

# Using Dialectical Behavior Therapy to Help Troubled Adolescents Return Safely to Their Families and Communities

The Grove Street Adolescent Residence of The Bridge of Central Massachusetts, Inc.

In May 2001 The Bridge of Central Massachusetts, Inc., a nonprofit human service agency, opened a community residence to treat youths between the ages of 13 and 21 years. The Grove Street Adolescent Residence (GSAR), which was developed in close cooperation with the Massachusetts Department of Mental Health, uses the principles of dialectical behavior therapy (DBT), an empirically supported approach to the treatment of individuals with impulsive and self-destructive behaviors. The nine-bed residence is located in a neighborhood of the town of Westborough. In addition to the nine youths who currently live in the residence, 20 youths have been served in the program since 2001. The Bridge consists of 30 programs serving children, adolescents, and adults who have mental health challenges, developmental disabilities, and complex family problems.

Most of the adolescents who are served by GSAR have significant difficulties controlling their emotions and display impulsive and self-destructive behaviors. They often are depressed and aggressive and have attention deficits and substance use problems. The environments they grew up in were often chaotic, and many experienced physical and sexual abuse. Parents and other caretakers often rejected their emotional experiences and punished emotional displays. As a result, adolescents enter the program with extreme emotional dysregulation and an inability to identify and label their own internal emotional states. For the adolescent to be admitted to the residence, the severi-

ty of the disturbance must be expected to worsen without intensive clinical intervention; there must be a documented assessment that the adolescent or his or her family would be placed at risk if the adolescent were to live at home; and a less restrictive setting must be ruled out as inappropriate or unavailable.

Successful treatment of the severely troubled adolescents who enter the program depends on a strong commitment to each individual resident—a commitment that transcends the best attempts of an adolescent to frighten and alienate anyone who tries to help. The principles of DBT provide program staff with a framework for making and sustaining such a commitment. In recognition of its commitment to improving the lives of adolescents who have often been failed by other care providers, the Grove Street Adolescent Residence was selected as winner of the 2004 Gold Achievement Award in the category of large academically or institutionally sponsored programs. The Gold Award winner for small community-based programs is described on page 1164. The awards were presented on October 6 during the opening session of the Institute on Psychiatric Services in Atlanta. Each winning program will receive a plaque and a \$10,000 prize made possible by a grant from Pfizer Inc.

## Use of DBT with adolescents

In the early 1990s, Marsha Linehan's seminal work demonstrated the efficacy of DBT in reducing suicidal and self-injurious behaviors among women with borderline personality

disorder. Later in the decade, Alec Miller and his colleagues at Montefiore Medical Center and Albert Einstein College of Medicine in New York City modified the standardized manualized treatment for DBT to address the needs of adolescents with multiple problems. Research has shown that use of this approach with adolescents reduces suicidal behavior, dropout from treatment, psychiatric hospitalization, substance abuse, anger, and interpersonal difficulties.

DBT posits that borderline personality disorder is caused by pervasive emotional dysregulation. Symptoms of borderline personality are thought to result when an adolescent who is biologically and emotionally vulnerable is placed in an environment that repeatedly communicates to the child that his or her reactions, feelings, and thoughts are faulty or inaccurate. Self-injurious behaviors may serve to regulate emotions and to elicit help from an environment that is otherwise unsupportive.

The core dialectic of DBT treatment balances acceptance of the patient and the simultaneous need for change. DBT treatment uses validation strategies that require the therapist to search for, recognize, and reflect to the patient—and to each family member—the validity inherent in his or her response to events and the environment. Linehan described six levels of validation: listening nonjudgmentally; accurate reflection; mind-reading, or articulating unspoken thoughts and feelings; understanding the historical background of a behavior; confirming thoughts, behaviors,

and feelings on the basis of current circumstances; and radical genuineness, which requires the therapist to speak authentically to the patient and his or her family.

### **GSAR treatment modalities**

The GSAR program offers several forms of DBT treatment and services: individual therapy; group skills training; a structured environment, including a behavior management system; coaching in crisis; family therapy and skills training; and a staff consultation team. The program also offers case management, psychiatric consultation, and work with individuals in the family's support system.

