

1.2 DIALECTICAL BEHAVIOUR THERAPY TO ENHANCE EMOTIONAL REGULATION & RESILIENCE AMONG STREET-INVOLVED YOUTH

Elizabeth McCay & Andria Aiello

INTRODUCTION

It is well known that youth who are homeless experience a high degree of emotional and psychological distress (McCay et al., 2010). Mental health challenges such as depression, anxiety, and self-harm are often linked with difficulties regulating emotion on a day-to-day basis. Taken as a whole, these challenges often interfere with the capacity of street-involved youth to engage in the full spectrum of health and social services intended to support them in exiting the street so they will then be able to engage in independent, healthy adult lives. There is an overwhelming need for evidence-based interventions to address the mental health challenges faced by youth who are street involved in order to support adaption and reintegration (Altena, Brilleslijper-Kater, & Wolf, 2010; Coren et al., 2013). Furthermore, it has been observed that the current intervention literature overlooks the core mental health problems, such as emotional and psychological distress, experienced by these youth (Chen, Thrane, Whitbeck, & Johnson, 2006; McCay et al., 2010).

One evidence-based approach that offers promise in addressing the dramatic emotional needs of youth who are homeless is dialectical behaviour therapy (DBT). DBT is an evidence-based intervention designed to treat a range of serious mental health challenges, including mood and anxiety disorders, self-harm behaviour, and suicidality (Linehan, 2000; McMain, Korman, & Dimeff, 2001; Miller, Rathus, DuBose, Dexter-Mazza, & Goldklang, 2007a). DBT was originally developed for the treatment of borderline personality disorder, a serious mental disorder characterized by the inability to manage emotions effectively (Linehan, 1993). More recently, DBT has been adapted for a wide range of mental health challenges, and has proved to be effective across a range of adult and adolescent populations. While literature evaluating the effectiveness of DBT for youth who are homeless is limited, the treatment has demonstrated the capacity to decrease self-harm and suicidality, and to improve mental health indicators such as depression and anxiety (Bohus et al., 2004), all of which include problems with regulating emotion. These findings suggest that DBT may be effective in meeting the needs of street-involved youth.

Based on this strong evidence base, our research team implemented and evaluated DBT with street-involved youth across two Canadian agencies that provide services to this population (McCay et al., 2015a). The results from this collaborative study that involved 60 youth indicated that participants in the DBT intervention experienced a reduction in mental health distress. Specifically, they showed significant improvement in overall mental health problems, depression, hopelessness, self-esteem, social connectedness, resilience, and overall functioning. These improvements were maintained at four and 10 weeks post-intervention. In the qualitative component of the study, youth told us that DBT helped them manage their emotions and tolerate distress, improved their relationships, and strengthened their sense of self. Overall, the findings suggest that DBT is a promising approach to helping vulnerable youth become more resilient and lead independent lives.

This chapter provides an overview of DBT, including individual therapy and group skills training, as well as crisis support and consultation team meetings. We then discuss the adaptations we made to the intervention to better meet the needs of street-involved youth (McCay et al., 2015a). Given that engagement with this group can be challenging, we also describe strategies we used to build commitment and trust with youth. We then explain how we implemented the intervention, highlight what we learned during the process, and identify which aspects of the intervention youth found particularly helpful in making changes in their lives. Finally, drawing on our experiences of working with street-involved youth, we discuss important considerations in implementing DBT in community settings.

DIALECTICAL BEHAVIOUR THERAPY

From a theoretical perspective, DBT is based on the understanding that inadequate emotion regulation underpins a diverse range of difficulties in coping with life challenges. Emotion dysregulation or extreme emotional sensitivity may develop due to biological vulnerability and/or may arise within the context of invalidating interpersonal circumstances (Koerner & Dimeff, 2007). DBT is comprised of cognitive behavioural approaches in combination with acceptance-based practices originating from the Zen school of Buddhism (McMain, Korman, & Dimeff, 2001). DBT emphasizes the need for therapeutic acceptance, as well as the need to focus on changing maladaptive coping mechanisms, such as self-harm or substance abuse, which are used to avoid painful emotions and perceptions of the self.

