EFFECT OF DIALECTICAL BEHAVIORAL THERAPY ON SUICIDAL ATTEMPTS AND NON- SUICIDAL SELF-INJURY AMONG DEPRESSED PATIENTS

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ABSTRACT

Background: Dialectical Behavioral Therapy is a modality of cognitive behavioral therapy, which directs the process on the synthesis of opposites and the modification of maladaptive behaviors. It cognizes individuals with four significant compounds of skills to manage massive emotions, and innervate coping skills. **Aim:** This study aimed to evaluate the effect of dialectical behavioral therapy on depressed patients' suicidal attempts and non- suicidal self-injuries. **Subjects &Method: Design:** A control time-series quasi-experimental research design used. **Setting:** Eastern Governance for mental health hospital. **Subjects:** A total number of 40 patients participated in the study. **Tools:** Hamilton Depression Rating Scale, Non-Suicidal Self-Injury Assessment Tool and Lineman Suicide Attempt-Self-Injury Interview were used in data collection. **Results:** Significant reduction in suicidal attempts' mean scores throughout the program and follow up phases among the DBT group with high effect size procured between both DBT and usual care groups (Cohen's d = ranged from 0.500000 to 1.31689). **Conclusion:** This research showed that Dialectical Behavioral Therapy is a salutary, profitable and pre-eminent approach can be used with suicidal and NSSI patients as compared to usual care. **Recommendations**: There is imperious need to expand the use of this therapy with psychiatric patients (e.g. anxiety disorders; PTSD patients).

Key words: Dialectical Behavioral Therapy, Depressed Patients, Non- Suicidal Self-Injury Attempts

INTRODUCTION

Although depression is a common psychiatric disease it considered a critical and climacteric mood disorder; it depicted as a pathological feeling of sadness that have significant consequences on patients' cognition, affect and behavior. Plethora of researches and studies correlated it with diverse psychological factors such as; loneliness, low self-esteem, anxiety and drug abuse (Han &Richardson, 2010; Manna, Falgares, Ingoglia, Como, & De Santis,2016; Sowislo, Orth, Meier, & 2014),physical factors such as heart diseases and chronic kidney disease (Huffman, Celano, Beach Motiwala, &Januzzi, 2013; Kim, Moon, Kim, & Lee, 2017; Shanmugasegaram, Russell, Kovacs, & Grace, 2012) as well as personality traits (Jourdy& Jean-Michel,2017; Renner, Penninx, Peeters, Cuijpers,&Huibers, 2013).

The encumbrance of depression originates from its squeals; which is at most suicidal thoughts, plans and attempts (Wang, Shi, &Luo, 2017). In the study of Park et al, (2018) results illustrated that about ninety percent of patients perpetrated suicide, had depression and 74% were at high risk among patients with other psychiatric disorders. In this context, various studies proved the vigorous relationship between depression and suicide among mentally healthy population as adolescents, women, workers and university students (Albataineh, 2017; Breton et al, 2015; Dalglish, Melchior, Younes, &Surkan, 2015; Shani, Yelena, Reut, Adrian, & Sami, 2016; Shenouda &Basha, 2014; Takeuchi &Nakao, 2013; Yu-Hang, Zhou-Ting, &Qian-Ying, 2017),as well as mentally ill patients (Duhoux, Fournier, Gauvin, &Roberge, 2013; Li et al, 2017; Ng, How, & Ng, 2017; Whittier et al, 2016) .

Dialectical therapy is a modality of cognitive behavioral therapy, which directs the process on the synthesis of opposites and the modification of maladaptive behaviors (Yeo et al, 2020). It cognizes individuals with four significant compounds of skills with a view to manage massive emotions, and innervate coping skills. These skills are distress tolerance skills, mindfulness, emotional regulation and interpersonal effectiveness (Linehan, 2014). Dialectical therapy (DBT) is not lately innovative therapy; however, in 1993, Marsha Linehan developed it to help women chronically suicidal and meet criteria for borderline personality disorder. But considerable researches demonstrated its salutary outcomeson patients with bipolar disorders (Van Dijk, Jeffrey, & Katz, 2013; Zamani, Farhadi, Zamani, & Jahangir, 2017); substance abuse (Dimeff&Linehan, 2008); eating

disorders (Wisniewski & Ben-Porath, 2015) and anxiety disorders (Chapman,Gratz, Matthew,&Kean, 2011).

In order to teach patients distress tolerance skills, the therapy provides them with basic tolerance skills for negative emotions as distraction and relaxation, as well as advanced skills as safe place visualization, radical acceptance and creation of an emergency coping plan. Mindfulness deemed as the most potent core skills in DBT, it comprises training exercises such as inner- outer experience, thought diffusion, focus shifting and mindful awareness of emotions.

Emotion regulation skills postulated in DBT include nine skills aimed at controlling emotions and associated behaviors. These skills alternated from basic skills as recognizing emotions, overcoming the barriers to healthy emotions, reducing physical vulnerability and reducing cognitive vulnerability; to advanced skills such as emotion exposure, doing the opposite of your emotional urges and problem solving. The final stage of DBT is interpersonal effectiveness, which composite of social-skills training, assertiveness training, listening skills and negotiation skills. Eventually, the patient assigned for daily-presumed practices strengthen core DBT skills. Those practices involve mindfulness, deep relaxation, self-observation, affirmation and committed action proposing two or three exams and practices for each (Flynn, Gillespie, Joyce & Spillane, 2020; Yeo et al, 2020).

