

DBT for Individuals with Intellectual Disabilities: A Program Description

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The use of Dialectical Behavior Therapy (DBT) for the ID population is discussed with regard to the adaptations clinicians and programs must make in the standard manualized approach developed by Marsha Linehan. A specialized program developed by The Bridge of Central Massachusetts is presented along with examples and data from its implementation.

Keywords: DBT, personality disorders, behavior therapy, emotion regulation, skills training

DBT: An Overview

Dialectical Behavior Therapy (DBT) is a cognitive-behavioral therapy originally designed by Linehan (1993) as an outpatient treatment for people diagnosed with borderline personality disorder (BPD). In controlled outcome trials, DBT has been shown to be effective in reducing self-injurious behavior and inpatient psychiatric days in women diagnosed with BPD. It has also been shown to be helpful in reducing anger and improving social adjustment. DBT's approach balances therapeutic validation and acceptance of the person along with cognitive and behavioral change strategies.

More recently the use of DBT has been expanded to populations with additional diagnoses and in additional settings. In randomized clinical studies, DBT has been shown effective in reducing drug dependence (Linehan, Schmidt & Dimeff, 1999) and opioid use (Linehan, Dimeff, Reynolds, Comtois, Shaw Welch, Heagarty & Kivlanhan, 2002). An additional study showed significant improvements in depression scores and adaptive coping skills among depressed older adults (Lynch, Morse, Mendelson & Robins, 2003). Suicidal teens in DBT treatment were significantly more likely to complete treatment than those in treatment as usual and had significantly fewer hospitalizations (Miller, Rathus, Leigh, & Landsman, 1996). A study on primarily male forensic inpatients, most of whom had committed violent crimes, saw a significant decrease in depressed and hostile mood, paranoia and psychotic behaviors with DBT, as well as a significant increase in adaptive coping styles (McCann & Ball, 1996). Behavioral problems among juvenile female offenders decreased significantly following a DBT intervention (Trupin, Stewart, Beach, & Boesky, 2002). The number of binge episodes and days of bingeing decreased significantly among women with Binge Eating Disorder in DBT treatment (Telch, Agras, & Linehan, 2000). Finally, parasuicide rate was significantly lower

following the implementation of DBT on an inpatient unit (Barley, Buie, Peterson, Hollingsworth, Griva, Hickerson, Lawson, & Bailey, 1993).

What is DBT?

DBT understands problem behaviors in terms of the biosocial theory. The central idea is that people with significant difficulties with self-destructive behaviors, control of emotions, depression, aggression, substance abuse, and other impulsive behaviors often have problems with their emotion regulation system. These emotional problems are a result of a person's biological makeup as well as the persons' past experiences.

The theory postulates that such people are highly sensitive to emotional stimuli, have extreme emotional reactions, and return to baseline emotional functioning slowly. In addition, the environments in which they grew up were often invalidating environments that rejected their emotional experiences, punished emotional displays, and oversimplified the use of more adaptive and skillful behavior. As a result, these individuals suffer from extreme emotional dysregulation, an inability to identify and label their own internal emotional states, a tendency to vacillate between emotional inhibition and extreme displays of emotion, and an inability to shape their own behavior towards more adaptive responses to their emotions. Self-destructive behaviors are viewed as maladaptive attempts to manage extreme emotion.

The emphasis of the DBT model is on teaching the individual 1) to modulate extreme emotions and reduce negative behaviors that result from those emotions and 2) to trust their own emotions, thoughts, and behaviors. These two goals are accomplished through multiple treatment modalities, including: individual therapy, skills training, coaching in crisis, structuring the environment, and consultation teams for providers.

The focus of individual therapy includes: 1) teaching and strengthening new skills to decrease problematic behaviors due to skill deficits; and 2) addressing motivational and behavioral performance issues that interfere with use of skillful responses. Individual therapy sessions are structured with the use of daily diary cards, in which problematic behaviors, emotions, as well as adaptive skill use are recorded by the individual. The cards are used to assist in recalling and organizing details surrounding stressful behaviors. This is accomplished by conducting a detailed behavioral chain analysis, which includes antecedents, vulnerability factors, links leading to problem behaviors, and consequences of problem behaviors. As both the therapist and the individual gain greater understanding of the chain of events that lead to problematic behaviors, the therapist can then assist the individual in applying new coping skills in problematic situations.

In order to solve problems more effectively, individuals must learn new behavioral skills. In DBT, skills training consists of weekly groups for 2-2½ hours per week. Half of the group is devoted to presenting new skills. The remainder is spent reviewing homework practice for the skills currently being taught. The group is highly structured with an agenda set by the DBT manual developed by Linehan (1993).

Coaching in crisis is an integral part of the treatment. The rationale is that the clients often need help in applying the behavioral skills they are learning to problems in daily life as they occur. Individuals are able to access therapists by phone with the focus of this interaction on applying skills. Over time the frequency and duration of crisis interventions will decrease as the therapist responds consistently using these techniques.