Overall, DBT is a therapeutic intervention that balances acceptance of the individual's current difficulties with the need for change. Our study applied the adolescent version of DBT by Miller, Rathus, and Linehan (2007b), which shares many conceptual and practical similarities with the adult version. As in standard DBT, the adolescent version includes individual therapy, skills training, crisis support, and consultation team meetings. Each component is described in the following section.

COMPONENTS OF DBT

Individual therapy

The individual therapist assumes the role of coordinator for each individual's participation in DBT, and is responsible for conducting the individual therapy sessions and developing the crisis plan. DBT provides clear guidelines regarding the goals of the intervention. Foremost, the therapist must identify with the client the need to decrease:

- Life-threatening behaviours;
- Therapy-interfering behaviours, including coming late to sessions and missing sessions; and
- Behaviours that negatively affect quality of life, such as substance abuse, depression, school truancy, relationship problems, and disordered eating.

These hierarchical DBT goals give the therapist clear guidelines about what issues are priorities to be dealt with in the individual sessions. Clients complete diary cards to track problematic behaviours, which are then reviewed with the therapist. The therapist also employs a strategy called chain analysis, which is a detailed behavioural analysis that determines how a client arrived at a dysfunctional response. This understanding can then be used to help the client make a different choice in the future. The therapist also encourages clients to strengthen their behavioural skills by attending a DBT skills training group.

Skills training

The skills training component of the DBT intervention is provided in a group setting. In their book *Dialectical Behavior Therapy with Suicidal Adolescents*, Miller et al. (2007b) present a 16-week format for DBT skills training. The training involves four four-week modules, each focused on one of the following skills:

- Distress tolerance;
- Interpersonal effectiveness;

- Emotion regulation; and
- Walking the middle path.

All skills group modules include didactic content, role plays, and homework practice. Each module is structured as an independent entity, with the orientation to the principles of DBT and core mindfulness skills repeated at the start of each module. Mindfulness is integral to all of the modules and emphasizes being observant in the moment, as well as being non-judgemental.

Crisis support

The skills taught in the DBT skills training group are designed to address a number of problems, including impulsivity, emotional instability, and interpersonal problems (Miller et al., 2007b). As clients continue to learn and practise skills to manage difficult emotions, the DBT therapist is available via pager to provide crisis support as needed.

Consultation team meetings

The DBT consultation team is an essential part of the DBT intervention. The purpose of the team is to hold each therapist within a therapeutic frame and address problems that arise in the course of delivering the intervention. The goal of consultation is to allow therapists to discuss their difficulties providing DBT in a non-judgemental and supportive environment that also helps improve their motivation and capabilities.

ADAPTING DBT FOR STREET-INVOLVED YOUTH

Table 1.2-1 outlines the key adaptations we made to the 16-week DBT intervention described by Miller et al. (2007b) for the purposes of our study. While Miller et al. presented a 16-week DBT intervention for adolescents who were suicidal, our study implemented and evaluated DBT with street-involved youth who were either accessing or living in a shelter and who were experiencing elevated levels of distress, but were not necessarily suicidal (see Lynk, McCay, Carter, Aiello, & Donald, 2015).

TABLE 1.2-1: KEY ADAPTATIONS TO A DBT INTERVENTION FOR STREET-INVOLVED YOUTH

16-WEEK DBT INTERVENTION ^a	ADAPTED 12-WEEK DBT INTERVENTION
Target population	
Adolescents who are suicidal	Street-involved adolescents who are experiencing elevated levels of distress
Length of intervention	
16 weeks (individual therapy, skills training, crisis support, consultation team meetings)	12 weeks (individual therapy, skills training, crisis support, consultation team meetings)
Skills training modules	
<p>Four modules: distress tolerance, interpersonal effectiveness, emotion regulation, walking the middle path</p> <p>Core mindfulness skills are repeated at the start of each module.</p>	<p>Three modules: distress tolerance, interpersonal effectiveness, emotion regulation (walking the middle path, which deals with teenager–family dilemmas, is omitted)</p> <p>Core mindfulness skills are repeated at the start of each module.</p> <p>Youth-oriented examples are provided to reinforce concepts.</p>
Crisis support	
DBT therapist is available via pager to provide crisis support as needed.	<p>24-hour crisis support is available within the community agency.</p> <p>Youth complete a safety plan, which is available to crisis support staff.</p>

^a Miller, Rathus, & Linehan (2007).

