

DIALECTICAL BEHAVIOR THERAPY FOR ADOLESCENTS WITH BORDERLINE PERSONALITY DISORDER: HOW STRONG IS THE EVIDENCE?

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Borderline personality disorder (BPD) is one of the most challenging clinical presentations in adolescent psychiatry. Its main symptoms are pronounced emotional dysregulation, unstable interpersonal relationships, impulsivity, and a high risk of self-harm and suicidal behavior. Dialectical behavior therapy (DBT), developed by Marsha Linehan for adults with BPD, has been adapted for adolescents (DBT-A) through an abbreviated protocol combining individual therapy, group skills training, telephone coaching, and family involvement. Before DBT-A became available, conventional therapeutic approaches for adolescents with BPD produced inconsistent and largely modest results, marked by high treatment dropout. This review critically evaluates the efficacy of DBT in general and DBT-A in reducing BPD symptoms in adolescents by reviewing relevant randomized controlled trials (RCTs), naturalistic and qualitative studies, and systematic reviews and meta-analyses. The available findings consistently show that DBT-A significantly reduces non-suicidal self-injury (NSSI), suicide attempts, suicidal ideation, and depressive symptoms compared with standard treatment or supportive therapy, alongside relatively high treatment retention and particularly strong effects on emotion regulation, a domain that emerges as a key mediator of therapeutic change. At the same time, the evidence points to three notable boundaries on that efficacy. First, DBT is not consistently superior to other structured treatments such as general psychiatric management, leaving open the question of whether its effects are specific to DBT or reflect common therapeutic factors. Second, functional recovery remains limited, and in adolescents shows no statistically significant advantage over treatment as usual at the level of pooled meta-analytic data. Third, the evidence base for DBT-A specifically in

adolescents still rests on a small number of RCTs at high risk of bias, with high treatment dropout, warranting considerable methodological caution in generalizing its conclusions. The available evidence suggests that DBT-A is the most empirically supported intervention for reducing the acute, life-threatening symptoms of BPD in adolescence, but its efficacy is neither universal nor unconditional and depends on therapeutic alliance, treatment fidelity, and implementation context. Evidence on broader functional recovery and the long-term stability of personality change remains limited and calls for further, more methodologically rigorous longitudinal research.

Keywords: dialectical behavior therapy, borderline personality disorder, adolescents, self-harm, emotion regulation

**DIJALEKTIČKA BIHEJVIORALNA TERAPIJA ZA ADOLESCENTE SA GRANIČNIM
POREMEĆAJEM LIČNOSTI: KOLIKO SU JAKI DOKAZI?**

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Granični poremećaj ličnosti (BPD) predstavlja jedan od najizazovnijih psihijatrijskih entiteta u adolescentnoj psihijatriji. Glavne karakteristike su izražena emocionalna disregulacija, nestabilnost interpersonalnih odnosa, impulsivnost i visok rizik od samopovređivanja i suicidalnog ponašanja. Dijalektička bihevioralna terapija (DBT), koju je razvila Marsha Linehan za odrasle sa BPD, adaptirana je za adolescentnu populaciju (DBT-A) kroz skraćeni protokol koji uključuje individualnu terapiju, grupni trening veština, telefonsko konsultovanje i uključivanje porodice. Pre uvođenja DBT-A, konvencionalni terapijski pristupi kod adolescenata sa BPD, davali su nedosledne i uglavnom skromne rezultate, uz visoku stopu napuštanja terapije. Cilj ovog rada je da kroz pregled relevantnih randomizovanih kontrolisanih studija (RCT), naturalističkih i kvalitativnih studija, kao i sistematskih pregleda i meta-analiza, kritički proceni efikasnost DBT-A u redukciji simptoma BPD kod adolescenata. Dostupni nalazi dosledno pokazuju da DBT-A značajno smanjuje učestalost nesuicidalnog samopovređivanja (NSSI), suicidalnih pokušaja, suicidalne ideacije i depresivnih simptoma u poređenju sa standardnim tretmanom ili suportivnom terapijom, uz relativno visoku stopu zadržavanja pacijenata u tretmanu i naročito izražene efekte u domenu regulacije emocija, koja se pokazuje kao ključni medijator terapijske promene. Istovremeno, dokazi ukazuju na tri značajne granice efikasnosti. Prvo, DBT nije dosledno

