Adolescent Borderline Personality Disorder and Dialectical Behavior Therapy

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Abstract

Previous research supports the reliability and validity of using Borderline Personality Disorder (BPD) as a diagnosis with adolescents. There are numerous treatment options for the disorder, but outcome studies indicate the best results are achieved with Dialectical Behavior Therapy (DBT). In this article, the literature surrounding adolescent BPD will be reviewed, followed by a summary of the model of DBT that is used with adolescents and their families. The author will also explore the fit between DBT and social work values.

Introduction

The Diagnostic and Statistical Manual of Mental Disorders (4th ed., Text Revision; American Psychiatric Association, 2000) allows a child or adolescent to be diagnosed with a personality disorder if the pattern of pathology is present for at least a year and is pervasive, persistent, and unlikely to be limited to a developmental stage or an Axis I disorder. Clinicians, however, have been reluctant to make Axis II diagnoses in clients under the age of 18 (Paris, 2005). This article will therefore discuss the reliability and validity of diagnosing Borderline Personality Disorder (BPD) in adolescents. Further, it will examine how children and adolescents who are diagnosed with BPD can benefit from Dialectical Behavior Therapy (DBT), the premier empirically based treatment for BPD. In conclusion, an application of DBT principles to the social work practice with children and adolescents will be presented.

Biosocial Theory of Borderline Personality Disorder

In order to consider diagnosing BPD in adolescents, it is first important to look at the biosocial theory of BPD. The foundation of this theory, developed by Marsha Linehan, is that:

> BPD is primarily a dysfunction of the emotional regulation system; it results from biological irregularities combined with certain environments, as well as from their interaction and transaction over time. The characteristics associated with BPD are sequelae of, and thus secondary to, this fundamental emotional dysregulation. Moreover, these same patterns cause further deregulation. Invalidating environments during childhood contribute to the development of emotional dysregulation; they also fail to teach the child how to label and regulate arousal, how to tolerate emotional distress, and when to trust her own emotional responses as reflections of valid interpretations of events. (Linehan, 1993, p. 42)

Per Linehan (1993), emotional dysregulation is due to emotional vulnerability and an inability to regulate emotions. Emotional vulnerability includes: a "high sensitivity" to emotional stimuli (reacts quickly and has a low threshold for emotional reactions), "emotional intensity" (extreme emotional reactions), and a "slow return to emotional baseline" (long-lasting emotional reactions) (p. 43–44). An invalidating environment is one in which there is a poor fit between the environment and the child's temperament, and can also include physically or sexually abusive environments (Katz, Gunasekara, & Miller, 2002). In such environments, the parent and/or caretaker does not validate the child's personal experiences (the child is instead punished or trivialized), and the parent and/or caretaker does not acknowledge the child's behaviors, the intent, or the motivation behind the behaviors. Such invalidation tells the child that she or he is wrong in his or her view of what is causing emotions, thoughts, and behaviors. In addition, the child attributes experiences to having socially unacceptable characteristics. The child in turn takes on the characteristics of the invalidating environment and learns to invalidate his or her own emotional experiences (Linehan, 1993).

Areas of Impairment in Individuals with Borderline Personality Disorder

Linehan describes five areas of impairment in individuals with BPD. As noted earlier, the central problem is one of emotional dysregulation, which in turn is thought to contribute to the other areas of impairment: interpersonal, self, cognitive, and behavioral dysregulation. Interpersonal dysregulation can manifest itself in the form of fears of abandonment and chaotic relationships. Instability in one's emotions and relationships can lead to self-dysregulation, which can include an unstable self-image and a chronic feeling of emptiness. Cognitive

dysregulation can also be present in individuals diagnosed with BPD in the form of rigid thinking, irrational beliefs, paranoid ideation, and dissociation. Behavioral dysregulation is also common, which develops as a consequence of emotional dysregulation or as an attempt to regulate emotions. This type of dysregulation manifests as impulsivity and parasuicidal behaviors (Katz, Gunasekara, & Miller, 2002; Linehan, 1993). Individuals diagnosed with BPD are predisposed to difficulty in regulating emotions and may therefore develop maladaptive coping strategies, such as parasuicide, to regulate their emotions. Parasuicide is defined as "any acute, intentional self-injurious behavior resulting in physical harm, with or without the intent to die" (Katz, Cox, Gunasekara, & Miller, 2004, p. 276).

