviours and relationships (The National Health Service [NHS], 2019). DBT treatment comprises four 'modes': weekly individual therapy, group skills training, telephone coaching and therapist case consultation (Linehan, 1993). In a recent review, Panos et al. (2014) found that DBT was more efficacious than treatment as usual in reducing suicidal and parasuicidal behaviour, as well as reducing attrition during treatment. However, in this review, only one study included men, making the total sample only 2% men. This is common within the evidence base, with the Cochrane review (Stoffers et al., 2012) of psychotherapy for BPD only having 11% of 1804 participants being men. Furthermore, no single study included in either review had a balance of genders.

DBT is based on biosocial theory (Linehan, 1993), which states that biological differences combined with childhood dysfunctional (invalidating) environments, as well as their interaction and transaction over time, create a dysfunction of the emotion regulation system. This emotional dysregulation is a combination of 'emotional intensity', which means that emotional reactions are extreme and intense, and 'slow return to emotional baseline', which means that these reactions are long-lasting (Linehan, 1993). Difficulties in behaviours (such as suicidal behaviour and aggression) are therefore sequelae of the fundamental problem of emotional dysregulation; these behaviours serve the function of attempting to regulate intense and long-lasting emotions (Linehan, 1993). However, some of these behaviours, although adaptive in the short term, can become maladaptive over time and cause difficulties with achieving goals and maintaining relationships.

Although DBT's stated focus was initially towards self-harming and suicidal behaviours, it was also recognised from the conception that the treatment could also be helpful more generally for difficulties associated with emotional, cognitive and behavioural dysregulation (Linehan, 1993). Adaptations have been made for disorder-specific difficulties, including post-traumatic stress disorder (Bohus et al., 2013), drug dependence and substance use (Courbasson et al., 2012), binge eating disorder (Telch et al., 2001) and other populations, including psychiatric inpatients (Bloom et al., 2012) and those with intellectual disabilities (McNair et al., 2017). Broadly, these have demonstrated efficacy; however, still a significant number of studies to date are including only all-female or unbalanced gender populations, often without reporting the results for men and boys separately.

Implications for practice and policy

- Dialectical behaviour therapy (DBT) is now a widely used therapy in current clinical practice. This systematic review finds preliminary evidence supporting the use of DBT with men and boys for difficulties with anger and violence as well as emotional dysregulation; however, the current evidence has proven to be sparse, limiting definitive conclusions about the efficacy of the therapy for this population.

2 | GENDERED DIFFERENCES IN DIAGNOSIS AND THERAPY

Historically, BPD was thought to have been a disorder more prevalent in women than in men, with a ratio of around 3:1 (DSM IV-TR; American Psychiatric Association, 2000). However, this assumption is changing, with large epidemiologic surveys uncovering that the disorder is equally prevalent across the sexes (Grant et al., 2008). One possible reason for this historically assumed difference could be a 'sampling bias' (Bjorklund, 2006), specifically that women may be more likely to self-direct, or internalise, their behavioural (and maladaptive) coping strategies, resulting in such behaviours as self-harming, whereas men are more likely to externalise their behaviour and so engage in more criminal or substance abuse behaviours (Sansone & Sansone, 2011) in an attempt to cope. As such, women become overrepresented in psychiatric care and men in the criminal justice system; therefore, males become overlooked in psychiatric research. Other research on gender differences in BPD seemed to validate this argument. Zlotnick et al. (2002) found that although overall clinical distress remained comparable between the sexes, men were more likely to experience substance use, antisocial features and explosive temperament, whereas women were more likely to experience more eating disorders. Interestingly, attempting suicide or self-harm seems to be equivocal among men and women with BPD (Sansone et al., 2010).

Bjorklund (2006) proposes that, to varying degrees, sociocultural factors play a role in the expression of both BPD symptomology and clinicians' perceptions of patients exhibiting emotional dysregulation and impulsive behaviour. Seager and Barry (2019) propose the 'Gamma Bias', which is a tendency to magnify some gender differences whilst minimising others. For example, if a man does harm to someone, the male characteristic may be magnified and then the man or boy could be labelled criminal or 'toxically masculine', whereas if a woman performed the same action, the male elements are underemphasised and so she might have her behaviour described as due to trauma or deprivation. This may explain why more males receive a diagnosis of antisocial personality disorder (APD), whereas women are more likely to receive a diagnosis of BPD, even when symptomology is equitable (Bowen & John, 2001).

However, these differences in coping behaviour could be, in part, a demonstration of how men and women are socialised differently, including early aversive experiences. There is evidence that men, because of their gender, experience disproportionate rates of physical violence in childhood, academic difficulties, mental health problems, interpersonal violence, substance misuse and homelessness (American Psychological Association, Boys and Men Guidelines Group, 2018), whereas women experience disproportionally higher rates of childhood sexual abuse (American Psychological Association, Boys and Men Guidelines Group, 2018). These differences may explain variation in clinical presentation, as well as the tendency to either externalise or internalise self-injurious behaviour (Linehan, 1993).

It is also important to state that biological differences occur between the sexes, which may have an impact on psychological differences, including temperament and physicality (Barry & Owens, 2019; Sell et al., 2012). Both these factors could be implicated in men's predisposition for violence, such as having greater tolerance of danger (Liddon & Barry, 2021).

