Providing services to individuals with Borderline Personality disorder in the context of ACT:
Research base and recommendations.

Final Report

Prepared for:

The Queensway ACT team
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September, 2002
EXECUTIVE SUMMARY

Although Assertive Community Treatment (ACT) programs have not been commonly perceived as gearing services for individuals with Borderline Personality Disorder (BPD), many ACT teams have in fact been offering services to a minority of clients with this diagnosis. Based on this observation and a desire to better meet the needs of individuals with BPD, the Queensway ACT team requested information from the research literature to guide their work with this population.

The findings from the literature review revealed that:

- Individuals with BPD present with complex needs.
- There appears to be an ongoing shift from institutional-based treatment to community-based treatment for such clients. Nonetheless, there is little consensus on how to best offer services to these individuals in community-based settings and reluctance among some ACT teams to offer services to this group.
- Dialectical Behaviour Therapy (DBT; Linehan, 1993a), has been developed specifically to meet the needs of individuals with BPD. DBT is the most widely researched treatment for individuals with BPD and has been shown to be more effective than other community-based treatments in reducing: parasuicidal behaviours, hospital visits, attrition from therapy, as well as other indicators of psychological functioning such as occupational functioning, anger, and social adjustment.
- DBT has been successfully adapted into ACT team programs. Preliminary evidence from these programs has shown that this model has been welcomed by ACT team staff and clients and has produced client gains.
- Three recommended options for integrating DBT within an ACT program were presented to the Queensway ACT team. These were:
  - Implement a self-contained DBT program.
  - Work in partnership with a local DBT program.
  - Partial implementation of DBT in advance of full implementation.
ACKNOWLEDGEMENTS

We would like to acknowledge Janice McFarlane, manager of the Queensway ACT team, for her guidance throughout this work. We would also like to thank Carla Larose, Queensway ACT program assistant, for her assistance with the time study data collection. Finally, we are grateful to all the members of the Queensway ACT team for helping to orient the authors to the Queensway ACT program and for their suggestions throughout this process. We hope that the information contained in this report will be of assistance in planning specialized ACT services for individuals with Borderline Personality Disorder.
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1. THE CONTEXT

The Queensway Assertive Community Treatment (ACT) was established in January, 2001. The team consists of: a program manager with a Master’s degree in social work, a psychiatrist, a social worker, three mental health workers with specialties in addictions, vocational counseling, and familial work, four nurses, a peer support worker, and a team administrator. As of June 2002, the Queensway ACT team was providing services to 34 clients with a range of clinical diagnoses, but especially Schizophrenia and Bipolar disorder. The Queensway ACT team has also been providing services to a small number of individuals with Borderline Personality Disorder (BPD), a population not typically targeted by ACT. The team has expressed an interest in continuing to offer services to this population, albeit as a minor proportion of their caseload. The Centre for Research on Community Services at the University of Ottawa was hired to provide a review of the scientific research literature on mental health interventions for individuals with BPD and how these interventions can be integrated into services provided by an ACT program. The focus of this report is to provide the Queensway ACT team with a synthesis of the available research on how ACT programs may best meet the needs of individuals with BPD.

First, an overview of ACT and BPD is provided below. This is followed by a review of the need for services for individuals with BPD in Ottawa. Treatment options are then reviewed with a focus on a review of Dialectical Behaviour Therapy (DBT), a mode of therapy that has been developed specifically for individuals with BPD. This is followed by a summary of how DBT has been successfully incorporated into two ACT programs. Finally, recommended options for further consideration by the Queensway ACT team are provided.

2. ASSERTIVE COMMUNITY TREATMENT

Over the past three decades there have been drastic changes in the mental health care system. These changes have included the downsizing of psychiatric hospitals and increased reliance on community-based care. Various clinical case management models have emerged with the general goal of helping individuals with severe and persistent mental illness to maintain the highest level of independent functioning in the community, to access community services, and to meet their rehabilitation needs (Chamberlain & Rapp, 1991; Mueser, Bond, Drake, & Resnick, 1998; Solomon, 1992). ACT is a model of community-based case management that has demonstrated its effectiveness (The Advisory Network on Mental Health, 1997).

ACT is a clinical framework where services are provided by a multi-disciplinary team, coverage is available for 24 hours per day and 7 days per week, and services are
characterized by an assertive outreach approach, and by the provision of services to clients in their own milieu (Advisory Network on Mental Health, 1997). Service provision is flexible and is tailored to meet the daily needs of individual clients. This approach provides a combination of clinical treatment, which is focused on clients’ needs, skill development, and the provision of support.

The Advisory Network on Mental Health (1997), a group of mental health researchers working for Health Canada, reviewed the research literature on case management services for persons with severe mental illness. They concluded that:

- ACT has been shown to reduce number and length of hospitalizations and to lower levels of symptoms.
- Most studies have provided evidence that reduced reliance on hospitalization by ACT programs has been associated with substantial cost-savings when compared to hospitalization with standard after-care.
- Most studies have provided evidence that ACT is associated with high levels of client and family satisfaction with the services.
- Evidence has accumulated suggesting that both ACT and non-ACT case management approaches have been successful in fostering independent community living and in improving social and vocational functioning.

Recently, some have called for increasing involvement of ACT teams in work with individuals with personality disorders (Links, 1998; Schwammle, Wollert, & Abney-Cunningham, under review), with a particular focus on the needs of individuals with BPD. Prior to elaborating on this issue, however, it is important to first provide a definition of personality disorders, followed by a description of the characteristics of individuals with BPD.
3. BORDERLINE PERSONALITY DISORDER

Personality disorders refer to pervasive and long-standing traits that have an inordinate and negative impact on the way affected individuals view themselves and their surrounding environment, their ability to regulate emotion, and their interpersonal functioning (Perry, Banon, & Ianni, 1999). These difficulties also cause significant distress and functional impairment. The fourth edition of Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994) has identified three clusters of personality disorders:

**Cluster A (characterized by odd and eccentric behaviour):** Paranoid Personality Disorder, Schizoid Personality Disorder, and Schizotypal Personality Disorder.