superioran u odnosu na druge strukturisane tretmane poput opšteg psihijatrijskog menadžmenta, što otvara pitanje da li su njegovi efekti specifični za DBT ili odraz opštih terapijskih faktora. Drugo, funkcionalni oporavak (obrazovanje, zaposlenje, socijalno funkcionisanje) ostaje ograničen i kod adolescenata nije statistički značajno različit od uobičajenog tretmana na nivou objedinjenih meta-analitičkih podataka. Treće, dokazna osnova specifično za DBT-A kod adolescenata i dalje se oslanja na mali broj RCT studija visokog rizika od pristrasnosti, uz visoke stope napuštanja tretmana, što nalaže znatnu metodološku opreznost pri generalizaciji zaključaka. Na osnovu dostupnih dokaza, može se zaključiti da DBT-A predstavlja empirijski najbolje potkrepljenu intervenciju za redukciju akutnih, po život opasnih simptoma BPD u adolescenciji, ali njena efikasnost nije univerzalna niti безусловna, već zavisi od terapijskog saveza, vernosti protokolu i konteksta implementacije. Dokazi o širem funkcionalnom oporavku i dugoročnoj stabilnosti ličnostnih promena i dalje su ograničeni i zahtevaju dodatna, metodološki rigoroznija longitudinalna istraživanja.

Ključne reči: dijalektička bihejvioralna terapija, granični poremećaj ličnosti, adolescenti, samopovređivanje, emocionalna regulacija

Introduction

Borderline Personality Disorder

Borderline personality disorder (BPD) is a chronic condition characterized by emotion dysregulation, an unstable self-image, impulsivity, and intense, unstable interpersonal relationships, along with a high risk of self-harm and suicidal behavior [1]. Affective shifts are typically abrupt and reactive, and the resulting psychological crises lead to high rates of emergency department and inpatient psychiatric service utilization, with significant impairment in educational, occupational, and interpersonal functioning [1,2]. Comorbidity with depressive disorders, substance use disorders, and eating disorders is common, further complicating risk assessment and treatment planning [2]. Non-suicidal self-injury (NSSI) has a lifetime prevalence of 17–23% among adolescents in the general population, with a significantly higher rate among girls (21.3%) than boys (13.7%), with peak onset between 12 and 14 years of age and peak prevalence between 15 and 16 years, thereafter declining toward the end of adolescence [3,4]. According to CDC data for the United States [5], adolescents aged 12–17 years account for the highest proportion of emergency department visits for suspected suicide attempts of any age group. In 2024, approximately 2.7% of adolescents aged 12–17 reported a suicide attempt in the preceding year, and suicide remains the third leading cause of death in the 14–18 age group [5,6], with peak frequency occurring around 15–16 years of age.

Among adolescents hospitalized with a diagnosis of BPD, the lifetime rate of NSSI is approximately 90%, and the rate of suicide attempts approximately 75%, figures nearly identical to those reported in adult BPD patients, although adolescents with BPD report considerably more frequent and more extreme lifetime patterns of self-harm, particularly cutting [7]. The clinical prevalence of BPD is high in this population: it is estimated at 11% among adolescents receiving

outpatient treatment, and as high as 78% among suicidal adolescents presenting to emergency departments [8]. The literature indicates that between 3% and 10% of individuals with BPD across all age groups die by suicide [9]. Longitudinal data on completed suicide specifically among adolescents with BPD are not currently available as a separate, reliably isolated dataset [10].

Diagnostic Criteria for Early Identification of BPD

According to the DSM-5-TR, BPD may be diagnosed prior to age 18, provided a key condition is met: a stable pattern of symptom expression must have been present for at least one year [1,8,11]. The clinical and research literature further indicates that BPD can be reliably diagnosed as early as age 11, although in clinical practice diagnosis is often delayed due to stigma associated with early diagnosis [8,12].

