

# The Brown University Child and Adolescent Behavior Letter



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Our page 1 stories this month look at how to use DBT to treat suicidal and other conditions, and how to assess family digital social media use.



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— Anne S. Walters, Ph.D.

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Monthly reports on the problems of children and adolescents growing up

# CABL

## DBT

## Getting unstuck: Dialectical strategies to reduce suffering and build a life worth living

By Andrea L. Gold, Ph.D., and Mona Yaptangco, Ph.D.

Case: Katharina is a 16-year-old female referred for adolescent dialectical behavior therapy (DBT-A) following her second psychiatric hospitalization for suicidal intent and plan. She presents with chronic suicidal ideation, frequent nonsuicidal self-injury, severe hopelessness and worthlessness, and recent academic decline. Katharina's life-threatening behaviors emerged last year in the context of worsening depression, anxiety, irritability, disordered eating, and increased familial conflict, particularly around limit setting. Her pervasive and severe emotion dysregulation had not improved following outpatient psychotherapy with multiple cognitive behavioral

therapists, pharmacotherapy, and inpatient and partial hospitalizations.

Katharina's case exemplifies the high-risk "multiproblem adolescent" for whom DBT-A was developed: suicidal adolescents with chronic emotion dysregulation, multiple coexisting psychiatric disorders, and subthreshold or full criteria for borderline personality disorder (Miller, Rathus, & Linehan, 2006). Among this population, numerous forms of treatment noncompliance are rampant. Indeed, Katharina was often noncollaborative during sessions and exhibited numerous therapy-interfering behaviors. Katharina and her family  
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## Social media

## Talking with teens and families about digital media use

By Sarah Rocha, M.D.

Use of digital media such as cell phones, tablets, video games, television, and associated social media seems nearly ubiquitous among adults and youth. A recent Pew Survey indicated that 95% of teens have access to a smartphone, and 45% say they are on the internet nearly constantly. The rise in use of digital media is correlated with evidence of increasing rates of adolescent depression, anxiety, and suicide, and mental health clinicians report use of digital media is a frequent source of family conflict. Hence, parents may seek advice from mental health and other professionals regarding their teen's media use, and there is some evidence that parental involvement may mitigate some of the risks associated with media

use. Clinicians face challenges assessing family digital media use and providing evidence-based recommendations for many reasons, including lack of training, the rapid pace of change of technology, lack of knowledge about normative versus abnormal usage, and lack of evidence base regarding evaluation and management of problematic media use. This article aims to provide a framework and a review of expert-derived guidelines for talking with families about digital media use.

Many technology-based parent monitoring strategies exist, such as services that monitor or limit phone or internet usage, and these may be helpful for many families; however, these solutions in isolation  
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## DBT

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reported feeling “stuck” more often than not, and her therapist frequently sought consultation to improve her own motivation and capabilities when similarly feeling “stuck.”

To help clients build a life worth living, DBT therapists integrate three paradigms: *change strategies*, theoretically rooted in behavioral science and represented in cognitive behavioral therapy techniques; *acceptance strategies*, based on the study and practice of Zen meditation and implemented in mindfulness and validation practices; and *dialectical strategies*, which balance the opposite poles of change and acceptance. Linehan rooted DBT in dialectics: the balance and the synthesis of opposing positions by finding and holding valid elements from each side (Linehan, 1993; Swenson, 2016). For example, DBT therapists believe that clients are doing the best they can (acceptance-based) *and* they need to do better, try harder, and be more motivated for change (change-based).

DBT therapists apply a dialectical framework in three ways. First, therapists explicitly attend to the dialectics of the therapeutic relationship and maintain a dialectical position of blending acceptance and change, rather than becoming polarized on either side. This therapeutic stance combines flexibility with centeredness, balances nurturance with demanding, and focuses on both capabilities *and* deficits.

