Dialectical Behavior Therapy: A New Direction in Psychotherapy

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Abstract

Dialectical Behavior Therapy (DBT), a treatment originally developed for individuals diagnosed with Borderline Personality Disorder, shows promise for individuals with dual diagnoses (mental illnesses and developmental disabilities). DBT addresses a number of problems frequently seen in individuals with dual diagnoses, including emotional instability and dysregulation, inability to tolerate distress, and interpersonal difficulties. DBT focuses treatment on these areas in both an individual and a group format, achieving the goal of greater effectiveness in the above areas using skill-building techniques coupled with mindfulness training. DBT also provides a method of helping the professionals involved in treatment to work together as a more effective team. This presentation will address the ways in which DBT can be adapted to be effective and accessible to people with developmental disabilities.
Dialectical Behavior Therapy: A New Direction in Psychotherapy

Clinical lore often leads one to believe that psychotherapy for individuals with developmental disabilities and mental illness is limited to behavior modification in the areas of social skill training, self-injurious behavior, and adaptive functioning. However, there is a growing appreciation that individuals with developmental disabilities suffer from the same difficulties in life that persons of average intelligence suffer from, such as grief, feelings of depression and anxiety, and so forth (Charlton, 2002; Bütz, Bowling, & Bliss, 2000; Nezu & Nezu, 1994).

There are a number of issues that need to be addressed when providing psychotherapy to individuals with developmental disabilities and mental illness, including but not limited to the level of functioning of the individual, the therapist’s biases and views of psychotherapy and persons with developmental disabilities, and the mode of psychotherapy provided (Bütz, Bowling, & Bliss, 2000; Sue & Sue, 1999). As Hurley and colleagues (1996) noted, effective psychotherapy must be adapted according to the idiosyncrasies of the individual a therapist is working with.

One of the popular psychotherapeutic treatment modalities currently being used is Dialectical Behavior Therapy (DBT). DBT is an empirically validated, comprehensive treatment program addressing deficits in emotion regulation, distress tolerance, and interpersonal relationships. This therapeutic intervention was originally developed by Marsha Linehan and is outlined in *Cognitive-Behavioral Treatment of Borderline Personality Disorder* (1993a) and the accompanying *Skills Training Manual for Treating Borderline Personality Disorder* (1993b). Though it was initially developed as a treatment for individuals diagnosed with Borderline Personality Disorder, the treatment’s use has been expanded to address the needs of a wide variety of clients suffering from severe and chronic Axis I and II multiple diagnoses of mental illnesses that are difficult to treat (Manning & Reitz, 2002). We believe that this treatment, in an adapted form, will also be effective in addressing the needs of individuals with developmental disabilities and mental health problems.

Dialectical Behavior Therapy appears to be an effective treatment method for persons with developmental disabilities and mental health troubles for a number of reasons, including the focus...
on strength-based instruction, concrete skill building and built-in repetition, as well as its multi-dimensional approach. The first area, strength-based intervention, is vital when working with individuals with dual diagnoses. The DBT treatment model helps clients use their current skills more effectively by teaching them to use those skills in new ways and/or in new situations. The skill building does not stop there, however. DBT also teaches clients new skills and how to use the new skills most effectively. As mentioned above, the skills specifically addressed are emotion regulation, distress tolerance, and interpersonal effectiveness; mindfulness is also a skill (and way of being) that is trained and incorporated throughout the three modules. Furthermore, the treatment sessions build upon one another and skills already learned are reviewed and further generalized, thus providing the repetitive learning that the persons with dual diagnoses generally benefit from. Finally, DBT skills are naturally generalized, as the skills and skill modules are taught in a group therapy format, reviewed and practiced in individual therapy, and reinforced during interaction with any other DBT team member(s).

Because of the high level of care that individuals with dual diagnoses need, a multi-disciplinary treatment team is often involved. This presents another area in which DBT can be effective. If one is to start a DBT program, it is recommended that the whole team (broadly defined to include everyone who interacts with the clients from office manager to program director, case managers, and therapists) be trained in DBT principles and be kept up-to-date with what is occurring in the skills groups and individual therapy (Fruzzetti, Waltz, & Linehan, 1997; Linehan, 1993a), keeping in mind the ethics of confidentiality. This team approach is effective as the team is unified and using the same language, as well as reinforcing the same use of skills. This hinders any attempts by clients to manipulate or “split” various care providers working in any number of capacities, as it maintains consistency in the treatment. The focus of DBT on strength based interventions helps to facilitate problem solving among team members as it discourages judgmental comments and blaming, while helping team members look for solutions. Furthermore, as team members use DBT techniques and engage in the processes of using DBT, they model the skills that
are being taught for their clients, as well as become more effective in their own lives (Fruzzetti et al., 1997).