**Cluster B (characterized by dramatic, emotionally reactive and erratic behaviour):** Borderline Personality Disorder, Antisocial Personality Disorder, Histrionic Personality Disorder, Narcissistic Personality Disorder.

**Cluster C (characterized by anxious and fearful behaviour):** Avoidant Personality Disorder, Dependent Personality Disorder, and Obsessive-Compulsive Personality Disorder.

From among these types of personality disorders, BPD is recognized as being among the most difficult mental health problems to treat. According to the fourth edition of Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994), BPD is viewed as a pervasive pattern of instability in several life domains (i.e., self-image, interpersonal relationships, emotional regulation) along with a pattern of marked impulsivity, which begins in early adulthood.

Five of the following symptoms are necessary to receive a diagnosis of BPD:

1) Frantic efforts to avoid perceived abandonment.
2) A pattern of unstable social relationships.
3) Unstable sense of self or self-image.
4) Marked impulsivity that is self-damaging, in at least two areas (e.g., spending, sex, substance use, reckless driving, binge eating).
5) Recurrent suicidal gestures, threats, or self-mutilation.
6) Affect instability and hyper-reactivity.
7) A chronic feeling of emptiness.
8) Inappropriate and intense anger.
9) Dissociative symptoms and transient paranoid ideation which is brought on by life stressors.

It is estimated that 2% of the general population have this disorder, although individuals with BPD represent approximately 10% of individuals being seen in mental health outpatient clinics and approximately 20% of psychiatric inpatients (American Psychiatric Association, 1994). These are believed to be underestimates, given that many clinicians
may be reluctant to apply this label, due in part to the potential stigma attached to it (Linehan, Kanter, & Comtois, 1999). BPD is also a pervasive disorder in that someone with this diagnosis is likely to continue to meet diagnostic criteria for many years and it is estimated that individuals with BPD consult with an average of 6.1 mental health professionals during their lifetimes. For example, long-term follow-up data indicated that 4-7 years after initial assessment, 57-67% of individuals with BPD continued to meet diagnostic criteria for this disorder, and 15 years after initial assessment, 25-44% continued to meet diagnostic criteria (see Linehan et al., 1999 for a review). Nonetheless, it appears that the severity of this disorder is worst during young adulthood with symptoms tending to gradually wane over time (DSM-IV, 1994).

This population is also notoriously difficult to treat as clients tend to present with complex difficulties. For example:

- Most individuals with this disorder (i.e., 70-75%) have a history of at least one “parasuicidal” act, defined broadly as any intentional non-fatal self-injurious behaviour with or without suicidal intent (e.g., drug overdoses, cutting) (see Linehan, Cochran, & Kehrer, 2001, for a review).

- It has been estimated that approximately 10% of individuals with BPD eventually commit suicide (see Linehan, Rizvi, Welch, & Page, 2000, for a review).

- Rates of substance abuse are high among individuals with BPD and when substance abuse occurs in this population it is typically severe (see Linehan et al., 1999, for a review). For example, Links, Steiner, Offord and Eppel (1988) found a high co-morbidity rate for alcohol abuse among individuals with BPD and this co-morbidity appears to be a negative prognostic indicator (Links, Heslegrave, Mitton, Van Reekum, & Patrick, 1995).

- Individuals with BPD also have a high incidence of co-morbidity with depression, anxiety disorders, and eating disorders (see Linehan et al., 1999, for a review).

- Individuals BPD also account for a disproportionately high percentage of hospital admissions and overall health care expenses (Linehan et al., 1999), due in part to repeated hospital admissions.

> Although the high rate of hospital admissions and service consumption reflects the complex nature of these individuals’ difficulties (i.e., parasuicidal acts, suicide attempts, drug abuse, and co-morbidity with other mental illnesses), Linehan et al. (1999) have argued that this disproportionate representation also reflects the idea that outpatient services have often not met the needs of these clients.
4. ACT AND THE TREATMENT OF BPD

Given the complex difficulties experienced by persons with BPD, it is not surprising that some ACT teams have been reluctant to work with this population due to fears that these clients may tax staff resources or destabilize team functioning (Schwammle et al., under review).

Nonetheless, some have argued that ACT teams are well-positioned to deal with this clientele given their flexibility, their intense support to clients, and their individually-tailored approach (e.g., Schwammle et al., under review). Shared workload, use of a multidisciplinary team, and regular team consultations are also particularly helpful for work with this population. In short, “ACT was developed for the difficult to treat and personality disorders are difficult to treat” (Schwammle et al., under review, pp. 7).

Regardless of whether or not an ACT team chooses to actively engage clients with BPD, ACT providers have observed that this population exists on most teams. To date there have been very few studies that have specifically focused on the outcome of treating individuals with personality disorders within ACT teams.

Links (1998) however, identified six ACT effectiveness studies that specifically mentioned that they included individuals with personality disorders in their samples. In these six studies, an average of 13% (ranging from 2-26%) of the samples were identified as having personality disorders. The outcome data from these studies provided evidence of reduced hospitalizations and days spent in hospital, better compliance with medication, and decreased legal problems for clients receiving ACT services. In interpreting these findings, it is important to note that data were not provided specifically for the minority of individuals on these teams with personality disorders.

Recently, Schwammle et al. (under review), reported on the experiences of two ACT programs who have integrated Dialectical Behavior Therapy (DBT; described below), a treatment specifically designed for individuals with BPD, into their programs:

- Data from an ACT program in the Grey-Bruce region of Ontario that integrated DBT into their services provided evidence of a preliminary trend toward decreased hospitalization days and emergency room visits among clients with BPD after the DBT program was initiated.

