

Dialectical Behavior Therapy for Special Populations:

Enhancing Treatment Approaches for Individuals with Intellectual and
Developmental Disabilities and Concurrent Mental Health Needs

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Developmental Enhancement, PLC

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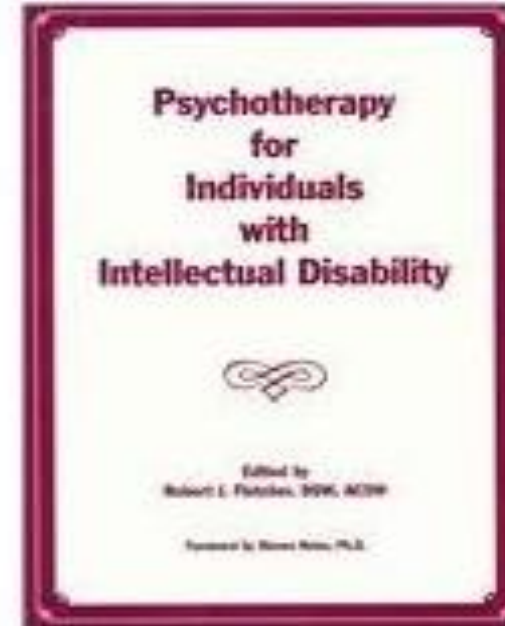
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<http://www.developmentalenhancement.com>

<http://www.thecenterforcd.com>

Treatment Resource

- Psychotherapy for Individuals with Intellectual Disability.
- Available from NADD (www.thenadd.org)



Dialectical Behavior Therapy:

An Overview

General Philosophy

- Worldview of Dialectics
- Functional Contextualism
- Developmental-Behavioral Perspective
- Working Assumptions
- The DBT Team

Dialectical Worldview

- A “dialectic worldview” is a way of thinking that embraces a non-absolute ‘truth’ model, allows for (seemingly) conflicting perspectives, and sees ‘truth’ as developing, evolving, and constructed over time.
- This is middle ground between Universalism (ABSOLUTE TRUTH) and complete Relativism (NO TRUTH – ITS ALL RELATIVE)

Dialectical Worldview

- This worldview advocates the use of words such as '*AND*' instead of '*BUT*' or "*NOT*" and is intentionally inclusive in nature.
- Its about seeing the middle ground between seeing two seeming contradictions.

The “Dialectic” in DBT

- There are three primary characteristics of a dialectical worldview:
 - The principle of wholeness and interrelatedness
 - The principle of polarity
 - The principle of continuous change (thesis, antithesis, and synthesis)

The “Dialectic” in DBT

- Practically, this approach seeks to balance acceptance (validation) and change.
- Recognizing the functionality of current behaviors and the inherent potential for growth in each client, the therapist works to facilitate change through skill-building and mindfulness training, as well as acceptance strategies.

Foundations of DBT

- Philosophical Underpinnings

- Functional Contextualism

(contemporary radical behaviorism)

- Philosophy of science
 - undergirds behavior analysis
 - Whole-person-in-context perspective
 - Involved in many contemporary approaches that utilize Acceptance and Mindfulness strategies

Developmental-Behavioral Perspective

Developmental

- Development as a lifelong process
- Many opportunities for disruption and remediation
- Need for “redoing” and “relearning”
- Expectations based on whole-person factors, not simply chronological age or any other single factor

Behavioral

- Principles of Learning (reinforcement, etc)
- Focus on act-in-situation
- Insight, Awareness, Understanding are fine, but don't necessarily cause change to occur

Foundations of DBT

- Bio-Psycho-Social Theory
 - highly emotionally reactive to environments and problems returning to a baseline arousal level
 - history of trauma and severe emotional dysregulation
 - skills deficits that inhibit effective coping with such experiences
 - results in crisis-ridden lives characterized by chaotic interpersonal relationships and poor day-to-day functioning

Foundations:

Bio-Psycho-Social Theory

- Application: the interplay between our biology, psychology, and social experiences (among other factors) is the foundation for understanding and working
 - A WHOLE-PERSON, CONTEXTUAL, PERSON-CENTERED APPROACH

Working Assumptions

(taking a DBT stance)

- Clients are doing the best they can
- Clients want to improve
- Clients need to do better, try harder ...
- Clients have not caused all of their problems but they have to solve them anyway
- Clients' lives are unbearable as they currently are
- Clients must learn new ways of being in all relevant situations
- Clients can not fail in treatment
- Treators (everyone on the DBT Team) need assistance and support when working with individuals with intensive problems

The DBT Team

- This means **EVERYONE!**
 - Direct Care Staff
 - Administrative Managers
 - Case Management
 - Clinicians
 - Nursing
 - Psychiatrist
 - Consultants
 - ...



