Dialectical Behavioral Therapy for Brief Inpatient Settings

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Introduction

The purpose of this paper is to provide an overview of Dialectical Behavioral Therapy (DBT), to describe inpatient DBT and to review randomized controlled trials of its uses and effectiveness in inpatient and outpatient settings, specifically those practicing brief therapeutic interventions. The findings of the trials will be used to provide recommendations for practice by guiding the development of a short term, not longer than three weeks, inpatient model. This model may be effective for reducing suicidal, and parasuicidal behaviors, lengths of hospitalization, recidivism rates, treatment dropout rates, improving interpersonal functioning, and anger management in heterogeneous Veteran’s Affairs inpatient settings. The model would be specifically for patients with borderline personality disorder alone, or with comorbid substance abuse disorders, as well as for patients with common Axis I mental disorders such as, bipolar, major depressive disorder, substance abuse disorders and other personality disorders.

Overview of Dialectal Behavioral Therapy

Dialectal Behavioral Therapy (DBT) was originally developed by Marsha M. Linehan in 1991 to treat actively suicidal individuals and continues to be refined to address the needs of Borderline Personality Disordered patients who are suicidal. In recent years, DBT has been modified to address the treatment needs of a variety of personality disordered patients including, substance abuse disorders, eating disorders and antisocial behavior comorbid with Borderline Personality Disorder (BPD) in a variety of settings including inpatient, outpatient and incarcerated patients (Swenson, Sanderson, Dulit, & Linehan, 2001). It has been demonstrated to decrease self-harm (parasuicidal) behaviors,
length of hospitalization, treatment dropout rate (Linehan, Armstrong & Suarez, 1991); (Linehan, Heard & Armstrong, 1993), while developing anger management skills, as well as interpersonal functioning (Linehan, Tutek & Heard, 1994). DBT has also been modified to treat the combination of substance abuse and BPD (Linehan & Dimeff, 1996). In addition to inpatient settings, DBT has been revised for day treatment, residential and forensic settings, case management, emergency services, family and adolescent treatment of eating and dissociative disorders in large scale mental health systems in Canada, the United States, Europe and Australia (Swenson et al., 2001).

DBT is a variation of cognitive-behavioral therapy specifically for BPD (Linehan, 1993), which requires an adherence to a balance between acceptance strategies derived from Zen teaching and practice, and change strategies taken from cognitive and behavioral therapies. DBT integrates exquisite validation, empathy, and acceptance of the patient coupled with a radical acceptance of things as they are in the moment. It simultaneously insists on a relentlessly rigorous and consistent focus on behavioral change and problem solving (Swenson et al., 2001). The treatment evolves from a biosocial theory of the etiology and preservation of BPD and hypothesizes that the underlying problem is emotional dysregulation. Emotion dysregulation is viewed by the creator of DBT, Linehan, as having roots in a vulnerable temperament, and is shaped and maintained by an invalidating environment, resulting in a lack of emotion modulation skills, and motivational deficiency (Linehan, 1993). Characteristic behaviors of BPD include suicidal, parasuicidal i.e., cutting, burning, and impulsive behaviors, which are viewed as direct outcomes of maladaptive efforts to regulate painful and chaotic emotions (Swenson et al., 2001).
Dialectical Behavioral Therapy in the Inpatient Setting for Patients with Borderline Personality Disorder-Rationale and Overview

Swenson et al. (2001) have observed that treatment of Borderline Personality Disordered patients in the inpatient setting is typically burdened with impediment and failure. Staff and patients frequently become entwined in intense negative spirals that eradicate the potential for effective, focused, realistic treatment interventions. Inpatient care of persons with BPD has been notoriously problematic for all involved. Inpatient staffs, which are already stretched to the limits, are untrained to effectively address the real needs of BPD patients, who present life-threatening behaviors, impulsive episodes, and intense emotional lability. The patients, frequently in crisis in their emotionally vulnerable state, encounter a strained, often invalidating environment involving numerous restrictions. Certain typical features of inpatient treatment are not congruent with the DBT position. The power differential between staff and patients, the common bias against borderline patients, the inclination of staff to join together in the treatment of the patient, reinforcement of submissive and passive behaviors is contrary to DBT’s collaborative therapeutic relationship between patient and staff, non-critical emphasis, predilection for consulting with the patient regarding how to manage difficult communications with other professionals, and reinforcement of active emotional expression and assertiveness (Swenson et al.). Additionally, inpatient units are laden with emotional triggers, which can impede patients’ ability to learn new behaviors that must then be generalized to natural outpatient settings. Further, hospitalization itself may reinforce maladaptive behaviors in some BPD patients.
Swenson et al. (2001) reports that although these obstacles can be formidable, DBT shows promise of being an excellent model to educate and orient newly admitted BPD patients and their families, to provide target behaviors for patients and staff, to delineate new active and collaborative treatment relationships, and to facilitate and reinforce skills to promote expeditious discharges and decreased recidivism. DBT can provide the model on a heterogeneous unit or a BPD homogeneous unit with longer admissions. There are innumerable opportunities on inpatient units to coach DBT skills and to observe behavioral change that are unmatched in the outpatient setting. Suicidal, parasuicidal or other egregious behaviors such as breaking objects, hitting walls, peers or staff, can be immediately addressed by a planned response protocol integrating skills training, contingency management (management of therapy interfering behaviors), and behavioral analysis. The inpatient setting can provide the guidance for outpatient practitioners to consult to for problem cases, and can provide a safe environment in which to practice exposure procedures to address and decrease unbearable emotions. Fortunately, the role of nursing on an inpatient DBT unit is systematic, pragmatic, and consistent with nursing philosophy (Swenson et al., 2001)

Outpatient resources for BPD patients have typically been uncoordinated and insufficient, which has further encumbered the inpatient task. BPD patients may appear similar to other mood-disordered patients on the unit but, frequently are unresponsive to the usual helping strategies. When confronted by the BPD patient’s continued communication of their experience of pain, the staff becomes frustrated and angry, resulting in common negative transactional spirals, with mutual blaming, punishment, and misunderstanding. This frequent scenario results in some of the more agonizing
experiences of inpatient work (Main, 1957; Gabbard, 1986). With experience, the staff comes to anticipate resistance, manipulation, and hostile behavior, from BPD patients (Gallop, Lancee & Garfinkel, 1989), who come to expect injustice mistrust, punishment, and rigidity from inpatient staff (Sadovoy, Silver & Book, 1979). Within this context, positive outcomes and a focused, brief hospitalization intervention are difficult (Swenson et al., 2001).

Psychoanalytic therapists initially developed milieu-based “holding environment” treatment models for BPD patients, which utilized psychodynamic therapy (Adler, 1973; Levine & Wilson, 1985). Most such units have disappeared as a result of declining lengths of stay and withdrawn support from reimbursers. Other authors, more influenced by cognitive-behavioral and pragmatic perspectives have presented short term inpatient models, emphasizing clear rules and punishment (limit-setting), contracting, early setting of discharge dates, and direct approaches for attaining clearly established target behaviors (Swenson, 1992; Miller, Eisner & Allport, 1994).

Stages and Targets of Inpatient DBT

DBT philosophy fosters problem solving in the outpatient environment, which is consistent with its inpatient goal of elimination of future hospitalizations. As in the example of a newly admitted suicidal patient, the DBT team focuses on the behaviors that led to hospitalization, rather than suicidal behaviors per se, with the aim that the patient is more likely to remain out of the hospital during future suicidal episodes. These are the target categories for a short-term inpatient treatment (Swenson et al., 2001).

Dialectical synthesis is a mainstay during inpatient treatment. Staff constantly looks for opportunities to utilize DBT’s dialectical strategies to move the patient, the team and
the treatment from rigidity, polarity, and stasis, in the direction of flexibility, synthesis, and change (Swenson et al., 2001).