DBT emphasizes teaching individuals to solve their own problems and navigate skillfully within their own environments. In other words, DBT teaches individuals to do for themselves, rather than have others do for them. This concept, in which treatment providers teach and guide individuals in how to solve their own problems, is called consultation to the patient. However, when the outcome is important and the individual is unable to solve the problem on their own, treatment providers are called upon to structure the environment for the individual (Linehan, 1993, pp.402). This might include providing training to family members, support people or other service providers, solving problems, coordinating treatment, and arranging contingencies to support skillful, rather than maladaptive, behavioral responses.

DBT assumes that attention must be paid to effective treatment provider behavior. Treating such challenging individuals can be extremely stressful and staying within the DBT therapeutic frame can be tremendously difficult. Consultation teams are designed to provide ongoing training to improve the skill level of treatment providers, to hold the treatment providers within the therapeutic frame and to address problems that arise in the course of treatment delivery (Linehan, 1993).

Why is DBT a viable treatment intervention for individuals with persons with ID?

According to biosocial theory individual's emotional dysregulation is a product of the biological vulnerabilities that they possess along with exposure to an invalidating environment. There are a number of reasons why this model is especially applicable to people with intellectual disabilities.

Biological Vulnerability

There is a long research tradition which suggests that individuals with intellectual disabilities are over-represented with regard to psychiatric disorders (e.g., Eaton & Menolascino, 1982; Campbell & Malone, 1991). Matson (1985) has linked this increased relationship to the presence of brain damage, seizure disorders, sensory impairment, and the variety of genetic syndromes associated with the population. Such co-morbid conditions associated with mental retardation may influence not only whether an individual is psychiatrically predisposed to disturbance, but also how others in their lives eventually interact with them. For example, medical fragility and subsequent hospitalizations may affect one's biological vulnerability by reinforcing somatic complaints and a dependent personality style. Different physical or facial characteristics may increase one's vulnerability because of how others may or may not be attracted to someone. Brain related discrepancies resulting in unusual learning disabilities may predispose someone to high expectations in all areas of their life when they may be significantly deficient in others. A history of early protective limitations may influence

whether someone learns the requisite skills to negotiate the world independently or their anxiety level over learning new things.

Characteristics of the Invalidating Environment

Though the construct of the invalidating environment was developed by Linehan (1993) to describe the often experienced acculturation of an individual with BPD, it is also a useful description for many individuals who grow up with ID. Each of Linehan's conceptualizations reflects a comparable experience by individuals with mental retardation. Additionally, ID individuals have the increased likelihood of being invalidated due to histories of abuse and institutionalization. The characteristics of invalidating environments as it relates to the ID population are depicted in Table 1.

TABLE 1. Characteristics of the Invalidating Environment

Standard DBT (Linehan, 1993)	Common invalidating experiences of those with ID	Example
Others reject communication of private experience.	Many decisions are made on the consumer's behalf despite their verbal protests and complaints.	Mother of consumer becomes the guardian for her adult child "for his own good" despite his ability to assert and make choices she does not agree with.
Others punish emotional displays and intermittently reinforce emotional escalation.	Caretakers may not attend to (or hear) individuals' needs until they display a certain crescendo of behavior.	Staff at a group home insists on a consumer going on a non-preferred outing despite his verbal protests. When he has a significant tantrum at the ballgame he requires physical restraint in public and ruins the outing for everyone. Ultimately they leave the game early.
Others oversimplify the ease of problem solving and of meeting goals	Caretakers wonder why individuals haven't already resolved a problem or wonder when they will turn themselves around.	Foster parent is shocked and dismayed after her charge loses her 3 rd consecutive job due to interpersonal problems. "He does so well when he is home."
Estimates of childhood sexual abuse history for people with borderline personality is between 65%-85% (Linehan, 1993, pp. 53)	A high percentage of mentally retarded individuals (25-83%) have been victimized by sexual abuse (Lumley & Miltenberger, 1997)	After a recent series of risky incidents and following a stable period the consumer is accused of "going back to old behaviors" in a dismissive "blame the victim" manner.

What are the benefits of providing DBT for individuals with ID?

In the spirit of normalization, as well as evidence-based practice, one needs to ask the question, “Why should persons with intellectual disabilities be denied a potentially effective treatment?” In fact, there are a number of important reasons why they should not. First, individuals with intellectual disabilities that possess personality disorders and particularly BPD are an extremely challenging population. Reiss (1994) has indicated that they are at high risk for restrictive treatment and Wilson (2001) has pointed out that their treatment is complicated by helplessness, confusion, and hostility held by those providers responsible for their care. Many such individuals are extremely treatment resistant which often results in team discord and burnout among providers. Such individuals often take an inordinate amount of treatment and emergency time and develop reputations, thus resulting in a difficulty obtaining community treaters. Many present high costs in medical care in addition to their high costs in mental health community care.

