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An Overall Understanding of Dialectical Behavior Therapy to Control the Symptoms of Borderline Personality Disorder – A Research Review

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Abstract
Dialectical Behaviour Therapy is considered as the best therapy for the treatment of Borderline Personality Disorder. It is extremely helpful in reducing the symptoms of BPD patients. The aim of this research review paper is to review the effectiveness of DBT to reduce the symptoms of BPD patients. For this purpose, the open data source is used. Research and review papers available freely on the internet are used to understand the impact of DPT on BPD patients. The result revealed that DBT helps BPD patients to overcome their BPD symptoms in an effective way. Emotion regulation technique works like wonder on BPD patient's emotion. It was also found that DBT is capable enough to reduce the suicidal, non-suicidal and physical harming of BPD patients in both general and forensic settings.
Keyword: *Dialectical Behaviour Therapy, Borderline Personality Disorder, Effectiveness Of DBT, BPD treatment therapy*

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I. INTRODUCTION

Borderline Personality Disorder is distinguished by a well-established pattern of the unpredictability of mood, interpersonal relationship, self-image, and impulsivity (Diagnostic Statistical Manual of Mental Disorder -5). A person diagnosed with BPD make frantic efforts to avoid abandonment, recurrent suicidal behaviour, chronic feeling of emptiness, and exhibit unusual anger (American Psychological Association). The onset of BPD is by early adulthood (DSM-5). DSM –IV has recognized one out of ten personality disorder patients as a Borderline personality disorder patient. In psychiatric settings, it reckoned at about 15% of the population and about 50% of the patients with other personality disorders (Widiger & Weissman,1991). The name borderline was coined by "Adolph Stern" in 1938, but in 1980 only BDP would recognize officially as a diagnosis. Since then, it is being used vigorously to diagnose patients under this category. It is estimated that 20% of psychiatric patients and 3 to 5 % of the general population are diagnosed (Frances & Widiger, 1986). The term borderline personality disorder is being used for patients on the 'borderline' between neurosis and psychosis; however, its definition is not as simple as the term seems. It is the most common, complex and severely impairing personality disorder (Anon 2006), and those diagnosed with BPD are often afflicted by intense emotional pain and distress (Miller 1994, Perseius et al. 2005). Despite this, much of the literature reflects a negative attitude towards patients with BPD, who are regularly stereotyped by health professionals and often assumed to be manipulative and attention-seeking (Fallon 2003; Brooke & Horn 2010). It is also reported that psychiatric nurses are more socially rejecting BPD clients than those diagnosed with depression or schizophrenia (Markham 2003) and less empathetic towards patients with BPD than those with affective disorder and 'other' diagnoses (Fraser & Gallop 1993). However, those diagnosed with BDP express as most useful having someone they can talk to in times of crisis (Nehls 1999), but they often feel that they are not being listened by and that their views and opinions are often rejected (Rogers & Dunne 2011).

A borderline personality disorder is diagnosed predominantly with about 75% (two thirds) in women (Diagnostic Statistical Manual of Mental Disorder - V). Mood disorders are also common with borderline personality disorder, with 24% to 74% having major depression and 4% to 20% bipolar disorder (Widiger & Rogers, 1989). Up to 67% of the people with personality disorder are also diagnosed with at least one induced disorder (Dulit et al.,1993). BPD may also coexist with somatoform disorders. A meta-analysis found that 30% of those with BPD also have one or more somatoform disorders (Schmaling & Fales, 2018). Most common bio-psycho-social vulnerabilities, such as histories of trauma, could promote emotion dysregulation as a shared factor contributing to coexisting symptoms of BPD and Somatization, that is, bodily symptoms associated with distress.

Many different types of psychotherapeutic approaches are available to treat BPD patients; these include cognitive behavioural therapy, mentalization-based therapy, schema-focused therapy, transference-focused

therapy and dialectical behaviour therapy (DBT) (Stoffers et al. 2012). For this purpose, DBT has been studied the most (Stoffers et al., 2012). DBT has shown a significant effect on the treatment of BPD patients (Jane Davenport, Miles Bore, & Judy Campbell, 2010).

