A Pragmatic Therapeutic Approach to Address the Attrition of Adolescents and Young Adults With Borderline Personality Disorder in Dialectical Behavior Therapy Programs

Jaiganesh Selvapandiyan, MD[a,*]

Addressing the conundrum of the diagnostic validity of borderline personality disorder (BPD) in adolescents, several research studies[1–5] indicate that BPD can be reliably diagnosed in adolescence. The diagnostic criteria for adolescent BPD are almost isomorphic to the adult BPD criteria with matching symptom profiles. In clinical practice, dialectical behavior therapy (DBT) is the recommended treatment of choice for adult BPD, and research informs the effectiveness of DBT in the adolescent population as well. A significant proportion of patients who undergo psychotherapy discontinue before completing the prescribed treatment, and most of them do so at an early stage before a significant treatment benefit is theoretically possible.[6] Many randomized controlled trials[7,8] of DBT in the adult population reveal high dropout rates of up to 60%. Extrapolation of the data to the adolescent and young adult BPD population cautions for the possibility of an even more increased risk of dropouts during the therapeutic process because adolescents occupy a unique position in the developmental trajectory. DBT comprises cognitive-behavioral therapy (CBT) techniques with an infusion of mindfulness strategies, with some authors acknowledging the practice difficulties involved in certain recommended techniques.[9] The decision by an adolescent to abort DBT treatment may be a consequence of the perceived burden of the treatment, which is partly a function of his/her cognitive immaturity. Therefore, the administration of DBT to an adolescent creates a unique challenge from a developmental perspective that is mainly predicated on the cognitive capacity of the adolescent to learn the intricate steps of the therapy.[10] In this context, the purpose of this report is to describe a pragmatic therapeutic approach that can be administered to an adolescent receiving DBT, who may perceive certain steps in therapy as burdensome and subsequently drop out of psychotherapy.

[a]All India Institute of Medical Sciences, Mangalagiri, Vijayawada, Andhra Pradesh, India

*Corresponding author: Jaiganesh Selvapandiyan, MD, All India Institute of Medical Sciences, Mangalagiri, Vijayawada, Andhra Pradesh, India (jai8887tkmc@gmail.com).

Prim Care Companion CNS Disord 2021;23(3):20l02596

To cite: Selvapandiyan J. A pragmatic therapeutic approach to address the attrition of adolescents and young adults with borderline personality disorder in dialectical behavior therapy programs. *Prim Care Companion CNS Disord*. 2021;23(3):20l02596.