Despite arguments on a binary gender axis between men and women, it is also important to consider that men and boys are a heterogeneous group with intersecting identities, constructed through

social, cultural and contextual norms as well as biological differences (American Psychological Association, Boys and Men Guidelines Group, 2018). Men and boys could be seen to have different needs based on their biology as well as societal norms that become internalised and govern their behaviour, including how others in society treat them differently. Ultimately, their experience of psychological distress and treatment engagement may not be equitable to women, and this is reflected in recent guidelines for specifically engaging males in psychological therapy (The British Psychological Society [BPS], 2022). The culmination of men's and boys' socialisation, as well as biology, have also been seen to influence both their help-seeking behaviour and their engagement in psychological treatment. Some men have commented on the need to reduce the stigma that receiving treatment is 'unmanly' (Staiger et al., 2020).

Previous research has suggested that men's help-seeking behaviour regarding psychological treatment is attributed to traditional masculine norms, such as being strong, reliant, in control and capable, along with an emphasis on avoiding emotions (Emslie et al., 2006). For instance, Seager et al. (2014) proposed the notion of gender-specific schema, or a 'male gender script', and commented on the positive connotations, such as 'being a fighter or winner' and 'being a provider and protector'.

However, this script also highlighted an increased potential for criminality and risk-taking behaviour. Furthermore, it can be argued that having psychological difficulties is 'incompatible' with traditional masculinity due to emotional experiences being perceived as feminine (Emslie et al., 2006). Even though traditional masculine norms play an important role in reinforcing men's reluctance to seek help, qualitative studies suggested that some men benefitted from perceiving these ideals as a healthy resource (Skärsäter et al., 2003) and acted as a positive motivator for the male patient; for example, the belief that you can be a better provider for your family if you have some sessions of therapy (Liddon & Barry, 2021).

3 | CURRENT REVIEW

Men and boys are not generally excluded from DBT treatment due to their gender in current NHS services, despite DBT currently only being clinically recommended for women with BPD and self-injurious behaviour (National Institute for Health and Care Excellence, 2019). Large epidemiological studies, such as by Grant et al. (2008), have demonstrated that BPD is as prevalent in men and women. Furthermore, the levels of clinical distress remain equitable across the sexes (Zlotnick et al., 2002). Also, it is evident that men and boys are being included in studies, albeit in a small percentage; however, the results are not being reported separately; therefore, it is unknown whether the efficacy of the treatment is being potentially masked by the scores in women and girls. It is proposed that due to a female-dominated evidence base and known differences in presentation between the sexes in emotional dysregulation and behavioural sequelae, a review focussing explicitly on the efficacy of DBT for men and boys is required.

To date, there has been no systematic review of the evidence regarding the effectiveness of DBT for men and boys. Given that a significant number of men and boys may be being referred to, attending and completing DBT treatment each year, it seems of the utmost importance to establish the efficacy of the current evidence base.

This review aims to include both men and boys within its search. Socialisation to the male gender role has been suggested to begin from birth and will continue for the man's life (Bem, 1993). Research suggests that by 6 months, a baby can distinguish between male and female voices and, by 18–24 months, male and female faces (Martin & Ruble, 2010). A boy's concept of his own gender will then continue to develop through his biology as well as the environment he is exposed to, with strong gender preferences developing by infancy (Liddon & Barry, 2021). As such, limiting this review's scope to those aged 18 or older seems to unnecessarily restrict the participant pool. Instead, this review will aim to capture those who identify as male who are participating in DBT across the lifespan. However, this inclusion could potentially expose the review to increased heterogeneity of participants, which includes not only age but also the reality of the different contexts in which boys and men live their lives.

The current review aims to answer the following question: Is DBT an effective treatment for men and boys?

4 | METHODS

4.1 | Search strategy

The conduct and reporting of this review adhere to the general principles recommended by the Centre for Reviews and Dissemination (Akers et al., 2009). After several scoping searches, five bibliographic databases (Web of Science, PsychINFO, MEDLINE, Psych Articles and CINAHL Plus) were searched for relevant and unpublished literature from their inception until November 2021.

Searches were devised in collaboration with an academic librarian and contained no disorder-specific keywords that would limit results to specific study designs or diagnostic groups. MeSH subject headings were trialled in the search strategy; however, this made no change to the papers retrieved and so was not included in the final searches. Appendix 1 details the search syntax used for each database. The authors' own files were examined for any additional relevant literature as well as searching the reference lists included in the full text of relevant studies.

4.2 | Inclusion and exclusion criteria

The relevance of each study was assessed according to the Participants, Intervention, Comparators and Outcomes (PICO) checklist (Yensen, 2013) inclusion criteria stated in Table 1. The first reviewer screened all titles and abstracts, with a second reviewer independently screening 10% of the total papers. The second reviewer also screened 10% of the data extracted from the included

TABLE 1 PICO inclusion criteria.

