INTRODUCING DIALECTICAL BEHAVIOR THERAPY WITH AN ADOLESCENT POPULATION

Dialectical Behavior Therapy (DBT) is the treatment of choice for adult populations with Borderline Personality Disorder (BPD) symptoms. Because of the strong research supporting DBT (SAMHSA, 2010), and the tendency for this population to be treatment resistant, complex, and high utilizers of services; funders, referral sources, and regulatory bodies are increasingly requesting the implementation of a DBT model by service providers who treat any individuals with high risk issues related to BPD (i.e. self injurious behaviors, suicidality, multiple hospitalizations). In response, more and more programs have been modifying DBT in an effort to treat younger clients presenting with these symptoms, and the research community is prioritizing the design and publication of randomized controlled trials to establish DBT's evidence base with an adolescent population (Miller, Rathus & Linehan, 2007).

In 2004, I formed a weekly outpatient group for adolescent females (through Psychological Service and Human Development Center [PSHDC] in Fort Washington, PA) using a modified DBT model. Since that time, the group has grown in status and attendance, with referrals coming from parents, local schools, hospitals, partial programs, and outpatient professionals who are in need of a structured program that offers DBT for this difficult and high risk population. In addition, I have had multiple requests by clinical directors for consultation, training, and program model development by programs wishing to apply DBT principles to their adolescent populations. My passion and belief in the use of this model with this population, coupled with my experience with the increasing demand for adolescent DBT programs over the years has motivated me to provide my colleagues with a monthly column on the topic for BHC, beginning with this introductory column.

What is DBT?

Developed by Marsha Linehan over 15 years ago, DBT is one of the treatment models considered to be the third wave of Cognitive Behavioral Therapy (CBT; Hayes, Follette, & Linehan, 2004). It was the first model to offer a solution to the frustrations encountered by clients and clinicians who were failing to see results from standard CBT as applied to BPD. The model combines three important elements; valid behavioral science, dialectical philosophy, and zen practice (Salsman & Linehan, 2006).

Valid Behavioral Science

DBT falls under the umbrella of CBT in that it provides clients with concrete opportunities to acquire & practice skills by emphasizing homework, practice, and repetition to generalize skills to the client's natural environment. Behavioral principals like reinforcement, behavioral analysis and shaping are integrated into the model, as well as cognitive methodologies like examining faulty beliefs and the use of self affirmations.

Dialectical Philosophy

The symptoms inherent in BPD (as discussed below) cause clients to struggle with extreme behaviors, emotions, and thoughts. The dialectical philosophy helps these clients find balance in these extremes, through the synthesis of opposing ideas, feelings and behaviors. By developing empathy for others, examining multiple perspectives of a single situation, and increasing accountability for both clients and clinicians, the dialectical philosophy is a core component of DBT.

Zen Practice

The integration of dialectical philosophy and valid behavioral science is enhanced by the practice of zen. The ultimate goal of DBT is to create a life worth living (Linehan,1993), a standard of care that we as professionals are constantly striving for. Clients become more attuned to themselves and their environments through meditation, relaxation, and mindfulness. Although mindfulness is becoming increasingly popular in both psychology and pop culture, its application can be confusing and overwhelming for many. DBT offers a "one step at a time" approach to learning and using mindfulness to overcome the symptoms of BPD.

Does BPD actually exist in an Adolescent Population?

It is clear that DBT is the treatment of choice for BPD, but what is BPD, and what does it look like in adolescents? According to the DSM-IV-TR (American Psychiatric Association; APA 2000), a BPD diagnosis is rarely appropriate for a person under the age of 18, due to the nature of personality development. However because parents, teachers, and service providers often see age-specific manifestations of BPD symptoms in youth, this diagnostic limitation can create a barrier to care. The table below compares the standard DSM-IV-TR symptoms of BPD (of which only 5 need by present), along with examples of the way symptoms may present in adolescence:

Adult Symptom according to DSM-IV-TR	Adolescent Presentation of symptom
1) Frantic efforts to avoid real or imagined abandonment	Clinginess with friends or family; lack of trust in others; sensitivity to rejection; over-reacting to criticism or feedback; perfectionism
2) A pattern of unstable & intense interpersonal relationships alternating between idealization & devaluation	Volatile friendships; inappropriate romantic relationships; lack of boundaries with others; frequent peer conflict
3) Identity disturbance: markedly & persistently unstable self-image or sense of self	Readily willing to take on the identities of others; often switch from one group of friends to another; pours self into the identities of others; unsure of values, beliefs, goals; struggles to be him/herself
4) Impulsivity in a least 2 areas that are potentially self damaging (spending, sex, drinking, eating, etc.)	Eating disordered behavior; substance abuse/dependence; sexual acting out; running away; breaking curfew; poor decision making
5) Recurrent suicidal behaviors, gestures, threats or self mutilating behavior	Suicidal threats or attempts; lack of interest in life or bettering oneself; cutting, burning, picking, scratching, head banging, or pulling one's hair; multiple tattoos or peircings; multiple hospitalizations for suicidality
6) Affective instability due to a marked reactivity of mood	High sensitivity to emotions; difficulty regulating moods; inability to recognize or express emotions; inability to reverse escalation of emotions; slow return to baseline emotions
7) Chronic feelings of emptiness	Self report of a "hole" inside; feeling chronic loss or emptiness, even when relationships are good or positive rewards or consequences are in effect
8) Inappropriate intense anger	Either extreme may be present—lashing out at others, threatening others, verbal or physical abuse, destruction of property, tantrums, school suspensions/expulsions, defiance of authority; or refusal to acknowledge anger when anger is appropriate, passive or passive-aggressive responses
9) Transient, stress related paranoid ideation or severe dissociative symptoms	Temporary paranoid thinking such as "no one loves me", "everyone's out to get me", "things will never improve"; severe numbness to emotions; detaching from interactions; forgetting conversations, interactions or behaviors

Why should we use DBT?