At the same time that such individuals are sorely in need of an effective treatment model, DBT presents itself as an approach that is very consonant with one for use with the ID population. For one, DBT is a skills based model that is consistent with psycho-educational and habilitative practice. Second, DBT is fundamentally non-pejorative in its language and positive in its aspirations without blaming the victim. Third, DBT has a strong focus on teaching individuals to advocate for themselves within the system of providers (the “consultation to patient” model) which is decidedly consistent with values of assertiveness, independence, empowerment, and self-advocacy.

What are the challenges to providing DBT for an ID population?

Despite the logical need for DBT treatment with the population there are some general reasons why it is a particularly challenging endeavor. For one, it is largely a cognitively based treatment. Linehan’s model is full of metaphors and acronyms. Those individuals with poor or no reading skills or a poor memory will have difficulty in a standard DBT framework. It is also a very complicated treatment modality that even seasoned clinicians may find challenging. In fact, as part of the model the treaters themselves are expected to constantly learn and relearn the skills as part of the consultation team. Complicated treatments can and should only be taken on if there is a strong administrative commitment to the use of the model for the long haul, especially in light of frequent staff turnover in human services. Indeed one of the key issues in the face of a managed care system is that DBT, for this population, needs to be considered a longer term treatment requiring multiple repetitions, repetitions that are persistent and embedded in a milieu or culture in which the central themes of DBT resonate many times over.

For particular individuals with cognitive deficits, there are additional challenges. As an example, one of the standard teaching techniques for working with ID individuals is to keep things simple by encouraging single answers, right or wrong, a choice of this or that, etc... Such teaching is probably counter-dialectical as it portrays the world as black and white without encouraging the shades of gray. Another challenge is that some individuals may not be ready to participate in some aspect of the treatment. This would be most common in the event that an individual is not group ready and may get dysregulated in the context of other group members, thus destroying the treatment for other members. A

third challenge in treating some individuals is that most individual service plan (ISP) goals are predicated on the development of consistent treatment planning by providers in different parts of the service network. This may at times be in contrast to the DBT principle of “consultation to patient” in which consumers are taught that they must learn to negotiate the system, fend for themselves, and accept that everyone does things in somewhat different ways. The last point relates to DBT’s high value on the generalization of skills, as the ability for an individual to practice skills in the individual therapist’s office or the treatment group setting is not sufficient. Practice in real world settings needs to be encouraged to have a meaningful impact on peoples’ lives. In point of fact, generalization needs to be planned for and not merely assumed in order to occur.

DBT for ID at The Bridge of Central Massachusetts: A Description

In this implementation a team of 5 clinicians who were intensively trained in DBT carefully developed, monitored, and supervised its adherence over the last 4 years. On a day to day basis there are two DBT clinicians who serve the identified consumers who are referred by the state for DBT treatment. The program receives a small amount of funding from the Massachusetts Department of Mental Retardation to pay for the intensive clinical services that are offered. Clinicians have a caseload of approximately 8 consumers and are responsible for providing the full complement of DBT therapy modes.

Standard DBT has five modes of therapy according to Linehan (1993); individual therapy, group skills training, coaching in crisis, structuring the environment to support treatment, and the consultation team. Adjustments were made to each of these modes in order to support an ID population that while still maintaining adherence to the basic tenets of DBT structures.

Individual Therapy

Individual therapy was conducted for each consumer in approximately 1 hour per week. Therapists generally had a caseload of 8 consumers and met individuals at their office or in some cases at their homes or other convenient locations. Because of their small caseloads they could be more accommodating by meeting twice per week for 30 minute appointments if necessary.

In orienting an individual to DBT, the therapist explains the biosocial theory in simple terms. This assists the individual in clarifying confusing and maladaptive thoughts about themselves related to impulsivity and emotional dyscontrol. This may include statements like, “You are a good person, but your brain is wired to have difficulty with emotions. This is not your fault. Certain events or people (the invalidating environment) may have made things difficult, even unfair, but DBT skills can help you gain better control”. The therapist must link consumer goals to the treatment of DBT. This may be derived from questions related to interpersonal difficulties with family, friends, housemates, or bosses or harm to self through risky activities including cutting, overdosing, poor medical compliance, substance abuse, and the like. Validation of the individuals’ concerns is a key element of initial contact and ongoing follow-up care. There must be a healthy balance of therapeutic validation in order to inspire change in the consumer. This

frequently may mean that the therapist must show some tolerance and view an individuals' thoughts emotions and behaviors as perfectly sensible in light of their history and experience.

In DBT the role of the therapist is to help the individual acquire skills, help with the strengthening of skills, and help with the reinforcement of skills. The therapist plays the role of coach and cheerleader throughout. As the therapist becomes more of a reinforcing entity they may be in a stronger position to use their personal reinforcing leverage in the service of behavior change. The therapist needs to be cautious that they maintain a non-judgmental stance and not blame the victim when a consumer does something inappropriate. The mantra according to DBT is that "the consumer is doing the best that they can".