Diagnosing Adolescent Borderline Personality Disorder

As previously stated, clinicians have traditionally been reluctant to make Axis II diagnoses, such as BPD, in clients under the age of 18 (Paris, 2005). The rationale behind this reluctance is that "adolescence has been seen as a time of transition that can be marked by turmoil. Since personality disorders are chronic, by definition, clinicians understandably prefer to wait and see before coming to conclusions. Nonetheless, there is no reason why the same pathology should be called one thing before a defined age and another afterward" (Paris, 2005, p. 237–238).

There is empirical support for the validity of diagnosing adolescents with BPD. For example, Durrett & Westen (2005) identify that "personality pathology is not limited to adulthood. To the extent that DSM-IV provides criteria useful for assessing adults, these criteria yield diagnoses with similar operating characteristics in adolescents" (pp. 457–458). Paris (2005) further supports the belief that many symptoms in adolescents are identical to those seen in adults with personality disorders. Moreover, longitudinal studies have shown that an adolescent's presentation of symptoms consistent with a personality disorder is a potential correlate of serious pathology in young adulthood.

Researchers have supported the frequency and reliability of diagnosing adolescents with BPD (Becker, & Grilo, 2005). "Research findings suggest that clinicians should seriously consider diagnosing BPD when patients present with the classical features of the disorder, that is, affective instability, chronic suicidality, self-mutilation, a wide range of impulsivity, and micropsychotic phenomena" (Paris, 2005, p. 241). The most important predictors of continuation of personality disorder symptoms into adulthood are severity and age of onset, with a greater severity and younger age of onset predicting a greater continuation of symptoms. BPD typically begins in adolescence; most clients who present with symptoms of BPD state an onset of symptoms around puberty. Psychosocial risk factors seen in adolescent and adult cases are also effectively the same (Paris, 2005). Additionally, using structured interviews, adolescents (ages 12–17) meet the criteria for personality disorders at the same rates as young adults (age 18–37) (Durrett & Westen, 2005).

Certain features present in adolescents diagnosed with BPD diverge from those features in adolescents without the diagnosis of BPD, which can assist the clinician in making an appropriate BPD diagnosis in an adolescent. Adolescents with BPD are more likely to have diagnoses of posttraumatic stress disorder, affective disorders, and substance abuse disorders than adolescents without BPD. Adolescents with BPD symptoms and/or a BPD diagnosis also more commonly report histories of neglect, abandonment, physical and sexual abuse, delinquent activity, and parasuicidal behaviors (Pinto, Grapentine, Francis, & Picariello, 1996). A study by Pinto and colleagues (1996) compared depressed adolescents with a BPD diagnosis to depressed adolescents without a BPD diagnosis on measures of affective and cognitive features of BPD. They found that both groups displayed significant feelings of anxiety, anger, and hopelessness. They displayed external loci of control, self-deprecatory attributes, and poor self-concepts. Even though both groups displayed these symptoms, the adolescents with BPD displayed a greater level of symptomatology in these areas. The only area in which a *significant* difference was found was in self-concept. The adolescents diagnosed with BPD reported significantly poorer self-concept, particularly on measures of popularity, physical appearance, and happiness/satisfaction. The Pinto et al. study found that the difference in self-concept was not due to depression severity; thus, negative self-concept appears to distinguish adolescents with a BPD diagnosis from adolescents who were depressed without a diagnosis of BPD. These results are important when attempting to distinguish between depression and BPD among adolescents, a distinction that may not always be clear in this population. This finding can be used to assist clinicians in making the appropriate diagnosis.

