



Stopping the Nonadherence Cycle: The Clinical and Theoretical Basis for Dialectical Behavior Therapy Adapted for Adolescents With Chronic Medical Illness (DBT-CMI)

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Most adolescents with chronic illness do not adhere to their regimen. A novel transdiagnostic adaptation of dialectical behavior therapy (dialectical behavior therapy for chronic medical conditions; DBT-CMI) is presented to improve medical adherence in adolescents. The authors describe the approach of DBT-CMI and the model's conceptualization of nonadherence, with specific focus on the core concepts of non-adherence across illness in adolescence.

DBT-CMI has been piloted in two disease groups with preliminary benefit. DBT-CMI lends itself theoretically as a transdiagnostic approach due to specific skills that target core concepts of nonadherence in adolescence. Future research is warranted on the applicability of DBT-CMI across other pediatric medical conditions to replicate findings and examine long-term outcomes.

INCREASING numbers of children in the U.S. are living with chronic health conditions due to the unfortunate rise of asthma and obesity, as well as advances in medical technology that have decreased morbidity and mortality rates of those diagnosed with significant medical illnesses (McGrady & Hommel, 2013). Living with chronic illness places heavy burdens on the patient and family, particularly given the often overwhelming nature of medical regimens, frequency of medical appointments, and the emotional loss of a pre-illness life. In addition to these burdens, children and adolescents often experience unique stressors due to their developmental stage, pressure to fit in with peers, and urge to test environmental limits. These developmentally normative acting-out behaviors can become increasingly high-risk when medical illness is added to the picture. For adolescents in particular, nonadherence to medical treatment regimens is quite common, with estimates upwards of 50% of teens not taking medications as prescribed or not following medical recommendations (Borus & Laffel, 2010; Rapoff, 2010). Higher percentages of nonadherence (85%–90%) are found in underserved and impoverished areas where additional barriers to adherence exist and further impede adherence (Butz, 2006).

Keywords: dialectical behavior therapy; pediatric chronic medical illness; adherence

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Medical nonadherence in youth has gained widespread attention given the medical consequences and challenges as youth progress into adulthood and the large financial cost to the health care system for chronic nonadherence (McGrady & Hommel, 2013). Much research has been conducted to identify and address the nonadherence problem, with increasing emphasis on the importance of adherence assessment and the introduction of several promising disease-specific interventions (Graves, Roberts, Rapoff, & Boyer, 2010). However, to date there are no psychosocial interventions in place to target the themes of medical nonadherence across pediatric chronic illness categories. Of note, there are evidence-based interventions, such as motivational interviewing (MI), that have been utilized in clinical settings and shown improvement in health behaviors; however, these interventions have been disease-specific and most include MI as an augmentation to other evidence-based therapies, such as CBT (Martino, 2011; Powell, Hilliard, & Anderson, 2014). A recent meta-analysis of MI interventions in pediatrics indicated preliminary effectiveness; however, the authors noted concerns about a lack of attention to study quality and measurement of fidelity to treatment which limited conclusions (Gates & Steele, 2014).

A stand-alone, noncategorical therapeutic model that targets common factors exists in the field of psychology, where a Unified Protocol (Barlow, Allen, & Choate, 2004; Barlow et al., 2010) has been developed to improve emotion regulation across psychiatric diagnoses among

adults with depression and anxiety. This protocol has been adapted for youth (Ehrenreich, Goldstein, Wright, & Barlow, 2009) and several additional transdiagnostic approaches have been designed for children and adolescents (Chu et al., 2016; Ehrenreich-May & Chu, 2013). Treatments that target core components of a diagnosis allow for a broad treatment approach that can be disseminated on a larger scale to a range of behavioral problems. Adherence is clearly a core component of all chronic health conditions and these authors believe that a noncategorical approach that addresses the common factors that lead to adherence problems in most conditions may be effective. However, the previously developed transdiagnostic interventions typically address problem areas within a diagnosis that can be “in remission” (e.g., depression, anxiety, etc.). An adherence intervention for chronic medical illnesses requires a specific focus on acceptance of illness rather than a primarily problem-solving approach used in a more traditional CBT model such as the Unified Protocol. Specifically, an intervention that balances both change and acceptance strategies may be most beneficial. Dialectical behavior therapy (DBT) offers such an approach (Linehan, Heard and Armstrong, 1993; Ritschel, Miller, & Taylor, 2014).