The DBT Team: Client Focused

- Provide a safe, consistent, therapeutic environment
- Create a positive teaching milieu
- Develop a validating, accepting, change promoting culture

The DBT Team: Team Focused

- Support & Encourage
- Teach & Learn
- Hold Accountable



DBT Team Agreements

- Dialectical Agreement
- Consultation to the Patient
- Consistency Agreement
- Empathic Orientation
- Fallibility Agreement

Clients and Selves

- Remember core assumptions:
 - We are all doing the best we are able in this moment
 - Things are okay the way they are (validation) and change can happen and will be beneficial

Moving from DBT to DBT-SP

DBT-SP Methods

- Group Skills Training
- Individual Therapy
- Consultation/Supervision
- Research/Outcomes Evaluation

Fidelity to the Model

- DBT and DBT-SP are organized in an intentional fashion
- The components are purposefully emphasized

Why DBT-SP?

- 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
- There is a clear need for innovative treatment approaches for people with intellectual disabilities
- Standard DBT can be difficult to comprehend for those with learning challenges, for kids/adolescents, and for those whose cognitive/intellectual skills are even temporarily compromised

Why DBT-SP?

- Some client characteristics include:
 - Difficult to treat using typical “talk therapy”
 - Difficulties with regulating emotions
 - High levels of interpersonal conflict
 - High levels of impulsivity
 - Display self injurious behavior at times
 - Multiple Diagnoses

Why Should DBT-SP Work?

- Common characteristics between populations for which DBT has been found to work and people with developmental disabilities
 - Higher incidence of trauma than the general population
 - Impaired impulse control
 - Difficulty identifying and managing frustration appropriately
 - Problems with regulation of emotion
 - Lack of effective methods for self-soothing

DBT-SP and Trauma

- Some people will be able to move quickly into the trauma work that is needed
- Others may be experiencing significant dysregulation and unable to function well without fundamental skill training prior to trauma-based therapy

What About Self-Regulation?

- Areas Prone to Dysregulation:
 - Emotions
 - Overt Behaviors
 - Cognitive Activity
 - Sleep
 - Blood Pressure/Heart Rate

Why Regulation Matters

- Emotions
 - Mental Health: Mood Disorders, Anxiety
- Overt Behaviors
 - ADHD, Aggression, Mania
- Cognitive Activity
 - Executive Functions, Mood Disorders
- Blood Pressure/Heart Rate
 - Hypertension, Coronary Disease, etc.
- Sleep
 - All of the above

Neurological Underpinnings

- You Name It – it's involved
 - Thalamus, Hypothalamus, Pituitary, Prefrontal Cortex, Suprachiasmatic Nucleus, etc.
 - Serotonin, Dopamine, Melatonin, etc.
 - Autonomic Nervous System
 - Sensory Systems

DBT-SP

Group Skills Training

Mindfulness

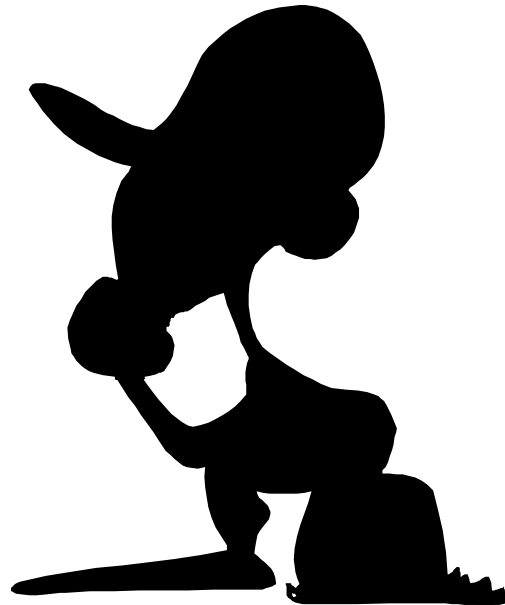
- What is Mindfulness?
 - “Being in the moment”
 - “Paying attention on purpose”
 - “Mindful vs. Meditative”
- Why Mindfulness?
- How to be Mindful

Mindfulness: Handout 1

- States of Mind
- Thinking Hot vs. Thinking Cool
- Examples?
- Wise Mind ~ The Middle Ground