- Similarly the ACT team of Kalamazoo, Michigan found evidence of client improvement after integrating DBT into their services. Specifically, after implementing the DBT into their ACT program clients with BPD showed:
  - Fewer hospital days per client
  - More vocational activity
Graduation to lower intensity mental health services upon discharge.

In short, although the application of ACT for the treatment of BPD has not been widely studied, ACT teams have already been serving this population and there is some preliminary evidence to suggest that these programs have been helpful.

5. TREATMENT OPTIONS FOR INDIVIDUALS WITH BPD

Given the definition of personality disorders as enduring and stable it had previously been believed that change did not seem to be likely. More recently, this belief has changed as evidence from naturalistic follow-up studies have shown that patterns of instability and impulsivity in individuals with BPD appears to taper with increasing age (Perry et al., 1999). More importantly, reviews of the psychotherapy treatment literature have shown generally positive effects of psychotherapy for individuals with personality disorders (Crits-Christoph, 1998; Perry et al., 1999; Sanislow & McGlashan, 1998), although these individuals have been more resistant to change relative to individuals without personality disorders and required an increased length of services to make changes. Within these studies, BPD has been the most widely investigated personality disorder. The studies generally showed evidence for change in the behavioural symptoms that have been specifically targeted.

Linehan et al. (2001) provided a review of treatments that have been proposed for treating BPD. These included: psychodynamic therapy, cognitive-behavioural therapy (CBT), and interpersonal therapy. These approaches offer promise in providing suitable treatment for individuals with BPD but they do not provide a unifying theoretical framework specifically developed for working with individuals with BPD.

Dialectical Behaviour Therapy (DBT), a mode of CBT that has been specifically tailored for individuals with BPD, provides such a framework. DBT, which was developed by Marsha Linehan (Linehan, 1993a) has been the most widely researched treatment option for individuals with BPD and is the only treatment available for individuals with BPD to be included on a list of “probably efficacious” treatments by the American Psychological Association (Chambless et al., 1998). Given the promise of this approach and the potential utility of integrating this approach within ACT services, a detailed summary of DBT along a synthesis of the available outcome research on this approach follows.

DBT is the most widely research treatment option for individuals with BPD and is the only such treatment to be listed as “probably efficacious” by the American Psychological Association.
6. DIALECTICAL BEHAVIOUR THERAPY (DBT)

The descriptions presented below are based on the writings of Dr. Linehan and her colleagues. For further elaboration please refer to:

Linehan (1993a) – Book on DBT.
Linehan, Cochran, & Kehrer (2001) – Book chapter with a detailed overview of DBT (includes transcripts of DBT therapy sessions).
Linehan, Kanter, & Comtois (1999) – Book chapter with an overview of DBT.

6.1 Theoretical underpinnings

DBT was developed specifically for individuals with complex problems associated with BPD. The approach is based on Linehan’s conceptualization of BPD as a problem with emotional regulation, which is believed to result from a combination of biological irregularities, dysfunctional environments, and interactions between these over time. According to Linehan, a central factor in the etiology of BPD is an “invalidating home environment”. Such an environment fails to teach children how to label and regulate emotion, how to tolerate emotional distress, and how to trust their emotional responses as valid. In such an environment, intrapersonal experiences (emotional experiences, interpretations of events) are not taken as valid responses, are punished, disregarded, or are viewed as socially unacceptable.

The consequences of such an environment include deficits in learning to label and modulate emotions, to tolerate distress, and to trust one’s emotional responses. Because of difficulty in trusting one’s own emotional state, the individual scans her/his environment in search of cues guiding how to act. In doing this however, the individual does not develop a stable and cohesive sense of self. In dealing with his/her environment, one who lacks emotional regulation skills becomes more dysfunctional and in response, the environment becomes progressively more invalidating. Individuals with BPD tend to engage in impulsive behaviour such as self-mutilation, which appears to be a desperate attempt to regulate emotion. Difficulty with emotional regulation also often leads to a pattern of unstable interpersonal relationships. Because emotional expression is often suppressed or invalidated in these families, the individual may vacillate between a struggle to contain one’s emotions and a burst of expressed emotion. In addition, they may learn that extreme displays are necessary to get needed reactions.

In summary, individuals with BPD often lack important self-regulation and interpersonal skills and their environments inhibit the further development of these skills.
Linehan has re-organized the diagnostic criteria for BPD in accordance with her formulation to comprise of the following (Linehan et al., 2001):

1) **Emotional dysregulation and instability** (marked reactivity, mood instability, difficulties with depression, anxiety, and anger).
2) **Behavioural dysregulation** as evidenced by extreme impulsive behaviour (self-destructive behaviour such as self-mutilation, and suicide attempts).
3) **Cognitive dysregulation** (temporary thought dysregulation, depersonalization, dissociation, and delusions that are often brought on by stress).
4) **Unstable sense of self** (e.g., feeling empty)
5) **Interpersonal dysregulation** (e.g., intense or chaotic interpersonal relationships, desperate attempts to prevent abandonment from others).

### 6.2 Overview of DBT

DBT merges three areas of study: behavioural science, dialectical philosophy, and Zen / Buddhist practice. As applied to DBT, **dialectics** conveys the meaning that the treatment balances strategies aimed at conveying understanding and validation with those aimed at behavioural change. Dialectics is also intended to convey the idea that part of the therapeutic work is aimed at replacing a rigid and often dichotomous view of the world with a more flexible one.

