TOPIC #2: ORIENTING INDIVIDUALS TO ADOLESCENT DIALECTIC BEHAVIOR THERAPY

Last month, we discussed the concept of "dialectics", and how a dialectical philosophy can help individuals overcome the symptoms of Borderline Personality Disorder (BPD). The topic of this article is orientation, a fundamental component of improving the success rate of youth in DBT. Orientation includes communicating the program components to youth and referral sources, establishing and communicating appropriate referral procedures, remaining aware of the challenges and assumptions of DBT, and establishing clear and appropriate group rules.

Program Components

The DBT model is very flexible, in that it can be delivered in any setting or level of care (i.e. outpatient programs, residential programs, etc). Basic DBT consists of weekly group psychoskills training, weekly individual therapy, and between-sessions "skills coaching" as needed (described below). Because the group is more educational than therapeutic, individual therapy is crucial to client's success, and because individual therapy focuses on integrating skills into the individual's daily life struggles, group is where clients learn the skills they need to use to foster change. And as is true for any type of combined-modality program, the success of a DBT program begins with a strong referral process.

Referral

With any successful program comes increasing demand. For example, I hear from many parents who have independently researched DBT, and who contact me because they want their children to have the same success rates that have been reported in the literature, rather than contacting me because they truly feel their child is a fit for the program. Similarly, providers often discharge clients due to self harm or other dangerous behaviors and refer them to my DBT group, when the client may not be functional enough for an outpatient a group modality. While being in high demand is a problem that any professional likes to experience, with high demand for our programming comes more responsibility to maintain our integrity, and to monitor treatment fidelity closely.

Although DBT is becoming a standard of care for clients who are hard to treat, "resistant", or high service utilizers, it is important to avoid viewing DBT as a "dumping ground", or as a respite for frustrated clinicians or parents. The best way to avoid inappropriate referrals is for programs to establish and maintain appropriate inclusionary and exclusionary criteria, and to effectively communicate these practices to referral sources. The table below provides a sample of typical criteria for an adolescent DBT group, and a description of how to apply these criteria:

Inclusionary Criteria	Exclusionary Criteria
Age 15-19	Adults or pre-teens
Average or better IQ; Ability to think abstractly	Below average IQ; inability to discuss and process abstract concepts
Voluntary participation	Involuntary participation
Ability to focus and delay impulses during group	Extreme impulsivity or hyperactivity that prevents participation in a group setting
Willingness and ability to share verbally in a group setting	Nonverbal/limited verbal skills; extreme social anxiety/anger that inhibits participation
Secondary impulsive, self destructive behaviors; Chronic suicidality or multiple treatment episodes	Primary impulsive, self destructive behaviors; Active suicidal plan and intent
Affective instability, anger management problems or oppositional symptoms	Inappropriate affect due to unmanaged mood disorder; Violent or severe conduct disordered behaviors
Poor boundaries, lack of assertiveness skills and inappropriate social interactions or relationships with peers	Lack of ability to interact socially due to Autism spectrum disorders or other primarily social disorders
Dissociative behaviors due to trauma history, Acute Distress or PTSD	Lack of reality testing abilities due to active psychosis that is not stabilized

1. Age: One common mistake providers make in adolescent programming of any kind is to mix pre-teens with teens, or to place adolescents in adult programs. The drastic difference between a 12 or 13 year old and a 17 year old is not only frustrating for the clients but is also taxing for the clinicians. Similarly, placing a 17 or 18 year old with people facing mid life problems is limited in it's effectiveness. Ideally, providers should have a pre-teen, teen, young adult, and adult program to meet these different developmental needs. However, most programs do not have the resources to develop specialized programming, and therefore should limit the age range of their groups to what is clinically appropriate, rather than trying to accommodate inappropriate referrals.

2. Average or better IQ; bility to think abstractly: Many of the skills taught in DBT are very concrete, tangible skills that are easy to understand, practice and apply. However, the foundation of DBT is mindfulness (to be discussed in future topics), which can be frustrating for those unable to think abstractly. Similarly, acceptance is a practice encouraged in DBT, and is not easily adopted by those without abstract reasoning skills.

3. Voluntary participation: DBT requires a commitment to the program. The behavioral component of practice is what teaches individuals to generalize skills learned in therapy to all contexts and environments. Although involuntary clients may be appropriate for DBT, high levels of resistance and refusal to participate counteracts the focus on behavioral change, and lowers the productivity level of the group. Many clinicians assume that adolescents equal involuntary

participation. However, if the orientation process is done properly and the group is run so that the youth involved are enjoying it, voluntary participation becomes a rule not an exception. In addition, prescreening youth to ensure they want to participate reduces the frequency of inappropriate referrals, and makes the intake session go much more smoothly.

