

#NAMIcon16

Dialectical Behavior Therapy with Adolescents

Michele Berk, Ph.D.

**Department of Child and Adolescent Psychiatry
Stanford University School of Medicine**

Claudia Avina, Ph.D.

**Department of Child and Adolescent Psychiatry
Harbor-UCLA Medical Center/David Geffen School of Medicine at UCLA**



Adolescent Suicide: Overview

- Suicide is an urgent public health problem among teens.
- Suicide is the 3rd leading cause of death among 10-14 year-olds (behind accidents and malignant neoplasms) and the 2nd leading cause of death among 15-24 year olds (behind accidents).
- Prior suicide attempts are one of the strongest predictors of completed suicide and subsequent suicide attempts in youth (e.g., Lewinsohn et al., 1993).
- NSSI is also a predictor of subsequent suicide attempts among depressed youth (Asarnow et al., 2011; Wilkinson et al., 2011).
- Adolescent suicide attempters are a high risk population in need of effective interventions.

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**% of High School Students in the United States Who Reported “Seriously Considering Attempting Suicide” in the Past Year
(YRBSS; Kann, 2016)**

	Female	Male	Total
Caucasian	22.8	11.5	17.2
Latino	25.6	12.4	18.8
African-American	18.7	11.0	14.5
Total	23.4	12.2	17.7



% of High School Students in the United States Who Reported Attempting Suicide in the Past Year (YRBSS; Kann, 2016)

	Female	Male	Total
Caucasian	9.8	3.7	6.8
Latino	15.1	7.6	11.3
African-American	10.2	7.2	8.9
Total	11.6	5.5	8.6



Definitions

- **Suicide attempt:** A potentially self-injurious behavior, associated with some evidence of intent to die
- **Non-suicidal self-injury behavior:** Self-injurious behavior not associated with intent to die (intent may be to relieve distress or communicate with another person), often called “self-mutilation,” “suicide gesture.”



Non-suicidal self-injury behavior

- No intent to die
- Risk factor for suicide attempts
- Not “suicide gestures”
- Treatment involves determining function of the behavior and helping client attain function in alternative ways
- Generally does not require hospitalization
- Remove means of self-harm



Common reasons for NSSI

- Affect regulation/avoidance
- To reduce dissociation
- Interpersonal communication
- Self-punishment

Klonsky, 2007.



Relationship between Suicidal Behavior and NSSI

- NSSI is a predictor of subsequent suicide attempts among depressed youth (Asarnow et al., 2011; Wilkinson et al., 2011).
- Adolescents often engage in both NSSI and suicidal behavior concurrently (Whitlock et al., 2012).
- NSSI increases the risk of engaging in suicidal behavior and may serve as a “gateway” to attempting suicide (Whitlock et al., 2012).



Risk Factors

- Past suicide attempt
- Non-suicidal self-injury
- Access to weapons/lethal means
- Psychopathology: Depression, substance abuse, conduct disorder (males)
- Severe emotion dysregulation
- The tendency to be aggressive and violent, and to engage in dangerous, illegal, or risky activities
- Impulsivity
- Alcohol and drug use/abuse
- History of child sexual abuse
- Family conflict
- Precipitants/triggering events leading to humiliation, shame, or despair (e.g., loss of relationship, conflict with peers, family members – real or anticipated)
- Hopelessness, the belief that problems cannot be solved, poor problem solving ability
- Family history of suicide
- Severe insomnia and agitation
- Acute psychosis
- Bullying
- LGBT
- Contagion



Safety Measures

- Remove lethal means
 - Decreases odds of an impulsive suicide attempt
- Safety Planning
- Parental Monitoring
- Obtain evidence-based mental health treatment!



What can parents do to help?

- Reduce family conflict.
- Increase family support/validation.
- Increase parent safety monitoring.
- Take all talk about suicide and self-harm seriously.
- Listen very closely to what is on your child's mind and what he/she may be trying to tell you. Validate their feelings. Suicidal behavior is a "cry for understanding." You want to convey this understanding BEFORE your child hurts themselves.



Treatment Approaches

- Despite the severity of the problem, there is little guidance from the literature on how to best treat suicidal adolescents.
- Only 13 randomized, controlled trials (RCTs) of treatments specifically targeting adolescent suicide attempters with repeat suicide attempts as an outcome variable.
- Only 6 studies demonstrated significant decreases in suicide attempts.