Population	Men and boys
Intervention	Dialectical behaviour therapy including at least one mode of full standard DBT
Comparator	The stated intervention to either TAU or other therapeutic intervention or no intervention
Outcome	Validated or idiosyncratic measure which aims to capture treatment outcomes
Study design	Exclude single-case designs
Setting	All clinical settings including child and adolescent and adult services
	Outpatient/inpatient settings including forensic services

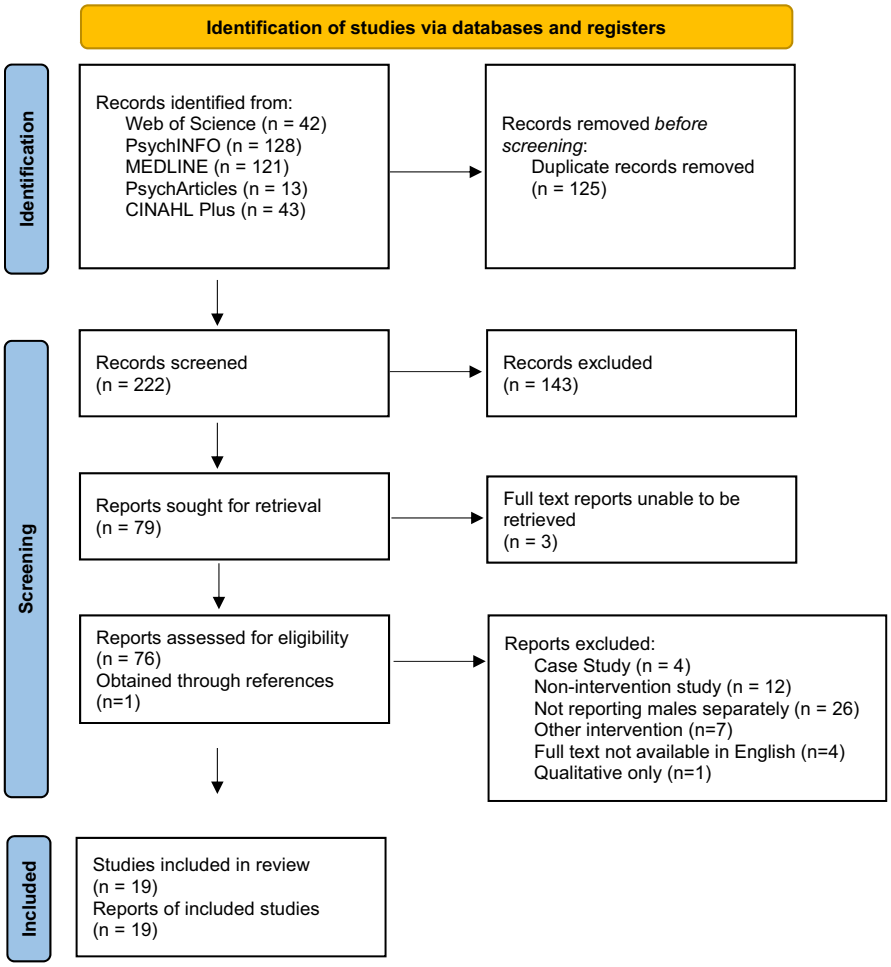

FIGURE 1 PRISMA flow diagram.

studies. Any discrepancies were resolved by consensus. Studies that did not meet the criteria were excluded.

5 | RESULTS

5.1 | Quantity of available research

A flow diagram for the screening process reported as per Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; Shamseer et al., 2015) guidelines is displayed in Figure 1. A total of 19 studies were available that met the inclusion criteria.

5.2 | Population

Three of the studies involved outpatient adolescents with forensic risk (Agnew, 2013; Anestis et al., 2020; Apsche et al., 2006). Two of the studies involved adolescents in secure settings (McCredie et al., 2017; Shelton et al., 2011). Three of the studies involved adults in prison settings (Asmand et al., 2015; Moore et al., 2018; Shelton et al., 2009). Four of the studies involved forensic psychiatric inpatient adults (Bianchini et al., 2019; Evershed et al., 2003; Rice, 2016; Servos, 2009). One study included ADHD adults in compulsory care for substance use disorder (Bihlar et al., 2016). One included

forensic adult outpatients (Wetterborg et al., 2020). One included people with intellectual disabilities in a secure setting (Evershed et al., 2003). One included substance use outpatients (Rezaie et al., 2021). Two included adult psychiatric inpatients (Rice, 2016; Spitzer et al., 2019). One included Website visitors to a suicide prevention Website (Whiteside et al., 2019).

5.3 | Quality and methodological assessment

The JBI critical appraisal tool (Quasi-Experimental Studies; Tufanaru et al., 2017) was used to assess the quality of the included studies in the review. Overall, the methodological quality of the studies was poor. Only 10 of the 19 studies included some form of control group. Furthermore, only six of these adequately described conditions similar for the intervention group and the control group. Most of the included studies adequately described multiple measurements of outcome, namely pre and post. Only four of the 19 studies adequately described performing follow-up outcome measurements. For full quality appraisal, see Table 2.

5.4 | Data synthesis

A meta-analysis was not performed due to poor research quality, heterogeneity in study design and outcomes used. Instead, a narrative synthesis was conducted to synthesise and explore the relationships textually (Popay et al., 2006). Three elements were combined to achieve the narrative synthesis in this review. First, a preliminary synthesis was developed by organising the effects of the included studies, which were then tabulated to enable a clearer visual of the included studies (see Table 3). The data were then explored for relationships between the studies, and both the characteristics and findings of the different studies were included and represented thematically to best present the included data to fulfil the review's aims. Finally, the robustness of the synthesis was assessed considering the quality assessment.

