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PRESENTATION OUTLINE

Why DBT-A?
- ✓Statistics on SI and NSSI
- ✓Why do Teens Self-Harm?
- ✓Biosocial Theory of Emotion Dysregulation

Full- Fidelity Dialectical Behavior Therapy
- ✓Spirit, Components, Stages of Treatment, Behaviors to Decrease/Increase
- ✓Consultation Team: Agreements and Structure
- ✓Assumptions about Clients
- ✓Dialectical Dilemmas
- ✓Case Examples

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STATISTICS

Suicide

- 2nd leading cause of death in individuals 10-14 and 15-19 years old (CDC, 2017)
- In 2019, 18.8% of high school students reported **seriously considering suicide** (Youth Risk Behavior Survey, 2019)
  - 15.7 % made a plan
  - LGBTQ individuals reported 46.8%
- In 2019, 8.9% reported **attempting suicide** (YRBS, 2019)
  - 2.5 % required medical attention
  - LGBTQ individuals reported 23.4%
- Female more likely to attempt, males more like to complete
  - Suicide rate for ages 15-19: 14.2 % males, 5.1% females (CDC, 2017)

Non-Suicidal Self-Injury (NSSI; APA, 2015)

- 17% of adolescents reported engaging in NSSI at least once
- About equal rates for males and females
- Females – more likely to cut
- Males- more likely to bruise self, hurt self while using substances, or have someone else hurt them

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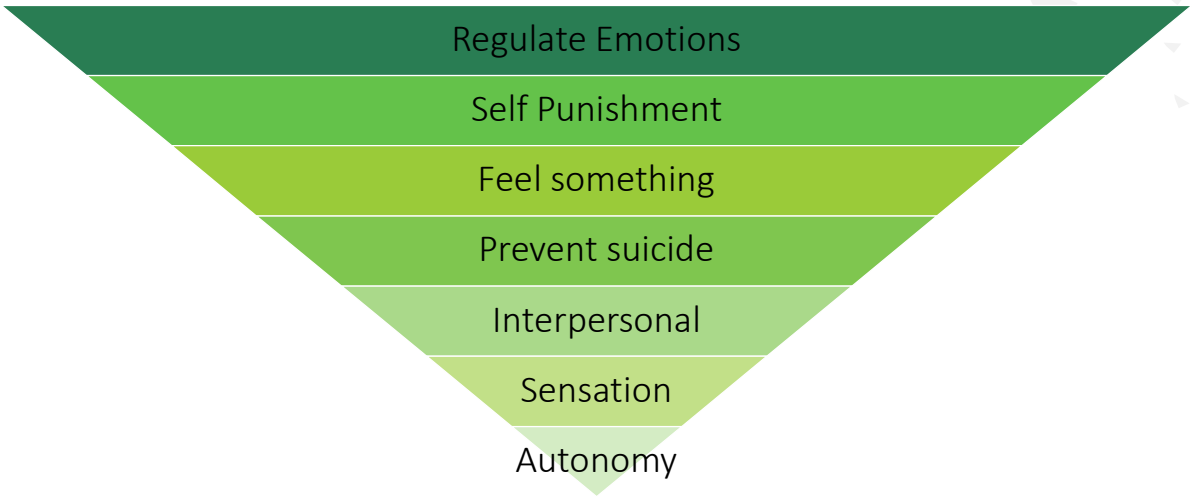
WHY DO TEENS ENGAGE IN NSSI?



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BIOSOCIAL THEORY OF EMOTION DYSREGULATION

Bio ⟷ Transactional Relationship ⟷ **Social**

Biological Vulnerability to Emotions
1. High sensitivity
2. High reactivity
3. Slow return to baseline

PLUS

An inability to effectively regulate emotions

Over time leads to:
1. Self-invalidation
2. Multiple problem behaviors (e.g., cutting, suicidal behavior, drug use)
3. Chronic emotional dysregulation

Invalidating Environment
1. Rejects internal experiences
2. Punishes emotional displays
3. Reinforces emotional escalation
4. Oversimplifies problem-solving

"There's something wrong with me." " I shouldn't feel angry." "I'm crazy."