II. OBJECTIVE OF STUDY

The sole objective of the research paper is to examine the evidence supporting the DBT significance to control the symptoms of BPD patients. To prove the significance of DBT on BPD, studies that have been the base to develop this therapy and modern studies are being included. Studies available on the open data source are being used in this review paper. Only those studies are being reviewed, which were conducted on BPD patients to gaze at the efficiency of DBT. There are very few research review papers showing the importance of DBT for patients with BPD. Still, there is a lack of research review paper showing the overall effectiveness of DBT for BPD patients. Hence, this paper aims to review the overall effectiveness of the DBT to reduce the symptoms of the BPD patient without the barrier of inpatient, outpatient, male patient and female patients.

What Is DBT

Within the past 15 years, a new psychosocial treatment termed Dialectical Behavior Therapy (DBT) was developed specifically to treat Borderline Personality Disorder. This technique looked promising in the treatment studies (Koerner,&Linehan,2000). Dialectical-behavioral-therapy (DBT) is a multi-modal cognitive-behavioural therapy that is empirically supported therapy. It was first developed as a treatment for highly suicidal patients but subsequently refined for BPD treatment. DBT is one of the psychosocial interventions developed especially for the treatment of BPD. Several well-controlled clinical studies have proven its efficacy (NICE, 2009). Some empirical evidence also suggests that this treatment could be associated with changes in the activation of brain areas involved in emotion regulation (anterior, temporal and posterior cingulate, amygdala and left insula, and both hippocampus; Schnell & Herpertz, 2007).

DBT borrows its principles from behavioural and cognitive-behavioural psychotherapy, dialectical philosophy, and Zen concepts. The focus of the therapy is to teach the individuals how to live in the moment, how to make a balance between inner conflicts and reality, regulate emotions. It not only teaches patients to live life but also to make like worthy and blissful. DBT is an approach to psychotherapy, where therapists specifically address four areas that tend to be particularly problematic for individuals with BPD: self-image, impulsive behaviours, mood instability and problems in relating to others (M.Ghuffran, 2011). DBT incorporates the principles of cognitive behaviour therapy combined with mindfulness, acceptance and dialectics. DBT differs from CBT in that it places less emphasis on using cognitive methods and instead focuses on the learning and practice of new skills (Amner 2012). DBT works on four major behavioural skill areas: mindfulness, distress tolerance, emotional regulation, and interpersonal effectiveness (M.Ghuffran, 2011). Mindfulness is a prevalent part of DBT as it helps individuals be in the moment, allowing patients to realize and understand the emotions, impulses, desires, and needs that are storming inside them. Distress tolerance helps BPD patients to accept themselves as they are. Furthermore, it also helps the patients to accept their current situations. It incorporates four techniques to handle a crisis; distraction, improvisation of moments, self-soothing, focusing on the pros and cons of not tolerating stress. Emotional regulation skill lets the BPD patient address and manage to navigate emotions, reduce emotional vulnerability, and navigate negative emotions to positive and balanced emotions. Interpersonal effectiveness skill is centered on enhancing interpersonal relationship and self.

Components of dialectical behaviour therapy
(from Palmer 2002 and Soler et al. 2009) (Palmer R.L. (2002)) B. O'CONNELL1 RGN

Skill-based training is designed to augment the capabilities and problem-solving skills of the individual, and it allows for practice of the same in the form of role-playing within the group. Comprises of approximately two hours per week (Palmer R.L. (2002)

Individual psychotherapy is delivered every week for 60–90 min, with its function to relate the skills learned in the group to the client's circumstances. It also allows time for addressing commitment to the therapy and aims to reduce identified problem behaviours. (Palmer R.L. (2002))

Telephone consultation is designed to briefly assist clients in utilising appropriate skills to overcome obstacles effectively. Also, it aims to maintain the therapeutic relationship and help the individual ask for help. (Palmer R.L. (2002))