5.5 | DBT interventions

The treatments described in the articles vary considerably. However, all the articles included used DBT as a guiding framework and most reported to use at least one of the modes of full-package DBT. Although DBT was initially validated as full outpatient treatment including all four modes, from its inception it was recognised that modes could be condensed or supplemented (Linehan, 1993) and, as such, implementation differs across settings. The methodological quality of the included studies also varied widely, with DBT implementation being poorly described in many of the reports. DBT treatments ranged in length from 6 to 78 weeks, with a mean duration of 28.1 weeks ($SD = 23.7$). One notable exception was Whiteside et al. (2019), in which Website visitors, on average, stayed for 1 min and 31 s.

5.6 | Gender differences

Two studies directly compared a male treatment group with a female treatment group. One study found that very limited differences were observed between the groups apart from generally lower effect sizes across all measures for men (Spitzer et al., 2019). One study suggested that aggression reduced for men because of DBT treatment but not for women, whereas depression symptoms reduced for women but not for men (McCredie et al., 2017).

5.7 | Treatment modes

5.7.1 | Individual therapy

Standard outpatient DBT includes weekly individual therapy sessions, which generally range from 50 to 60 min (Linehan, 1993). Of the 19 studies, 11 utilised individual therapy sessions in their specified treatment. Sessions ranged from 30 min per week (Shelton et al., 2009) to 90 min (Rezaie et al., 2021), though the majority were of standard treatment protocol of 60 min (Apsche et al., 2006; Asmand et al., 2015; Bianchini et al., 2019; Evershed et al., 2003; McCredie et al., 2017; Morrissey & Ingamells, 2011; Servos, 2009; Spitzer et al., 2019; Wetterborg et al., 2020).

5.7.2 | Group skills training

Standard DBT includes a weekly structured skills training group for around 2 h. The core components covered in the skills training are mindfulness, distress tolerance, emotional regulation and interpersonal effectiveness (Linehan, 1993). Thirteen of the studies included a skills training group in their treatment protocol. Of those, seven exclusively used skills groups as their sole treatment format (Agnew, 2013; Anestis et al., 2020; Bihlar et al., 2016; DiSciullo, 2021; Moore et al., 2018; Rice, 2016; Shelton et al., 2011). The frequency of the groups ranged from 1 h a week (Moore et al., 2018) to 4 h a week split into two skills groups (Bihlar et al., 2016; DiSciullo, 2021; McCredie et al., 2017); however, the majority completed 2 h a week (Anestis et al., 2020; Bianchini et al., 2019; Evershed et al., 2003; Servos, 2009; Shelton et al., 2009, 2011; Spitzer et al., 2019; Wetterborg et al., 2020). Three studies did not adequately describe the frequency of treatment in their reports beyond stating that sessions occurred weekly (Agnew, 2013; Apsche et al., 2006; Morrissey & Ingamells, 2011). One study did not adequately describe the frequency of groups at all (Rice, 2016).

5.7.3 | Telephone coaching

In standard DBT, therapists are made available to clients for in vivo skills coaching outside the sessions (Linehan, 1993). This is generally used in times of crisis to promote adaptive skills use and

TABLE 2 Quality assessment.

Author (s)	Is it clear in the study what is the 'cause' and what is the 'effect'?	Were the participants included in any comparisons similar?	Were the participants included in any comparisons receiving similar treatment/ care, other than the intervention of interest?	Was there a control group?	Were there multiple measurements of the outcome both pre and post the intervention?	Was follow-up complete?	Were the outcomes of participants included in any comparisons measured in the same way?	Were outcomes measured in a reliable way?	Was appropriate statistical analysis used?
Agnew (2013)	Y	Y	N/A	N	Y	N	N/A	Y	Y
Anestis et al. (2020)	Y	N	N	Y	Y	N	Y	Y	Y
Apsche et al. (2006)	Y	Y	N/A	N	Y	N	N/A	Y	N
Asmand et al. (2015)	N	Y	N	Y	Y	N	Y	N	N
Bianchini et al. (2019)	Y	Y	Y	Y	Y	N	Y	Y	Y
Bihlar et al. (2016)	Y	Y	N/A	N	Y	N	N/A	Y	Y
DiSciullo (2021)	Y	Y	Y	Y	Y	N	Y	Y	N
Evershed et al. (2003)	Y	N	N	Y	Y	Y	Y	Y	Y
Moore et al. (2018)	Y	Y	N/A	N	Y	N	N/A	Y	Y
McCredie et al. (2017)	Y	N	N/A	N	Y	N	N/A	Y	Y
Morrissey and Ingamells (2011)	Y	N	N/A	N	Y	N	N/A	N	N
Rezaie et al. (2021)	Y	Y	Y	Y	Y	Y	Y	Y	Y
Rice (2016)	Y	N	N	Y	Y	N	Y	Y	Y
Servos (2009)	Y	Y	Y	Y	Y	N	Y	Y	N
Shelton et al. (2011)	Y	Y	N/A	N	Y	N	N/A	Y	Y
Shelton et al. (2009)	Y	Y	Y	Y	Y	Y	Y	Y	Y
Spitzer et al. (2019)	Y	Y	Y	Y	Y	N	Y	Y	Y
Wetterborg et al. (2020)	Y	Y	N/A	N	Y	Y	Y	Y	Y
Whiteside et al. (2019)	N	N	N/A	N	N	N	N/A	N	Y

TABLE 3 Description and results of included studies.