The reader may notice the frequent use of the term effective or effectiveness; there is good reason for this. DBT has roots in the behavior analytic tradition, and consequently holds pragmatic goals, such as effective working. Recognizing the ubiquity of human suffering, DBT is not aimed at reducing or getting rid of ordinary pain or discomfort, nor on ridding oneself from particular thoughts or feelings, but rather is focused on reducing unnecessary suffering (similar to its “relative” Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999) in the behavior analytic tradition). Oftentimes individuals increase their suffering by struggling against that which they cannot change, such as trying to rid themselves of their respective histories. In contrast, the focus of DBT is on reducing unnecessary suffering through pursuing valued life directions despite feeling pain, experiencing negative emotions, or thinking negative thoughts. In short, the focus is on achieving a balance between changing that which one is able to change and accepting that which is unchangeable, so that the individual can make progress toward his or her valued life goals. During the process, particular thoughts and feelings may be modified so they are more pleasant, but this is not guaranteed. The relative concreteness of these ideas makes them accessible enough for many people to understand and utilize them, including persons with developmental disabilities. In summary, DBT encourages clients to take responsibility for their actions, advancing the dictum that “no matter what, I choose how to act.”

Method

With this information, one may begin to ask how this philosophy and theory may be put into practice with persons with developmental disabilities. Adaptation begins with an overall assessment of the philosophy and theory, gauging its applicability to the targeted population. As mentioned above, it seems that DBT is a “good fit” for persons with developmental disabilities and mental illness. From here, adaptation moves to the areas of language and presentation. The main tenets as outlined
above remain unchanged; however the presentation and language must be adjusted to a level that persons with developmental disabilities can comprehend. Just as when working with any “special population,” one must adapt materials to meet the clients needs (Hurley et al., 1996; Pfadt, 1991). With this in mind, the curriculum has been adjusted in a number of ways. First of all, the language has been changed so that individuals with developmental disabilities will be able to understand the concepts. Second, some of the concepts have been paired down and/or simplified so as to allow clients with developmental disabilities to better comprehend and apply the material. Third, the handouts have been re-written and re-formatted so as to increase attention and aid in understanding. Finally, client feedback, repetition, and rehearsal have been incorporated into the therapy structure to aid in the learning, retention, and generalization processes.

Currently, this adaptation of Linehan’s Dialectical Behavior Therapy is being used with adolescent clients in a day-treatment program in Aurora, Colorado. An outcome study is underway with regard to this project, including individual and group data collection. While the adaptation has been made with adolescents in mind, the treatment and the adaptation is flexible enough so as to be applicable to adults with developmental disabilities as well.

Results

In modifying each of the handouts suggested for use in the DBT skills modules (Linehan, 1993b) we worked to use language that was accessible to and easily understood by our clients. For example, rather than talking about reducing emotional vulnerability, we worked on understanding how emotions effect us and on making good decisions when experiencing an emotion (figure 1). We also used a visual presentation style that would make it easier for clients with developmental disabilities to absorb the information. This type of adaptation is illustrated in figure 2 where we reduced the number of interactions we attempted to teach, used more prominent arrows, illustrated the components with different types of shapes to help make them easier to remember, and simplified the language. As “choice” was a main concept we wished to teach in this module, we also added it
to this handout to provide an additional repetition.

Another example of the type of adaptation we made is with regard to the topic of emotional vulnerability. Linehan (1993b) uses the acronym “PLEASE MASTER” in her handout addressing how to reduce vulnerability to negative emotions. We modified this to “SEEDS GROW” and discussed controlling emotions instead of reducing vulnerability (see figure 3). This modification allowed us to use simpler language that was already in our clients’ vocabulary, provided another opportunity to emphasize that we control our emotions—they do not control us, and simplified the visual presentation of the material.

