Dialectical Behavior Therapy for pre-adolescent children: Helping parents help their kids

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Target Population

Target population

Pre-adolescent children 7-12 years of age with:

1. High emotional sensitivity:

- High reactivity
  - Immediate reactions
  - Low threshold for emotional reaction
- High intensity
  - Extreme reactions
  - High arousal dysregulates cognitive processing
- Slow return to baseline
  - Long-lasting reactions
  - Contributes to high sensitivity to next emotional stimulus

2. Corresponding behavioral dyscontrol:

- Frequent temper outbursts (physical and/or verbal aggression)
- Suicidal ideation/behaviors and/or NSSI

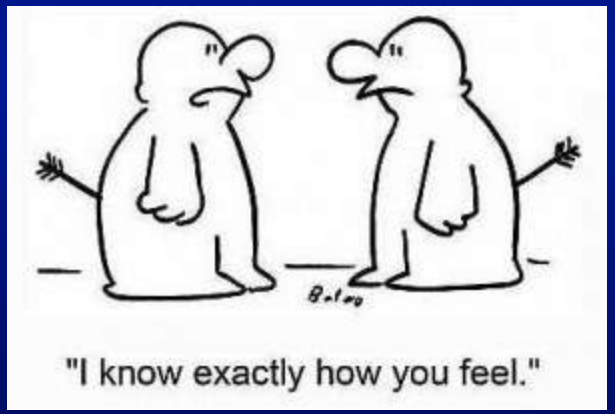
It Comes In A Package

Children with high emotional sensitivity frequently have some of the following difficulties:

- Will look for ways to avoid effort (Double Gravity)
- Dislike change and transitions
- Are easily bored
- Low tolerance for delayed gratification
- Have rapidly shifting attention
- Hyperactive
- Display impulsive behaviors
- Have sensory sensitivity (auditory, touch, smell, taste)
- Have hyper-reactivity (e.g., anxiety, temper outbursts, NSSI)
- Have severe interpersonal difficulties (e.g., with parents, siblings)
- Have extreme thinking styles (e.g., black and white thinking)
- Have difficulty with brushing teeth and other forms of hygiene

Emotional Sensitivity: Advantages

- Enhanced experience of positive emotions
- Ability to read other people's emotions
- Enhanced empathy
- Increased creativity



Akinola & Mendes, 2008; Ceci & Kumar, 2016; Spinrad & Stifter, 2006; Zahn-Waxler, Robinson, & Emde, 1992

Supersenser

Term "supersenser":

- Decreases a risk of pathologizing
- Avoids a risk of invalidation
- Provides a dialectical view of presenting issue
- Gives children and parents a sense of relief and even contentment
- Increases child's interest and willingness to learn techniques

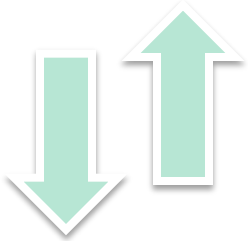
Emotional dysregulation in childhood: Adolescent and adult outcomes

- Current:
  - Disruptive Mood and Dysregulated Behaviors
- Future:
  - Personality Disorders
  - Depressive Disorders
  - Anxiety Disorders
  - Alcohol Use
  - Substance Use
  - Suicidality
  - NSSI

Althoff et al. (2010); Okado et al., (2014); Pickles et al., 2009

DBT-C: Biosocial Theory of DMDD

Emotional Sensitivity



Invalidating Environment

Pervasive Emotion Dysregulation

Invalidating Environment

- **In many cases it's not physically or emotionally abusive**
- **In many cases its good-enough parenting turned invalidating/critical/judgemental/retaliatory through a pervasive transaction between what the child needs and parental inability to meet these needs.**
- **Invalidating environment pervasively negates or dismisses behavior independent of its actual validity.**

Super-parent

Super-parents are like firefighters:

- Don't start fires
  - avoid modeling verbal and physical aggression
  - avoid retaliation
  - avoid invalidation
- Are not afraid of fires
  - avoid accommodation
- Calmly and skillfully put down fires and work on preventing fires
  - holding and containing the child
  - validating
  - prompting and reinforcing adaptive behaviors
  - using effective parenting techniques
  - doing daily reinforced skills practice with the child

