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Universal Dialectical Behavioral Therapy:
Investing in the Mental Health of Adolescents

Adolescents contending with depression are underrecognized, leading to more than half of this population being untreated. This reality leads to individual and societal consequences including psychosocial discontent commonly leading to learning difficulty, interpersonal difficulty, and low motivation but is also closely linked to non-suicidal self-injury, suicide attempts, and suicide completions.[1] Our current approach to pediatric mental healthcare also sees a significant societal financial toll estimated to be approximately multiplied by four for each child that struggles with mental illness as opposed to children without mental illness.[2]

There are many factors that lead to our ineffectiveness to support this population. Barriers to mental care can be organized through how our system is set up and how our culture approaches mental healthcare.[3] Stigma regarding mental disorders contributes to the barriers we experience. These barriers include fiscal challenges families face and their inability to pay out of pocket for mental health support, temporal challenges with families' schedules balancing occupational responsibilities, education, and additional extracurricular activities. Furthermore, there is a significant lack of access to behavioral health specialists, especially for rural, low-income, and non-white families.[3] According to Healthy People 2030, in 2019 only 43.4% of adolescents across the United States who experience depression receive treatment.[4] The goal is clearly to increase this number and we need to make a significant investment in mental healthcare. The approach to pediatric mental health support needs to evolve from a reactive stance, which is consistently failing more than 50% of adolescents with depression, to a

proactive approach that gives youth the tools to become more self-aware, advocate effectively for themselves, and be more adherent to mental healthcare interventions. We can accomplish these goals proactively by implementing universal dialectical behavioral therapy in the public school system.

An intentional response within the pediatric mental healthcare sphere is vital. According to the CDC, approximately 2.7 million children between the ages of 3-17 reported having bouts of depression.[5] Furthermore, when surveyed about "ever having been diagnosed with either anxiety or depression", children aged 6-17 responded yes at a rate of 5.4% in 2003, 8% in 2007, and 8.4% in 2012.[5] Most recently, the CDC reports that in 2018-2019 reporting, 15.1% of adolescents aged 12-17 reported that they had at least one major depressive episode.[5] This issue is intensifying for a myriad of reasons. The current approach has not been working and it will continue to be ineffective in supporting each successive generation of adolescents. To be effective, further education regarding pediatric mental healthcare and recognition that stress is continued to be applied to a fractured system needs to occur.

To reiterate the severity of mental illness among youth, pediatric mental disorders impact approximately one in five children globally.[3] 50% of serious mental health disorders develop by the time adolescents turn fourteen-years-old.[3] Researchers have observed that the transition from early childhood to adolescence has a significant correlation with conditions such as depression among other mental health disorders and risky behaviors (anxiety, drug use, suicidal behaviors, etc.).[6] These mental health difficulties and the behaviors that cyclically propagate mental health illness do not curtail as adolescents transition into young adulthood. According to a Healthy Minds Study which collecting data from 373 campuses nationwide, during the 2020-2021 school year, 60%+ of college students met criteria for at least one mental health disorder.[7] Untreated mental health illness is particularly detrimental because of the behavioral patterns that can be

created in response to emotional dysregulation. Human behavior is not always logical, especially when emotional dysregulation is present. For emotionally dysregulated individuals, there can be a "mismatch between their goals, responses, and/or modes of expression, and the demands of socio-cultural context."[6] In response to emotional intensity, detrimental consequences can arise from behaviors such as non-suicidal self-injury and other maladaptive coping strategies.[6] Non-suicidal self-injury (NSSI) functions for individuals to impact emotional regulation by distracting from emotional pain, to reduce dissociation, as a means to communicate interpersonally, and self-punish.[8]

Non-suicidal self-injury is at its peak during adolescence, with global surveys showing that between 10%-20% of adolescents self-report suicidal ideation and suicide attempts within the past year.[9] According to the National Alliance on Mental Illness, depression is one of the major risk factors for self-injurious behavior. Just as the prevalence of depressive episodes is increasing, so are mental health related crises leading to emergency department visits among the adolescent population. In comparison with 2019 data, "emergency departments saw increases in visits related to self-harm, drug poisonings, and eating disorders among this age group since the pandemic's onset."[7] Looking at how data is trending, Adrian et al. note that NSSI has become established as a major threat to physical and psychological health in the adolescent population. NSSI is also a predictor of future suicide attempts among depressed youth.[8] Understanding the connection between NSSI and suicide is key because among 10-14 year-olds and 15-24 year-olds, suicide is the third leading cause and the second leading cause of death respectively.[8] Interestingly, our culture is not unique in its mishandling of pediatric mental health. NSSI has a comparable prevalence among adolescents from different countries.[10] Therefore, we can extrapolate from a Norwegian study useful information when researchers learned that among child and adolescent suicides between 1993-2004, 25% met diagnostic criteria for a psychiatric

illness and 30% had depressive symptoms at the time of their death.[1] Additionally, when the parents of the suicide victims were surveyed, 60% said their child had incurred a stressful conflict prior to their death.[1]