The growing popularity of DBT speaks for itself, however it is my experience that more family members contact me seeking DBT than professionals do. If you are unsure if DBT is worthwhile for you or your clients, take a minute to consider what I believe to be the top 5 reasons to use DBT with your clients:

1. ***Respect for our clients and ourselves:*** Before DBT hit the scene, the stigma surrounding BPD clients was shameful. Too often, clients would fail out of treatment or even be turned away for treatment because professionals were ill equipped to handle them. This actual rejection only contributed to the underlying fear of abandonment that clients with BPD are driven by. Our willingness to label these clients as "difficult", "resistant", or "untreatable" often came out of our own inadequecies and inability to manage their behaviors. Marsha Linehan acknowledged not only that clients with BPD need more acceptance and validation, but also that the professionals treating them need more support, structure, flexibility, consultation, and time (Linehan,1993).

2. ***Evidence-based model*:** Since it's inception in 1993, multiple studies have proven DBT is a valuable treatment model for reducing suicidality, self injurious behaviors, volatile emotions, & interpersonal conflict with adult populations (Linehan, Heard & Armstrong, 1993; van den Bosch, Koeter, Stijnen, Verheul & van den Brink, 2005). The sole use of CBT has proven to be insufficient for the needs of this population (Linehan, 1993), and the complex symptom presentation inherent in the diagnosis requires professionals to take steps to improve access of care for these clients.

3. ***Practical tools (skills) to teach clients:*** A complaint I often encounter in my daily practice is that clients or their loved ones cannot articulate any practical, concrete skills or gains of treatment. This is not only frustrating for clients, but also for many professionals who are at a loss for what to teach clients and how to teach it. The four core modules of DBT (mindfulness, distress tolerance, emotion regulation, and interpersonal skills) are embraced by professionals, funders and clients because of the objective, measurable goals and interventions they teach. Even without a diagnosis of BPD, these skills are essential to all of our quality of life.

4. ***Versatility:*** DBT was designed to compliment and integrate other models and interventions such as psychopharmacology, 12 step and co-occurring addiction models, behavior modification, and cognitive and humanistic approaches. It can be applied throughout multiple levels of care, settings, and modalities. Although intensive training is the standard of care, for those who are unable to invest in intensive training, there is a self help book and treatment manual readily available to the public.

5. ***A universal method of interacting:*** Particularly for higher levels of care, DBT offers a common language and understanding that helps reduce power struggles, treatment refusal, and physical restraints (Linehan, 1993). The common division of care both internally and across treatment providers disrupts treatment and is often confusing and detrimental to the client's recovery. The standard behavioral principals of DBT, coupled with its unique terms and processes, facilitate communication among and between clients and professionals.

Why should we use DBT with adolescents?

The DBT model aligns with the developmental needs of teenagers nicely. Its blend of concrete skills with abstract zen concepts assists them in their transition from childhood to adulthood, and prompts them to consider their values and morals during this transition. It gives them the social skills needed to avoid peer pressure and abusive relationships, and helps them develop empathy and personal responsibility. Finally, as their identity is developing, DBT encourages them to discover the person they are, establish who they want to be, and identify what goals they must accomplish to get there. Specifically, professionals are using these skills to help youth:

- Reduce suicide risk and instill a sense of empowerment and hope for the future
- Achieve abstinence from cutting, substance use, or other self-destructive behaviors
- Increase insight into faulty beliefs and self-defeating thoughts
- Master appropriate communication skills
- Replace unhealthy peer relationships with healthy ones
- Develop effective strategies for managing extreme moods
- Begin to develop a positive identity that will reduce susceptibility to peer pressure and enhance self esteem
- Adopt meaningful coping skills to achieve more balance in their thoughts, emotions, and behaviors

Ultimately, the reasons for applying DBT with adolescents are the same as the reasons for its use with adults; to assist them in developing a life worth living. Suicide is the third leading cause of death in adolescents (Miller, Rathus & Linehan, 2007), and although the diagnosis of BPD is unlikely assigned to youth, many of the symptomology is present. Over the past 5 years or so, more professionals are applying DBT to a younger population, and preliminary research shows promise for similar results (Miller, Rathus & Linehan, 2007).

Ongoing topics with regard to DBT

In an effort to provide you with an understanding of DBT as a promising intervention for adolescents, I will be providing a series of columns investigating the application and benefits of applying DBT with a younger population. We will explore the application of various DBT concepts, ideas, and approaches with youth, as well as common dilemmas, barriers, or uses within the model. Please feel free to contact me at PSHDC with any questions/concerns you may have regarding this column, or in general about DBT.

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