The targets of the Pre-Treatment Stage, are (1) Agreeing on goals, (2) Committing to the treatment plan. The initial assessment concludes with discussion of treatment targets with the therapist working to elicit commitment from the client to working on those goals. Since a large number of borderline patients are admitted involuntarily, it may be challenging to arrive at that commitment. Some patients may not be able to move beyond the pre-treatment stage, here it is necessary for staff to recognize that as the problem, rather than act as though some agreement has been reached, when it has not. The pretreatment stage is an opportunity to orient patients to the unit, DBT, to validate their pain and difficulty and structure initial problem solving, including an analysis of those behaviors prompting hospitalization along with an introduction to crisis survival skills (Swenson et al., 2001)

In Stage 1, treatment is directed by individualized targets developed for each patient during the Pre-Treatment Stage, which are taken from two umbrella categories. The first involves decreasing behaviors which prolong/prompt hospitalization and it has three subcategories of which suicidal, homicidal, and near lethal i.e. severe anorexia are the highest priority. The second subcategory regards inpatient treatment destroying behaviors of staff or patient that prolong inpatient treatment and outpatient behaviors of staff or patient that destroy treatment and prompt admission. Patients’ treatment-destroying behaviors include extreme nonattendance, noncollaboration, noncompliance, interference with other patients’ treatments. Therapist treatment-destroying behaviors include examples of serious imbalance such as being far too rigid or far too flexible, as well as
egregious behaviors, such as gross disrespect. Depending on who is responsible for the treatment destroying behavior, the inpatient team could consult with the patient, the inpatient staff member, or the outpatient therapist(s). Egregious and parasuicidal behaviors are the third category of targeted behaviors and specific techniques have been developed to address those behaviors, which will be discussed below (Swenson et al., 2001).

Another aspect of work done during Stage 1 is reducing behaviors that prompt or prolong hospitalization. The patient collaborates with the team to increase skills for getting out and staying out of the hospital. These skills include, Crisis Survival Skills learned in the Distress Tolerance module, Troubleshooting Skills used to anticipate and address barriers to creating a life worth living, and as is possible, DBT skills from other modules (Swenson et al., 2001).

Each patient’s Priority Target List is used to organize that individual’s care. For the head of the treatment team it is the treatment plan. Nurses, doctors, therapists, and other staff use it as a guide for meetings and sessions and the patient uses it to remain focused, and to monitor progress. Target lists are behaviorally specific, and are constructed in collaboration between the patient and therapist. They list targets in order of priority and can be modified over time. Primary targets are monitored on a diary card, which is a DBT rating form filled out daily, or more frequently by the patient (Swenson et al., 2001).

Discipline and creativity are required to identify a realistic number of treatment organizing targets for use in a brief inpatient stay. Frequently this leads to a battle between staff and patient over the agenda of a particular session, pitting the already defined targets against the patients other intense concerns of the moment. In DBT, this is
considered a conflict with potential for practice of DBT skills. For example, in his/her daily interview with the patient, the nurse might insist they address the patient’s suicide threat of that morning, but the patient prefers to talk about another issue. The nurse can negotiate that some work on the suicide threat could be followed by the patient’s preferred topic, thereby reinforcing the overall agenda of target-focused work. The impact of consistently addressing target priorities can be somewhat difficult for the patient and staff, but it facilitates an effective course of hospitalization (Swenson et al., 2001).

*Contingency Management*

Swenson et al. (2001) note that the use of Contingency Management, when used thoughtfully and consistently, can be extremely effective in assisting patients to move toward their targets, while maintaining necessary limits on the unit. Contingency management involves the therapeutic application of behavioral consequences, designed to increase adaptive and decrease maladaptive behaviors. Contingency management principles include positive reinforcement, negative reinforcement, random intermittent reinforcement, extinction, punishment, and shaping. Staff have access to patients twenty-four hours per day and as such have myriad opportunities for reinforcing small skillful steps in target directions using positive reinforcement, to extinguish maladaptive behaviors, by withholding reinforcement and soothing the patient, and to punish egregious behaviors when absolutely necessary. Immediate reinforcement is more effective than delayed, natural consequences are more effective than artificial ones, and extinction is preferred to punishment. The ideal is an atmosphere permeated with positive reinforcement for small gains, using punishment effectively and as sparingly as possible.
It is unfortunate that often inpatient units unwittingly, reinforce the same behaviors targeted for reduction and extinguish and punish behaviors targeted for increase. For example, typically on an inpatient unit, the patient who has injured him/herself receives much attention related to their injury; such attention can reinforce such behaviors throughout the unit, where as, skillful coping and communication if unreinforced, can be extinguished (Swenson et al., 2001). The DBT staff, when confronted by maladaptive behavior, asks, what is the purpose of this behavior? What stimuli triggered the chain of events, leading to this behavior? And what internal and external reinforcers were in effect? Further, it is important for staff to ask, what might we be doing that inadvertently is strengthening this behavior. How can we extinguish this behavior and at the same time promote more adaptive choices? At what point, will it be necessary to institute punishment in order to extinguish this behavior? It is encouraging that if the staff consistently focuses on the patient’s target behaviors, maintains an atmosphere of caring about the patient, and is constantly alert to new developments, they will be automatically and effectively be utilizing the majority of learning principles. Staff training, however, in behavioral principles is vital (Swenson et al., 2001).

An example of the above would be a patient who has been cutting herself daily. After each episode of cutting, there is a flurry of attention paid to the patient by staff and fellow patients. The patient is even at times, placed in restraints and on close observation status, requiring her to have a one-to-one staff member present to observe her activity 24 hours per day with her doctor meeting with her in the seclusion room. Attempting to assess with the patient, during a calm interlude, the causes of the cutting behavior, yielded little information, but did reveal that the unit’s response was reinforcing the behavior. Time
with the staff and doctor soothed the patient and made her feel special. Being in restraints provided longed-for physical contact and the disruption of the flow of the unit provided the patient a sense of power in a frightening environment. The DBT team met and it was decided to eliminate the reinforcers for her parasuicidal behavior. When the cutting behavior occurred, the patient would no longer be met by soothing staff contact and private doctor visits to the seclusion room. When staff sat with the patient on close observation status, their interaction would be much more austere. An important aspect was a worksheet that the patient filled out, guiding her through an exploration of the precipitating events, her thoughts and feelings. When the worksheet, called a Behavioral Chain Analysis, was completed by the patient, a staff member, nurse, or therapist reviewed the Behavioral Chain with the patient, striving for understanding, and reinforcing the patient for identifying her thoughts and feelings. She then attempted to repair any interpersonal damage she had caused, and was further reinforced for her efforts. Immediate and emphatic reinforcement was provided for any constructive attempts to communicate distress (Swenson et al., 2001). After reinforcers for the target behavior had been removed, there was an initial increase, in intensity and severity of the cutting behavior, a “behavioral burst” or “extinction burst,” which must be anticipated and temporarily tolerated prior to an actual decline in the behavior (Swenson et al., 2001).

Protocols for Suicidal and Egregious Behavior

Some DBT inpatient units have implemented protocols defining staff responses to self-destructive and egregious behaviors. Some of those behaviors are universal, ones that would be considered completely unacceptable and disruptive on any inpatient unit i.e.,
violence, as well as behaviors that are disruptive given the purpose or limits of a particular unit i.e., hoarding food on an eating disorders unit. These protocols merge contingency management, behavioral analysis, and skills training involving certain steps. Immediately following a self-destructive or egregious act, the charge nurse decides if a protocol is to be initiated. If so, a staff member explains the protocol to the patient and provides him/her with a written introduction to the protocol and a behavioral chain analysis worksheet. There are three parts to the protocol: (1) the behavioral analysis chain, (2) presentation of the analysis to peers, and (3) repair (Swenson et al., 2001).