The behaviors specified above have been researched more in-depth in recent years but there has been minimal progress for sixty years. Self-harm and suicidality persist as substantial burdens at every level, from individual to overarching health systems.[9] Campo et al. note that increased access to mental health services can impede the growing rate of suicide amongst children and adolescents.[3] While there have been insufficient randomized clinical trials to provide data suggesting pharmacological treatments for self-harm and suicidal behavior, there has been data showing effective treatment with some nonpharmacological interventions, namely psychotherapy modalities.[9] According to Bahji et al., several meta-analyses have synthesized data from RCT's presenting dialectical behavioral therapy, cognitive behavioral therapy, and mentalization-based therapy as the interventions.[9] CBT is the most extensively studied intervention for the treatment of children and adolescents with depression.[11]

While CBT shows promising results[11] according to Katz et al., DBT was developed by psychologist Marsha Linehan when CBT proved insufficient to treat the chronically suicidal females under her care.[12] "DBT is a comprehensive, cognitive behavioral therapy comprised of principles from behavioral science, dialectical philosophy, and Zen practice."[12] Since the birth of DBT, numerous studies have been done in multiple settings with patient populations including adolescents and adults showing effectiveness to "significantly decrease depressive symptoms during a relatively short period of time" as well as reducing NSSI and suicidal behavior when compared with control groups.[13, 9] Gasol et al. note DBT to be "a multi-component, comprehensive, and flexible treatment approach" that "has been recently applied to other populations of adults and adolescents with a wide range of emotion regulation difficulties."[14]

One notable advantage to utilizing DBT as a treatment modality is its adaptable nature. Depending on the setting, age, and type of emotion dysregulation, DBT has been modified for its audience. Linehan, Wetzler and Leigh were first to modify DBT for suicidal adolescents. They included family involvement, reduced the length of treatment from one year to twelve weeks and simplified the skills to make them appropriate for the developmental level of the adolescent participants.[12] However, despite the development of therapeutic modalities such as CBT and DBT, our ineffectiveness with treating adolescents with depression is evident in the statistics. Our effectiveness in treating adolescent mental illness, specifically depression, is so low because we have been improperly emphasizing mental healthcare.

The primary healthcare setting has been posed as an important setting for pediatric mental health screening and many mental health advocates are arguing that primary care clinicians need to improve their screening methods and treatment approaches for pediatric mental illness.[3] Critiques argue that "real-world" primary care management is currently unsatisfactorily meeting guidelines for treatment and follow-up with at risk pediatric patients, with low rates of case recognition, incongruence with evidence-based treatment, and completed referrals to specialty mental healthcare providers.[3] Pediatric primary care providers agree with the aforementioned critiques, citing training, confidence, time and reimbursement challenges rendering them inadequately equipped to face the growing issue of pediatric mental illness.[15] Kelleher and Stevens echo that despite primary care clinicians raising concerns regarding their capacity and training for mental healthcare management, "financing systems such as behavioral health carveouts and utilization management of specialty care push mental health into the primary care system."[16] We have unfairly stressed the primary care setting as the first line place to screen for pediatric mental illness. We need to emphasize a different setting that will ultimately be more

conducive at identifying mental illness and more practical at providing useful interventions for depressive and other emotional dysregulation episodes.

As children enter early adolescence, peer settings become increasingly salient and provide potentially powerful opportunities for emotional development."[6] As people move into adolescence, peer-to-peer interactions become more influential to a person's wellbeing. While peers can help individuals process stress, they can also be a significant source of it.[7] For children under the age of sixteen, nearly 40% remarked that "friendship difficulties" were the most prominent factor prior to their suicide attempts.[9] Alternatively, high school students who indicated that they "were very depressed and perceived a high level of friendship support" were less likely to engage in suicidal behavior than peers who were "depressed and endorsed a low level of friendship support."[9] Providing interpersonal assistance to adolescents in an environment most densely packed with peer-to-peer interactions, their schools, will curtail negative mental and physical health outcomes while providing opportunities for positive psychosocial and mental health benefits.

