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INTEGRATIVE BORDERLINE ADOLESCENT FAMILY THERAPY: MEETING THE CHALLENGES OF TREATING ADOLESCENTS WITH BORDERLINE PERSONALITY DISORDER

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Abstract

With the growing acceptance of the borderline personality disorder diagnosis for adolescents has come a need for specialized treatments for this challenging population. Further, because of the prominence of the family system during early and later adolescence, family treatments are particularly needed. The purpose of this article is to present the integrative borderline adolescent family therapy (I-BAFT) model that emerged from a National Institute on Drug Abuse–funded (Stage 1) treatment development and enhancement effort. I-BAFT integrates (a) key interventions from the family treatment of adolescent drug abuse (D. A. Santisteban et al., 2003; J. Szapocznik & W. Kurtines, 1989), (b) skills training shown effective with adults with borderline personality disorder (M. Linehan, 1993a) and adapted for adolescents, and (c) individual treatment interventions that promote motivation for treatment and enhance the integration of the 3 treatment components.

The diagnosis of borderline personality disorder (BPD) has become more widely used with adolescents (Egan, 1988; Kernberg, 1990; Mc-Manus, Brickman, Alessi, & Grapentine, 1984), despite concerns that the instability of adolescent behavior patterns might preclude its use with this population (T. Shapiro, 1990). Increasingly, clinicians working with adolescents agree with Kernberg's (1990) observation that "children can show traits in individualized combinations which endure over time and situations and are expressed in maladaptive, inflexible ways" (p. 478). Currently, the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; American Psychiatric Association, 1994) diagnostic criteria are adjusted for adolescents by requiring a 1-year duration for key symptoms (e.g., unstable and intense personal relationships, impulsivity, suicidal behavior, and affective instability). The clinical and research work reported in this article is based on the identification of adolescents with co-occurring disorders, in this case adolescents who meet criteria for drug abuse and who demonstrate a stable pattern of borderline symptomatology, meeting criteria for BPD.

An unfortunate consequence of the reluctance to use the BPD diagnosis with adolescents is the shortage of specialized treatments for adolescents with BPD and, more broadly, for the treatment of co-occurring disorders. Particularly lacking has been a treatment model with a

strong family therapy component that can specifically address family interactions central to a child's and adolescent's life. Whether viewing the borderline constellation from the perspective of separation/individuation (Masterson, 1985), emotion regulation and invalidating communications (Linehan, 1993a), or deteriorated personality structures, social customs, and family networks (Millon, 1987), a family treatment that is designed to address both core family processes unique to the borderline syndrome and to the complex adolescent developmental stage is essential. Factors unique to this developmental stage include substantial physical changes, the further development of cognitive abilities and social skills, negotiation of increasing independence in the context of the family, and the pressure to perform competently in many life domains (e.g., making career decisions, developing sexuality in relationships).

Developing the Integrative Borderline Adolescent Family Therapy Model (I-BAFT)

The I-BAFT model described in this article was the result of a process of treatment development and enhancement (Stage 1 study) funded by a National Institute on Drug Abuse grant. Stage 1 studies are designed to encourage innovation and to specify the components of novel treatments in manualized form that can undergo varying levels of efficacy testing (Rounsaville, Carroll, & Onken, 2001). This Stage 1 study was designed to develop an enhanced family treatment for adolescents with BPD that integrated the best of structural family therapy (Minuchin & Fishman, 1981) and empirically tested family therapy with adolescents who abuse drugs and have behavior problems (Santisteban et al., 2003; Szapocznik & Kurtines, 1989) with empirically tested dialectical behavior therapy (DBT) strategies and interventions designed for adults with BPD (Linehan, 1993a). Although there is now a strong literature on the efficacy of family interventions with externalizing and drug-abusing youth (Chamberlain & Rosicky, 1995; Liddle & Dakof, 1995), these models are limited in their ability to address the unique characteristics of adolescents with BPD who abuse drugs. Linehan's (1993a) DBT model, although not designed to have an adolescent or family focus, has emerged as an exceptionally well-developed, individually oriented model that combines Eastern philosophy, acceptance, cognitive-behavioral interventions, and life skills training. The DBT model contributes much to the handling of complex and sometimes life-threatening challenges such as suicide risk and attempts, the establishment of boundaries in the treatment relationship, and the therapy process complications that the therapist may inadvertently create. The integration of DBT and established family intervention and concepts has led to an enhanced I-BAFT model for modifying recalcitrant adolescent behavior.

The treatment development process that led to the I-BAFT model included a number of coordinated and systematic stages. The first stage consisted of a clinical analysis of videotaped family therapy sessions with adolescents showing borderline features (taken from the University of Miami Center for Family Studies' extensive library of videotaped clinical trials cases covering 25 years of work). This analysis helped identify family issues that emerged in treatment and therapy strategies that seemed to succeed and fail with this specific population. The second stage included the adaptation for adolescents of DBT

strategies and skills-training interventions and their integration with a family therapy model of treatment. This work included direct consultation and guidance from Dr. Linehan and from a very experienced family therapy team. This stage also included the treatment of 5 cases involving adolescents with BPD during which new interventions were integrated and patient feedback utilized. The third stage consisted of a mini-randomized trial, including the treatment of a set of 10 cases with the refined I-BAFT model in intensive consultation with a full clinical team (an additional 3 cases were randomly assigned to the treatment-as-usual condition). This process of development led to the creation of an individual therapy component, to the modification of both the family and skills components, and to a sharper focus on the core family processes that were most proximal to the target symptoms.