Authors	Sample	Country	Study setting	Population	DBT intervention	Control intervention	Outcomes	Pre-/post-DBT intervention. Within-group effect sizes (Cohen's *d**)
Agnew (2013)	54 boys *M* age = 12.09 (range: 11–14)	USA	Forensic setting	High-risk male teens	6 weeks of DBT skills group	N/A	CBCL Aggression/ depression YSR Aggression/ depression	CBCL aggression $d = 1.36$ YSR aggression $d = 0.74$ CBCL depression $d = 1.11$ YSR depression $d = 0.39$
Anestis et al. (2020)	31 DBT, 22 control *M* age = 16.71	USA	'Military style' Bootcamp	High risk male youth	12 week adapted DBT-A group whilst at a bootcamp	DBT vs. DBT + Bootcamp TAU	DERS DTS	DERS $d = 0.43$ DTS $d = 0.50$
Apsche et al. (2006)	20 boys, 10 DBT, 10 MDT *M* age =16.1	USA	Residential treatment centre	Male teens with aggression	6 months of weekly DBT skills group and individual DBT therapy	DBT vs MDT	BDI-II SIQ Observed aggression	BDI-II $d = 1.45$ SIQ $d = 1.66$ Physical aggression = significant reduction
Asmand et al. (2015)	64 men, DBT & REBT 16 per group, 32 control Age range 18–40	Iran	Prison	Antisocial PD offenders	16 individual sessions of individual DBT	DBT vs REBT vs Control	BAI Jones illogical belief	BAI $d = 0.05$
Bianchini et al. (2019)	21 *M* age = 41.79 (*SD* = 8.14)	Italy	Secure hospital	Forensic psychiatric patients	12 months of individual and group DBT	DBT vs TAU	DERS TAS-20 BIS-11	BIS-11 $d = 0.76$ DERS $d = 0.84$ TAS-20 nonsignificant
Bihlar et al. (2016)	28 men *M* age = 27.5 *SD* = 8.01	Sweden	Compulsory care service	ADHD patients	DBT adapted for ADHD 6 weeks, with two group skills training	DBT only	SCL-90-R VAS (general well-being) ADHD symptoms	Self-ratings ADHD symptoms: total $d = 0.77$ ADHD symptoms: attention deficit $d = 0.29$ ADHD symptoms: impulsivity $d = 0.70$ Externalising behaviour $d = 0.87$ Psychiatric symptoms (SCL-90-R) $d = 0.54$ General well-being $d = 1.04$ Ward staff ratings ADHD symptoms: total—nonsignificant ADHD symptoms: attention deficit—nonsignificant ADHD symptoms: impulsivity: nonsignificant Externalising behaviour: nonsignificant

(Continues)

TABLE 3 (Continued)

Authors	Sample	Country	Study setting	Population	DBT intervention	Control intervention	Outcomes	Pre-/post-DBT intervention. Within-group effect sizes (Cohen's *d**)
DiSciullo (2021)	88 men 45 in START NOW *M* age =32.47 (range 22–56)	USA	Prison	Male offenders	Adapted DBT (START NOW) plus level system of increasing privilege 2 group skills training sessions per week for 3 months	START NOW plus behaviour level system vs TAU	Mental health referrals Use of force Precaution status Use of restrictive housing	Use of restricted housing $d=0.2$
Evershed et al. (2003)	8 DBT 9 TAU M age =35.75 (*SD*=9.07)	UK	High-security hospital	Male forensic patients	18 months of adapted DBT consisting of weekly individual and group sessions and ward-based coaching	DBT vs TAU	Frequency of violent behaviour Violence seriousness STAXI NAS	STAXI state $d=-0.05$ STAXI trait $d=0.28$ STAXI anger out $d=0.18$ STAXI anger in $d=0.00$ STAXI anger con $d=-0.86$ STAXI anger exp $d=0.32$ NAS cognitive $d=0.33$ NAS arousal $d=0.43$ NAS behavioural $d=0.39$ NAS provocation $d=0.17$
McCredie et al., 2017	48 (22 Male) M Age=15.2 (*SD*=1.24)	USA	Secure residential	Adolescents	12 months of individual and group DBT-A ward-based coaching	No control	YSR aggression YSR depression aggressive behaviour	Aggressive behaviour showed a significant interaction with gender, decreasing for males but not differing significantly for females
Moore et al. (2018)	16 men M Age=34.79 (*SD*=8.48)	USA	Jail	Male offenders	8 weeks skills group only	No control	WCCL PAI-BOR	DBT-WCCL—nonsignificant PAI-BOR—nonsignificant
Morrissey and Ingamells (2011)	6 DBT (no reported age)	UK	High-secure hospital	Patients with learning difficulties	18 months adapted DBT for LD. Weekly group and individual	Waitlist control	Global severity of distress (BSI) Aggressive behaviour	Global Severity of Distress Scale of the Brief Symptoms Inventory—significant but no reported statistic aggressive behaviour—no significant differences
Rezaie et al. (2021)	50 (25 MMT + DBT, 25 MMT) M age=34.05 (*SD*=5)	Iran	Outpatient	Patients with opioid dependence	16 weekly sessions of adapted DBT, 90 min each	DBT + TAU vs TAU	BDI-II ERQ DTS DDQ	ERQ $d=1.9$ DTS $d=3.91$ DDQ $d=0.84$ BDI-II $d=1.38$
Rice (2016)	15 in DBT age range=26–59	USA	Psychiatric hospital	Male patients	DBT group sessions M=23.02 *SD* 5.66	DBT vs MTREM vs art and healing group	HCR20	HCR-20r—nonsignificant
Servos (2009)	70 (35 DBT, 35 control) no age reported	USA	Psychiatric residential service	Male sex offenders	6 months of individual and group DBT	DBT vs CBT	GAF	GAF—nonsignificant