Standard DBT Target Hierarchy

1. Reduce life-threatening behaviors (suicidality, non-suicidal self-injury)
2. Reduce treatment interfering behaviors
3. Reduce quality of life interfering behaviors
4. Skills training

DBT-C Treatment Target Hierarchy

I. Decrease risk of psychopathology in adolescence and adulthood

1.Life threatening behaviors of a child (e.g., suicidality, NSSI)

2.Therapy destroying behaviors of a child (e.g., severe aggression in session)

3.Therapy interfering behaviors of parents (e.g., not following treatment plan)

4.Parental emotion regulation (e.g., DBT-C skills, parental psychopathology)

5.Effective parenting skills

II. Parent-child relationship

6. Improve parent-child relationship

III. Current child's symptoms

7. Risky or unsafe behaviors (e.g., physical aggression)

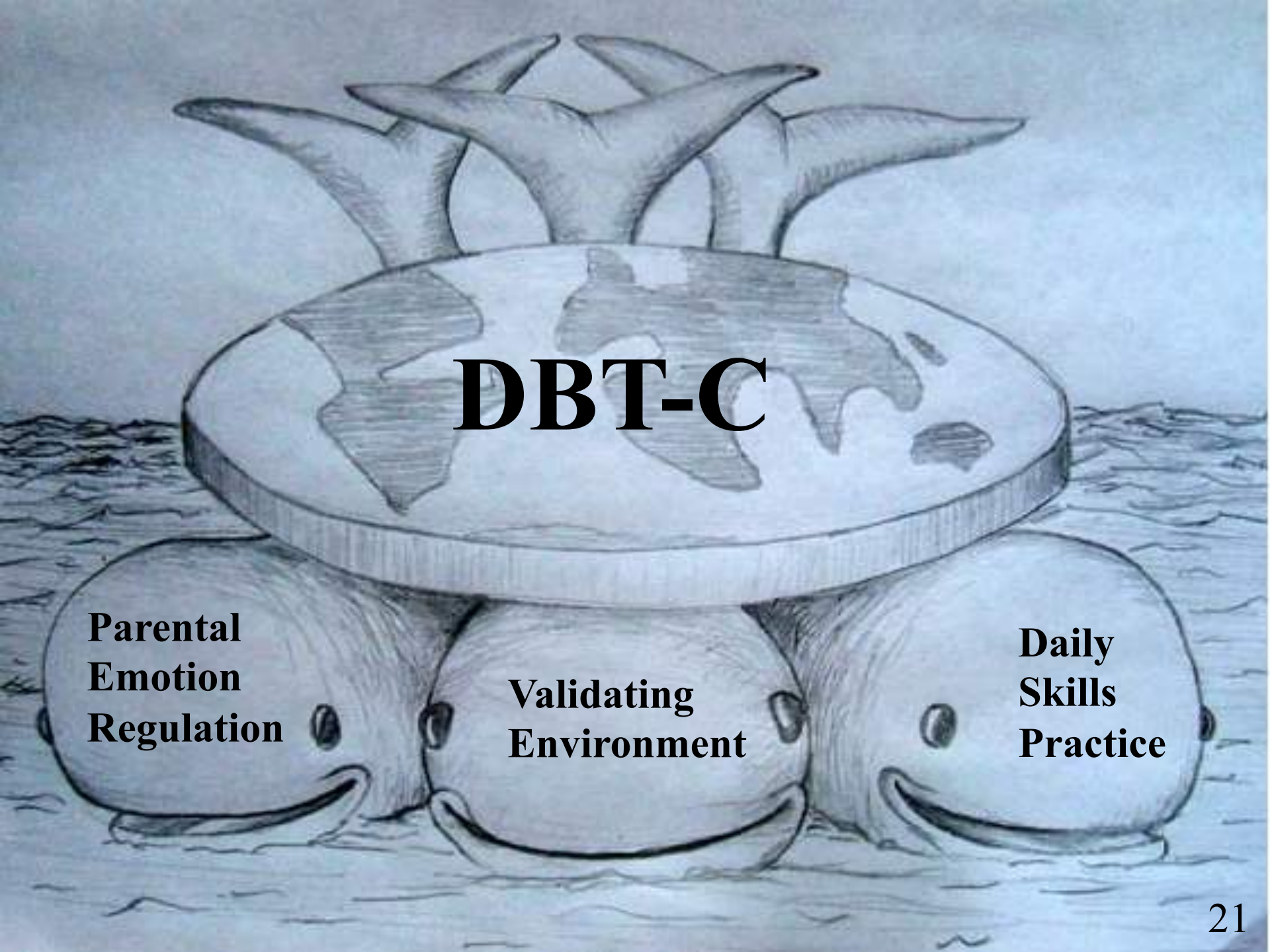
8. Quality of life Interfering behaviors (e.g., verbal aggression, anxiety)