In accordance, researchers broaden the studies on the application of DBT due to its valuable and advantageous effects in order to encompass other psychiatric disorders. For example, in 2016, Habibi, Akbari-Pourbahadoran, Falahatpishe-Baboli, Narimani and Abedi-Parija used DBT with dysthymic patients and reported its significant improving effect on related symptoms. Additionally, khani, Belir, Zamani and Zamani (2015) studied mothers with major depressive disorder using quasi-experimental study, and their study results stated that there were significant differences in the mean scores of depressive symptoms among the experimental and control groups after application with lower observations on the experimental group.

On the same context, Soler et al (2012) reported in their study that DBT has a positive impact on attention among borderline personality individuals. On the same context, Stepp, Epler, Jahng and Trull(2013)continued to use DBT with borderline persons and exposed that "Over the course of one year of DBT treatment, patients

indicated an improvement in overall BPD features, as well as in the affective instability and negative relationships features".

Significance of the study

Dialectical Behavioral Therapy_also proved its considerable significant effect on persons with eating disorders. After twelve sessions of DBT program on adolescents with bulimic disorders, the study resulted in significant decline in the score of clinical symptoms in experimental group, simultaneously with increased scores of self-efficacy and satisfaction about body image (Hassan, &Hassan, 2016).Latterly, scientists and researchers pursued other trajectories to reconnoiter the felicitous impacts of this therapy; thus this research is an attempt to apply DBT with depressed patients exhibited suicidal attempts or non-suicidal self-injuries in order to evaluate its leverages and therapeutic effects in more inclusive trial with regular frequent measurements of variables.

AIM OF THE STUDY

This study aims to evaluate the effect of dialectical behavioral therapy on depressed patients' suicidal attempts and non- suicidal self-injuries.

Hypothesis1. There will be no significant differences among mean scores of patients' non-suicidal self-injury attempts before and after the program implementation.

SUBJECT AND METHOD

1.Technical Design

Research Design

Quasi-experimental research design (One group control and one group experimental)

Study Setting

The study conducted in Eastern Governance for mental health hospital in Saudi Arabia.

Subjects

Psychiatric patients involved in the study were 40 patients (20 patients enrolled in the experimental group and other 20 patients included in the control group). Inclusion criteria encompassed; presence of at least three diagnostic criteria for depression; suicidal attempts or ideation within last two weeks as well as a history for non- suicidal self-injury attempts for the last two weeks. Moreover, illiterate patients, patients with borderline personality and patients with other psychotic disorders were excluded from the research.

Tools of Data Collection

1. A questionnaire designed by the researcher regarding patients' personal characteristics (e.g. age, sex, marital status), as well as clinical characteristics (e.g. onset of illness, previous psychiatric hospitalization, other co-morbid psychiatric disorders) utilized for this study.
2. The researchers also used Hamilton Depression Rating Scale; it was developed by Max Hamilton in 1960 and used in this research in order to assess severity of symptoms of depression among the participants as agitation, insomnia, mood, feelings of guilt and somatic symptoms (Hamilton, 1960). Scores range from 0 to 54 reflecting the following levels; normal (<9), mild (10-13), moderate (14-17) and severe (>17), (Hamilton, 1960).

Primary outcomes

It includes the frequency and the severity of Non-Suicidal Self Injury (NSSI) as well as suicidal ideation, intensity of ideation, intent and attempts. The non- suicidal self-injury and suicide was measured six times in this study as follows; once in the baseline (week 2, pre-implementation phase), three times during the implementation phase of the program (11, 20, 27 weeks, after each module) and finally two times in follow- up phase (29 and 33 weeks). Assessment was done by utilizing the following questionnaires:

3. The Non-Suicidal Self-Injury Assessment Tool (NSSI-AT). Developed by Whitlock, Exner-Cortens, and Purington (2007) and adopted by the researchers in order to assess characteristics, functions, frequency, practice patterns, It composed of 39 open- ended questions. and perceived life interferences of NSSI.
4. Inventory of statements about self-injury (ISAS). Another questionnaire related to assessment of self-injury developed by Klonsky& Olino (2008). The tool contains two parts, the first part involves seven open-ended questions aiming to assess behaviors related to self-injury, while the second part of the tool includes 39 items concerning functions related to self-injury, each item has three responses (0= non relevant, 1= somewhat relevant and 2= very relevant).
5. Linehan Suicide Attempt-Self-Injury Interview (SASII) -standard (short) version developed by Linehan, Comtois, Brown, Heard, &Wagner, (2006) was also used. It included 27 open-ended supplemental and experimental qualitative questions assessing suicide attempt and self-injury, such as thoughts, feelings, intent, communication of intent and client reasons for SASI.
6. Beck Suicidal Ideation scale. The tool was designed by Beck, Kovacs, &Weissman, 1979. It emphasize on screening patients' suicidal thoughts or intent by using 19 rating

statements. It utilized to assess thoughts related to patients' wish to die, suicidal tendencies and frequency, as well as patients' readiness for suicidal attempts, rated on three- point scales (0-2). Higher scores indicate severe suicidal ideation.