TABLE 3 (Continued)

Authors	Sample	Country	Study setting	Population	DBT intervention	Control intervention	Outcomes	Pre-/post-DBT intervention. Within-group effect sizes (Cohen's *d**)
Shelton et al. (2009)	45 males (63 total)	USA	Prison	Male offenders	16 weeks DBT-CM with 8 weeks of 30-min weekly follow-up coaching	DBT-CM + TAU vs TAU	BPAQ PANAS BPRS	Not reported
Shelton et al. (2011)	26, M Age = 17.92 (*SD* = 0.796)	USA	Prison	Male adolescent offenders	16 weeks DBT-CM group	No control	Frequency of violent behaviour WCCL BPAQ	BPAQ—significant but no reported statistic WCCL—distancing—significant but no reported statistic Disciplinary tickets—significant but no reported statistic PANAS—nonsignificant WCCL self-control nonsignificant
Spitzer et al. (2019)	79 men, 366 women, age range 18–60	Germany	Inpatient	Male patients	Average 71.6 days (*SD* 11.7) group and individual	no control DBT men vs. women	BSL BSI PHQ-D SF-12	
Wetterborg et al. (2020)	30 men	Sweden	Outpatient	BPD & ASPD with forensic history	12 months	DBT only 1-h individual a week 2.5 h group	Diary cards ASR KABOSS:BP D BDI-II	Diary cards self-harm RR = 0.30 Property offending RR = 0.17 Drug offending RR = 0.55 Violent offending RR = 0.39 Aggression *d* = 0.91 Rule-breaking aggression *d* = 0.79 Rule breaking *d* = 0.55 KABOSS: BPD *d* = 1.26 BDI-II *d* = 0.84
Whiteside et al. (2019)	514 (14% of survey sample) identified as men aged 36–64 years	USA	Online Website	Website visitors	Web-based resource for suicidal thoughts	No control	Suicidal ideation Negative ideation	For men aged 36–64, severity of suicide ideation decreased *d* = 0.08 For men aged not 36–64, severity of suicide ideation decreased *d* = 0.14 For men aged 36–64, overall negative emotion decreased *d* = 0.14

generalisation. Most of the studies did not report any use of telephone coaching in the treatment protocols. Two studies adapted telephone coaching to their inpatient settings and trained ward staff to be used for the same function (Evershed et al., 2003; McCredie et al., 2017).

5.7.4 | Therapist consultation groups

Therapist consultation groups are the final mode of standard DBT and incorporate weekly meetings of a DBT team. Three of the studies reported or adequately described therapist consultation groups in their intervention protocols. Two of these used the prescribed weekly consultation model (Evershed et al., 2003; McCredie et al., 2017), whereas one used a frequency of 4–6 weeks (Morrissey & Ingamells, 2011).

5.8 | Treatment outcomes

Across 19 studies, DBT improved symptoms in 17, with only two studies reporting no significant difference across any included measure. The methodological quality of many of the papers had a bearing on the reporting of treatment outcomes in this review. Only six of the included 19 studies adequately described a control group with a similar population to that of the intervention group (Bianchini et al., 2019; DiSciullo, 2021; Servos, 2009; Shelton et al., 2009; Spitzer et al., 2019). As such, the treatment outcomes should be interpreted tentatively.

5.8.1 | Emotional regulation

Of the included studies, five used measures related to emotional regulation. Three studies found that difficulties with emotion regulation significantly decreased whereas the control group either did not change (Bianchini et al., 2019; Rezaie et al., 2021) or increased (Anestis et al., 2020). One study found increased adaptive emotional regulation (Spitzer et al., 2019).

5.8.2 | Anger and aggression

Five studies measured either anger or self-reported feelings of aggression. Three found significant improvements as a result of the DBT intervention (Agnew, 2013; Shelton et al., 2009; Wetterborg et al., 2020). These studies generally had better methodological quality than others, although a major limiting factor was no inclusion of control groups in their design. One study found modest improvement, with measures of anger and aggression either remaining stable or improving because of treatment; however, they also found that the control group significantly deteriorated (Evershed et al., 2003). One study compared measures of aggression against a female cohort and found that both men and women significantly improved because of treatment, although the male cohort had a smaller effect size (Spitzer et al., 2019).