Consultation team meetings Meeting between the therapy team every week to facilitate case discussion and enhance the therapists' skills and provide support and motivation. It also helps therapists adhere to the treatment plan and helps to prevent therapist burnout. (Palmer R.L. (2002))

The multi-pronged approach of dialectical behavioural therapy matches with the biopsychosocial model coined by Linehan (1993b), who suggested that BPD is primarily a dysfunctional emotional regulation system. Originally DBT was developed as an out-patient treatment; it provides weekly one-to-one sessions, skills group training, access to individual therapists in times of crisis. It represents four modes of interventions; group therapy, individual psychotherapy, phone coaching and consultation team meetings. Generally, these techniques are for a period of a year (Table 1). Research pieces of evidence also support that DBT is highly effective in reducing BPD symptoms among patients who are being treated as in-patients (Bloom et al., 2012). Studies conducted across multiple clinical research settings have also supported that DBT is an effective treatment for BPD, either with or without comorbid substance use disorders. (Nicholas L. Salsman, PhD, and Marsha M. Linehan, PhD; 2006).

DBT: Background

During the 1990s, DBT started showing its competency to treat BPD patients effectively. All credit goes to epoch scholar Marsha Linehan of North America. In 1961 at the age of 17, she was admitted to hospital for the habitual cutting off her legs, hands, stomach, and burning of her wrists with cigarettes. She said: I was in a hell' while describing those days. She also says: I made a vow; when I would get out, I would come back and get others out of here. (Carey 2011). Linehan studied clinical psychology and developed DBT. Initially, she designed it to treat women with the tendency of chronic self-harm and suicide (Linehan 1993).

Linehan et al. (1991, 1993, 1994) conducted a series of studies initiated with a RCT (randomized controlled trial) measuring the efficiency of a psychosocial treatment for borderline personality disorder. The trial was conducted on the chronically suicidal woman diagnosed with BPD (n = 44). They took measurement to see the efficiency of DBT, which was performed on half of the group and compared it with the rest half of the group got TAU (treatment as usual) over one year. Linehan et al. (1991) reported a bunch of prevalent information focusing on the advantages of DBT over TAU in treating BPD patients. It was reported that 83% of individuals who were assigned to DBT continued to attend their therapy for the year; on the other hand, only 42% of individuals assigned to TAU continued to attend their therapy. The report also showed a visible fall in the hospitalization of the DBT group, on an average of 8.6 days stay per year, far less than when compared with 38.8 days stay per year for the control group. Linehan et al. (1993) found that in a follow-up of 6 and 12 months, women who went under DBT had an apparent reduction of anger, significant improvement in social adjustments, and better work performance than their TAU group.

Another study conducted by Linehan et al. 1994 found that DBT was better than TAU in enhancing both general and interpersonal adjustment of BPD. However, improvements in many areas were shown by the DBT patients, but still, few areas were significantly impaired after a year. Linehan et al. (1994) concluded that even though DBT was efficient enough, treatment of one year is not sufficient for BPD patients. Hence, the time duration of the DBT should more than a year.

Empirical support favouring the effectiveness of DBT for BPD patients

As time passed decades by decades lots of empirical supports came into existence showing the relevance and effectiveness of DBT to BPD. There are mountains of evidences to show the usefulness of DBT. We will discuss a few empirical proof of DBT to show its significance for BPD patients.

Linehan et al. (2020)

Linehan et al. (2020) researched treatment for borderline personality disorder and its secondary effect on somatization. The sole purpose of this study was to measure the effectiveness of DBT on BPD patients having somatization as a co-morbidity. The secondary effect of DBT in somatization as a comorbid (Karen B. Schmaling, Jessica L. Fales, and Marsha M. Linehan, 2020). One hundred one women between the age range of 18- to 45 years who also met the diagnostic criteria of BPD were randomly selected. These women had two or more than two suicidal attempts or self-injuries attempts in the past five years and one or more of which was in the 8 weeks before study evaluation.

In this study, participants were assigned to anyone group from two groups. The first group was - one year of DBT, and the second group was - community treatment by experts (CTBE). All Participants were being assessed on seven occasions. These were; before treatment assignment, on three occasions, every four months during treatment years, and on three occasions, every four months after the treatment. Participants who discontinued their treatment were asked to complete all their assessments.