Second, therapists model and teach dialectical behaviors to families, with the goal of finding the “middle path” and moving from *either-or* to *both-and*. DBT-A teaches three sets of skills to address polarities in the behavioral patterns of families with multiproblem adolescents: (1) behaviorism: skills to facilitate change; (2) validation: skills to foster and communicate empathy and acceptance; and (3) dialectics: skills to balance acceptance and change (Miller et al., 2006). Families learn how to negotiate with one another, view and articulate another’s perspective, and acknowledge multiple truths rather than viewing situations as right or wrong.

Finally, DBT offers therapists dialectical strategies to use throughout treatment. These strategies draw from diverse perspectives and modalities, and may be applied whenever one feels “stuck” (e.g.,

frustrated, unheard, hopeless, unmotivated). Linehan (1993) teaches eight dialectical strategies to help therapists and clients “get unstuck” when faced with dialectical failures, such as extreme “black-and-white” thinking styles. Dialectical strategies also serve to reorient and re-establish commitment in response to a therapeutic impasse. In DBT, dialectical patterns of thinking and behavior not only permeate every clinical interaction, but also infuse treatment supervision and consultation. Thus, while the following strategies are illustrated with examples involving clients, they are no less relevant when interacting with other providers in supervision and the DBT consultation team.

### Dialectical strategies

1. **Entering the paradox** is a strategy to get someone’s attention when faced with a paradox. The therapist presents the paradoxical contradictions of the client’s behavior, the therapeutic process, and reality in general. While the client typically reacts with rational explanations, the therapist unexpectedly responds with silence, another question, or a slightly different paradox or story to help (but not completely) resolve the struggle. Here the therapist highlights how the two sides of a contradiction can both be *true and not true*, that an answer to any question can be *both yes and no*.

Examples of entering the paradox include coaching clients to accept even their own inability to accept, or to control their excessive efforts to control. Similarly, clients become more independent by learning how to effectively obtain help from others. Entering the paradox pushes the client to struggle with, confront, and break through paradoxes. By resolving the dilemma on their own, clients learn to let go of rigidity and embrace more spontaneous and flexible patterns of thinking, feeling, and acting.

2. **Metaphors**, storytelling, parables, myths, and analogies, teach dialectical thinking in ways that tend to be creative, interesting, and memorable, offering a nonthreatening context. Metaphors compare something the client can understand to something the client does not (or is not willing to) understand. This strategy is particularly effective in helping clients to

redefine, reframe, and find solutions to their own problems and problems in the therapeutic relationship.

For example, Katharina’s therapist used metaphors, such as those described by Linehan, equating the intensity of Katharina’s emotional pain with hell. She then described treatment in the following terms: “the only way out of hell is to climb the scorching hot ladder up out of hell, without gloves or shoes — it hurts like hell!” Katharina shared feeling validated by this metaphor, stating, “You actually get it; you understand.” This helped Katharina join with her therapist while tolerating and accepting “short-term pain for long-term gain.”

3. Therapists play **devil’s advocate** by presenting the extreme, maladaptive end of the continuum, leading the client to argue in favor of the more adaptive end (Koerner, 2012). Once the client moves toward the adaptive response, the therapist uses this strategy to strengthen the client’s position.

Katharina, like many teens, was hesitant to start treatment. After employing orientation and commitment strategies that enhanced Katharina’s motivation, her therapist played devil’s advocate, asking with a straight face, “Why in the world would you commit all these hours to therapy *and* skills group *and* homework *and* coaching calls? That’s a hell of a lot of time and effort. Why not just do some other treatment that’s only 45 minutes per week?” This surprised Katharina, who argued the opposite position and articulated the pros of participating in DBT-A.

4. **Extending** occurs when the therapist takes the client more seriously than she takes herself, or takes an aspect of the client’s communication more seriously than the patient intends it to be.