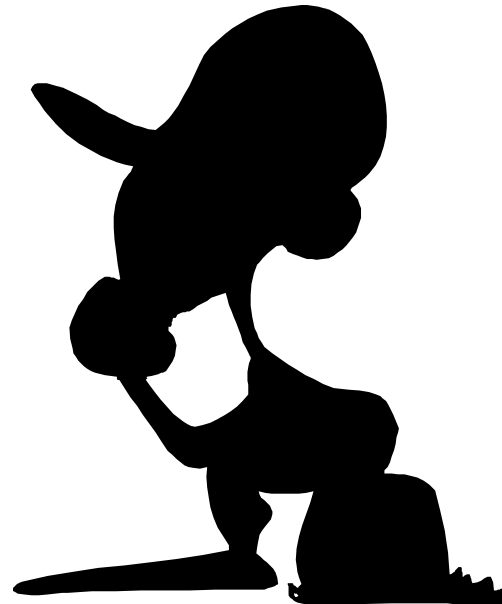
Mindfulness: Handout 2

- Mindfulness: What To Do
 - Observe
 - Describe
 - Participate



Mindfulness: Handout 3

- Mindfulness: How To Do It
 - Accept
 - One Thing
 - Effectively

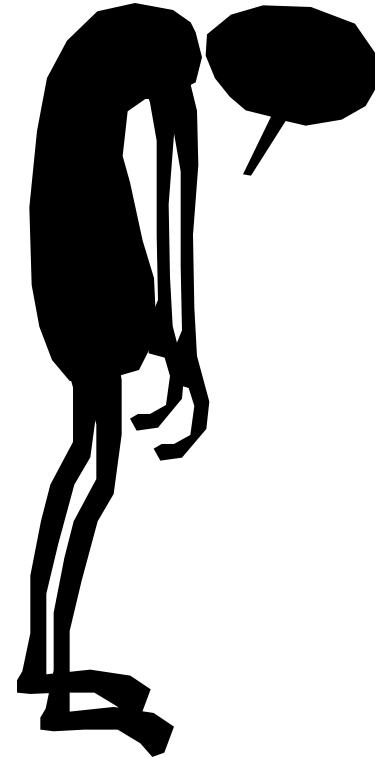


Mindfulness Activities

- List of Ideas
- Others?

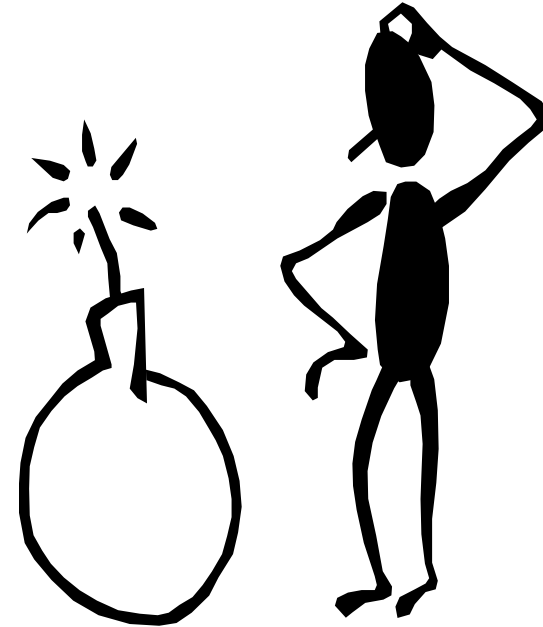
Distress Tolerance

- Overview of Module
 - Why Distress Tolerance?
 - What is it all about?



Distress Tolerance: Handouts 1 & 2

- Teach Mindfulness
- Goals of DT
 - Life happens, so ...
 - Acceptance vs. The Struggle
 - Understand, Accept, Survive



Distress Tolerance

- Handout 2: Reasons to use skills
- Handout 3: Ways to survive
 - Distract
 - Calm
 - Choices

Distress Tolerance

- Handout 4: Distracting
 - Wise Mind Accepts
 - Activities
 - Contribute
 - Compare
 - Emotions (opposite)
 - Push Away
 - Thoughts
 - Sensations

Distress Tolerance

- Handout 5: Ways to survive bad times
 - Self-soothing with our senses
 - Seeing
 - Hearing
 - Smelling
 - Tasting
 - Touching

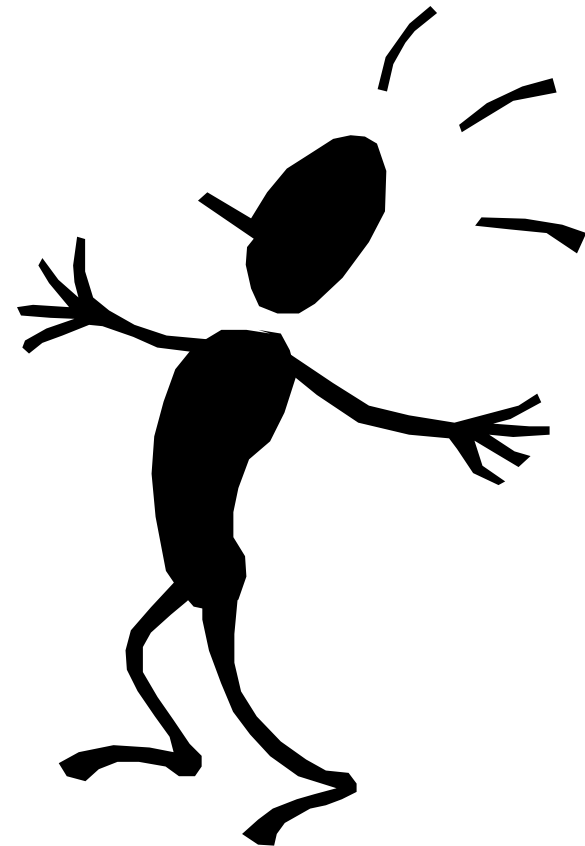


Distress Tolerance

- Handout 6: Thinking about your choices
 - Remember to focus on cause-effect relationships
 - Outcomes can be positive or negative
- Handout 7: Accepting Reality
 - Radical Acceptance
 - Turning Your Mind
 - Willingness

Distress Tolerance

- Handout 7: Accepting Reality
 - Radical Acceptance
 - Turning Your Mind
 - Willingness
- Handout 8: Accepting Reality
 - Breathing
- Handout 9: Accepting Reality
 - Half-Smiling
- Handout 10: Accepting Reality
 - Focusing



Distress Tolerance

- Review of Basic Concepts
- Questions, Comments, Etc.