Commitment is a key concept in DBT individual therapy, first for the client to commit to staying alive and improving their life, then to commit to all the facets of therapy including group and individual work, then to try out specific individual therapeutic techniques that are part of individual DBT. It has been our experience that some commitment strategies have worked better than others with the ID population. These have included the use of pros and cons, principles of shaping, and the use of cheerleading through generation of hope. Commitment is seen as a two-way street. As some of the referrals to our program were less than stable with regard to their housing, therapists often outreached them at shelters, food pantries and the like. Over time it was hoped that individuals would eventually arrive independently to therapy appointments. Commitment is seen as waxing and waning in the course of therapy with the notion of recommitment a continuous and active entity.

In the DBT treatment hierarchy, life threatening behaviors are always prioritized in therapy. Any behaviors or thoughts that present such risks are actively pursued in session. Following life threats are treatment interfering behaviors which include medication refusals, non-compliance with therapy or medical appointments, or other behaviors which may serve to burn out the therapist or members of the treatment team. The third category of behaviors in the DBT therapy hierarchy is quality of life interfering behaviors. These may include issues related to money, housing, substances, work, or interpersonal conflict. In DBT, trauma treatment would not be conducted until an individual has learned the skills to mitigate against the more risky behaviors in the treatment hierarchy.

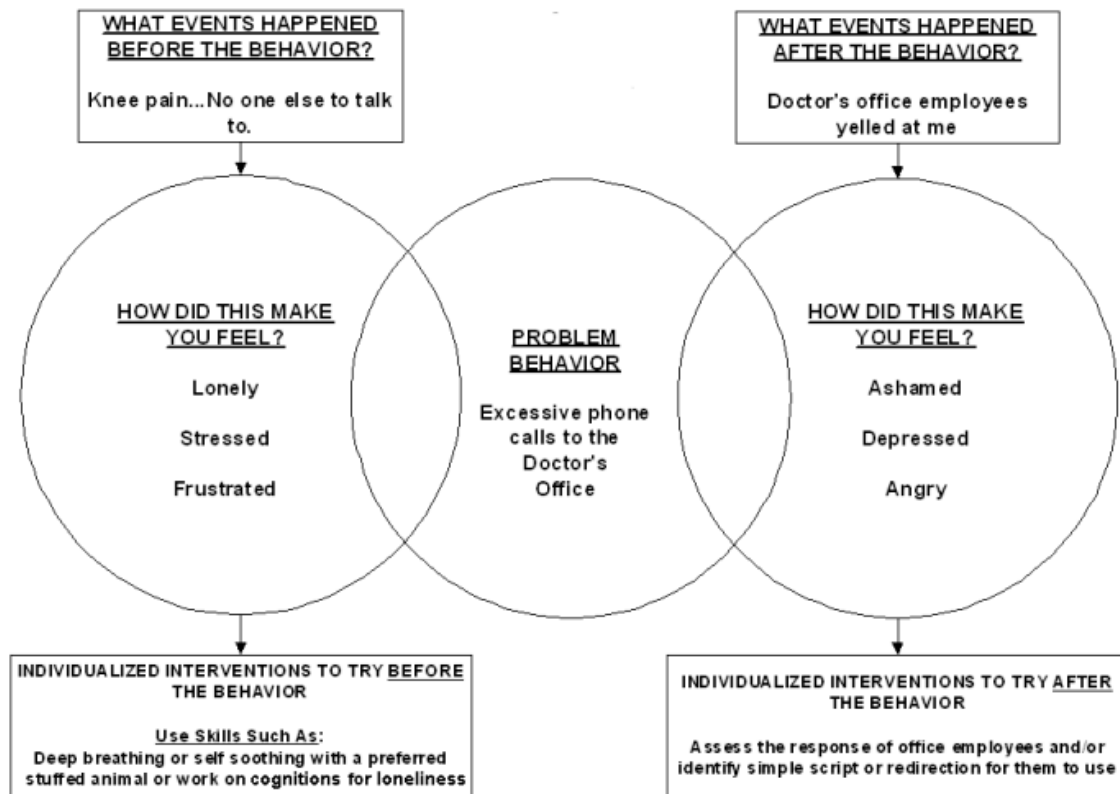
A key source of client data in DBT treatment are diary cards used on a daily basis. Linehan's diary cards are far too sophisticated for the ID population. The creative use of pictorial cues on the cards is useful in getting non-readers to participate. Diary cards were phased in for this population starting with positive skills practiced on a daily basis. Where possible, community supports such as family members or staff were recruited to gently reinforce the practice of this self-monitoring mechanism. Eventually target thoughts and behaviors were included on the cards. A sample card is included in Figure 1. Adapted diary cards differ from Linehan's standard format by being simpler, more focused, and developed with the awareness that others in the environment may help encourage that the card will be adhered to.

