Dialectical Behavior Therapy with Multi-Problem Adolescents: Evolution and Updates
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• In the 1990s, Rathus and Miller began adapting DBT as the first comprehensive treatment for multi-problem adolescents at high risk for suicidal and self-injurious behavior.

• We developed DBT for adolescents (DBT-A) to address the complex and unique challenges that arise during treatment with multi-problem adolescents and their families.
Dialectical Behavior Therapy with Multi-Problem Adolescents: Evolution and Updates

• This webinar:
  — Evolution of DBT-A.
    • Overview of the adaptations made to standard DBT to address needs of adolescents and their families:
      — Treatment modalities (including multi-family skills training group and family therapy sessions)
      — Adolescent and family secondary treatment targets
      — Latest DBT skills for adolescents/caregivers
  • Suggestions for additional training and self-study in DBT-A

Learning Objectives

• Describe the evolution of DBT-A.

• Understand changes to treatment modalities in DBT-A and additions to DBT secondary treatment targets.

• Review recent updates to DBT skills for adolescents and their caregivers.
Dialectical Behavior Therapy with Multi-Problem Adolescents: Evolution and Updates

EVOLUTION OF DBT FOR ADOLESCENTS (WITH CHANGES IN MODALITIES AND TARGETS)

Development of DBT for Adolescents

• 1990s Montefiore Medical Center’s Adolescent Depression and Suicide Program, Bronx, NY

• Population: mostly suicide attempters, self-injurious behaviors, or SI, with multiple problems (school, family, substance abuse, trauma) & emotion dysregulation (many with BPD or features)
Limitations of Current Adolescent Research

- At the time, no empirically validated treatments for these adolescents
- The related treatments focused on depression, excluded suicidal adolescents or those with multiple diagnoses, or were ER-based crisis interventions for suicide attempters
- Alas! DBT: an evidence-based treatment for suicidal patients diagnosed with BPD
DBT is designed for the severe and chronic multi-diagnostic, difficult-to-treat patient with both Axis I and Axis II disorders.

DBT Research Support
Randomized Clinical Trials with Adults

16 RCTs at 13 independent sites

- Linehan
- Koons
- Safer & Telch
- Craighead
- van-den Bosch & Verheul
- Lynch
- McMain
- Carter
- Turner
- Clarkin
- Feigenbaum
- Pistorello
- Van Dijk
Randomized Clinical Trials

DBT Superior to Comparison Treatments in Reducing:
- Suicide attempts and self injury
- Premature drop out
- Inpatient/ER admissions and days
- Drug abuse
  - Depression, hopelessness, anger
- Impulsiveness

And Increasing:
- Global Adjustment
- Social Adjustment

Treatment development: The problem

• In the 1990’s, we began piloting DBT within this inner-city outpatient clinic with teens and parents.
• Used original Linehan (1993) skills manual in its entirety – got participant feedback
• Many had difficulty reading the handouts and comprehending the material.
• Developmental needs were different
• Family context needed to be addressed; families needed to be engaged.
Modifications

We modified only where necessary, based on characteristics inherent to adolescents

We thought, “we should use DBT, but we’ve got to make it fit well for this population.”
DBT for Adolescents: Modifications

• Skills training
  – Based on feedback from cohorts of families
    • Modified language and look of original skills HOs
    • We at first shortened the length of treatment (12 – 16 weeks)
      (also because of setting restraints)
  – Teaching notes, examples, stories
  – Include families
• As-needed family interventions:
  – Family therapy sessions
• Using quasi-experimental design, published first adaptation (Rathus & Miller, 2002) which revealed promising results with suicidal teens

DBT for Adolescents: Modifications
Miller, Rathus & Linehan, 2007; Rathus & Miller, 2015

• Skills training
  – Modified language and look of original skills HOs
  – Added Linehan’s new skills and expanded several
  – Gradually re-introduced most material, expanding to six-month model (for 5 modules)
  – Teaching notes, examples, stories
  – Articulated our strategies for managing multi-family skills training
DBT for Adolescents: Modifications
Miller, Rathus & Linehan, 2007; Rathus & Miller, 2015

Dilemmas and Problems:
Families getting polarized (repeating themes),
individual family members swinging from extremes,
not seeing one another's perspectives,
and relying on ineffective means of trying to get their family members to change

DBT for Adolescents: Modifications
Miller, Rathus & Linehan, 2007; Rathus & Miller, 2015