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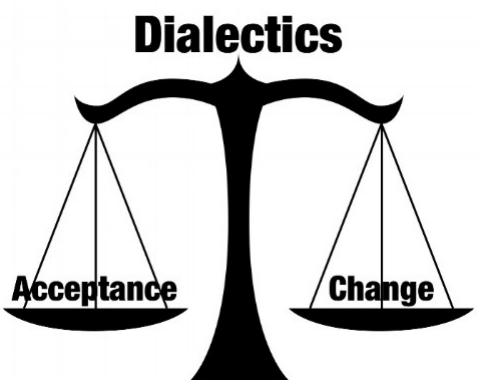
The SPIRIT of DBT

"When you can do nothing, what can you do?"

- Zen Koan



Thesis: Because I make a lot of mistakes, I am worthless.
Antithesis: Making mistakes is not a big deal. I shouldn't really care about it at all.
Synthesis: Acknowledging and improving on my mistakes is important AND does not diminish my worth as a person.

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WHAT IS FULL-FIDELITY DBT for Adolescents?

Individual Therapy

Function: Improve motivation to change

Frequency: Once a week

Mode: Diary Card, Behavior Chain Analysis, Exposure, Cognitive Restructuring, Didactics, etc.

Family Therapy

Function: Structure environment to support client

Frequency: As needed

Mode: Caregivers with or without client. Validation and behaviorism.

Multifamily Skills Group

Function: Enhancing capabilities

Frequency: Once a week

Mode: Mindfulness practice, homework review, didactic skills teaching

Phone Coaching

Function: Skill generalization

Frequency: Varies

Mode: Quick (usually <15 minutes) phone call to assess problem and generate skillful solutions

Consultation Team

Function: Enhance capabilities and motivation of therapists

Frequency: Weekly

Mode: Therapy for the therapists

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DBT-INFORMED VS. FULL-FIDELITY

- DBT-Informed has some components of full-fidelity DBT
  - Examples: DBT Teen Skills Group, Teaching DBT Skills in Individual Sessions
- MUST be part of a consultation team to do full-fidelity DBT
- May be appropriate for lower-risk individuals
  - Anxiety and depression without safety issues
  - Mild self-harm or passive suicidal ideation
  - Use during 'building coping skills' portion of TF-CBT

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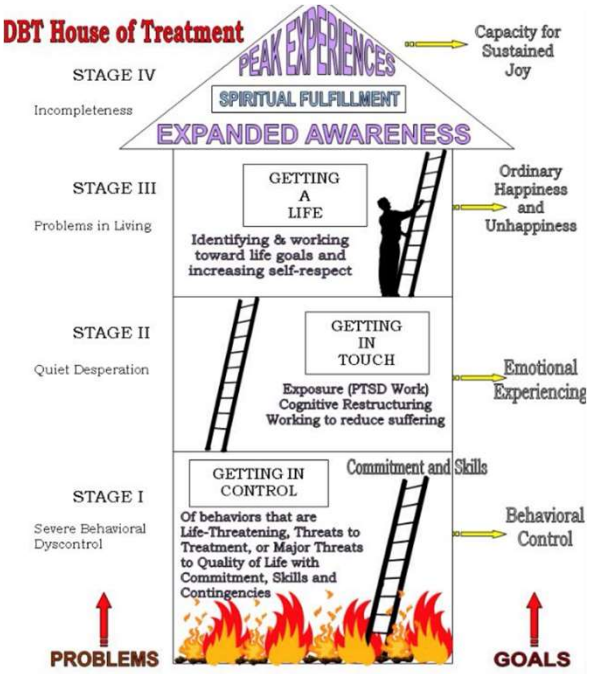