The result of the study supported data. The participants who received DBT showed more significant decreases in emotional avoidance over time than those who received CTBE (Neacsiu et al.); both treatments

were very effective for reducing non-suicidal thoughts, self-injury behaviours, and suicidal thoughts ideation as well. Hence, this study showed a significant change in the emotional avoidance in the BPD patients while using DBT. Furthermore, a drastic decrease in somatization (Karen B. Schmaling, PhD) was also found in this study. The changes in somatization were also clinically significant.

Based on the finding, we can clearly understand the effectiveness of DBT for BPD patients with self-injury and suicidal tendencies. It is not only helpful for the patient suffering from BPD but also helpful to the patient having somatization as a co-morbidity with BPD. Hence, it is clear that if a patient is diagnosed with BPD with the co-morbidity of somatization, a clinician can use DBT to reduce the symptoms of BPD and Somatization as well.

However, there are a few limitations of this study: this study was conducted on women only, so we can't apply the finding of the studies on male and children. Furthermore, in this study, patients had BPD as the major illness with the co-morbidity of somatization. Hence we can't guess the scene of the DBT if the major illness is somatization with the co-morbidity of BPD.

Skye Fitzpatricka et al. (2019)

This study was conducted by Skye Fitzpatricka, Jennifer Ipb, Lillian Krantzb, Richard Zeifmanb , and Janice R. Kuo in 2019. This study was conducted to understand the role of emotion labelling (DBT) in regulating emotion in BPD patients. The sole purpose of the study was to investigate the impact of self-generated emotion labelling to decrease negative emotion in self-report, sympathetic, and parasympathetic domains (i.e., skin conductance response, respiratory sinus arrhythmia). Furthermore, to know that weather this effects differ across BPD group and HC group (healthy control). A total of 60 subjects participated in this study, where 30 subjects were in the BPD group, and 30 subjects were in the HC group (Skye Fitzpatricka, Jennifer Ipb). 86.7% female and 13.3% male participant were there. To find out the answer of these questions, both groups' participants were instructed to listen to emotion evocating scripts. They were instructed to either label their own emotions or objects that they could imagine in the script (control) and then implemented mindfulness or cognitive reappraisal. Visual analogue scales and BIOPAC 6-channel acquisition system (Model MP150) were used for data collection.

The finding of this study suggested that emotional labelling is capable of activating emotion regulatory systems among patients with BPD (Skye Fitzpatricka, Jennifer Ipb). It is also capable of being used as a therapeutic strategy. It has also been reported that, in HCs, emotion labelling can enhance the effectiveness of intentional emotion regulation but only in some domains (i.e., self-report). Hence, the use of emotional labelling (DBT) is of the great importance to control the emotion regulation of BPD patients (Skye Fitzpatricka, Jennifer Ipb).

There are a few limitations of this study as well. Thirty subjects were assigned in each group for the study. This number is very small. It may assume that if the number of subjects of each group increases, then a different result could be found. Furthermore, in this study, patients were engaged for 2 minutes for gazing emotional labelling and two and half minutes for gazing intentional emotion regulation. Such a small exposure cannot measure correctly and perfectly the emotional labelling, emotion regulation and the effect of emotional labelling on intentional emotional regulation. As a whole, we can say that this study is capable enough to reveal the impact of emotional labelling (DBT) on the emotional regulation of patients of BPD, both male and female. This study indicated that using the emotional labelling technique; we can activate the emotion regulation of BPD patients. Emotional labelling proved itself a promising therapy to work on the emotion regulation of BPD patients. However, the sample size taken for this study and the time given to each patient to assess their emotional labelling and intentional emotion regulation was much less. However, still, this study at least gives us the direction of the result provided by emotional labelling. It indicates that emotion labelling has a positive impact on the emotional regulation of BPD patients. If the number of participants in each group and time allocated to assess the emotional labelling and emotional regulation would increase, then also it will give result in a positive direction more or less. It's not like the direction of the finding would completely be changed. Hence emotional labelling (DBT) is a powerful technique to improve emotional regulation in male and female BPD patients.

