Improving Accessibility to Dialectical Behaviour Therapy for Individuals with Cognitive Challenges

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The Oxford Handbook of Dialectical Behaviour Therapy
Edited by Michaela A. Swales

Subject: Psychology, Clinical Psychology Online Publication Date: Nov 2017
DOI: 10.1093/oxfordhb/9780198758723.013.24

Abstract and Keywords

Many individuals with developmental and intellectual disabilities (ID) who are dually-diagnosed with mental health problems experience emotional, cognitive, and behavioural regulation difficulties. The comprehensive, multi-modal approach offered by Dialectical Behaviour Therapy (DBT) addresses the complex intra- and inter-personal challenges that create and maintain patterns of dysregulation and challenging behaviours. This chapter presents information to help DBT therapists understand factors relevant to applying DBT with individuals with dual-diagnosis and emotion regulation skills deficits. Although standard aspects of DBT are critical, adjustments to improve access for individuals with ID are necessary. Therapists treating this population must be competent in standard DBT and in managing factors associated with cognitive load to modify interventions in ways that remain fundamentally DBT. This chapter addresses accommodations that alter delivery mechanisms, not changing core processes, and introduces the Skills System, an adapted curriculum with which the DBT therapist can help individuals with ID improve intrinsic emotion regulation capacities.

Keywords: Intellectual disabilities, developmental disabilities, dual-diagnosis, emotion regulation, challenging behaviours, Skills System

Key Points for Clinicians

1. Accommodations to DBT for individuals with ID need to remain adherent to the model; the delivery mechanisms are altered, rather than core processes.
2. It is essential for the DBT therapist to have heightened self- awareness regarding perceptions and communication patterns in to foster positive transactional patterns in the client.

3. the DBT therapist treating individuals with ID must understand how to manage factors associated with cognitive load in order to design and adjust treatment interventions.

4. The therapist needs to understand, be empathetic about, and manage the complex environmental factors that impact the lives of individuals with ID.

5. The complex and detailed skills curricula that form part of standard DBT require some adaptation for clients with ID. The Skills System is one such adaptation that provides the client with an accessible emotion regulation skills framework that promotes self-regulation and co-regulation processes to enhance the generalization of skills into the individual's natural environment.

Introduction

The development of Dialectical Behaviour Therapy (DBT) expanded treatment options for individuals with borderline personality disorder (BPD), who, prior to Linehan's work (1993a, 1993b), were largely perceived as untreatable. DBT is a comprehensive model that includes a foundational theory, principles, and strategies to support people with BPD to improve core regulation capacities. There is a new group of perceived "untreatables," individuals with intellectual disabilities (ID) who experience various types of dysregulation. Again, DBT is a potential solution, but because of this population's intensified needs, delivery mechanisms need adjusting and additional scaffolding is necessary to improve accessibility to DBT. This chapter addresses specific strategies to help the DBT practitioner treat people with ID and emotion regulation challenges.

The goal is to make accommodations *and* remain adherent to DBT. This is best achieved by examining the functions of the DBT treatment mechanisms, keeping essential concepts, and adjusting delivery systems to improve access, while not disturbing core curative elements. This process—evaluating and altering of the delivery methods—must focus on the treatment needs and available resources of the individual. To strengthen the evidence-base of this adaptation, it is necessary to rely on research in alternate fields of study (e.g., ID, emotion regulation, and cognitive load theory) to understand barriers and solutions. This chapter reviews each component of DBT (Linehan, 1993a), and highlights challenges and possible accommodations related to the implementation of DBT with individuals diagnosed with ID.

Bio-social Theory and the Beginning of DBT

Bio-social theory, which is the theoretical under-pinning of DBT, posits that there are transactional relationships between vulnerable individuals and invalidating environments that intermittently reinforce emotionally dysregulated responses. Individuals diagnosed with ID experience deficits in cognitive and executive processing which increase vulnerability and hinder adaptive functioning. Broad spectrums of aetiologies exist within the diagnosis of ID, as well as diverse constellations of strengths and weaknesses related to individual functioning capacities that create heterogeneity within this group. Generally speaking, deficits impact the individual's abilities to manage cognitive load demands in complex situations and impede the execution of adaptive chains of goal-directed behaviour.

In addition to cognitive difficulties, the literature highlights multiple factors that can increase the vulnerability of individuals with ID. For example, a diagnosis of co-occurring mental illnesses in this group is more likely than in that of its non-disabled counterparts (Hove & Havik, 2008; Weiss, 2012). These individuals also experience higher rates of victimization (e.g., neglect, physical, sexual, and witnessing violence) (Beadle-Brown, Mansell, Cambridge, Milne, & Whelton, 2010; Mevissen, Lievegoed, Seubert, & Jongh, 2011; Sullivan & Knutson, 2000). Sullivan and Knutson (2000) found that youth with ID were 30% more likely to experience abuse. Although this is alarming, researchers predict that the prevalence rates are even higher because of the widespread underreporting of victimization (McCormack, Kavanagh, Caffrey, & Power, 2005; Bedard, Burke, & Ludwig, 1998). A concerning double-bind exists; despite heightened risks, this population experiences fewer treatment options specifically designed to accommodate the impact of the ID (Emerson & Hatton, 2014).

Transactional Social Relationships

The bio-social theory contends that negative transactions between vulnerable individuals and invalidating environments create and maintain patterns of dysregulation. These patterns can happen within families, support environments, and potentially within the DBT treatment relationship. Therefore, it is vital to be aware of how various micro- and macro-bio-social factors may transact to ensure effective management of the DBT therapeutic relationship.

Vulnerable Environments

Individuals with ID have intensified needs which potentially creates increased pressures for the families/systems supporting them. Norona and Baker (2014) studied 225 families and examined transactional parenting behaviours and emotion regulation capacities of both ID and non-disabled youths across three time points. These authors found that children with ID were significantly more dysregulated at all time points when compared to non-disabled age-mates. Additionally, the mothers of the children with ID demonstrated fewer “scaffolding behaviors” at ages three and five (Norona & Baker, 2014, p. 3209). The authors found that a lack of effective parental scaffolding behaviours contributed to the emotion regulation skills deficits of the children. Because of the increased demands implicit in supporting a person with ID and co-occurring mental health issues, it may be useful to reframe the elements of the bio-social theory for individuals with ID as a transactional relationship between a vulnerable person and a vulnerable environment. This reframe will aid the DBT practitioner in understanding and validating the experiences of people within the support system to facilitate change.

Power Imbalances

Individuals with ID experience higher levels of social stigmatization (Ali et al., 2013; Ditchman et al., 2013). Jahoda et al. (2009) highlight how receptive and expressive language problems impact power distributions in the relationships between individuals with ID and their therapists. The authors assert that bi-directional transactional communication dissonances can complicate the assessment and treatment processes for both participants and care providers. Beyond therapy settings, power imbalances commonly occur within relationships between individuals with ID and other people in social contexts (Jahoda et al., 2009; Irvine, 2010; Coons & Watson, 2013). On an institutional level, these imbalances may hinder transactions that include processes associated with autonomy and self-determination (Petner-Arrey & Copeland, 2014).