Another way to understand the nature of BPD diagnosed among adolescents is by studying the diagnostic efficacy of BPD criteria. Becker, Grilo, Edell, and McGlashan (2002) compared the diagnostic efficacy of BPD criteria in hospitalized adolescents and adults. Diagnostic efficacy was defined as "the extent to which diagnostic criteria (or symptoms) are able to discriminate individuals with a given disorder from those without that disorder" (p. 2043). In this study, the adolescents and adults had similar base rates for the BPD diagnosis and for the BPD criteria, suggesting general similarities between the age groups with respect to BPD. They found that five of the BPD symptoms—impulsiveness, affective instability, uncontrolled anger, suicidal thoughts or gestures, and emptiness or boredom—were present in at least two-thirds of the adolescents. In the adult group, no one symptom had a clear advantage as an inclusion criterion, which is consistent with the DSM-IV perspective that all symptoms are viewed as having equivalent predictive power. However, in the adolescent group some criteria did have significantly higher positive predictive power than others. In this study, abandonment fears had the greatest utility as an inclusion criterion. The absence of impulsiveness was found to be the best exclusion criterion for adults (impulsiveness also had the greatest predictive value for the adults), but the absence of uncontrolled anger was the best exclusion criterion for adolescents. When both positive and negative predictive capacity were taken into account (the symptom's power as an inclusion or exclusion criterion) the researchers found that affective instability, uncontrolled anger, and identity disturbance had the most overall utility in diagnosing BPD among adolescents, with affective instability being the greatest predictor. Overall, the adolescent symptoms had significantly higher positive predictive power than the adult symptoms. The implication of this finding is that adolescents with a single BPD symptom are more likely to receive a BPD diagnosis than are adults with a single BPD symptom. These findings are also consistent with the results of Pinto and colleagues (1996), in that identity disturbance is more useful than most BPD symptoms in leading to a correct diagnosis. The only symptoms with equal or better predictive value in adolescents are affective instability and uncontrolled anger. These findings suggest that symptoms of poor affect regulation may be the most characteristic of adolescents with a BPD diagnosis (Becker et al., 2002), which is also consistent with Linehan's biosocial theory, in that the main problem in individuals with BPD is emotional dysregulation.

Even though BPD can be reliably and frequently diagnosed in adolescents (Becker & Grilo, 2005), clinicians should still use care when making this diagnosis due to the overlap between BPD and Axis I disorder symptoms, as well as with "normal" adolescent behaviors. Becker and Grilo (2005) examined the validity of BPD among adolescents. They looked at the factor structure of BPD among adolescents and whether the factors were related to specific Axis I disorders. Four factors emerged from their analysis. Factor one consisted of "suicidal threats or gestures" (behavioral dysregulation) and "emptiness and boredom" (self dysregulation) and was significantly associated with major depression and dysthymia. Factor two contained "affective instability", "uncontrolled anger" (emotional dysregulation), and "identity disturbance" (self dysregulation), and corresponded to oppositional defiant disorder and anxiety disorders. Factor three, which consisted of "unstable relationships" and "abandonment fears" (interpersonal dysregulation), also corresponded to anxiety disorders. Factor four consisted of "impulsiveness" (behavioral dysregulation), and conduct disorder was associated with this factor. When a BPD diagnosis is not made, adolescents are likely to receive a diagnosis of major depressive disorder if they present with internalizing symptoms, or a diagnosis of conduct disorder if they present with externalizing symptoms (Paris, 2005).