Dialectical Behavior Therapy for Chronic Medical Illness (DBT-CMI; Hashim, Vadnais, & Miller, 2013; Lois, Corcoran, Miller, Sweeney, Bauman, & Heptulla, in preparation) has shown preliminary efficacy across two chronic illness categories thus far, with significant improvements found in both adherence and depression for participants. The treatment is being proposed as a noncategorical approach to more effectively manage medical nonadherence across pediatric chronic conditions. The purpose of this paper is to describe the approach and its conceptualization of the nonadherence problem, with specific foci: (a) the core concepts of nonadherence across illness in adolescence; (b) how DBT-CMI attempts to target these concepts; and (c) future implications for intervention. The authors also describe the use of DBT-CMI with two research pilots in different disease categories. Lastly, a clinical vignette will be presented to illustrate the DBT-CMI adaptation in practice.

Common Themes of Nonadherence in Adolescence: Looking Across Chronic Illness Categories

We present the core concepts of nonadherence in adolescence as adapted secondary targets, based on Linehan et al. (1993) description of secondary targets as behavioral components of the dialectical dilemmas that she discovered in developing DBT. These secondary targets help to aid in case formulation. In addition to typical factors that pose risk for nonadherence, such as health beliefs, complex treatment regimens, and medication side effects, the developmental level of adolescents

leads to unique challenges (Seiffge-Krenke, Aunola, & Nurmi, 2009; Ratcliff, Blount, & Mee, 2010). For one, adolescents often hold the belief that they are invincible and the exception to the rule of negative consequences (*nonacceptance/invincibility*), which can lead to limit-testing, defiance, and nonengagement in health care (*high emotional vulnerability and avoidance*); they do not yet possess adequate executive functioning, planning skills (e.g., planning, organization, and judgment) to cope ahead with challenging situations or manage their emotions more effectively. Secondly, adolescents have a strong desire for autonomy and independence (*shift of illness responsibility between parent and teen*). This desire for autonomy is a necessary step, and yet it poses a real concern for youth with chronic illness who may not be ready for independence. Thirdly, peer groups become increasingly important during adolescence, with teens turning to their same-aged cohorts for feedback and validation (*teen social pressures*). The “differentness” that often results from having a chronic medical condition is perceived as a direct threat to these relationships, which can lead to nonadherence behaviors to avoid being “discovered” or “outed” as not fitting in with the group. All of the above secondary targets (nonacceptance/invincibility, high emotional vulnerability and avoidance, shift of illness responsibility between parent and teen, and teen social pressures) are common themes for nonadherence in adolescence, regardless of specific illness (Reed-Knight, Lewis, & Blount, 2011; Taddeo, Egedy, & Frappier, 2008), and may be important treatment targets in a noncategorical intervention approach.

Dialectical Behavior Therapy

DBT is a form of cognitive behavioral therapy (CBT) originally developed for use with suicidal adults diagnosed with borderline personality disorder (Linehan, 2015). Many of these patients had long histories of nonadherence with treatment and did not improve with more traditional CBT approaches. At its core, DBT synthesizes CBT change strategies with acceptance-based strategies, while strategically moving between these seemingly opposite approaches. These latter strategies help the patient to feel more understood and accept his/her current circumstances and his/her awareness of emotions and behaviors, which has many benefits, including enhancing commitment to treatment. Multiple studies have demonstrated the effectiveness of DBT as compared to usual care for difficult-to-treat populations in a wide range of psychiatric and behavioral issues (Ben-Porath, Wisniewski, & Warren, 2009; Hofman, Sawyer, Witt, & Oh, 2010; Linehan et al., 2006; Linehan et al., 2002; Lynch, Morse, Mendelson, & Robins, 2003).

DBT has also been adapted and well-studied in multi-problem adolescents (Miller, Rathus, & Linehan, 2007;

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