A Literature Review of Dialectical Behavior Therapy

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Dialectical Behavior Therapy (DBT) is an evidence-based, cognitive-behavioral treatment. DBT was developed by Marsha Linehan (1993a) out of the University of Washington. DBT was developed for the treatment of adult women with borderline personality disorder (BPD) who have a history of suicidal ideation, attempts, urges to self-harm and self-mutilate. The purpose of this literature review is to provide (a) an overview of DBT, (b) research indicating the efficacy of DBT, (c) cross-cultural client populations, and (d) recent developments and innovations.

DBT is based on the theory that problems develop from the interaction of biological factors, a person’s physiological makeup, and environmental factors which together makes emotion management difficult (Linehan, 1993). Furthermore, the dialectics of DBT include acceptance and change (Linehan, 1993a). The patient and the therapist need to accept reality while maintaining a conscious commitment towards change (Linehan, 1993a).

Linehan (1993a) states that DBT must meet five critical functions. The therapy must (a) enhance and maintain the client’s motivation and engagement to change, (b) enhance the client’s capabilities, (c) generalize new capabilities to various environments, (d) enhance therapist’s capabilities and motivation, and (e) structure the environment that is most conducive for change.

DBT is a skills base therapy (Linehan, 1993a). DBT is broken into five subgroups or modules including, core mindfulness, emotion regulation, distress tolerance, interpersonal effectiveness, and problem solving (Linehan, 1993a). Each module is skill specific. For example, the distress tolerance module includes the skill “ACCEPTS”
The “ACCEPTS” skill is an acronym which targets to distract individuals from emotional distress. The acronym is a helpful way for the client to remember the skills. The “A” stands for activities like playing a board game or playing basketball. The “C” stands for comparisons. In comparisons, the person compares themselves with others and how they might react in similar situations. The “C” stands for contributing. A person who can do something for someone else, for example is more likely to be able to distract from emotional suffering. The “E” stands for emotion. With this skill, the person acts opposite to whatever emotion is distressing. For example, if the person is angry, then smile. The “P” means pushing away from the problem. The “T” stands for thoughts and the ability to monitor and control one’s own thoughts. The “S” stands for sensations. One can distract from emotional suffering by holding a piece of ice, for example.

DBT has been generalized into many different settings to treat various disorders and problem behaviors (Braun, 2005). No longer is DBT specific to adult women with BPD. Today, DBT is used to treat bulimia, emotion dysregulation, drug dependence, suicidal adolescents, sex offenders, victims of sexual abuse and attention deficit-hyperactive disorder (ADHD) (Robins, 2000).

**Efficacy of DBT**

DBT is thought to be the most promising treatments for BPD (Van Den Bosch, Koeter, Stijnen, Verheul, Van Den Brink, 2005). Hayes, Masuda, Bissett, Luoma, and Guerrero (2004) state that DBT has a small but growing body of supporting research. Hayes et al. (2004) believes that the efficacy of DBT appears proportionate to the strength that their originators ascribe.
According to Dingfelder (2004), evidence appears to back DBT for the treatment of BPD. Verheul, Van Den Bosch, Koeter, De Ridder, Stijnen, Van Den Brink, (2003) examined the effectiveness of DBT with 58 women with BPD. The participants were either assigned to DBT or treatment as usual (a weekly session with a psychotherapist). After seven months of therapy, the participants who received DBT substantially reduced suicide attempts, self mutilating and self damaging behaviors than those who received treatment as usual. Additionally, the participants who received DBT were more likely to stay in therapy.

Linehan, Tutek, Heard, and Armstrong (1994), studied interpersonal outcomes of cognitive behavioral treatment for chronically suicidal borderline patients. Twenty-six female patients with borderline personality disorder were assigned to either DBT or a treatment-as-usual comparison condition. Participants who completed DBT had significantly better scores on measures of anger, interviewer-rated global social adjustment, and the Global Assessment Scale than did treatment-as-usual. These participants also tended to rate themselves better on overall social adjustment. These results indicate that DBT shows potential as a psychosocial intervention for improving interpersonal functioning among patients with BPD.