The resulting I-BAFT model focuses on changing specific individual- and family-level factors that directly contribute to adolescent drug abuse and other self-harm behaviors. Consistent with the integration of the theoretical orientations of both SFT and DBT models, drug abuse and other self-harm behaviors are seen as resulting from adolescent emotion dysregulation and impulsivity; adolescent failure to establish life goals and to develop life skills; unstable family relations; and family interactions that maintain, rather than work against, the behavior problems. The purpose of this article is to (a) describe those individual and family factors hypothesized to be proximal to, and strategically important in the treatment of, adolescent borderline and drug abuse symptoms; (b) present the treatment strategies that have evolved into the I-BAFT model; and (c) present some preliminary feasibility/acceptability data.

I-BAFT Treatment Parameters

I-BAFT is an intensive outpatient treatment model that integrates weekly family therapy, individual therapy, and skills-building interventions. I-BAFT is designed as a three-session per week treatment implemented over a 6- to 8-month period. Separate therapists and skills trainers are recommended because it is extraordinarily difficult for one therapist to conduct skills training, which is highly structured, while postponing other urgent clinical issues typical of therapy sessions. The therapist conducts individual and family therapy sessions while the skills trainer focuses solely on the acquisition of new psychosocial skills. Although the therapist does not teach skills, she or he must promote the use of a new skill (e.g., expressing needs or other interpersonal effectiveness skills) in family therapy sessions as well as in other daily situations.

I-BAFT Treatment Goals

There are a number of individual- and family-level factors that are targeted by the I-BAFT model because they are hypothesized to be the foundation of key BPD symptoms like impulsivity, drug use, instability of relationships, and so on. I-BAFT seeks to promote/strengthen those factors that sustain healthy adolescent development and to modify those forces that can disrupt healthy adolescent development. At the individual level, I-BAFT seeks to promote/increase the following: (a) the adolescent's skills needed to regulate emotions and maintain adaptive relationships, (b) the adolescent's setting of life goals consistent with his or her developmental stage, and (c) the adolescent's motivation to

achieve goals (e.g., career and family) and actively participate in treatment. I-BAFT seeks to modify/decrease the following: (a) suicidal and parasuicidal behavior (i.e., nonfatal, intentional self-injurious behavior), (b) drug abuse, (c) other impulsive behaviors, and (d) severe emotion dysregulation. At the family level, I-BAFT seeks to promote/strengthen the following: (a) parental leadership/guidance/nurturance, (b) parent–adolescent attachment, and (c) validating communications. I-BAFT seeks to modify/decrease the following: (a) ongoing verbal, physical, and/or sexual violence in the family; (b) family interactions that reward/reinforce emotion dysregulation (i.e., coercive processes) and, often, parasuicide behavior; and (c) parent–adolescent disengagement due to a history of poor parental protection, neglect, or abusive behavior.

When speaking of maladaptive family patterns, it is important to note that some patterns may have preceded the BPD behaviors and helped them to blossom whereas others may have formed after the emergence of the BPD behavior in a type of maladaptive adaptation that unwittingly maintains the BPD behaviors over time. From a treatment perspective, it is inefficient to attempt to modify recalcitrant borderline and drug abuse symptoms in adolescents without simultaneously modifying the powerful systemic factors, and vice versa. For example, failing to change parental communications that invalidate the adolescent's point of view will hinder any progress in the adolescent's emerging ability to effectively express needs. Likewise, verbal and/or physical violence in the family can trigger the adolescent's emotion dysregulation problems, and vice versa.

The innovation of I-BAFT is that it targets the core symptoms of BPD and drug use with specific manualized interventions using a multifaceted approach specifically designed for adolescents. For example, emotional dysregulation is modified by skills training (emotion regulation, distress tolerance, and crisis management), by family therapy that targets family relationship patterns that exacerbate emotion dysregulation (invalidation, intense negativity, and coercive processes that reinforce emotional explosions), and when necessary, by medication (e.g., mood stabilizers, antidepressants). Separation/abandonment vulnerability is addressed by family therapy interventions (e.g., solidifying the family member attachments, and facilitating healthy and adaptive individuation), by individual therapy (e.g., goal setting), and via skills training (e.g., effectively expressing needs). The multiple interventions used to modify specific BPD core problems can be found in the Appendix.

Before describing the individual, family, and skills goals in greater detail, we note that there are certain I-BAFT interventions and strategies that cut across all treatment components. One such intervention is the creation of a reward/reinforcement system that rewards the adolescent for key therapy-enhancing behaviors. Behaviors that are reinforced include arriving to sessions on time, actively participating in sessions, completing homework, and having a clean urine analysis. Adolescents are given raffle tickets for these accomplishments and a raffle is held every 2–3 weeks.

A second strategy is the identification and modification of therapy-interfering behaviors at the individual, family, and therapy-system levels. This focus (described more fully in the following sections) ensures that a set of therapy-interfering behaviors do not continue throughout the therapy process. Although adolescent and family interfering behaviors are

most commonly discussed, there can also be therapist interfering behaviors that must be addressed. The therapist's therapy-interfering behaviors that can emerge with challenging patients can include therapist hopelessness that leads to a low level of follow-up of missed appointments, therapist frustration that leads to rigid rule setting, therapist avoidance of intense family issues, and clinic or office policies that make it difficult for therapy to progress smoothly. Because it is difficult for the therapist to identify these issues, it is always recommended that the therapist have a consulting team/peers to point out therapy-interfering behaviors by the therapist.

A third strategy is to have a well-thought-out response to suicide-related behavior. BPD individuals often experience suicidal urges and self-harm urges (e.g., self-mutilation, ingestion of very high amounts of drugs that put them at physical risk). These behaviors cannot be taken lightly even if they are frequent or have a manipulative tone because the emotion dysregulation and impulsivity, especially in the presence of drug abuse, greatly increase risk. The therapist's position on involuntary commitment and the probable response to threats of imminent suicide should be clearly worked out and communicated to the patient at the beginning of therapy. The decision on hospitalization may be complex because the goal of keeping the patient out of danger in the short term may lead the clinician to intervene in a more active fashion. Conversely, a highly active intervention may reinforce the suicidal behavior and inadvertently increase the likelihood of future suicide behavior. The main point, however, is that this complexity must be worked through and a strategy agreed upon prior to the crisis (for an in-depth analysis of the decision-making process see Linehan, 1993a).

