Applying Dialectical Behavior Therapy to Suicidal Multi-Problem Youth in Outpatient Settings

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Outline

• Overview of Adolescent Suicide and Nonsuicidal self-injurious trends
• Borderline Personality Disorder reorganized for adolescents
• DBT Treatment Targets, Structure, Modes/Functions
• Treatment Outcome Research
Adolescent Suicide:
The Problem (CDC, 2016)

In the previous year nationwide, 9th-12th graders reported...

- 17% seriously considered suicide
- 14.3% made a plan for how to commit suicide
- 9.6% attempted suicide
- 2.7% made SA requiring medical attention
Adolescent Suicide

• Hispanic high school students are more likely than any other group to attempt suicide (CDC, 2006).
• Between 31-50% of all adolescent suicide attempters re-attempt suicide (Shaffer & Piacentini, 1994).
• 27% (males) and 21% (females) of adolescent suicide attempters re-attempt within 3 months of their first attempt (Lewinsohn et al., 1996).
• Up to 77% of adolescent suicide attempters who present at ER do not attend or fail to complete treatment (Trautman et al., 1993).
In a Typical High School Classroom...

1 male and 2 females may have attempted suicide in the past year

American Association of Suicidology
Source: King (1997, p.66)
Problem of NSSI

- **Clinical Samples**
  - 21%-61% in youth
    - Age of onset is typically between 12-14
  - 20% in adults

- **Gender Differences**
  - Not consistently evident, especially among adolescents

- **Ethnic Differences**
  - Not consistently evident
Theory of Etiology and Maintenance

- **Emotion Regulation Function**
  - Most common reason for NSSI (Prinstein, 2008):
    - Suppress negative affect (i.e., automatic negative reinforcement function)
    - Increase feelings (i.e., automatic positive reinforcement function) for those who feel numb
THE PROBLEM TO BE SOLVED

AVOIDANCE OR ESCAPE

CUES

Intolerable Aversive Emotional State

Problem Behavior:
- Suicide Ideation
- NSSI
- Suicide Attempt
- Binge/Purge
- Drugs/Alcohol
- School Refusal

TEMPORARY RELIEF

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Borderline Personality Disorder
(Re-organized)

Emotional Dysregulation
- Affective lability
- Problems with anger

Interpersonal Dysregulation
- Chaotic relationships
- Fears of abandonment

Behavioral Dysregulation
- Suicidal and NSSI behavior
- Impulsive behavior

Self Dysregulation
- Identity disturbance/ difficulties with sense of self
- Sense of emptiness

Cognitive Dysregulation
- Dissociative responses/ paranoid ideation
BPD in Adolescents?

- To diagnose or NOT to diagnose...that is the question.
- Hall’s (1904) storm and stress theory of adolescence vs. more pervasive and severe symptomatology that may result in chronic personality disorders beginning in adolescence (P. Kernberg et al., 2000).
Adolescent BPD Symptoms in the Community: 20 year follow-up (Winograd et al., 2008)

Research questions:

1) To what extent do early adolescent borderline symptoms predict ‘derailments’ (Skodol, 2005) in functioning during transition to adulthood in community sample?

2) What relationship might such borderline symptoms have to the attainment of expected life goals in one’s thirties (two decades later)?
   - Domains include romance, education, occupational status
Summary
(Winograd et al., 2008)

• 20-year prospective design that measures numerous domains of functioning, and studies borderline symptoms over and above Axis I disorders (N=638)

• Conclusion:
Adverse outcomes are associated with higher borderline symptoms in adolescence, and extend to many important and interrelated life domains throughout early-mid adulthood. Relationship, academic, and interpersonal dysfunction continues far beyond high school.
Achieving treatment success with BPD has been known to be notoriously difficult!

- BPD has been associated with worse outcome in treatments of Axis I disorders including MDD, OCD, bulimia, and substance abuse (Markowitz, 2006).

