



Adapting dialectical behavior therapy to help suicidal adolescents



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Including the family, other changes increase DBT's efficacy for these patients

Treating suicidal adolescents is fraught with challenges. Antidepressants may be associated with increased suicidal ideation in adolescents,¹⁻³ although some data suggest that increased adolescent suicide rates are correlated with decreases in antidepressant prescribing.⁴ Adolescents hospitalized after a suicide attempt are likely to attempt suicide again after they are discharged.^{5,6} Such patients might not attend outpatient psychotherapy; a study of 167 adolescents discharged after a suicide attempt found that 26% never attended follow-up appointments and 11% went once.⁷

Emerging research supports the effectiveness of dialectical behavior therapy (DBT) for suicidal adolescents. DBT is a form of cognitive-behavioral therapy that combines individual therapy, skills training, and telephone coaching and is implemented by a therapist consultation team that meets weekly. This article reviews evidence supporting the efficacy of DBT for suicidal adolescents and describes principles of outpatient DBT for these patients as developed by Miller et al.⁸

Evidence of DBT's effectiveness

A review of DBT research found strong evidence for DBT's effectiveness for suicidal adults.⁹ Recently, DBT has been adapted to treat adolescents with suicidal behavior and nonsuicidal self-injury (NSSI).¹⁰⁻¹⁵

In a nonrandomized trial, Rathus and Miller¹⁰ compared 29 suicidal adolescent outpatients receiving DBT with 82 participants receiving treatment as usual

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Table 1

Characteristics of an invalidating environment

Characteristic	Result
Indiscriminately rejects communications of private experiences	Adolescents learn to actively self-invalidate and do not learn to validate themselves, label their emotions, or effectively regulate their emotions
Actively punishes displays of emotions, interspersed with intermittent reinforcement of emotional outbursts	Adolescents develop problematic emotion regulation strategies that oscillate between suppression and extreme outbursts
Oversimplifies problem solving	Adolescents develop high perfectionism and sensitivity to perceived failure, form unrealistic goals, and experience intense negative arousal in response to challenging feedback

Source: Reference 8

Table 2

6 levels of validation employed by DBT therapists

Level	Validation practices
Accurate reflection	Paraphrase what an adolescent says; communicate that you accurately understand what the adolescent has said
Mindreading	Communicate that you understand the adolescent's private experiences or that which is unsaid. Articulate private experiences of the adolescent based on your knowledge of him or her
Observing and listening	Use nonverbal and paralinguistic cues to indicate interest. Communicate that you wish to know the adolescent's emotions, thoughts, and behaviors
Validating in terms of causes	Make sense of behavior based on the adolescent's learning history or biology. Describe how a behavior is effective for short-term but not long-term goals
Validating in terms of the present	Search for and reflect the wisdom and truth in the adolescent's behavior by saying things such as 'Of course you feel this way! Anyone would feel the same in your situation'
Radical genuineness	Act natural, like a real person, rather than a 'therapist.' Communicate belief and confidence in the adolescent

DBT: dialectical behavior therapy

Source: Reference 16

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In a nonrandomized trial, adolescents treated with DBT had significant reductions in suicidal ideation and other symptoms

(TAU). Patients were assigned to DBT if they had a suicide attempt in the previous 16 weeks and ≥ 3 borderline personality disorder (BPD) features or to TAU if they met only 1 of those conditions. Patients in the DBT group had more axis I disorders and pretreatment hospitalizations than the TAU group. Compared with those receiving TAU, patients treated with DBT had fewer hospitalizations (13% in TAU vs 0% in DBT) and a lower dropout rate (60% in TAU vs 38% in DBT). The DBT group experienced significant reductions in suicidal ideation, BPD symptoms, and general psychiatric symptoms. There was 1 suicide attempt in the DBT group vs 7 attempts in the TAU group; however, this difference was not statistically significant.