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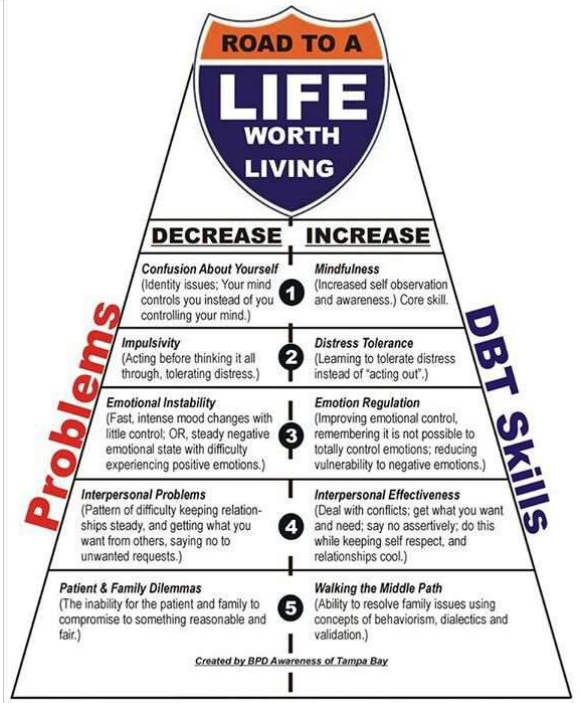

"The desire to commit suicide, however, has at its base a belief that life cannot or will not improve. Although that may be the case in some instances, it is not true in all instances. Death, however, rules out hope in all instances. We do not have any data indicating that people who are dead lead better lives."

— Marsha M. Linehan, Cognitive-Behavioral Treatment of Borderline Personality Disorder

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DBT Team Agreements

1. Dialectical agreement: search for the synthesis rather than the truth
2. Consultation-to-the-client: coach client to intervene skillfully
3. Consistency agreement: Inconsistency is an opportunity to practice skills

Consultation Team: Norms

4. Observing limits: observe and communicate own limits, do not judge others' limits
5. Phenomenological empathy: search for nonpejorative and empathic interpretation of behavior
6. Fallibility agreement: All therapists are jerks! Don't be defensive.

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CONSULTATION TEAM: STRUCTURE

Agenda

1. Mindfulness
2. Review an Agreement
3. Behavior Chain/Repair (if applicable)
4. Review Cases

- *Therapists put THEMSELVES on the agenda. Ask the team for Validation or Problem-solving
- Life –threatening behaviors always take priority

Roles

- Team Leader: responsible for functioning of team as a whole
- Meeting Leader: sets and manages the agenda
- Notetaker: documents topics discussed in team
- Observer: monitors groups and gently rings the bell for judgments, defensiveness, nonadherence to agreements, etc.

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DBT Assumptions about Clients

1. Client are doing the best they can
2. Clients was to improve
3. Clients need to do better, try harder, and be more motivated to change
4. Client may not have caused all of their own problems, AND they have to solve them anyway
5. The lives of our clients can be unbearable and are painful as they are currently being lived
6. Clients must learn new behaviors in all relevant contexts.
7. Clients cannot fail in therapy
8. DBT team members need support

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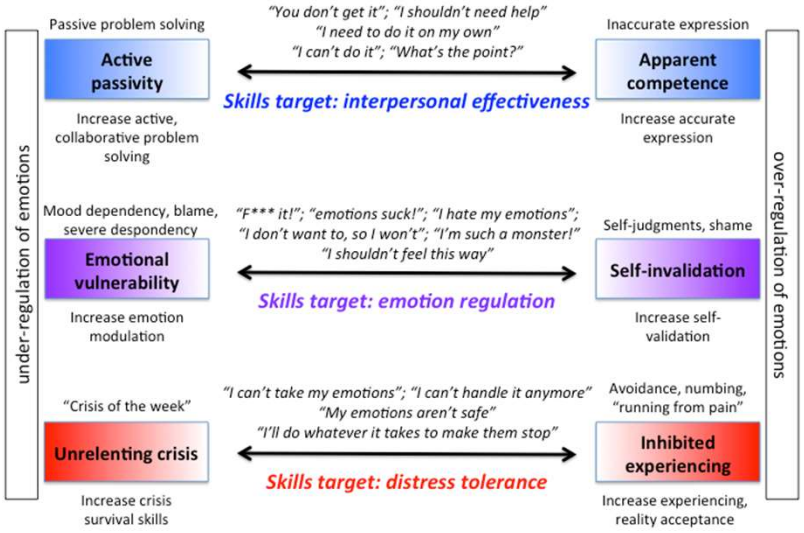
DIALECTICAL DILEMMAS/SECONDARY TARGETS