- Skills training
  • Modified language and look of original skills HOs
  • Added Linehan's new skills and expanded several
  • Gradually re-introduced most material, expanding to six-month model (for 5 modules)
  • Teaching notes, examples, stories
  • Family-based skills: Walking the Middle Path
    - New Dialectical Dilemmas and Secondary Treatment Targets
  - As-needed family interventions:
    • Family therapy sessions
    • Parent training sessions
    • Phone coaching for caregivers
What remains the same

- Dialectical underpinnings
- Biosocial theory of disorder
- Functions
  - Modes: Skills Training, Individual, Phone Coaching, Team
- Assumptions
- Target hierarchy
- Change procedures (exposure, cognitive modification, contingency management, skills training)
- Treatment strategies (i.e., core, dialectical, stylistic, case management)
- Skills (retained virtually all original DBT skills)

### DBT Functions and Modes

<table>
<thead>
<tr>
<th>Function</th>
<th>Standard DBT</th>
<th>Adolescent</th>
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<tbody>
<tr>
<td>Improve client motivation</td>
<td>Outpatient Individual therapy</td>
<td>Outpatient Individual therapy</td>
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<tr>
<td>Enhance client capabilities</td>
<td>Outpatient group skills training</td>
<td>Outpatient multi-family group skills training</td>
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<tr>
<td>Assure generalization to</td>
<td>Phone consultation</td>
<td>Phone consultation (primary therapist coaches teens; skills trainers coach parents) (and including parents in skills training)</td>
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<tr>
<td>environment</td>
<td></td>
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<tr>
<td>Structure the environment</td>
<td>Case management: Family and organizational interventions</td>
<td>Case management: Sessions with family, parents, contact with school or other providers (agreed upon by teen and therapist)</td>
</tr>
<tr>
<td>Enhance therapist</td>
<td>Therapist consultation meeting</td>
<td>Therapist consultation meeting</td>
</tr>
<tr>
<td>capabilities and motivation</td>
<td></td>
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</tbody>
</table>
**Adolescent Modes**

- Outpatient Individual Therapy
- Multi-Family Skills Training Groups
- Telephone Coaching for Teens and Family Members
- Family Sessions (as needed)
- Parent Sessions (as needed)
- Therapist Consultation Meeting
- Graduate Group
- Uncontrolled Ancillary Treatments
  - Pharmacotherapy
  - Therapeutic/Residential Schools
- Acute inpatient hospitalizations

**Individual Therapy**

- Strategies
- Diary Card review
- Targeting
- Behavioral Chain Analysis
- Solution Analysis
Stage 1 Primary targets

Pre-Treatment ▶ Commitment & Agreement
• Decrease
  — Life-threatening behaviors
  — Therapy-interfering behaviors
  — Quality of life interfering behaviors
• Increase behavioral skills
  — Mindfulness
  — Distress Tolerance
  — Interpersonal Effectiveness
  — Emotion Regulation
  — Middle Path (adolescent-family adaptation)

Targeting: Start with Diary Card to Organize Session Agenda
Primary targets - teens

• Quality of Life Target emphases
  — School-related problems
  — Peer-related problems
  — Social media-related problems
  — Family-related problems
• Diary card personalized
**WEBINAR**

**Dialectical Behavior Therapy with Multi-Problem Adolescents:**  
Evolution and Updates  
March 12, 2015 | Jill Rathus, PhD

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**Modifications**

**The Problem**

- Developmentally relevant, cognitive processing and capability differences

**The Solution**

- We identified adolescent-quality-of-life treatment targets (e.g., school-related, curfew, family conflict, peer-related, risk behaviors)
- Emphasized teen-appropriate examples, stories, exercises, and visually-engaging HOs.
Modifications

The Problem
• How to engage, teach, and treat the family.

The Solution
• We included families in treatment, identified adolescent-family secondary treatment targets, overall increasing use of environmental intervention.