#### *Individual therapy*

Individual therapy is provided on-site by a clinician experienced in the treatment of families and adolescents. DBT treatment strategies focus on teaching the adolescent the skills needed to manage extreme emotional dysregulation and destructive behaviors in order to return safely to the community. During assessment and analysis of problem behaviors, the therapist weaves in strategies to increase motivation for change and reinforce skillful behavior.

One-hour individual therapy sessions are usually scheduled once a week, with increased contact and coaching during a crisis or at the beginning of treatment. Between sessions the adolescent completes diary cards that document suicidality, self-injurious behaviors, substance use, school attendance, other individualized target behaviors, intensity of emotions, and use of skills. The cards are used to determine the focus of the weekly session.

#### *Group skills training*

DBT skills are designed to help modulate emotions and behaviors. There are four skills: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. Mindfulness and distress tolerance are acceptance-based modules that teach residents how to live with reality "as it is." Emotion regulation and interpersonal effectiveness are change-oriented modules that teach residents how to alter themselves or alter their environments.

The DBT skills group meets twice a week at the residence for a total of two hours. Half of group time is spent reviewing homework practice for current skills, and the other half is devoted to presenting new skills. The skills are taught in six-month rounds. Because adolescents frequently lose their motivation and commitment, the program modified the structure of the group to include an expectation of increased participation as adolescents enter their second and third rounds. By the third round, adolescents are expected to regularly lead mindfulness exercises, rotate leadership of homework review, and teach a skill to the rest of the group. This structure provides adolescents who are engaged in treatment with an increase in status in the house and creates mentors within the program to model skill use to newer residents.

#### *Structured environment*

The program's direct services include a therapeutic milieu in a comfortable home setting, a structured routine of daily activities, and age-appropriate recreational activities. A critical element of the program milieu is a behavior management system consisting of points and levels that rewards effective behavior. It also teaches skills in a systematic and positive way that emphasizes success and progressive accomplishment.

#### **Behavior management system.**

The overall philosophy of the GSAR's milieu treatment encourages positive and proactive behavior management. Residents receive feedback and coaching when they are not using skills. They earn increased freedom and responsibility as they acquire the skills necessary for community safety. The point and level system is based on DBT principles. The contingencies are structured to reinforce behaviors that maintain safety, demonstrate adherence to treatment, and maintain and improve quality of life.

**Mini-chain analysis.** The GSAR uses a mini-chain analysis, which was modified from the extremely detailed chain analysis developed by Linehan. The mini-chain, which includes information about antecedents, vulnerability factors, links leading to problem behaviors, and consequences of prob-

lem behaviors, is completed by key residential staff with the resident after a target behavior has occurred. The purpose is to help the resident remember the behavior and teach behavior self-monitoring. A complete chain of the behavior is completed later in individual therapy.

#### *Coaching in crisis*

Residential staff are trained to recognize cues indicating that an adolescent is beginning to experience emotional and behavioral difficulties. Initial responses include immediate, nonjudgmental feedback about a behavior and its impact on others, as well as coaching in skills that might be useful. Residents who are able to manage their behaviors with feedback and coaching are placed on coaching status and receive increased supervision, support, and coaching. Adolescents who do not respond to coaching are placed on safety status, which includes decreases in privileges, repairs to the community for any disruptions, a mini-chain analysis of the problematic behavior, and a discussion of alternative solutions.

#### *Family therapy and skills training*

The GSAR treatment team views families as essential partners. The parent skills training group is a two-hour monthly group designed to provide support and education to families who often struggle with their child's extreme behaviors. Training is designed to improve the dysfunctional environment to which the adolescent plans to return and to teach family members how to model and reinforce adaptive behaviors. Parents learn the same DBT skills that adolescents learn, as well as a fifth skill module designed by Alec Miller and his colleagues, "Walking the Middle Path." This module includes training in biosocial theory, basic behaviorism, validation strategies, and use of dialectical strategies in parenting.

The residence also offers family therapy, with parents and children participating conjointly. Topics include resolution of past problems, conflict resolution, negotiation of ground rules for weekend visits, and planning for return home. Family

therapy generally occurs two to four times per month.

