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Dialectical Behavior Therapy and Adolescence

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Abstract:

Dialectical behaviour therapy (DBT)is a state-of-the-art, evidence-based form of cognitive behavioural therapy for teenagers and adults who experience significant trouble managing their emotions, thoughts and behaviours.

In order to more effectively manage intense emotions that can lead to impulsive decision-making and problematic behaviours, patients participating in DBT learn how to practice mindfulness — fully being present in the moment and focusing on one thing at a time, without judgment — along with new problem-solving skills. This approach has helped teenagers and young adults who struggle with any or all of the such as impulsive/disruptive behaviours, frequent mood swings, self-injurious and suicidal behaviours, depression and anxiety, family and peer conflict, anger outbursts, eating disordered behaviours, drug or alcohol abuse, poor coping skills. Considerable research has been conducted on DBT for adolescents and adults, and multiple randomized controlled research trials have demonstrated its effectiveness.

SEVEN MAIN ADAPTATION OF DBT FOR ADOLESCENTS

First, family members, usually parents, are included in multifamily skills training groups to enhance generalization and reinforcement of skills and structure adolescents' environments. Parental participation in skills training is designed to provide a common vocabulary for therapeutic techniques within families and enhance parents' ability to provide validation, support, and effective parenting. Including family members in skills groups also offers the added benefits of providing in vivo opportunities to role play skills, fostering interfamily support, reducing adolescents' disruptive behaviours in group, and enhancing treatment compliance. Family members may also receive telephone coaching and consultation from the skills group therapist for skills generalization, while adolescents receive telephone coaching from the primary individual therapist.

Second, family therapy sessions are conducted on an as-needed basis. Although individual sessions with significant others are incorporated into standard DBT for adults, adapted DBT for adolescents focuses more explicitly on this mode of treatment. Family therapy sessions were added because much of the turmoil in the lives of suicidal adolescents involves their primary support system. Family sessions are conducted when the relationship with a family member is a central source of conflict or when a crisis erupts within the family. The therapist may also initiate family sessions if the treatment would be enhanced by educating family members about particular skills or aspects of treatment or if contingencies in the home are too powerful for the adolescent to ignore and continue to

reinforce dysfunctional behaviour. Goals of family sessions include preparing the adolescent for family interactions, increasing parental understanding of adolescent's emotional vulnerability, addressing parents' own emotion dysregulation, improving familial communication, modifying contingencies in the familial environment, and crisis management. Typically, selected family members will attend 3 to 4 sessions out of the adolescent's 16 weeks of individual therapy, though more or fewer sessions can be scheduled as needed.

A third adaptation involves the development and teaching of three adolescent–family dialectical dilemmas. The first dialectical dilemma, excessive leniency versus authoritarian control, involves placing too few behavioural demands or limits on the adolescent, or being excessively permissive, versus enacting coercive parenting methods limiting freedom, autonomy, and independence. Normalizing pathological behaviours versus pathologizing normative behaviours, the second dialectical dilemma, involves viewing developmentally normal adolescent behaviours as deviant versus failing to address or perceive deviant adolescent behaviours as such. Lastly, forcing autonomy versus fostering dependence involves acting in ways that inhibit an adolescent's autonomy (e.g., excessive caretaking, overreliance on parents) versus parents' severing ties with the adolescent such that he or she is prematurely forced to separate and become self-sufficient.

Fourth, the treatment length was reduced from 1 year to 16 weeks. This may be the biggest change from standard DBT because the time in treatment is significantly reduced but the content (e.g., dialectical dilemmas, skills training modules) is increased. According to Miller et al., treatment length was modified so it would be more appealing to adolescents, given that suicidal adolescents tend to complete only a limited number of therapy sessions. Also, Miller et al. aimed to offer a brief treatment because they were including many clients with first-time non-suicidal surgical injury or suicide attempts, many of whom did not meet full criteria for borderline personality disorder. Thus, they believed they could treat many of these adolescents with a short-term treatment and offer optional additional therapy (i.e., a graduate group or repeat of first phase of treatment) for those who continued to exhibit behavioural dyscontrol.