Six Studies Demonstrating Significant Decreases in Suicide Attempts:

1. **Multi-systemic therapy** was shown to be more effective than hospitalization at decreasing rates of youth-reported suicide attempts (Huey et al., 2004).
2. **Developmental group therapy** was shown to be more effective than routine care at decreasing deliberate self-harm (Wood et al., 2001).
3. **Mentalization-based treatment** was shown to be more effective than TAU at decreasing self-harm (Rossouw & Fonagy, 2012).
4. **Integrated CBT** for co-morbid suicidality and substance abuse was shown to be more effective than TAU at decreasing suicide attempts (Esposito-Smythers et al., 2011).
5. **Dialectical Behavior Therapy** was shown to be more effective than enhanced usual care at decreasing self-harm behaviors (Mehlum et al., 2014).
6. **Parent-only psychoeducation: Resourceful Adolescent Parent Program (RAP-P)** was shown to be more effective than routine care at decreasing self-harm behaviors (Pineda & Dadds, 2013)



Treatment Research

- None of these 6 studies have been replicated.
- At present, there are no well-established empirically-supported treatments for adolescent suicide attempters.
- Additional research is urgently needed.



DBT is a promising treatment for suicidal youth:

- Dialectical Behavior Therapy (DBT) with adults has multiple RCTs supporting its efficacy in decreasing suicide attempts in adults.
- DBT has been adapted for adolescents (Miller, Rathus, & Linehan, 2007) and small, non-randomized trials of DBT with adolescents have yielded promising results.
- In response to clinical need, DBT is being widely used with adolescents.
- One RCT of DBT with adolescents has been conducted in Norway demonstrating greater reductions in self-harm behaviors than enhanced usual care at 19 week and one year follow-up (Mehlum et al., 2014; 2016).
- Second RCT is currently underway in the United States looking specifically at whether or not DBT is effective at decreasing suicide attempts (NCT01528020: Collaborative Adolescent Research on Emotions and Suicide [CARES], PI: Linehan, McCauley, Berk, & Asarnow).

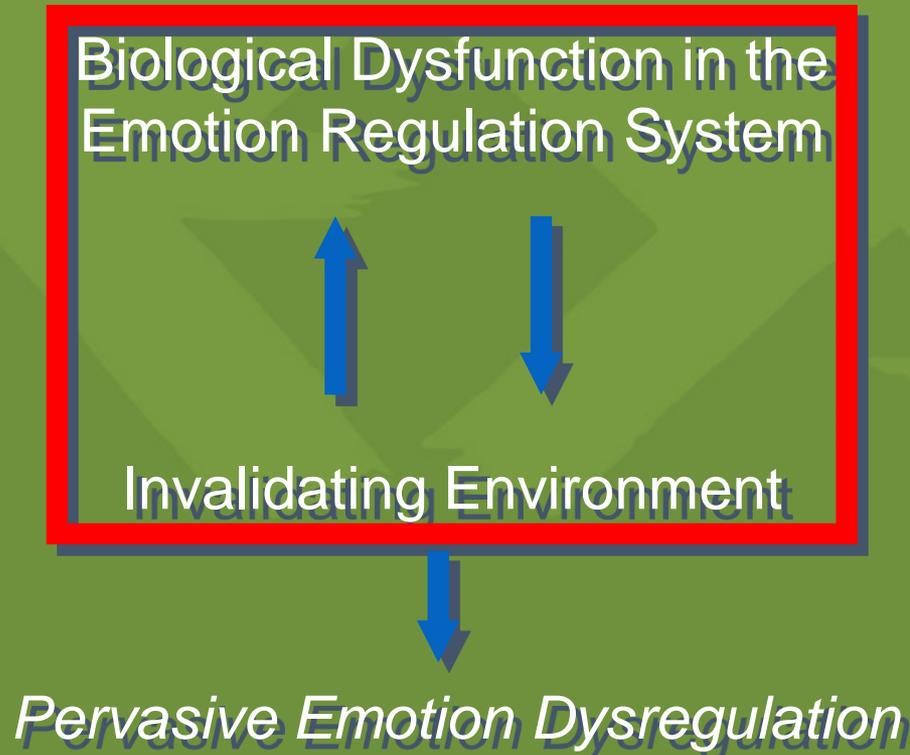


What is DBT?

- Cognitive-behavioral treatment approach developed by Marsha Linehan, Ph.D. for treating chronically suicidal patients with Borderline Personality Disorder.
- Important DBT references:
 - Linehan, M.M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford Press.
 - Linehan, M.M. (2015). DBT skills training manual. New York: Guilford Press.
 - Linehan, M.M. (2015). DBT skills training handouts and worksheets. New York: Guilford Press.
 - Miller, Rathus, & Linehan (2007). Dialectical behavior therapy with suicidal adolescents. New York: Guildford Press.
- For more information about DBT:
 - <http://www.behavioraltech.com>



DBT - Biosocial Theory



Emotional Vulnerability

- **High Sensitivity**
 - Immediate Reactions
 - Low threshold for emotional reaction
- **High reactivity**
 - Extreme Reactions
 - High Arousal dysregulates cognitive processing
- **Slow return to baseline**
 - Long-lasting reactions
 - Contributes to high sensitivity to next emotional stimulus



Invalidating Environment

Invalidates the valid through pervasive communication that responses of the individual are incorrect, faulty inappropriate or otherwise invalid and oversimplifies changing invalid responses by failing to respond to the individual's needs.