Emotion Regulation

- Overview of Module
 - Why Emotion Regulation?
 - What is it all about?



What Is Regulation Really?

It **DOES** mean ...

- Influence
- Change
- Alter
- Shift
- Direct

It **DOES NOT** mean ...

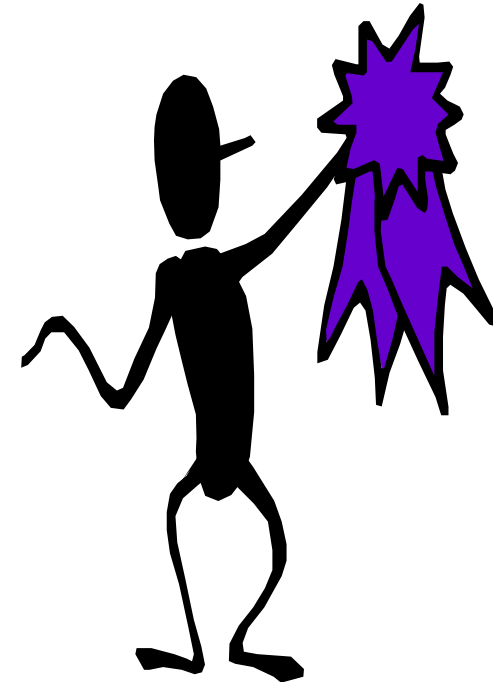
- Control
- Get Rid Of
- Eliminate

Development of Regulation Abilities

- Reliance on others → • Self Regulation
- External/Behavioral → • Internal, Private
- Concrete, Specific → • Flexible, Multiple, Broad
- Avoidance-based → • Approach-based
- Short term → • Long term (goal directed)

Emotion Regulation: Overview

- The point is not to get rid of emotions ...
- Overview of Skills
 - Identifying and Labeling Emotions
 - Identifying Obstacles
 - Reducing Vulnerability
 - Increasing Positive Emotion Events
 - Increasing Mindfulness
 - Taking Opposite Action
 - Applying DT Techniques



Emotion Regulation

- ER Handout 1: Goals of ER
 - Understand Emotions
 - Control Behavior (Make Choices)
 - Stop Feeling Bad All The Time
- ER Handout 2: Lies and Truths
 - Focus is on “myth-busting” emotion-related beliefs and establishing universal truths about emotions



Emotion Regulation

- ER Handout 3a: Unhealthy Model of Emotions
 - Stuff Happens, I Feel, I React, More Stuff Happens
- ER Handout 3b: Healthy Model of Emotions
 - Stuff Happens, I Feel and I Think, I Choose
- ER Handout 15: Homework Sheet

Emotion Regulation

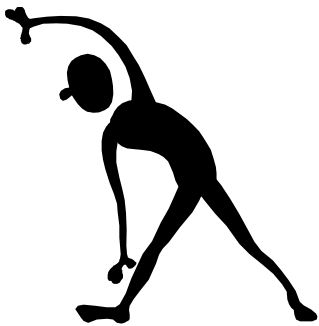
- ER Handouts 4-8: Feelings For Emotions (happy, sad, mad, scared, embarrassed)
 - Increase client awareness and vocabulary
 - Establish/Reinforce/Generalize concept of prompting events

Emotion Regulation

- ER Handout 9: What Good Are Emotions?
 - Emotions Communicate to Others
 - Emotions Communicate to Ourselves
 - Emotions Prepare for Action

Emotion Regulation

- ER Handout 10: Keeping Control of Your Emotions
 - SEEDS GROW
 - Sickness needs treatment
 - Eat right
 - Exercise
 - Drugs are bad
 - Sleep well
 - GROW every day



Emotion Regulation

- ER Handout 11: Feel Better More Often
 - Have Fun
 - Short Term and Long Term
 - Be Mindful
- ER Handouts 12 & 13: (101) Ways to Have Fun
- ER Handout 14: Change How You Feel
 - “Cut the strings” of emotions by using “Opposite Action”

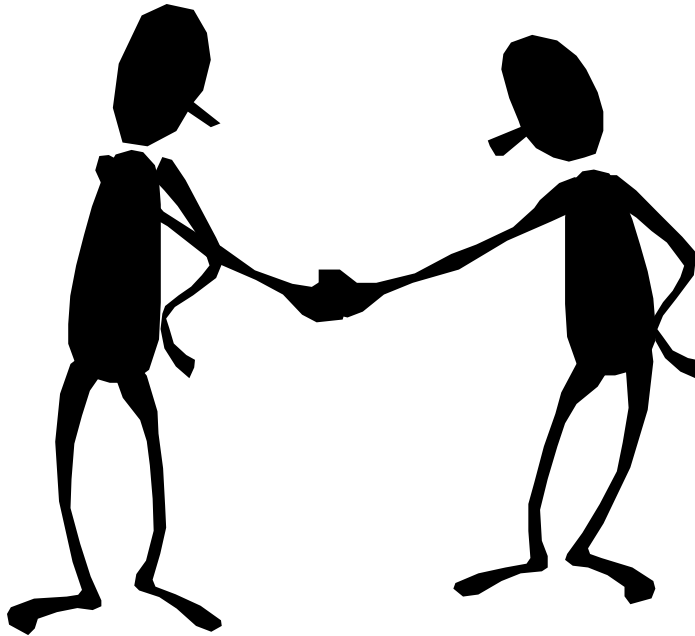
Emotion Regulation

- Review of Basic Concepts
- Questions, Comments, Etc.