All tools were translated into Arabic language, and were validated by a jury of five experts in psychiatric medicine and psychiatric nursing

Operational Design

A. Preparatory phase:

It included reviewing of related literature and theoretical knowledge of various aspects of the study using books, articles, internet periodicals and journals to develop the tools for data collection.

Validity:

Content validity was conducted to test the tool for appropriateness, relevance, correction and clearance through a jury of 5 experts from nursing and medicine faculty staff of King Faisal University, their opinions were elicited regarding the tool format layout, consistency and scoring system.

Reliability:

All questionnaires were tested for reliability and it was at acceptable level. For NSSI-AT scale the Cronbach's alpha was 0.82. While regarding the ISAS and SAS-II Scales the Cronbach alpha value were 0.89 and 0.88 respectively. Finally, Beck suicidal ideation scale tested for reliability and Cronbach alpha value was 0.89.

Pilot study:

Prior to performing the actual study, a pilot study was carried out on 10% of patients to test the applicability, visibility, clarity of questionnaire and arrangement of items, and estimate the time needed for each sheet. The participants included in the pilot study were excluded from study.

Field of work:

Assessment of the studied variables

Psychiatric patients involved in the study were 40 patients resorted to outpatient clinics for follow up and previously diagnosed with major depression and newly with self-injury and/ or suicidal attempts. Both DBT therapy and usual care was provided by specialized therapists.

Dialectical Behavioral Therapy Intervention

This study was implemented in 33 weeks and through three main phases. The pre-implementation phase included two stages. First stage (Week 1) was concerned with diagnostic screening of the studied variables during patients' follow up visits in the outpatient clinics, followed by expounding the program to all participants in order to develop a collaborative commitment, thus program objectives, program stages, skill training modules, patients' activities, responsibilities of both patients and researchers as well as the mode of therapy were elucidated to patients. Moreover, patients' and their caregivers' consent of approval for participation in the therapy program was also obtained in this stage. Subsequently, through the use of relationship acceptance and relationship enhancement strategies, the researchers started to inspire an alliance, that participants choose their group leader. Thereafter, the researchers presented the skill training guidelines, assumptions and structure.

Second stage (Week 2) included assessment procedures. Patients (sometimes with their caregivers) have been interviewed individually with both researchers to fill in the questionnaires and scales related to dependent variables (suicidal attempts, non- suicidal self-injuries), personal and clinical characteristics as well.

Implementation phase included 24 weeks to conduct the three modules of DBT. The researchers adopted Linehan Standard Adult DBT Skills Training model,https://adoeci.com/sites/default/files/grupos/dbt-skills-workbook.pdf. It comprised two weeks (orientation and basic mindfulness skills), six weeks for distress tolerance skills, seven weeks concerned with emotion regulation skills, and finally five weeks for interpersonal effectiveness skills; with repetition of two weeks before each module (for regular measurements of dependent variables and advanced mindfulness skills training). Every single week also included 60 minutes for individual session and 120 minutes for group session.

In each session of therapy, patients were assigned for homework assignment or self-monitoring diary "card diary"; in order to stimulate patients to practice between sessions. Moreover, the card diary is a beneficial method for self- evaluation; it also helped the researchers to assess patients' threatened behaviors and its associated factors.

After 24 weeks of therapy, the researchers thanked the participants for their cooperation and started an open discussion in order to explore patients' opinions regarding the therapy program. Furthermore, researchers informed the patients about the follow up plan and affirmed their continuous cooperation and commitment, which is a necessity for program succession. Then, researchers interviewed patients individually for about one hour for each in order to reassess the dependents variables.

During *the follow up phase*, the researchers reassessed patients' condition regarding suicidal attempts and self-injury behaviors in individual interviews. Only seventeen patients (experimental group) and nineteen patients (control group) from the 40 participants completed and attended for follow- up. Follow- up was done in the 29 and 33 weeks.

Usual care

Twenty patients enrolled in control group received their usual care in the clinics however for the research purposes, the participated psychiatrist provided at least one treatment session per week for 24 weeks (treatment incorporated both pharmacological and psychotherapeutic approaches, based on therapist judgment as well as patients demands). Follow- up then done in the 29 and 33 weeks.

Administrative Design

An official letter has issued from the College of Applied Medical Sciences, King Faisal University to the directors of Eastern Governance for mental health to obtain the permission to conduct the study.

Ethical considerations

Prior conductance of the research, approvals possessed for the implementation of the study after approval of the CAMS ethical committee, King Faisal University. Likewise, for patients' safety observances assessment of patients for eventuality for suicide was done frequently, if any patient prospected to life threatening suicidal thoughts or self-injuries, emergency management provided instantly.