9. Skills training

10. Therapy interfering behaviors of a child (e.g., playing with iPhone in session)

Parent or Therapist?

- DBT-C is time limited intervention
- Children are not at the cognitive and developmental level to fully appreciate and take advantage of the skills training and will require continuous support
- We cannot train parents to become therapists, AND we need for them to assume therapist's role
- Parents have to assume the role of a counselor to their child once treatment is completed


DBT-C
Parental
Emotion
Regulation
Validating
Environment
Daily
Skills
Practice

Parental Emotion Regulation

Parents have to:

- Model skills use
- Reinforce adaptive behaviors
- Ignore dysfunctional behaviors
- Suppress dangerous behaviors
- Validate child's distress
- Create a change-ready environment

Parent Training Component

1. Biosocial Theory and Transactional Model
2. Creating a change-ready environment
3. Creating a validating environment
4. Introduction to behavior modification techniques
5. Essential behavioral modification techniques
6. Behavioral capability
7. Punishment
8. Introduction to Dialectics
9. Dialectical Dilemmas
10. Walking the Middle Path

Functions of a Positive Parent-Child Relationship

1.It models a positive relationship built on trust, reinforcement, shared interests and mutual respect that helps instill in the child the sense of self-love, safety and belonging

2.It increases the child's desire to spend time with parents, which provides parents with more opportunities to model adaptive coping, prompt effective responding, and provide validation and reinforcement

3.It increases the child's motivation to behave in ways that please parents, make them proud, and earn rewards

4.It helps build pathways in the child's developing brain associated with adaptive behaviors

What interferes with effective parenting:

1.Difficulty with letting go of attachment to outcome and "should"
2.Difficulty with the need to champion behavior change
3.Difficulty with accepting DBT-C model
4.Difficulty with having to "hold and contain" the child
5.Difficulty with tolerating escalation
6.Difficulty with letting go of the over-reliance on punishment and the use of shaming
7.Difficulty with letting go of self-blame
8.Difficulty with letting go of emotional priorities
9.Difficulty with a prospect of becoming a super-parent
10.Difficulty with self-care

Skills Practice

Skills can be practiced with children in four main ways:

"In real mode"

1. During an actual problematic situation

"In pretend mode"

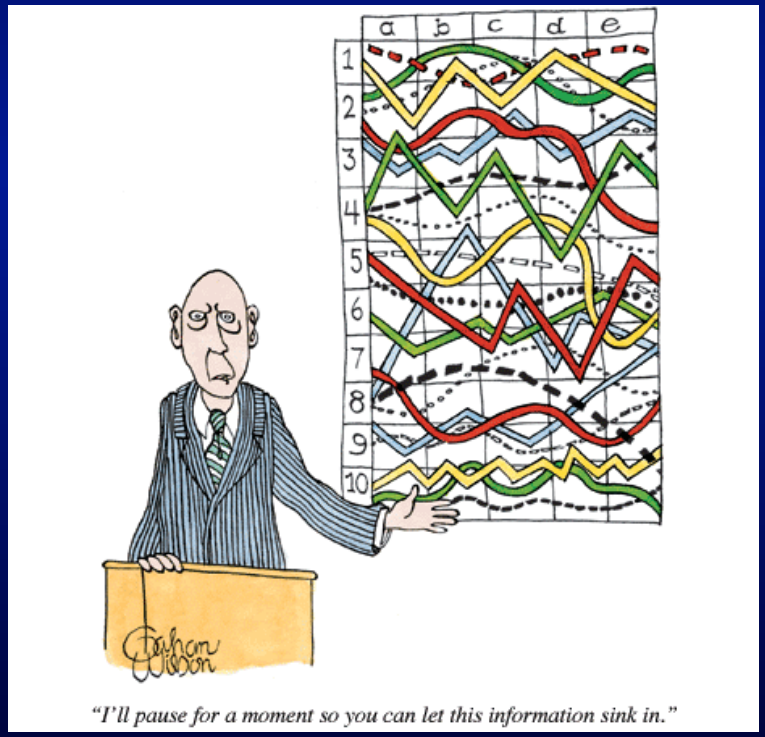
2. While processing of a problematic response after an outburst has occurred and rehearsing alternative solutions
3. While doing practice of skills in hypothetical problematic situations via role-plays
4. While coping ahead of problematic situations that are likely to happen in a near future and deciding on how to respond.