Relationship Effectiveness

(How To Make Relationships Work)

- Overview of RE Module



Relationship Effectiveness

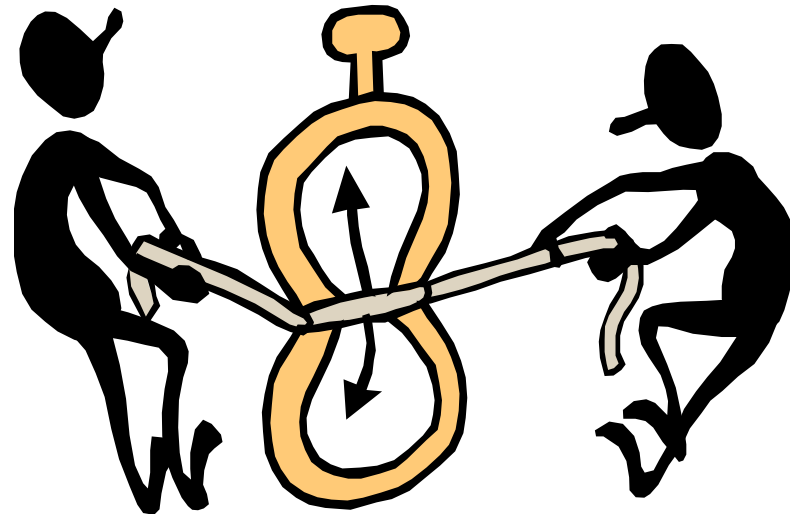
- RE Handout 1: Goals of RE
 - Getting What You Want
 - Getting or Keeping Good Relationships
 - Improving Self-Respect
- RE Handout 2: Lies and Truths About Relationships
 - Set the stage ...
 - Have clients identify areas they are susceptible

Relationship Effectiveness

- RE Handout 3: Making Choices
 - Asking
 - Saying No
- Practice these skills frequently ~ have clients role play, give examples, etc.

Relationship Effectiveness

- RE Handout 4: Making Choices – Things to Think About
 - Priorities
 - The Relationship
 - Rights
 - Authority
 - Respect
 - Time
 - Ability



Relationship Effectiveness

- RE Handout 5: Why Use Skills?
 - Taking Care of Relationships
 - Balancing Wants and Shoulds
 - Building Self-Respect
- RE Handout 6: Getting What You Want
(DEAR MAN)
 - Describe
 - Mindfulness
 - Express
 - Appropriate Behavior
 - Ask/Say No
 - Negotiate
 - Reward



Relationship Effectiveness

- RE Handout 7: Respecting Yourself (FAST)
 - Fair
 - Apologies
 - Sticking to what you believe in
 - Tell the truth

- RE Handout 8: Keeping Good Relationships (GIFT)
 - Gentle
 - Interest
 - Funny
 - Try to Understand

Relationship Effectiveness

- RE Handout 9: Sometimes Using Skills Is Hard
 - Validate difficulties
 - Emphasize need to keep trying
- RE Handout 10: Practicing RE
 - Discuss other examples

Relationship Effectiveness

- Review of Basic Concepts
- Questions, Comments, Etc.

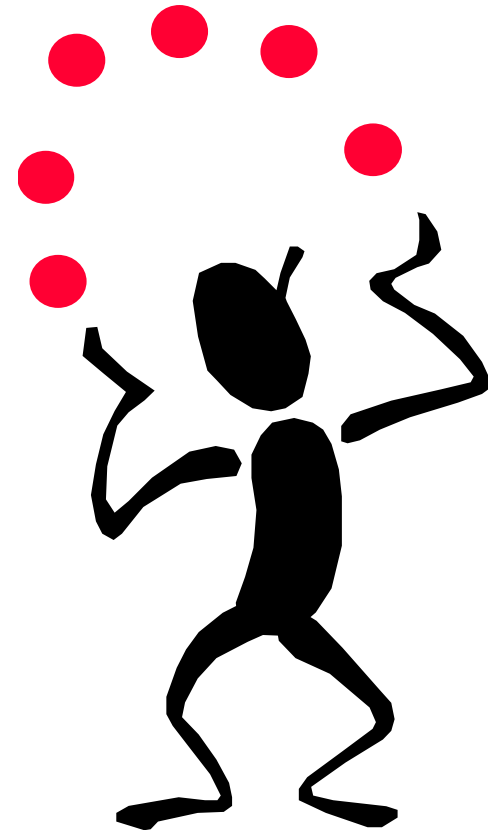
Groups and Group Dynamics

Group Dynamics

- Groups as a Social Microcosm
 - Here-And-Now Interactions
 - Real-Time Problem Solving
 - In-Vivo Relationship Building