Statistical Design

Data Analysis

Descriptive statistics of the present study was measured by frequencies, percentages, means and values. To examine the research hypothesis, the researchers utilized the time series analysis with general trend line chart in order to reflect the dependent variable (Suicidal attempts &NSSI) measurement analysis for each participant before the DBT program (baseline phase) and during the application of the program (intervention phase) and after program application (follow- up phase). A random intercept model done for each patient separately in line with an unstructured variance- covariance matrix applied for both groups in order to control the unobserved heterogeneity. In relation to suicidal attempts and NSSI frequency, generalized estimating equations were used to test through

both groups' differences in the average of these attempts. All tests were 2- sided and significance level was obtained at 0.05 and .0.01.

RESULTS

Table (1): Personal characteristic of the participants illustrated in **Table 1**. As clear, more than half of the participants in both DBT and usual care groups were female (65.0%, 75% respectively), moreover, 20% of participants in DBT group compared to 20% in usual care group were divorced. As regard the clinical characteristic of the studied groups.

Table (2): reveals that 65% of patients in DBT group compared to 50% in usual care group stated that their complaints started since a year. Looking at level of depression, the table clears that more than half of the DBT group patients (60%) had severe level compared to 40% of usual care group who had moderate level of depression. Noticeably, no significant differences spotted between both DBT and usual care groups, which imply homogeneity between study samples.

Table (3): reflects the non-suicidal self-injury behaviors among the participants in both DBT and usual care groups. As intelligible from the table, cut wrists, arms, legs, torso or other areas of the body were declared by 40% and 45% of DBT and usual care groups respectively.

One quarter of the patients enrolled in the intervention (25%) professed to injure themselves in hopes that someone would notice that something is wrong or that others will pay attention, while 20% noted to relieve their anger and negative emotions. Seventy percent reported to injured themselves within a week before the assessment phase and one third (35.0%) stated to have from 2 to 3 attempts of NSSI per day. Most wounds appeared in hands and legs (50%, 45% respectively) and ranged from severe to moderate level of severity (80%, 20% respectively).

More than half of the patients (55%) in the DBT group stated to always intentionally hurt themselves in private, and 85% proclaimed to disclose their NSSI attempts to clinicians. No significant differences predestined between DBT and usual care groups in relation to NSSI history data.

Table (4): displays data related to suicidal attempts exhibited by the studied patients in both groups. Concerning the intervention group, more than half of patients (55%)

proclaimed to consider suicide on the time of attempt, furthermore, suicidal ideation amplitudes to severe and moderate level (50%,40% respectively). Active suicidal ideation with plan and without plan was reported by 20% and 30% respectively. Regarding suicidal attempts about half of the participants stated to had actual attempts followed by aborted attempts and interrupted attempts (45%, 25% and 20% respectively).

One patient from the DBT group and two patients from the usual care group were excluded from the displayed results in relation to dependent variables due to their incompliance with the intervention period (exceeded 8 sessions drop out).

As revealed in **Table (5)**, suicidal intent was not reported in DBT group after module 1 measurement (M= 0.000). Moreover, significant decrease in suicidal ideation measurements along with the program and follow up phases was observed among the DBT group (measurements compared to baseline mean= 3.050). Otherwise, highly statistical significant differences obtained between both DBT and usual care groups in relation to suicidal intent, ideation and ideation intensity (P= 0.01, 0.03, 0.00 respectively).

In **Table (6)** , the results demonstrate significant reduction in suicidal attempts' mean scores throughout the program and follow up phases among the DBT group with high effect size procured between both DBT and UC groups (Cohen's d = ranged from 0.500000 to 1.31689). In relevance to NSSI, there were high statistical significant differences observed among the mean scores of NSSI frequency and severity as well level of depression in the DBT group as compared to usual care group.

Eventually, **figure (1)** illustrated the comparison between patients received DBT and patients received UC in suicidal attempts and NSSI frequency during the intervention modules and follow up periods, the figure distinctly reveals the prominence and significance of DBT in decreasing the suicidal and NSSI attempts.

Table (1): Distribution of personal characteristics of both experimental and control groups

Personal characteristics	DBT group (N=20)		Usual care group (N=20)		P
	N	%	N	%	
Age (in years)					
<20	7	35.0	6	30.0	0.677[b]
20-<30	9	45.0	9	45.0	
30-40	4	20.0	5	25.0	
Sex					
Male	7	35.0	5	25.0	0.503[a]
Female	13	65.0	15	75.0	
Marital status					
Single	2	10.0	3	15.0	0.798[b]
Married	14	70.0	11	55.0	
Divorced	4	20.0	6	30.0	
Work status					
Not working	11	55.0	8	40.0	0.355[a]
Working	9	45.0	12	60.0	
Income					
Not enough	20	100.0	2	10.0	0.154[a]
Enough	0	0.0	18	90.0	
Level of Education					
Primary	0	0.0	1	5.0	0.259[b]
Secondary/ Middle	8	40.0	10	50.0	
College	12	60.0	9	45.0	

[a] t-Test [b] one way

Table (2): Distribution of clinical characteristics of both experimental and control groups

Items	DBT group (N=20)		Usual care group (N=20)		P
	N	%	N	%	
Onset of illness					
Sudden	4	20.0	6	30.0	0.478[a]
Gradual	16	80.0	14	70.0	
Length of illness					
<1 year	13	65.0	10	50.0	0.296[b]
1-<3	5	25.0	6	30.0	
3-5	2	10.0	4	20.0	
Number of hospitalization					
Once	11	55.0	8	40.0	0.357[b]
2-3	7	35.0	8	40.0	
3-4	1	5.0	3	15.0	
4-5	1	5.0	1	5.0	
Last hospitalization from					
< one month	11	55.0	9	45.0	0.645[b]
1-< 3 months	5	25.0	6	30.0	
3-<5	2	10.0	3	15.0	
5-<6	2	10.0	2	10.0	
Level of Depression					
Moderate	8	40.0	10	50.0	0.358[a]
Severe	12	60.0	10	50.0	

[a] t-Test [b] one way ANOVA

Table (3): Distribution of Non-Suicidal self-injuries as reported by both patients in experimental and control group prior the study intervention.