4. Ability to focus and delay impulses during group: In any group modality, individual participants are not only responsible for themselves, but are also responsible for how their behaviors impact their peers. Because of this added responsibility, adolescents joining a DBT group should be capable of managing their impulsive behavior during group time, and must be easily redirected if they are off task or are struggling with impulsivity or urges to act out.

5. Willingness and ability to share verbally: As mentioned earlier, DBT groups are not therapeutic in nature, but rather, are educational. The focus of a DBT group is skill development, rather than interpersonal sharing. Individual participants are expected to complete and share their homework weekly, and to participate in discussions and activities where skills can be understood, practiced, and assimilated.

6. Secondary impulsive, self destructive behaviors; Chronic suicidality or multiple treatment epidsodes: 40% of adolescent inpatients report a history of self injurious behaviors (Darche, 1990). Adolescents with BPD or BPD traits will exhibit self-destructive behaviors such as cutting, bingeing/purging, substance use, aggression towards others, or suicidal behavior. These behaviors are secondary to the thoughts, feelings, and impulses inherent in BPD, rather than due to a primary disorder of substance use, conduct disorder, etc. Because of the popularity of DBT, desperate parents, caregivers, and clients themselves often view it as a solution. However youth may not be appropriate to the dynamics of the group if they do not exhibit these behaviors as a result of BPD symptoms, although most youth will present with co-occurring issues such as mood disorders, substance use disorders, or anxiety disorders (Darche, 1990; Favazza & Conterio; 1989 Favazza, 1996). It is up to the assessor to accurately determine the primary and secondary symptoms that youth are presenting with.

7. Affective instability, anger management problems or oppositional symptoms: Similarly to self destructive behaviors, youth with BPD often act out their anger in response to painful emotions or sensitivity to rejection or criticism, and their moods can take drastic swings several times a day. This is not to be confused with bipolar highs and lows, anger towards authority, or severe conduct disorder, although these issues or diagnoses may be present as well. Youth must be functional most of the time, and when cycling through a bipolar manic and depressive episode, these symptoms could potentially take a client out of group for weeks, which is disruptive to the group's functioning level.

8. Poor boundaries, lack of assertiveness skills and inappropriate social interactions or relationships with peers: Clients with autism spectrum disorders or social anxiety are often referred to DBT to learn social skills, and while this is taught in DBT, this is typically an inappropriate referral. For youth with BPD symptoms, social inadequacies are the result of low self worth, fear of abandonment, or rejection by peers due to BPD symptoms, and are likely to be a major concern, but are not ***the primary*** concern.

9. Dissociative behaviors due to trauma history, Acute Distress or PTSD: There is a high comorbidity of (PTSD) and BPD (Favazza & Conterio,1989). However youth need to be capable of reality testing in order to fully participate in DBT. Paranoid ideation and dissociative responses are to be expected, and individuals providing DBT must learn and practice trauma informed care, in order to avoid re-traumatization. However, actively psychotic individuals who are not stabilized will struggle to grasp the concepts of DBT, and will likely not be functional enough to practice the skills learned outside of group without assistance.

Although not all youth presenting for DBT will be appropriate, it is important to note that an alternative to the recommended model of DBT is to deliver the skills individually to clients if they are not appropriate for group, although this of course will reduce treatment fidelity. However with any treatment model, modifications are sometimes necessary in order to meet the needs of each individual. Many youth who do not meet the inclusionary criteria for a DBT program can benefit from individual DBT sessions, and deserve the opportunity to try DBT, particularly if other therapies have had limited success. When faced with the challenges of application, most of us are willing to sacrifice complete treatment fidelity in order to deliver the most appropriate care to our clients.

Challenges for providers considering using DBT

Just as inappropriate referrals can be a challenge for providers, the intensity of a true DBT model can be difficult to maintain, especially in an outpatient setting, where practitioners work more independently and are concerned with billable hours. For example post training, professionals are expected to participate in regular consultation groups among a DBT team, which may be difficult to assemble, or to fit into a busy schedule. Below are some other challenges facing individuals wishing to deliver DBT.

Training requirements: Although the original DBT manual and other DBT resources are readily available for clinicians who have not been trained in DBT, one is not prepared to deliver DBT to this high risk population through self training. Instead, Marsha Linehan strongly recommends that providers of DBT get intensively trained. This can be difficult since intensive DBT trainings require a week-long commitment, and are only offered at specific times and locations throughout the country. In addition, a team of four or more individuals are usually required to register for the trainings. Alternatively, many professionals choose to attend smaller, more frequent and less

intensive trainings to maintain competency in DBT. Having access to an intensively trained supervisor is ideal in cases where intensive training is not practical.

High risk symptoms: The risk factors present in youth receiving DBT are inherent in the disorder (i.e. substance abuse, bingeing/purging, unprotected sex, self harm, etc.). Professionals wishing to offer DBT must be properly prepared to handle these risks, to manage the behaviors appropriately in and out of session, and to monitor individual's safety at every encounter.