Thus far, we have taught mindfulness exercises and emotion regulation skills to a group of 8 clients in the Intercept Center’s day treatment program. They seem to be able to grasp the concepts when presented in the modified format. This comprehension is demonstrated by the fact that they spontaneously use DBT language when discussing how to manage their anger or anxiety in stressful situations. When staff cues them about using their “wise mind” to make appropriate choices, they respond well to the cue and seem to implement mindfulness exercises (such as deep breathing) in order to calm themselves enough to make a good choice. Furthermore, we are noticing an expanded use of vocabulary for the emotions they are experiencing. The clients are also better able to complete processing sheets after incidents that describe what happened when they lost control and how the situation can be handled more effectively in the future.

Two types of information are being collected for the pilot outcome study. All of the students in the study complete daily diary sheets on each day they attend the day treatment program (see figure 4). They are also rated on 5 individualized goals every hour as part of the structured behavior management used in the program. The information from the students’ individualized goals is summarized on a weekly basis as a percentage score (points earned/total points available). We collected the point and diary information for several weeks before beginning DBT training with this group and are continuing to collect data as the group progresses through the skills training modules. We will be presenting a second module, distress tolerance, to the group this fall and hope to have
sufficient data for analysis some time next year.

Discussion

Persons with developmental disabilities obtain significant benefits from participation in psychotherapy to address their mental health needs, provided the psychotherapy is presented in a manner that is accessible to them (Szymanski et al., 1994). At this time, only a few types of psychotherapy have been adapted specifically for use with this population; much additional work is needed to provide people with developmental disabilities the same range of options for treatment that the non-disabled population is given. The current effort to modify DBT to meet the needs of people with developmental disabilities is just a beginning. As more research is done in this important area, it is our hope that specific standards will be developed so that the types of modification that are most helpful in making psychotherapy accessible people with developmental disabilities are known. We believe, based on our current work, that psychotherapy methods that emphasize replacing old, maladaptive behaviors with new more adaptive ones, in the manner used in DBT skill building modules, will be particularly useful for this population.

Acknowledgments

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References


Figure 1

Emotion Regulation Handout 1

**EMOTION REGULATION GROUP**
(controlling your emotions)

**GOALS OF EMOTION REGULATION**

**Understand Your Emotions**
1. Label your emotions.
2. Identify your emotions.

**Control Your Emotions**
1. Understand how emotions affect you.
2. Make good decisions even when you are feeling thoughts - Don’t let emotions control you.

**Stop Feeling Bad All the Time**
1. Accept and then let go of painful emotions.
2. Good Choices = Good Outcomes
Figure 2

Emotion Regulation Handout 3

EMOTION REGULATION GROUP
(controlling your emotions)

Model of Emotions

1. Think about what happened
2. Decide how to change
   - Brain Changes
   - Body Changes
   - Voice Changes
   - Inner Cues
   - Four Times
3. Make a choice
4. Here the emotion
5. URGES
   - Urges: (acting, expressing)
   - Emotions: (acting, expressing)
**Figure 3**

Emotion Regulation Handout 6

**EMOTION REGULATION GROUP**

*(controlling your emotions)*

**Keeping Control of Your Emotions**

A good way to remember the skills is to remember the phrase: “SEEDS GROW.”

- **S**ickness needs to be treated. You need to take care of yourself and your body. See your doctor, take your medicine.
- **E**at right. You need to eat good food. Don’t eat too much or too little.
- **E**xercise. Do some exercise every day. Stay in shape.
- **D**rugs are bad. Stay away from drugs and alcohol. They make you out of control.
- **G**et enough sleep at night so you are not tired during the day.
- **R**eform every day. Do something you are good at every day and try doing something new every day.
Figure 4

Daily Diary Card

<table>
<thead>
<tr>
<th>Name: __________________________</th>
<th>Date: M T W Th F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercised: <strong>Yes</strong></td>
<td>No</td>
</tr>
<tr>
<td>Felt Sad: Yes</td>
<td>A little</td>
</tr>
<tr>
<td>Thought of Arguing: Yes</td>
<td>A little</td>
</tr>
<tr>
<td>Argued: Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Did you go to Time Out? Yes ______ No ______ By yourself? Yes ______ No ______
Did you argue with others? Yes ______ No ______