The patient works alone in Step 1 to complete the behavioral chain analysis worksheet. Following its completion, a nurse, briefly meets with the patient to review the analysis and reinforce good work in identification of thoughts, feelings, highlighting patterns, and suggesting alternatives. In Step 2, the patient presents his/her behavioral analysis to the other DBT patients with or without the presence of staff members, and receives feedback. During this “Protocol Meeting,” peers are coached and encouraged in the use of effective interpersonal and distress tolerance skills, while giving feedback. The patient again meets with a nurse at the end of Step 2, for feedback and to prepare for Step 3. The patient is required in Step 3 to attempt to repair any damage done by their previous egregious behavior; this may mean meeting with those individuals affected by the behavior. The patient does not attend any treatment meetings while on the protocol since protocol work is regarded as the highest treatment priority at that point in time. When these protocols are accurately adopted, adapted and endorsed by unit leadership, it has been demonstrated that they are consistently excellent as learning tools and in reducing the number and degree of egregious episodes. When this protocol is consistently utilized
on inpatient units, the suicidal and therapy interfering egregious behaviors become less disruptive (Swenson et al., 2001).

*Program within a Program*

DBT recommends the use of a structure for reinforcing the Pre-Treatment patient to choose to commit to working in treatment. This strategy involves the fact that committing to working in treatment is a reinforcer for most individuals in that by committing they will receive enriched treatment opportunities, such as more time with the staff. The patient who is unwilling to commit is offered a more limited program, whose focus is committing to the DBT program. One unit’s demonstration of this strategy was to offer a Commitment group to Pre-Treatment patients and offered individual and group therapy only to those patients committing to Stage 1 (Swenson et al., 2001).

*Observing Limits*

At all times and in all unit situations, DBT therapists and staff must be responsible for observing their own individual limits, which requires them to tactfully and courageously communicate those limits to patients. When staff observes their own limits, staff burnout can be prevented. Observing limits is different from setting limits, which is a unit-wide setting of uniform limits on patients. Observing limits, allows staff to individualize care, convey respect, and model effective self care to patients who are frequently unaccustomed to having their personal limits observed. When patients persistently violate staff’s stated limits, those violations become target behaviors, responded to by behavioral analysis and contingency management. The staff member provides positive reinforcement for observation of limits and reprimands violations (Swenson et al., 2001).
As an example, of observing limits, one staff member may be comfortable with profanity, while another is not; their observation of limits will differ in that area. One staff member might allow a patient to accompany him/her on hall rounds, but another may prefer to do that task alone. While in DBT, these staff limit differences are viewed as natural. Staff, which has been trained in models, emphasizing limit-setting and boundaries may, at first, feel frightened by the idea of units tolerating natural individual limits among staff, fearing that control of the unit will be lost, and that staff splitting will occur (Swenson et al., 2001).

Staff observes programmatic limits, defined by the program director. Program limits delineate individual staff member’s personal limits. For example, in the event of staffing shortages, the unit director may need to limit the amount of one-to-one contact that is conducted between nursing staff and patients. Staff then, clarifies this need to patients, who may find this limit very unsatisfactory. While the patient may not like the programmatic limit, they are not blamed for “neediness”. In the event of persistent patient non-adherence to program limits, staff consults with other DBT trained staff members, as well as addressing the problem in therapy and other DBT meetings with patients (Swenson et al., 2001).

**Support for Staff**

Feelings of helplessness and frustration are common among inpatient staff, which has experienced painful interactions with borderline patients. Sometimes, unfortunately, patients are blamed, when staff has not yet learned to effectively treat them. Weekly consultation meetings are held by DBT staff members to help each other avoid burnout, maintain their objectivity and compassion and practice consistent DBT. This system
serves to help each team member practice according to the guidelines of DBT, continue to gain knowledge of the treatment, and to preserve morale. Frequently, in these meetings, staff works to understand the function of the patient’s maladaptive behavior, rather than to criticize them for it. The meetings further serve to support each team member in identifying and complying with his/her personal limits or to validate and encourage a disheartened team member (Swenson et al., 2001).

The DBT consultation team exists separately from the regular inpatient interdisciplinary team in order to maintain a complete focus on carrying out DBT according to established guidelines and principles. It is definitely not necessary that all staff members on the unit are practicing DBT. DBT trained staff, on a heterogeneous unit, recognize that some staff are not similarly trained and DBT patients must be made aware of this fact (Swenson et al., 2001).

The DBT consultation team may need to assist an angry, frustrated team member return to a non-pejorative attitude. As an example, one angry, discouraged team member was describing how a borderline patient was, “sabotaging” his discharge by refusing to attend pertinent interviews. The consultation team leader, first validated, the member’s frustration, and then speculated aloud, whether the team could frame a more objective analysis of the patient’s behavior that was still consistent with staff observations. Another team member volunteered that the patient could be terrified of leaving, and so, was evading the discharge process. The member went on to state that it was important, now, to validate the patient’s feelings without backing off from the discharge planning (Swenson et al., 2001). The effective consultation team, helps team members on the way to dialectical balance, between validating the patient and assisting the patient to problem
solve, between maintaining involvement with the patient, while observing one's own limits, and between retaining realistic inpatient goals, while remaining cognizant of the vast problems in a patient’s life (Swenson et al., 2001).

**Splitting in Hospital Treatment**

It is common for inpatient staff to get into intense disputes about borderline patients. This has been explained, by psychodynamic theorists, as the activation, in the social field of the patient, of her fractured internal world. One staff member is treated as the “good object,” while another is the “bad object” or triggers an already existing rift among inpatient staff. The disagreement between the staff is regarded as an externalization of the patient’s internal conflict, and to provide the patient with relief and a sense of control. By evaluating the disagreement, light can be shed on the nature of the patient’s internal turmoil, which can mend the relationship between the two staff members or subgroups, who can then realize the role they have played in the patient’s internal world, and allow for the patient to receive a corresponding analysis of her conduct. This interpretation must be handled skillfully, or the patient will feel blamed for the dispute between staff members (Swenson et al., 2001).

The DBT method used in these situations is taken from DBT’s Dialectical, Consistency, and Consultation-to-the Patient Agreements. When two staff members cannot agree regarding a certain patient, the team seeks the validity in the opposing points of view and looks for an overarching conception that synthesizes the two. No assumption is made that the patient in question is intentionally or unconsciously attempting to split the staff, and there is no goal to formulate an explanation to the patient. This is done to arrive at a blend of the two opposing points of view that is
adequately complex and accurate. Disaccord of this nature between staff team members is thought to be a natural and predictable aspect of working with patients who are conveying pain and who are refractory (unresponsive) to therapeutic efforts. It is not in keeping with DBT to persuade staff members to have the same opinions about patients or to interact with them in the same manner. DBT holds that in life, individuals typically act and react differently from each other and the inpatient setting will be more similar to real life if normal differences between staff are expressed. When a patient complains to one staff member about another, it is considered a teaching opportunity to utilize interpersonal effectiveness skills. The DBT staff member will refrain from intervening on behalf of the patient to resolve problems for the patient. For example, a patient might say to Nurse A, “I hate Nurse B, she is out to get me. She avoids me when I want to talk, but she has plenty of time for the other patients.” Nurse A might say, “I see that you want more communication with Nurse B, let’s talk about how you might be able to get it. This is a chance to practice being effective at getting what you want from others and maybe it will help you with relationships outside the hospital.” Nurse A would generally not approach Nurse B about the issue (Swenson et al., 2001).