To share: https://doi.org/10.4088/PCC.20l02596

Case Report

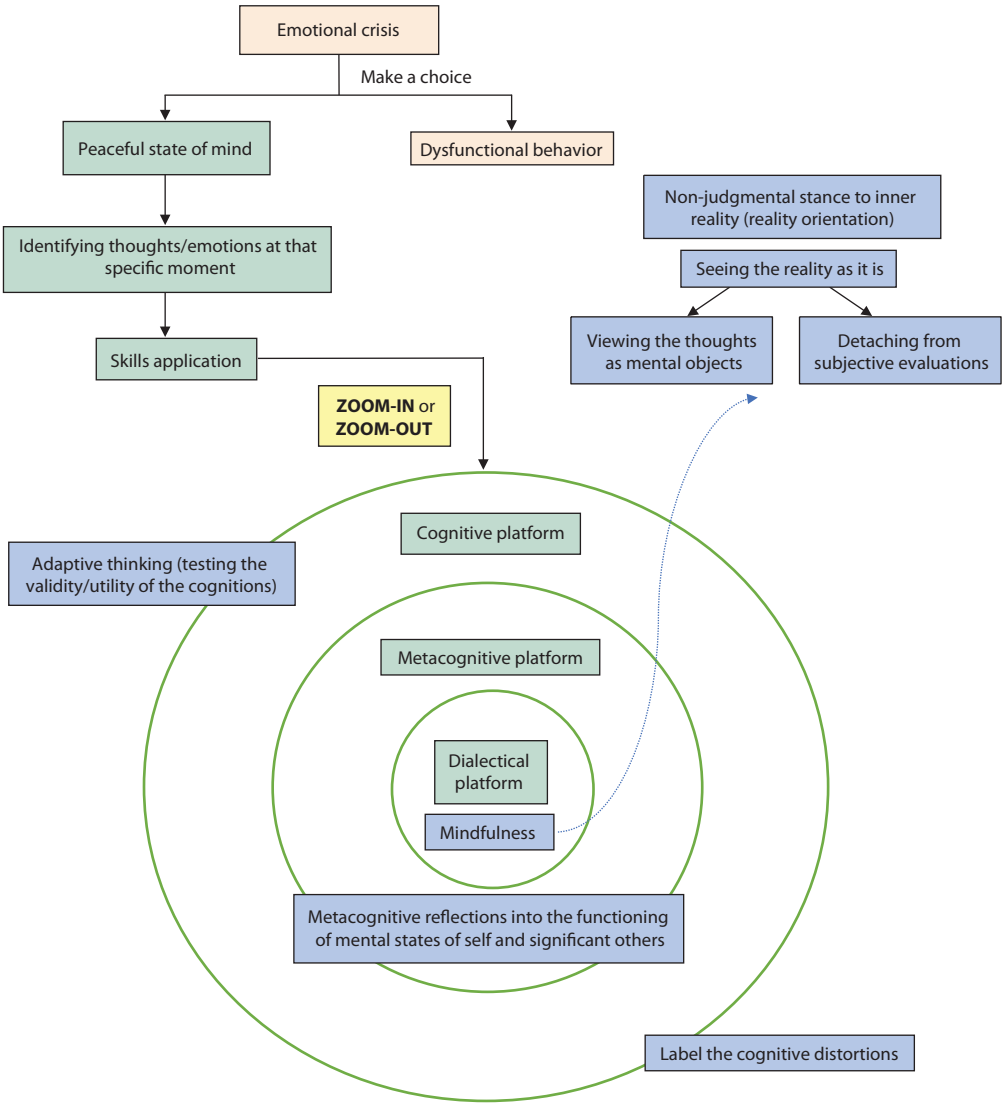
The patient, who was age 18 years and in her freshman year of college, was brought to the psychiatry department for consultation with complaints of anger outbursts with destructive impulsive behaviors and multiple self-harm attempts (slashing of wrists and consuming lethal substances to end her life) for the past 2 years. Her symptom profile indicated a diagnosis of BPD per *ICD-10* diagnostic criteria for research. Her score on the Zanarini Rating Scale for Borderline Personality Disorder (ZAN-BPD)[11] was 24 (the ZAN-BPD is the first clinician-administered scale for the assessment of change in borderline psychopathology). She was prescribed 32 once-a-week sessions of DBT spread across 8 months. The protocol framed by Linehan[12] was used for treatment with few adaptations.

For the first 10 sessions, the patient was trained in distress tolerance skills, emotion regulation skills, and interpersonal effectiveness skills. All these skills were primarily taught with a cognitive-behavioral backdrop using both didactic and Socratic methods. Major distortions addressed were polarized thinking, comparative statements, should statements, and self-invalidating core beliefs.

In the next 5 sessions, her metacognitive awareness was the focus for further intervention. Metacognitive mastery was improved through attentional training in metacognitive reflections into the functioning of her mind and her significant others' minds. After 15 sessions of cognitive and metacognitive therapeutics, mindfulness training was inducted into the DBT therapeutic regimen. This was achieved by training her in wise mind skill, "what" skills (observing, describing, participating), and "how" skills (nonjudgmentally, one mindfully, effectively). She experienced difficulty in understanding and implementing these DBT skills. Starting from the initial set of DBT skills (observing, describing), she reported extreme unfamiliarity with the specific strategy and complained of difficulty in application of the suggested technique to resolve her day-to-day emotional crisis. A possibility of early dropout was sensed through her parents' reports, and a therapeutic titration (Figure 1) to ease the process of learning the techniques was devised to encourage her to stay in the therapy. A technically less tedious cognitive and metacognitive platform for each session was introduced whenever the patient indicated hardship with mindfulness practice.