The research team and our community partners decided to shorten the intervention from 16 to 12 weeks because street-involved youth are often in and out of shelter. This was accomplished by omitting the “Walking the Middle Path” skills training module, which involves a family component focused on teenager–family dilemmas (Miller et al., 2007b). This seemed appropriate because the youth in our study did not live at home, and many of them had either very strained or non-existent relationships with family members.

The final key adaptation to the intervention involves crisis support. In standard DBT, therapists carry pagers so clients can reach out to them in times of crisis. In our study, it was not feasible for front-line community agency staff to carry pagers because they would not be available to respond to a crisis call after hours. However, the two community agencies in our study offered 24-hour crisis support to all youth residing there, and youth participants were encouraged to access this support if they needed it. Youth also developed a safety plan, which was kept as part of their file so it could be accessed easily by crisis support staff.

STRATEGIES TO PROMOTE ENGAGEMENT & COMMITMENT

Specific strategies were implemented to promote engagement in and commitment to the intervention. First, the DBT skills training group was offered in the late afternoon and early evening so participants who were going to school or working could attend. Pizza was provided at each group session, which helped create a welcoming environment. For each individual therapy and skills group session attended, participants received a \$5 honorarium to cover costs associated with attending, such as transportation.

As in standard DBT and in the adolescent version developed by Miller et al. (2007b), our study implemented the four-miss rule: group members who missed four consecutive skills training sessions (and/or four individual sessions) would have to leave the intervention. Not only was commitment to the intervention deemed to be of paramount importance, but the community agency's commitment to promoting engagement in the intervention was crucial as well. Both agencies in the study demonstrated flexibility in allowing youth who had transitioned to independent housing to also participate in the intervention, underscoring the recognized value of DBT in strengthening resilience for these youth. Furthermore, front-line agency staff delivering the intervention made efforts to maintain regular contact with study participants, sent email reminders about upcoming sessions, and were flexible in scheduling and sometimes rescheduling individual therapy sessions as needed, trying their best to accommodate participants' schedules.

In order to promote engagement in and commitment to the intervention, it was crucial for agency staff conducting individual therapy and running the skills training group to establish respectful, supportive, and trusting relationships with participants. Validation is an essential part of DBT. In keeping with the core dialect in the intervention—acceptance

and change—staff consistently recognized that youth were doing their best, and reinforced their strengths while encouraging them to do better, try harder, and be more motivated to change. In the individual and group sessions, staff gave relevant youth-oriented examples to reinforce concepts and elicit examples from youth themselves.

WHAT WE DID & WHAT WE LEARNED

We learned a great deal from delivering the adolescent version of DBT to a group of street-involved youth. We gained insights not only through observations that front-line agency staff who delivered the intervention made, but also through qualitative interviews with some youth participants about their experiences of DBT. Below we describe insights specific to individual therapy and the skills training group, as well as what we learned about the implementation process.

INDIVIDUAL THERAPY

The 12-week DBT intervention included one orientation session followed by 12 individual therapy sessions incorporating those DBT strategies and tools described earlier. For example, the DBT target pyramid was used to help define the youth’s specific problems as primary target behaviours. Together, youth and staff explored the need to:

- Reduce life-threatening behaviours;
- Reduce therapy-interfering behaviours;
- Reduce quality-of-life interfering behaviours; and
- Increase behavioural skills, prioritizing each according to this hierarchy.

Furthermore, youth participants were expected to fill out a DBT diary card every day to self-monitor target behaviours, emotions, and skills. Consistent with a strengths-based approach, youth were encouraged to track not only problematic behaviours, but also positive behaviours. By reviewing the diary card together at the beginning of every individual session, youth and agency staff collaboratively set the agenda for the session. To build awareness and acceptance of specific problems, youth and staff would complete a DBT behavioural chain analysis and then conduct a solution analysis to generate, evaluate, and implement alternative solutions.