Skills Training

An ideal setting for acquiring and strengthening DBT skills is the inpatient setting, particularly the Distress Tolerance Skills that may decrease the rate of recidivism. DBT skills can be facilitated in scheduled groups, practiced and reinforced daily, generalized in the milieu and outside the hospital in the patient’s familiar environment. It is crucial that there be some form of follow-up to assist in generalizing learned DBT skills to the
outpatient environment. In order to achieve this, some inpatient units, where there are no outpatient skills groups, have created follow-up groups (Swenson et al., 2001).

The inpatient DBT program teaches and promotes reinforcement of the specific skills as well as maintains a “skills culture” that is in some ways effective. The concentration is on practicality, concrete steps, and in the moment abilities. The atmosphere created provides a productive, change oriented focus, which absolutely runs counter to a negative focus on patients’ “bad behavior” and deep pathology that echoes patients’ own feelings of being hopelessly flawed, evil or crazy. This validating atmosphere aids in reducing shame and empowers the patient with practical skills and respect (Swenson et al., 2001).

The grouping of borderline patients and other personality disorder patients in skills training groups provides the added valuable effect of offering a group of peers for each patient, peers who may have similar ineffective coping behaviors and problems and who are learning skills together. Patients find support in the groups. Rules of the group prohibit criticism of one another or the discussion of group issues. Leaders clearly establish that members are there solely to help him or her self and to provide support for other group members in the learning of new skills. These groups have been shown to raise both patient and staff morale in most inpatient DBT settings (Swenson et al., 2001).

As the inpatient setting is 24 hours per day, 7 days per week, there is much opportunity for creative implementation of skills groups. Groups can be held multiple times per week including evenings and weekends. The teaching of new skills can be done by combining patients into larger groups. Homework is best reviewed in groups of six or fewer patients to allow a minimum of ten minutes of individual attention per patient. Additional groups can be included to enhance generalization of skills to other inpatient
groups, such as how to employ interpersonal skills in other unit groups, how to give potentially thorny feedback non-judgmentally, or for stressing the application of learned skills in the patient’s outpatient environment. On one unit a “consultation group” was run, wherein patients were encouraged to present any problematic situation and would receive coaching in thinking about which DBT skills might help resolve the problem. Mindfulness skills which involve seeking balance and being centered, in addition to being part of the regular skills curriculum, can become part of the daily structure of the unit, with “Mindfulness in the Morning” or “Mindfulness at mealtime” (Swenson et al., 2001).

As already stated, in the acute setting, a subset of the complete set of skills are taught, which are particularly likely to reduce future hospitalizations. Five, eight and ten lesson curricula have been developed (Miller, Eisner & Allport, 1994; Springer, Lohr, Buchtel & Silk, 1996) typically underscoring Distress Tolerance, and dealing with Mindfulness and Interpersonal Effectiveness to a lesser extent. Once the desired skills have been selected, they will be taught again and again in a cyclical fashion. New patients can be given an orientation to the skills in person or on video, and then be brought into the group at whatever point the group is at currently in the cycle. As in all learning, repetition is important for learning DBT skills, and patients whose stay exceeds a cycle of skills, can repeat the cycle (Swenson et al., 2001).

Any nursing staff familiar with specific skills can teach patients to use particular skills in opportune situations in the inpatient setting. This approach increases skills acquisition and fosters the process of generalization. For instance, a patient with panic, anger, parasuicidal urges, and fear can be trained to use crisis survival skills, such as self-
soothing or distracting, and can receive positive reinforcement for his or her effort. A patient refusing to speak to family members to whom he or she will be discharging, can be coached to use interpersonal effectiveness skills facilitated by role-play practice with staff members. The patient who commonly dissociates prior to self-injury can learn to use mindfulness skills to enhance voluntary intentional control at crucial predissociation moments. It has been found to be effective in some inpatient settings to rotate staff members into skills group facilitating positions, as a means to increase the skills-potency of the whole milieu (Swenson et al., 2001).

**Primary Therapy**

Like outpatient DBT, inpatient DBT requires a primary therapist to be the coordinator of the patient’s general treatment and treatment team. The primary therapist evaluates and orients the patient, determines target goals, and attempts to negotiate a commitment, supervises overall progress, and coordinates the DBT agenda of other team members. He or she engages in behavioral analyses of goal behaviors in sessions, interweaves skills and fosters realistic problem solving that is practical for a brief inpatient admission. The primary therapist sets the tone for the admission by working toward establishing balance between validating the patient, and insisting on behavioral change, a difficult challenge for a brief stay, given that the admission is usually precipitated by crisis behaviors (Swenson et al., 2001).

Some DBT units, driven by economic pressures, have delivered primary therapy services and strategies in group therapy settings, which can be advantageous in that it harnesses peer reinforcement toward change and capitalizes on the commonalities shared by patients. Further, the elimination of individual therapy in the inpatient setting,
reserving it for outpatients, may help to lessen the reinforcement for staying in the hospital. On one unit, the therapist sees patients individually only for assessment, orientation, goal targeting, and commitment and then patients join that therapist’s DBT group therapy. The DBT group meets two times per week for one and a half hour sessions, focusing sequentially on individual patient’s target behaviors which are visible to the group on a flip chart. Patients’ behavioral analyses are done during interaction between the therapist and the patient in focus at the moment. The last half hour of the group is devoted to strengthening the group relationship and discharge planning (Swenson et al., 2001).

The Relationship with the Outpatient Therapist

Relationships between outpatient therapists and their inpatients will vary. Regarding ongoing outpatient therapy, in which inpatient stays might reinforce being in the hospital, the DBT therapeutic stance is to let the patient go “at the door” and to “pine for her return” to outpatient therapy. In the case of the patient being new to therapy or if the patient, therapist bond is lacking, the outpatient therapist might plan to strategically contact the inpatient to draw out a stronger attachment. This kind of decision about contact should be made in collaboration with the patient, the outpatient therapist and the inpatient staff (Swenson et al., 2001).

Dialectal Behavioral Therapy Strategies

DBT procedures, which are designed to effect change, consist of consistent and systematic analysis of dysfunctional behavioral chains, behavioral skills training, contingency management to reduce or weaken reinforcement for self-injurious and other disordered responses, reinforce skillful responses, cognitive restructuring (seeking
evidence to support patients’ cognitive distortions), exposure-based stratagems focused on dismantling avoidance and moderating maladaptive emotions. The DBT therapist provides a validating environment, endeavors to extinguish maladaptive behaviors, teaches skills that foster effective emotion regulation, relationship building, and promote reinforcement, strengthening and generalization of skills to all relevant settings (Swenson et al., 2001). DBT therapy posits that therapists require support, which is in part, provided in a weekly DBT consultation team meeting, the goals of which are to reduce therapist burn-out and to enhance therapist adherence to the treatment model and competence in providing treatment to these patients (Linehan, 1993).

Acceptance strategies involve mindfulness i.e., focusing on the here and now, the activity in the moment, assuming a nonjudgmental perspective, and observance of effectiveness. Training provided to BPD patients, in its standard form, consists of once-weekly individual psychotherapy along with group skills training, skills coaching via phone with the primary therapist as needed and team meetings of DBT therapists (Sanderson et al., 2001).