Dialectical Behavior Therapy (DBT)

Dialectical behavior therapy (DBT) is the most widely implemented and empirically supported psychotherapy for BPD. It was developed by Marsha Linehan [13,14] for chronically suicidal individuals, integrating behavioral change strategies (exposure, contingency management, skills coaching) with acceptance-based strategies derived from mindfulness practice (validation, radical acceptance), organized around a "dialectical" philosophical stance that treats acceptance and change not as opposing goals but as a synthesis to be continuously balanced within the therapeutic relationship. This dialectical framework is grounded in Linehan's biosocial theory of BPD, which conceptualizes the disorder as arising from the interaction between a biological vulnerability to emotion dysregulation and an invalidating developmental environment.

Standard DBT is delivered through four coordinated treatment modalities: 1) weekly individual psychotherapy; 2) group skills training, comprising four core modules (mindfulness,

distress tolerance, emotion regulation, and interpersonal effectiveness, operationalized through structured skill sets such as "DEAR MAN," "GIVE," and "FAST"); 3) between-session telephone coaching to support skill generalization in daily life; and 4) a therapist consultation team, which structures adherence to the model and reduces the risk of clinician burnout [14]. Individual therapy (and, to some extent, telephone coaching) is hierarchically organized to prioritize the reduction of life-threatening behaviors first, followed by therapy-interfering behaviors, and then quality-of-life-interfering behaviors, whereas group skills training follows a fixed, predetermined curriculum of modules.

Dialectical behavior therapy for adolescents (DBT-A) is a developmentally adapted version of this model, first described by Miller [15] and formally manualized by

Rathus and Miller [16]. Key adaptations include a shortened treatment duration (typically 12–24 weeks rather than one year), a reduced and simplified skills curriculum, the introduction of a fifth skills module addressing family- and adolescence-specific interpersonal challenges ("Walking the Middle Path") [16,17], simplified psychoeducational language, and the structured involvement of parents or caregivers in the skills group and, where appropriate, in family sessions. These modifications were designed to account for the developmental, cognitive, and systemic (family-related) context in which emotion dysregulation and self-harm typically emerge in adolescents.

Literature Review

Evidence for the Efficacy of DBT

Evidence for the efficacy of DBT in adults with BPD derives primarily from randomized controlled trials. Early RCTs demonstrated the superiority of DBT over community treatment by

experts [18]. Subsequent trials comparing DBT with General Psychiatric Management (GPM) found that both treatments produced comparable, sustained reductions in self-harm and BPD symptom severity, with no significant superiority of DBT over GPM [19,20]. Meta-analytic data consistently indicate small-to-moderate pooled effect sizes for DBT relative to treatment as usual, particularly with respect to reductions in self-harm and suicidal behavior, whereas effects on broader personality pathology and long-term diagnostic remission remain more modest and heterogeneous across studies [21,22].

Beyond controlled efficacy trials, evidence for effectiveness also derives from naturalistic and applied settings, offering a complementary but more heterogeneous picture. Kröger et al. [23] reported moderate effect sizes and a 45% treatment response rate among 1,423 hospitalized patients receiving DBT, alongside substantial sample attrition, highlighting that real-world outcomes tend to be more modest than those observed in tightly controlled RCTs. Nee and Farman [24], in a study of three cases involving incarcerated women with BPD, reported significant reductions in self-harming behavior following 12 months of DBT delivered within a prison setting, accompanied by concurrent improvement on psychometric measures of dissociation, impulsivity, and self-esteem. Abbreviated formats based solely on skills training have also been evaluated. Heerebrand et al. [25], in a quasi-experimental study with a waitlist control group (N=114), found that the standalone skills-training component significantly reduced BPD symptoms, psychological distress, and depression ($p<0.001$), as well as emergency department presentation rates ($p=0.001$), supporting the theoretical model in which skills acquisition serves as the central mechanism of change. Vonderlin et al. [26] provided evidence that standard one-year DBT delivered via telehealth (N=39) achieved large effect sizes for BPD symptoms and quality of life, with a reduction in the frequency of self-harm from 80% to 28%, thereby extending the potential accessibility of treatment, although an elevated dropout rate was also recorded. The qualitative study by McSherry et al. [27] indicated

that group-based DBT led to improvements in interpersonal functioning and identity, through the increasingly automatic application of mindfulness and interpersonal effectiveness skills in daily life, alongside clearer communication, firmer boundaries, and a shift away from a "borderline" self-concept toward a more stable self-image. A case study demonstrated that standard DBT, applied as a transdiagnostic framework to comorbid BPD and eating disorder presentations, can result in complete loss of diagnostic criteria for BPD, alongside a concurrent reduction in eating disorder symptoms [28]. Another study, contrasting two clients with divergent treatment outcomes, indicated that therapeutic alliance is a plausible mechanism differentiating treatment responders from non-responders [29].