Two randomized trials indicated that DBT is more effective than treatment as usual in treatment of BPD and treatment of BPD with co-morbid diagnosis of substance abuse (Linehan, Armstrong, Suarez, Allmon & Heard, 1991; Linehan, Schmidt, Dimeff, Craft, Kanter & Comtois, 1999). Linehan, et al. (1999) studied DBT for drug dependent, suicidal women with BPD. Twenty-eight participants were divided into two groups, DBT and treatment-as-usual. The 12 participants receiving DBT, receive individual
psychotherapy, skills coaching, and skills training groups. Those who received treatment as usual, were referred to mental health counselors and community programs, or continued with their own psychotherapist. Results indicate improvements in those who participated in DBT. Drop-out-rate of DBT participants were 36% and 73% in treatment as usual. Additionally, DBT participants showed significant improvements in social and global adjustment at 16 month follow ups. Urine analysis indicates a reduction in substance abuse among DBT participants. These results suggest that DBT is an effective treatment for drug dependent, suicidal women with BPD.

Telch, Agras, and Linehan (2001) studied the effectiveness of DBT for binge eating disorder. Forty-four women with binge eating disorder (BED) were randomly assigned to DBT or wait-list control condition. The participants were administered the eating disorder examination in addition to measures of affect regulation, mood, and weight at baseline and post-treatments. DBT participants showed significant improvement on measures of binge eating and eating pathology. Additionally, 89% of DBT participants had stopped binge eating all together by the end of treatment. The results for this study were not significant.

Safer, Telch, and Agras (2001) studied the effectiveness of DBT for bulimia nervosa. Thrity-one participants were randomly assigned to 20 weeks of DBT or 20 weeks of a wait-list comparison control group. Emotion regulation skills were taught to DBT participants. An intent-to treat analysis showed a highly significant decreased in bulimia associated behaviors when treated DBT. However, secondary measures resulted with no significant group differences.
Lynch, Morse, Mendelson, and Robins (2003) piloted a randomized study on the effectiveness of DBT for depressed older adults. Lynch et al (2003) augmented medication with group psychotherapy of depressed older adults and assessed for benefits. Thirty-four chronically depressed individuals were randomly assigned to one of three groups; antidepressant medication plus clinical management group, medication alone group, or with DBT skills training and medication group. The mean self-rated depression scores significantly decreased in the medication plus DBT group. Additionally, on interviewer-rated depression, 71% of medication plus DBT participants were in remission at post-treatment, in contrast to 47% of medication only participants. The six month follow up showed a significant difference with a 75% of medication plus DBT participants in remission, as opposed to 31% of medication only participants. Medication plus DBT was the only group that showed significant improvements from pre- to post treatments. Overall, however results were not significant.

Trupin, Stewart, Beach, Boesky (2002) studied the effectiveness of a DBT as a program for incarcerated female juvenile offenders. Participants were from Echo Glen Children’s Center, a detention center for adjudicated youth. Two mental health cottages implemented DBT techniques. A third cottage, a control group did not use DBT techniques. Problem behaviors and staff punitive responses were compared before and after the intervention period. Results from the two female mental health cottages indicated that compared to the previous year, resident problem behaviors and staff punitive responses decreased. No change was observed in the third cottage. The efficacy of DBT in female mental health cottages as a program had mixed results. Results may
have been influenced by the lack of training that staff received and prior youth behavior problems.

Application to cross-cultural client populations

To date there has been no research that examines the cultural difference and efficacy of DBT (Robins & Duke, 2000). However DBT has been applied to client populations with various disorders and problem behaviors. DBT has treated binge eating disorder (BED) (Telch, Agras, & Linehan, 2001), sex offenders (Shingler, 2004), emotional dysregulation (Linehan, 1993a, b), suicidal adolescents (Linehan, 1993a, b), drug dependence (Linehan, et al., 1999), depressed elders (Lynch, et al., 2003), BPD (Linehan, 1993, a, b), co-morbid post traumatic stress disorder (PTSD), generalized anxiety disorder (GAD), reactive attachment disorder (RAD) and BPD (Lynch, et al., 2003). DBT has been used as an HIV prevention intervention for abused adolescents with affect dysregulation and dysfunctional thinking about sexuality (Lescano, Brown, Puster, & Miller, 2004). Additionally, DBT has been used as a program for relatives of persons with borderline personality disorder (Hoffman, Fruzzetti, Buteau, Neiditch, Penney, Bruce, Hellman, & Struenning, 2005).