FIGURE 1. Adapted Individual DBT Therapy Diary Card

Individual DBT Therapy Diary Card						
My Goals	Making Money			Controlling Blood Sugar Level		
Day and Date	Skipped Work Today	What emotion did you feel at the time?	What Skill(s) did you use to feel better? Mindful breathing, DBT Basket, Individual skill	Overate Sugars or Carbs Today	What emotion did you feel at the time?	What Skill(s) did you use to feel better? Mindful breathing, DBT Basket, Individual skill
Thurs _____						
Fri _____						
Sat _____						
Sun _____						
Mon _____						
Tues _____						
Wed _____						

As discussed, DBT views its fundamental dialectic as that of acceptance/validation along with change. DBT is primarily a cognitive-behavioral approach to treatment and includes a number of key change strategies. Some examples include behavior shaping where one might attempt to get a consumer to gradually sit around the table in a skills group rather than on its' outskirts, the use of exposure in which a consumer may learn to tolerate increased threatening content in therapeutic material in session, contingency management in which aspects of a individualized behavioral treatment plan may be negotiated with the treatment team to support the individual (See "structuring the environment"), and problem solving in which consumers are walked through the process of analyzing the functions of their behavior and challenged with regard to the choices, decisions, and solutions that they employ. This can be assisted by utilizing the chain analysis, a sample of which may be observed in Figure 2. This graphic includes prompting events to a behavior, the real world consequences to a behavior as well as the feeling states this engenders for an individual. This ultimately helps the consumer and therapist come up with practical interventions to employ for the next time a similar behavioral sequence occurs. A simple chain can be graphically displayed to consumers so as to assist those who cannot read. Therapists may work with consumers to select pictorial referents that are inserted in the chain to help them connect their feeling states with skills that they may practice as part of an individualized therapeutic plan.

FIGURE 2
Chain Analysis for an ID Consumer



Group Skills Training

Groups consisted of approximately 8 consumers along with two co-leaders as well as staff and parents of consumers. In this way the group served a training function for both the consumers and other significant people in the consumer's life. An entire group cycle would last approximately 23 weeks with individuals benefiting from 2-3 complete group cycles. The modules were as follows: Orientation and Group Rules(1), Mindfulness(2), Distress Tolerance(5), Mindfulness(2), Emotion Regulation(5), Mindfulness(2), Interpersonal Effectiveness(5), Celebration (1). Each group lasted approximately 2 hours of which the first 30 minutes devoted to a review of the homework and previous week's agenda, the next 30 minutes devoted to a dinner break and the last hour spent on the current week's agenda. Because of this population's history with school and learning as an aversive, there was great attention toward making it a fun, user friendly, non-threatening, and success oriented experience. As an example, homework was called practice. Because staff and family were invited to the groups each consumer had a 1:1 coach so that activities and role-plays had adequate supervision both in and out of the group. Repetition was a key in terms of skill acquisition and retention. Curriculum adaptations attempted to retain the clinical focus of Dr. Linehan's skills training (1993) material but emphasized hands-on applications such as tactile activities, visual and hearing modalities including film, music and pictures, along with attempts to truly individualize "what works" for each consumer. Examples of each of the skill modules with sample hands-on activities are included in Table 2.

TABLE 2. Sample Activities for Teaching DBT Skills to ID Individuals

Skill Module	Example
Mindfulness	<p>Simple Breathing (in and out) for 2-3 minutes repeated weekly in group and daily in practice.</p> <p>Observe and Describe common objects -by asking clients to “state the facts man” for objects such as a flower, candle, marble, etc...</p> <p>“Wise Mind” videos-such as Mr. Spock from Star Trek (rational mind), Cameron from Ferris Bueller’s Day Off (emotion mind) and Luke Skywalker from Star Wars (wise mind)</p>
Distress Tolerance	<p>Personalized Self-Soothe basket/box-the week by week acquisition of distress tolerating alternatives that are placed in defined baskets for easy access in client’s daily life.</p> <p>Pros and Cons role play- the use of video role playing of effective and ineffective solutions to problems. Have consumers give pros and cons of each solution in the group.</p>
Emotion Regulation	<p>Color of Emotions-choose 5 colors and the emotion associated with each one (red/angry, blue/sad, etc...)</p> <p>The Story of Emotion role play-have the consumers take different roles of prompting event, thought, physical sensation, action urge, etc... Play out in different sequences.</p>
Interpersonal Effectiveness	<p>Consumer/Staff Videos of each practicing DEAR-MAN skills, with opportunities to stop action and discuss the separate components of describing, asserting, reinforcing, expressing, etc...</p> <p>Role playing of skills using a simple rewarding activity such as asking others for a piece of candy in an interpersonally effective manner.</p>

With this population, there were indeed some individuals who were not group ready. Attempts were made to shape these individuals toward group readiness as well as giving them the option to let staff know how much they may tolerate in the group. The rules were negotiated with group members in advance and included aspects of taking turns, showing respect to one another, having no intimate relationships with others in the group, and not engaging in war stories. The group leader assumed the responsibility of managing the group agenda which was dictated by Linehan's skills while the co-leader assumed the role as the primary behavior manager in the event of therapy interference within the group. Such therapy interference was often dealt with between groups by the individual therapist and may have included a repair or correction procedure planned by the consumer for the next group. It would only be in truly egregious cases that a behavior would be considered "therapy destroying" and where an individual may be restricted from returning to the group for a defined period of time.