In the cognitive platform, the patient's symptomatology revealed key distorted assumptions in the area of dependence, suspiciousness, and self-invalidating core beliefs. At the

Figure 1. Psychotherapy Titration[a]



[a]The orange rectangles represent emotional crisis, the green rectangles and circles represent distress resolution, the yellow rectangle indicates the psychotherapy titration, and the violet rectangles provide the various strategies implemented within the therapeutic platforms.

automatic thought level, frequent dichotomous thinking masked the ability to evaluate things in gray shades, leading to abrupt and extreme behavioral outbursts. Adaptive cognitive evaluations of these dysfunctional thought patterns paved the way for an emergence of emotional tranquility.

In the metacognitive platform, the patient's dysfunctional processes revealed a key problem of having difficulty in differentiating between reality and fantasy. Metacognitive reflection into this aspect of the mind's functioning had helped the patient to re-perceive or decenter from the emotional crisis. Metacognitive subfunctions managed in the metacognitive platform included understanding her own mind, understanding others' minds, and mastery over the metacognitive state. Each of the subfunctions instituted in the metacognitive platform followed a path from basic comprehension to superordinate integration.

Flowchart depictions with added pictographic representations of the previously learned cognitive/metacognitive/dialectical tactics were used (Figure 1). In each session, the patient was advised to select a suitable method from the chart during times of difficulty while practicing mindfulness. The homework practice also used the same approach of moving to easily comprehensible and applicable second-generation cognitive steps. For all dialectical sessions, the same flexibility in using the different techniques was implemented. With the implementation of "psychotherapy titration," the patient became inquisitive with regard to learning the mindfulness techniques and was able to assimilate DBT strategies with ease. Her final score on the ZAN-BPD decreased to 4. During the follow-up period of 6 months, her mean ± SD ZAN-BPD score was 3 ± 1 (see Supplementary Appendix 1).

Discussion

From a theoretical standpoint, the areas of emphasis in CBT procedures give rise to the concept of "CBT coming in waves or generations," with mindfulness-based therapies and DBT being classified under third-generation therapies. The behavioral orientation of the first-generation CBT is expanded to include the information-processing approach of the second-generation CBT, which in turn is expanded to incorporate metaphysical considerations in the third-generation CBTs. The mindfulness-based therapies of the third-generation CBTs deal with a higher form of cognitive response compared to the first and second generations. The dialectical perspective of DBT as recommended by Linehan[12] advocates mindfulness training as the core component of the therapeutic process. It is natural that directly adopting mindfulness in DBT may prove to be difficult for an adolescent learner compared to the earlier variants of therapy (ie, cognitive and metacognitive approaches). The patient described in this report highlights that difficulty and the successful management of an imminent dropout by using a "psychotherapy titration" procedure, which suggests a balanced delivery of therapy by swapping among different therapeutic strata. It is designed to improve adherence to treatment by creating flexibility in the use of therapeutic approaches within every single psychotherapy session. As the spirit within mindfulness pedagogy places emphasis on process rather than outcome, a flip-flop protocol is chosen for mindfulness-based dialectical techniques that are tough to implement, and therapeutic shifts are intentionally made from dialectical to metacognitive to cognitive frameworks. In the cognitive and metacognitive therapeutic frameworks, the individual is primarily trained to identify the core cognitive and metacognitive processes and respond to them by using one of the strategies from the information-processing platform (ie, considering an alternative perspective, labeling the distortions, challenging the distortion by gathering evidence, testing the practicality of the distortions, pie charting to identify multifactorial causation, etc). In contrast, the mindfulness approaches demand a greater effort from the individual to manage his/her emotional difficulty with the "contextual framework" wherein the person is required to address the functionality of the cognitive disturbances by targeting his/her relational aspects. Generating adaptive responses to dysfunctional cognitions (cognitive) is relatively much easier than getting into an insightful metacognitive awareness (metacognitive), which in turn is more feasible than the mindful act of seeing thoughts just as thoughts (dialectical). The approach discussed here poses a hierarchical model to ease the therapeutic learning as the adolescent or young adult navigates through the tensions faced in implementing mindfulness, eventually leading to a better treatment outcome.

