Dialectical Behavior Therapy for Adolescents With Bipolar Disorder: A 1-Year Open Trial

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ABSTRACT

Objective: To describe an adapted version of dialectical behavior therapy for adolescents with bipolar disorder. **Method:** The dialectical behavior therapy intervention is delivered over 1 year and consists of two modalities: family skills training (conducted with individual family units) and individual therapy. The acute treatment period (6 months) includes 24 weekly sessions; sessions alternate between the two treatment modalities. Continuation treatment consists of 12 additional sessions tapering in frequency through 1 year. We conducted an open pilot trial of the treatment, designed as an adjunct to pharmacological management, to establish feasibility and acceptability of the treatment for this population. Participants included 10 patients (mean age 15.8 ± 1.5 years, range 14–18) receiving treatment in an outpatient pediatric bipolar specialty clinic. Symptom severity and functioning were assessed quarterly by an independent evaluator. Consumer satisfaction was also assessed posttreatment. **Results:** Feasibility and acceptability of the intervention were high, with 9 of 10 patients completing treatment, 90% of scheduled sessions attended, and high treatment satisfaction ratings. Patients exhibited significant improvement from pre- to posttreatment in suicidality, nonsuicidal self-injurious behavior, emotional dysregulation, and depressive symptoms. **Conclusions:** Dialectical behavior therapy may offer promise as an approach to the psychosocial treatment of adolescent bipolar disorder. *J. Am. Acad. Child Adolesc. Psychiatry,* 2007;46(7):820–830.
Key Words: bipolar disorder, therapy, psychosocial treatment.

Over the past decade, bipolar disorder (BP) in children and adolescents has gained increasing attention. Research suggests that BP affects approximately 1% of community adolescents (Lewinsohn et al., 1995), with estimates as high as 6% to 15% in clinical samples (Biederman et al., 1995; Pavuluri et al., 2006). Adolescents with BP exhibit a difficult illness course characterized by prolonged episodes, substantial interepisodic symptoms, and marked functional impairment (Birmaher et al., 2006). High rates of psychosis, comorbidity, and hospitalizations have also been reported in this population (Axelson et al., 2006). BP onset in adolescence is particularly pernicious due to its associations with drug and alcohol abuse, unprotected sex, and suicide (Brent and Lerner, 1994; Goldstein et al., 2005; McClellan et al., 1993). Evidence suggests the majority of adolescent-onset BP patients experience a deteriorating course into adulthood, with poor outcomes including chronic functional impairment and treatment resistance (Strober et al., 1995). Given the projected continuity and morbidity associated with adolescent BP, effective early intervention may minimize the long-term debilitating effects of the illness.

Although there has been progress in the area of pharmacotherapy for pediatric BP (Kowatch and DelBello, 2005), medications often leave patients with residual symptoms and side effects. Guidelines

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for the treatment of pediatric BP therefore identify psychosocial intervention that augments pharmacotherapy as a critical component of optimal treatment (Kowatch et al., 2005).

To date, there are no empirically validated psychosocial treatments for BP adolescents. However, several promising approaches are at various stages of treatment development. Miklowitz et al. (2004) demonstrated the feasibility of delivering a developmentally modified version of family-focused therapy (FFT-A) for BP adolescents in an open treatment development study. This 9-month psychoeducational/skills program was associated with decreases in manic, depressive, and problem behavior rating scores from intake to 1-year follow-up. Danielson et al. (2004) are testing a 12-session cognitive-behavioral therapy (CBT) for BP adolescents. For preadolescent BP, Fristad et al. (2003) tested the efficacy of a multifamily psychoeducational group. As compared with a waitlist control condition, parents receiving multifamily psychoeducational group therapy were more knowledgeable about their child's mood disorder and more successful obtaining health services for their child over 6-month follow-up. Pavuluri et al. (2004) treated school-age BP children by combining +components of FFT and CBT. In this open trial, treatment was associated with improvement in psychosocial functioning, mood symptoms, and medication adherence.

DBT (Linehan, 1993a) is an evidence-based psychotherapy developed for adults with borderline personality disorder. The main DBT target is emotional dysregulation, characterized by high sensitivity to emotional stimuli, extreme emotional intensity, and a slow return to baseline emotional state. Not surprising, research indicates that teens with BP exhibit a range of extreme positive and negative emotions (Birmaher et al., 2006). In fact, recent literature posits that the core clinical feature underlying pediatric BP is emotional dysregulation (Leibenluft et al., 2003). Studies indicate that emotion regulatory processes are developmentally acquired, determined by both biological and psychosocial processes, and under consolidation during adolescence (Dahl and Spear, 2004). Yet, none of the interventions for adolescent BP examined to date expressly target this core illness feature. BP in adolescence is also associated with suicidal behaviors (Goldstein et al., 2005; Lewinsohn et al., 1995), interpersonal deficits (Goldstein et al., 2006), and treatment nonadherence (Coletti et al., 2005)—all DBT targets.

As compared with treatment as usual (TAU), DBT has been shown to reduce suicidal behaviors, hospitalizations, and anger, while improving social adjustment and treatment adherence among adults with borderline personality disorder (Linehan et al., 1994). Miller et al. (1997) adapted DBT for suicidal adolescents by incorporating age-appropriate language, decreasing treatment length, and involving family members in skills training groups. In a quasiexperimental design adolescents receiving DBT had fewer psychiatric hospitalizations and greater treatment adherence than TAU patients. DBT was also associated with decreases in depressive symptoms and suicidal ideation from pre- to posttreatment (Rathus and Miller, 2002). Katz et al. (2004) used DBT on an inpatient unit for suicidal adolescents, reporting decreased behavioral incidents, but not suicidality, as compared with a TAU unit.

In light of the successful adaptation of DBT for adolescents and the role of emotional dysregulation in BP, we applied DBT to the treatment of BP adolescents. First, we describe clinical methods and treatment adaptations for this population. We then present data from an open trial of DBT and pharmacotherapy in 10 adolescents with BP.

METHOD

Treatment Development

The DBT intervention for adolescents with BP is based on the manual of Miller et al. (2006) incorporating age-appropriate modifications for suicidal adolescents. We further incorporated illness-specific modifications designed to meet the unique needs of a BP population. In this section, we describe basic principles for applying DBT to adolescent BP.

Treatment Structure

As in standard DBT, we employed two treatment modalities: skills training (adapted for individual family units) in which the primary focus was to teach new skills, and individual therapy, which aims to aid the adolescent in applying skills in their daily lives. The same therapist (the first author) delivered both modalities. Therapist training before conduct of the pilot study included attendance at a 2-day DBT training and completion of a 3-month clinical rotation at a DBT-based intensive outpatient program for suicidal and parasuicidal women. During conduct of the study the therapist received additional DBT training and supervision via a 6-month DBT training program conducted by a certified BehavioralTech trainer consisting of a 2-day workshop, weekly DBT seminar, and weekly individual clinical supervision in DBT.