Coaching in Crisis

The clinicians scheduled individualized proactive phone-in times for specific participants whose crises may be interrupted by supplemental therapist contact. Additionally, all clients were able to reach a DBT trained clinician 24 hours per day via pager. Consumers were educated around what to expect in coaching such as; only 10 minutes, no venting, asking what skills may be used to improve things, etc... To avoid therapist "burn-out" the supervising clinician and the two DBT clinicians rotated this pager. An "on-call book" was carried by the clinician on pager. This reference contained an individualized DBT plan for each client served which provided a quick reference for the clinician to guide the caller to skills that work for him/her. The book also contained demographic information in the event that the primary agent of care and or emergency response services needed to be contacted. In practice, with a group of eight individuals with intellectual disabilities, crisis calls averaged one every 1-3 days. Clients often had an integrated plan that limited "emergency" phone calls, but that encouraged independent use of his/her DBT skills and independent access of appropriate community services. All clients were coached to use the DBT pager before a crisis erupted. Clients were educated in noticing when body sensations arose indicating that a difficult emotion was building and an action urge may result in a target behavior. All clients had an individualized relapse prevention plan for crises that was a component of their individualized DBT plan.

The clinician 1) listens to and validates the client's concerns, 2) asks what skills have they used so far and which skills have worked and which haven't; develops a brief plan for the day then, redirects the client to the next scheduled phone check and/or therapy visit, and/or 3) refers clients to their natural supports available in their community (e.g., MD, or local Emergency Mental Health Service). Individuals are, however, immediately referred to the local ER if a self-injury/suicide attempt is threatened and or has occurred. At this point the therapist ends the phone contact and calls an ambulance for the client.

In practice with an ID population, some confusion will undoubtedly occur with the "coaching in crisis" model. For example, one individual called on New Year's Eve. Her mood was assessed as happy. Her reason for the call was to ask which channel Dick Clark could be observed on TV that night. Another woman called and promptly told

the answering clinician that she (the clinician), must have dialed the wrong number as the client only wanted to speak to her assigned clinician, not to the clinician who answered the page. In such cases clinicians handled such incidents with continued instruction about how coaching is to be used. In another instance a clients use of the on-call pager exceeded 15 times per day. This behavior was treated as therapy interference and extinguished after three trials of withdrawing the pager number for defined periods of time in a manner consistent with Linehan's notion of putting the client on vacation. In general, however, coaching in crisis is seen as a helpful part of this model as most consumers use it appropriately and, in turn, gain in their ability to manage difficult situations.

As part of the model, there is an ongoing attempt to have individuals use their natural supports to assist with coaching. This has at times included staff or family whom the individual has regular contact with. Clinicians model for them validation "in the moment" so that such individuals are not so dismissive as to advise their charges to "just use your skills" and thus be perceived as invalidating by the consumer.

Structuring the Environment to Support the Treatment

Clients involved in The Bridge DBT model may live independently, with family members or may be served residentially by another community provider. All were consumers of mental retardation supports in Massachusetts and some saw adjunctive therapists in the community. We have found that it is imperative to support the ISP "team" for all clients to ensure adherence to the DBT model. In working with an ID population it was essential that the therapist assume the role as consultant to the team via support, education, distribution of individualized materials, and clinical leadership in order to strengthen client and team motivation and the eventual generalization of skills to home and community. This was achieved in a variety of ways. Training was provided to residential staff supporters and family members via group training sessions with a primary focus on biosocial theory, validation and a DBT skill module overview. Individual training to a specific set of staff or family supporting any one client was provided as needed. Staff supporters and family members were required to attend DBT homework and skill groups to learn along with the client and to "coach" and support their client in group with small group activities and role play. The coaches sat with the group and assumed a parallel role with the client. Coaches participated in all aspects of the group as well as the completion of "at home" practice assignments.

As stated previously clinicians developed an individualized DBT treatment plan with all clients. In many cases this plan was developed in collaboration with the residential provider and or the family and was used in the client's natural environment. Adjunct clinicians and the state service coordinator also contributed to the development and implementation of the plan. Collaboration was essential to ensure that all supporters have an invested role in implementation of the plan and that information is gained from all supporters regarding previous success with various contingency models. A focus was on creating user-friendly environments for adherence to DBT. This included contracting with consumers and their coaches for the practice of skills, for building practice into formal schedules or for creating multiple self-soothe boxes that could be accessed at

home or at work. It was often necessary to blend or merge any existing behavior plans with the new DBT treatment plan.

