Applying Dialectical Behavior Therapy Methods to Personality Disorder Patients in Healthcare Settings

Abstract

This article provides an overview of the principles and strategies of Dialectical Behavior Therapy (DBT), an increasingly popular treatment for individuals with severe personality disorders. Numerous randomized controlled trials support DBT’s effectiveness for treating Borderline Personality Disorder (BPD) in outpatient therapy settings, and an increasingly large body of literature supports its application to other problems of emotion dysregulation and practice settings. As a flexible and principle-based treatment, DBT methods lend themselves for working with difficult-to-treat patients in a variety of healthcare environments. DBT is distinguished from traditional cognitive behavioral therapy in that it combines behaviorism, a technology of change, with Eastern principles of acceptance taken from Zen Buddhist practice. Dialectical philosophy is used to synthesize these change and acceptance strategies in order to support emotionally dysregulated patients to tolerate active clinical work, and to help therapists manage their emotional responses and maintain a compassionate understanding of challenging presentations. A clinical vignette illustrates how DBT principles and strategies are applied for orienting and engaging difficult-to-treat patients into treatment collaboration. Implications and potential benefits of applying DBT methods with difficult-to-treat patients in healthcare settings are discussed.

Applying Dialectical Behavior Therapy Methods in Healthcare Settings

Across medical settings, healthcare providers regularly encounter at least some patients who are difficult to work with because of their problematic ways of thinking, relating, behaving, and expressing emotions in and out of the treatment setting. For example, some patients may tend to blame others for their problems, they may engage in impulsive, self-destructive, and self-defeating behaviors including not following through with treatment recommendations, and they may be argumentative or have other intense and labile emotional expressions (Steinmetz & Tabenkin, 2001). Such individuals often have little insight into how their behavior creates difficulty for the medical providers who are attempting to help them, and they are rarely aware of how their behavior leads health providers to not want to work with them due to feelings of anger, frustration, resentment, hopelessness, or even fear for their own personal safety or fear that the patient may harm themselves. When such individual differences are stable across time and setting, that is, represent personality traits, and lead to impairments such as their difficulty participating in treatment, they may be consistent with a personality disorder diagnosis. Although recent years have seen significant advances in developing and validating treatments for personality disorders, few healthcare professionals are aware of how to access and apply their methods and strategies. This article will introduce personality disorder treatment methods that may be helpful for health providers who encounter such difficult-to-treat patients.

The formal diagnosis of personality disorders is somewhat complicated when applied in the Asian context given the different diagnostic systems concurrently in use. For example, Chinese psychiatrists are divided in using three different diagnostic manuals (Zou et al., 2008) including the American DSM-IV-TR (American Psychiatric Association, 2000), the International Classification of Diseases (ICD-10; World Health Organization, 1992), and the Chinese Classification of Mental Disorders-3 (CCMD-3; Chinese Psychiatric Association, 2001). This has occurred in part because Chinese psychiatrists were originally resistant to applying certain DSM diagnoses such as “Borderline Personality Disorder” (BPD) due to concerns that it was a vague construct and that some of its features (i.e., fear of abandonment, chronic feelings of emptiness) were not relevant to the Chinese (Jia, 1998). This state of affairs led to the creation of the alternative CCMD-3 diagnosis “Impulsive Personality Disorder” (See BPD and Impulsive Personality Disorder diagnostic criteria in Table1). This rejection of BPD is concerning because BPD is both one of the most severe and best studied personality disorders, with ever increasing research demonstrating the benefits of specialty treatments over standard practices of care (Stoffers et al., 2012). Also, research has clearly demonstrated that BPD is present among Chinese patients (Leung & Leung, 2009; Wang et al., 2012; Yang, 2002), and that the DSM-IV-TR, ICD-10, and CCMD-3 criteria sets largely identify analogous disorders in Chinese patients (Lai et al., 2012).

Research on the prevalence of personality disorders suggests that they are found in 9.1% to 14.8% of the general community in the United States and Europe (Grant et al., 2004; Lenzenweger et al., 2007; Torgersen, Kringlen, & Cramer, 2001), and 4.1% in China (Huang et al., 2009). The prevalence rate of personality disorders among treatment-seeking individuals is much higher, including 31.4% to 52% of psychiatric outpatients (Keown, Holloway, & Kuipers, 2002; Zimmerman, et al., 2005), 40% to 70% of psychiatric inpatients (Stevenson et al., 2011; Hayward et al., 2006), and as high as 32%...