Practicing "in pretend mode" alone, drastically reduces frequency, duration and intensity of behavioral outbursts

Main Messages to Parents During Treatment:

- Child's behavior is IRRELEVANT until environment is able to effectively support progress.
- Curb expectations. We work on promoting change AND we are not expecting any change from the child.
- Its not about what the child does; its about how the parent responds.
- Current behavior and progress are not as important as the long-term progress.
- Our main tools are validation, reinforced skills practice and own emotion regulation.
- Hold and contain you child's rage/anxiety/shame/sadness.
- Parenting is about promoting the following in the child:
  - sense of self-love
  - sense of safety
  - sense of belonging

Current Research on DBT-C



"I'll pause for a moment so you can let this information sink in."

Adapting DBT-C for pre-adolescent children with DMDD: Randomized Clinical Trial in outpatient care

Clinical site:
Weill Cornell Medical College
and New York Presbyterian Hospital,
White Plains, NY

Perepletchikova et. al. (in press)

Disruptive Mood Dysregulation Disorder

A. Severe recurrent *temper outbursts* that are grossly out of proportion in intensity or duration to the situation

   1. The temper outbursts are manifest verbally and/or behaviorally, such as in the form of verbal rages or physical aggression towards people or property
   2. Temper outbursts are inconsistent with developmental level

B. Frequency: The temper outbursts occur, average, three or more times per week

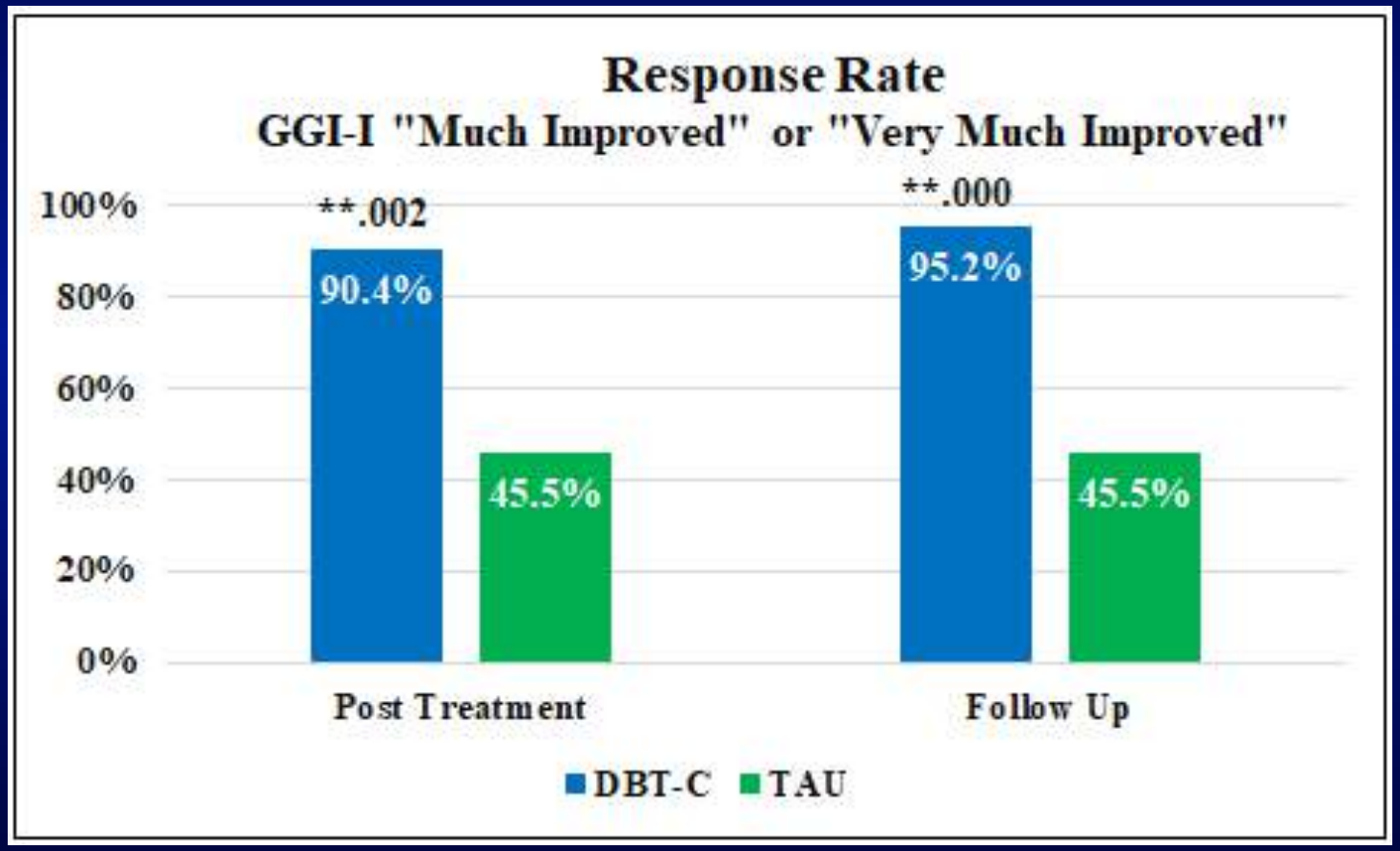
C. Mood between temper outbursts:

   1. Is persistently irritable mearly every day, most of the day
   2. is observable by others

Feasibility and Acceptability Oucomes

Variable	Mean		*p*
	DBT-C	TAU	
Drop-out rate (drop out before week 26)	0	8 (36.4%)	.004
Number of sessions attended in 32 weeks	28.48 (89.0%)	15.55 (48.6%)	.000
Child Treatment Satisfaction (range 7-28)	22.90	18.36	.03
Parent Treatment Satisfaction (range 7-28)	26.29	20.50	.001
Child Treatment Compliance (range 1-5)	3.71	3.30	ns
Parent Treatment Compliance (range 1-5)	4.33	3.90	.03
Therapist Treatment Satisfaction (range 15-60)	45.00	43.71	ns
Number of children on psychiatric medications	4 (19.1%)	12 (54.4%)	.03
Therapist Treatment Adherence level	4.20	n/s	n/s

Efficacy Outcomes: Clinical Global Impression Scale - Improvement



Results to highlight

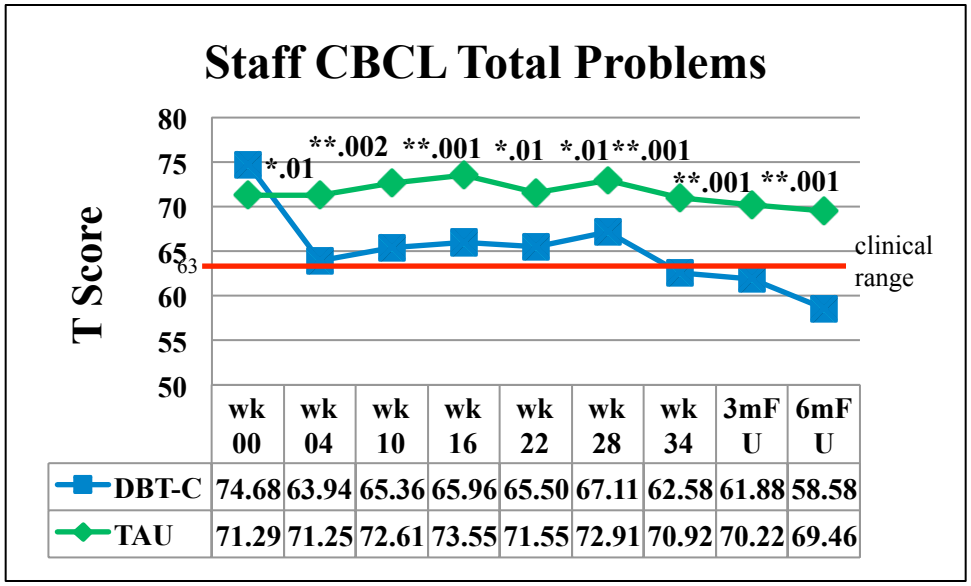
- DBT-C was more effective than TAU in reducing symptoms of DMDD despite a 3-fold difference in the use of psychiatric medications between conditions.
- Observed improvements were clinically significant.