Items	DBT group (N=20)		Usual care group (N=20)	
	N	%	N	%
Primary and secondary NSSI characteristics				
Severely scratched or pinched with fingernails	7	35.0	4	20.0
Cut wrists, arms, legs, torso or other areas of the body	8	40.0	9	45.0
Bitten yourself to the point that bleeding occurs	1	5.0	1	5.0
Engaged in fighting or other aggressive activities with the intention of getting hurt	4	20.0	6	30.0
NSSI Functions				
To feel something	2	10.0	2	10.0
As a self-punishment or to atone for sins	2	10.0	1	5.0
To cope with uncomfortable feelings	2	10.0	4	20.0
In hopes that someone would notice that something is wrong or that so others will pay attention to me	5	25.0	2	10.0
Deal with anger	4	20.0	5	25.0
To relieve stress	2	10.0	1	5.0
Feel good	3	15.0	2	10.0
Recency				
< 1week	14	70.0	14	70.0
1-<3 week	5	25.0	5	25.0
3-6 weeks	1	5.0	1	5.0
Frequency (Per day)				
Once	1	5.0	2	10.0
2-3 times	7	35.0	6	30.0
4-5	2	10.0	3	15.0
6-7	3	15.0	3	15.0
8-9	4	20.0	3	15.0
>10	3	15.0	3	15.0
Age of onset				
<10 years	11	55.0	13	65.0
10-15	9	45.0	7	35.0
Wound Locations				
Hands	10	50.0	13	65.0
Legs	9	45.0	7	35.0
Face	1	5.0	0	0.0

Table (3): Cont. Distribution of Non-Suicidal self-injuries as reported by both patients in experimental and control group prior the study intervention.

Items	DBT group (N=20)		Usual care group (N=20)	
	N	%	N	%
Initial Motivations				
I saw it in a movie / on television or read about it in a book and decided to try it	1	5.0	1	5.0
I accidentally discovered it	17	85.0	15	75.0
I wanted someone to notice me and / or my injuries	2	10.0	4	20.0
Severity				
Moderate	4	20.0	6	30.0
Severe	16	80.0	14	70.0
Practice Patterns				
I always intentionally hurt myself in private	11	55.0	12	60.0
I sometimes intentionally hurt myself in the presence of others	9	45.0	8	40.0
Habituation				
No	0	0	1	5.0
Occasionally	1	5.0	15	75.0
Habitually	19	95.0	4	20.0
Perceived Life Interference				
Yes	17	85.0	17	85.0
No	3	15.0	3	15.0
The fact that I intentionally hurt myself interferes with:				
None	3	15.0	3	15.0
My ability to complete school	5	25.0	5	25.0
My ability to complete work obligations	3	15.0	3	15.0
Relationships which are important to me	9	45.0	9	45.0
NSSI Disclosure				
Yes	0	0.0	7	35.0
No	20	100.0	13	65.0
To whom to disclosed				
Friend	3	15.0	1	5.0
Clinicians- Therapist	17	85.0	19	95.0
NSSI Treatment Experiences				
Yes	5	25.0	3	15.0
No	15	75.0	17	85.0
Personal Reflections				
I still cannot talk about it and sometimes even thinking about it is difficult	20	100.0	20	100.0

Table (4): Distribution of suicidal ideation and suicidal attempts among the studied participants in experimental and control group.

Items	DBT group (N=20)		Usual care group (N=20)	
	N	%	N	%
Suicide intent				
Intent	0	0.0	0	0.0
Consider episode suicide now	11	55.0	8	40.0
Consider episode suicide then	6	30.0	5	25.0
Conscious expectation of fatal outcome	3	15.0	7	35.0
Lethality of suicidal attempts				
Actual	20	100.0	19	95.0
Potential	0	0.0	1	5.0
Suicidal Ideation				
Low	2	10.0	1	5.0
Moderate	8	40.0	10	50.0
Severe	10	50.0	9	45.0
Rescue likelihood				
Yes	0	0.0	1	5.0
No	20	100.0	19	95.0
Risk/rescue Ratio				
Low	0	0.0	1	5.0
Moderate	1	5.0	1	5.0
High	19	95.0	18	90.0
Suicide Communication				
Want to communicate	20	100.0	20	100.0
Who to communicate:				
Communicate self/ feelings	13	65.0	9	45.0
Communicate with others	7	35.0	11	55.0
Interpersonal Influence				
Yes	10	50.0	12	60.0
No	10	50.0	8	40.0

Table (4): Cont. Distribution of suicidal ideation and suicidal attempts among the studied participants in experimental and control group.