The BPD symptoms of affective instability, uncontrolled anger, impulsivity, and identity disturbance are common in adolescents, which begs the question: How are these BPD symptoms differentiated from "normal" adolescent behaviors? In answering this question, Paris (2005) states, "One sometimes hears that all adolescents may be 'a little borderline.' No one denies that moodiness and some degree of impulsive behavior are common in this age group. But most adolescents are not seriously troubled or rebellious" (p. 240). This suggests that the severity of the adolescent's behavior and the impact those behaviors are having on his or her functioning can assist clinicians in differentiating non-pathological adolescent behaviors from those indicating that a BPD diagnosis may be appropriate.

Treatment Options for Adolescents Diagnosed with Borderline Personality Disorder

There are numerous treatment options for adolescents diagnosed with BPD, including standard cognitive-behavioral therapy, individual psychotherapy, and substance abuse treatment

(Swenson, Torrey, & Koerner, 2002). Because BPD has numerous symptoms that overlap with other disorders and because of the intractable nature of personality disorders, clinicians should understand that BPD is likely to be chronic (Paris, 2005). As a result, it is important for a therapist to have realistic expectations for clients and also to develop treatment goals that take into account the nature of the client's psychopathology and numerous symptoms. Therapists are guided by the empirical literature to modify personality traits and understand that a more conservative use of psychopharmacology and more active efforts at psychotherapy may be helpful (Paris, 2005). The best evidence-based outcomes for people with BPD are from Dialectical Behavior Therapy (Katz, Gunasekara, & Miller, 2002).

General Structure of DBT

DBT is based on dialectics, which is the continual synthesis of opposing ideas. The most fundamental dialectic of DBT is "the necessity of accepting patients just as they are within a context of trying to teach them to change" (Linehan, 1993, p. 19). Linehan developed this therapy for the treatment of chronically parasuicidal women diagnosed with BPD, and it is the first empirically supported treatment for this population (Katz, Gunasekara, & Miller, 2002). It blends standard cognitive-behavioral therapy with Eastern philosophy and meditation, and includes elements from psychodynamic, client-centered, gestalt, paradoxical, and strategic approaches. DBT supports a non-critical stance towards individuals diagnosed with BPD, which helps to correct the common tendency to blame them for their maladaptive behaviors (Swenson, Torrey, & Koerner, 2002). There are six core elements of DBT: a biosocial theory regarding BPD (discussed above), a conceptual framework of the stages of treatment, a hierarchy of treatment targets within each stage, an explanation of the functions of treatment, different treatment modalities that fulfill those functions, and sets of treatment strategies (Robins & Chapman, 2004).

Treatment Stages and Hierarchy of Targets

DBT is composed of a total of four stages of treatment, beginning with a "pretreatment" stage. During pretreatment (Orientation and Commitment), the targets of therapy are an orientation to treatment and the agreement on goals, during which the client makes a commitment to therapy. In the first stage of treatment (Attaining Basic Capacities), the targets are addressed in a hierarchical order of importance. The most important target is decreasing suicidal behaviors, which include suicide crisis behaviors, parasuicidal behaviors, intrusive suicidal urges, images, and communications, and suicidal ideation. After these behaviors have been addressed, the next target is decreasing behaviors that interfere with treatment. This includes problems that threaten the continuation of therapy and those that interfere with the process of treatment. Another target is decreasing quality of life-interfering behaviors. Behaviors causing immediate crises are targeted and easy-to-change behaviors are targeted over difficult-to-change behaviors. The final target is increasing behavioral skills. The skills, in order of importance, are: core mindfulness skills, interpersonal effectiveness, emotional regulation, and distress tolerance. The therapist addresses the highest priority target that is relevant at that time. The goal of stage 2 (Reducing Posttraumatic Stress) is the direct treatment of posttraumatic stress. This is only done after the client has the necessary skills and supports to resolve the trauma. Increasing self-respect and achieving individual goals are the targets of stage 3 (Increasing Self-Respect and Achieving Individual Goals).