### 6.3 Targets for therapy:

One integral component of DBT is that targets for intervention are prioritized in each session according to the following **hierarchy of importance:**

1) Reducing suicidal and life threatening gestures including parasuicidal behaviour.
2) Reducing therapy-interfering behaviours, defined as anything that prevents the therapist and client from working together.
3) Reducing quality of life-interfering behaviours (e.g., substance abuse, severe eating disorders, impulsive and out of control behaviour such as high risk sexual behaviour or inability to handle finances, criminal behaviour, employment problems, frequent hospitalizations, failure to comply with medication regimens, other health problems, homelessness, and financial difficulties).
4) Skills enhancement: Replacing maladaptive responses with skillful interpersonal behaviours, distress tolerance, enhanced emotional regulation, self-management skills, and non-judgmental self-awareness.
6.4 Modalities of DBT

Therapy is conducted across a variety of modalities. These include weekly individual therapy sessions, weekly skills training groups, telephone consultation, management of environmental contingencies, and supervision / consultation with team members.

1) Individual therapy sessions: Weekly individual therapy sessions are conducted by a primary therapist, who is responsible for overall case management and planning. The focus of the individual therapy sessions fluctuate according to the hierarchy described above. Individual therapists are also in contact with skills training group leaders and help facilitate the generalization of skills to the client’s environment.

2) Skills training groups: Skills training involves weekly meetings usually done in a group environment, and adopts a psycho-educational format whereby psychosocial skills (described below) are taught. Clients are required to attend individual therapy while they are in the skills training classes.

3) Telephone consultation: Telephone consultation is used to provide general support, to ensure generalization of skills, for emergency service, and to repair a rupture in the therapeutic alliance.

4) Structuring the environment: Environmental contingencies that reinforce maladaptive client behaviours are assessed. The staff coordinate their efforts to not reinforce maladaptive client behaviours and to provide reinforcement for adaptive behaviours.

5) Supervision / team consultation:
Given the stress of working with this population, regular staff consultation, supervision, and support meetings are an integral component of the service.

6.5 Treatment strategies

Individual therapy involves a balance of validation strategies with strategies aimed at changing behaviours. Additionally, skills enhancement groups are used to teach emotional and behavioural regulation skills. Dialectical strategies provide an overriding principle and are used throughout the therapy.

1) Dialectical strategies refer to the manner with which the therapist manages the dialectical tensions, or “pulls” that occur during the therapy. Individuals with BPD tend to exhibit extremes in their thinking, behaviours, and emotions. The goal in balancing acceptance with change is to help the clients “work through” these extremes in order to find a middle ground.

Example

Entering the paradox: Dichotomous thinking comes along with many paradoxes that may emerge in therapy. One example of such a paradox is that clients are provided with
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validation and are encouraged to see that they are not to blame for their maladaptive traits. Yet, they are also told that they are responsible for who they can become. The therapist does not solve these paradoxes for the client. Rather, the therapist facilitates the clients’ own process of trying to make sense of these paradoxes.

2) Skill Enhancement Groups: The emotional regulation difficulties that are seen among individuals with BPD are believed to reflect bona-fide skill deficits. Consequently the focus is on developing skills through modeling, instruction, rehearsal, feedback, coaching, and application assignments. These are typically done in the context of psycho-educational groups. Continued work on these skills is also integrated into other aspects of the treatment including individual therapy, and telephone consultation.

Skill enhancement groups focus on the following skills:

a) “Mindfulness” skills: These skills involve becoming more aware of oneself and context, self-observation without being judgmental, and focusing on what is effective.

b) Distress tolerance skills: Refers to the ability to experience thoughts, feelings, and behaviours in an accepting manner. These skills involve delaying the need for immediate gratification and learning to self-sooth during difficult periods without engaging in maladaptive behaviours.

c) Emotional regulation skills: Focuses on helping clients to become more aware of their emotions, to identify situations that evoke strong negative emotional reactions, and to learn not to avoid negative emotions. The goal of the latter is to help the clients to learn that negative emotions will reduce in intensity over time.

d) Interpersonal skills training: Involves developing problem-solving skills in relation to interpersonal conflict, identifying interpersonal objectives, and developing strategies to maximize the likelihood of achieving these objectives.

e) Self-management skills: Involves helping clients to learn to care for themselves. Specific strategies include learning to set realistic objectives and learning to conduct a behavioural analysis (e.g., leaning to identify factors that reinforce maladaptive behaviour).

3) Validation: In DBT, strategies for helping clients to change maladaptive behaviours are balanced with validation strategies. The validation strategies are aimed at helping clients to feel understood, that their behaviours make sense and are justifiable given their life experiences. The therapist focuses on:

- Attending to the client and taking his / her response seriously.
- Conveying an understanding of the client’s experience.
- Helping the client to see that her/his behaviour is justifiable given his/her life experiences and current context.
- Conveying acceptance and respect.
- Acting as a coach, encouraging the client, and conveying a belief that the client can overcome her/his difficulties.

4) Problem solving strategies: Consistent with a dialectical framework, validation strategies are balanced with strategies aimed at changing maladaptive behaviours.
a) Behavioural analysis and problem-solving framework: The goal in this set of strategies is to better understand the circumstances surrounding problematic behaviours. This in turn, informs the therapy. Questions that may be addressed include:
- Are environmental contingencies affecting the client’s behaviour?
- Are there skills deficits (e.g., emotional regulation, interpersonal conduct)?
- Are there patterns of avoidance?
- Are faulty assumptions affecting the client’s decisions and actions?

b) Techniques: The answers to these latter questions will guide appropriate interventions:

Cognitive modification strategies: In contrast to traditional CBT, the focus of cognitive modification strategies is on helping the clients to note and to better understand how environmental contingencies trigger distressing thoughts, and to make adjustments accordingly.