Dialectical Dilemmas

Emotional Vulnerability

Unrelenting Crises

Active Passivity

Biological Social

Apparent Competence

Inhibited Experiencing

Self-Invalidation
Dialectical Dilemmas: The task with adolescents

Distinguish true signs of
- Emotional vulnerability
- Self-invalidation
- Active passivity
- Apparent competence
- Unrelenting crises
- Inhibited grieving

from what is expected for adolescent development

Secondary Targets - Teens
Adolescent-Family Dialectical Dilemmas

- Excessive Leniency ("too loose")
- Forcing Autonomy
- Normalizing Pathological Behavior ("making light of problems")
- Pathologizing Normative Behavior ("making too much of normal teen behaviors")
- Fostering Dependence
- Authoritarian Control ("too strict")

Walking the Middle Path: How families can become polarized

Dialectical Dilemmas

- Too loose ----------------------------- Too strict
- Making light of ---------------------- Making too much of problem behaviors typical adolescent behavior
- Holding on too ---------------------- Forcing independence too soon ("you're on your own!")
**Dialectical Dilemmas: working toward synthesis**

- **Too loose vs Too strict:**
  - INCREASE AUTHORITATIVE PARENTING
  - Have clear rules and enforce them consistently. Pay attention to your teen’s comings and goings, and friends.
  - AND AT THE SAME TIME
  - Be willing to negotiate on some issues
  - Be firm, yet flexible and fair

- **Making light of problem behaviors versus making too much of typical adolescent behavior**
  - Recognize when a behavior “crosses the line” and try to get help for that behavior
  - AND AT THE SAME TIME
  - Recognize which behaviors are part of typical adolescent development
  - GIVE HAND-OUT: “What’s typical for adolescents and what’s not”
### What’s Typical for Adolescents, and What’s Not? (sample items)

<table>
<thead>
<tr>
<th>Typical?</th>
<th>Not Typical: Cause for Concern</th>
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<tbody>
<tr>
<td>Increased sexual maturation; increased focus on body image, self-consciousness</td>
<td>Sexual promiscuity; bingeing, purging, or restricting eating, social withdrawal</td>
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<tr>
<td>Sexual experimentation</td>
<td>Multiple partners; unsafe sexual practices; pregnancy</td>
</tr>
<tr>
<td>Increased parent-teen conflict</td>
<td>Verbal or physical aggression, running away, avoidance of all communication</td>
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<tr>
<td>Experimentation with drugs, alcohol, and cigarettes</td>
<td>Substance abuse, selling drugs, heavily substance-using peer group</td>
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<tr>
<td>Strong interest in technology; social media</td>
<td>Spends many hours/day isolating on computer; on high-risk websites, casually meeting partners on line; revealing too much on-line</td>
</tr>
<tr>
<td>Stressful transitions to middle school or high school</td>
<td>Lack of connection to school or peers; school truancy, failure, or drop-out</td>
</tr>
<tr>
<td>Messy room</td>
<td>Old, rotting food; teen not able to find basic necessities</td>
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</tbody>
</table>

### Dialectical Dilemmas: working toward synthesis

- **Holding on too tight versus Forcing independence too soon**
  - Give your adolescent coaching to help him/her figure out how to be responsible & solve problems
- **AND AT THE SAME TIME**
  - SLOWLY give your adolescent greater amounts of freedom and independence while continuing to allow an appropriate amount of reliance on others
Skills Training: Why Include Caregivers?

And Why the new Middle Path Module?

First, a word about DBT Treatment Settings with Teens…

• Standard outpatient – with caregivers
• Inpatient
• Partial/Day hospital
• Residential
  – Inpatient – longer term
  – Therapeutic boarding school
• Schools
• Forensic Settings
• Group homes
For settings where parents are not directly involved…

- Family meetings
- Orientation program
- Skills materials/readings/handouts/books
- Phone contact
- Referrals (e.g., Family Connections Program – Hoffman and Fruzzetti)

Skills Training: Why Include Caregivers?

And Why the new Middle Path Module?
Biosocial Theory of BPD (Linehan, 1993)

Biological Dysfunction in the Emotion Regulation System

Invalidating Environment

Pervasive Emotion Dysregulation

Why Include Family Members?

• Dialectical approach holistic, contextual
• Skills acquisition for parents, since:
  — May be dysregulated, overwhelmed
  — May not be interpersonally effective
  — May be inconsistent or extreme in parenting
• Intervenes directly: invalidating environment
• Parents must be engaged to bring teens, follow through, help teens solve problems
• Models for more effective skill use?
• Helps with skills generalization
• Helps structure the environment: more reinforcing of effective behaviors
• Exposure for adolescents to parents as emotion-eliciting stimulus
• Increases parents’ social support
Common Motives for Self-Harm in Adolescents
Nock & Prinstein (2005, 2009)

• Intrapersonal
  – Negative reinforcement
    • Reducing aversive arousal
    • Regulating emotions
  – Positive reinforcement
    • Producing pleasant or desired sensations