Behavioral Skills Modules

DBT addresses the five problem areas of BPD that were discussed earlier (emotional, interpersonal, self, cognitive, and behavioral dysregulation) with four corresponding behavioral skills modules: mindfulness, distress tolerance, emotional regulation, and interpersonal effectiveness. These skills modules are taught in a psychoeducational skills training group (Linehan, 1993). The support for skills training in the treatment for people diagnosed with BPD comes from the idea that:

> Many of the difficulties in BPD may be linked with deficits or disruptions in emotional regulation skills, which contribute to deficits and disruptions in interpersonal relations and skills, distress tolerance skills, and mindfulness skills. Teaching and rehearsing these skills would be expected to, among other things, help the patient develop greater capabilities to interact assertively, to regulate his or her emotions, to tolerate distress and inhibit behaviors that provide short-term relief from it but create long-term problems, to be more aware of his or her current internal states and external environment, and to be less judgmental. Developing such skills and having them reinforced by the environment would be expected to lead to a variety of positive mental health outcomes (Robins & Chapman, 2004, p. 85).

Mindfulness, the core skills module, addresses dysregulation. The skills utilized are psychological

and behavioral versions of meditation skills (Linehan, 1993). Six skills are taught to help clients observe their experiences in nonjudgmental ways and to put observations into words in order to change from making emotional choices to making balanced decisions (using both emotional and rational input), which are called "wise-mind decisions" (Katz, Gunasekara, & Miller, 2002). The six mindfulness skills are: observing, describing, participating, taking a non-judgmental stance, focusing on one thing in the moment, and being effective. The distress tolerance skills module targets behavioral and cognitive dysregulation. The goal of these skills is to help the client accept reality and survive crises. The emotion regulation skills module addresses emotional dysregulation by giving the client a non-judgmental place to experience emotions, therefore reducing emotional distress. The interpersonal effectiveness skills module addresses interpersonal dysregulation and teaches the client how to ask for what one needs, say no, and cope with interpersonal conflict (Linehan, 1993).

Functions and Modes of Treatment

Linehan describes five functions of comprehensive treatment of patients diagnosed with BPD, which serve to guide the structure of DBT. Each function is assigned to a different mode of treatment (Miller, 1999). The first function is to enhance the individual's capabilities, which is done through a weekly psychoeducational skills training group, utilizing the four skills modules discussed above. The second function is to improve the individual's motivation to change. To address this, the client has weekly sessions with an individual therapist to identify and reduce factors that interfere with the ability to use skills. The third function is to ensure the generalization of new capabilities from therapy to everyday life, which is facilitated through telephone contacts with the therapist on an as-needed basis. The client can call the therapist when crises arise, to give good news, or to repair the therapeutic relationship, if needed. The fourth function is to enhance the therapist's capabilities and motivation to treat effectively through a weekly case consultation group that offers technical help and emotional support. The fifth function is to structure the environment to support the client's and therapist's capabilities. This is done by ensuring that the client does not have to get worse in order to attain additional help and that the therapist has reasonable time demands to prevent burnout (Katz, Gunasekara, & Miller, 2002).

Core Treatment Strategies-Validation and Problem Solving

There are four categories of basic treatment strategies in DBT: dialectical strategies, core strategies, stylistic strategies, and case management strategies. Since a complete discussion of these strategies is beyond the scope of this article, only the core strategies will be presented here (see Linehan, 1993 for a complete discussion). The core treatment strategies in DBT are validation (acceptance) and problem solving (change), as DBT emphasizes accepting the client while also promoting change. Some ways in which the therapist can show validation towards the client are to accept the client's feelings; communicate that feelings are valid; encourage, praise, and reassure the client; actively express hope to the client; and focus on the client's capabilities (Linehan, 1993). In validating the client, the therapist actively communicates acceptance of the client. The act of validation allows the client and therapist to understand the client's responses. The therapist does not make valid what is not, but instead searches for some validity within the client's behaviors (Katz, Gunasekara, & Miller, 2002). The therapist balances this validation with strategies for change. Problem-solving strategies help the client understand and accept the problem and generate, evaluate, and carry out solutions (Linehan, 1993).