Items	DBT group (N=20)		Usual care group(N=20)	
	N	%	N	%
Suicidal Ideation				
Wish to die	3	15.0	4	20.0
Non-Specific Active Suicidal Thoughts	3	15.0	4	20.0
Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act	4	20.0	6	30.0
Active Suicidal Ideation with Some Intent to Act, without Specific Plan	6	30.0	4	20.0
Active Suicidal Ideation with Specific Plan and Intent	4	20.0	2	10.0
Intensity of suicidal ideation				
Moderate	12	60.0	13	65.0
Severe	8	40.0	7	35.0
Suicidal attempts				
None	2	10.0	3	15.0
Actual Attempt	9	45.0	5	25.0
Interrupted Attempt	4	20.0	5	25.0
Aborted Attempt or Self-Interrupted Attempt	5	25.0	7	35.0

Table (5): Means of suicidal intent, suicidal ideation and suicidal ideation intensity at the study baseline, after each module of intervention and at two follow up measurements in both of the studied groups.

Variables	DBT group (N=20)		Usual care group (N=20)		Effect size (Cohen's d)	P-Value slop
	M	SD	M	SD		
Suicidal Intent						
Baseline	2.8500	.67082	3.1000	0.78807		0.01*
DBT- Module 1	1.4000	1.31389	2.0500	0.99868	0.556995	
DBT- Module 2	0.0000	0.30560	1.0000	0.09700	4.410803	
DBT- Module 3	0.0000	0.29540	1.0900	0.32100	3.533618	
Follow-Up 1	0.0000	1.00000	1.8750	0.74500	1.275848	
Follow-Up 2	0.0000	0.98640	1.4984	0.50262	1.914107	
Suicidal Ideation						
Baseline	2.4000	0.68056	2.4000	0.59824		0.03*
DBT- Module 1	1.9460	0.72548	1.3500	0.48936	0.963175	
DBT- Module 2	0.0000	0.05200	1.8000	0.54442	4.654589	
DBT- Module 3	0.0000	0.36008	0.8000	0.89443	1.17339	
Follow-Up 1	0.0000	0.01864	0.8000	0.89443	1.217209	
Follow-Up 2	0.3500	0.48936	1.8500	1.13671	1.714099	
Suicidal Ideation Intensity						
Baseline	2.4500	0.51042	2.3500	0.48936		0.00**
DBT- Module 1	1.3500	0.87509	1.2500	0.44426	0.144101	
DBT- Module 2	0.0000	0.06435	1.1000	0.30779	4.947241	
DBT- Module 3	0.0000	0.10000	1.3564	0.45446	4.122302	
Follow-Up 1	0.0000	0.08743	2.0104	0.23004	11.55303	
Follow-Up 2	0.0200	0.98342	1.8000	0.95145	1.839666	

*Statistically significant at $P \leq 0.05$

** Highly statistically significant $P \leq 0.001$

Table (6): Outcomes' measurements for the studied groups at the study baseline, after each module of intervention and at two follow up measurements.

Variable	DBT group (N=20)		Usual care group (N=20)		Effect size (Cohen's d)	P-Value slop
	M	SD	M	SD		
Suicidal Ideation						
Baseline	3.0500	1.23438	2.8000	1.28145		0.04*
DBT- Module 1	0.8500	0.67082	1.9500	0.68633	1.620938	
DBT- Module 2	0.4000	0.50262	1.7000	0.73270	2.069135	
DBT- Module 3	0.0000	1.00000	1.2322	0.86540	2.013494	
Follow-Up 1	0.0000	1.00000	0.8098	0.64520	1.754057	
Follow-Up 2	0.0000	1.00000	1.9000	1.07115	1.934312	
Suicidal Attempts						
Baseline	2.1000	1.29371	2.5500	1.31689		0.00**
DBT- Module 1	0.0000	1.00000	1.3000	0.77016	2.386936	
DBT- Module 2	0.0000	1.00000	1.3000	0.77016	2.386936	
DBT- Module 3	0.0000	1.00000	0.8754	1.08765	1.138188	
Follow-Up 1	0.0000	1.00000	1.5300	0.50000	4.326628	
Follow-Up 2	0.0000	1.00000	1.9500	0.88704	2.945028	
NSSI- Frequency						
Baseline	3.5500	1.63755	3.4000	1.66702		0.01*
DBT- Module 1	1.0500	0.98850	2.6000	1.56945	1.181811	
DBT- Module 2	0.0900	1.00000	3.4000	1.66702	2.177417	
DBT- Module 3	0.0000	1.00000	0.4500	0.51042	1.245853	
Follow-Up 1	0.0000	1.00000	1.1297	0.43434	3.674416	
Follow-Up 2	0.0000	1.00000	3.5500	1.57196	2.185778	

*Statistically significant at $P \leq 0.05$

** Highly statistically significant $P \leq 0.001$

Table (6): Cont. Outcomes' measurements for the studied patients at the study baseline, after each module of intervention and at two follow up measurements.