Woodberry and Popenoe¹¹ examined the use of DBT for suicidal adolescents and their families in a community outpatient clinic. Adolescents reported reductions in overall symptoms, depression, anger, dissociative symptoms, and urges for intentional self-injury. Parents reported reductions in their children's problem behaviors and in their own depressive symptoms. In a study of DBT in 16 adolescent females with chronic intentional self-injury, patients reported significant reductions in incidents of intentional self-injury, depression, and hopelessness, and increases in overall functioning.¹²

Three studies have examined using DBT for suicidal adolescents in residential facilities. In a pilot study, Katz et al¹³ compared



DBT for adolescents

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DBT attempts to synthesize acceptance with the change-based strategies of behavioral science

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Table 3

Teaching adolescents 'opposite action'

Ask, what emotion am I experiencing? (eg, anger)
Ask, is it effective for me to experience this emotion? Does this emotion fit the facts of the situation? (If the answer to either of these questions is no, then proceed)
Ask, what is the action urge associated with this emotion? (eg, to attack)
Do actions that are opposite to the action urge (eg, gently avoid the person with whom you are angry)
Act opposite to the action all the way and completely (eg, have empathy and understanding for the other person, change your body posture by unclenching hands and relaxing facial muscles)
Keep repeating the opposite action until the emotion decreases
Source: Reference 8

DBT with TAU for 62 suicidal adolescent inpatients. At 1-year follow-up, both groups experienced significant reductions in suicidal ideation, NSSI, and depression. However, compared with those who received TAU, DBT patients had fewer behavioral problems during hospitalization. Sunseri¹⁴ used DBT to treat adolescent females in residential treatment. After DBT was implemented, residents were hospitalized because of NSSI and suicidality for fewer days than before DBT. Trupin et al¹⁵ taught DBT to staff who worked with female adolescent offenders at a juvenile rehabilitation facility. After the staff implemented DBT, the rates of problem behaviors and punishment by staff decreased on 1 unit; there were no behavior or punishment changes on another unit.

Theoretical foundations

Biosocial theory. The problems DBT treats in suicidal adolescents include emotion dysregulation, interpersonal conflict, impulsivity, cognitive dysregulation, and self-dysregulation.⁸ The biosocial theory postulates that these problems are the result of the transaction, or reciprocal relationship, between biologic predispositions

and an invalidating environment. The biosocial theory suggests 3 biologic characteristics often are found among suicidal adolescents:

- high emotional sensitivity
- high extremity in reactions
- a slow return to baseline after experiencing a surge in affect.⁸

Although these characteristics indicate higher emotionality, they are not sufficient to account for suicidal adolescents' difficulties. Problems arise when individuals with these biologic characteristics are raised in an invalidating environment, where the adolescent does not learn how to regulate emotions. Common characteristics of invalidating environments and their effects on adolescents are described in *Table 1 (page 19)*.⁸

Treatment theory. DBT for suicidal adolescents focuses on a synthesis between 2 seemingly opposite treatment strategies: change and acceptance. The change focus is derived from behavioral science, and treatment incorporates standard behavior therapy practices, including chain analysis (described below), skills training, contingency management, and exposure.

The acceptance focus draws upon principles of Zen and other Eastern spiritual traditions. Therapists teach patients to accept reality as it is in this moment, without judgment. A key extension of this acceptance is the use of validation—radical acceptance and acknowledgement that all behavior has validity and understandability. DBT therapists strive to use 6 levels of validation with their patients (*Table 2, page 19*),¹⁶ which often is a critical strategy for adolescents who reside in an invalidating environment.