An alternative to current mental health screening would be a modified version of DBT to be universally taught to adolescents that is developmentally appropriate for the primary school setting. There are two primary goals with this intervention. As the DBT curriculum is being taught, adolescent participants will have a decreased rate of emotionally dysregulating episodes and an increase in interpersonal effectiveness. Additionally, there will be better screening for adolescents with depression, mental healthcare destigmatization, and self-advocacy treatment adherence and by adolescents with depression. The loftiness of these goals is warranted because of the far-reaching nature of this intervention. The journey to see such a proactive change in our approach to pediatric mental healthcare seems daunting but there are already two roadmaps we can use in making this intervention a part of our reality.

One roadmap that can be utilized has already been created. By understanding our country's motivation and implementation of another all-encompassing modality of health education, effective funding can be achieved. Since the 1960's there has been expansive support for sexual health education in schools.[17] While the motivation behind the implementation of sexual health education has been complicated, a consistent thread is that society has recognized lack of education and awareness leads to many unwanted consequences at the individual and societal level. While sexual health education has faced opposition from some factions of our society in every decade, the awareness of its utility has allowed sexual health education to become increasingly accepted. This acceptance was recognized in 2010 when $130 million was federally appropriated for comprehensive sexual health education to reduce teen pregnancy and additional underlying risk factors.[17]

Another roadmap that can be utilized is by way of a study that was carried out and discussed in Spain. Gasol et al. similarly recognized that DBT can be implemented in varying contexts which include residential, inpatient, outpatient, and community settings.[14] While DBT was first designed for adults with suicidal ideation, it has been adapted to a range of emotional dysregulation problem among adolescents as well. This adaptation is known as the DBT Skills Training for Emotional Problem Solving for Adolescents (DBT STEPS-A) and can be utilized from mild to severe emotionally dysregulating events such as academic stress, peer pressure, familial and romantic relationships, bullying, abuse, and suicidality.[14]

Gasol et al. note that their Spanish study is not the first of its kind, however. Two schools in the south of Ireland and another "rural high school" universally implemented a DBT STEPS-A program with a total of 164 participants with results indicating "statistically significant reduction in emotional symptoms and internalizing problems, and. . . a treatment effect on social resilience and emotion regulation difficulties, as well as good understanding and acceptance of DBT

skills."[14] Within the curriculum that Gasol's research team utilized, a 30-week series of once-a-week fifty-minute classes explored mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness skills. During the pilot year, they provided DBT training to pre-established teachers prior to the start of the study and encouraged these teachers to cofacilitate and participate in sessions while certified DBT facilitators lead the first year with the hope of teachers leading sessions in successive years.[14] DBT is always done within the framework of a treatment team as opposed to isolated individualized therapy;[11] therefore, it is not dependent on any one person's expertise in the therapeutic intervention, but rather a collective understanding of its principles.

A universal approach to pediatric mental healthcare is needed because of the increasingly ubiquitous nature of pediatric mental illness. From 2012-2018, Tkacz and Brady note that childhood mental illness diagnoses have "increased substantially" and are disproportionately burdening our healthcare system.[11] Kelleher and Stevens write that "mental disorders, as a group, are the most common chronic conditions among pediatric patients. They cause extensive morbidity and mortality during childhood and into adulthood. Mental disorders are associated with high rates of health service use and costs of care."[16] To date, primary care providers have been given much of the responsibility to screen, diagnose, and treat pediatric mental health disorders with little support, despite their advocacy for help.

Providing mental healthcare support through a DBT STEPS-A curriculum at the community level would provide in-the-moment emotion regulation skills and effective language for adolescents to recognize how they are feeling and to communicate how they can best be supported. Gasol et al. found that following implementation of their modified DBT curriculum, students reported they were better suited to handle emotional dysregulation and social problems, and they reported a higher life satisfaction overall.[14] Researchers agree that there needs to be

more studies done on the implementation of universal DBT-A programs,[14] but our current approach is failing millions of adolescents across the United States. Millions of adolescents struggle every day with depression and other emotional dysregulation disorders and we need to make drastic changes in our society to provide the support that they need.

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