Variable	DBT group (N=20)		Usual care group (N=20)		Effect size (Cohen's d)	P-Value slop
	M	SD	M	SD		
NSSI- Severity						
Baseline	2.8000	0.41039	2.7000	0.47016		0.00**
DBT- Module 1	1.7500	0.63867	1.3000	0.73270	0.654741	
DBT- Module 2	0.2000	0.41039	2.7000	0.47016	5.665233	
DBT- Module 3	0.0000	1.00000	1.4000	1.50262	1.316902	
Follow-Up 1	0.0000	1.01000	2.4500	0.68633	5.047798	
Follow-Up 2	0.0000	1.00000	2.4500	0.68633	3.14151	
Depression						
Baseline	2.8500	0.67082	3.0000	0.78100		0.00**
DBT- Module 1	1.2500	0.44426	2.0000	0.56195	1.480649	
DBT- Module 2	0.0000	0.47016	1.6500	0.48936	2.813344	
DBT- Module 3	0.0000	1.00000	1.7653	0.43222	5.627369	
Follow-Up 1	0.0000	1.00000	1.4000	0.75394	2.603271	
Follow-Up 2	0.0000	1.00000	2.2000	0.41039	3.479888	

*Statistically significant at $P \leq 0.05$

** Highly statistically significant $P \leq 0.001$

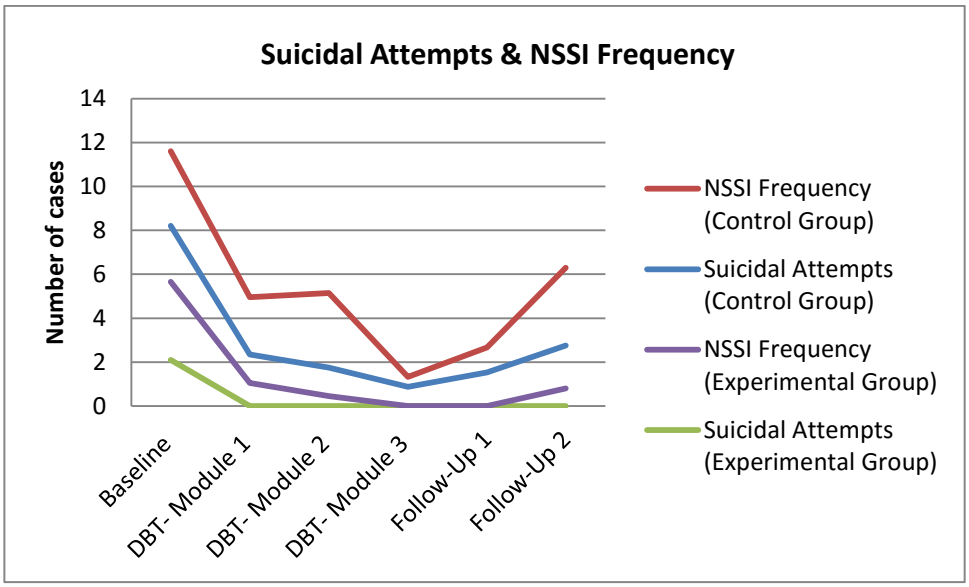

Figure (1): Comparison between patients received DBT and patients received UC in suicidal attempts and NSSI frequency during the intervention modules and follow up periods.

DISCUSSION

This study aimed to evaluate the effect of dialectical behavioral therapy on depressed patients' suicidal attempts and non- suicidal self-injuries. The results revealed that DBT is salutary, profitable and pre-eminent approach can be used with suicidal and NSSI patients as compared to usual care. Significant improvement observations regarding suicide obtained distinctly after module 2 (Basic & advanced emotion regulation skills), while the NSSI improvement was plainly observed after module 3 (Basic & advanced interpersonal effectiveness skills).

Noticeably, DBT was ascendant and preponderant than the UC in precluding suicidal ideation, intent and attempts with larger effect size for outcomes obtained in experimental group and continue to improve and amend until the second follow up measurement. By the end of DBT module-1, the mean scores of suicidal intent and ideation decreased significantly in experimental group patients as compared to control group, whilst the mean scores of suicidal attempts was zero. Certainly, DBT- module 1 focuses on teaching patient radical acceptance and distraction skills which consequently help patient to impart change process and deal with suffering as inventible positive experience to all human beings. This result is consistent with the results of Mehlum et al, (2014) which revealed that DBT is more effective in eliminating adolescents' suicidal and self-harm behaviors. On the same context, McCauley, Berk, and Asarnow, (2018) in their clinical trial concluded that secondary analysis of data showed that DBT is more advantageous in

reducing self-harm between adolescents as well as increase their response to treatment. Moreover, diversified researches, studies and clinical trials.

declared that DBT ultimately is a multi- component psychotherapeutic approach (McMain et al, 2018; Prada, Perroud, Rüfenacht, &Nicastro, 2018; Slomski, 2018).