Andrea Gold, Ph.D. (Warren Alpert Medical School of Brown University) & Seth Axelrod, Ph.D. (Yale School of Medicine), November 2019.
Adapted from *Cognitive-Behavioral Treatment of Borderline Personality Disorder* by Marsha Linehan (1993)

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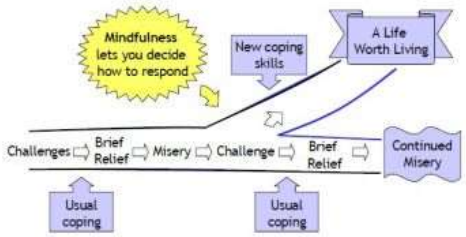
EXPLAINING DBT-A TO FAMILIES

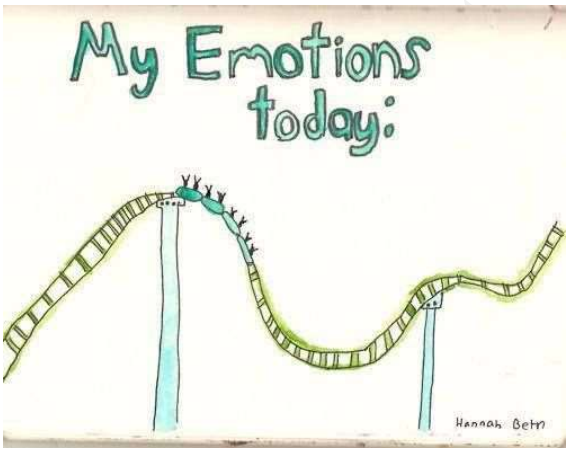
What the Heck is DBT? :https://www.youtube.com/watch?v=Stz--d17ID4

What's the Goal of DBT?

In DBT, self-destructive behaviors are understood as *solutions* for escaping from a life of misery. The goal of DBT is to learn new ways of coping and to move from a life of misery to a life worth living.



Dbtproviders.com



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Why DBT-A? It Works!

Trans-diagnostic

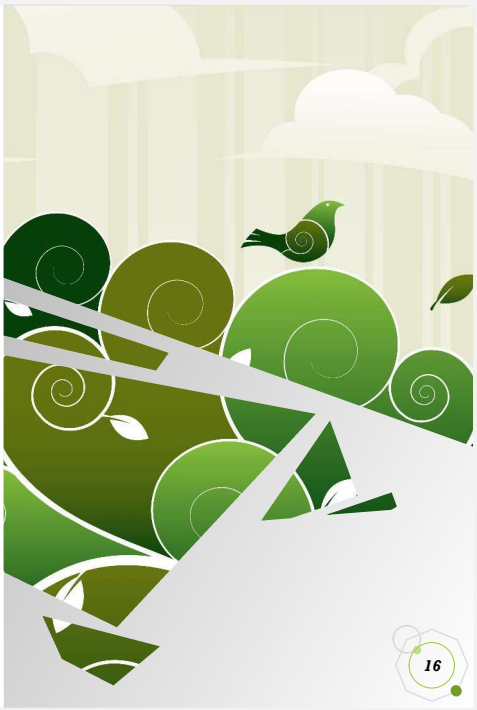
- Considered the only *well-established* intervention for treating chronic SI and NSSI in teens
- Targets family dysfunction
- Flexibly addresses multiple problems and suicidal risk factors concurrently

Cost effective

- Fewer inpatient admissions and psychiatric ER visits
- Up to 50% reduced cost from previous year before DBT treatment (adults)

Increased Completion

- Average number of sessions for suicidal adolescents is about 5
- Significantly higher treatment completion rates (76% vs. 55%)