Transactions: The Problem and the Fix

It is vital that a DBT therapists and skills trainers understand personal and social contexts that are relevant for this population. Linehan describes how “individual functioning and environmental conditions are mutually and continuously interactive, reciprocal, and interdependent” (1993a, p. 39). Within these types of transactional relationships, the entities are continually adapting and bi-directionally influencing each other. Factors associated with stigma and power differential processes emerge continually within therapy sessions, skills training groups, and interactions with support providers. These events create learning opportunities or the continuation of recursive problematic patterns. Fortuitously, DBT contains a myriad of practices designed to create and maintain egalitarian relationships between the client and the therapist.

Dialectical Dilemmas

Emotional Vulnerability Versus Self-invalidation

There is emerging literature related to the psychological functioning of individuals with ID, yet serious knowledge gaps remain. Although there are numerous barriers related to diagnostic precision (e.g., heterogeneity of this population, communication issues, lack of provider awareness, etc.), there is general consensus that individuals with ID appear to experience heightened emotional vulnerabilities. This means that a formal diagnosis of BPD in individuals with ID is rare, yet many may experience similar processes that underlie BPD. The combination of (a) reinforced patterns of emotional escalation in transactional relationships with invalidating/vulnerable environments and (b) inadequate learning experiences related to building effective emotion regulation skills contribute to patterns of emotional, cognitive, and behavioural dysregulation.

The conceptualization of emotional vulnerability in DBT (e.g., high sensitivity, slow return to emotional baseline, impact on cognitive processing capacities, and problematic behaviour functioning as a desperate attempt to regulate escalating emotions) are key for DBT therapists (and collaterals such as staff and family members) to understand. Oversimplifying the ease of coping and misattributing behaviours as manipulative fosters conflict and, ultimately, self-invalidation by the individual. The combination of acceptance strategies (that support the individual in the moment, as it is) and change strategies (that support the individual to be effective while in the moment) helps the individual develop a stronger sense of self- awareness, self-acceptance, self-value, and self-trust (e.g., self-validation).

Active Passivity Versus Apparent Competency

Several factors contribute to the individual with ID presenting with behaviours labelled as active passivity. For example, it can be difficult for support providers to accurately assess the specific support needs and shape interventions to build increasing capacities; teams often oscillate between over-doing and under-doing. Simultaneously, individuals experience skills deficits that affect their abilities to effectively manage intra- and interpersonal environments; individuals frequently oscillate between over-doing and under-doing. Additionally, the lack of foundational skills to complete complex tasks such as problem solving can promote resignation and derailment, often misattributed to passivity, while the root issue is a lack of adequate requisite problem solving and self-regulation competencies that are components of complex skills chains. In addition to skills deficits, individuals with ID tend to have low self-efficacy that can reduce engagement.

Competency is a complex construct in relation to people with ID. For example, the level of emotional and cognitive dysregulation may impact behavioural competency in the moment. Environments that provide ample scaffolding and supports specifically tailored to the needs of the individual are likely to witness the individual demonstrating increased

competency. Additionally, how the therapist conceptualizes competency impacts the evaluation of capacities. If the therapist defines competency as quantitative and academic abilities, they will view the client as more incompetent. If the therapist acknowledges areas of strength (e.g., creativity, compassion, spirituality, wisdom, humour, and intuition), they will assess the client as more competent.

Unrelenting Crisis Versus Inhibited Grieving

Individuals with ID often experience heightened risks and recursive challenges that block change. Cognitive processing deficits coupled with higher rates of mental illness, victimization, medical problems, and stigmatization affect the individual. Additionally, factors such as congregate living situations, staff supervision, vocational supports, and state involvement associated with their lives add stress. Psychiatric and psychological treatment options are often limited. Unfortunately, despite best intentions, supports can augment difficulties, rather than mitigate them. Often their lives are rich in crisis and light on resources to support adaptive emotional processing. Justified overwhelming stress and insufficient skills to correct the myriad of systemic factors that perpetuate negative transactions may initially appear as unrelenting crisis and inhibited grieving.

The DBT therapist has to see the individual, the world that surrounds the client, and the human potential that exists to address dialectical dilemmas. Building “a life worth living” requires that the individual actively self- and system manage to bridge these gaps. Building emotion regulation and social effectiveness skills that support these processes are essential to facilitate synthesis.

Overview of Treatment Strategies

DBT Therapist Preparation Assumptions

In addition to the basic DBT assumptions highlighted by Linehan (1993a, pp. 106–108), the DBT practitioner treating this population should consider engaging in behaviours that promote self-, social, and academic awareness of factors associated with ID. For example, DBT therapists require mindfulness of stereotypes related to developmental delays. Perceiving people with ID as “simple” and/or equating developmental status of adults to school-age children (e.g., mental age of five) blocks the treatment providers’ visions about strengths and the complexity of human development.

Alternatively, Greenspan discusses the “individual developmental time-table” (Greenspan & Lourie 1981, p. 729), related to the psychological development of individuals with ID. Greenspan explains that the individual can “catch up” and “such learning, however, may have a different developmental sequence and final configuration” (p. 726). If the DBT

therapist characterizes the adult with ID as a non-disabled child, it may create power imbalances, oversimplify developmental processes, and invalidate the person being an adult human. No amount of DBT craft related to strategies will offset this type of foundational inequity.

Behavioural Targets in Treatment

Dialectical Thinking

One of the goals of DBT therapy is to help the individual cultivate dialectical thinking capacities; these perspectives in turn increase activation of dialectical or balanced lifestyle behaviours. Dialectical thinking involves having the capacity to appraise thesis and antithesis forces (e.g., [thesis] I dislike my staff when they tell me what to do *and* [antithesis] I like it when my staff pays attention to me). A dialectical synthesis would involve reconciling the polarities through a reappraisal process (e.g., re-thinking the situation) in a way that integrates both perspectives. An example of dialectical thinking in this case would be: Even though it bugs me [appraisal], I know my staff are helping me reach my goals [reappraisal/synthesis]).

Assessing Dialectical Thinking

DBT therapists need to understand the transactional elements of assessing dialectical thinking. Individuals with ID often engage in concrete or black and white cognitive processing. Executive functioning deficits impact the person's capacities to sequence/organize and ultimately communicate complex perceptions in a way that others can understand fully. Both (a) the individual's level of arousal and (b) the receptivity-status of the other person impact the individual's ability to communicate multifaceted concepts to someone. Support providers with biases/narrow interpretations of capacity, lack of experience with dysregulation, or who fail to establish effective bi-directional communication that supports non-judgmental exploration create barriers to effective communication. Just because the individual struggles to effectively communicate the nuances and "grey" areas within complex situations does not mean that they do not understand it on various levels.