• Interpersonal
  – Attains desired social outcomes
    • Increases social support – peers
    • Increases parental support

How including caregivers in DBT can treat BPD features/emotion dysregulation

• Treats context – targets familial antecedents & consequences of problem behaviors (e.g. suicidal behaviors, NSSI, impulsive behaviors, ineffective emotion displays)

• Biosocial Theory educates parents – re: emotional vulnerability – allows for effective responses (e.g., seeing suffering rather than “drama” or “manipulation”)
  – Different attitude + compassion + effective responses = decreased emotional and behavioral escalations
How including caregivers through DBT skills training and family/parenting sessions can treat BPD features/emotion dysregulation

- Increases caregiver validation & decreases invalidation
  - As such, can increase teen’s emotion identification, emotion regulation, emotion expression, self-regulation and identity, and problem solving
- Increases interpersonal effectiveness & decreases interpersonal conflict and anger
- Increases effective contingency management/parenting strategies

How including caregivers in DBT can treat BPD features/emotion dysregulation

- Treats parents
  - Parents acquire DBT skills
  - Can reduce teen problems
    - social learning
    - increased effective communication
    - increased authoritative parenting (Baumrind: leads to increased self-regulation and best child outcomes)
Dialectical Behavior Therapy with Multi-Problem Adolescents: Evolution and Updates

RECENT UPDATES TO DBT SKILLS FOR ADOLESCENTS/CAREGIVERS

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DBT for Adolescents: Skills Updates

Multi-Family Skills Training Group Format

Core Mindfulness

- Distress Tolerance
- Interpersonal Effectiveness
- Emotion Regulation
- Walking the Middle Path

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Family-Related Modifications in DBT for Adolescents
Rathus & Miller, 2015; Rathus & Miller, 2002; Miller, Rathus & Linehan, 2007

• Involve family members - skills training groups (multifamily format)

Skills Updates

• Managing Group
• New skills
  – Expansion of Middle Path module
  – Skills changes by module
Skills Updates

• Managing group
  — The challenges/needs brought up by including parents
  • Many people in room
  • Managing time, TIB, dysregulation, dialectical tensions

Skills Updates

• Managing group
  — Using DBT strategies in group
  • Acquisition, strengthening, and generalization
  • Didactic, model, practice
    — Manage affect and engagement through activity choices that up-regulate or down-regulate emotions
  • Validation and change — shaping
  • Warmth and irreverence; speed, movement & flow
  • Dialectics “what a fabulous opportunity to practice your skills!”
  • Engage members through teaching and theatre
Walking the Middle Path
- Expanded
Rathus & Miller, 2015; Rathus & Miller, 2002; Miller, Rathus & Linehan, 2007

– Dialectics & Dialectical Dilemmas
– Validation
– Behavior Change

MIDDLE PATH: DIALECTICS

• Dialectics
  – What is it?
    • Two things that seem like opposites can both be true
    • More than one way to see a situation or solve a problem
  – How to use it?
    • Move from “either-or” to “both-and”
    • Examples:
      – Working to accept your situation AND change it
      – You’re doing the best you can AND you need to do better
      – My mom is really strict AND she cares a lot
    • Practice looking at all sides of a situation; find the kernel of truth in every side
      – Your point of view makes sense AND my point of view makes sense
Dialectical Dilemmas:
working toward synthesis

- Psychoeducation: dilemmas
- Provide scenarios for each pole of dilemmas; ask participants to generate middle path solutions
- Rate themselves on the poles - Discuss goals for reaching a Middle Path
- Teach & discuss middle path solutions
  - Continue in family sessions
MIDDLE PATH: THINKING MISTAKES

- Review “thinking mistakes” such as:
  - all-or-none thinking
  - labeling
  - “should” statements
  - mental filter
- These push us toward extreme thinking

The cycle of invalidation

(Fruzetti & Shenk, 2008)
MIDDLE PATH: VALIDATION

- Validation
  - Definition
  - What can we validate
  - Validating self and others
  - Why should we validate?
  - A “how-to” guide with six steps
    - Range from active listening/staying focused to conveying you understand how the person feels/looking for how the thoughts, feelings, or actions make sense
  - Validation role plays

MIDDLE PATH: BEHAVIORISM

- Expanded with more examples & worksheets
- Behavior Change
  - Positive reinforcement
    - Consider behaviors to change in self and other
    - Positive tracking HW
    - Shaping
  - Extinction/planned ignoring – when and how
  - Effective and judicious use of consequences
    - Develop menu of “wise mind” consequences
    - Pitfalls of punishment
Acceptability of Walking the Middle Path (Rathus, Miller, Campbell and Smith, in press, Amer. J. of Psychotherapy)

• Results: High acceptability of module, to teens & parents.
• Middle Path skills ranked highly among DBT skills perceived most helpful.
• The Middle Path skill Validation was considered most beneficial skill (to parents and teens) among all DBT skills, with reinforcement close behind.