Individual psychotherapy sessions revolve around clearly prioritized targets and are aimed at reducing maladaptive response patterns i.e., life threatening behaviors, therapy interfering or threatening behaviors, severe Axis I disorders, and behavior patterns that prevent a reasonably satisfying quality of life and improving motivation for skillful behaviors. Problems and behaviors experienced since the previous session determine the foci of particular individual sessions. Patients receive psychoeducational skills training, which teach mindfulness, distress tolerance, emotion regulation, interpersonal effectiveness, and self-management skills (Sanderson, et al., 2001).
Overview of Studies Supporting DBT

The following are reviews of trials of the clinical use of DBT utilizing Linehan’s (1993) model, in inpatient settings and one outpatient setting. In all but one study, the patients all carried the diagnosis of borderline personality disorder, along with Axis I diagnoses such as substance abuse and eating disorders. Most were Caucasian; the majority was female between the ages of eighteen and forty. Most study participants had a history of suicidal behavior, as well as multiple psychiatric hospitalizations and had suffered childhood and adult sexual abuse. The majority of the trials are randomized with controls. They are studies of short term interventions ranging from five days to ten months. Patients were evaluated pre-treatment and post-treatment, and in some cases again as long six months following treatment for evidence of changes in their rates of suicidality, parasuicidality, anger, depression, anxiety, and dissociation.

Evidence Based Practice Question/Search

Clinical Question: For the Borderline Personality Disorder inpatient population, is brief Dialectical Behavioral Therapy (DBT) more effective in reducing anger, depression, self-harm and rates of recidivism than treatment as usual (TAU)?

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Data Base: National Guideline Clearing House

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The studies reviewed in this project are all Level II, Evidence obtained from at least one properly designed randomized controlled trial, Level III, Evidence obtained from well-designed controlled trials without randomization or as in one case Level VII, evidence from opinion of authorities and/or reports of expert committees. The results of the evidence are valid. Random assignment was used in some of the studies and not in others. The control groups were appropriate in those studies that included controls. The instruments used were valid and reliable. The findings are relevant to my patients. There were no identified risks to treatment and benefits were identified. The intervention is feasible in my treatment setting. This writer would recommend integrating the evidence derived from these studies into the brief inpatient psychiatric setting for treatment of borderline personality disorder patients.

Evidence Supporting DBT

Linehan, M. M., Comtois, K. A., Murray A. M., Brown, M. Z., Gallop, R., et al. (2006) replicated her 1993 outpatient study in a large two-year randomized controlled trial of DBT in which standard DBT was compared to community treatment by experts (CTBE). One hundred eleven female subjects who met DSM-IV criteria for BPD were randomly assigned to either DBT (60) or CTBE (51) and matched for total number of suicide attempts, incidents of self-injury, number of psychiatric hospitalizations, and presence of factors associated with negative therapeutic outcomes such as severe depression low global functioning scores.
The DBT group demonstrated superior treatment outcomes, particularly on goals targeted by treatment. The DBT assigned subjects were half as likely to attempt suicide as the CTBE group. The assessed medical risk of self-inflicted injuries by DBT subjects was significantly less than that of the CTBE subjects. Subjects assigned to the DBT intervention had a significantly lower number of visits to emergency or inpatient services. Also consistent with prior studies, DBT assigned subjects were less likely to drop out of therapy or change therapists. There were no outcomes measured that demonstrated greater effectiveness of CTBE (Linehan et al., 2006).

Simpson, Pistorello, Begin, Costello, Levinson, & Mulberry, et al. (1998) observed a women’s brief partial program conducted at Butler Hospital affiliated with Brown University School of Medicine in Providence, Rhode Island. Women who meet three or more DSM-IV criteria for borderline personality disorder are given seven hours per day of brief, intensive, DBT treatment, five days per week for five weeks. They attend the program during the day and return home at night. Women who graduate from the program are eligible for six months of outpatient skills training. The authors report that after two years of operation, and working with more than five-hundred women, there is significant anecdotal evidence that DBT, an outpatient methodology, can be effectively adapted to hospital settings (Simpson et al. 1998).

A study done at the Durham, North Carolina VA Medical Center involved twenty women veterans who met DSM-III-R (1987) criteria for BPD. The women were randomly assigned to two groups of ten, with one group receiving six months of outpatient DBT as outlined by Linehan (1993) and the other receiving treatment as usual
(TAU) for the same period of time. The mean age of the participants was 35, seventy-five percent were Caucasian and twenty-five percent were African American. Seventy-five percent had a history of parasuicidal behavior including a history of previous suicide attempts. Fifty-five percent had been admitted to a psychiatric inpatient setting and twenty-five percent had a history of substance abuse. Sixty percent met the McIntyre Trauma Questionnaire criteria for sexual abuse before the age of thirteen, sixty-five percent had experienced partner related battery, eighty-five percent reported having been raped as an adult, and forty-six percent while in the military (Koons et. al., 2001).

DBT treatment was shortened to six months from the previous one-year program of Linehan (Linehan et al., 1991). Linehan et al. (1991) reported significant advancement by four months of treatment. Standard DBT includes weekly group skills training, individual therapy, and a therapist consultation meeting. In this treatment, the skills training group and the therapist consultation were condensed to ninety minutes per week. The clinicians providing individual DBT consisted of a psychiatrist, two psychologists, a clinical nurse specialist in psychiatry and a clinical social worker. All clinicians had received intensive training in DBT (10 days plus 6 months practice and homework) by Linehan and her associates.

The treatment as usual control group (TAU) was offered sixty minutes of individual therapy weekly with a VA clinician. The standard of care received by the TAU group was at or exceeded the usual care received by women veterans at that VA medical center. Additionally, the TAU participants were offered a choice of several supportive and psychoeducational groups. The TAU clinicians consisted of three psychologists, a clinical nurse specialist in psychiatry, two resident psychiatrists, and two clinical social workers.
They had agreed to use the therapeutic interventions that they would normally use for patients with borderline personality disorder and none had been trained in DBT. All participants except one in the DBT group were receiving pharmacotherapy, which included a Sustained Serotonin Reuptake Inhibitor (SSRI) and some patients also received a mood stabilizer and or neuroleptic (Koons et al., 2001).

Outcomes were measured at baseline, after three months and then again after six months of treatment. Behaviors were measured that were both common to borderline individuals but also for which there are standardized measures. Measured outcomes evaluated were, parasuicidal behavior, hopelessness, measures of depression, anxiety, anger, suicidal ideation and dissociation. Also assessed were rates of psychiatric inpatient admissions to the hospital. The results generally supported the effectiveness of DBT. Participants in DBT changed significantly more than those in TAU in four outcome variables, suicidal ideation, Beck depression scale, anger out and hopelessness. For four other variables, number of parasuicides, number of hospitalizations, dissociation and anger in, only DBT participants demonstrated significant change. On two variables, number of BPD criteria, and Hamilton depression scale, both groups changed significantly and on one variable, anxiety, there was no significant change by either group. The authors note that a major shortcoming of this study is its small sample size; only ten participants in each treatment group. Of note, half of the TAU clinicians reported that their clinical orientation as cognitive-behavioral, so their treatment may have been similar in some manner to DBT although this was not assessed. No follow-up data exist for this study to evaluate the robustness of effects (Koons et al., 2001).
Kroger et al. (2006) conducted a study at the University of Luebeck in Germany that involved 44 women and 6 men who met DSM-IV (2000) criteria for BPD. Exclusionary criteria for the study included, mental retardation, drug or alcohol dependency, and schizophrenia. The fifty participants were treated in a three-month inpatient setting utilizing the guidelines of DBT. Patients received one hour per week of individual therapy which integrated validation (acceptance, empathy), along with problem solving techniques (skill training, contingency management, cognitive restructuring, exposure to emotional cues). The focus of each individual therapy session was determined by a target priority list and the patient’s behaviors in those target areas. Group therapy sessions lasted a hundred minutes, three times per week. Group therapy taught skills in mindfulness, emotion regulation, interpersonal effectiveness, distress tolerance, and self-management strategies (Kroger et al., 2006).