- Parental active participation in treatment may be more important than child's compliance and engagement for symptom relief.
- In DBT-C and TAU, parental engagement in treatment was comparable (96.8% and 78.2%, respectively). Since parent involvement was high in TAU, the differences in the content of training between conditions may have contributed to outcomes.
- Therapist enthusiasm for treatment did not appear to affect outcome, as therapist satisfaction with the provided treatment was not significantly different between conditions.
- At posthoc, average causal mediation effects of the number of sessions and time in session on CGI-Improvement were not significant.
- At posthoc, average causal mediation effect of the improvement in emotions regulation in children on CGI-Improvements at follow-up was significant.

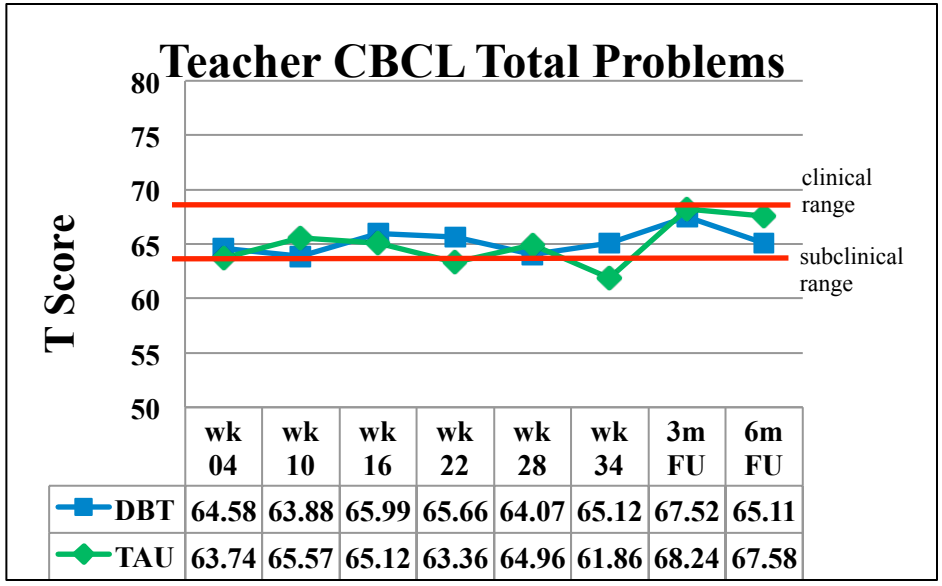
DBT-C for pre-adolescent children in residential care: Randomized Clinical Trial

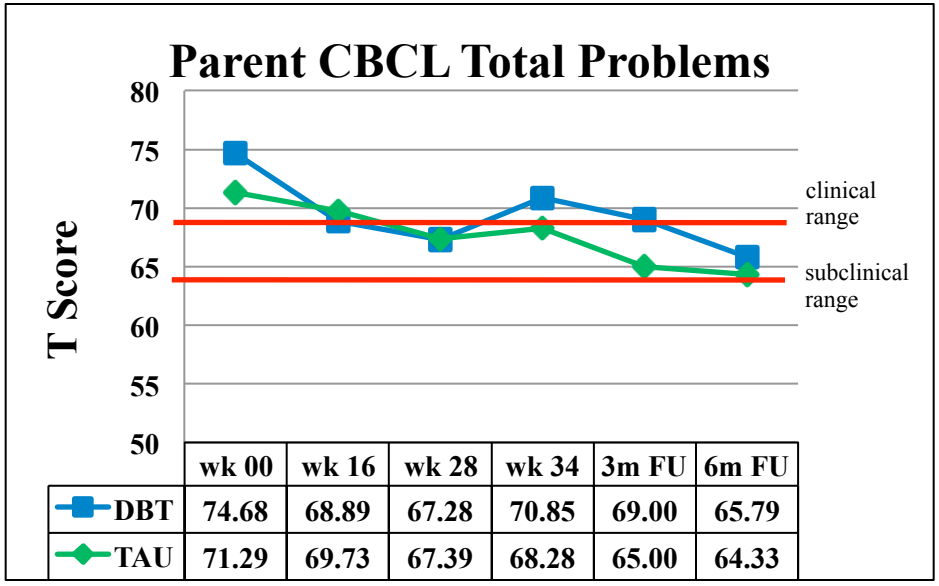
Clinical site:
Green Chimneys Residential Treatment Center