The main problem to be treated in individuals diagnosed with BPD is emotional dysregulation. Extreme behaviors are viewed as either a result of emotional dysregulation or an unsuccessful attempt to regulate emotion, so the therapist analyzes the nature and etiology of the emotional dysregulation to understand the function of the maladaptive behavior. Additionally, the therapist and client together identify triggers and consequences that maintain behavior by looking at the events leading to a certain behavior, the client's response, and the environment's response to the behavior. The therapist also asks whether the client has the skills to respond effectively, and if not, capability enhancement strategies are used. If the client has the necessary skills but is not using them, the impediments to adaptive responses are addressed (Katz, Gunasekara, & Miller, 2002).

Dialectical Behavior Therapy Modified for Adolescents

DBT has been modified for use with different psychopathologies (substance abuse, eating disorders) and age groups (adolescent inpatients and outpatients) (Robins & Chapman, 2004). Several changes to the general structure of DBT have been made for its use with adolescents. One change is that DBT can be used at the same time as, or as part of, family treatment.

When being used with an individual adolescent, the first stage of treatment is shortened from one year to 12 weeks. The main focus of treatment is initially on the pretreatment targets of commitment to treatment and agreement on goals, and then on the first-stage targets of stability, connection, and safety. Goals in this stage include decreasing life-threatening behaviors, decreasing behaviors that interfere with therapy and quality of life, and increasing behavioral skills (Miller, 1999). The second-stage target of addressing posttraumatic stress and the third-stage targets of increasing self-respect and achieving individual goals are not formally addressed in working with adolescents (Katz, Gunasekara, & Miller, 2002).

For a family intervention, some modifications in the implementation of the five functions of treatment have been made. Parents are included in the skills-training group to increase the generalization and maintenance of skills. The goals are to teach the family to use the skills and improve the adolescent's home environment. Also, the number of skills addressed in the group is reduced to accommodate for the shorter time period, and the language on the skills handouts has been simplified to be developmentally and culturally appropriate (Katz, Gunasekara, & Miller, 2002). A new skills-training module has also been added to the group called "Walking the Middle Path." This skills module was added in order to address conflicts and dilemmas often found in parent-adolescent relationships (Miller et al., 2002). An additional modification is that parents and other family members are included in the individual sessions as needed (Katz, Gunasekara, & Miller, 2002). In the individual sessions, the same hierarchy is used as in standard DBT. Nothing else is discussed until self-harm is addressed. If there have not been any parasuicidal behaviors since the previous session, the session focuses on anything that may be interfering with treatment or quality of life (Miller, 1999).

DBT with adolescents addresses the same five goals as standard DBT. The adolescent and his or her parents address capability enhancement in a weekly 2-hour skills training group, which provides opportunities for learning skills through instruction and modeling, and for skill-strengthening through the rehearsal of skills and the reinforcement of new skills. The adolescent's motivation is enhanced in weekly individual sessions where the client reviews a weekly diary card and does a behavioral analysis of maladaptive events; works on skill strengthening and generalization; and focuses on emotional dysregulation, cognitive errors, and contingencies that can compromise motivation. As in standard DBT, the therapist is available for telephone consultation for the purpose of preventing parasuicidal behaviors, facilitating generalization of skills, sharing good news, or repairing the therapist-client relationship. The therapist also attends a weekly DBT consultation group to enhance the capacity and motivation to treat clients effectively. Lastly, the therapist structures the environment by including family, other treatment providers, and the school in treatment to ensure the client does not have to get worse in order to get help (Miller, 1999; Katz, Gunasekara, & Miller, 2002).