A fourth important therapeutic strategy is to continue therapy even when the adolescent is detained in a hospital or short-term residential setting. It is therapeutic to present crises as part of the treatment and recovery process and to frame a move to a more restrictive environment as a planned, thoughtful therapeutic strategy rather than as an act of desperation and failure. Crises should be framed as opportunities for change and can bring about a reevaluation of habitual behaviors. It is also important to form a collaborative working relationship with the new facility's staff to permit continued therapy in the facility. Simultaneously, work with the family members can focus on many critical issues such as the adolescent's transition back home, the promotion of sustained parental engagement with the adolescent, and increased structure in the home. Likewise, it is important to have well-thought-out strategies for working in other important domains of the youth's ecology. Many of our interventions took place with the juvenile justice system in which the youths were involved and with school personnel who made decisions on changes in school and who could recommend smaller and more structured classes. Therapists intervene directly in these systems to make their impact therapeutic but, even more important, also to help the parents understand these systems and develop the skills needed to advocate directly on their youngsters' behalf.

Components of the I-BAFT Model

Many of I-BAFT's treatment strategies are presented in a phasic manner. That is, there are certain treatment goals (e.g., engaging, goal setting, and reframing) that are expected to

occur most frequently early in treatment (Sessions 1–4), although they may emerge as needed throughout the course of therapy. Other goals and their associated interventions will occur more frequently in the midstage of treatment in which the bulk of change occurs. In the final stage, which constitutes the last month of therapy, termination and maintaining treatment gains are the main foci.

Individual Therapy Component

Individual therapy sessions are conducted by the primary therapist and have five major goals, as outlined below.

Goal 1: Ensure a strong engagement between the adolescent and the primary therapist—The demands of a comprehensive I-BAFT program (e.g., 3 hr of treatment weekly, including family sessions) require a strong therapeutic alliance between the adolescent and the therapist. The multiple alliances with family members can cause the adolescent to take longer to trust the therapist than if the treatment was solely individual therapy. In family therapy sessions, the therapist may sometimes appear to side with a parent or other family member. For these reasons, the early stages of treatment must include a very strong engagement of the adolescent fully into the therapy endeavor. This includes getting to know the adolescent and her or his world in a way that does not focus exclusively on symptoms or dysfunction but includes areas of his or her life that are healthy. It also includes better understanding the adolescent's agenda for treatment and finding a way to get the healthy parts of that agenda met.

Goal 2: Help the adolescent establish personal goals in key domains (self, family, peers, school/career, and community)—A normative struggle for the adolescent stage of development is the establishment of life goals. I-BAFT focuses on working with the adolescent to set personal goals and to clarify her or his vision of the future that is separate from the goals of parents. The adolescent's goals must be referred to often when difficult family issues and/or other life events trigger self-destructive behaviors in the adolescent, loss of hope, and disengagement from treatment. Goal-setting strategies help promote those forces within the adolescent that desire healthy change so that the driving force is within the adolescent rather than solely external (e.g., parents, therapist, courts). The adolescent develops his or her own reasons for change and for determining why the effort is worthwhile. Strategies used to increase motivation follow the philosophy described as "motivational interviewing" by Miller and Rollnick (1991). It is also important to remember to avoid challenging the existing family power structure prematurely. If the adolescent is firmly in power, the therapist cannot challenge that power prematurely or the adolescent will end therapy (Santisteban & Szapocznik, 1994; Santisteban et al., 1996; Szapocznik et al., 1988). A successful initial strategy is to help the adolescent use that power to achieve healthier goals.

Goal 3: Monitor self-destructive behaviors that may not be as easily monitored in family sessions—Behaviors such as recent drug use, other criminal behavior, and urges to self-harm must be carefully monitored during individual sessions. These behaviors are not only downplayed or concealed by the adolescent in conjoint

sessions but they may also inadvertently take a back seat to intense family interactions. Diary cards developed by Linehan (1993a) and modified slightly for our work can be very helpful in individual sessions and can assist in the reporting of such things as urges to use drugs, urges to self-harm, and their triggers (e.g., anger, emotional pain, emptiness, family conflict). These reports help the therapist to better understand the sequences of how urges and self-destructive acts occur as well as what adaptive factors (e.g., support from significant others, use of specific skills) might block the sequence between urges and behavior. One of the most complex decisions for clinicians is the extent to which certain potentially self-destructive behaviors such as drug use are kept confidential versus being fully and immediately discussed in family sessions.

The level of confidentiality that is guaranteed to the adolescent is limited by the fact that it is destructive to keep health-threatening information about a minor from parents. There will always be a balancing act between ensuring some level of confidentiality, which will lead to greater honesty and openness regarding serious urges to use drugs or to self-harm, and the need to help parents protect the adolescent. Beyond the usual legal limits (danger to self or other, child or elderly abuse), in this population the therapist must discuss confidentiality regarding issues such as escalating drug use, extremely risky sexual behavior, and criminal behavior that brings high risk of loss of life. It is often helpful to inform both parties that confidentiality will be kept until there are signs of serious and sustained deterioration in the youth's drug use, criminal behavior, or psychiatric symptoms. Given that a major goal of this program is to strengthen the ability of the family system to protect, nurture, and guide the adolescent, keeping parents in the dark about critically important deterioration in the adolescent's status would directly undermine treatment.