Using the word "and" to link the thesis and anti-thesis can be a useful tool to promote dialectical thinking capacities. This joining creates an opportunity for dialectical synthesis and reappraisal. It is a simple word that is accessible to even non-readers; writing it on a note card and using it as a visual cue can facilitate exploration of dialectical perspectives.

Primary Behavioural Targets

The DBT therapist is thoughtful about the targeting process. Assessing the difference between life-threatening, therapy-interfering, and quality of life issues is an important process in DBT. All of the standard DBT targeting strategies are relevant when treating

individuals with ID. The role of staff support may reduce the level of apparent dangerousness of a behaviour, yet this layer of containment should not influence the decision about whether an action is life threatening or not.

Therapy-interfering Behaviours

Therapy-interfering behaviour (TIB) management follows standard DBT practise. Carefully examining the function of the TIB to (a) understand the reason behind the action and to (b) explore any transactional factors associated with the therapist's behaviour results in more effective intervention. Communication deficits and power imbalances may reduce the individual's capacities to address problems in the therapy relationship directly or in a pro-active way.

Quality of Life

Often the individual has a primary goal of increasing independence, self-determination, and/or autonomy. For example, if the individual currently lives in a group home where he has 24-hour per day supervision, perhaps lower levels of supervision, supported living, or independent living are long-term goals. The highest threats to this increased freedom (behaviours that may result in incarceration or homelessness, e.g., child molestation, fire-setting, and non-homicidal aggression) would become the focus of quality-of-life targets. Behaviours that negatively impact the individual's independent functioning (e.g., rule infractions that result in privilege losses and increases in restrictive procedures) are often the next priority.

In addition to the salient residential factors, the DBT therapist supports the individual to define and reach short- and long-term goals related to personal functioning (e.g., mind, body, and spirit), social connections, vocational opportunities, and family relationships. These changes hinge on the individual enhancing adaptive intra-personal and interpersonal coping skills. The myriad of challenges (e.g., cognitive, trauma, co-occurring mental illness, challenging behaviours, polypharmacy, and stigmatization) create multi-factorial transactional patterns that complicate the change process. Skill deficits, low self-efficacy, and incalcitrant complex environmental factors can negatively affect follow-through and execution of adaptive behaviours.

Increasing Behavioural Skills

Because of pervasive skills deficits, increasing behaviour skills is integrated into all target levels. Designed for individuals who have academic capacities (e.g., reading and writing), the standard DBT skills curriculum features complex language and acronyms that increase cognitive load demands, and hinder encoding, recognition, and recall. In addition, the standard model assumes intact executive functioning; individuals are able to learn the material in four modules and synthesize discrepant information into elaborated chains of adaptive behaviour while experiencing moderate or strong emotions. The standard model anticipates a degree of impairment in learning consequent to clients' difficulties with emotion regulation, and teaches every skill twice within a 12-month treatment programme to address these difficulties. However, this modification alone is insufficient to address the challenges faced by clients with an ID. Deficits in executive functioning, attentional control, and memory hinder an individual with ID's capacities to know (a) which skills (or elements of skills) to use, (b) how many skills to use, (3) the sequence of skills to use, and (4) the timing of skills use, even at low levels of emotion. Because of the barriers to learning essential DBT skills and the inability to execute multiple skills together in adaptive chains (replacing maladaptive patterns across the spam of dysregulated emotions), accommodations are required.

The Skills System, presented in *Emotion Regulation Skills System for the Cognitively Challenged Client: A DBT®-Informed Approach* (Brown, 2016), is an adapted skills curriculum specifically designed for use in treating individuals diagnosed with moderate or mild ID. The term DBT-SS reflects an adapted model for vulnerable learners that integrates DBT individual therapy and the Skills System curriculum for skills training.

Structuring DBT-SS Treatment: Who Can Participate?

Individuals who have (a) moderate or mild severity ID, (b) basic verbal communication skills, and (c) emotional, cognitive, behavioural, self and relationship dysregulation are candidates for DBT-SS treatment. Individuals referred for therapy often have multiple mental health diagnoses, take several psychotropic medications, and demonstrate challenging behaviours (CBs). Because there are few adequate solutions for the individual, he or she may be a multiple-system user that may include numerous psychiatric hospitalizations, ER visits, residential placements, and involvement with the criminal justice system. CBs are often the reason for referral.

Remaining adherent to DBT is essential. For example, the modes of treatment used with this population include individual therapy, group skills training, consultation team involvement, and phone skills coaching. Although there are trends towards skills-only DBT treatment, individual DBT therapy is the foundation of the treatment for individuals with ID. Individual therapy offers comprehensive supports and essential scaffolding to sustain the skills building process.

The Five Functions of DBT

This section highlights factors within DBT-SS that support fulfilment of the five functions of DBT, i.e., enhancing client capacities, improving motivation to change, generalizing skills into the environment, structuring the environment, and enhancing therapist capabilities. The information focuses on (a) additional interventions that address the unique needs of this population, (b) prerequisites for the function to be addressed, and (c) specific conditions that commonly impact individuals with ID related to the DBT function.

Enhancing Client Capabilities

Learning new skills lies at the heart of standard DBT. For clients with an ID the standard curriculum requires modification to enable increased access to the treatment. Brown extracted the core functions and altered the delivery system of the skills to improve accessibility to DBT, and the Skills System is a tool used to enhance the individual's capacities in multiple ways. The design of the skills model, as well as strategies that integrate the concepts into DBT treatment, bridge gaps for vulnerable learners.

Skills System Design

The Skills System has nine core DBT-based skills and three System Tools that helps the individual cognitively assemble and execute adaptive chains of behaviour throughout each day. The three base skills lead the individual to engage in mindfulness (Skill 1. Clear Picture), goal-directed thinking/cognitive restructuring (Skill 2. On-Track Thinking), and behavioural activation (Skill 3. On-Track Action) in each situation. Linking these skills together helps individuals to (a) be present, (b) create effective plans (even at high levels of emotion, and (c) demonstrate goal-directed behaviours. The other six skills (Safety Plan, New-Me Activities, Problem Solving, Expressing Myself, Getting It Right, and Relationship Care) supplement the base skills to manage diverse situations.

The Skills System is designed to fit all learning abilities. For example, each of the nine skills have sub-skills that provide elaborated skill options for individuals that have advanced capacities. Conversely, individuals with greater impairment may use single skills or partial skills chains. DBT therapists who use the Skills System should be competent in the model to be able to maximize benefits in teachable moments with individuals with complex learning profiles.