Exposure therapy: Focuses on helping clients to engage in previously avoided behaviours or situations in order to help the client to reconstruct dysfunctional associations (e.g., learning to confront negative emotions and tension which was previously avoided by going to the hospital).

Skills training: The DBT skills developed via the groups are continually developed throughout the therapy. As presented above, these are: mindfulness skills, distress tolerance, emotional regulation, interpersonal skills, and self-management skills.

Contingency management: Contingency management procedures are based on the principle that interpersonal behaviours may be reinforced or punished and that altering these contingencies can have an impact on one’s behaviour. Applied in a DBT context, this involves working toward identifying environmental factors that may be reinforcing clients’ maladaptive behaviours (e.g., parasuicidal behaviours). The team typically coordinates efforts in altering such contingencies.

6.6 Treatment planning within a DBT model

DBT also incorporates a unique approach to treatment planning.

1) Consultant to client strategy: This is the dominant treatment planning model that is used in DBT. In this approach, the client is involved in all levels of case planning. Therapists typically offer consultation to clients in helping them to make their own adjustments in dealing with their environments. For example, rather than have the therapist contact another professional on behalf of the client, the client may do this on his / her own in consultation with the therapist. When meetings occur to discuss the client’s situation, the client is typically present. This is a novel approach. Consequently, at the beginning of therapy it is important to sensitize the other professionals who are involved to this approach. The rationale for this approach is that 1) clients learn to better manage
on their own and to interact effectively with their environments, and 2) clients are given
the implicit message that they are capable of taking care of themselves.

2) Environmental intervention: The consultant to client strategy is the dominant
approach except when the client is in immediate danger. At these times, the therapist may
directly intervene.

6.7 Outcome research on DBT:

To date, there have been two clinical trials designed to determine the relative
effectiveness of DBT over other treatments. The outcomes of these studies are
highlighted below.

1) Randomized-controlled clinical trials by Linehan’s group: Linehan, Armstrong,
Suarez, Allmon, & Heard (1991) provided DBT to 22 severely dysfunctional women
with BPD, who were between 18 and 45 years of age and who were exhibiting
parasuicidal behaviour. This group was compared to 22 similar individuals who received
their choice of referrals for treatment as usual (TAU) in the community.

The findings showed that relative to the group who received TAU, those who
received DBT:
- Exhibited less frequent and less medically risky parasuicidal acts.
- Were more likely to remain in therapy with the same therapist (e.g., 17% of those who
received DBT dropped their first therapist, compared with 58% of those who received
TAU).
- Had significantly fewer hospitalizations per person and spent fewer days in the
hospital (8.46 days per year for DBT compared with 38.86 days per year for TAU).
- However, no differences between DBT and TAU were found in levels of suicidal
ideation, depression, hopelessness, and perceived reasons for living. Both groups
continued to exhibit clinically significant levels of difficulty in these areas of functioning
although improvements in these areas were noted (Linehan, Tutek, Heard, & Armstrong,
1994).

In a second set of analyses from this study, client and interviewers’ ratings of
psychosocial functioning were done (Linehan et al., 1994; Linehan, Heard, &
Armstrong, 1993). Compared to the participants who received TAU, those who
received DBT were:
- Rated by interviewers as more socially adjusted and more globally functional.
- Perceived themselves as less angry, less anxious, more socially adjusted, and more
functional in their work-role performance.
- However, despite these improvements, clients in both groups continued to show
clinically significant impairment in these areas of functioning compared to samples of
other psychiatric patients and norms from the general population, reflecting the idea that
this form of therapy seems to improve functioning but does not lead to complete
resolution of targeted problems.
Long-term outcome data: In a follow-up study of these same individuals at 6 and 12 months post-treatment Linehan et al. (1993) found that many treatment gains were maintained. Specifically:

At 6-month follow-up those who received DBT maintained their relative gains in:
- Fewer and less medically severe parasuicidal episodes.
- Better perceived employment performance, less anger, and better perceived social adjustment.
- Better interviewer-rated global adjustment.

Between 6 and 12 months post-treatment those who received DBT continued to maintain their relative gains in:
- Fewer hospital in-patient days.
- Better perceived employment performance and perceived social adjustment.
- Better Interviewer-rated global and social adjustment.

2) Randomized controlled study by other researchers:
Koons et al. 2001, conducted a second randomized controlled trial where they compared DBT to a control group of female war veterans who met criteria for BPD but who were less parasuicidal and less frequently hospitalized than those who were treated in Linehan’s trials. The control group received therapy with a variety of approaches including CBT and psychodynamic therapy.

After six months of treatment those who received DBT showed:
- Greater reductions in suicidal ideation, depression, hopelessness, and anger expression relative to the control group.
- Reduced parasuicidal acts relative to those in the control group.
- Both treatments were helpful in reducing depression, and in reducing the number of symptoms of BPD.

In summary, DBT has been shown to be more effective relative to other therapeutic approaches in reducing parasuicidal behaviour, hospitalization time, attrition from therapy, and anger, along with improving social and employment-related adjustment. There was less consistent evidence of DBT clients showing more improvements in the areas of depression, hopelessness, and suicidal ideation.

For further elaboration see:
Linehan et al. (2001) - Review of the DBT outcome research.
Scheel (2000) - Critical review the DBT outcome research.
6.8 What components of DBT are effective?

In short, not enough research has accumulated to answer this question. However, a series of studies have begun to investigate several issues that is relevant to the integration of DBT and ACT services. Of particular relevance to the Queensway ACT team are the answers to the following questions: **Is it helpful to adopt DBT group skills training without the other components of DBT?** What therapy process variables seem to be effective? Is DBT cost-effective?

Is it helpful to adopt DBT group skills training without the other DBT components?

The answer to this question is particularly important since adopting sub-components of DBT may be more manageable than a complete DBT program, particularly for agencies with resource limitations.