Goal 4: Ensure the generalizability of the skills being acquired in skills training into the adolescent's daily life—

The I-BAFT skills program (adopted from the work of Linehan, 1993b) covers five modules—core mindfulness, interpersonal skills, emotion regulation, distress tolerance, and HIV risk reduction—designed to address the life situations adolescents with BPD confront. Individual therapy sessions are used to help the adolescent identify situations in which skills can be used, to identify which specific skills can be used, and to identify any obstacles to their use. Role play can be used to practice skills. To ensure the generalizability of skills, the therapist must know the skills program and keep up-to-date on the specific skills her or his client is working on with the skills trainer each week. It should be noted that the skills trainer can help the adolescent use skills effectively with the primary therapist and that the therapist can coach the adolescent on how to incorporate the skills in family therapy sessions and situations outside the family. One of the major topics of consultation between therapist and skills trainer is the identification of the family interactions patterns that tend to create barriers to the effective use of adolescent skills in the family (see the example in the next section).

Goal 5: Prepare the adolescent for difficult family enactments that must take place in family therapy—

Families have habitual and deeply entrenched patterns of interactions that are recalcitrant to change. When a family member (i.e., the adolescent) deviates from the script, the family system has very powerful forces that are engaged to pull

the members back into their accustomed roles. For example, in some families the pattern is to criticize and invalidate a youngster until she or he explodes. When the adolescent explodes verbally or physically, or injures herself or himself, the aversive interaction ends. Adolescent attempts to use newly acquired skills during this sequence may elicit more of the pattern of criticism/invalidation because the habitual and expected endpoint (i.e., the explosion) has not occurred. Part of the work of individual sessions is to prepare the adolescent for this likely scenario so that she or he does not give up prematurely. By disrupting the adolescent contribution to this interaction, the therapist can isolate and change the family system contribution to this destructive pattern. All of these therapy processes serve two main purposes. One purpose is to inoculate the adolescent against the habitual family interactions that can trigger emotion dysregulation. The second purpose is to strategically plan how to use skills to facilitate change in the habitual family pattern.

Family Therapy Component

A novel and core part of our work with adolescents with BPD is the articulation of specific family interaction patterns that can nurture healthy adolescent development and, conversely, those that can elicit or maintain borderline behaviors and drug use. This work does not assume that maladaptive family patterns “created” the adolescent’s borderline behavior. There are many factors related to temperament and extra-familial factors that can contribute to the emergence of borderline symptoms and the underlying emotion dysregulation as described by Linehan (1993a). The basis of the I-BAFT model is that maladaptive family interactions, some of which are the result of the adolescent borderline behavior and others which have always existed in the family, begin to interact with the adolescent’s vulnerability to emotion dysregulation in such a way that the family becomes the fertile ground in which the borderline behaviors, including drug abuse, blossom fully.

In the remainder of this section, six targets of intervention for the family of adolescents with BPD are presented. As was the case in the individual therapy component, certain family interventions must be more prominent in the early stages as compared with later stages.

Target 1: Develop the family members’ understanding of the adolescent’s vulnerability to emotion and behavior dysregulation—One of the important goals of I-BAFT family interventions is to create a new “frame,” or way of understanding/perceiving the adolescent. Because of the often dramatic, challenging, and self-destructive behavior displayed by adolescents with BPD, it is often difficult for the family to see the emotional distress experienced by the adolescent and to understand the adolescent’s vulnerability to emotion dysregulation. This increased understanding of the adolescent’s struggle can help family members stay more consistently connected to the adolescent during difficult times.

Target 2: Make the presenting problem interactional/systemic in nature—Because family therapy is very focused on modifying the way family members interact and includes powerful in-session enactments, it is helpful for family members to accept a systemic view of family behaviors and an individual’s symptoms. Family members are helped to identify and to understand how certain family behavior can elicit or exacerbate the

problematic behavior. One example is when other family members appear to get along better when adolescents are acting out. This occurs when the parents'/spouses' conflicts are detoured by a focus on an acting-out adolescent. Another example occurs when certain maladaptive behaviors, such as suicidal gestures/attempts are reinforced by the intense attention provided by previously disengaged family members. Given the adolescent's desire for proximity and intimacy, these powerful relational reinforcers for such behaviors as suicidality, intensification of drug use, delinquency, and so on, are very powerful and maladaptive.

Another type of reinforcement that can become very problematic is akin to the coercive process described by Patterson, Reid, and Dishion (1992). In many families with chronic negativity, negative interactions often continue without limit. Angry/violent outbursts such as the breaking of objects, most often by the adolescent with BPD, can serve the function of terminating a conflictual and hurtful interaction. At a critical point in the aversive sequence, the violent behavior is reinforced through its ability to end the chronic negativity and leave the adolescent in a position of power. I-BAFT modifies this sequence of interaction so that more adaptive interpersonal skills can be used, rather than outbursts, to resolve conflicts.

Target 3: Improve communication between the adolescent and family

members—Adolescents with BPD and their families have often become entrenched in maladaptive and invalidating communication patterns. An I-BAFT goal is to identify parent or adolescent behaviors that disrupt the process of good communication (e.g., shutting down, detouring communication, and reacting explosively) and to modify these interactions in vivo. One of the most destructive communication patterns in the families of adolescents with BPD involves the inability to empathize with and validate the adolescent's emotions, goals, and beliefs. *Invalidation* refers to a longstanding pattern of not acknowledging, or of directly contradicting, the experience of another individual. Invalidating communications can often result from long histories of parent–adolescent confrontations, adolescent behaviors that are dramatic and ineffective, or parents who may be overwhelmed with other life circumstances or their own emotion dysregulation. In I-BAFT, family members are helped to replace invalidating responses with responses that validate emotions and ideas even if they do not necessarily agree with them. They are taught that the “right or wrong” of the emotion or idea is unimportant when compared with the effect of acknowledging the thoughts and feelings behind them.

Family interventions also seek to promote the adolescent's adaptive expression of physical and emotional needs and the family's adaptive responses to these needs. One of the important interpersonal skills taught to the adolescent is to monitor her or his own relationship needs and to not wait until she or he is absolutely frustrated before expressing the unfulfilled needs and requesting a change in the interaction (Linehan, 1993b). When applicable, this same pattern of unexpressed needs that lead to explosive frustration should be identified and modified in other family members.