Published online: May 13, 2021.

Potential conflicts of interest: None.

Funding/support: None.

Patient consent: Consent was received from the patient and her guardians to publish this case report, and information has been de-identified to protect anonymity.

Supplementary material: Available at PSYCHIATRIST.COM.

REFERENCES

1. Kaess M, Brunner R, Chanen A. Borderline personality disorder in adolescence. *Pediatrics.* 2014;134(4):782–793.
2. Sharp C, Fonagy P. Practitioner review: borderline personality disorder in adolescence—recent conceptualization, intervention, and implications for clinical practice. *J Child Psychol Psychiatry.* 2015;56(12):1266–1288.
3. Chanen AM, Jackson HJ, McGorry PD, et al. Two-year stability of personality disorder in older adolescent outpatients. *J Pers Disord.* 2004;18(6):526–541.
4. Kaess M, von Ceumern-Lindenstjerna I-A, Parzer P, et al. Axis I and II comorbidity and psychosocial functioning in female adolescents with borderline personality disorder. *Psychopathology.* 2013;46(1):55–62.
5. Chanen AM, Jovev M, Jackson HJ. Adaptive functioning and psychiatric symptoms in adolescents with borderline personality disorder. *J Clin Psychiatry.* 2007;68(2):297–306.
6. Landsheer JA, Smit JH, van Oppen P, et al. Assignment refusal and its relation to outcome in a randomized controlled trial comparing cognitive therapy and fluvoxamine in treatment-resistant patients with obsessive compulsive disorder. *Psychiatry Res.* 2015;226(1):198–203.
7. Barnicot K, Katsakou C, Marougka S, et al. Treatment completion in psychotherapy for borderline personality disorder: a systematic review and meta-analysis. *Acta Psychiatr Scand.* 2011;123(5):327–338.
8. Verheul R, Van Den Bosch LM, Koeter MW, et al. Dialectical behaviour therapy for women with borderline personality disorder: 12-month, randomised clinical trial in The Netherlands. *Br J Psychiatry.* 2003;182(2):135–140.
9. Didonna F, Ed. *Clinical Handbook of Mindfulness.* New York, NY: Springer Science & Business Media; 2009.
10. Bolton B. Cognitive behaviour therapy for children and adolescents: some theoretical and developmental issues. In: Graham P, ed. *Cognitive Behaviour Therapy for Children and Families.* New York, NY: Cambridge University Press; 2005:9–25.
11. Zanarini MC, Vujanovic AA, Parachini EA, et al. Zanarini Rating Scale for Borderline Personality Disorder (ZAN-BPD): a continuous measure of *DSM-IV* borderline psychopathology. *J Pers Disord.* 2003;17(3):233–242.
12. Linehan MM. *Skills Training Manual for Treating Borderline Personality Disorder.* New York, NY: Guilford Press; 1993.

See supplementary material for this article at PSYCHIATRIST.COM.

THE PRIMARY CARE COMPANION
FOR CNS DISORDERS

Supplementary Material

Article Title: A Pragmatic Therapeutic Approach to Address the Attrition of Adolescents With Borderline Personality Disorder in Dialectical Behavior Therapy Programs

Author: Jaiganesh Selvapandiyan, MD

DOI Number: https://doi.org/10.4088/PCC.20l02596

List of Supplementary Material for the article

1. Supplementary Appendix 1

Disclaimer

This Supplementary Material has been provided by the author(s) as an enhancement to the published article. It has been approved by peer review; however, it has undergone neither editing nor formatting by in-house editorial staff. The material is presented in the manner supplied by the author.

Supplementary Appendix 1: Session-Wise Zanarini Score Rating