The number of RCTs conducted in adolescent populations remains small relative to the adult literature (Table 1). Evidence for adolescents has accumulated relatively recently, though with increasing methodological rigor. The largest and methodologically most rigorous adolescent trial to date [30] found that DBT-A produced significantly greater reductions in suicide attempts and self-harm compared with individual and group supportive therapy. These findings were synthesized in the systematic review and meta-analysis by Kothgassner et al., [31], which pooled data from RCTs, controlled clinical trials, and pre-post evaluations, confirming moderate treatment effects of DBT-A on self-harm and suicidal ideation in adolescents, alongside a secondary reduction in borderline personality disorder symptoms. This synthesis has recently been expanded and updated: [32], pooling 12 RCTs (N=844 adolescents) of various structured psychotherapies, including DBT-A, confirmed a small but statistically significant effect on BPD symptom severity ($SMD=-0.27$), with no evidence that DBT-A is superior to other approaches such as Mentalization-Based Treatment for Adolescents (MBT-A), Cognitive Analytic Therapy (CAT), or Emotion Regulation Training (ERT).

Fleischhaker et al. [33] reported a sustained reduction in suicidal and non-suicidal self-injurious behavior at one-year follow-up in a German pilot cohort. Mehlum et al. [34,35] conducted a randomized trial comparing DBT-A with enhanced usual care in Norwegian adolescents with repeated self-harm, in which DBT-A proved superior in reducing self-harm, suicidal ideation, and depressive symptoms, with effects sustained at one-year follow-up. Syversen et al. [36], in an outpatient sample of 41 adolescents receiving 20 weeks of DBT-A, reported moderate-to-large effect sizes for the reduction of self-harm over the course of treatment ($d=0.64$ at 1–5 weeks, increasing to $d=1.68$ by the end of treatment). During treatment, nine participants were hospitalized and five attempted suicide, although no suicide was completed.

Sesma Pardo et al. [37], in a sample of adolescents (mean age 15.4 years), obtained findings comparable to those reported by McSherry et al. [27] in adults: mindfulness and distress-tolerance skills became increasingly automatic over the course of DBT skills training, alongside improved reflective capacity and intrapsychic change. Family involvement adds a systemic/family-based dimension to DBT-A, as demonstrated by Smith et al. [38], whose study of 41 parents/caregivers who completed a 6-month parallel DBT skills training program found significant reductions in parental distress and improvements in family communication and functioning.

HERE TABLE 1

Counterarguments to DBT's efficacy

Lack of unique superiority over other structured treatments

In the previously mentioned RCT by McMain et al. [20], with a two-year follow-up after one year of treatment, DBT did not outperform GPM on any outcome, fewer than half of participants completed all treatment phases, and functional recovery remained limited. Because

DBT and GPM share overlapping therapeutic components (structure, crisis planning, psychoeducation), isolating mechanisms specific to DBT is difficult. This finding places a boundary on the claim that DBT is the "gold standard" and suggests that its benefits may partly stem from common therapeutic factors rather than from mechanisms exclusive to DBT. With respect to adolescents, Brandrett and Gajwani [39], pooling 7 RCTs (N=657) of adolescents and young adults with BPD features, found that improvements in functioning were not statistically significantly different from treatment as usual (TAU), either immediately post-treatment (SMD=0.13) or at follow-up (SMD=0.12). Bo et al. [40] note that available RCTs in adolescents generally show modest results and that different structured treatments produce approximately equivalent effects, suggesting that further improvement in outcomes may require extending the therapeutic focus beyond individual psychotherapy toward the adolescent's broader socioecological context (family, school, peer environment).