In an unpublished study, Linehan, Heard, and Armstrong (as cited in Linehan, 1993a, p. 25) addressed the question of whether there were any added benefits of participating only in a DBT skills training group (rather than the complete DBT treatment package). The participants in this study were 19 individuals with BPD who were receiving individually tailored (non-DBT) treatment. Eleven of these individuals were randomly selected to also attend a DBT skills training group whereas the remaining 8 participants did not attend this group. The results showed no evidence for an added benefit for those who participated in the DBT skills training groups. It appears that the DBT skill groups alone are not enough to yield an added benefit for clients.

Similarly, in adapting a DBT program to a hospital inpatient setting, Barley et al. (1993) studied the incidence of parasuicidal behaviours before the implementation of a DBT program, as the program was being developed (with only the DBT skills-training groups implemented), and after the full DBT program was implemented. They found evidence for reduced parasuicidal behaviours after the full program was implemented but not for the period in which the program was only partially implemented (ie., skill groups only).

However, it is important to note that formal research on a partially implemented DBT program within an ACT team has not yet been done. Consequently, it is not yet clear whether or not adding select components of DBT (e.g., DBT skills) within an ACT program would yield added benefits to clients. This format is notably different from the research described above because in the context of ACT, these skills would be taught individually, in-vivo, with phone support, and as needed by the clients. It is possible that such a format could provide the necessary personalized coaching, ongoing feedback, and the reinforcement necessary to yield benefits for clients.

General Conclusion: To date, there has been no empirical support for an added benefit of adopting only the skills training group component of DBT. It appears that other components of DBT including individual therapy may be necessary to yield
favorable results. Nonetheless, implementing only the DBT skills component within an ACT program has not yet been investigated.

**What therapy process components of DBT seem to be effective?**

At least one study has begun to investigate associations between therapy process variables and client / therapist changes. Specifically, Shearin and Linehan (1992) studied such process variables in a study with four therapist-client dyads. This study provided some preliminary evidence that:

- Combining acceptance and change strategies was closely associated with reductions in parasuicidal urges and suicidal ideation.
- Therapists also rated how much they thought the clients liked them. During times that the therapists felt that the clients perceived them as warm, there were decreases in clients’ suicidal behaviour. This provided support for the idea that the more DBT supervision and consultation can be used to help therapists to see past a client’s often confrontational stance and to maintain a warm demeanor, the more the clients will respond favorably.
- After therapists modeled nurturing and self-care skills, clients were rated by the therapists as exhibiting better self-care skills.

**General conclusion:** The balance of client acceptance and change strategies, therapist warmth and validation, and modeling self-care seem to be “on the right track”, with this population.

**Is DBT cost effective?**

Given the complexities of treating BPD, it is not surprising that this disorder is expensive to treat. DBT has been shown to reduce some of the factors associated with this cost including: hospital admissions, length of inpatient stays, and parasuicidal acts. A preliminary analysis of the cost-effectiveness of DBT suggested that although DBT is more expensive to offer relative to other community-based treatments, DBT was found to be cost-effective in that savings in hospital expenses in the United States more than offset the added cost of DBT (Linehan et al., 1999).

### 7. ACT and DBT

Given the encouraging research findings on DBT, several ACT program have begun to integrate DBT into their service provision for individuals with BPD. To date, at least two such programs exist: the Grey Bruce, Ontario ACT Team and ACT of Kalamazoo, Michigan (Schwammle et al., under review). In discussing the integration of these two approaches, Schwammle et al. have argued that ACT and DBT are compatible in several ways:
1) Both involve teaching life skills to help clients enhance their capabilities in dealing with their environments.

2) Both work to improve motivation to stay in therapy by focusing on skills generalization to the clients’ natural environments.

3) Both are “assertive” in their approach to client engagement

4) Both specialize in providing services to clients who have been resistant to treatment and who may be difficult to engage.

5) Both incorporate telephone consultation and after-hours crisis services.

6) Both approaches emphasize the importance of peer support and supervision for the staff in enhancing the therapists’ capabilities and well-being.

Experiences of ACT of Kalamazoo, Michigan (Schwammle et al., under review; Cunningham, Wolbert, & Lillie, in press):

The ACT program in Kalamazoo, Michigan has been providing DBT within their program since 1995. This ACT program provides treatment to 190 clients via three separate ACT teams which each consist of: an MSW team supervisor, a nurse, five other staff members with Bachelors or Masters degrees, a part-time case aide, and a part-time consulting psychiatrist.

At the time that their DBT program started, 8% of their clients had a diagnosis of BPD, although this group was consuming 17% of total staff time and 50% of the after-hours crisis contacts. Since the DBT program was implemented, approximately 15% of the total caseload has consisted of individuals with BPD (28 clients).

The program was implemented as follows:

- Four team members received intensive training in DBT via two five-day workshops. These team members provide individual DBT, with one staff member acting as the individual therapist for each client.

- The trained team members oriented the remaining staff to the DBT model.

- The team later sponsored a two-day DBT workshop, for all of the staff to attend.

The DBT protocol consists of the following components:

- Weekly 1-hour individual DBT sessions are provided for each client, with one trained member of the team acting as the therapist. The sessions are either conducted in the clients’ home or at the ACT office.

- Weekly DBT skills groups are co-led by two members of the team, who lead the groups on a rotating basis. Although different members of the team take turns in facilitating the groups, the rotations are organized such that one facilitator from the previous week’s session always remains to ensure continuity.
DBT skills coaching is integrated within the program’s telephone on-call system, and is provided by the team. The primary therapist is available for consultation with the team regarding his/her client.

Skills generalization to the clients’ natural environment is conducted through regular client contacts.

Skills trainers and therapists meet for weekly supervision and consultation.

All staff attend ongoing training in DBT.