Target 4: Help develop the strong parenting skills needed to deal effectively with an adolescent with BPD—Our work is consistent with E. R. Shapiro's (1992) observation that the person with BPD's underdeveloped inner psychological structure makes

him or her very vulnerable to a family's lack of structure. This is particularly true around issues such as lack of parental availability, poor rule enforcement, and the types of parental neglect highlighted by Gunderson, Kerr, and Englund (1980). For this reason, I-BAFT has a strong focus on parenting and on creating stable, predictable family interactions.

Consistent and predictable parental leadership and guidance: Adolescents with BPD often complain that parents are disengaged when behavior problems are not prominent, and drug abuse has been linked to inconsistent parenting practices and monitoring. Parents of adolescents with BPD must recognize and monitor any tendencies toward disengaged or inconsistent parenting. Parental withdrawal can trigger extreme behaviors in adolescents that are labile and vulnerable to these changes. The disengaged period, often resulting from a sense of hopelessness and frustration or from parental overburden, leaves the adolescent feeling abandoned and alone. Adolescents can also feel that love and affection are being withheld because of their behavior. The I-BAFT goal of creating a more predictable family structure is necessary for stabilizing very sensitive and vulnerable adolescents. I-BAFT reinforces parent actions and communication that display leadership and modifies communication that denotes abdication of leadership or responsibility. It is not easy for parents to change, particularly if they themselves have poor distress or frustration tolerance or are overwhelmed by difficult life circumstances. In these cases, an important step is to attend to the parent's own pain and needs through direct interventions or referrals. Within I-BAFT, the therapist may strategically attend to relationship ruptures/disconnections between parents and their support network (e.g., extended family) that may be leading to lack of support and overburden.

One important area around which the I-BAFT therapist can help the parent establish leadership is the adolescent's career and school goals. Although the therapist works directly with the school systems to stabilize this important domain of adolescent functioning, it is also important to promote parent leadership and guidance in this area so that parents can be advocates for their daughter or son's interests. It should be noted that even if parents have very little direct knowledge of the issues to consider in terms of career, they can help their adolescent find good resources and they can find more ways to stay involved in the process of building a future based on adolescent strengths and competencies.

Developing effective parental behavior control strategies: A natural consequence of inconsistent parental engagement is that the monitoring of unwanted behavior and the implementation of appropriate consequences do not occur consistently. In addition, parents may not have a good sense of what types of behavior-control activities may be age appropriate and which may not be. Family interventions can specifically address topics of behavior control by tailoring strategies that are appropriate for the specific behaviors and age level of their adolescent. Parents are encouraged to consult with the therapist over the phone when an important incident occurs and an important consequence must follow. This collaboration is designed to help shape the way a parent evaluates an incident of poor behavior, to help him or her stay engaged in the difficult moment, and to select an appropriate and effective consequence. For adolescents who abuse drugs and for adolescents with severe behavior problems, consequences can typically include outside systems like the

police, the juvenile justice system, and mental health services (e.g., psychiatric crisis unit). The therapist and parents work as a team in dealing with these outside systems as part of a well-planned strategy.

Providing a safe environment in which the child/adolescent feels protected: Many parents of children or adolescents with BPD have been unable to provide their youngsters with a structured, safe, and supervised family environment. When parents become overwhelmed and disengaged, they often grant adolescents an unhealthy level of freedom and autonomy. It is often the case that the dramatic and self-destructive behaviors of adolescents can be understood as ways of eliciting controlling and monitoring behavior from parents. It is also important to keep in mind that younger siblings of the adolescent with BPD are at high risk for similar behavior patterns because of the family's lack of protective functions.

Target 5: Increase the size of the supportive network around the adolescent—

Because adolescents with BPD can be very demanding and challenging, parents may sometimes lack the emotional resources needed to meet the adolescent's needs by themselves. One treatment strategy is to enhance outside support by promoting interactions with other empathic adult figures in the adolescent's life. The I-BAFT therapist searches for individuals in the adolescent's natural network (e.g., older siblings, extended family members, non-blood-related kin) who show potential for entering into mentoring relationships with the adolescent. In treating people with BPD, therapists too often focus solely on addressing maladaptive relationships that are limited in their potential for change. This limited focus fails to see possible relationships that can have a powerful, positive, and stabilizing impact on the adolescent. Family systems therapists are uniquely qualified to directly assess the network of support potentially available for the adolescent, understand how adolescent behaviors have caused these figures to disengage, and repair/reestablish disrupted relationships. The therapist must be prepared to modify adolescent behaviors that would undermine the building of this supportive bond and replace them with the relationship-maintaining skills they have acquired, while encouraging the potential mentor to remain involved while the adolescent struggles with a new way of relating.

Target 6: Reduce negativity in family interactions—The families of adolescents with BPD may vary widely in the profile of negativity they display. Some families may show a high frequency of negativity (chronic negative communications) whereas others are characterized by the high intensity of infrequent negative interactions. In moments of heated conflict, setting limits on violations of physical boundaries is extremely important in the families of adolescents with BPD because it is not uncommon to have grabbing and holding that escalate into physical aggression. This critical transition point in the sequence toward violence is one that must be modified by I-BAFT. This perspective may help family members to monitor their behavior more closely rather than act on intensely negative emotions. Further, because many adolescents with BPD have histories of sexual or physical abuse, any such aggression can cause them to relive the earlier trauma, creating great emotional upheaval.

Individuals with BPD often report a history that includes physical or sexual abuse that has contributed to serious communication and relationship disruptions. Adolescents with abuse in their past often feel that the abuse and all of the pain and anger associated with it were never acknowledged or processed by the family. After the obvious and immediate issues of safety are addressed, these incidents must be carefully processed and used as the content around which powerful validation must occur. Parents are shown how their inability to process and validate the adolescent's feelings can be very powerful because it elicits a reexperiencing of the traumatic event and the associated lack of protection. In addition, healthier family interactions ensure that the lack of protection that previously existed will not resurface.