Group and individual therapy was implemented by four psychiatrists and three psychologists. Medication use was supervised by nurses and psychiatrists, but not controlled by the protocol. Thirty-one participants were receiving antidepressants (SSRIs or tricyclic antidepressants). Benzodiazepines were given as a last resort in crisis interventions for acute suicidality or refractory dissociative states for a maximum of three days; no patients received mood stabilizing medications or neuroleptics (Kroger et al., 2006).

Outcomes were assessed at pre-treatment, at discharge and at follow-up after fifteen months. Participants had on average 6.1 axis I lifetime disorders, 5.5 current pre-treatment disorders, but sustained a reduction to 4.2 axis I disorders after treatment. The score of the Global Severity Index (GSI) or the SCI-90—R decreased over time as did the
score of the BDI. The GAF score increased significantly. These results indicate a significant reduction in depression and psychopathology, however all individuals treated with DBT continued to demonstrate suffering from pathological levels of symptoms at the termination of treatment and at follow-up (Kroger et al., 2006).

The authors note that limitations of the study include, a lack of assessment of parasuicidal behavior, a lack of a control group, and that interviewers were not blind to the treatment. They also suggest a possible confounding effect by medications (Kroger et al., 2006).

A brief interview with creator of DBT, Marsha Linehan at the December 3-4th 2007 Dialectical Behavioral Therapy Conference in Chandler, Arizona yielded a response to a clinical question posed by the writer: When is it appropriate to initiate a Behavior Chain Analysis after an episode of self-harm? Dr. Linehan responded that it is appropriate to wait twenty-four hours after the event to initiate and review the Behavior Chain Analysis (M. Linehan, personal communication, December 3, 2007).

Bohus, Haaf, Stiglmayr, Pohl, Bohme & Linehan, (2000) evaluated the effectiveness of a four month inpatient DBT program at the University of Freiburg in Germany. This study hypothesized that the course of outpatient DBT could be accelerated if it were preceded by a three month inpatient treatment of DBT. Data comparing patients’ pretreatment incidence of self-harm and dissociative episodes as well as ratings of depression, anxiety, and global stress was compared with data one month post inpatient treatment (Bohus, et al. 2000).

This study of twenty-four female patients, which evaluated data gathered on admission and one month post treatment produced encouraging results. One month post
discharge, patients retained significant improvements in ratings of dissociation, depression, anxiety and global stress as well as a significant reduction in self-harm events (Bohus, et al. 2000).

Barley, Buie & Peterson, (1993) investigated a homogeneous BPD unit with a several month average stay that had adapted certain features of DBT: DBT orientation upon admission, DBT target goals, individual therapy, group skills training, self-monitoring, utilizing diary cards, unit-wide adaptation of contingency management strategies, an emphasis on validation, and behavioral chain analysis. A comparison was made of average parasuicide rates over three time intervals: the 19 months on the unit preceding the introduction of DBT, the 10 months of the instruction of DBT and the 14 months in which DBT was being fully operationalized. Parasuicidal rates were significantly lower during the last period than during the previous two, and by contrast, there was no change in parasuicidal rates during the same 43 month period, on a more traditional general psychiatric unit in the same hospital (Barley et al., 1993).

A study, by Springer, Lohr, Buchtel, & Silk, (1996) compared outcomes between patients assigned to a Creative Coping (CC) group which incorporated DBT skills on a brief stay unit, (12.3 average days) with outcomes of patients assigned to a Wellness and Lifestyles Discussion group. Both groups of patients attended approximately six sessions. Compared with the control group, the CC patients “acted out” more on the unit, but were more likely to believe that the skills would help them after discharge. Patients in the CC group, contrary to the recommendations of Linehan’s (1993) manual, were encouraged to openly discuss their self-injurious behaviors, which may have induced a contagion effect (Springer et al., 1996).
Bohas, Haaf, Simms, Limberger, Schmahl, & Unckel, (2004) examined pre and post data of a three-month comprehensive inpatient DBT treatment program, provided as a precursor to long-term outpatient therapy. The treatment consisted of behavioral analysis of target behavior, orientation to the basics of BPD and DBT skills training aimed at reducing future hospitalizations, and contingency implementation of reinforcers following self-injurious behaviors. The month prior to hospitalization and the month after were compared and it was found that post treatment, there were significantly fewer parasuicidal acts and significant improvements in ratings of depression, dissociation, anxiety and global stress (Bohas et al., 2004).

A two-stage study done by Alper and Peterson (2001) investigated the impact of DBT on both patients and staff nurses. The first question investigated the effect of DBT on self-injurious behavior over time, when BPD patients receive DBT in a regional treatment center. The second question focused on how nurses responded to the use of DBT with BPD patients in the inpatient setting.

Quantitative data were collected from a review of medical records of inpatients treated at a regional treatment center. The center is a state-operated facility caring for mentally ill and chemically dependent patients, utilizing a DBT approach to treatment. Specifically, the relationship between the incidence of parasuicidal (self-injurious) behaviors and the use of behavioral chain analysis, as defined by Linehan (1993) as an aspect of DBT was examined (Alper & Peterson, 2001). Behavioral chain analysis consists of the patient involved in self-injurious behavior completing a behavioral chain analysis form, on which the patient is asked to identify the precursors, thoughts and feelings leading to the self-injurious behavior. The patient spends an hour in seclusion, regardless of the actual
time needed for its completion. The staff nurse then sits briefly with the patient and reviews the behavioral chain, noting patterns, and providing the patient with reinforcement for identification of feelings. Further, the patient is assisted to identify alternative coping skills that could have been used instead of the self-injurious behavior. The staff nurse assumes an austere manner to avoid the potential for reinforcement of self-injurious behavior by staff attention. Medical records of 65 potential subjects were evaluated for eligibility. Inclusion criteria included: A psychiatrist’s diagnosis of BPD, being inpatient on the DBT unit for a 4-week consecutive period and existence of incident reports of self-injurious behavior (Alper & Peterson, 2001).

There were 473 incident reports generated by the 65 potential subjects. Incident reports relevant to the study included incidents of falls, possession/use of contraband, ingestion of foreign objects, and suicide attempts.

Nurses’ responses to the use of DBT with BPD patients were evaluated using a qualitative design. Only four nurses met the inclusion criteria, which was having worked on the unit at the regional treatment center both before and after the institution of DBT. A semi-structured interview was used to collect data related to the nurses’ experiences, which included the following questions:

1. Tell me about your preparation to use DBT.

2. How would you compare your experiences working with patients with BPD before you used DBT and now that you are using it?

3. What effect do you think DBT has had on patients with BPD (Alper & Peterson, 2001).
4. The results over the 4-week consecutive time period, showed a decrease in incidents of self-injurious behavior. Concerning the nurses’ preparation, there were four primary themes:

1. Attended a seminar on DBT Learned by doing it.
2. Determined the approach is consistent with one’s personal philosophy.
3. Received information before attending a DBT seminar.
4. All nursing subjects reported having attended a 2-day seminar, which they considered useful. There were weekly luncheon meetings in which chapters in Linehan’s book (1993) were presented by staff (Alper & Peterson, 2001).

There was one primary response to what it was like working with BPD patients without DBT, “It didn’t work.” Three themes emerged related to what it was like working with patients using DBT:

1. It is characterized by flexibility in that what is not working is reevaluated and revised.
2. It promotes self-knowledge i.e., self development, and recognizing your own limitations.
3. It is fundamentally a team approach because staff rapidly learns to become a very equalized team which includes the patient.