How did the Kalamazoo ACT team perceive the DBT program?

An informal interview with the Clinical Director of the Kalamazoo ACT team was conducted. He indicated that the overall team’s perceptions of the DBT program were favorable. Although integrating a DBT program within their ACT program involved a commitment of time and financial resources, the director’s perception was that the DBT program provided the staff with a structured approach and with concrete suggestions that were manageable. Additionally, the staff perceived positive changes in their clients as a result of the program. This progress was noted even during the initial stages of integrating DBT into their ACT services.

Experiences of the Grey Bruce, Ontario ACT Team (Schwammle et al., under review).

The Grey Bruce ACT Team has been offering services since 1999 to a large catchment area in rural Ontario. This team consists of four nurses, two social workers, three occupational therapists, a program manager and a secretary. Due to a strong need for services for individuals with personality disorders in their community, this team immediately accepted individuals with personality disorders into their program and based on a review of available treatments, they embraced the DBT treatment model. Currently, 27% of their caseload (10 clients) have been identified as having a personality disorder, and six of these individuals have received DBT services. The implementation of their DBT program was similar to the ACT team of Kalamazoo, Michigan (described above).

8. OTHER APPLICATIONS OF DBT IN NON-TRADITIONAL SETTINGS

It is also noteworthy that DBT services have been successfully implemented in several other contexts other than the traditional out-patient format. These have included applications in hospital in-patient units (Barley et al., 1993; Swenson, Sanderson, Dulit, & Linehan, 2001), a partial hospital program (Simpson et al., 1998), and a residential rehabilitation program for individuals with mental health problems (Wolpow, Porter, & Hermanos, 2000).
For example, in implementing a DBT program in a hospital in-patient setting where patients typically stay for several months, Barley et al. reported that the staff were first trained via a two-day DBT workshop. A skills training group was the first component of DBT to be implemented and was led by a clinical psychologist. This was followed by the implementation of a DBT homework group, which was led by psychiatric nurses and focused on the application of the DBT skills. Because the skills group was run on an ongoing basis, a “fundamentals” group was implemented, focusing on orienting new members to the DBT skills. Additionally, the nurses maintained ongoing interactions with the patients where they provided the patients with feedback and further guidance in applying DBT skills to resolve life difficulties. The DBT principles of balancing behavioural analysis and problem-solving strategies (including contingency management strategies) with validation strategies were employed and coordinated throughout the unit. Finally individual therapy was provided by the team psychiatrists who adhered to the therapeutic principles of DBT.

9. THE CLIENTS SPEAK: ANECDOTAL ACCOUNTS OF PARTICIPANTS IN A DBT / ACT PROGRAM

Cunningham, Wolbert, and Lillie (in press) conducted open-ended semi-structured interviews with 14 of the individuals who received DBT services in the context of the Kalamazoo ACT program. In an effort to present the Queensway ACT team with information about how clients perceived the integration of ACT and DBT, the results of this qualitative analysis are presented below.

General Perceptions

The clients perceptions of the DBT program were generally positive. In particular some clients reported that the program provided them with the necessary skills to better modulate their emotions and to tolerate distress. Clients also reported that this program helped them to become more interpersonally effective, which led to a wider range of adaptive coping behaviours and less of a need to engage in self-harm.

Clients’ perception of the individual therapy

Therapist-client rapport factors and in particular, the ability of the therapist to maintain a non-judgmental and validating stance emerged as extremely important for the clients.

In particular:

- Some clients perceived effective therapists as striving to achieve a balance between non-judgmental / validating styles while also pushing and challenging them. Dissatisfaction emerged for clients who felt that they were either pushed too hard when they were not ready, or who were not pushed hard enough.
- Some clients also reported that the therapists treated them as equal partners and that they were working toward mutually agreed upon goals. They found this component to be helpful.
Clients’ perception of the DBT skills

Clients’ varied in the degree to which they found the skills to be helpful and applicable to their lives.

- One factor that emerged was the importance of helping clients to clearly understand each of the skills, which were at times difficult for them to grasp. It was suggested that the clients be shown practical applications of these skills so that they could be readily applied to their own life contexts.
- The clients also perceived the therapists’ skills at monitoring and adjusting the flow of the meetings to be very important (i.e., balancing the need to attend to clients in crisis while also monitoring the flow of the meetings).
  - Given the perceived importance of skill trainers’ knowledge base, it was recommended that less experienced skill trainers work initially with more experienced trainers.

Clients perceptions of group work

The support that the clients received from their peers during the skills training group interactions appeared to be extremely important for them. The group format helped the clients to realize that others shared similar difficulties, and facilitated the process of learning from each others’ experiences.

Skills coaching

In general, the clients appreciated the skills coaching and found this to be helpful. They particularly appreciated the skills coach’s flexibility and variable degrees of involvement.

The clients’ reported on two problems that emerged during skills coaching:

- That the variability among the skill coaches suggestions were often confusing for the clients. Nonetheless, as Schwammle et al. noted, this provided the clients with the opportunity to cope with such confusion and frustration in a more adaptive way.
- Many clients felt that they could have used more validation during the skills coaching.

Summary of findings:

- ACT team clients appreciated the DBT approach and believed that this helped them to develop important emotional regulation skills. Additionally, the opportunity for peer support and exchange of experiences appeared to be an important process for clients.
- Therapists’ skill level and their ability to balance validation with change-oriented strategies appeared to be paramount for clients.
It is important for skills group facilitators to convey DBT skills in a concrete manner that could be practically applied to clients’ lives. Clients sometimes felt confused by the presence of multiple skills coaches who were present on the ACT team. Consequently, if multiple members of the team act as skills coaches it is important to foster consistency among the team members during group consultation meetings. However, when inconsistencies are perceived this may be used as an opportunity to help clients learn to tolerate frustration and ambiguity.