Outcomes depend on therapeutic alliance and engagement, not on the method alone

A qualitative comparative case study, which followed two clients ("Marie" and "Dean") with equally weak initial therapeutic alliances, found divergent outcomes after one year of treatment [29]. The client who developed a collaborative working alliance, consistently completing diary cards, practicing skills outside of sessions, and tolerating emotional exposure, showed steady progress across all target domains. The client with persistent alliance ruptures and ambivalence toward skills practice showed limited clinical gains. The authors concluded that DBT's technical strategies (behavioral chain analysis, contingency management) lose effectiveness when the balance between acceptance and change is not successfully maintained, indicating that a positive outcome is not guaranteed by the protocol alone but depends significantly on the quality of the therapeutic alliance and client engagement.

Contextual influences on treatment effects, remission maintenance, and dropout

Findings from Kröger et al. [23] challenge the claim of DBT's universal efficacy: although symptom improvement occurs, remission rates remain low and treatment dropout high. The study analyzed data from 1,423 hospitalized patients with BPD receiving DBT. Symptom improvement was rated as moderate (effect size ≈ 0.54): 45% of patients met treatment response criteria, 31% showed no significant change, and 11% deteriorated, while the remission rate was low (14.8%). Younger patients and those with comorbid substance use disorders were more likely to drop out of treatment, and dropout rates were higher in units with inconsistent functioning of the consultation team, suggesting that efficacy depends on patient characteristics, treatment intensity, and specific implementation, particularly in high-acuity settings.

Modest and unstable effect sizes at the level of pooled meta-analyses

Cristea et al. [41], in a meta-analysis of 33 RCTs (N=2256) of psychotherapies for BPD in adults, found that although DBT and psychodynamic approaches show statistically significant effects on BPD symptoms (self-harm and suicidality), effect sizes are small, inflated by risk of methodological and publication bias, and particularly unstable at follow-up. This finding represents a systemic limitation on all preceding claims of efficacy, suggesting that enthusiasm for DBT as a leading intervention rest partly on studies of lower methodological quality, whose effects diminish once corrected for bias.

Insufficiency and weakness of the evidence for psychological therapies, including

DBT-A

Jørgensen et al. [42], in a systematic review and meta-analysis incorporating Trial Sequential Analysis, identified only 10 relevant RCTs of psychological therapies (including DBT-

A) for adolescents with BPD or BPD features. All included studies were rated at high risk of bias, and the overall quality of evidence was judged "very low," with treatment dropout rates ranging from 15% to 75% across the experimental interventions. The authors conclude that, given the high risk of bias, high dropout rates, and underpowered studies, it is difficult to draw any reliable conclusion regarding the efficacy of psychological therapies for BPD in adolescence. This finding is directly relevant to the subject of the present paper, as it indicates that the enthusiasm generated by individual RCTs [30,34,35] should be interpreted with methodological caution.

Conclusions

The findings suggest that, in the treatment of BPD, DBT produces durable, multidomain psychological benefit rather than isolated symptom relief. At the same time, the reliance on case studies, quasi-experimental, and naturalistic designs, rather than on a larger body of well-powered RCTs, means these conclusions should be interpreted as convergent evidence rather than definitive causal proof, given the limitations in implementing DBT under real-world clinical conditions.

None of the counterarguments presented call into question that DBT produces measurable clinical improvement, but they do establish three key limits on how its efficacy should be interpreted. First, DBT is not consistently superior to other structured therapies, leaving open the question of whether its effects are specific to DBT or reflect common therapeutic factors. Second, at the level of individual process, outcome depends on therapeutic alliance and client engagement, indicating that the manualized protocol alone does not guarantee success. Third, at the population and implementation level, real-world clinical contexts, whether inpatient or meta-analytic, consistently show more modest, less stable, and more heterogeneous effects than those suggested by individual, well-controlled RCTs. When these findings are extended to the adolescent population, this limitation becomes even more pronounced. DBT-A, although promising in

individual adolescent RCTs, rests overall on a small number of studies at high risk of bias, with high treatment dropout rates, warranting considerable caution in generalizing conclusions about its clinical efficacy. Current knowledge suggests that further improvement in DBT-A outcomes would require extending the therapeutic focus beyond individual psychotherapy toward the adolescent's broader socioecological context, primarily the family, school support teams, and peers.

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