Ueli Kramer (2017)

Ueli Kramer (2017) researched "The Role of Coping Change in Borderline Personality Disorder: A Process-Outcome Analysis on Dialectical-Behaviour Skills Training". The sole purpose of the study was to find out those aspects of the coping strategies of DBT which will be beneficial for BPD patients to degrade symptoms. For this purpose, 31 BPD patient were selected and went through two individual clinical interview assessments. Half of the patients were provided DBT skill training, and half were on the waitlist. Coping Action Pattern Rating Scale, Outcome Questionnaire-45.2, Borderline Symptom List 23 were used to gather data.

The finding of the study supported the impact of DBT coping skill training on the coping function of BPD patients and general distress. Its impact was far better than the impact of other skill training. There was an increase in relatedness coping when the stress was viewed as a challenge and a decrease in autonomy coping where the stress was perceived as a threat. Furthermore, emotion regulation was viewed as a potential coping skill to improve the coping skill of BPD patients.

It is apparent from the above discussion that Ueli study was conducted on both male and female both; hence the finding of this study is applicable for both male BPD patients and female BPD patients equally. As we know that most studies in the field of DBT are focused upon female studies only. Therefore this study becomes crucial for the future researcher and article writer to get an insight into the impact of DBT on male BPD patients. As the sole purpose of the study to see the effect of DBT coping skill on the symptoms of BPD patients, it was found that emotion regulation is the most powerful technique to change and improve the coping skill of BPD patients. Furthermore, it was more capable of changing and improving the coping skill of BPD patients than other techniques.

However, this study has a few limitations; first, the sample size was tiny. Only 31 BPD patients were selected for this purpose, which is not enough to study such a complex topic. Hence, there is a big question mark on the finding of this survey. Nevertheless, we can't deny the importance of this study, as it revealed the impact of DBT coping skill techniques on BPD patients. Apart from this, it comes under those very few studies conducted on male BPD patients.

Boch et al. (2012)

Boch et al. (2012) researched DBT in out-patients in Forensic settings. In forensic psychiatry, the main problem with BPD patients is criminal recidivism rather than suicidal and self-injury behaviour. Hence, the sole purpose of the study was to see the effectiveness of DBT to control criminal recidivism of BPD forensic psychiatry patients. For this purpose, a DBT treatment program was implemented in the Netherland's out-patient forensic clinic. Ten male and nineteen female BPD forensic patients were taken as participants, and data found from them were compared with the data found from fifty-eight non-forensic BPD patients. The decided age for men was 34 and age for the women was 35 The study revealed that it is possible to implement DBT for forensic BPD patients as both patients show BPD symptoms. 70% of male and 79% of female completed the DBT program, which resulted in an overall drop in the rate that was very similar to the DBT program for female BPD patients when compared to a regular mental health and also with addiction treatment setting. It was recorded that forensic BPD patients committed no suicidal attempt, homicidal and physical violence during the treatment. Therefore, we can say that we can apply DBT to reduce BPD symptoms in forensic patients. There is a specific problem in applying DBT in the forensic setting. In DBT, suicidal behaviors are considered a coping behaviour associated with pain and suffering. As DBT is based on the consultation-to-the-patient principle (Linehan, 1993), the DBT therapist can never intervene unless it seems that there is a high chance of taking harmful action by the patients.

There is no doubt that, the study revealed a new aspect of DBT; however like other studies, this study also has some limitations. First, it used too small sample size, making this study less liable to detect group difference. Second, half of the patient participated after the court order; therefore, behavior showed by him is under a big question mark. Third, the researcher took into account only those crimes and offences of the forensic patients for which they were convicted. Still, they never think about the crimes and offences, for which patients were never convicted but patients themselves reported it.