All the nurses had positive responses about the effects of DBT for patients with BPD. They claimed that it works, and had three observations:

1. It decreases recidivism.
2. It promotes safety and decreases self-injurious behavior.
3. There is a need for more community-based programs (Alper & Peterson, 2001)
A study done by Bohus at al. (2004) on the effectiveness of inpatient dialectal behavioral therapy for borderline personality disordered patients done at the Borderline Research Unit of the Department of Psychiatry and Psychotherapy at the University of Freiburg Medical School in Germany recruited all female participants who met DSM-IV (2000) criteria for BPD. Those selected for the study were required to have had at least one suicide attempt or two parasuicidal (self-injurious) acts within the past two years. Exclusion criteria were a diagnosis of schizophrenia, bipolar I disorder, current substance abuse or mental retardation. Patients currently receiving outpatient DBT therapy or subsequent DBT after discharge were excluded from the study. Only experienced and trained clinicians conducted the diagnostic assessments.

There were no between group differences on age, number of psychiatric hospitalizations, number of lifetime suicide attempts or pattern of current axis I comorbid disorders. The DBT group did meet criteria for significantly fewer BPD criteria than did the waiting list group (Bohus et al., 2004).

The DBT program was begun in 1995 and included: individual therapy 2 hours per week, group skills training 2 hours per week, group psychoeducation 1 hour per week, peer group meetings 2 hours per week, mindfulness group 1 hour per week, individual body-oriented therapy 1.5 hours per week and therapists’ team consultation meetings 2 hours per week. The individual therapy, skills training, and therapists team consultation meetings were implemented according to Linehan’s DBT manual (Linehan, 1993). Psychoeducation classes incorporated expanded instruction in Linehan’s bio-behavioral theory of BPD along with updated information on theory and research on BPD. The body-oriented therapy involved classes about psychomotor interaction and individually
adapted exercises which focused on improvement of body concepts. Therapists and staff were trained and given weekly supervision by the first author, who is a senior DBT trainer. The major focus of the milieu staff was to coach patients in the use of DBT skills in their daily life and to apply crisis intervention techniques (Bohus, et al., 2004).

All members of the waiting list had some form of professional mental health care during the 4-month waiting period. Twelve of the 19 participants were hospitalized at least once in a non-DBT psychiatric unit. Fourteen of the 19 members were treated with some form of outpatient care, with an average of 6.1 sessions (Bohus, et al., 2004). Seventy-four percent of the DBT participants and seventy-nine percent of the WL participants were receiving psychotropic medications (antidepressants: DBT=38%, WL=63%; neuroleptics: DBT=29%, WL=37% (Bohus, et al., 2004).

Outcome measures included: Lifetime Parasuicide Count (LPC; Linehan & Comtois, 1994), Symptom-Checklist (SCL-90-R; Derogatis, 1977); Hamilton Anxiety Scale (HAMA; Hamilton, 1959), State-Trait-Anxiety Inventory (STAI; Spielberger, Gorsuch, & Lushene, 1970), Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), Hamilton Depression Scale (HAMD; Hamilton, 1960), State-Trait-Anger Inventory (STAXI; Speilberger, 1988), Dissociations Experiences Scale (DES; Bernstein & Putnam, 1986), Global Assessment of Functioning Scale (GAF: Endicott, Spitzer, Fleiss, & Cohen, 1976, and Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Baer, & Ureno, 1988) (Bohus, et al., 2004).

Assessments were done at the initial interview for WL participants and during inpatient admission for the DBT group. Post-testing was done at four months after the
initial assessment, which was four weeks after discharge for the DBT group (Bohus, et al., 2004).

Between-group comparisons revealed that 62% of the DBT group compared with 31% of the WL group abstained from self-mutilation at post-assessment.

Several findings emerged from this study. First, when assessed one month after discharge from the three month DBT inpatient treatment program, BPD patients exhibited significant reductions in frequency of self-mutilation as well as significant improvement in dissociation, depression, anxiety, interpersonal functioning, social adjustment and global psychopathology. Second, when compared with individuals put on the waiting list awaiting DBT treatment, those participants in the inpatient DBT program had a significantly greater clinical progress on all but two outcome measures. No significant between-group differences were found in reductions of dissociation (due to a large standard error) or anger. Third, unlike those on the waiting list, who demonstrated no significant advancement over the four-month waiting period, analyses based on Jacobson’s criteria for clinically relevant change indicated 41.9% of those receiving DBT had clinically recovered on a general measure of psychopathology (Bohus, et al., 2004).

The findings of Bohus (2004) study are quite similar to the findings of Barley et al. (1993), and quite different from those of Springer, et al. (1995). Springer’s study added a “creative coping group” vs. a “wellness and lifestyles” to standard inpatient treatment for personality disorders. The creative coping group was based on the DBT skills training manual which was shortened for inpatient use. Both groups received ten 45 minute group sessions over 10 days. Both groups showed improvement in a variety of clinical outcomes, but there were no between-group differences. This absence of between-group
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Differences is similar to the findings of Barley et al., (1993), who found no significant progress in inpatient outcomes during the first phase of DBT, but did report significant improvement when the model was implemented in its entirety (Bohus, et al., 2004). Barley’s first phase of DBT consisted of solely adding DBT skills to the standard milieu, which was quite like the Springer et al. (1996) intervention. These findings suggest that partial implementation of DBT may not be effective. Further there is no data demonstrating that skills training, without DBT individual therapy is effective. An important revelation of the Springer study was that individuals assigned to the abbreviated DBT creative coping group actually had significantly increased rates of acting out behaviors, threats, attempting to leave against medical advice, hitting objects and self-mutilation on the unit (Bohus, et al., 2004).

The success of Barley’s program and the inpatient DBT program being reported here, give further evidence that DBT may be ineffective and possibly harmful if not properly applied. Both Barley and Bohus were trained by Linehan, the creator of DBT. It is noteworthy that, the clinicians in the Springer et al. (1996) trial did not have the degree of training of Barley and Bohus and their implementation of DBT breached a fundamental proscription of DBT skills training, in that it allowed patient group members to discuss with each other, their parasuicidal history and fantasies, which is ruled out in DBT because of the risk of contagion of such behaviors. Support for the notion that an important determining factor, for successful implementation of DBT resides in the training of its therapists. Trupin and Richards (2003) found that outcomes of incarcerated juveniles improved when their counselors had 80 hours of DBT training, but not when they only had 16 hours (Bohus, et al., 2004).
Bohus et al. (2004) reports that about 50% of female BPD patients who complete the three-month inpatient treatment program, improve to a clinically significant degree. The longevity of these effects during follow-up remains to be proven.

Springer, et al. (1996) examined whether DBT could be modified for brief inpatient stays of less than two weeks for a population of both men and women that included other personality disorders as well. A version of DBT called Creative Coping (CC) was being used in that setting for the two years prior to the start of research. A discussion group, called Wellness and Lifestyles (W&L), was created as a control group. Patients with personality disorders who agreed to participate in the study, were assigned to one group or the other by a randomization procedure (Springer, et al., 1996).

One set of hypotheses attempted to replicate the findings of Linehan et al. (1991) which were that there would be no between-group differences in the areas of depression, hopelessness, and suicidal ideation. A second set of hypotheses predicted that CC group patients would show improvement in areas addressed by that group: interpersonal effectiveness, mindfulness, emotion regulation, and distress tolerance. Particularly: 1) CC patients should demonstrate less anger than controls since addressing the managing of anger is a major focal point of the CC group; 2) CC group participants should feel increased control over their external environment, especially in their interpersonal relationships which should be indicated by a change in locus-of-control in the direction of an increasingly internal orientation; 3) CC group subjects should show behavioral changes via fewer self-injurious or treatment interfering behaviors while inpatient compared with the control group; and 4) CC group members should demonstrate greater
acquisition of the group lessons regarding emotion regulation, interpersonal

Thirty-one of the subjects in the study were women and twenty-one were men. A
subsample of thirteen subjects met criteria for borderline personality disorder by scores
higher than seventy on the Millon Clinical Multiaxial Inventory, Version II (MCMI-II).
Thirty-one of the subjects participated in at least four group sessions. The Creative
Coping group, developed by senior clinicians and nursing staff, was derived from
Linehan’s DBT for use on a short-term unit. The group is psychoeducational and is
facilitated by nurses with experience in leading groups for inpatients with personality
disorders. A ten session format is followed and is repeated if the patient remains in the
hospital after completion of the ten sessions. CC groups meet for forty-five minutes each
weekday, and are expected to complete homework assignments between groups. The ten
sessions encompass five lessons on emotion regulation, four on interpersonal
effectiveness, and one on distress tolerance (Springer, et al., 1996).