An example of collaborative efforts and training could be seen in our implementation of the Distress Tolerance skill module specific to the self-soothe skill. Data was gathered from clients in group relative to what worked best to soothe or calm him/her when using the five senses. Each individual was then provided with a personalized self-soothing basket/box containing some of their preferred items as indicated in Table 2. Home supporters were provided with a self-soothe list for the client and staff was trained as to when to encourage an individual to choose an item and/or activity from the box. When the self-soothe box was used the home supporter would then encourage and or assist the client to record it on his/or her diary card if they have not done so independently. On-going consultation with home supporters was a key to making the necessary changes to chosen skill related items/activities as any particular consumer may lose interest or satiate on their initial choices over time.

Consultation Team

The agency provided two levels of consultation team within its' developmental disabilities services. A developmental disabilities team composed of agency clinicians, division director, clinical director, director of DBT services, and residential management staff met weekly. An interagency DBT consultation team composed of community clinicians with whom cases are shared, community residential providers with whom cases was shared, Massachusetts Department of Mental Retardation clinicians, agency clinicians and supervisors met monthly.

Consultation team agreements are established to adhere to the following:

- 1) To accept the dialectical philosophy-that there is no absolute truth, 2) To consult with the client on how to interact with other therapists and not to tell other therapists how to interact with the client 3) To accept that consistency of therapists with one another (even with the same client) is not necessarily expected 4) All therapists are to observe their own limits 5) To search for non-pejorative, phenomenological empathic interpretations of client's behavior and 6) To agree that all therapists are fallible.

Each consultation team began with a Mindfulness activity. Participants provided feedback in response to the activity in terms of it's adaptability to an ID population. An agenda was taken with first priority given to case review and consultation regarding any client who was presenting with life threatening behaviors. Secondary priority for agenda was to review and consult regarding therapy interfering/destroying behaviors by an individual client and/or a clinician. Therapist burn-out was given third priority before any other agenda items are undertaken. Therapist burn-out has been known to occur after 5 consecutive weekend crisis calls from a consumer. In such a manner the team could serve to support therapists and providers who needed to remain motivated in working with a very challenging population.

Other agenda items primarily focused on enhancing the skills of the members via the rotation of training topics presented to the consultation team, discussion and evaluation of

on-going groups, preparation for future groups and issues that occurred during the course of individual therapy. The consultation teams strove to remain adherent to the DBT model while simplifying ideas for teaching skills that are interactive and understandable to an ID population.

Data Collection

In this first cohort of individuals exposed to a DBT intervention, 8 individuals were included. They were all referred to the program by the Massachusetts Department of Mental Retardation. All 8 were females with an age range from 25-61. Seven of the eight were diagnosed with mild mental retardation and the eighth was considered moderately retarded. The average number of Axis I diagnoses per consumer was 1.38 with the most common diagnoses identified as Major Depression (38%) and Schizoaffective Disorder (25%). Five of the eight had diagnosed personality disorders. Four of the eight women had significant medical issues including diabetes, vascular dementia, and status post head injury. Seven took medication for physical conditions and all eight were on psychiatric medications. All were considered priorities by the DMR and had been identified as multi-problem individuals who were risks in the community and/or clinically underserved using current services.

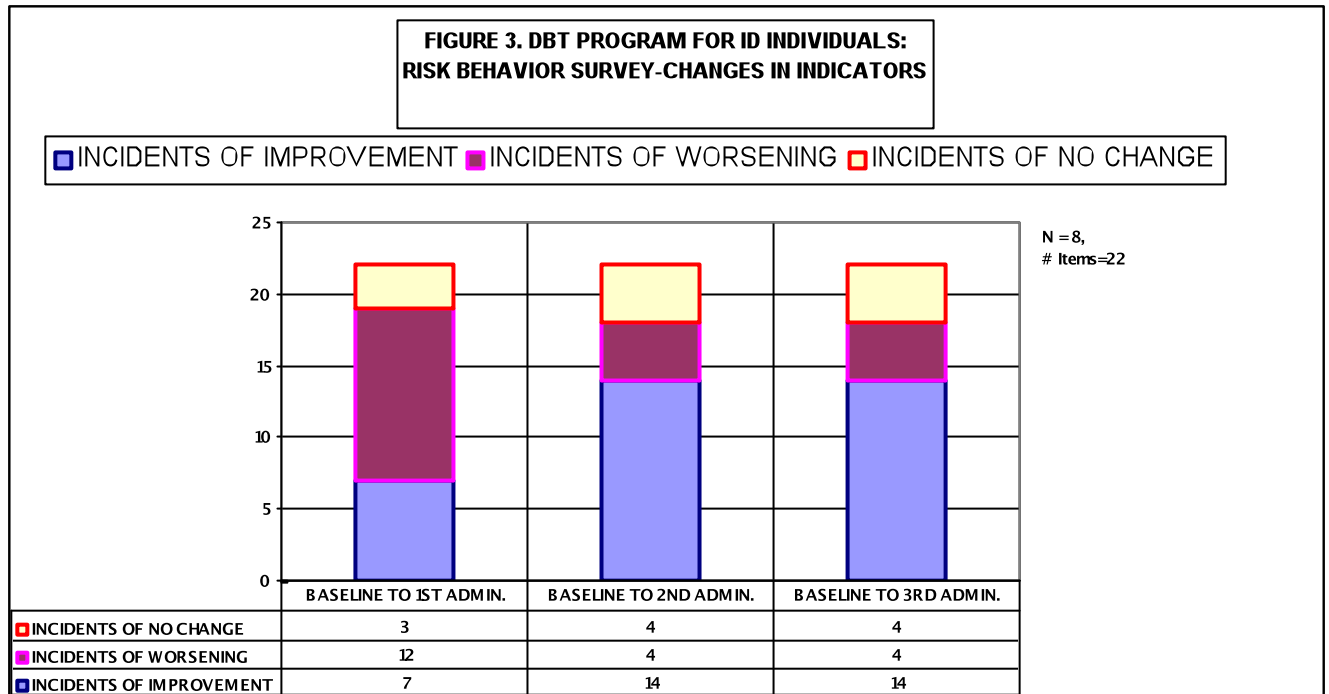
Data were taken on an adapted version of the Youth Risk Behavior Survey or RBS (2001) which is used by the Centers for Disease Control and Prevention to assess the risky behaviors of high school youth across the nation. Out of the 87 total items 22 were selected that were thought to be most relevant to the ID population and sampled questions regarding areas of safety and violence, harm to self, substance use and misuse, sexual risk, and eating disorders. Data were collected by gathering a consensus of team members participating in the ISP meeting scheduled for each of the 8 identified consumers at 6 month intervals (Baseline, 6-month administration, 12-month administration, 18-month administration) Teams ranged from 3-5 members in size and members needed to agree on assessment data.