Despite many limitations, this study paved the way to understand the wide range of effectiveness of DBT for BPD patients. Whether the patient is a general BPD patient or forensic BPD patient, DBT is helpful for both types of patients in an equal manner. However, the sample size was tiny , but it at least showed us that DBT could treat forensic BPD patients in the same way as we do with general BPD patients. This study touched the very unusual but widely present type of BPD patients, forensic BPD patients, for which this study deserves appreciation.

Neacsiu et al. (2010)

Neacsiu et al. (2010) researched DBT skills as a mediator and its treatment for borderline personality disorder, using a hierarchical linear modelling approach. They examined 180 women diagnosed with BPD. From this, 63 women with recurrent suicidal attempt and 45 women with drug dependence. They all participated in three random control trials throughout a year of treatment and four months of follow-up sessions. DBT ways of coping checklist (DBT-WCCL) by Vitaliano, Russo, Carr, Maiuro, & Becker, 1985, Suicide attempt and self-injury interview (SASII) by Linehan, Comtois, Brown, Heard, & Wagner, 2006, Hamilton rating scale for depression (HRSD) by Hamilton, 1960 and State-trait anger expression inventory (STAXI) by Spielberger, 1988 were used for data collection.

This study gave four significant findings; First, all participants revealed that they were using some skills of DBT before treatment started. Second, participants using DBT reported using those skills throughout the treatment more significantly than the control group. Third, DBT showed a fully mediated effect on suicidal attempts and partial mediation on non-suicidal-self-injury. Forth, it showed a reduction in some emotional distress like anger control and depression over time.

Hence we can say that there is no doubt that DBT is fruitful for BPD patients. However, this study was conducted only on women to show the impact of DBT on BPD patients having suicidal and non-suicidal behaviour. This study revealed many aspects of DBT effect on women only, neither on man nor on adolescence. In this regard, it is not a wise decision to apply these findings to man and adolescent patients with BPD. To understand the impact of DBT, we must conduct and read few studies specifically worked on the effect of DBT on male and adolescent BPD patients. Nevertheless, we can say that this study is giving an overall idea about the effectiveness of DBT skills on the patients of BPD having suicidal and non-suicidal tendencies irrespective of male, female and adolescent. The findings on female BPD patients would be more or less identical with the result of male and adolescent patients; if any difference were, it would be on the extent and time take to show the impact of DBT on BPD patients.

OLDER Studies

By 1994, three studies were conducted to check the effectiveness and mechanisms of DBT. Two of these investigations were the outcome of studies conducted by Linehan et al. Hence, these investigations recognized as the first studies to show the effectiveness of a psychosocial treatment for BPD (Shearin EN, Linehan MM). The remaining investigation was merely a process study conducted by Shearin & Linehan to test hypotheses such as; how DBT was postulated to work (Shearin EN, Linehan MM;1994).

Shearin & Linehan (1994)

There are lots of therapeutic techniques, which are being used on BPD patients freely. These all techniques are different from each other and hence require different skills also. This study was related to knowing that whether DBT skills training without individual DBT treatment was also effective or not. A random selection of 11 subjects was made to DBT skills group, and a random selection of 8 subjects was made to no-treatment control condition. In the study, all subjects were receiving individual treatment already in the community.

After 1 year, it was found that there were no differences between groups regarding any variable. The results also suggested that adding a DBT skills group to any other type of therapy is unlikely to have therapeutic benefits (LINEHAN MM, 1994).

Like other studies, this study also has some limitation; as the sample size of the study was very small, it doesn't give a broad understanding of the effect of DBT on the patients having group treatment of DBT. It was not capable enough to show group difference between independent and dependent groups.

However, this study proved itself a milestone in the field of DBT. It effectively tests the hypothesis for which it was conducted. It made psychologist understand that DBT is always an effective therapy, no matter whether you are providing it individually or to a group of patients.