Burn out: Because of the nature of BPD, the burnout rate is high for professionals. There are many ways to avoid burnout, some of which are inherent in the DBT model. This topic will be discussed more in future series' topics.

Coaching Sessions: In-between session coaching is expected in the DBT model, for non-emergency situations. This requires individuals who are DBT trained to be available to clients who call and request help with the skills they have learned, and that a check and balance system is in place to ensure coaching is implemented properly.

DBT Assumptions

The challenges that we are faced with in delivering DBT are important to be aware of before and during program implementation. In addition, the DBT model includes eight assumptions about treatment that are important to be aware of, as they are intended to drive treatment planning (Linehan, 1993, see pgs. 106-108). Detailed explanation of these assumptions are beyond the scope of this topic, but they are mentioned here because of the importance of discussing them with those being oriented to DBT, and they will be referred to periodically throughout future articles. These assumptions are:

- Patients are doing the best they can
- Patients want to improve
- Patients need to do better, try harder, and be more motivated to change
- Patients may not have caused all of their own problems, but they have to solve them anyway.
- The lives of suicidal, borderline individuals are unbearable as they are currently being lived
- Patients must learn new behaviors in all relevant contexts
- Patients cannot fail in therapy
- Therapists treating borderline clients need support

These assumptions are a large part of what makes DBT vastly different from more traditional treatment models. For example, other models may label a client "resistant", however the DBT model encourages us to re-structure that belief to encompass the first assumption; that individuals are doing the best they can and want to improve. The dialectic in this however is that these same individuals need to do better, try harder, and

become motivated if we are to see change occur. This assumption not only makes the client accountable for change, but also the provider.

DBT Group Rules

A final crucial part of orienting individuals to DBT is the rules. As with any adolescent group, structure and consistency are crucial to ensure the group is safe and productive. For youth with the complex symptoms involved with BPD, orienting clients to the group rules and strategizing ways to help them be successful in following the rules is essential. Although Linehan provides a group rule sheet in her workbook (Linehan, 1993*b*), these rules are not sufficient for an adolescent population. For youth the rules must be clearer, more specific, and worded in a way that is appropriate to their development and to the typical challenges of adolescence. At the conclusion of this article is a sample of group rules developed by Psychological Service and Human Development Center (PSHDC) for the adolescent DBT group.

Summary

It is important to note that the above description of orientation components in an adolescent DBT program is not all inclusive, but does provide readers with an understanding of some of the key factors necessary to begin and maintain such a program. Properly orienting youth, referral sources, and parents to what DBT is, what BPD is and how the skills help reduce symptoms, assumptions and expectations for the program, is vital to the success of each individual. In addition to orienting external participants, internal staff must be a part of the DBT team as well, and challenges facing those who provide DBT to youth must be acknowledged and monitored. Next month's topic will continue to examine some of these orientation components within the context of the first module of DBT, mindfulness.

Adolescent DBT Group Rules

The following group rules are from Linehan's workbook (Linehan, 1993*b*), however many have been added or modified to be more applicable to an adolescent population.

1. If you drop out of group or miss three consecutive groups without prior approval, you are out of group. Re-entry requires a meeting with the group leader to determine appropriateness for return.

2. Because DBT group is a skills training group, each person attending group must be in ongoing individual therapy.

3. No one is to come to group under the influence of drugs (Unless taken as prescribed by your doctor) or alcohol.

4. No one is to glorify self-destructive behaviors with other group members, in or outside of group sessions.

5. Information obtained during groups, including the presence of other group members is CONFIDENTIAL, and is not to be shared with anyone outside of group. If a group member becomes concerned about another group member while attending group, he/she should immediately discuss this with the group leader. The group leader must break confidentiality under specific, imminent life threatening situations (To be explained upon first meeting and after upon request).

6. If group members form private relationships outside of group, these situations MUST be addressed openly with the group leader.

7. Romantic relationships are NOT permitted between group members at any time.

8. Each person must come to group prepared with his/her binder, completed homework from the previous group, and a writing utensil.

9. Respect is MANDATORY. ALL group members and leaders must respect themselves and each other. This includes attention when others are speaking, responding when being spoken to, silencing and ignoring cell phones, and appropriate communication at all times.

10. There are no breaks from group unless there is an emergency situation.

11. Group members may use telephone consultation between groups if necessary and appropriate. There are 3 situations where telephone consultation is appropriate (Adopted from Alec Miller in live training May 2008):

    a. A situation where you need coaching on what/how to use skills.
    b. Sharing good news.
    c. To help group relationships (ex. You are hurt/offended by something the group leader or a group member said or did).

12. Group members are expected to clean up after themselves at the end of group, before leaving the group room.

13. If you experience an emergency between groups, you should call 911, the emergency on-call person with PSHDC (215-540-5860), or your therapist's emergency on-call phone number and follow the directions to remain safe.

14. All group members must check in with the receptionist and wait in the waiting room for the group leader to call you in.

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