### *Staff consultation team*

DBT assumes that effective treatment must pay as much attention to the therapist's behavior and experience in therapy as it does to the client's. Treating these clients can be extremely stressful, and staying within the DBT therapeutic frame can be tremendously difficult. The Grove Street consultation team meets weekly with all program staff to provide ongoing training to improve the skill level of program staff, to identify and address therapy-interfering behaviors, and to monitor ongoing treatment interventions.

### *Case management*

The treatment team must interact with an entire system of involved people, including state agencies, hospitals, psychiatric emergency services, schools, and parents. It is essential that the treatment team and the individual, when possible, manage the contingencies that maintain problematic behavior. For example, adolescents often find the hospital a comfortable place to be—a place where parents visit and comfort them. Hospitalization may thus reinforce unsafe behaviors. The treatment team makes efforts to educate the system and parents to minimize unintentional reinforcement. These strategies might include short hospital stays, coaching parents to respond to their children when they are using skills rather than during times of crisis, and coordinating crisis plans with schools.

### *Consulting psychiatrist and collateral services*

A consulting psychiatrist supports the DBT programming at the residence, provides psychopharmacology, and helps the residence in its interactions with emergency services and local hospital units. The psychiatrist meets monthly with individual residents and with the DBT treatment team to share data and to make well-informed psychiatric decisions. The GSAR actively involves other members of the service system such as the Massachusetts Department of Mental Health, schools, courts, and outpatient therapists and psychiatrists.

### **Staff and funding**

The GSAR program is administered through The Bridge of Central Massachusetts. The program was created by the senior administrative team consisting of Barent Walsh, Ph.D., executive director; Stephen Murphy, M.A., director of program operations; Christy Matta, M.A., director of DBT services; and Marvin Lew, Ph.D., clinical director. Pat Harvey, M.S.W., division director, and Carl Moran, program manager, have overseen the day-to-day operation of the program.

The staff consists of 18.7 full-time-equivalent (FTE) positions, including 9.5 FTE counselors, 1.8 FTE registered nurses, and other supervisory staff. A master's-level clinician provides the individual and family therapy and participates in the group skills training. The behavior management system, coaching in crisis, and minichain analyses are overseen by the residential counselors. The program began with a capacity of six residents but requests from funders has increased the census to nine residents, which is the maximum the facility can accommodate.

Funding for the GSAR—about \$888,000 annually—is provided through a contract with the Massachusetts Department of Mental Health. The program also receives about \$5,000 a year from the lunch program of the U.S. Department of Education.

### **Outcome data**

Data on a variety of outcome measures are collected at intake, every six months, and six months after discharge. Data are available for the first 20 youths who have lived in the residence during the time that it has been open, including 14 girls and six boys. Their average age was 16.6 years (range, 13 to 18 years). The average length of stay in the residence was 10.3 months (range, three to 20 months). The residents had an average of 2.3 axis I diagnoses (range, one to four).

Although the program staff recognize that the small sample size and the lack of a comparison group, they are encouraged by the outcome data. Twelve of the 20 youths had completed the program; at six months after

discharge, eight were living in the community, three were in a group residence, and one was hospitalized. Ten of the 20 residents had many lifetime hospitalizations. In the six months before program entry, four spent a total of 690 days in the hospital. Six months after discharge, only two had been hospitalized for a total of 183 days (180 days were for one individual). Nine of the 20 youths had a history of self-injury, including 23 reported incidents in the six months before entering the residence. Twelve incidents of such behavior were documented in the first six months, one in the second six months, and none among the four who stayed in the program for more than 12 months. No incidents were reported in the six months postdischarge.

Data on the program's effectiveness were presented in a clinical workshop at the International Society for the Improvement and Teaching of Dialectical Behavior Therapy conference in November 2003. As a result, the program has attracted attention from clinicians and families from around the country and serves as a model for an application of DBT that is in its initial stages of dissemination. The program has served as a training site for clinicians from the department of counseling psychology of Assumption College and the department of psychiatry at the University of Massachusetts Medical School.

The adolescents who come to the Grove Street Residence often do poorly in programs that are not equipped to make a commitment to them when they become too threatening or self-injurious. A child psychiatrist who evaluated the program for the APA awards committee said, "These adolescents need to know that they will not be kicked out of the program. That they can't be obnoxious enough, psychotic enough, or high enough to be sent away. The DBT system of care understands that provocative behaviors need to be modified and can be modified."

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