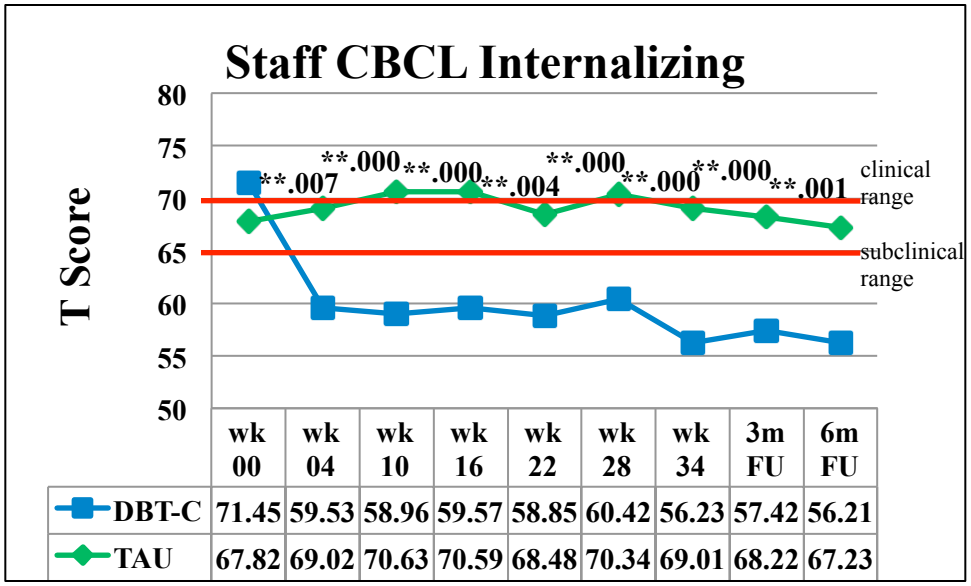
Primary Outcomes: Feasibility and Acceptability

Variable	Mean		p
	DBT	TAU	
Individual Attended	26	25.4	ns
Group Attended	38.1	38.1	ns
Parent Attended	5.2	3.6	ns
Treatment Compliance Total Child	62	61.5	ns
Treatment Compliance Total Parent	48	56.3	ns
Therapy Satisfaction Total Therapist	48	45.7	ns
Therapy Satisfaction Total Parent	21.3	21.8	ns
Therapy Satisfaction Total Child	21.8	21.9	ns
Therapist Treatment Adherence Level	4.17	n/a	n/a