Shearin & Linehan (1994)

This study was nothing but a small process to test the relationship of therapeutic strategies prescribed by DBT to monitor week-by-week changes in patient behavior. In this study, the subjects consisted of 4 patient-therapist dyads and were followed for the first thirty-one weeks of DBT treatment. All patients received a standard DBT treatment in a form of weekly individual and group sessions, being supervised by Linehan. There was a change related to the therapists, they were graduate psychology and nursing students rather than trained practising therapists as it was in early studies. Even though several hypotheses were tested in this study, the two most important hypotheses were acceptance and change. The described hypotheses were worded in terms of patient and therapist, also ratings of each other along with patient suicidal behaviour. Patients and therapists ratings were being measured per week using the short form of Benjamin's Structural Analysis of Social Behavior (SASB) INTREX ratings (BENJAMIN LS. SASB).

This study enlightens two facts; first, that increased patient ratings regarding the therapist instruction, control, and providing autonomy were directly associated with decreased suicidal behaviour in the patients. Second, increased therapist ratings regarding the patient about liking the therapist were also followed by decreased suicidal behaviours in the following weeks for the patients as a whole.

This study also suggested that DBT may be an important factor in the reduction of suicidal behaviour in BPD. The acceptance technique helps borderline patients to feel accepted and validated and also help them to tolerate their psychological pain in any life-threatening and progress inhibiting process. As far as change

techniques are concerned these techniques motivate patients to be functional towards long-term solutions to their problem.

As a bottom line, we can say that when patient and therapist develop a cordial, warm and faithful relationship then the efficiency of DBT skills drastically increases to treat the symptoms of BPD among patients. Furthermore, when the patient feels accepted then automatically it reduces the patient's psychological pain and any life-threatening behaviour. Hence, feeling of acceptance matters a lot for BPD patients and DBT works on this aspect effectively.

Shearin & Linehan (1994)

In this study (Shearin EN, Linehan MM;1994), 44 female subjects were randomly assigned between 2 groups. The first group got DBT treatment and the second group got treatment as usual (TAU). Both groups had 22 subjects in each condition. There was a selection criterion for subjects, which they had to meet to get selected for the study, It was DSM-III criteria for BPD and also needed a score of 7 (out of 10) on the Diagnostic Interview for Borderline patients (3, Gunderson JG, Kolb JE, Austin Y); must have at least 2 incidents of para-suicide in the past 5 years with 1 during the past 8 weeks. Absence of bipolar disorder, schizophrenia, current substance dependence or mental retardation as per DSM – III criteria; age span of 18-45; and agreement to all conditions related to present study, along with termination of other psychotherapy if assigned to the DBT condition(Shearin EN, Linehan MM;1994).

During one year of treatment, subjects were assessed at pre-treatment and four, eight and twelve months post-treatment. Subjects were assessed based on attempts of para-suicidal acts and episodes (indistinguishable acts), medical risk of para-suicide, the types and amounts of professional mental health and medical treatment including inpatient psychiatric care. Subjects were also been assessed on adjustment and mood using questionnaires and observers rating measures with subjects in the second of two waves treated (twenty-two subjects) receiving a much larger number of measures. Subjects were subsequently contacted at six and twelve month's post-treatment (LINEHAN MM, HEARD HL) as a naturalistic follow-up.

The finding of the study revealed that DBT was effective in reducing both the number of parasuicidal acts and the medical risk for the para suicides that occurred than TAU (LINEHAN MM, ARMSTRONG HE, SUAREZ A,). The follow-up result of 6 and 12 months post-treatment, also revealed the superiority of DBT when compared to TAU.

However, this study was limited to female-only and the number of participants was also very less. Any study requires a great number of participants to show its effects and replications but this study studied only 44 females to know the impact of DBT on BPD patients, hence it simply limits the efficiency of this study. It is again limiting itself by assigning only women to the study because it is not showing the impact of DBT on male BPD patients and adolescent BPD patients. Nevertheless, this study comes under those studies which paved the way for further research in the area of DBT regarding BPD patients, therefore we can't deny its importance.

III. DISCUSSION

On the basis of empirical evidence, it can be suggested that DBT is now the best treatment for the treatment of BPD (Linehan et al. 1991, 1993, 1994, 2006, Koons et al. 2001); however, some people are of the thought that it is not because of efficiency of DBT rather it is because the lack of evidence supporting the effectiveness of other therapies (Stoffers et al. 2012).