Skills System Skills Training

It is important to consider an individual's functioning capacities (e.g., academic and communication abilities) when designing a skills training programme. For example, due to the high cognitive load demands of instruction and the need to adjust teaching to optimize comprehension, group sessions are limited to one hour. Similarly, adherence to the Skills System concepts is imperative, yet the delivery methods of the concepts must

be tailored to fit the individual's situation. Individuals with ID often live in complex support environments, and the skills training format realistically needs to fit within the support context to promote sustainability.

Although Brown's (2016) manual provides a detailed 12-week group curriculum of 60-minute groups (multiple 12-week cycles are recommended), it is only one option. Therapists may need to consider individual one-to-one skills instruction; often there are too few clients with ID to form a group in a geographical area. If an individual is unable to learn information, because of high levels of behavioural dysregulation in groups, 1:1 training may be necessary as a preliminary step. While it is preferable to separate one-to-one instruction from DBT individual therapy, setting up a second appointment during the week for skills training, or dividing the session into two discreet sections, are options.

Skills System Pilot Data

Brown, Brown, and DiBiasio (2013) reported outcome data of a pilot study of DBT-SS, which reported statistically significant reductions in behavioural outcomes for 30 individuals with co-occurring ID and mental illness with histories of challenging behaviours. Currently, the Skills System is the only manualized adapted-DBT™ skills curriculums for this population.

Improving Motivation to Change

The primary task of the therapist is to collaborate with the individual with ID to create a strong therapeutic relationship that can sustain the movement and flow of DBT strategies across the connection. For example, tactics to increase awareness and motivation include oscillating between validation and change strategies, commitment strategies, didactic instruction, and dialectical strategies. Behavioural strategies can reinforce adaptive patterns of behaviours, as well as provide contingencies for less-effective ones to increase motivation. There may be a tendency to over-rely on behavioural strategies with individuals with ID, especially if there are communication challenges that appear to hinder the use of strategies that foster intrinsic motivation.

There are two related factors that are essential elements that help create an environment within which a therapeutic relationship can develop and sustain motivation. The first is bi-directional communication. Establishing reciprocal communication is a pre-requisite for developing a functional therapeutic relationship. Second, the DBT therapist needs to be continually aware of and actively manage cognitive load demands of all interactions and interventions, so the individual can remain present in the dialogue. Understanding how the individual's ID may impact these processes will optimize progress toward this DBT function.

Communication and Cognitive Load

Many factors can impact communication patterns within transactional client-therapist relationships. For example, in a study of non-disabled individuals, Hansen, Kutzner, & Wanke (2013) reported that, in low-demand situations, people tend to have increased capacity for “abstract, top-down processing” (p. 1155), while in more stressful situations, concrete thinking helps to adjust for the increased cognitive load. This natural shift in high-stress situations, coupled with other cognitive deficits (e.g. executive functioning) may increase concrete processing for the client. Therefore, the therapist may notice that at low levels of arousal the client may be able to process and communicate abstract concepts more effectively than when experiencing stress.

Sweller (1988; 2010) highlights several factors related to the design of teaching interventions that increase and/or decrease cognitive load demands for the learner. Processing is impeded by interventions that increase extraneous cognitive load, for example, complex language and concepts. Similarly, unlinked or divergent information that lacks association connecting essential elements causes extraneous cognitive load that strains processing abilities. Information that is similar, difficult to differentiate, and/or lacks transitions also increases extraneous cognitive load. Likewise, high levels of emotional content can contribute to cognitive overload. Continually evaluation cognitive load demands during interactions will aid the DBT therapist to accurately assess behaviour and adjust strategies.

Cognitive overload can impact bi-directional communication patterns (Sweller, 2010; Brown, 2016). For example, when the individual experiences high cognitive load demands, his or her ability to organize and sequence his narrative may reduce. In this state, the individual may be more likely to shift to an associated topic without transition. When experiencing stress, the individual may use fragmented/partial sentences or concrete terms to express abstract or complex concepts. Similarly, the individual may be more likely to shift between polarities, because expressing synthesis-oriented points may be more difficult during cognitive over-load. When overwhelmed in this way, the individual may demonstrate idiosyncratic communication styles such as mono-syllabic answers, disclosures that appear to be random, and/or perseveration.

As a result, the therapist may also experience increased cognitive load demands. It may be difficult for the therapist to fully understand what the individual is saying. During this type of transactional communication break-downs and relationship ruptures are more likely. Therapists will benefit from taking time to explore (in a non-judgmental way) what is being communicated. If the therapist is able to establish reciprocal communication in these situations, important therapeutic work can happen. Misattribution of cognitive load as a lack of insight, resistance, and/or wilfulness can hinder the development of and even destroy the therapeutic relationship.

Reciprocal communication breakdowns should prompt the therapist to notice (a) what potentially clinically-relevant material discussed is increasing demands and (b) whether the client-therapist communication pattern itself is contributing to cognitive and

communication challenges. The therapist must continually self-monitor related to communication behaviours, making adjustment such as simplifying language, using visual aids, and/or breaking complex concepts into component parts (Brown, 2016). The therapist may want to ask clarifying questions to ensure reciprocal understanding of points. Creating positive versus negative transactions requires the DBT therapist to persist to bridge communication gaps when discussing relevant topics, rather than shifting the focus of the conversation.

Quick Step Assessment

Brown (2016) introduced the Quick Step Assessment strategy, based on Sweller's (1988; 2010) Cognitive Load Theory, which is intended to help therapists design effective interventions:

- Step 1 prompts therapists to be mindful of the cognitive load demands of an intervention prior to implementation. Factors such as complexity, simultaneous processing, emotional content, divergent topics, and rapid transitions without orientation create extraneous cognitive load, potentially causing cognitive over-load for the client.
- Step 2 asks the therapist to monitor the individual's responses to the intervention, watching for direct and indirect signs of emotional and/or cognitive processing difficulties. Cognitive over-load may manifest as confusion, disorganization, avoidance, resistance and/or wilfulness.
- Step 3 helps the therapist adjust the intervention to reduce cognitive load demands. Simplifying the language, using a metaphor that is easily understandable, and breaking down complex concepts into component parts (e.g. task analysis) can reduce cognitive load demands.

When the individual appears resistant, the therapist needs to use the Quick Step Assessment immediately to explore the therapist contribution to the strained transaction.

Generalizing into the Natural Environment

There is general consensus in the disabilities field that individuals with ID have difficulty generalizing skills into natural contexts. A multi-level approach is necessary to ensure the individual has adequate supports in place to build competency in executing adaptive patterns of behaviour. For example, the design of the Skills System, the enhanced teaching strategies outlined in the text, and individual therapy techniques create in-session learning experiences that are the foundational for generalization. Extending supports beyond the therapy office offers scaffolding that facilitates competency in real-life situations. Phone skills coaching as well as training support providers to be in-vivo skills coaches can enhance generalization of Skills System concepts. The skills coach

needs to (a) learn skills and sub-skills and (b) be able to apply the DBT-based Skills System coaching techniques.