With reference to NSSI among the studied patients, conspicuously NSSI frequency as well as severity means scores were considerably decreased by the end of DBT module-2 and disappeared by module-3 and till the end of the follow up phase. This result implies that DBT has salutary and incontrovertible affirmative effect on patients' coping mechanisms as well as emotional reactions and regulations. By the end of module 3, patient learn to regulate emotions, be mindful aware of his/her emotions without judgment, overcome negative experiences as well as learn social skills and assertiveness in order to enhance their interpersonal relationships and communication. This result is in line with the results of Zeifman, Boritz, Barnhart, Labrish, &McMain, (2020), as in their randomized trial of DBT skills training found improvements in mindfulness, and particularly acceptance without judgment among BPD patients. On this context, Kells, Joyce, and Flynn, (2020), also stated in their study that DBT can regulate emotional disturbances as well as coping dysregulations.

Also, Krantz, McMain, &Kuo, (2018), "studied the association between four distinct dimensions of DBT skills training mindfulness and frequency of NSSI in individuals with BPD and detected a significant effect of skills training on the frequency of NSSI episodes". Furthermore, Mehlum et al, (2019), discovered that after three years of follow up, DBT still has its therapeutic effects on decreasing the self-harm behaviors among youth.Moreover, Andreasson et al, (2017), in their randomized observer- blinded trial deduced that DBT is advantageous in treating suicidality and self-harm in BPD adolescents.

Eventually, depression mean scores observed to be constringed in both experimental and control groups during the program implementation, with salient and perspicuous observations on patients received DBT sessions.

CONCLUSION

This study signified the prominence of DBT on eliminating suicidal ideation and intent as well as NSSI attempts in patients with depressive disorders strikingly after the first

module of therapy. DBT is a substantial and significant approach to be recommended in therapy of patients with behavioral disturbances such as personality disorders.

RECOMMENDATIONS:

The researchers may presume that this trial seek to conquer other studies' limitations (Fitzpatrick, Bailey, &Rizvi, 2020) whose mentioned that their study had limited measurements and recommended to have frequent measurements of variables along the program; thus in this trial, the researchers procured periodic assessments after each DBT module; this also illustrated a comprehensive and a perspicuous evaluation of each module separately. On the same context, the study of Mehlumet al, (2014) recommended long-term follow up evaluations for DBT effectiveness, which was also considered in this research.

Through DBT implementation phases, the researchers observed its subservient impact on restricting patients' emotional and affectional disturbances as well as patients' inappropriate behaviors. This may implicate the use of this therapy with patients with emotional or coping problems (e.g. people with adjustment disorders; persons with antisocial personality). Moreover, the researchers may recommend expanding the use of this therapy with psychiatric patients (e.g. anxiety disorders; PTSD patients), as this study was an attempt applied with depressed patients and confirmed its salutary therapeutic effect.

Limitations

Although this quasi-experimental has various strengths, it has finite limitations. Firstly, the number of the participants was quietly few; but this due to bounded cases of depressed patients with NSSI attempts. Secondly, control group within this study did not extradite a standardized consolidated protocol of treatment, which may induce deficient distinct results. Thirdly, although this trial followed randomization in the selection of sample, the number of female participants was almost two thirds in both groups, which may affect the presentation of male patients. Finally, some of the participants were not obliged with homework assignments that scheduled during the program modules.

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تأثير العلاج السلوكي الجدلي على محاولات الانتحار وإيذاء النفس غير الانتحاري بين مرضى الاكتئاب

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أستاذ مساعد التمريض النفسي- كلية التمريض جامعة بورسعيد ، طبيب مقيم و باحث بسمتشفى الاحساء للصحة النفسية

الخلاصة

الخلفية: ان العلاج السلوكي الجدلي هو أحد أساليب العلاج السلوكي المعرفي، والذي يوجه الى توليف الأضداد وتعديل السلوكيات غير المقبولة اجتماعياً. إنه يعلم المرضى أربعة مهارات مهمة مثل مهارات التحكم بالمشاعر ومهارات التأقلم مع التغييرات. هدفت هذه الدراسة إلى تقييم تأثير العلاج السلوكي الجدلي على محاولات الانتحار وإصابات النفس غير الانتحارية بين مرضى الاكتئاب.و قد تم الاستعانة بالمنهج البحثي شبه التجريبي حيث كان هناك 40 مريضًا شاركوا في الدراسة. تم استخدام مقياس تقييم هاملتون للاكتئاب، وأداة تقييم الإصابة الذاتية غير الانتحارية، واستبيان ليندمان لإصابة النفس بمحاولة الانتحار في جمع البيانات. و فيما يخص نتائج الدراسة تم ملاحظة تحسن كبيربين المرضى فيما يتعلق بالانتحار و اصابات النفس غير الانتحارية قبل و بعد تطبيق البرنامج. و في الخلاصة أظهر هذا البحث أن العلاج السلوكي الجدلي هو نهج مفيد و فعال ويمكن استخدامه مع مرضى الانتحار ومرضى إصابات النفس غير الانتحارية و ذلك بالمقارنة بالرعاية الطبية المعتادة، وهنا يوصي الباحثان بأن هناك حاجة ملحة لترسيخ استخدام هذا العلاج مع المرضى النفسيين (مثل اضطرابات القلق ؛ مرضى اضطراب ما بعد الصدمة).

الكلمات المرشدة *:* العلاج السلوكي المعرفي؛ مرضى الاكتئاب، اصابات النفس غير الانتحارية.