Results and Discussion

All 8 women participated in the program throughout its duration. One individual chose not to participate in groups but did receive the full complement of other DBT services with skills taught during individual sessions. Modal group attendance was 5 with participants intermittently missing groups and individual sessions for typical and reasonable reasons.

Risk Behavior Survey

The 8 dually diagnosed women in this study were indeed individuals who presented a fair amount of risk at baseline. Of the 22 items measured by the RBS the women averaged 6.0 indicators of risk with a range from 2-11.



A general pattern seemed to emerge from the implementation of DBT treatment with this population. This may be observed in Figure 3. There is some indication that risky behaviors, measured as indicators on the RBS actually got worse compared with baseline after the first 6 months of treatment. That is, of the 22 indicators 30% improved, 16% stayed the same and 54% got worse. This pattern appeared to change quite dramatically by the second assessment (12 months) when 60% of the indicators improved from baseline, 22% stayed the same and 18% got worse. This improved pattern stayed intact during the third (18 month) assessment period.

Of particular significance is the decrease in the overt behavior of harm to self, one that is quite germane to the practice of DBT. Here a pattern of slow but gradual reduction from a baseline of 6 individuals who had demonstrated harm to self in the prior 6 months (to baseline) to 5 (at 6 months of treatment) to 3 (at 12 months of treatment) to 2 (at 18 months of treatment) was observed.

The finding that there was a worsening of risk at the 6 month juncture may seem surprising, but would appear to have a credible explanation in light of doing DBT with the ID population. For one, even in Linehan's outpatient model with non-retarded individuals, it is considered essential to teach individuals the skills necessary to cope prior to helping consumers through their trauma. This leads to the differentiation of Stage 1 (behavioral targets) treatment and Stage 2 (trauma targets) treatment. Certainly with mentally retarded individuals, the likelihood of uncovering trauma through active (albeit not trauma) treatment is there. Also, it is likely that it actually takes longer for such individuals to absorb the skill set so that they can help themselves to address these issues.

This may serve to explain how their risky behaviors may have at first gotten worse before later improving.

Linehan (1993, pp. 402) refers to “conditions mandating environmental intervention” and she advises “intervening when the (person) is unable to act on her own behalf and the outcome is very important”. What was unique in this study was the incorporation of a number of systems’ interventions that explicitly describe how clinicians might tailor the integration of DBT and a care management system for a dually diagnosed population. Given the appropriate confidentiality sign-offs; parents, families and paraprofessionals were included in the assessment and referral process. Specific DBT trainings were conducted on their behalf to establish strong components of validation and crisis coaching since these support people were often at the front line when an individual began to have difficulty. Community team members were important contributors to individual DBT plans. Finally, extensive planning was initiated with significant community resources including ER’s, hospitals and particularly longer term community therapists so as to sensitize and incorporate others and to establish a framework which may contribute to the maintenance of the program for years to come.

An obvious limitation of this study is the fact that only 8 individuals were included. Until these results are replicated, they should be considered tentative. Additionally, because of the augmentative funding (some \$6000) per consumer, there may be limitations in many states with regard to the application of this model. Nonetheless, it is encouraging that the Linehan model, which was originally developed for outpatient treatment of a non-ID population may be integrated into a potentially efficacious model for those with mental retardation.

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