Structuring the Environment

Standard case management strategies (e.g., environmental interventions, consultation-to-the-patient, and consultation-to-the-therapist) are all *vital* aspects of DBT and DBT-SS. Consultation-to-the-patient strategies guide the DBT-SS therapist to function as a consultant to the client, rather than to the support system. The tendency might be for the therapist to destabilize the client and over-engage with members of the support team, undermining the power and responsibility of the client. The DBT-SS therapist orients and discusses these consultation-to-the-patient strategies with the individual on an ongoing basis.

The consultation-to-therapist strategies, as applied in the consultation team, provide the DBT therapist with support to maintain intra- and inter-personal balance within the therapeutic relationship. The consultation team is mindful of judgment, biases, frustrations, ethical dilemmas, confidentiality, environmental interventions, and managing the consultation-to-the-patient strategies. Practicing dialectical perspectives in consultation team increases the likelihood those attitudes will generalize into the therapists DBT practice.

These consultation team practices are of special value when clients may also be in receipt of other interventions in their wider environment, and the DBT therapist must balance consultation to the patient with environmental intervention. For example, an individual's support plan often includes Applied Behaviour Analysis (ABA) interventions. Baseline data and a functional analysis generally delineates four functions of behaviour escape/avoidance, attention seeking, seeking access for materials, and sensory stimulation. This process yields behavioural treatment plans that include (a) positive reinforcement (e.g., incentive programs), and (b) contingencies (e.g., restricted access to the community), both of which are designed to increase adaptive behaviours.

Although behavioural strategies are an important ingredient of DBT, the process of understanding and explaining the functions involves a more comprehensive, interactive, transactional, ongoing data collection approach that informs the implementation of behavioural strategies. Through a DBT lens, the functions of behaviours are not divided into four categories; it could be considered invalidating to over-simplify the complex/dynamic processes involved in motivation. Additionally, replacement behaviours in ABA plans do not tend to integrate instruction of comprehensive skills sets design to enhance intrinsic emotion regulation capacities. Therefore, pairing ABA behavioural strategies and Skills System concepts can create a valuable synthesis.

Interacting with the Individual's Support Team

Whenever possible it is optimal to prompt the individual to engage with his or her psychologist (behavioural treatment plan developer) to improve the plans. For example, encouraging the client to advocate for the team to pair ABA-based incentives with the Skills System concepts (e.g., incentives for effective Safety Planning or engaging in New-Me Activities). The DBT-SS therapist may encourage the individual to self-advocate to change behavioural plans and ultimately terminate them as capacities improve.

Enhancing Therapist Capabilities

Successful therapists depend both on a sound knowledge base, as well as adequate funding, when treating their clients. Intensive training in DBT for therapists is crucial, and advanced training and supervision by a DBT expert is recommended. Optimally, the consultant should have experience in treating individuals with ID. Staying abreast of current disabilities field literature can increase DBT therapists' understanding of the myriad of relevant processes that impact this heterogeneous population.

Additionally, funding can be challenging. Payments for each element of comprehensive DBT services (over a year or more) may require the therapist to explore available resources through the State, provider agencies, and/or insurance companies. The Brown, Brown, and DiBiasio (2013) Skills System pilot data article contains an analysis of the State's cost savings; sharing the article with funders may be helpful.

Beginning DBT-SS Treatment

Intake Process

The individual's family, agency staff, or a state social worker are likely to initiate the referral for DBT therapy. Orienting the care providers to DBT to ensure adequate resource allocation to support the multi-modal treatment process will be a good investment of time. It is also important to make consistent transportation arrangements at the outset. Determining the team members' commitment to learning the DBT Skills and functioning as in-vivo skills coaches are important. Additionally, the team should acknowledge that the client will need to have access to phone skills coaching with the therapist in between sessions.

The person making the referral may initially not have all of this information. The DBT therapist may need to have multiple conversations with different team members prior to the first session with the client. Although the team discusses preliminary arrangements, without contact with the client, it is impossible to accurately assess whether a bridge between the client and therapist will form.

Receiving a comprehensive packet of referral information from collateral contacts prior to the first session can be useful. The DBT therapist will want information from the individual, yet gaining clarity about historical information may be an evolving process. Asking the team for any past evaluations and summaries can supply the therapist with frames of reference that can structure the history gathering process with the individual.

Optimally, the client contacts the therapist directly (with staff assistance if necessary) to arrange a first session. It may be easier to speak with the staff, but it is important for the therapist to begin immediately investing in the relationship with the individual. This approach hopefully signals to the individual that the DBT relationship is radically different from other helping relationships previously experienced.

Initial Sessions and Understanding Autonomy

During the first session, the DBT therapist tries to establish communication and a rapport with the individual. If possible, the therapist talks to the individual without the staff in the room. This demonstrates that DBT therapy is a 1:1 relationship between equal people, it assumes capacity.

Completing an informed consent document is one of the preliminary activities the therapist and individual do. The DBT therapist needs to orient the individual about the therapy process, so that the client can make a self-determined, autonomous decision about being in the session and what the guidelines are. Posing clarifying questions and asking the individual to re-explain concepts to the therapist creates an opportunity for the therapist to ensure comprehension and rectify misunderstood points.

There may be intra-personal and environmental factors associated with individuals with ID acting autonomously. For example, Petner-Arrey & Copeland (2014) highlighted that there are “significant challenges within the support service system that often prevent promotion of autonomy for people with ID” (p. 42). The barriers included, consumers and staff having competing interests or mandates, staff asserting their agenda rather than including the individuals’ priorities, disagreement between the consumer and staff about safety being a primary focus of support, and institutional goals outweighing individual goals.

The therapist must be aware of engaging in similar patterns, assess whether the individual may be deferring to authority or offering superficial compliance to placate the therapist. The DBT therapist will want to have ample discussions related to goal setting and commitment. Asking multiple clarifying questions and DBT commitment strategies can help determine the client’s level of commitment to engaging in therapy or attempting to satisfy others.

Assessing Whether DBT Fits the Dyad

As in standard DBT, the dyad of therapist and client discuss the client's challenges, goals, and commitment. Regarding the exploration of historical information, executive functioning and memory deficits may impede the person's ability to sequence and organized synthesized timelines. In addition to cognitive processing difficulties, the individual is likely to have experienced challenges and/or trauma associated with a myriad of social systems from family relationships, education systems, community settings, vocational placements, and congregate living arrangements that may produce emotions during the assessment process. During interactions, the therapist can use the Quick Step Assessment to evaluate the individual's level of dysregulation and adjust interview strategies. It is the evolving process, rather than external time frames, that determines the pace of therapy.