Effects of the Invalidating Environment

- Individuals do not learn to accurately label emotions
- Individuals do not learn how to tolerate distress
- Individuals learn to self-invalidate
- Individuals learn that only escalated expressions of negative affect are taken seriously



Summary of DBT Theory

- Individuals who are biologically predisposed to experiencing very strong emotions
- AND experienced invalidation of their emotions by caregivers
- Experience very strong negative emotions but know few skills to manage them.
- Suicidal/self-injurious behavior is used as a maladaptive means of coping with negative emotions.
- DBT teaches positive coping skills.



Overview of DBT Treatment



Standard DBT Components

- Outpatient Individual Psychotherapy
- Outpatient Multi-family Group Skills Training
- Therapists' Consultation Meeting (DBT Team)
- 24/7 Telephone Coaching



Overarching DBT Goal “Building A Life Worth Living”



Mindfulness

- Meditation practice
- Attention training
- Awareness of the present moment without judgment
- Awareness of thought processes leads to greater control over behavior
- Acceptance



Validation

- Letting the client know behaviors “make sense” and that the therapist understands his/her thoughts, feelings, or behaviors.
- Linehan added validation to DBT in order to facilitate change.



Dialectics

- “the synthesis of opposing forces”
- Opposite emotions, “truths,” and ideas can co-exist
- Targets extreme, erratic behaviors seen in BPD
 - “black and white” thinking
 - “splitting”
- With adolescents, targets parent/teen conflict
- Key dialectic: **“validation and change.”**



DBT Skills Modules

- Mindfulness
- Distress Tolerance
 - Distraction
 - Self-soothing
- Middle Path (Adolescent DBT Only)
- Emotion Regulation
- Interpersonal Effectiveness



DBT in a Community Setting

- Adolescent DBT Program started at Harbor-UCLA Medical Center in March, 2006
- Program is housed within the larger Los Angeles County Department of Mental Health clinic, which is connected to a county hospital.
- Treats approximately 20 adolescents per year.
- Majority of adolescents treated are underserved, disadvantaged, ethnic minorities (primarily Latino).
- Services are provided in both English and Spanish.



Development of the Harbor-UCLA Program

- Dr. Berk only staff member trained in DBT
- Adolescent DBT book and manual were not published when we started our program, leaving a lot of unanswered questions.
- Needed to educate staff about DBT is and evidence-based treatments
- Needed to determine inclusion/exclusion criteria, treatment length
- Team included both permanent staff and trainees
- Adopt or adapt? Empirical support is for full DBT program only
- Over time we were able to “adopt” full program.
- Staff reactions: “why are you better able to treat these patients than us?”
- Other staff reactions: wanted to refer every severe client to DBT program, regardless of fit.
- What about patients who don’t commit?

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Working with Latino Families

- Language Issues
 - Individual Therapy
 - Availability of Spanish speaking providers
 - Translational issues between child and parent
 - Multi-Family Group
- Cultural Issues
 - Peeling the layers of an onion
 - Don't ask, don't tell
 - I'm not Buddhist
 - Family roles



Special Issues Related to Engaging Community Youth and Families in Treatment

- Improving Access to Mental Healthcare
 - Transportation, Geography, Case Management
 - Caregiver involvement
 - DBT has specific therapeutic strategies geared at keeping clients committed to treatment
- Navigating systems of care



Typical Teen and Family Reactions about DBT

- Teens state that DBT was helpful despite resisting the skills group during treatment
- Family members recognize the benefits to themselves in addition to their teen
- Over time, family members support DBT's treatment hierarchy of prioritizing safety over other issues



Who needs DBT?

- DBT originally evaluated with suicidal and severely emotionally dysregulated adult clients
- There is promising empirical support that DBT is effective with emotionally dysregulated adolescents
- A comprehensive DBT program is an intensive and structured treatment package
- Other evidence-based practices may be effective in treating suicidal adolescents



Tips for Finding DBT in Your Community

- Look on behavioraltech.org for trained DBT providers
- If needed, encourage providers in your area to get trained in DBT
- Ask about prior training in DBT
- Ask about experience in treating suicidal adolescents
- Consider comprehensive DBT programs
- Be prepared to invest time and effort in the DBT program



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