10. RECOMMENDATIONS TO THE QUEENSWAY ACT TEAM

Based on a review of the DBT literature and the use of DBT in ACT programs, the following recommended options are suggested for the Queensway ACT team to consider:

Option #1: Implement a self-contained full DBT program

This option would involve implementing a full DBT program as described above. Such a program would include: individual therapy, DBT skill training groups, telephone consultation, efforts to coordinate contingency management, DBT approach to treatment planning, and supervision / team consultation.

Disadvantage: Given the complexities of a full DBT program, this option would involve a financial commitment to fund staff training and a significant time commitment to implementing the program.
Advantage: Full implementation of DBT has received the empirical support described above.

Suggested implementation strategy

✓ Select a team leader who will oversee implementation and staff training.

✓ Arrange for formal DBT training.

✓ Form a study group for staff to review Linehan’s treatment manual and supplied readings.
✓ Orient clients and other professionals involved to the DBT approach.

✓ Implement the program gradually; Development of a DBT skills group may be a good place to start. Members of the team may run the skills training groups on a rotating basis.

✓ Integrate DBT skills into client contacts and telephone support services.

✓ Other DBT strategies to integrate include: balancing validation and change strategies, contingency management, DBT treatment planning approach, hierarchy of treatment targets.

✓ Telephone support and supervision / consultation are already present within the ACT team. Adaptations that are consistent with the DBT philosophy may be necessary.

✓ Individual therapy should be conducted by a member of the team who has received intensive DBT training.

Option #2: Work in partnership with another agency where a DBT program us already established

A proposal for funds to establish a DBT program was recently submitted by Centretown Community Centre (2001) in partnership with the Hôpital Montfort and with the Ottawa Hospital. The proposal stated that the DBT program would consider accepting referrals from local ACT teams, with whom they would coordinate case planning efforts. If this option is implemented, it is recommended that the established DBT program conduct the individual therapy and run the skill groups. The Queensway ACT team would require some formal training in DBT to coordinate efforts in contingency management, treatment planning, and supervision / consultation with the DBT program. It is also recommended that a member from the Queensway ACT team participate in weekly consultation meetings with the DBT program. The realization of this option is dependent on a DBT program being available for clients of the Queensway ACT program.

**Advantage:** This model would allow for the clients to benefit from specialized DBT services while maintaining coordination and continuity of care with the Queensway ACT team. Although formal training would be necessary, this option would involve a substantially reduced time and financial commitment relative to developing a self-contained DBT program.

**Disadvantages:**
• Local DBT programs may not be available or accessible. For example, the demand on a separate DBT program may exceed the resources available to accept referrals from the Queensway ACT team.
• Potential difficulties of coordinating treatments offered by two “intensive” programs.
Suggested implementation strategy

✓ Select a team leader who will oversee implementation and staff training.

✓ Send some staff for some formal training (e.g., two-day seminar). Alternatively, directed reading of Linehan’s (1993a, 1993b) treatment and skills manual may be coordinated by the team.

✓ Orient clients and others involved to the DBT approach.

✓ DBT skills groups and individual therapy would be offered by the established DBT program at an outside agency.

✓ ACT team staff would participate as skills coaches, and facilitate the generalization of skills to the clients’ environment.

✓ The ACT team would also incorporate the DBT philosophy of care into their services (e.g., treatment planning approach, contingency management).

✓ Members of the ACT team would participate in weekly consultation / supervision meetings with the DBT program to ensure continuity of care.

Option #3: Partial implementation of DBT in advance of full implementation

In this option, the Queensway ACT team would implement selected components of DBT into their services. The components would be selected based on both client needs and based on staff perceptions of which DBT components may be implemented. Examples of DBT areas that may be implemented include: DBT skills, balance of validation and change strategies, and contingency management. During informal communications the Clinical Director of the Kalamazoo ACT team reported that his team had gradually implemented selected components of DBT into their service provision prior to implementing a full DBT program. Although he noted client improvements even with a partial implementation of DBT, he also advised that it would be important to maintain a commitment to and a plan for implementing the remaining components of DBT.

Advantage: If this option is selected, the Queensway ACT team can take immediate steps to select and to implement components of DBT into their program.

Disadvantage: To date, the effectiveness of selected components of DBT has not been demonstrated empirically. In fact, the limited existing research on implementing only the DBT skills component has indicated no added benefits to clients.
Suggested implementation strategy

✓ Select a team leader who will oversee implementation and staff training.

✓ Maintain a commitment to and a plan for continued training, along with a schedule for adding other components of DBT. Other components of DBT may be added either within the Queensway ACT team or through a separate DBT program (i.e., option #2).

✓ Send some staff for formal training.

✓ Select a team leader who would oversee implementation and staff training.

✓ Form a study group for staff to review Linehan’s (1993a, 1993b) treatment manuals and/or supplied readings. One member of the team should take responsibility for organizing this.

✓ Select a component of DBT with which to start (e.g., DBT skills training)

✓ Orient clients and others involved to the DBT approach.

✓ Work with a consultant who has experience in offering DBT services.

Staff response to the recommendations

The members of the Queensway ACT team responded favourably to the information presented. More specifically, the consensus was that elements of the DBT model would be helpful in serving their clientele. Although no decisions were made regarding the recommendations, the group felt that elements of DBT were consistent with their approach and could be used effectively with their clientele; In fact, DBT skills had already been integrated into the services by two members of the Queensway ACT team who had already undergone five days of intensive training in DBT. They felt that option #2 (i.e., to work in partnership with a local DBT program) was the most feasible approach to take. As was mentioned above, the realization of this option is dependent on a DBT program being available for ACT clients. The team is also considering implementing selected components of DBT into their services.
12. REFERENCES