5.8.3 | Violence

Seven of the included studies involved a measure of violent behaviour. Six of them included some form of observation record of the violent behaviour. Only three of the studies saw a significant reduction in violent behaviour (Apsche et al., 2006; Evershed et al., 2003; Wetterborg et al., 2020). Despite this, when DBT was compared with a control group, it was found that the reduction was only for seriousness rather than frequency (Evershed et al., 2003). One study found that when comparing genders, violent behaviour reduced for males but not for females (McCredie et al., 2017). Two studies reported no significant reduction in violent behaviour following treatment (DiSciullo, 2021; Morrissey & Ingamells, 2011), or if compared with a control group, DBT was demonstrated as no more effective than another treatment (Rice, 2016).

5.8.4 | Depressive symptoms

Five studies included measures of depression, and four found significant reductions in these symptoms. One found a significant reduction when compared to the control group (Rezaie et al., 2021), although this report has significant limitations given its poor methodological quality. Spitzer et al. (2019) found that the effect sizes in the male group were lower than in the female group; however, there was no difference in the outcome measures between women and men at the end of treatment. McCredie et al. (2017) found that mean scores for the female group decreased, whereas scores for the male group did not change. One study found a significant reduction in depressive symptoms over the course of treatment, with a large effect size, and this was maintained at follow-up (Wetterborg et al., 2020).

5.8.5 | Self-harm and suicidality

Only two of the studies involved some measure of suicidality or self-harm. Of these, Wetterborg et al. (2020) demonstrated a significant reduction in self-harming behaviour through the use of self-reported diary cards, which significantly reduced further at follow-up. However, suicide attempts did not significantly change either pre-to-post or at follow-up. This was generally a good-quality study but did not include a control group in its protocol. Another study (Whiteside et al., 2019) that surveyed visitors to a suicide reduction Website found a very modest, yet significant, reduction in suicidality for men.

6 | DISCUSSION

This review aimed to assess the effectiveness of DBT for men and boys. Broadly, DBT has demonstrated some efficacy in various domains of symptomology; however, adherence to treatment protocol was limited and the sampled populations were limited and small. Furthermore, the methodological quality of the included papers was generally poor. This may, in part, be explained by the exploratory nature of many of the empirical papers. The included studies in this review demonstrated improvement in some domains, including those of emotional regulation, anger and violence, depression and self-harm and suicidality. Furthermore, of the two studies that compared genders, it was found that differences may occur between outcomes for men and boys compared with women and girls.

The strongest evidence was provided by a limited number of the included studies. Spitzer et al. (2019) directly compared genders and was the only paper to report results for all included outcome measures. Promisingly, this study found limited differences between the groups; however, the lower effect sizes across the board for men when compared to women require further investigation.

These results could imply that DBT is an effective treatment for men and boys. However, the results suggest that the effect of DBT interventions may be better for a female cohort. Furthermore, evidence by Wetterborg et al. (2020) demonstrated similar self-harm reduction (72%) and pre- to post-treatment recovery rate to that of previous research of female-only samples (Linehan et al., 1991; Verheul et al., 2003). However, this paper also suffered from methodological quality issues. Both the papers by Shelton et al. (2009, 2011) provided a good-quality intervention protocol in the report but failed to adequately describe the outcome measures when comparing genders; thus, only tentative conclusions can be drawn as to its efficacy when comparing results between males and females. Despite these papers providing the strongest evidence for the effectiveness of DBT in men and boys, the methodological limitations mean that this review is unable to draw any firm conclusions.

There were also some notable nonsignificant results in the included studies. One study found that although self-reported measures of externalising behaviour improved because of treatment, observation measures showed no significant differences (Bihlar et al., 2016). One study found no significant difference as a result of treatment in a skills group only within a jail (Moore et al., 2018). Furthermore, three studies found that when DBT was compared with another treatment, there was either no difference (Asmand et al., 2015; Rice, 2016) or poorer outcome for the DBT intervention (Servos, 2009). Further exploration to inform understanding of why and when there is no treatment effect from DBT is required.

Fifteen of the studies involved samples of either forensic, high risk for violence or APD populations, which is in line with the previous literature assessment of men with emotional regulation problems becoming overrepresented in forensic care (Sansone & Sansone, 2011). Again, this may, in part, be due to the externalising nature of how emotional regulation difficulties such as outward expression of violence or substance use are presented in men. However, this may also be partly due to the 'gamma bias' proposed by Seager and Barry (2019), which described that violent behaviour is interpreted differently if performed by a man. This then leads the individual towards a forensic pathway of care rather than the traditional psychiatric pathway.

Among the studies including a measure of depression, men were demonstrated to have both a significant effect and a nonsignificant effect in the included studies. In addition, when compared to a female cohort, men had either a nonsignificant or a smaller effect size than women. Although it should be highlighted that the treatment goal for DBT was not to reduce depressive symptoms, other reviews have found no significant effect of DBT in the treatment of depression (Panos et al., 2014).

Regarding the inclusion of men and boys within the studies, of the studies that reported age, the range was 15.2–60 years. Furthermore, the studies that included boys were qualitatively similar to those that included men; hence, this review benefitted from the lifespan inclusion of participants. Future research may benefit from this widened scope of including those who identify and are socialised as males from across the lifespan.

6.1 | Limitations

6.1.1 | Literature reviewed

The literature does provide some evidence for the efficacy of DBT for men and boys, yet the methodological limitations, specifically the heterogeneity of samples, measures and interventions, make it difficult to draw definitive conclusions. None of the included studies were randomised control trials, with only around half of the studies involving some form of control group. Only two of these directly compared male and female cohorts. Most of the included studies did not use a follow-up measure. The length of treatment varied considerably between the studies, which, though understandable given the time-limited nature of some settings (e.g. juvenile incarceration), prevents comparison of effects across studies.