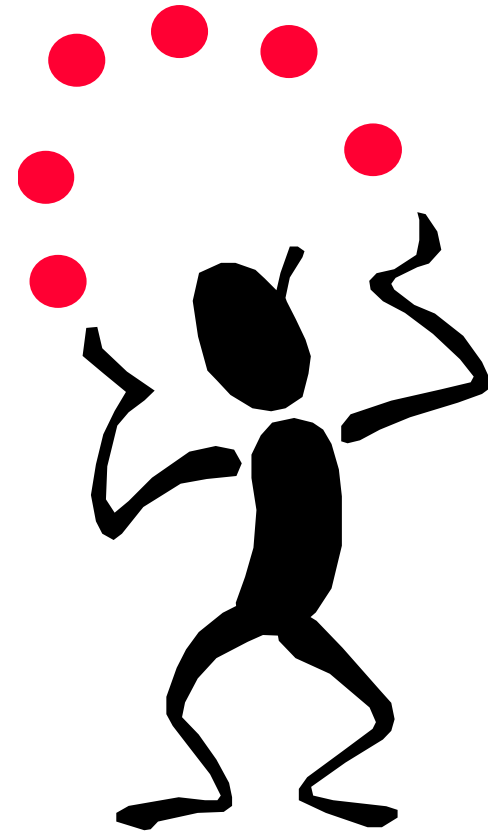
Therapist Tasks

- Setting the Stage
 - Group Topic(s)
 - Group Format
 - Group Size and Characteristics
 - Environmental Considerations
 - Group Rules
 - Group Contract



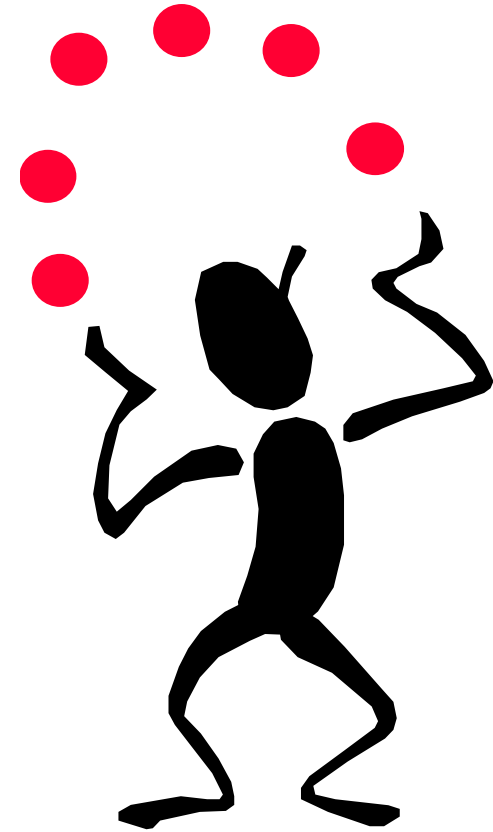
Therapist Tasks

- Primary role:
 - Create and Maintain
 - Rules
 - Norms
 - Expectations
 - Ensure Survival
 - Police, Firefighter, EMT ...



Therapist Tasks

- Culture Building:
 - Technical Expert
 - the WHAT
 - Model Setting Participant
 - the HOW



Discussion

- Nuts and Bolts
- Qualities/Roles of Leaders
- Icebreakers/Cohesion Exercises

Ways to Develop Groups

- Check-ins
- Sentence Completion
 - Superpowers
 - Favorite ... (games, animals, movies, etc.)
 - Personal Characteristics
 - I need/want ...
- Personal Bingo/Scavenger Hunt
- Have You Ever/Do You Have
- On and on and on ...