Skills Acquisition Component

Linehan's (1993b) DBT skills training program covers modules aimed at teaching regulation in four areas: core mindfulness, interpersonal effectiveness, emotional regulation, and distress tolerance skills. Because of the high-risk sexual behavior of adolescents with BPD, we added a fifth module, HIV risk reduction, to the skills components area of I-BAFT. One of the critical questions in any type of skills training is the degree to which learned skills will be implemented in real-life stressful circumstances. I-BAFT establishes guidelines for the therapist and the skills trainer to work together to encourage the adolescent's use of skills in everyday situations. The skills trainer and the therapist must discuss the content area for that week's skills session as well as the adolescent's responses and statements about how they used or did not use skills in particular situations. In turn, the therapist uses the content area to encourage the adolescent to implement these skills in their family interactions, peer interactions, school activities, and so on. In the initial stage of I-BAFT skills training, each of the modules is introduced in a 3- to 4-hr session. For the duration of treatment, the adolescent meets with the skills trainer weekly for 45 min, and each of the modules is implemented more slowly and carefully, ensuring that generalization of the skills to the adolescent's daily life is emphasized.

Goal of the core mindfulness module: Teach adolescents to spend more time in wise mind—Core mindfulness is central to Linehan's (1993b) DBT model and describes three states of mind: (a) reasonable mind, (b) emotion mind, and (c) wise mind. *Reasonable mind* involves rational, logical thinking and behavior. *Emotion mind* is active when thought and behavior are controlled by the current emotional state and therefore logical, rational thinking is difficult. The goal of core mindfulness skills training is the synthesis of emotion mind and reasonable mind to create what Linehan (1993b) describes as "wise mind." *Wise mind* is an integration of logical thinking and emotional experience. The failure of people with BPD to use wise mind is demonstrated by impairment in their capacity to step back and observe their own actions. As a result, their behavior is often impulsive and mood dependent. Core mindfulness involves paying full attention to events as they occur, becoming aware of one's own thoughts and feelings, and not judging oneself for imperfect reactions.

Goal of the interpersonal effectiveness module: Teach interpersonal effectiveness skills to help the adolescent establish interpersonal goals and

effectively achieve them—Unstable relationships are a core feature of BPD and so the development of more adaptive interpersonal skills is an important goal for skills training. It should be noted that interpersonal problems are also related to deficits in other skill areas such as emotional regulation and distress tolerance. Consequently, Linehan (1993b) indicated that interpersonal effectiveness relies on the simultaneous improvement of other skill areas. In addition, success with this module requires integrating cognitive information with in-session practice of new behaviors.

Adolescents with BPD have a tendency to either confront people very forcefully or to avoid conflict altogether. Their inability to effectively manage conflict stems from skills deficits as well as their becoming overwhelmed by negative appraisal of the situation or negative emotions (Linehan, 1993b). Interpersonal effectiveness skills training challenges people with BPD's negative appraisal of themselves, their relationships, and their environment. In addition, this module teaches specific assertiveness and problem-solving skills. The aim is for people with BPD to develop effective means of obtaining what they need from interpersonal relationships without destroying these relationships or losing their self-respect. Specifically, this module teaches them how to get what they desire from others and how to effectively resolve interpersonal conflict.

Goal of the emotion regulation module: Teach adolescents to more effectively handle emotions and to reduce their disruptive potential—Individuals with BPD often experience intense and aversive emotional arousal. They are easily overwhelmed by these negative emotions that impair their capacity to develop adaptive coping behaviors. Substance use or parasuicidal behavior by adolescents can be maladaptive attempts to regulate overwhelming negative emotions (Linehan, 1993a). In addition, because many adolescents with BPD live within family environments that do not validate the expression of basic emotions, they often learn not to trust their own emotional experience and may attempt to regulate their emotions by instructing themselves not to feel (Linehan, 1993b). In summary, the emotional intensity and lability, together with maladaptive attempts at control, necessitate the implementation of emotional regulation skills. The emotion regulation module focuses on teaching the adolescent how to identify and label emotions and what the functions of emotion are. Other skills that are taught help adolescents learn how to reduce negative emotion states and to increase positive events in their lives.

Goal of the distress tolerance module: Teach distress tolerance so that adolescents better handle distressing circumstances and reduce their maladaptive reactions—DBT proposes to shift the person with BPD's focus on avoiding painful circumstances to accepting, tolerating, and finding meaning for their distress (Linehan, 1993b). Distress tolerance skills training addresses tolerating pain in life and surviving crises. Distress tolerance skills training also teaches four crisis survival strategies: distracting, self-soothing, improving the moment, and thinking of pros and cons (Linehan, 1993b). A primary goal of distress tolerance training is for the adolescent with BPD to accept that life sometimes brings pain or distress. Failure to accept that life is painful actually leads to increasing pain and distress. Distress tolerance skills training draws directly from mindfulness skills. Mindfulness allows people with BPD to accept in a nonjudgmental

manner both themselves and the current situation they experience, however painful. The person with BPD makes a choice to accept reality as it is. However, this approach should not be confused with approval of destructive elements in the person with BPD's environment that can be changed. Distress tolerance also involves the ability to experience one's own emotional state without attempting to change it. Here again, this strategy draws on the mindfulness skill of observing one's own thoughts and behavior without prematurely attempting to modify them.