DBT is used in various settings (Linehan, 1993a). Some of these settings include residential settings, detention settings, emergency rooms, out patient therapy, day time therapy, crisis intervention settings, private practice, and group therapy (Robins & Chapman, 2004).

The setting in which DBT is applied may influence the therapeutic outcome. McDonagh, Taylor, and Blanchette (2002) found the quality of DBT in residential settings is dependent on adequate training of staff and sufficient resources. McDonagh,
et al. (2002) relates that residential staff is usually not equipped with the needed training and materials to confidently utilize DBT. Furthermore, Robins and Duke (2000) suggest that insufficient training, staffing, financial resources and the ability to distinguish which aspects of DBT are needed to treat a given population are potential obstacles for effective DBT.

**Limitations and contraindications of DBT**

McDonagh, et al. (2002) identify several contraindications and limitations. Mcdonagh et al. (2002) identifies four points of correction. Their critique is targeted at institutional facilities that use DBT as a program. First, the language of DBT is confusing. Not only do residents struggled to learn DBT vocabulary and acronyms, the staff do as well. Several staff members and participants described the language too difficult and confusing. This confusion has led to a hindrance to the overall success of the treatment approach. The language and training material should be revised so they are clear, concise and understandable by target populations. Additionally, acronyms such as “PLEASE MASTER” (Linehan, 1993a, b) and “DEAR MAN” (Linehan, 1993a, b) should be reviewed, as they may have potential to cause anguish to women who have been victims of male-perpetrated violence.

McDonagh et al. (2002) suggest that treatment tools, such as the behavior chain analysis (BCA) and diary cards are hard to understand. The BCA and diary cards use challenging language and confusing format structure. Additionally, in residential facilities, staff often uses BCA’s and diary cards as punishments, not as helping instruments.
McDonagh et al (2002) states that a few technical changes to the training manual would better equip readers to find information easier. The training manual does not have page numbers, a table of context, nor divider tabs. Addressing these needs as well as making the manual available on the computer would further support staff and residents in an institutional setting. Additionally, the examples in the training manual are specific to women with BPD. It would be helpful for examples in the training manual to address other populations that utilize DBT.

Robins and Duke (2000) identify expanding applications of DBT including prospects and pitfalls. They suggest potential obstacles for effective treatment, such as financial resources, insufficient training, staffing, and the need to consider which aspects of DBT are needed to treat a given population effectively and efficiently. Additionally, they suggest that clinical dissemination is outpacing controlled data. DBT has been well received despite its methodological difficulties and limited research base (Scheel, 2000).

**Recent developments/ Innovations**

Although empirical support exists for DBT, more is needed (Smith & Peck, 2004). Overall, DBT is empirically supported for the treatment of BPD, but additional research is necessary and findings should be evaluated with an understanding of the treatment (Smith & Peck, 2004). Additionally, more research is needed for other areas that DBT is being generalized into.

According to Trupin, et al. (2002), a DBT intervention is most effective when it is matched with appropriate behavior problems (i.e. suicidal, aggressive and non-compliant) and implemented with intensive training for the therapist and client. Trupin et al. (2002) states that future research should examine equally emotionally and behaviorally disturbed
youth, and equally training committed staff. Studies should be randomized and include DBT verses treatment as usual.

Most of the reviewed studies suggest that DBT is a promising treatment for BPD. Verheul, et al. (2003) states that because DBT and BPD has received so much attention, further advances may be made so that DBT may be generalizable to the other nine personality disorders. Lynch, et al. (2003) states “it’s too early to report results, but we are in the process of writing up a manual on how to alter DBT for personality disorder other than borderline” (p. 41).
References