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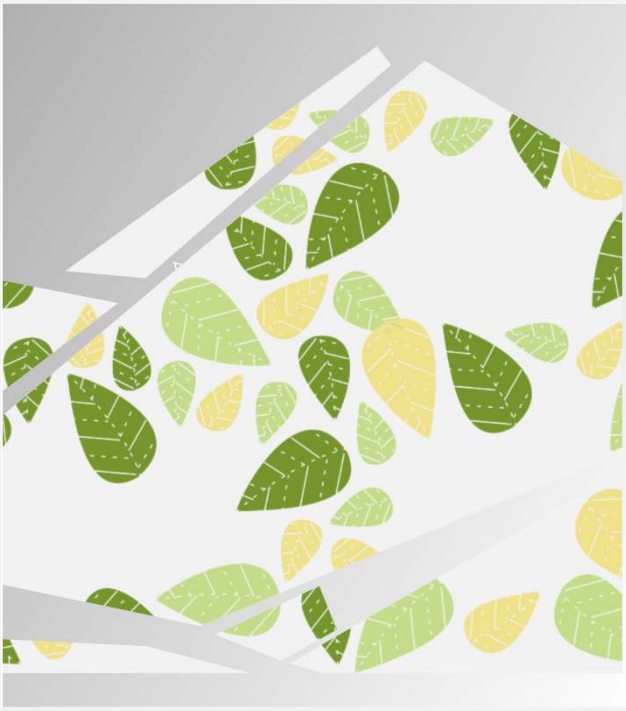

Who Does DBT Help?

Adolescents (12-18)

- BPD traits or full diagnosis
- Repeated suicidal and/or self-harming behaviors
- Depression/Bipolar disorder

Children (6-12)

- Severe emotional and behavioral dysregulation
- Disruptive mood dysregulation disorder

College Students (18-25)

- BPD traits or diagnosis
- Suicidality and self-harm
- Depression

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WHO MIGHT NOT BENEFIT FROM DBT?

- Primary psychotic disorder AND actively psychotic
  - e.g., schizophrenia with delusions and hallucinations not managed by medication
- Below-Average IQ or Significant Cognitive Impairments
- Autism
  - Unless very high-functioning and primary issues are related to depression and suicidal ideation/self-harm (not specifically associated with stemming or repetitive behaviors)
- Primary substance use disorder

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Case Example 1

Case Example 1: J.

Stage 1 Targets:

1. Suicidal statements, self-harm, suicidal ideation
2. TIB: Minimization of problems, active passivity, inhibited grieving
3. QOL: School functioning, gender dysphoria
4. Increase skill use: Mindfulness of thoughts, self-validation, emotional awareness and expression, interpersonal effectiveness, problems-solving and opposite action

Stage 2 Targets:

1. Depression/anxiety
2. Trauma

14-year-old transgender Jewish male with a history of significant cutting with razor blades (legs, arms, stomach) since age 12, making suicidal statements when overwhelmed, anger outbursts, frequent suicidal ideation, and 9 hospitalizations. No suicide attempts. Father and mother recently divorced. Father actively using alcohol and mother with cognitive and emotional deficits. Significant school avoidance. During treatment, client disclosed past domestic violence and neglect from father (e.g., father drunk driving with client in the car) as well as coercive sexual encounters within previous romantic relationship. Began smoking weed and had episodes of binge-drinking during treatment. Client was diagnosed with MDD, recurrent, severe, with anxious distress and gender dysphoria. LWL goals: become an art teacher and LGBTQ advocate.

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Case Example 2

Case Example 2: L

Stage 1 Targets:

1. Decrease reinforcement of suicidal behavior/statements
2. TIB: Guardedness, paranoia, lying/distractions, argumentativeness
3. QOL: Genuine interpersonal relationships, improve functioning at school
4. Skills: Willingness, mindfulness of emotions and thoughts, interpersonal effectiveness (effective expression of anger), Check the Facts

15-year-old cisgender female of Dominican and French descent. History of 2 significant suicide attempts by overdose on Tylenol. Significant over-report of somatic/psychotic symptoms. Interpersonal paranoia and guardedness that manifested as lying and distracting with stories/symptoms (e.g., feigning deafness during session) in therapy sessions. Very involved in social media culture around cutting/suicidality. Argumentative with therapists and parents. Performing poorly at art/media school and at-risk of getting kicked out. Diagnoses of Borderline Personality Disorder and MDD, severe. LWL goals: None until more than halfway through treatment. Client was eventually able to develop LWL goals of working in wildlife preservation. She also loved horseback riding and started helping out with horseback lessons for individuals with disabilities at her stable.