Goal of the HIV risk reduction module: Provide adolescents with the knowledge and skills needed to stay healthy via safe sex or abstinence—The goal of teaching HIV risk reduction skills to adolescents is to educate them about HIV infection and to teach them the interpersonal skills needed to prevent them from engaging in risky sexual behaviors. Ultimately, the goal of the training is that the adolescents change their behaviors (e.g., avoid placing themselves in risky sexual situations). One goal of the program is to educate the adolescent about HIV and AIDS and about how he or she can and cannot contract it. Another goal is to encourage adolescents to better understand the level of risk associated with various sexual behaviors and to make decisions about the level of risk they are willing to accept. It is essential that adolescents recognize that their sexual behaviors are within their own control. HIV risk reduction skills training also explores the relationships between alcohol, drugs, risky sexual behavior, and HIV. In addition to teaching adolescents, the program also provides an educational component for parents so they can be sufficiently informed and capable of discussing safer sex practices with their adolescents.

Termination and Maintenance of Therapeutic Gains—Interventions in the Last Stage of I-BAFT

When we began to implement I-BAFT, we conceptualized termination as preparing the adolescent to transition out of our intensive treatment, to use their newly acquired skills, to rely on their parents and siblings for support as a result of supportive interactions developed in family therapy, and to develop or continue supportive relationships with other adults outside of the family system. Together, all these objectives could be conceived as consolidation of gains achieved in all areas of I-BAFT (i.e., skills training, individual therapy, and family therapy). What occurred within I-BAFT was a complex termination process, often resisted by our participants and the treatment team. In this section, we present our experience of the complexity of the process.

With respect to transitioning out of the therapeutic relationships provided in I-BAFT, we anticipated encountering the same difficulties reported in the clinical literature on adults with BPD, such as feelings of abandonment by the I-BAFT team or regression after discussing termination. What we discovered was, first, how long the discussion of termination needed to occur before actual termination. Parents expressed concern that problematic behaviors would return when treatment ended. The adolescents themselves expressed gratitude, fondness, and also sadness at leaving the I-BAFT team. Within that experience, we recognized how attached they had become, most strongly to their primary

therapist, but also to their skills trainer and even to the research assistant who had interviewed them several times throughout the intervention.

We did not experience actions suggesting fear of abandonment such as suicidal gestures; however, there was some regression, loss of therapeutic momentum, and attempts to extend treatment. One participant would miss sessions until she was close to breaking the missed sessions rule such that the consequence of being terminated from the program became imminent. At that point, she came in for one or two sessions and the pattern would repeat itself. Her termination phase of I-BAFT extended over many months. Toward the end, she admitted that she missed sessions in the hope of prolonging her time in the program. That is the most dramatic example; however, for almost all our cases, there was some attempt to extend treatment.

As we have indicated elsewhere, we considered the borderline traits of the I-BAFT adolescents as less entrenched than those found among adults with BPD and therefore more amenable to modification. In retrospect, the structural family therapy concept of joining together with DBT's emphasis on the balance of acceptance and change helped us to understand how powerful their attachment to the treatment team had become. Our stance was consistently in support of them addressing their maladaptive behavior without judgment and joining with their families to work at creating an environment that would support these adolescents beyond the I-BAFT program.

Termination was addressed across all components of the I-BAFT program. In family therapy, parent expectations for relapse both in drug use and conduct problems were systematically addressed by highlighting new adaptive family strengths that can help address the relapse as well as strategies for seeking additional professional and natural social support resources as needed. Referrals were made when appropriate; most often these were for continued pharmacotherapy for the adolescent and mental health treatment for the parent, usually for a mood disorder. In individual therapy, a review of the steps already taken in I-BAFT toward accomplishing key goals (e.g., in the areas of school, career, and significant relationships) was conducted, as well as an assessment of steps needed to be taken in the future beyond I-BAFT. Particularly during individual therapy, the importance of the therapeutic relationship was a consistent theme, including the meaning of the loss of the therapeutic relationship for both the adolescent and therapist as well as specific discussions concerning the extent of the therapist's availability for communication outside of the intervention period. In skills training, termination was handled in a structured format, consistent with the didactic quality of this modality. All the modules were reviewed, paying special attention to those in which the adolescent had the most difficulty in generalization. Particular attention was given to the managing crises section of the distress tolerance module, consolidating plans already made for the adolescent to manage the inevitable crises of life. Maintaining practice of skills learned and applying them in everyday life were also major foci.

I-BAFT Preliminary Project Indicators of Feasibility/Acceptability

In the early stages of treatment development, one of the first and most basic indicators of promising treatment models is feasibility/acceptability. Among other things, programs should demonstrate patient acceptance of new treatments (e.g., retention) and the feasibility of treatment delivery with the proposed types of therapists, patients and treatment settings (Rounsaville et al., 2001). These are particularly important indicators for a population of people with BPD, who have the reputation of being difficult to engage, retain, and treat and for a treatment that is designed to be fairly intensive (i.e., 2–3 sessions per week).

The small sample in our pilot study consisted of 13 youngsters (10 assigned to I-BAFT and 3 to treatment as usual). Participants reported a mean of 14.8 years of age; 77% were female; and 15% were African American, 23% were White American, and 62% were Hispanic. In terms of drug use, 13 reported marijuana use (mean age of onset = 12.8 years old), 10 reported cocaine use (mean age of onset = 14.0 years old), 11 reported alcohol use (mean age of onset = 12.4 years old), and 9 reported acid use (mean age of onset = 13.6 years old). Although we have not yet analyzed the treatment outcome indicators, our feasibility/acceptability indicators are quite promising. Our first indicator is rate of engagement and retention of those assigned to the I-BAFT condition. Of 10 cases assigned to I-BAFT, 7 (70%) were considered successfully engaged and retained in treatment. Those 7 cases received a minimum of 23.0 and a maximum of 63.0 sessions ($M = 43.0$ sessions). The 3 cases (30%) that were not successfully engaged and dropped out of treatment prematurely received an average of only 2.3 sessions. Despite the challenges of this population and the intensity of the treatment, this rate of retention compares favorably with rates reported in the treatment research field (Kazdin, 1990) and our own previous retention rates (using briefer treatment models with a larger sample of adolescents without BPD) that ranged from 60%–65%, depending on treatment conditions (Santisteban et al., 2003).