Dialectical Behavior Family Treatment

Since most adolescents live with their families and a core contributing factor to the development of BPD is thought to be an invalidating family environment, the transaction between the adolescent and family becomes an important focus in treatment (Woodberry, Miller, Glinski, Indik, & Mitchell, 2002). Family therapists believe the power of family therapy is its ability to change interactions between family members; combining family treatment and DBT, then, may reduce invalidation within the family—a major contributing factor to emotional dysregulation. Additionally, it may be easier to decrease risk and increase protective factors in an adolescent's environment than to change individual characteristics within the adolescent (Miller et al., 2002).

A therapist who combines DBT with family therapy will be required to evaluate and understand a situation from multiple, and often opposing, perspectives. The therapist helps the adolescent and the family to integrate opposing viewpoints (Miller et al., 2002). There are certain family therapy targets that need to be addressed, which may be related to behaviors by the adolescent that DBT will attempt to change. The first is decreasing family risk factors, including abuse, neglect, high levels of conflict and stress, and parental psychopathology. Family therapy attempts to reduce skills deficits and increase skills among family members. Another target is to enhance familial protective factors, such as warmth, closeness, emotional involvement, family stability, cohesion, motivation, adaptability, and dialectical thinking and behaviors. A final target is improving interpersonal interactions by enhancing mindfulness of interaction patterns, encouraging reciprocal validation between the adolescent and the family, and increasing affective reciprocity, in which the parents decrease reactivity and the adolescent

decreases negativity (Woodberry et al., 2002). Combining these two modalities allows the therapist to gain an integrated and empathic view of the family. If an adolescent is only being seen in individual therapy, the therapist is more likely to view the adolescent as a victim of rather than as a participant in the invalidating environment (Miller et al., 2002). Genograms can also help to give the family and the therapist insight into the intergenerational transmission of invalidation, thus allowing the therapist, adolescent and family to be more validating of the family's behavioral patterns and interactions. "Validation acknowledges an understanding of how the person came to act, think, and feel a certain way. The DBT therapist utilizes this understanding to help the adolescent and family members recognize that while thinking, feeling or acting in a certain way makes sense in terms of past history, it may no longer be effective in the present context" (Woodberry et al., 2002, pp. 574–575). All of the targets of standard DBT can be modified for use in family sessions by emphasizing interactions between family members rather than individual behavior, with the first priority always being the adolescent's suicidal or parasuicidal behavior. Family relationships can also be used as a source of strength that can help adolescents cope with emotional dysregulation (Miller et al., 2002).

Advantages to Using Dialectical Behavior Therapy with Adolescents

There are advantages to using DBT with adolescents. DBT structures treatment and guides the therapist's focus according to the treatment hierarchy by making the adolescent's behaviors (especially life-threatening and parasuicidal behaviors) the primary treatment target (Katz, Gunasekara, & Miller, 2002). DBT is client-centered in that it instructs the therapist to assess where the client is on a particular day and use that information to guide the current session. If a therapist is unsure of how to address an adolescent's behavior, DBT provides guidance, thereby reducing the therapist's anxiety and thus diminishing the chance that the therapist will respond in a way that is unhelpful to the client. Though a treatment modality should not be chosen based on the therapist's needs, the fact that DBT can reduce therapist anxiety is an advantage as long as the client's needs remain primary. DBT also directly targets treatment noncompliance and focuses on keeping adolescents engaged in treatment (Katz, Gunasekara, & Miller, 2002) through the pretreatment targets of collaboratively agreeing on goals and committing to change. This is important because engagement in treatment and compliance can be difficult to achieve when working with this population. Adolescents may be more likely to engage in treatment if they feel a sense of control over the treatment goals. Additionally, the areas addressed by DBT (e.g., emotional instability, impulsivity, interpersonal problems, and confusion about oneself) are consistent with the developmental tasks of adolescence (Katz, Gunasekara, & Miller, 2002).