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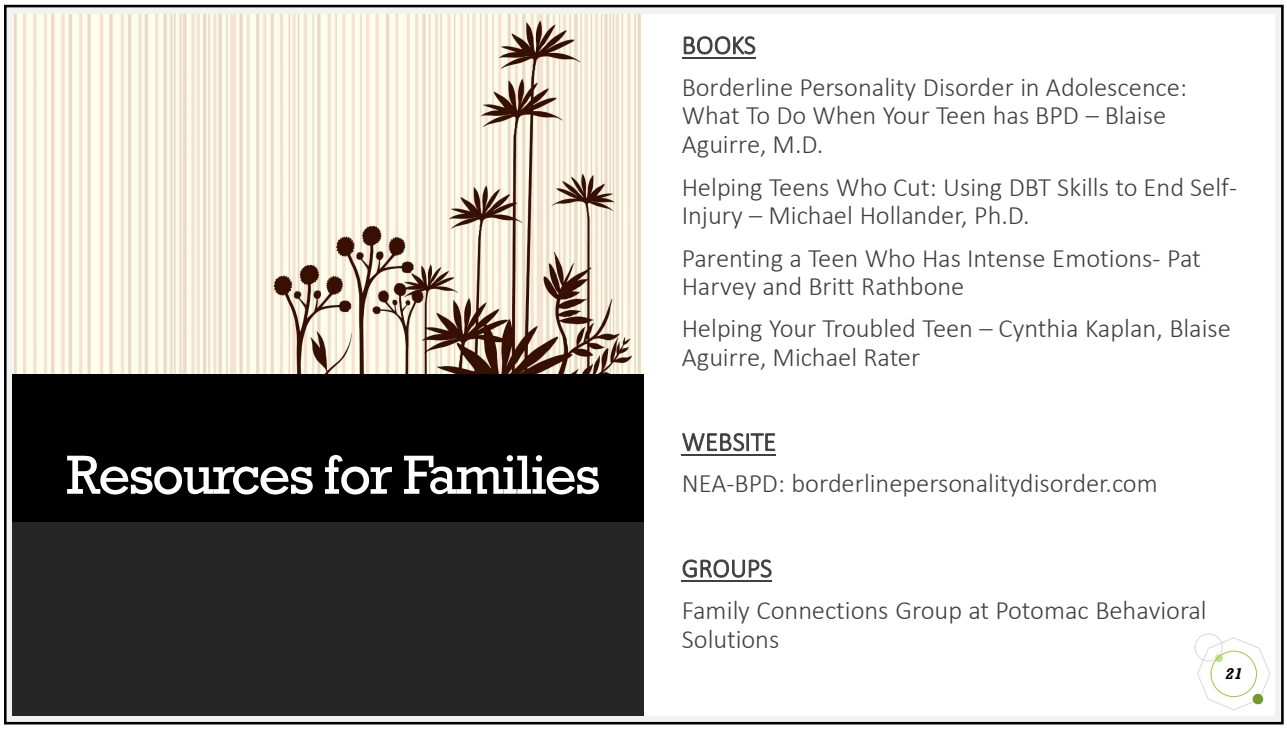
Resources for Families
BOOKS
Borderline Personality Disorder in Adolescence: What To Do When Your Teen has BPD – Blaise Aguirre, M.D.
Helping Teens Who Cut: Using DBT Skills to End Self-Injury – Michael Hollander, Ph.D.
Parenting a Teen Who Has Intense Emotions- Pat Harvey and Britt Rathbone
Helping Your Troubled Teen – Cynthia Kaplan, Blaise Aguirre, Michael Rater
WEBSITE
NEA-BPD: borderlinepersonalitydisorder.com
GROUPS
Family Connections Group at Potomac Behavioral Solutions
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Thank You!

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