A second measure of acceptability consisted of adolescent and parent self-reports of working alliance with the therapist. Working alliance was measured by using the total score on the Working Alliance Inventory (WAI; Horvath & Greenberg, 1986), which was collected at several points during the treatment. Each adolescent and parent received a mean item score, and a mean for all I-BAFT cases was calculated. Scores on the WAI range from 1 to 7 with higher scores reflecting better working alliance. Adolescents' mean score was 5.69 ($SD = 0.76$), whereas parents' overall mean score was 6.10 ($SD = 0.73$). This high level of alliance is an excellent indicator of agreement on the goals and tasks of therapy and of the general bond between therapist and client.

The third indicator of feasibility/acceptability is self-reported satisfaction with the different I-BAFT components (i.e., individual, family, and skills training) as reported by the adolescents and parents who participated in the program. Satisfaction was measured at two time points (midtreatment and posttreatment) for all participating parents and adolescents. Parents could report only on their satisfaction with family therapy because they did not participate in individual or skills sessions. Adolescents were asked to report on their satisfaction with all three components. The items assessing overall satisfaction with the different components were rated on a Likert scale with endpoints 1 (*very harmful*), 3

(*neutral*), and 5 (*very helpful*). Parents' average score for satisfaction with family therapy sessions was 4.75. Adolescents' average scores for satisfaction were as follows: 4.36 for individual therapy, 4.00 for family therapy, and 4.29 for skills training. These scores reflect a positive assessment of each of the components of treatment, even by adolescents who were not self-referred and were originally not interested in treatment.

Conclusions

The purpose of this article is to present an integrated family therapy model for working with adolescents with BPD who use drugs and display other self-destructive behaviors. This work is based on the hypothesis that well-integrated and focused interventions are needed for this challenging population and that any treatment of adolescents must include a strong family component. Consistent with the findings in much of the literature on people with BPD, we encountered the emotion dysregulation described by Linehan (1993a) and the maladaptive parenting practices, lack of availability of parental figures, and adult-adolescent attachment problems described by Gunderson et al. (1980). I-BAFT is an innovative treatment because it integrates the best of empirically supported models to address the unique needs of adolescents with BPD. It also addresses the paucity of family treatments for these adolescents. The literature convincingly points to the importance of family therapy during the adolescent stage of development. However, for adolescents with BPD, generic family treatment would be insufficient. I-BAFT contains the additive element of individual therapy, which provides a place for the adolescent to develop healthy life goals and appropriate steps to achieve them and to address destructive behaviors such as suicide attempts and drug use. Further, by adapting Linehan's (1993b) skills training, we were able to construct I-BAFT so that it provided adolescents with new resources to overcome severe emotion dysregulation, impulsivity, identity disturbance, and drug use and so that it also provided them with skills for repairing and maintaining significant relationships. All together, the I-BAFT treatment model provided a well-balanced integrative approach to address the challenging symptoms of BPD.

On the basis of our clinical observations and the families' enthusiastic reports at termination, we consider I-BAFT to be a promising intervention with high feasibility and acceptability. We are currently analyzing outcome data for the pilot trial cases. It should be noted that although I-BAFT is in the process of establishing its empirical validity, the precursor models from which interventions were drawn already have empirical support. Specifically, the family therapy arm of I-BAFT was derived from structural family therapy (Minuchin & Fishman, 1981), empirically supported work conducted with brief strategic family therapy (Santisteban et al., 2003; Szapocznik & Kurtines, 1989), and a developmental focus articulated by Liddle et al. (2000). I-BAFT also drew heavily on Linehan's (1993a) work with adults with BPD, using DBT. Controlled studies have shown that DBT is more effective than alternatives in treating adults with BPD who have suicidal tendencies and abuse drugs ("Dialectical Behavior Therapy," 2002; Koerner & Linehan, 2000; Linehan, 1993a).

Despite this promise, many challenges remain in the treatment of adolescents with BPD who abuse drugs. First, the chronic nature of drug abuse and borderline symptoms may require a

model of continuing care or booster sessions as articulated by Kazdin (1998) to maintain treatment effects over time. Second, there is much to be learned about the specific manner in which emotional and interpersonal stressors trigger substance abuse and self-harm in this population and how that sequence can be modified. Third, the severe disruptions in the adolescent's ecology (e.g., school, peers) continue to be a challenge in treatment. Finally, the complexity of pharmacological interventions (particularly for co-occurring disorders) and how these can be successfully integrated into treatment is yet to be fully addressed.

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Appendix

Table 1
I-BAFT Linking of Interventions to Treatment Targets

Core BPD problems		Family treatment		Skills training		Individual treatment
Emotion dysregulation & impulsivity ^a	1	Family patterns that maintain coercive processes	1	Emotion regulation	1	Identification of triggers
			2	Distress tolerance	2	Role of drug use in exacerbating problem
	2	Invalidating communications	3	Crisis management	3	Goal development
	3	Intense negativity				
Separation/individuation struggles	1	Family attachment	1	Identification & expression of needs	1	Goal development
	2	Healthy individuation			2	Future planning
	3	Age-appropriate guidance & leadership			3	Coaching on more adaptive interactions
Underdeveloped interpersonal skills	1	In vivo shaping of family patterns of relating	1	Interpersonal effectiveness skills	1	Development of interpersonal goals
			2	Emotion regulation	2	Coaching on more adaptive interactions
			3	Crisis management		
Identity disturbance	1	Acceptance & validating communications	1	Goal setting	1	Goal development
	2	Age-appropriate guidance			2	Validation

Note. I-BAFT = integrative borderline adolescent family therapy model; BPD = borderline personality disorder.

^aMedications may also target emotion dysregulation, impulsivity, and co-occurring psychiatric disorders.

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