Limitations with the Use of Dialectical Behavior Therapy

There are several limitations to using DBT with adolescents. A chief limitation of DBT is that it is resource intensive (Paris, 2005). DBT involves twice-weekly therapy (one individual session and one psychoeducational skills group), family treatment if indicated, 24-hour access to the therapist, and a therapist case consultation group. Due to the intensive nature of this treatment and the additional training required for clinicians, it may not be available in all communities, which can also lead to difficulty in accessing treatment. An additional issue that must be addressed is using short-term treatment with adolescents believed to be presenting with a personality disorder. In adults, DBT is a longer-term treatment, with the first phase typically lasting one year. In adolescents, however, this first phase has been shortened to 12 weeks. One of the main goals of this phase is stabilization of the adolescent, which includes control of suicidal or parasuicidal behaviors (Katz, Gunasekara, & Miller, 2002). The goal of this phase is also to teach the adolescent and his or her family skills needed to increase functioning. While these sessions may be helpful in controlling behavior that could be harmful to the adolescent and in improving the interactions between the adolescent and the family, it may not be as effective as longer-term treatment.

Applications to Social Work Practice

DBT is based on the premise that emotional dysregulation results from the interaction between the biology and characteristics of an individual within the social environment (Linehan, 1993). This premise is consistent with the "person-in-environment" perspective held by social workers. In adolescents diagnosed with BPD, it is not enough to look at the characteristics within the individual and use them as treatment targets, but the individual's environment must also be a target. The client's environment is always important, but this is especially true with adolescents since they typically are living in their parents' or caregiver's home, attending school, and

may be involved with other service providers. Because an invalidating environment is thought to be a contributing factor in the maintenance of emotional dysregulation, the DBT therapist works collaboratively with the family, school, and other service providers to best help the adolescent.

DBT also focuses on accepting clients as they are and providing them with empathy. Even if a certain behavior is inappropriate or even harmful, the therapist finds validity in it based on the client's context and life experiences. Each individual session is structured based on where the client is and the hierarchy of treatment targets. Regardless of what the therapist may want to address during a session, the highest priority target for the client is addressed, especially with suicidal or parasuicidal behavior. The stance of non-judgment in DBT also helps the therapist to maintain empathy towards the client. If the therapist becomes frustrated with the client's destructive behaviors, she or he might begin to blame the client for causing his or her own suffering and see the client as resisting therapy. The biosocial theoretical principles that form the foundation for understanding BPD may alleviate this blame by illustrating how maladaptive behaviors can develop from "normal responses to dysfunctional biological, psychological, and environmental events" (Linehan, 1993, p. 26).

DBT also fits with social work practice in its use of a strengths-based perspective. Linehan (1993) mentions several assumptions about borderline individuals, which include that they are doing the best they can and that they want to improve. The DBT therapist focuses on positive qualities within the individual and validates the client's current capabilities and behaviors. The therapist believes in the client's inherent ability to build a more satisfying life, focuses on the client's strengths, and believes in the client (Linehan, 1993). The skills groups also focus on increasing strengths as opposed to decreasing pathology. The goal is to increase the client's capabilities. This also serves to empower the client by teaching the client to be his or her own case manager. The therapist helps the client gain the skills needed to solve problems. This strategy is used because the therapist believes in the client (Linehan, 1993).

Conclusion

The use of the BPD diagnosis for adolescents has been substantiated by a growing body of research. However, regardless of whether a clinician is comfortable formally diagnosing a personality disorder in an adolescent, the BPD construct can be used to evaluate DBT as a potential treatment for adolescents displaying symptoms of the disorder. This is especially so given that certain aspects of DBT are consistent with the way social workers practice. DBT incorporates a person-in-environment viewpoint, a strengths perspective, a belief in empowerment, and a priority on the involvement of the family in treatment. As such, to the extent that adolescents display sufficiently severe characteristics of BPD (beyond those typically associated with adolescence), social workers can responsibly use DBT to teach adolescents skills for regulating emotions, impulsivity, problems in interpersonal relationships, and confusion about themselves.

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