- Pharmacotherapy studies find large drop out rates and poor medication compliance, with > 50% of clients and 87% of therapist reporting medication misuse, including overdosing as a method of attempting suicide.
Why DBT for teens?

• **Data!** (RCT, quasi-experimental, and open trials)

• **Biosocial Theory:** Offers a compassionate explanation of the etiology and maintenance of emotion dysregulation to students, families and professionals. The theory directly informs the treatment targets.

• **DBT is skills-based** and helps us all recognize the notion of skills deficits and the need for skills training. Teaching, learning, rehearsing, generalizing.

• **The multi-modal** nature of DBT affords us multiple entry points into the teens lives (via individual counseling, skills group, family involvement, and inter-session coaching).
Problem Areas

1. Reduced Awareness and Focus; Confusion about Self
2. Impulsivity
3. Emotional Dysregulation
4. Interpersonal Problems Effectiveness
5. Teenager and Family Challenges (i.e., non-dialectical thinking, invalidation, poor contingency mgmt)

Skills

1. Mindfulness
2. Distress Tolerance
3. Emotion Regulation
4. Interpersonal Effectiveness
5. Walking the Middle Path
Structure the Milieu and Modes of Treatment

Standard DBT is Outpatient Treatment
Structure the Comprehensiveness of Treatment

DBT Structures Treatment by Function
Five Functions of Comprehensive Treatment

1. Enhance capabilities
2. Improve motivational factors
3. Assure generalization to natural environment
4. Enhance therapist capabilities and motivation to treat effectively
5. Structure the environment
Adolescent DBT Modes

Phase I: 6 months
- Multi-family skills training group
- Individual psychotherapy
- Telephone consultation (w/ teen & parent)
- Family therapy, PRN
- Therapist consultation meeting

Phase II: 16 weeks (optional) & recommit
- Graduate group
- Telephone consultation
- Family therapy, PRN

+All patients are eligible for pharmacotherapy
+Orange color = adolescent adaptation
Youth DBT Research Findings
Adult DBT Research
> 30 Randomized Clinical Trials

DBT Superior to Comparison Treatments

Reducing:
• Suicide attempts and self-injury
• Premature drop-out
• Inpatient/ER admissions and days
• Drug abuse
• Depression, hopelessness, anger
• Impulsiveness

Increasing:
• Global adjustment
• Social adjustment

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Outpatient Study

Dialectical Behavior Therapy Adapted for Suicidal Adolescents

JILL H. RATHIUS, PHD, AND ALEC L. MILLER, PSYD

We report a quasi-experimental investigation of an adaptation of Dialectical Behavior Therapy (DBT) with a group of suicidal adolescents with borderline personality features. The DBT group ($n = 29$) received 12 weeks of twice weekly therapy consisting of individual therapy and a multifamily skills training group. The treatment as usual (TAU) group ($n = 82$) received 12 weeks of twice weekly supportive-psychoodynamic individual therapy plus weekly family therapy. Despite more severe pre-treatment symptomatology in the DBT group, at post-treatment this group had significantly fewer psychiatric hospitalizations during treatment, and a significantly higher rate of treatment completion than the TAU group. There were no significant differences in the number of suicide attempts made during treatment. Examining pre-post change within the DBT group, there were significant reductions in suicidal ideation, general psychiatric symptoms, and symptoms of borderline personality. DBT appears to be a promising treatment for suicidal adolescents with borderline personality characteristics.