For example, Katharina stated in a family session, “If I can’t go on this road trip with my friends, I’ll kill myself!” Whereas the client wants her therapist/parents to take the *problem* seriously (permission and resources for the trip), the therapist takes seriously the *consequences* (suicidal statement) and extends them even further: “How could we possibly discuss a topic as unimportant as gas

money and hotel fare when your life is in danger? We need to deal with this threat to your life if you're in so much distress you're going to kill yourself!" When used effectively, this technique helps the client to replace her extreme, escalated communication with direct communication. The therapist's job is to then take the problem seriously and attend to problem-solving, while reinforcing the client for the direct communication.

5. DBT teaches clients skills for identifying three states of mind: reasonable mind, emotion mind, and wise mind. **Activating "wise mind"** directs clients to their wise mind, which combines emotional experiencing and logical analysis with intuitive knowing. Therapists assist clients to identify their current state of mind, then redirect to wise mind by asking "What does your wise mind say about ...?" This strategy aims to balance what one *feels* to be true (emotion mind) and *thinks* to be true (reasonable mind), leading to the synthesis as what one *knows* to be true (wise mind).

Katharina's therapist taught her ways to access "wise mind," such as breathing and mindfulness practices. She also coached Katharina to identify what she would tell a friend in the same situation, which allowed Katharina the space she needed to access her values and intuitive knowledge, her wise mind.

6. By **making lemonade out of lemons**, therapists create an asset out of something that appears problematic. Therapists characterize problems that emerge in and out of therapy sessions as opportunities to practice, generalize, and master skills.

Katharina applied this skill by identifying how experiencing her own emotional hell enhances her ability to

validate and support others. Reflecting the dialectical perspective, Linehan cautions against communicating that clients' lemons are already lemonade; instead, therapists skillfully find the silver lining while simultaneously acknowledging the cloud is indeed black.

7. DBT therapists assume that change is a natural life occurrence. **Allowing natural change** reflects a dialectical strategy that allows the inconsistencies and developments inherent in any environment to proceed naturally. This does not involve therapists imposing change or instability, nor does it mean artificially creating stability or consistency. Natural change includes ambiguity, uncertainty, unpredictability, and inconsistency, which emerge in both therapeutic and everyday relationships. By allowing change to proceed naturally, therapists promote opportunities for clients to cope effectively, learn to accept reality as it is, and develop comfort with change.
8. **Dialectical assessment** searches for the answers to the question: "What is being left out here?" Rooted in dialectics, this assessment encompasses the client's immediate environment, past learning and family histories, and the larger social, political, and economic contexts in which one's personal context is embedded.

## Concluding remarks

Dialectical strategies reflect an essential aspect of DBT. Beyond DBT, dialectical strategies offer psychotherapists across treatment modalities ways to get unstuck when faced with therapy "logjams." In addition to encouraging flexibility and creating movement, dialectical strategies enhance collaborative therapeutic relationships by modeling and teaching ways to reduce

suffering and resolve tensions through the process of synthesis. Therapists benefit from listening to their own intuitive knowledge, or wise mind, regarding what works for each unique therapeutic relationship in terms of effective timing and delivery of dialectical strategies. When combined effectively with the change and acceptance strategies, dialectical strategies promote the overarching goal of therapy: to build a life worth living.

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## Social media

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are not sufficient. In general, experts promote "active monitoring" over "restrictive monitoring." Effective active monitoring may include co-viewing or co-experiencing media with their teens, and certainly should involve parents having conversa-

tions with their teens about the media use. These conversations should occur at frequent intervals and can occur in the moment in response to circumstances or may be part of a more structured conversation such as a family dinner or family meeting. Parents who are not sure how to begin may appreciate the following suggestions to facilitate a collaborative approach to the discussion. Asking teens about what

sorts of media (shows, apps, websites, etc.) they are interested in, why they like them, and how they work allows the teen to take on the role of teacher and helps a parent understand more about what is important to the child in their digital world. Often parents are particularly focused on the risks posed by media use; however, a balanced discussion of media use can include both the pros and cons and may facilitate