If the individual demonstrates CBs on a regular basis, it may make sense to discuss a safety plan prior to delving into challenging topics. Initially, the client may opt to speak to the staff member, call a support person, or take a brief walk with staff. Being familiar with the client's support plan helps the DBT therapist generate solutions that fit within the individual's guidelines. Once the therapist and client have a therapeutic relationship, in-session activities such as paced breathing or a card sort (dividing a standard deck of playing cards first by colour and then by suit) help decrease arousal and allow the client to remain engaged in the session.

Therapy Agreements

The DBT therapist will orient the individual to the concept of therapy agreements. Developing written therapy agreements (client and therapist) may be helpful, provided that they use simple language and/or images to address elements included in standard DBT agreements. For example, the statement "I agree to be in DBT therapy for one year," followed by a check box labelled "yes" or "no" creates a tangible reference to the client and therapist committing to the therapy process. Be sure the client clearly understands how long a year is. A thorough discussion of all related topics needs to happen prior to writing, reviewing, and signing therapy agreements so that genuine commitment exists.

Ending Sessions

Prior to ending a session, the DBT therapist communicates with the individual about his level of emotion, regulation status, and strategies the individual will use to manage stress between sessions. Reviewing basic concepts related to the Safety Planning and New-Me Activities can be helpful. If there is a staff or family member present, the therapist may consider consulting with the individual about checking in with the support person prior to leaving the office. This conversation can be an in-vivo practice session where the client communicates about his or her status and advocates about regulation and co-regulation

activities (involving collateral supports) that may facilitate his or her effective self-management between sessions.

Basic Treatment Strategies

Dialectical Strategies

Understanding vulnerability factors, transactional communication patterns, and managing cognitive load (e.g., Quick Step Assessment) help the DBT-SS therapist use standard DBT strategies, such as dialectical strategies, effectively with the ID population. Standard dialectical strategies are key with this client group, as long as the DBT therapist is mindful of the individual's cognitive load status during the intervention. Although speed and flow are crucial, rapid shifts without ample explanation or transition can induce cognitive overload. Similarly, the individual must understand any metaphors used. When overloaded, the individual is unlikely to discuss the confusion; conversely, some form of conflict, avoidance, and/or superficial compliance may happen. The therapist may misattribute the controlling variable of this TIB as wilfulness, rather than cognitive overload, potentially creating a negative transaction. When the client comprehends all of the points in the discussion, he or she may be more likely to remain cognitively regulated and benefit from the DBT "dancing" experience (Linehan, 1993a, p. 203).

Validation Strategies

As in standard DBT, validation strategies are vital with this client group. The major difference is in the enhanced responsibilities of the therapist to provide functional validation related to (a) establishing effective bi-directional communication and (b) making adjustments to interventions to improve accessibility for the individual with ID. Similarly, the therapist must understand the complex environmental factors that the individual has dealt with throughout their lifetime in order to provide salient verbal validation.

Stepping back and attempting to live within the individual's context can augment awareness and increase the relevance of validation. For example, an adult with ID may receive 24-hour supervision. Individual monitoring and behaviour-related feedback are available to the client 24/7, every year. Supervision and instructions for the client may come from a therapist far younger than themselves, which might be demoralizing. The staff may not have adequate training about how to interact in a way that fosters respect and self-determination. The staff may be from a culture that has different norms related to disabilities. The staff may speak English only as a second language, which may impact communication transactions. Programmes may be chronically mismanaged or under-funded; under-staffing may reduce opportunities for community access and choice. Unfortunately, individuals with ID often experience highly complex problems within the care system framework, and may have limited resources to address them.

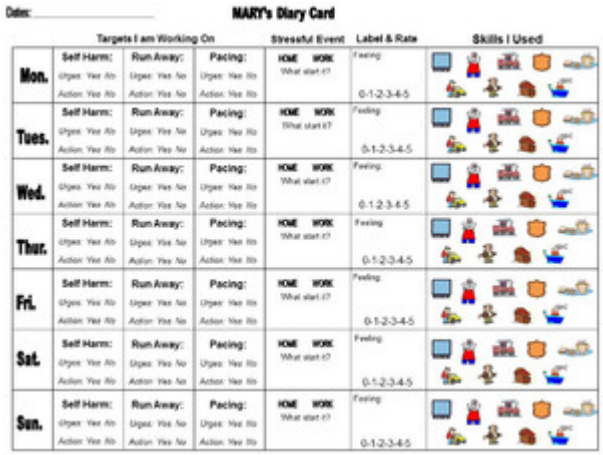
The DBT therapist needs to empathize with the individual related to these issues, rather than treat the client with ID as different from herself. The therapist must be mindful not to recreate similar problematic transactions. Additionally, these types of environmental factors can exacerbate target behaviours and therapists should acknowledge any possible antecedents during the behaviour chain analysis processes. Solution analysis must include tactics to alter systemic problems and accept factors that are temporarily unchangeable.

Problem Solving

Problem solving is a dynamic, multiple-step process. Individuals with ID often experience difficulties with problem solving because (a) the support systems are complex, (b) power imbalances and biases impact transactions, and (c) the ID impacts the individual's execution of problem-solving strategies. The Skills System provides a structured framework that teaches the steps of problem solving, as well as the requisite emotion regulation tactics that support those processes.

Behaviour Analysis and Solution Analysis Strategies

Diary cards function to help the therapist “obtain information on a daily basis about relevant behavior” (Linehan, 1993a, p. 184). The goal is to be able to efficiently address target behaviours through the spectrum of DBT strategies (e.g., validation, behaviour chain analysis, solution analysis). The individual’s academic abilities impact the design of the diary card (Figure 1); non-readers will need simple text and visual representations (e.g. cue pictures, circling images, and check boxes) to document the frequency and intensity of emotions, urges, and actions. Creating individualized modified diary cards in session with the client to target specific behaviours currently addressed in treatment can be helpful. Adjusting the diary card form until it functions effectively is often necessary.



Click to view larger

Figure 1. Example of an adapted diary card

In addition to a modified diary card, if the client receives staff supervision, creating a daily communication sheet that support staff complete during day and evening activities may also help. The communication sheet should highlight targets, activities, and skills use. The client may want to work collaboratively with collaterals to complete the communication sheet each day. Reviewing the diary card and communication sheet in the beginning of session together can facilitate targeting and the behaviour chain analysis process. Greater amounts of information results in less time spent to gain clarity of time frames (i.e., sequencing can be challenging due to executive functioning difficulties in those with ID).

The client and therapist should discuss possible power imbalances that may occur related to collaterals completing communication sheets. On the positive side, reading the staff reports may aid evaluation and intervention with staff behaviours that contribute to problematic transactions. If the client cannot read and write, seeing people write notes about them may understandably elicit strong emotions. Overall, the benefits may outweigh the difficulties in Stage 1 of treatment, when there are complex targets that require behaviour chain analysis, solution analysis, and practicing adaptive alternative behaviours.