DBT attempts to synthesize the acceptance-based Zen tradition with the change-based strategies of behavioral science through a dialectical philosophy. A fundamental postulate of dialectical philosophy is that a tension occurs when an initial truth or thesis is opposed by an apparently contradictory truth or antithesis.⁸ DBT therapists work with adolescents to find a synthesis that is the "middle path," which includes the truth in both positions as well as what is left out of both. For an example of how this might work

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DBT for adolescents

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DBT treatment for adolescents lasts 12 to 16 weeks because suicidal teens frequently fail to complete longer courses of therapy

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Table 4

Mindfulness practices: Teach adolescents to live in the present moment

Practice	Description
Mindful eating	Provide patients with a piece of food such as a carrot slice, raisin, saltine, candy, etc. Instruct them to eat the food using all of their senses. Tell them to observe it visually, notice the smells and textures, the taste, etc. Encourage patients to notice all that goes into the process and mechanics of chewing and swallowing. Observe the taste, changes in texture, and even sounds
Observing different body parts	Ask patients to get in a comfortable, relaxed, and still position. Provide verbal instructions to attend to a body part. For example, 'Focus your attention on your left knee.' If you notice your mind wandering, bring your attention back to your left knee.' Spend about 30 seconds attending to the body part and then switch to another body part (eg, upper lip, right ear lobe, third toe on your left foot, etc.)
Mindful blowing bubbles	Provide patients with bubbles and ask them to blow bubbles. Pay attention to the activity and the bubbles themselves. If patients get distracted or have judgments about the activities, instruct them to notice these thoughts and bring themselves back to participating

Source: Reference 8

for an adolescent patient with NSSI, visit this article at CurrentPsychiatry.com.

How DBT works

DBT serves 5 functions. It enhances patient capabilities, increases patient motivation, structures the environment to increase the likelihood of success, works to assure generalization from therapy to the natural environment, and enhances therapists' capabilities and motivation to treat patients effectively.⁸ Outpatient DBT for suicidal adolescents uses 4 modes of treatment:

- weekly individual therapy
- weekly skills training
- telephone coaching
- weekly therapist consultation team meetings.⁸

Although Linehan's original research with adults was based on a 1-year treatment model,¹⁷ treatment lasts 12 to 16 weeks in the adolescent DBT model designed and studied by Miller et al.⁸ Treatment for adolescents is shorter because research indicates that suicidal adolescents frequently fail to complete longer courses of therapy.¹⁸

Individual therapy. The rank-ordered targets of individual therapy in the first stage of DBT are to:

- 1) eliminate life-threatening behavior, including NSSI
- 2) stop therapy-interfering behaviors (eg, not showing up to sessions)
- 3) change behaviors that interfere with the adolescent's quality of life (eg, substance abuse)
- 4) enhance the adolescent's use of skills.⁸

The individual therapist sets treatment goals in accord with these targets, monitors progress, integrates all modes of therapy, and balances acceptance and validation of the patient with being a catalyst for change. Family members may be included in therapy sessions when family problems emerge as the highest priority.

DBT therapists use chain analysis—which is a process of assessing the series of events, link by link, that lead from a prompting event to a problem behavior (eg, suicide attempt)—to assess problematic behavior and identify methods of change.⁸ The therapist and patient use this process to develop alternative behaviors for the patient to use to reach a more effective outcome.

DBT therapists also ask adolescents to fill out a daily diary card that tracks targeted behaviors, including NSSI, suicidal urges, and important emotions. The diary

Table 5

Adapting DBT skills training for adolescents

Alteration	Reason
Added 'walking the middle path' skills	This skill set was added to elaborate on topics including validation, polarities in behavioral patterns in the family, and how to apply learning principles to the self and others. The goals of these skills are to decrease parent and teen conflict, increase understanding of typical vs pathological teen behavior, and effectively change behavior through contingency management
Parents and family members of the suicidal adolescent attend weekly skills training	Generalization of the skills outside of therapy is more likely to occur with families' help. Additionally, having family members practice the skills will decrease the likelihood that the home environment invalidates the adolescent, reinforces problematic behaviors, and/or persists in familial dysfunction
Duration of skills training decreased to 16 weeks	Increases the likelihood that adolescents complete therapy by reducing the number of skills taught
Some handouts have been modified	The forms are more appropriate for adolescents and family members

Source: Reference 8

card helps the therapist determine what needs to be targeted in therapy, increases mindfulness and understanding of problem behaviors, and helps change targeted behavior.