DBT-SP

Individual Therapy

Individual Therapy

- Role of Therapist
- Role of Therapy
- Therapy vs. Skills Coaching

Individual Therapy

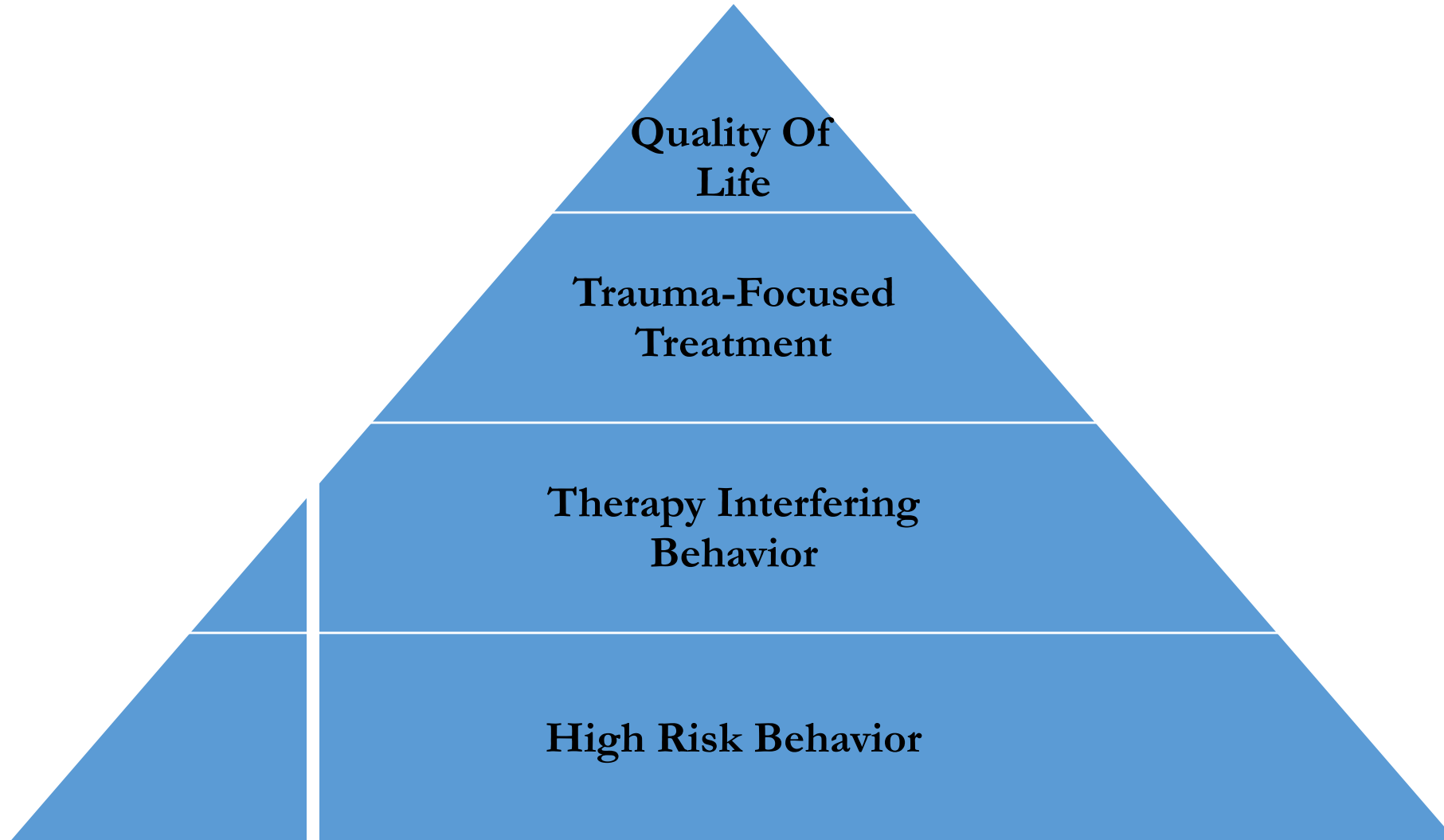
- CBT-Rooted
- Skills-Based approach
- Solution focused
- Works to inhibit problematic, maladaptive behaviors
- Replaces them with skillful responding
- Role-plays, review homework & diary cards, etc.

Individual Therapy: Hierarchy of Focus

- Decrease high risk behaviors (including suicidal behaviors).
- Decrease therapy interfering behaviors.
- Decrease behaviors that interfere with quality of life.
- Improve ability to maintain and generalize behavioral skills.

DBT-SP Individual Therapy:

Hierarchy of Targets with Traumatized Individuals



High risk behavior

- Analyze stressors and use behavioral chains to problem-solve
- Teach coping skills and facilitate accesses to resources
- Facilitate use of skills and resources
- Ensure environmental characteristics are not working against reducing high risk behaviors
- Achieve greater behavioral regulation

Therapy interfering behaviors

- Establish and develop relationship
- Check for motivation for treatment
- Analyze behavioral chains and problem solve
- Double-check relationship
- Teach in-vivo relationship skills and give feedback (transference/countertransference?!?)
- Triple-check relationship

Axis I issues

- Anxiety
- Mood disorders
- Grief, trauma
- Etc.

Trauma-Focused Treatment

- Utilize acceptance and change based strategies to work through trauma
- Examples of trauma treatment models that fit:
 - Trauma Focused Cognitive Behavior Therapy (TF-CBT; Cohen, Mannarino and Deblinger, 2006)
 - Interactive-Behavioral Therapy (Razza & Tomasulo, 1994)
 - Acceptance and Commitment Therapy for Trauma/PTSD (Follette & Pistorello, 2007; Follette, Palm, & Hall, 2004)
 - And others (c.f. Follette & Ruzek, 2007)

Quality Of Life

- Generalize new skills
- Target specific areas one at a time
- Teach situation specific skills (refine discernment)
- Maintain motivation for new change/new way of being
- Generalize and sustain progress on Axis I issues
- Facilitate movement towards personally fulfilling/valued activities