As in standard DBT, conducting behaviour chain analyses are primary strategies. The DBT therapist helps the client define the problem behaviour, conducts a chain analysis, and generates hypotheses. In DBT-SS, the six parts of Skill 1: Clear Picture (e.g., notice the breath, notice surroundings, do a body check, label and rate feelings, notice thoughts, and notice urges) explore the micro-transitions of behaviour that comprise the chain links. The DBT-SS therapist helps the client get a Clear Picture of the antecedents, the

problem, and the consequences. Additionally, Skill 2: On-Track Thinking (e.g., Stop and Check It [thumbs up for on-track urges and thumbs down for off-track urges], Turn It, Cheerleading, and Make a Skills Plan) are integrated into this investigation. Finding the discriminating stimulus or point when the client gave thumbs up, instead of thumbs down, to off-track urges is important. The behaviour chain analysis includes Skill 3: On-Track Action as the dyad discusses whether actions were, upon reflection, on-track or off-track to the individual's goals.

Using the Skills System framework to understand problem behaviour chains lays the foundation for developing a solution analysis plan. Often the individual goes off-track when he engages in Calm Only skills (i.e., Skill 6: Problem Solving, Skill 7: Expressing Myself, Skill 8: Getting It Right, and/or Skill 9: Relationship Care) at too high a level of emotion, reducing effectiveness. The dyad produces an improved skills chain that takes into account the situation and any forces that may undermine the success of the chain. Ideally, each chain contains mindfulness processes (Clear Picture), reappraisal and planning (On-Track Thinking) and behavioural activation (On-Track Action) of adaptive responses (e.g. Safety Plan, New-Me Activity, Problem Solving, Expressing Myself, Getting It Right, and Relationship Care).

When conducting a behaviour chain and solution analysis, the therapist uses the Quick Step Assessment and other tactics to accommodate cognitive challenges. Memory deficits, executive functioning impairment, and communication difficulties can affect the process of assembling synthesized time lines. Visual aids representing elements of the chain can help the dyad put the puzzle together. Accomplishing an effective assessment of the situation combined with an adequate solution analysis with an opportunity for practice of the adaptive skills requires effective time management and is frequently a challenge.

The following case example exemplifies how various strategies can be integrated during a behaviour chain analysis (Box 1). The client, Mary, a 33-year-old woman, has been diagnosed with PTSD, BPD, and Mild ID. She reads and writes at approximately a second-grade level. Mary has a history of self-harm that includes, cutting, swallowing objects/toxic chemicals, tying cords around her neck, head banging, and darting into traffic. She lives in a community residence with three other women and receives 24-hour supervision and attends a vocational day programme. She has been in DBT-SS treatment for 10 months. This dialogue begins after Mary entered the therapy office, greetings were exchanged, and the therapist has started reviewing the documentation (diary card and staff communication sheets).

Box 1.

Case example (treatment strategies in **bold**).

Dialogue	Therapist Thoughts and Strategies
Therapist: (Reading the diary card) Mary, I see that you circled that you had urges to self-harm on Wednesday and that you did self-harm on Thursday. Is that right? Mary: Yes. Therapist: You and I spoke on Wednesday afternoon, right? Mary: Yeah, after I got home from work. Therapist: Calling was an On-Track Action. We talked about your urges to swallow a battery. We talked on the speaker phone with Kate (staff) about you doing a written safety plan together. Mary: We did it. Therapist: So, Thursday. You and I didn't talk. Mary: No, had a problem at the day programme. I was mad at Justin (boyfriend). Therapist: Were there any other targets this week? Mary: No. Therapist: How about you and I read through the staff communication sheets. Are you OK with doing that? Mary: I hate it when they write about me, it gets me upset. Therapist: I can understand that, … Good Clear Picture of your feeling, though that sounds like the 'anger' emotion. Ok if we look through the sheets? Mary: Yes, I guess so. Staff piss me off. They don't listen to me. Therapist: Ok, I see here that you talked to staff on Wednesday. Kate said you did a good job the Safety Plan. I see you went to the ER on Thurday night.	**Diary card review:** I need to make sure I know about all of the level 1 targets. I need to have a clear sense of Mary's week related to her targets so I can use all DBT strategies effectively. **Reinforcing adaptive behavior:** I positively reinforce her calling for skills coaching on Wednesday. **Secondary target:** Not calling on Thursday is a therapy interfering behavior that will get addressed at some point. **Assessing vulnerability factors:** Justin seems to be a stressor. **Assessing primary target:** Mary has executive functioning deficits; I need to triangulate data from multiple sources to pinpoint target. **Validation strategies:** I validated the feeling and reinforced skill use. **Assess transactional patterns:** The staff sheets can help me find missing information and diagnos transactional patterns that trigger Mary. **Selection of primary target:** I reinforced adaptive behavior and pivoted to non-judgmentally highlighting of

Mary: I swallowed a AA battery from the TV remote. Therapist: I don't see any other incidents in the staff sheets. Did you have any other self-harming behaviors this week? Mary: No, I know I should've called you. I was just really upset. Therapist: We can talk about that in a few minutes. We have to do our behavior chain about your self-harm on Thursday so we can see what happened. You good with that? Mary: I hate talking about this because it makes me upset all over again. Therapist: I get that. The good news is, you are a skills master when you do On-Track Actions like this. We can both know what happened and then we can talk about what we can do differently next time. What level are you at now? Mary: About a 3. Therpist: So, you are saying that you can talk and listen and still be on-track right now? Mary: Yeah, but I might go to a 4. Therapist: True. It isn't easy doing our behaviour chains. If you go to a level 4 what should we do? Mary: Maybe take a break. Do some breathing. Therapist: Last week you did really well when we practiced the seated mountain pose. Mary: That was pretty good. I'll try that. Therapist: Ok, so Thursday. What happened? Mary: I was really mad at Justin. He was sitting with Carol at lunch—you remember his ex at day programme. I started looking around for stuff. Therapist: Stuff?	TIB. We need to stay focused on the self-harm primary target chain analysis. **Behavior Chain Analysis:** I define the problem behaviour. I want to partner with her so I get informed consent about moving ahead. **Reinforcing dialectical functioning:** I highlight that she is feeling uncomfortable and facing the moment as it is; the "good news" comment addresses dialectics in a concrete way. **Defining beginning, middle and end of the chain:** I use the Feeling Rating Scale (0-5) to map the chaining process. I confirm the rating to be sure she is not under- or over-rating (at a level 3 she can talk and listen and be on-track). **Cope Ahead:** Mary has difficulty with transitions. I want her to know what to do at a 4 (strong emotion with off-track action urges), before she gets there, so that she can shift gears and be effective at all levels of emotions. **Searching for the discriminating stimulus:** I need to find the second she shifted from a on-track to off-track. When did she shift from a 4 to a 5 emotion (overwhelming emotion: harming self, other, or property)?