There was some uncertainty about whether participants would use the diary card. Some did fill out their diary cards independently between sessions, but others required more prompting and completed their entries with agency staff during sessions. Overall, youth found they gained self-awareness through participating in the DBT intervention, and the diary card was important in facilitating this self-awareness. Filling out the diary card helped them understand their emotions and the relationships between their emotions and behaviours.

The diary card was also helpful to front-line agency staff who were delivering the intervention because it provided direction and focus in individual therapy sessions. Beyond the use of concrete tools such as the DBT diary card, it was the core principles of the intervention that had a profound impact on both youth and staff. Not only did youth feel validated and understood, but the balance between acceptance and change that is central to the intervention provided a new way for agency staff to have difficult conversations with youth. It was this balance between acceptance and change that enabled staff to establish and maintain trust with the youth while enforcing agency rules.

SKILLS TRAINING

The 12-week intervention included 12 skills training group sessions that were delivered concurrently with the individual therapy sessions. As described earlier, the DBT skills training group included three modules—distress tolerance, interpersonal effectiveness, and emotion regulation—each of which ran for four weeks. Each module began with an orientation and a review of core mindfulness skills. New participants had the opportunity to join the DBT skills training group at the beginning of each new module. As in standard DBT, participants received handouts, as well as homework or practice sheets as tools for summarizing and reinforcing DBT concepts.

Each skills training group session lasted 1.5 hours. Sessions began with a mindfulness exercise, followed by an overview of the session content and a homework practice review. The first half of each session was largely dedicated to exploring with the youth their application of DBT skills. During the second half, front-line agency staff presented the didactic material on the new skills being taught, assigned the homework practice exercise for the upcoming week, and led a wind-down exercise.

There was some uncertainty about whether participants would engage in and benefit from the mindfulness exercise at the beginning of each skills group session. Like the diary card, the mindfulness exercises enhanced self-awareness, creating space for reflection and making different choices. One participant who was struggling with drug abuse commented that engaging in mindfulness gave him a sense of separation from his thoughts and emotions that he had previously sought through drugs, but without any of the harmful side effects. This separation created the space in which he could observe his thoughts and emotions, rather than be overwhelmed by them.

Participants benefited greatly from sharing their experiences, challenges, and successes with one another in the skills training group. They explained that it was validating and empowering to be in a group with other youth who had endured similar circumstances and struggles. The support of front-line agency staff was equally important in creating a safe and validating group environment. As we explained earlier, the flexibility of staff was key to promoting engagement in the intervention; for example, youth participants were not permitted to use their cell phones during the group sessions, but drawing was allowed if it helped them focus or manage anxiety.

CRISIS SUPPORT

The front-line agency staff who delivered the individual therapy sessions introduced the crisis support plan during the orientation session. Youth were reminded that they could access the agency's 24-hour crisis support if they experienced a crisis after hours. It was the responsibility of the individual therapist to follow up with other agency staff about any crisis calls. Together, youth and staff developed a safety plan. As part of the plan, the youth identified coping mechanisms they found helpful and signed an agreement to adhere to the plan. This plan was then made available to crisis support staff.

Crisis supports were consistent and readily available through our agency partners, and as such, crisis support was incorporated within the DBT intervention offered to youth. It became evident that even though our adapted DBT intervention did not adopt the 24-hour pager model, the availability of the 24-hour crisis support through the agency and the adoption of a youth-oriented safety plan were effective at providing crisis support for youth in the study.

CONSULTATION TEAM MEETINGS

Weekly consultation team meetings were held over the course of the intervention to support ongoing skill development and adherence to DBT for front-line agency staff delivering the intervention. To accommodate geographic distance between the sites, these peer-led meetings were conducted via teleconference, and included both agency staff delivering the intervention and members of the research team. The meetings were held at the same time every week and lasted one hour. Together, agency staff discussed their experiences and challenges around delivering DBT. In keeping with the core dialect in the intervention—acceptance and change—these experiences and challenges were validated, while the team worked together to increase adherence to DBT principles, thus enhancing each member’s ability to respond to challenges and deliver the intervention more effectively.