Suicide accounts for more adolescent deaths in the United States than all natural causes combined and is one leading cause of death among youth. Epidemiological studies suggest a parallel increase in the incidence of attempts to suicides among young people (Shaffer, 1990).
Subjects: n=111 (DBT=29, TAU=82)

- Referrals to the Adolescent Depression and Suicide Program, 78% female and 22% male
- Age range 12-18 years
- 68% Hispanic, 17% African American, 8% Caucasian, 1% Asian, 6% other
Subjects: Assignments to Condition

**DBT Inclusion Criteria:**

- Either made a suicide attempt within the last 16 weeks
- OR
- report current suicidal ideation
- Met diagnostic criteria for BPD or ≥ 3 borderline personality features (SCID-II)
Design: Quasi-Experimental

**Conditions:**
DBT for Adolescents vs. Treatment-as-Usual

**Time Frame:** 12 weeks

**Assessments:**
Pre-Treatment
Post-Treatment (12wk)
Pre-Treatment Difference

DBT group:

- More Axis 1 diagnoses
- More depressed
- More BPD characteristics
- Greater # of prior hospitalizations
- 1 yr older
Summary: DBT with Adolescents

Preliminarily, DBT - A:

- Reduces hospitalizations
- Increases treatment retention
- Reduces suicidal ideation
- Reduces depression, anger, anxiety, and interpersonal sensitivity (SCL90)
- Reduces borderline symptomatology (confusion about self, interpersonal chaos, emotional dysregulation, impulsivity)

Rathus & Miller, 2002
Adolescent DBT RCTs


4) U of Washington & UCLA Marsha Linehan, Liz McCauley, Joan Asarnow, & Michelle Berk (PIs) (JAMA, 2018)
   - 24 weeks of DBT-A vs. Supportive psychotherapy (manual)
   - Elevated suicidal ideation, NSSI and 1 lifetime SA adolescents

2) Cooney, E, Davis, K, Thompson, P, Wharewera-Mika, J, Stewart, J, & Miller, AL. (under review) *Feasibility of comparing Dialectical Behavior Therapy with treatment as usual for suicidal & self-injuring adolescents: Follow-up data from a small randomized controlled trial.* (NEW ZEALAND)

Dialectical Behavior Therapy for Adolescents with Recent and Repeated Self-harming Behaviors - First Randomized Controlled Trial

Lars Mehlum M.D. Ph.D.
National Centre for Suicide Research and Prevention
University of Oslo, NORWAY

Reference:
Overall Aim

To determine the efficacy of DBT-A compared to enhanced usual care in adolescents with recent and repetitive self harm and with three or more borderline personality disorder criteria.
Design

- Randomized Controlled Trial with independent and blinded pre-, post and follow-up evaluations
- Measurements at:
  - Baseline (interview, self-report and testing)
  - 6 weeks 12 weeks, 16 weeks
  - 1 year posttreatment follow-up (interview, self-report and testing)
  - 2 years posttreatment follow-up (interview, self-report and testing)
  - Ten year follow-up planned

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Treatment Methods

1. DBT – Adapted for adolescents – 16 weeks

2. Enhanced Usual Care (EUC) – 16 weeks
   Psychodynamic or CBT oriented therapy (non-DBT)

Treatments were delivered at five Child and Adolescent Outpatient Clinics in Oslo, Norway
Conclusions

- Patients receiving DBT-A experienced significant reductions in all 3 primary outcome measures, in contrast to patients receiving EUC where only self-reported depression was significantly reduced.

- Patients who received DBT-A had a significantly
  - Stronger reduction in the number of self-harm episodes
  - Stronger decline in suicidal ideation
  - Stronger reduction in interviewer rated depressive symptoms
  - Stronger reduction in hopelessness feelings
  - Stronger reduction in borderline symptoms
Reasons to Be Hopeful...

• The development and dissemination of evidence-based interventions in clinical settings and schools for anxiety, depression, suicide, and self-harm continues....

• Effective therapies, specifically comprehensive DBT for youth
  • Delivered in treatment centers around the world
  • Delivered in Schools (Elementary-high school, and college counseling centers)
    – Prevention/social emotional learning (STEPS-A)
  • Taking into account staff stress and burnout
  – NY State Department of Education mandating mental health education in schools

  – Stigma reduction
    • Mental health and treatment in Student Health Councils; “School Wellness Days”; Staples HS “Zen Den”

• Celebrities and organizations joining the cause

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Adolescent DBT Books/Manuals


For more treatment and training information:

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