

Dialectical Behavior Therapy Group Skills Training for Bipolar Disorder

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There is growing evidence that the capacity for emotion regulation is compromised in individuals with bipolar disorder. Dialectical behavior therapy (DBT), an empirically supported treatment that specifically targets emotion dysregulation, may be an effective adjunct treatment for improving emotion regulation and residual mood symptoms in patients with bipolar disorder. In this open, proof-of-concept pilot study, 37 participants engaged in a 12-week DBT group skills training program, learning mindfulness, emotion regulation, and distress tolerance skills. Repeated measures mixed models revealed skill acquisition in the areas of mindfulness, emotion regulation and distress tolerance, as well as improved psychological well-being and decreased emotion reactivity. The results of this study support a burgeoning literature that DBT is a feasible adjunct intervention for patients with bipolar disorder.

Keywords: bipolar disorder; dialectical behavior therapy; emotion regulation; group skills training

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THE CAPACITY TO REGULATE emotion through conscious and unconscious psychological and physiological processes is essential for effective psychosocial functioning (Gross, 2002; Thompson, 1994). Growing evidence suggests that this capacity may be compromised in bipolar disorder (e.g., Green, Cahill, & Mahli, 2007; Johnson, Gruber, & Eisner, 2007; Murphy et al., 1999; Phillips, Ladouceur, & Drevets, 2008). Difficulties regulating emotion may be exacerbated by the tendencies of individuals with bipolar disorder to experience more intense emotional responses compared to those without bipolar disorder (Johnson et al., 2007), and to interpret neutral stimuli as negative (Gur et al., 1992; McClure, Pope, Hoberman, Pine, & Liebenluft, 2003). Although specific neurological mechanisms have yet to be elucidated, compared to controls, individuals with bipolar disorder have shown greater limbic system activation in response to emotional stimuli (Phillips et al., 2008) and while appraising emotional material (Chen et al., 2006), and they have demonstrated greater difficulty inhibiting emotional responses (Murphy et al., 1999). Additionally, there is a growing and robust literature that suggests bipolar disorder involves maladaptive exaggerated responses to emotional stimuli and diminished use of adaptive responses to regulate strong emotions (Johnson, Tharp, Peckham, & McMaster, 2016; Phillips et al., 2008).

Notably, following treatment for a mood episode, most patients with bipolar disorder continue to experience persistent subthreshold mood symptoms

(Fagiolini et al., 2005; Keck et al., 1998), which put them at greater risk for the recurrence of subsequent mood episodes (Perlis et al., 2006). While pharmacotherapy can be effective for maintaining mood stability, for most patients, medication fails to achieve sustained, full symptom remission (Keck et al., 1996). For this reason, adjunctive psychosocial group interventions such as psychoeducation and mindfulness-based cognitive therapy have been used to complement pharmacotherapy for individuals with bipolar disorder. However, deficits in emotion regulation, a core component of this disorder, are not directly addressed in these interventions.

Dialectical behavior therapy (DBT) is an empirically supported treatment for borderline personality disorder that specifically targets emotion dysregulation. In DBT, emotion dysregulation is understood as a consequence of emotional vulnerability coupled with inadequate, or maladaptive, affective modulation strategies (Linehan, 1993a). Emotional vulnerability is characterized as high negative affect at baseline, sensitivity to emotional stimuli, and intense emotional responding to stressors, usually with a slow return to affective baseline. DBT teaches mindfulness as well as interpersonal effectiveness, emotion regulation, and distress tolerance skills to improve emotion regulation, reduce vulnerability to negative emotions, and reduce maladaptive coping behaviors associated with strong emotions (McMain, Korman, & Dimeff, 2001).

Because of DBT's well-established utility for addressing emotion regulation challenges in borderline personality disorder, it has been suggested that DBT might also be used to target emotion regulation problems in bipolar disorder (Goldstein, Axelson, Birmaher, & Brent, 2007). In a preliminary trial of adolescent-focused DBT (Miller, Rathus, & Linehan, 2006) adapted for bipolar disorder, Goldstein and colleagues (2007) determined that incorporating family group skills training (conducted with individual family units), and individual DBT therapy could be successfully delivered to adolescents with bipolar disorder. The authors found that those receiving DBT were more adherent to treatment and experienced greater reductions in depressive symptoms when this intervention was delivered as an adjunct to pharmacotherapy. Later, in a randomized trial of DBT versus treatment as usual (TAU) for adolescents with bipolar disorder, Goldstein and colleagues (2015) found that those receiving DBT attended significantly more therapy sessions over the course of treatment than did adolescents receiving TAU. Study participants receiving individual DBT + family group skills training demonstrated significantly less severe depressive symptoms, as well as improvements from pre- to posttreatment in manic symptoms and

emotion dysregulation compared to participants receiving TAU. Additionally, those receiving DBT were also nearly three times more likely to demonstrate reductions in suicidal ideation.

Standard DBT, as it was originally designed and tested, consists of four components: individual therapy, group skills training, between-session coaching, and a consultation team for DBT therapists. Standard DBT has been well studied and found to be effective for treating a range of psychiatric disorders. However, due to feasibility and resource challenges commonly faced by treatment outlets, there is a growing trend toward offering stand-alone DBT skills groups to complement TAU (Neacsiu, Eberle, Kramer, Weissmann, & Linehan, 2014). Such DBT skills groups have been found to reduce negative affect, emotion dysregulation, aggression, and impulsivity across psychiatric presentations including borderline personality disorder, depression, bipolar disorder, attention-deficit disorder, problem drinking, incarcerated women with histories of trauma, while also reducing number of hospitalizations, and improving social adjustment and global functioning (see Valentine, Bankoff, Poulin, Reidler & Pantalone, 2015, for review).

To date, however, only one study has examined DBT skills group training as an adjunct treatment for adults with bipolar disorder. Concurrent to the present investigation, Van Dijk and colleagues (2013) ran a small, 12-week randomized controlled trial of DBT skills group that combined psychoeducation for bipolar disorder and DBT skills training in addition to TAU compared to wait-listed controls receiving TAU only. DBT + TAU resulted in a trend toward greater reductions in depression symptoms, compared to TAU only. Additionally, DBT group skills training led to greater mindful awareness and lower fear of and need for control over emotional states. Participants receiving DBT group skills training also had fewer emergency room visits and mental health-related admissions in the 6 months following treatment.

Using an open-trial design intended to test proof of concept, we explored the feasibility and efficacy of a brief DBT skills group for adults with bipolar disorder with residual mood symptoms. To gauge treatment efficacy, we assessed changes in mood and well-being, as well as associations between psychosocial change and measures of skill acquisition that correspond to the modules taught in the DBT. We hypothesized that participants receiving 12 weeks of DBT group skills training would show decreases in mood symptoms and improvements in global well-being, and that these improvements would be associated with increases in mindfulness, emotion regulation, and distress tolerance.

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