Existing literature has highlighted various adaptions for engaging men in psychological therapy, including specific process skills, language adaptations and changing therapist treatment styles (see Seidler et al., 2018, for review). Whilst adaptations were made for the age of participants, restricted environments or working with a population with learning difficulties, these were not considered for the gender of the participant.

Suicidality, the primary measure of the initial treatment protocol, was only measured in two studies. As previously discussed, there is some evidence that the rates of engaging in suicidality and self-harm are similar among men and women with BPD (Sansone et al., 2010); therefore, this is a significant omission in the literature on the use of DBT in males. However, this is not unusual and is similar to other reviews of DBT using nonstandard treatment samples (Bloom et al., 2012).

6.1.2 | Current review

The current review did not use BPD as a part of the search strategy or as an inclusion criterion given the historic inequality of diagnosis of women and men presenting with emotional dysregulation, based on either gendered differences or societal perception of behaviour. This review aimed to capture a more comprehensive population of males being treated with DBT. This review also chose to exclude single-case designs in an attempt to include studies with more rigorous methodology, yet due to the preliminary searches, studies without controls, which would ordinarily be perceived as having less rigour, were included.

This review is not immune from the effects of 'sampling bias'. Given the literature available for DBT with men has largely explored forensic samples, this review inevitably reiterates and includes these studies.

6.2 | Clinical implications

This review highlights the lack of a good-quality clinical evidence base for DBT in the treatment of men and boys. Furthermore, the vast differences in clinical implementation from these studies would make it difficult in any certain terms to draw overall clinical utility beyond that of there being some preliminary evidence for the efficacy of DBT. Interestingly, some of the studies found some differences based on gender either in the significance of treatment effect or to what extent the treatment was efficacious. Therefore, when considering DBT as a treatment intervention for men and boys, careful clinical consideration should be made to meet the individual context of the client. As the literature also reported nonsignificant effects, care should be given to considering any possible contraindications of offering DBT in clinical practice.

6.3 | Research implications

As a priority, future research should employ more robust designs to address the severe methodological limitations present in the current review. Of the included studies, many did not report a control group similar to that of the intervention group, with some not even adequately describing the DBT intervention itself.

To aid in the investigation of understanding any possible gender differences for those attending treatment for DBT, researchers should consider reporting outcomes specifically by gender even if not explicitly investigating gender. This would go some way in being able to provide a meaningful quantitative synthesis in future without unnecessary replication of studies, which are already been conducted.

More research is also required for the efficacy of DBT for men and boys, especially including standard outpatient treatment, as most of the included studies involved samples in restrictive or forensic environments, with some emerging evidence that male help-seeking and male adherence to treatment may be different to that of women and girls, such as some reported benefits of 'male-only' groups (Staiger et al., 2020). Specific attention should be given to not only comparing single-sex samples but also comparing these against mixed-gender cohorts. Finally, given the preventative nature of DBT, which places focus on a person's current difficulties, the inclusion of men and boys in research is paramount in providing an evidence base for early intervention in males with difficulties in emotional dysregulation.

7 | CONCLUSION

This review presented an overview of the implementation and current efficacy of DBT treatment for men and boys. There is some preliminary evidence supporting the use of DBT for males, specifically targeting anger and violence as well as emotional regulation and suicidality. Despite this, the limitations, methodological quality and heterogeneity from the current studies preclude this current review from drawing any strong conclusions about the overall efficacy of the treatment.

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APPENDIX 1

SEARCH STRATEGY

Database	Syntax
Web of Science	'dialectical behaviour therap*' OR 'Dialectical behavior therap*' OR DBT (Title) and 'dialectical behaviour therap*' OR 'Dialectical behavior therap*' OR DBT (Abstract) AND TI = (men OR male* OR man OR boy*) OR AB = (men OR male* OR man or boy*)
Psych INFO	TI ('dialectical behaviour therap*' OR 'Dialectical behavior therap*' OR DBT) OR AB ('dialectical behaviour therap*' OR 'Dialectical behavior therap*' OR DBT) AND TI (men OR male* OR man OR boy*) OR AB (men OR male* OR man OR boy*)
MEDLINE	TI ('dialectical behaviour therap*' OR 'Dialectical behavior therap*' OR DBT) OR AB ('dialectical behaviour therap*' OR 'Dialectical behavior therap*' OR DBT) AND TI (men OR male* OR man OR boy*) OR AB (men OR male* OR man OR boy*) Same results when OR MeSH subject Heading OR DBT search AND male
Psych Articles	TI ('dialectical behaviour therap*' OR 'Dialectical behavior therap*' OR DBT) OR AB ('dialectical behaviour therap*' OR 'Dialectical behavior therap*' OR DBT) AND TI (men OR male* OR man OR boy*) OR AB (men OR male* OR man OR boy*)
CINAHL Plus	TI ('dialectical behaviour therap*' OR 'Dialectical behavior therap*' OR DBT) OR AB ('dialectical behaviour therap*' OR 'Dialectical behavior therap*' OR DBT) AND TI (men OR male* OR man OR boy*) OR AB (men OR male* OR man OR boy*)