Mary: Stuff I could swallow. Therapist: When did you swallow the battery? Mary: I'm not sure. Therapist: Was it before or after lunch? Mary: It was right after lunch. Therapist: How were you doing before lunch? Mary: I was cleaning the offices. Then I went to the day programme. Therapist: Tell me about when you got there. Mary: Not good! I saw him sitting with HER. Therapist: Tell me about that moment when you saw them? Mary: I was at a 5. Therapist: You hurt yourself right then? Mary: No, it was after that. I guess I was a 4. But it felt like a 5. Therapist: True, good observation. A level 4 can feel super intense, the difference is that at a 5 we are hurting ourselves, others, or property. (Mary nods). How about we go through the Clear Picture handout so we understand a little more about what was happening. Mary: OK, that's fine. Therapist: So you were at a 4 … what emotion were you feeling? Mary: Pissed off. Therapist: What's next on the sheet? Mary: My breath. I think I was breathing really fast. Therapist: Excellent (Therapist points to the next picture). How about your surroundings in that moment? Mary: I was coming in the door and they were at the table by the window. Therapist: Good job, how about this one?	**Quick Step Assessment:** Mary has difficulty with sequencing. I chunk the time frames, so we are oriented. **Assessing antecedents:** I want to see if she was stressed in the morning before lunch. I want to map her escalation pattern. **Continually assess accuracy:** I have to be sure the rating is accurate in relation to ther behavior versus self-reported affect. **Didactic strategy:** I positively reinforced her adjusting the rating and highlighted how we can (dialectically) feel terrible and still be on-track. **Reciprocal strategy:** I get consent for the shift to another activity. **Quick Step Assessment:** The worksheet will offer structure to abstract concepts/time frames; it also teaches the skill Clear Picture. **Mindful awareness:** I want to start with what Mary already is aware (rating the emotion) of to increase self-efficacy. Then we expand to the other parts of Clear Picture. **Pinpointing the discriminating stimulus:** She said the urge, great! I think she is still at a 4 at this point. I positively reinforce her having a Clear Picture and

Mary: Body check. My heart was pounding. I wanted to run. Therapist: Good Clear Picture of your urge. Did you run? Mary: No, I started pacing. Therapist: What was happening when you were pacing? Mary: I was spaced out. I start staring at stuff. Therapist: Did you say anything to staff? Or did they say anything to you? Mary: No. They weren't paying attention. I walked by the clicker and grabbed it. I took the battery out and ate it. Therapist: I know it isn't easy to go back over this and you did a good job. I feel like I understand what happened. Thank you. Now, how about we go back over two important times and think about what skills could help you in that moment. (counting on my fingers) First, is when you walked into the day program and saw them. And then second, when you get spaced out and start pacing. We have to know what to do at both of these times. Does that make sense? Mary: OK.	wanted to separate the urge and action. **Antecedent:** Mary was cognitively dysregulated ("spaced out"). Pacing is on her diary card as an antecedent behavior. We have talked before about her doing a Talking Safety Plan in that situation. She shifted from a 4 to a 5 at this point. **Solution analysis:** I positively reinforce her engaging in the behavior analysis. I orient her to our need to look at two situations (with the visual aid of my fingers) that need solution analysis. I ask for consent before moving ahead.

Insight Strategies

Although insight is not a mechanism of change in DBT, the ability to understand patterns of one's own behaviour is a useful skill. It is a myth that individuals with ID lack the capacity for insight and self-awareness. To support the standard DBT insight strategies, the DBT-SS therapist integrates the Skills System language to scaffold complicated constructs creating a common language that the dyad can build upon. Using the Quick Step Assessment helps the therapist adjust communication so that there are seamless transitions across complex ideas, rather than gaps that derail the individual's ability to fully understand abstract concepts.

Commitment Strategies

Commitment strategies are used in their standard forms, as low self-efficacy, academic failures, traumatic experiences, and foundational skill deficits can reduce the individual's enthusiasm for engaging in novel activities. Taking sufficient time to explore commitment and non-commitment alternatives using multiple commitment strategies can help individuals make informed choices. The DBT therapist should assess the client's level of commitment, or whether he is verbalizing commitment that reflects merely superficial compliance. Additionally, revisiting commitment is necessary; validating the changeable nature of commitment can foster the shift from polarization to synthesis processes during treatment.

Change Procedures

As in standard DBT evaluating whether the individual with ID has requisite behaviour in his behaviour repertoire is a first step. The Skills System builds basic emotion regulation, distress tolerance, interpersonal effectiveness, and mindfulness capacities. Salient points to evaluate should include an examination of what reinforces problem behaviours.

The in-session use of contingencies is similar to standard DBT. The DBT-SS therapist orients the individual to contingency management, uses reinforcement, highlights natural consequences, and implements extinction to shape behaviours. Similar to standard DBT, aversive contingencies warrant thoughtful consideration. Communication breakdowns can confuse situations, and any misunderstandings need clearing up before using an aversive contingency due to the deleterious potential impact to the therapeutic relationship. As with standard DBT, DBT-SS includes informal exposure practices; the Skills System offers strategies to help the individual experience uncomfortable emotions in session and to assemble effective responses. Limited data exists relating to formal exposure techniques with this population.

Observing Limits Procedures

Communication challenges may enhance the need to explain limits thoroughly and confirm comprehension of the parameters. Memory deficits may impede recognition and recall. Verbal cues and visual aids may remind the individual about the issue and prompt more adaptive responses.

Suicide Crisis Protocol

Communication and cognitive processing challenges may impact the delivery of the standard DBT special treatment strategies, but not the functions. Higher cognitive load may happen when an individual is in crisis, which can impede communication patterns. Ensuring clear communication is a foundational step to managing crisis and suicidal behaviours. Creating written safety plans (using language and/or visual aids as needed) for use during high-risk times can help the individual manage behaviours.

The therapist may need to orient the client and communicate with the team directly when the client verbalizes intent to self-injure or harm others. The therapist should ensure that the agency has adequate procedures in place to manage high-risk situations as well as a framework to evaluate when the individual requires emergency services. Additionally, the therapist may need to foster inter-team communication (e.g., nurse, primary care doctor, and/or psychiatrist) related to managing acute behaviours to ensure the safety of the individual.

Summary

Many individuals diagnosed with ID experience emotional, cognitive, and behavioural dysregulation. Standard DBT includes comprehensive treatment elements essential to addressing these problems, yet accommodation is necessary to improve accessibility to DBT for individuals with cognitive impairment and co-occurring mental health issues. This chapter highlights transactional and vulnerability factors that commonly impact both the intra- and interpersonal patterns of behaviour. The material also offers practitioners strategies to facilitate adjusting standard individual therapy techniques in terms of cognitive load demands, while maintaining adherence to DBT. Additionally, it shows an adapted DBT-informed skills curriculum (Skills System) specifically designed for this population, as well as information relative to how to integrate the skills framework.

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