Skills training addresses skills deficits believed to be causing the suicidal adolescent's problems. DBT systematically teaches 5 skill sets:

- emotional regulation
- mindfulness
- interpersonal effectiveness
- distress tolerance
- "walking the middle path."⁸

These skills are designed to treat specific problems common among suicidal adolescents and their families. For example, suicidal adolescents often experience a spike in emotions that leads to urges for ineffective behavior, such as attempting suicide or attacking another person. *Table 3 (page 20)* provides steps that teach "opposite action," which can reduce ineffective emotions and problematic urges associated with these emotions. *Table 4* provides mindfulness practices that can help patients address problems such as mindlessness and avoiding the present moment. Although adolescent DBT skills training is similar to that in adults, *Table 5* describes key differences.

Telephone consultation. The purpose of brief (5 to 15 minutes) telephone consultations between a patient and therapist is to:

- enhance the likelihood of effective behavior
- coach the use of skills
- decrease the likelihood of problematic behaviors.

DBT telephone consultation for adults differs from that for suicidal adolescents. In DBT for adults, if a patient engages in NSSI or suicidal behavior, there is no telephone contact for 24 hours. This rule aims to avoid reinforcing the behavior with additional contact. However, this rule does not apply to adolescents because restricting adolescents' access to resources for managing the aftereffects of self-harm could increase their risk of injury or death. Nonetheless, adolescents are strongly encouraged to use telephone coaching before rather than after self-harm. A second difference is that in DBT for adolescents, telephone coaching is offered to parents to help them use skills in the home. To avoid complications with dual relationships, the parents' telephone coach should not be the adolescent's individual therapist.

Consultation team meetings. The consultation team meets weekly to increase therapists' capabilities and motivation.

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Telephone coaching is offered to parents and patients to help them use DBT skills in the home

Therapists who treat suicidal adolescents often have a high degree of burnout, which leads to ineffective treatment and/or quitting.⁸ The team provides support, engages in problem-solving, and helps therapists adhere to the treatment model to improve effectiveness. Clinicians interested in participating a consultation team may review <http://behavioraltech.org/resources/crd.cfm> for a directory of existing DBT programs. Those interested in starting a consultation team may explore training programs such as those offered at www.behavioraltech.org.

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Related Resources

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Disclosure

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Weekly consultation team meetings help clinicians adhere to the DBT treatment model and avoid burnout

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Bottom Line

Evidence suggests dialectical behavior therapy (DBT) can effectively help suicidal adolescents and their families. DBT for these patients includes individual psychotherapy, skills training to regulate emotions and avoid problematic behavior, telephone coaching, and weekly consultation meetings of the adolescent's treatment team.

DBT for nonsuicidal self-injury: A ‘middle path’ example

Many adolescents who receive dialectical behavior therapy (DBT) find that nonsuicidal self-injury (NSSI) leads to physiological, affective, and/or cognitive relief from suffering. Research indicates that persons who engage in NSSI have significant improvement in mood and reductions in dissociation after NSSI^a and significantly higher analgesic response to pain than healthy controls.^b The antithesis of this is that NSSI causes long-term suffering by, for example, alienating friends and family.^c

One resolves this dialectical tension—ie, the validity in 2 opposing truths—by seeking

a synthesis that maintains the truth in both sides and looks for what is being left out from both. In this case the DBT therapist must accept that NSSI provides benefits and validate the adolescent’s attempts to ease his or her emotional suffering. The therapist and patient also must recognize the harm and exacerbation of suffering that results from NSSI. The therapist and adolescent work to create a “middle path” to replace the NSSI with more skillful means that provide short-term relief, don’t exacerbate long-term suffering, and help the adolescent reach goals.

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