Dialectical Behavior Therapy for Suicidal Adolescents with Borderline Personality Disorder

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KEYWORDS

• Adolescents • Suicidal • Dialectical behavior therapy
• Borderline personality disorder

Dialectical behavior therapy (DBT) was first adapted for use with multiproblem suicidal adolescents more than a decade ago in response to a dearth of empirically supported psychosocial treatments for this population.[1] Miller and colleagues[1,2] retained the core principles and strategies of Linehan's[3] original DBT for suicidal women with borderline personality disorder (BPD), and made modifications based on developmental and contextual considerations for adolescents and their families. Although research to date on DBT for adolescents has its limitations, growing evidence suggests that DBT is a promising treatment for adolescents with a range of problematic behaviors, including but not limited to suicidal and nonsuicidal self-injury.[4] The purpose of this article is to introduce dialectical behavior therapy's theoretical underpinnings, to describe its adaptation for suicidal adolescents, and to provide a brief review of the empirical literature evaluating DBT with adolescents.

DEVELOPMENT OF DIALECTICAL BEHAVIOR THERAPY FOR ADULTS

Theoretical Underpinnings

The theoretical influences of DBT include behavioral science, dialectical philosophy, Eastern contemplative practice, and the biosocial theory of personality functioning.[3] It began as an application of standard behavioral therapy for the treatment of chronically suicidal women diagnosed with BPD. These patients lacked the requisite skills for coping with life problems and considered suicide their best solution. However, in

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the process of developing the treatment, it became evident to Linehan[3] that a focus solely on change was too emotionally dysregulating for patients who were exquisitely emotionally sensitive and reactive. These patients felt as though the therapist did not understand how difficult it was for them to change their thinking and behavior. Yet, relinquishing the emphasis on change and becoming exclusively acceptance oriented was equally problematic because it often resulted in patients feeling that the therapist was not taking their pain seriously or, even worse, was thinking that they were too dysfunctional to be able to change. These clinical observations led to Linehan's discovery that by flexibly balancing and synthesizing acceptance (Eastern contemplative practice) *and* change (cognitive-behavioral strategies) in her therapeutic interactions, her suicidal patients felt better understood (validated/accepted) while also recognizing the need for them to change their own behavior. It is this synthesis of acceptance and change that is most fundamental to DBT and led to its description as dialectical behavior therapy. Dialectical refers to the notion that there is no absolute truth and that seemingly opposite constructs can both be true at the same time (eg, you are doing the best you can in the moment *and* you need to do better, try harder, and be more motivated to change). DBT therapists teach their patients to move away from either-or thinking to both-and ways of thinking to reduce thinking processes and behaviors becoming polarized.

At its core, DBT shares the same underlying assumptions as other behavioral treatments.[3] A fundamental assumption of behavioral treatments is that the causes or maintaining conditions of behavior exist in the current environment. Hence, DBT focuses on current rather than historical determinants of behavior and relies on ongoing behavioral assessment and data collection. Target behavior is specifically defined, treated, and measured. In DBT, cognitive and behavioral interventions serve as the technology of change and focus on the alteration of learned, maladaptive emotional, cognitive, and behavioral sequences. Even more than other behavioral approaches, DBT relies on collaboration between patients and therapist and emphasizes the importance of the working therapeutic relationship. As a behavioral science, DBT is informed by basic research in psychology and is described in objective terms so that replication is possible.

Dialectical philosophy is also central to DBT.[3] First, it provides a philosophic position on the fundamental nature of reality that serves as the basis for DBT. According to the dialectical perspective, reality is an interrelated system comprised of internal opposing forces that are in a continuous state of change because of the inherent tensions (polarities) of reality. The dialectical worldview assumes there is no absolute truth or indisputable fact and posits that the synthesis (or balance) of seemingly opposite positions produces wisdom and new meaning. The core dialectic in DBT is accepting patients where they are in the moment *and* working to help them change. Second, dialectical philosophy provides a framework for therapeutic interactions and interventions so that therapeutic movement can occur. Dialectical strategies elicit change by persuasion and by making use of the opposites inherent in the therapeutic relationship. They include strategies for balancing the dialectical tensions inherent in the therapeutic relationship, including change and acceptance, flexibility and stability, challenging and nurturing, and deficits and capabilities. They also include instruction for reducing behavioral extremes (ie, cognitive, emotional, and behavioral patterns) and moving toward more dialectical (ie, balanced) ways of thinking and acting. Lastly, dialectic strategies include methods for highlighting contradictions in patients' behavior and thinking by offering opposite or alternative positions (eg, entering the paradox, using metaphor, and playing devil's advocate). It is the application of these treatment strategies that produces the movement, speed, and flow characteristic of DBT.