A fifth adaptation, also involving the structure of DBT, is a second phase of treatment: a 16-week optional graduate group (with other treatment modes utilized as needed) for clients who continue to exhibit difficulties following the first phase of therapy. Youth may repeat the graduate group as many times as necessary in order to achieve their identified goals. Both phases of treatment address only the DBT stage one targets of reducing life-threatening behaviours, reducing therapyinterfering behaviours, reducing quality-of-life-interfering behaviours, and increasing behavioural skills. The graduate group is designed to address the DBT treatment functions of improving capabilities, improving motivation, and promoting generalization of skills, but in a way that requires less intensive adolescent participation and fewer program resources. The goal of the graduate group is to reinforce and generalize skills previously taught. Group sessions involve adolescents reviewing and teaching skills to peers and consulting and problem solving with group members to foster peer coaching and support rather than reliance on the therapist. During this phase, the therapist consultation team also continues, addressing the functions of treating the therapist and structuring the environment as needed. Continuing treatment in a separate, second phase with reduced intensity allows for clients to feel an increased sense of mastery without removing structural resources that may be helping to maintain progress.

Sixth, the number of skills taught within each module was slightly reduced and a fifth adolescent-specific skills module was added. Most of the original DBT skills were maintained because there is no theoretical or

empirical basis for which skills to include or eliminate. In addition to the four original DBT skills modules (i.e., mindfulness, interpersonal effectiveness, emotion regulation, distress tolerance), a fifth skills module, walking the middle path, was developed for adolescents and their families. This module teaches validation of self and others, behavioural principles (i.e., how to reinforce, extinguish, punish, and shape behaviour), and three adolescent–family dialectical dilemmas with the goal of finding the middle path, or balanced synthesis, in each dilemma. The dialectical dilemmas are introduced in the multifamily skills training groups and are targeted in individual and family therapy sessions.

Lastly, group skills handouts were modified to improve their appeal and applicability to adolescents. Modifications include simplification of terminology, streamlined language, simplification of visual layout to decrease visual overstimulation (via reduced amount of variability in font size, bold print, underlining, and italicizing), and addition of adolescent-geared graphics. Other important modifications when teaching skills include adapting examples of each skill to make them more applicable to adolescents and utilizing more experiential and in vivo, rather than didactic, methods.

Thus, DBT for adolescents is based on the same theoretical underpinnings and generally follows the same framework, including functions of treatment, targets, modes, and strategies, as standard DBT for adults. However, adaptations involving inclusion of family members in skills training, addition of family therapy sessions, development of new adolescent–family dialectical dilemmas, reduction of treatment length, addition of an optional graduate group, implementation of a new skills module, and modifications to handouts and delivery of content in skills groups make DBT more applicable and appealing to adolescents and their families.

LIMITATION OF DBT FOR ADOLESCENTS

- Learning a lot of skills can be quite overwhelming.
- It's not usually beneficial on its own for illnesses other than BPD.
- There is the possibility of increased risky behaviour at times and therefore it can require highly specialised/ trained professionals.
- Usually, depending on what's offered, it requires multiple commitments per week for an extended period of time.

CONCLUSION

DBT has been adap-ted for use with adolescents who present with similar problems. Current adaptations of DBT target youth with BPD features, suicide ideation and behavior, NSSI, ODD, BD, EDs, and TTM. DBT has also been applied transdiagnostically among youth with varied psychiatric and behavioral problems in correctional facility, residential, long-term inpatient, and day treatment settings. Rationale for using DBT with these adolescents rests in the common underlying dysfunction in emotion regulation across ages, diagnoses, and problem behaviors. Treatment adaptations and length vary depending on the presenting problem and setting. However, most adaptations are modeled after the adolescent DBT manual (Miller et al. 2007b) and involve inclusion of family members in skills training, addition of DBT has been adap-ted for use with adolescents who present with similar problems. Current adaptations of DBT target youth with BPD features, suicide ideation and behavior, NSSI, ODD, BD, EDs, and TTM. DBT has also been applied transdiagnostically among youth with varied psychiatric and behavioral problems in correctional facility, residential, long-term inpatient, and day treatment settings. Rationale for using DBT with these adolescents rests in the common underlying dysfunction in emotion regulation across ages, diagnoses, and problem behaviors. Treatment adaptations and length vary

depending on the presenting problem and setting. However, most adaptations are modeled after the adolescent DBT manual (Miller et al. 2007b) and involve inclusion of family members in skills training, addition of DBT has been adapted for use with adolescents who present with BPD features, suicide ideation and behavior, non-suicidal surgical injury, oppositional defiant disorder and Trichotillomania. DBT has also been applied trans diagnostically among youth with varied psychiatric and behavioral problems in correctional facility, residential, long-term inpatient, and day treatment settings. Most adaptations are modeled after the adolescent DBT manual and involve inclusion of family members in skills training, addition of family therapy sessions, inclusion of new adolescent– family dialectical dilemmas, reduction of length of treatment, addition of optional graduate group, implementation of a new skills module, and modifications to handouts and delivery of content in skills groups.

Thus, DBT appears to be a promising intervention for adolescents presenting with a broad array of emotion regulation difficulties.

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