Informal feedback suggests that agency staff found the regular staff teleconferences to be most helpful in supporting the implementation of DBT within their respective agencies. Specifically, staff reported that ongoing consultation and clinical support were a key factor in supporting the therapist’s confidence and learning (McCay et al., 2017).

IMPLEMENTATION CONSIDERATIONS

GETTING STARTED

Successful implementation of DBT takes into account the life circumstances of street-involved youth, as well as the potential impact on organizational programs, staff roles, and client interactions. At the same time, the implementation process can highlight existing strengths in service delivery. Many of the principles of DBT build on and are reflected in the therapeutic relationships between staff and youth, making for a more focused structure to existing practices rather than major organizational change.

If possible, having a staff person act as lead in implementing DBT will make for a smoother transition. As well, our collaboration between a university and a community agency serving youth was central to the success of the project. Partners may bring different perspectives to care delivery; ideally they should share similar values in working with youth. The advantage of partnerships is that they bring together the expertise and

resources (human and material) of each organization in planning and implementation, specifically, sharing decision making and collaborating in navigating challenges that may arise (McCay, Cleverley, Danaher, & Mudachi, 2015b).

The DBT intervention may need to be modified so it aligns with organizational capacity and the needs of youth. Clear outcomes and realistic time frames for implementation are essential for integrating the intervention within current practice so it is feasible and sustainable. Staff will be adopting an approach to working with youth that involves acquiring new knowledge and shifting perspective. Even with comprehensive training, it takes time to be comfortable with the material and develop skill in addressing the range of issues presented by youth. Putting in place the necessary supports (e.g., ongoing consultation) is critical to sustaining the change that is being implemented.

ENGAGING STAFF & PROVIDING TRAINING

Successful implementation of DBT requires the commitment and support of agency administration and staff. Strong administrative support sets the expectations for the agency and ensures access to the needed resources, such as for training and consultation. Furthermore, engaging staff who work directly with youth is a critical step in the implementation of DBT. Our approach was to meet with staff to describe the study, specifically the components of the intervention and the nature of staff involvement in concrete terms.

Staff training is an opportunity to build staff capacity in acquiring a new therapeutic skill, but it requires planning and dedicated time. The individual or group delivering staff training should have the necessary expertise in DBT and plan to be available for consultation going forward in order to assist staff. We employed a multifaceted approach that took into account the demands on staff time and different learning styles, and that provided follow-up support to reinforce content. A range of methods was used that enabled staff members to learn the material at their own pace. (For more information on the training, see McCay, et al. [2015].)

KEY MESSAGES FOR PRACTITIONERS

- DBT is a highly promising approach to meet the mental health needs of street-involved youth and strengthen resilience.
- The core dialectic of validation, while supporting the need to change, is central to the DBT youth-centred approach.
- Front-line staff members are essential to the successful implementation of DBT and require training and organizational support.

CONCLUSION

Our experience suggests that DBT is a promising approach to support street-involved youth in coping with mental health challenges. This in turn strengthens overall functioning, emotional regulation, and resilience. Further, the success achieved in this study was due in large part to the commitment and dedication of staff, who conveyed unconditional acceptance while supporting the need to change. Finally, although the positive results attained in our study are promising, there is a need for further research to demonstrate DBT's effectiveness in helping youth make positive changes in their lives.

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ABOUT THE AUTHORS

Elizabeth McCay, RN, PhD, is a professor at the Daphne Cockwell School of Nursing at Ryerson University in Toronto. Her research focuses on the emotional and psychological consequences of challenging life experiences, particularly for vulnerable youth, and on developing strengths-based interventions to promote healthy self-concepts, resilience, and adaptive capacity in vulnerable populations.

Andria Aiello, RN, MN, CPMHN(C), has worked in mental health nursing for 17 years. At the Daphne Cockwell School of Nursing at Ryerson University in Toronto, she was the research coordinator for two national studies with street-involved youth: one about dialectical behaviour therapy and the other about a resilience and motivational intervention to engage these youth.