Individual Therapy: Tasks Therapists Address

- Expand client capabilities
- Motivate the client to engage in new behaviors
- Generalize the use of new behaviors
- Establish a treatment environment that reinforces progress
- Maintain capable and motivated therapists

DBT Team Consultation

- This is a vital component to maintaining a healthy, effective team
- Typically structured
- Format includes practicing skills we teach, consulting on tough cases, and ongoing learning
- Very inclusive group – especially working with adolescents

Self-Care, Burnout, and Caregiver Fatigue

- The Team is designed to promote self-care and prevent burnout
- Warning Signs:
 - Difficulty with working assumptions
 - Increased judgment
 - Feelings of dread, annoyance, or dismissiveness
 - Poor self-management
- This can happen to all of us...none of us are immune

Self Management

- Controlling what you say, how you say it.
- Self-awareness of your natural responses to events (what pushes your buttons, what has little effect, etc.). Watch out for anger, fear, and pride-based responses.
- Self-Management requires conscious attempts to become more self aware of your reactions & then choose how to respond.
- Self Management is key to providing a safe, nurturing, therapeutic residential treatment environment

Self Care Activities

- Vacation
- Social Activities
- Team Support
- Pleasure Reading
- Consultation/Supervision
- Training
- Taking Breaks
- Spending Time with Loved Ones
- Exercise
- Play
- Sleep
- Eating Well
- Take Walks
- Go to the Beach
- Diversify Work
- Art and Music
- Spiritual/Religious Practice
- Personal Therapy
- Meditation
- Journaling

Program Feedback

Feedback from clinicians about DBT-SP:

- Increased sense of competence
- Gave structure to treatment
- Content in manual was vital
- Felt less burned out
- Experienced real change with clients
- Consultation provided is very helpful
- Clinician productivity up
- Reduced crisis resource costs (time, money, etc)

Transition: DBT-SP to Trauma to TF-CBT

Dysregulation

- Behavioral, Emotional, Cognitive
 - Are they really distinct?
 - All characterized by
 - Over-reactivity, Unpredictability, Instability
- Illustrations
 - A great rollercoaster
 - A broken thermostat
 - Weather
 - Ballast

Emotional Dysregulation: Definitions

- Heightened intensity of emotions
- Poorer understanding of emotions
- Greater negativity to emotional experience
- Less ability to self soothe after negative emotions
 - (Mennin, Heimberg, Turk, & Fresco, 2004)
- "The inability to engage in goal-directed behaviors when experiencing distress."
- "Lack of awareness, understanding, and acceptance of emotions."
- "An unwillingness to experience emotional distress as part of pursuing desired goals."
- "Lack of access to adaptive strategies for modulating the intensity and/or duration of emotional responses."
 - (Gratz & Roemer, 2004)

Trauma, Dysregulation, and Neurology

- The parts of the brain that are most involved in PTSD are the amygdala, hippocampus, medial front cortex, thalamus, hypothalamus and the hypothalamic-pituitary-adrenal axis.
- Along with these, chemicals in the brain such as noradreneline, dopamine, serotonin, the opiod systems, insulin, and cortisol all play complex roles in the PTSD symptom producing process.

Adapted Trauma Treatment Work Group



- Subgroup for Deaf and Hard of Hearing
- Subgroup for Developmental Disabilities

Experiences of People with DD/ID in the Community

- Higher rates of maltreatment than the general population.
- Perpetrators perceptions:
 - Ideal victims
 - Lack credibility
 - Unable to report

Vulnerabilities

- Higher level of assistance from caregivers
- For longer periods of time
- For invasive daily functions
- Higher level of stress on the family
- People are less able to meet parental expectations

Charlton, Kliethermes, Tallant, Taverne, & Tishelman (2004)

Vulnerabilities

- Cognitive disability interferes with:
 - The ability to predict high-risk situations
 - Understand what is happening in an abusive situation
- Barriers to reporting:
 - Mobility challenges
 - Restricted ability to communicate

Charlton, Kliethermes, Tallant, Taverne, & Tishelman (2004)

Trauma?

- Broadly defined as any event or experience that:
 - Significantly conflicts with/alters worldview
 - Calls into question issues of safety
 - Compromises trust with caregivers/authority

Trauma May Take Many Forms

- Natural disasters
- Accidents
- Invasive medical procedures
- Physical abuse
- Emotional abuse
- Sexual abuse
- Refugee of war

Normal Response to Trauma

- Loss of control during the event.
- After the event:
 - Intrusion of material from the event
 - Numbing
 - Emotional constriction
 - Intense efforts to control experiences that might elicit memories
 - Dissociative splitting off or aspects of the experience
 - Hypervigilance (enhanced startle response and sleep disturbance)
 - Shattered sense of safety
 - Disruption of self-identity

Trauma Information

- It is important that normal trauma responses not be attributed to the person's developmental disability or pre-existing mental illness.
- People with developmental disabilities generally have the same types of symptoms following trauma that anyone else would: sleep disturbance, startle response, numbing, emotional constriction, disrupted sense of safety, shattered self-identity, etc.
- Trauma responses generally represent a change from the person's normal level of functioning.