It was found in the studies that DBT is very useful for BPD patients not only for nearby future but also for the long term also (Shearin EN, Linehan MM;1994). Even though medications may be provided as an adjunctive treatment for patients diagnosed with BPD and with other co-morbid psychiatric symptoms, nowadays, DBT is the only empirically supported treatment for patients with BPD. Therefore, all clinicians must understand when a patient should provide DBT treatment (Jennifer M. May, Toni). Studies conducted in this field also revealed that DBT is equally useful for adolescent, male and female BPD patients.

It was reported in the studies that DBT is always useful for BPD patients no matter whether the patients are being skilled individually or they are being skilled as a group. It was found that after 1 year of the DBT skill program for the patients of BPD some patient on the individual level and some patients on the group level were equally effective (LINEHAN MM,). Fitzpatricka et al, (2019) have also suggested based on their studies on BPD patients that emotional labelling is capable of activating emotion regulatory systems among patients with BPD (Skye Fitzpatricka, Jennifer Ipb). It was also founded that, in HCs, emotion labelling can enhance the electiveness of intentional emotion regulation but only in some domains (i.e., self-report). Hence it the use of emotional labelling (DBT) is of great importance to control the emotion regulation of BPD patients (Skye Fitzpatricka, Jennifer Ipb).

Besides this, DBT has also shown a great impact on the patients having co-morbidity. Many BPD patients are having other mental illness like; somatization, anxiety, and depression etc. In this regard, DBT has proven itself as the best therapy to apply to BPD patients. It doesn't attempt to changes the co-morbidity rather

its impact on BPD affects or changes the severity of co-morbidity. It is now, worldwide known that DBT reduces the symptoms of BPD and as BPD symptoms start getting vanished, the symptoms of co-morbid illness also start vanishing Karen B. Schmaling, PhD,). Apart from this, DBT skill is very effective for BPD forensic patients as well (Boch et al, 2012). It can be used with full confidence with forensic BPD patients showing suicidal, sel- injury behaviours, homicidal and physical violence. When DBT treatment was given to BPD forensic patients, there was a huge drop in the violent activity of patients. Not a single patient attempted to commit suicide.

As far as the coping skill of DBT is concerned, it again proved itself best when compared to coping skills of other therapies. Ueli Kalmar (2017) found the emotion regulation technique as the best technique to improve the coping skill of BPD patients. Furthermore, again Fitzpatricka et al, (2019) found emotional regulation as the best technique to work with the emotional labelling of BPD patients.

DBT was also found effective in reducing both the number of para-suicidal acts and the medical risk for the para suicides that occurred in BPD patients than TAU (LINEHAN MM, ARMSTRONG HE, SUAREZ A,). The follow-up result of 6 and 12 months post-treatment, also revealed the superiority of DBT when compared to TAU. DBT has also shown its importance in the reduction of suicidal behaviour in BPD patients. Furthermore, the acceptance technique of DBT helps borderline patients to feel accepted hence making the patient more confident to deal with their psychological pain, any life-threatening and progress inhibiting process. As far as change techniques are concerned these techniques motivate patients to be functional towards long-term solutions to their problem (LINEHAN MM, ARMSTRONG HE, SUAREZ A,).

However, there are a few limitations of this research review paper. First, most studies being reviewed in this paper are based on female participants. Only a few studies a based on male participants. Besides this not a single study was reviewed which was conducted on adolescent. Second, not all the four technique of DBT treatment namely; mindfulness, distress tolerance, emotion regulation, and interpersonal relatedness are reviewed separately in detail. Third, most of the studies, reviewed in this paper have small sample size, hence exact group difference is hard to find out.

Nevertheless, based on the above studies we can say that DBT is a very powerful technique to control the symptoms of BPD patients no matter whether the patient is male or female, in-patient or out-patient. According to Uli Kalmar (2017) "there is no doubt that DBT skill program concept is the best to push emotion regulation of BPD patients in a positive direction". DBT has shown a significant effect on the treatment of BPD patients (Jane Davenport, Miles Bore, & Judy Campbell, 2010).

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