New skills developments and adaptations

• Interpersonal Effectiveness
  —THINK skill for perspective taking and benign interpretations (Think about other’s view, Have empathy, multiple interpretations for other’s behavior, including at least one benign interpretation, Notice ways they’ve been trying/struggling, use Kindness)
  —Multiple teen-friendly scenarios of DEAR MAN, GIVE, FAST, + using together
New skills developments and adaptations

• Emotion Regulation
  – Parent-teen shared pleasant activities (behavioral activation + family cohesion)
  – Expansion of PLEASE
    • Sleep hygiene
    • Balanced eating
  – Cope Ahead (from Linehan, 2015)
  – Check the facts/Problem solving (from Linehan, 2015)
  – Teen values and priorities when considering long-term goals (adapted from Linehan, 2015)
  – Expanded list of emotions for opposite action (e.g., jealousy, love; Linehan, 2015)

New skills developments and adaptations

• Distress Tolerance
  – TIP
  – Distress Tolerance Kits – HW show & tell
  – Mindfulness
    – Cheat Sheet
    – Why bother?
Feasibility/pilot studies of DBT for adolescents (Mehlum, 2012, ABCT)

- DBT for suicidal / self-harming adolescent outpatients
  - Rathus & Miller, 2002
  - Woodberry et al, 2008
  - James et al, 2008
  - Cooney et al, 2010
  - Fleischhaker et al, 2011

- DBT for suicidal adolescent inpatients.
  - Katz et al, 2004
- DBT for long-term adolescent inpatient care
  - McDonell et al, 2010
- DBT for adolescents with bipolar disorder
  - Goldstein et al, 2007
- DBT for adolescents with anorexia
  - Salbach-Andrae et al, 2008

RCT Data!

- Mehlum and colleagues (2014; University of Oslo, Norway) compared 16 weeks DBT with Enhanced Usual Care with adolescents with repeated suicidal behavior and self-harm (JAACAP, 53 (10): 1082-1091)

- DBT associated with
  - Decreased frequency of self-harm episodes
  - Reduced severity of suicidal ideation
  - Reduced depression

- DBT successful at engaging and retaining patients (treatment retention good in both conditions)
CARES Study

- Large-Scale, multi-site adolescent-family RCT – U Washington & UCLA
  - Collaborative Adolescent Research on Emotions and Suicide (CARES) Linehan, Berk, Asarnow, McCauley (in progress)
  - 26 weeks of DBT compared to supportive psychotherapy
  - Adolescents with suicidal behavior and self-harm

DBT for Adolescents: Evolution and Updates

- A Coming of Age for Adolescent DBT
Conclusions

• DBT for Adolescents is standard DBT – Modifications for adolescent development
• DBT for Adolescents designed to involve families
• Large-scale RCTs complete and near completion

Conclusions

• Research is needed to determine
  – Critical components
  – Optimal length
  – Does including Middle Path improve outcomes?
  – Does including caregivers enhance outcomes, and in what formats?
Conclusions

• Future Directions
  – DBT and DBT skills have been applied to a broad range of populations, many of whom not suicidal
  – DBT in Schools (Mazza, Mazza, Murphy, Miller, & Rathus, in press, Guilford)
    • Comprehensive DBT in schools
    • Skills only in schools for general or indicated populations

Training and Self-Study Opportunities

• Self-study of books/articles
  – Linehan (2015a; 2015b; 1993a; 1993b)
• Future webinars in this series may be of interest
• Watch the Btech training schedule for selection of training options this summer/fall
“Youth is a time of opportunity 
But also a time of risk. 
The risk for us is that 
If we fail to support the 
rapidly growing population of 
young people around the world, 
we will be left to pick up the 
pieces.”
Robert Blum, MD, 
MPH, PhD, Johns Hopkins, 2007

Thank you
For more training information, please visit
www.behavioraltech.org