The studies’ W&L control group, was designed to discuss topics of interest to the
patient that are meaningful to their lives, but not using a psychotherapeutic approach.
Introspection and self-understanding were definitely not to be group goals. The five
topics selected were: recreation, health and fitness, families, hobbies and current events.
The W&L group also met for forty-five minutes each week day (Springer, et al., 1996).

Change was assessed by subjects completing questionnaires and interviews at
admission and just before discharge. Change measure tools administered were the Beck
Depression Inventory (BDI); the Hopelessness Scale (HS); the Adult Suicidal Ideation
Questionnaire (ASIQ); the State-Trait Anger Expression Inventory; the Internal-External
Locus of Control Scale; an the Creative Coping Questionnaire (CCQ) (Springer, et al., 1996).

As was predicted, both groups of subjects improved significantly during their hospitalization, on measures of hopelessness, suicidal ideation, and depression. Also as predicted, there were no between group differences using these change assessment tools, which yielded results similar to those of Linehan et al. (1991). It was predicted that the CC subjects would demonstrate more improvement in locus of control, anger, increased knowledge of coping skills, and therapy interfering behavior than the W&L group. This prediction was not supported by outcomes. The only significant between-group outcomes was that CC group subjects agreed much more strongly, than W&L subjects, that things they learned in the CC or W&L group will help them to better handle painful or difficult circumstances they might encounter in life (Springer, et al., 1996).

As predicted, both groups exhibited significant improvement in suicidal ideation, hopelessness, and in depression. These results suggest that even in brief hospital stays, important gains are possible. Another, interpretation of the findings of this study, was that subjects with borderline personality disorder did not experience different outcomes from the CC group than those with other personality disorders (Springer, et al., 1996).

**Synthesis and Recommendations for Practice Based on Evidence**

It is evident from the studies reviewed, that DBT has demonstrated effectiveness in a variety of settings and with patients with a variety of diagnoses including female veterans with borderline personality disorder. While the current Veterans’ Association inpatient mental health care system is not budgeted for three to six month inpatient stays, as in some of the studies discussed in this project, there are many indicators that brief inpatient
DBT can be effective. As mentioned before, nursing staffs who have been trained in DBT feel strongly that they now have tools with which to address the myriad behavioral issues encountered when treating this difficult population. Use of these tools prevents staff burn out, boosts morale and translates into improved working conditions. Staff no longer feels helpless, hopeless, frustrated or defeated. Patients who are hospitalized and have received DBT training on an outpatient basis do not suffer a regression effect if they are admitted to a setting practicing a DBT model.

The psychiatric inpatient unit at the Southern Arizona Veteran’s Affairs Health Care System (SAVAHCS) is a twenty-six bed setting. There are approximately fourteen beds allocated for psychiatric patients, six for alcohol and substance detoxification and six for post traumatic stress disordered patients. There is an attending physician assigned to each of those programs, as well as each program having one or two resident physicians, who complete four month rotations. The VA is a teaching hospital, so there are also medical and nursing students in clinical rotations. The psychiatric population is comprised of the full range of psychiatric diagnoses, including borderline personality disorder, schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, and patients who are dually diagnosed, with a psychiatric disorder and a substance abuse disorder. Approximately 20-30% of the psychiatric population is comprised of borderline personality disordered patients.

The writer recommends the implementation of Dialectal Behavioral Therapy for both in and outpatient mental health settings and thinks there is strong evidence to support the adaptation of the full model in the inpatient setting at the SAVAHCS. Twenty to thirty percent of the inpatient mental health population at the SAVAHCS has substance abuse
problems and another twenty to thirty percent have borderline personality disorder. A significant number of the BPD patients have comorbid substance abuse problems, so it may be reasonable to conclude that even if the benefits of inpatient stays of ten to fifteen days have not yet yielded studies demonstrating significant changes in parasuicidal behaviors, depression, anger, or interpersonal effectiveness, improvements may exist.

DBT must be implemented and practiced as outlined by Linehan (1993). There is significant evidence suggesting that while staff trained in DBT report improved morale, related to feeling empowered in the management of BPD patients, the data do also indicate that improperly or inadequately trained staff and improper or incomplete implementation of inpatient DBT can precipitate detrimental outcomes.

The mental health administration at the SAVAHCS has demonstrated encouraging support for the implementation of inpatient DBT by allocating funds for the education of mental health staff via one or two-day, eight or sixteen hour training that has been occurring since April of 2007. Crucial components lacking at the SAVAHCS for an effective inpatient DBT program are the program leadership and staff training provided by a DBT therapist and weekly inpatient DBT therapy for personality disordered and substance abusing patients. This inpatient therapy would focus on problem solving and generalization of DBT skills to the outpatient setting. In the inpatient psychiatric setting at the SAVAHCS we have provided DBT training to about one third of our staff. Patients identified as having borderline personality disorder traits are given an orientation to DBT lasting approximately forty-five minutes and are introduced to introductory Distress Tolerance skills. Daily one-hour DBT groups are facilitated by trained staff while untrained staff observe. Since we have begun this program about a year ago, we have
observed an apparent reduction in patient self-harm, anger, depression, and anxiety in patients who have received outpatient DBT training, although data has not yet been collected which supports this. Morale has improved and feelings of hopelessness have been replaced by empowerment among staff who have already received training and even among staff who have not received formal training as they are receiving guidance from trained staff. There is significant promise for increased positive outcomes in our inpatient population when a DBT therapist is added to the milieu, as we have already witnessed encouraging outcomes even without this important component. Additionally, this writer will be endeavoring to facilitate the transition of inpatient borderline patients receiving DBT to the outpatient DBT program.

Summary

Multiple randomized controlled studies have demonstrated that Dialectical Behavioral Therapy (DBT) created by Marsha Linehan, when used as proposed by Linehan in inpatient or outpatient settings, in long-term or brief inpatient settings, can be effective for reducing behaviors that prevent individuals from achieving a life worth living. It has been effective toward reducing suicidal behavior as well as parasuicidal gestures, anger, depression, in addition to number and length of hospitalizations. Created to treat borderline personality disordered patients, it has shown effectiveness in the treatment of substance abuse, forensic populations, families, adolescents, eating disorders and veteran populations. The purpose of DBT is the treatment of individuals suffering from cognitive, emotional, behavioral, and interpersonal dysregulation. This treatment is implemented by the teaching of emotion regulation, distress tolerance, and interpersonal effectiveness skills which revolve around a core of mindfulness meditation. DBT is taught in group
settings, but also in individual therapy. DBT is particularly effective with regard to improving staff morale related to working with difficult borderline patients. Staff trained to implement DBT feels empowered and much less helpless, angry and frustrated.

Dialectical Behavioral Therapy offers promise for the treatment of veteran populations suffering from borderline personality disorder, substance abuse, or personality disorders with comorbid substance abuse. Facilitation of a comprehensive inpatient DBT program requires a trained DBT therapist, which is currently lacking at the Southern Arizona Veteran’s Health Care System, but is a role that may be filled, as there is considerable awareness of and support for DBT on the part of the mental health administration.
References


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