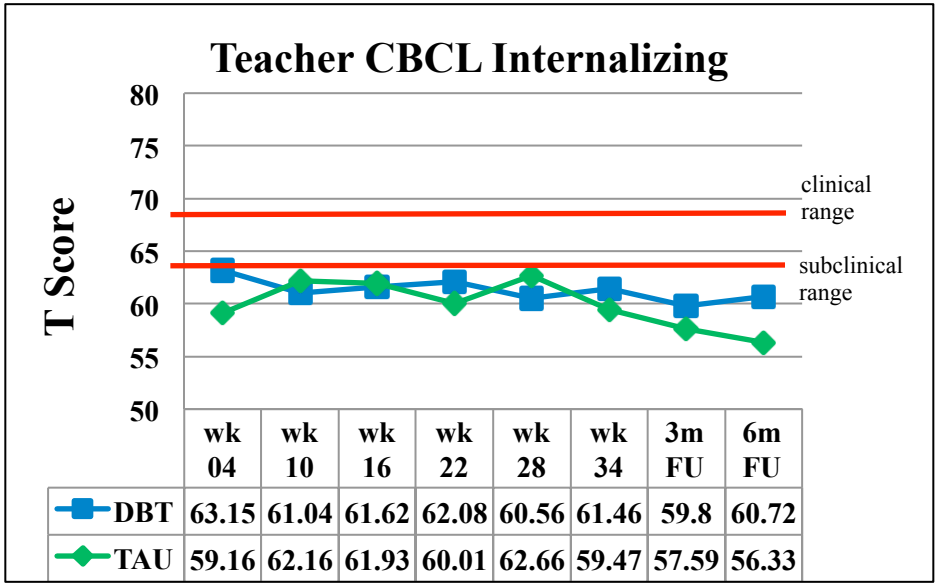

Staff CBCL Total Problems
T Score
80
75
70
65
60
55
50
63
*.01
.002 **.001 *.01 *.01.001
**.001 **.001
clinical range
wk 00 | wk 04 | wk 10 | wk 16 | wk 22 | wk 28 | wk 34 | 3mFU | 6mFU
DBT-C | 74.68 | 63.94 | 65.36 | 65.96 | 65.50 | 67.11 | 62.58 | 61.88 | 58.58
TAU | 71.29 | 71.25 | 72.61 | 73.55 | 71.55 | 72.91 | 70.92 | 70.22 | 69.46


Teacher CBCL Total Problems
T Score
80
75
70
65
60
55
50
clinical range
subclinical range
wk 04 | wk 10 | wk 16 | wk 22 | wk 28 | wk 34 | 3m FU | 6m FU
DBT | 64.58 | 63.88 | 65.99 | 65.66 | 64.07 | 65.12 | 67.52 | 65.11
TAU | 63.74 | 65.57 | 65.12 | 63.36 | 64.96 | 61.86 | 68.24 | 67.58

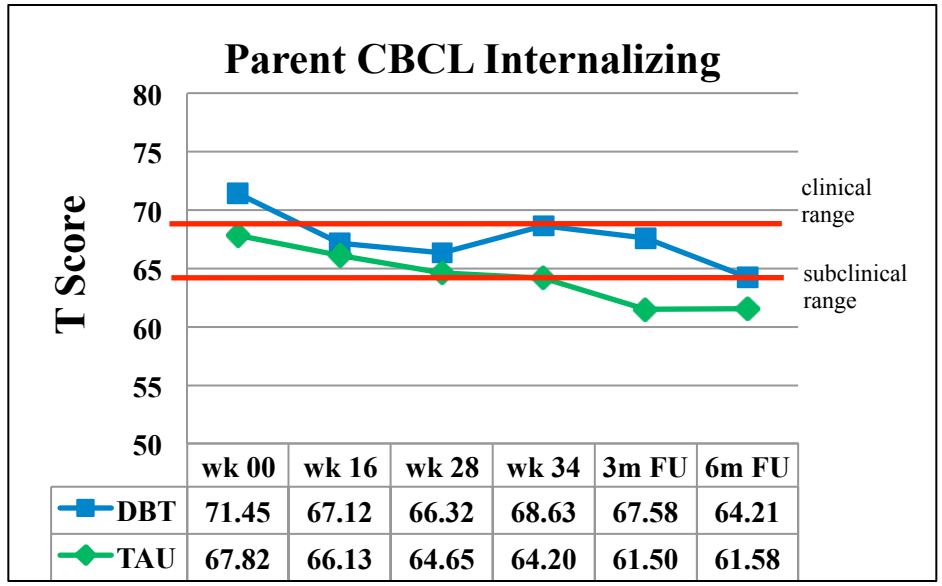

Parent CBCL Total Problems
T Score
80
75
70
65
60
55
50
clinical range
subclinical range
wk 00 | wk 16 | wk 28 | wk 34 | 3m FU | 6m FU
DBT | 74.68 | 68.89 | 67.28 | 70.85 | 69.00 | 65.79
TAU | 71.29 | 69.73 | 67.39 | 68.28 | 65.00 | 64.33



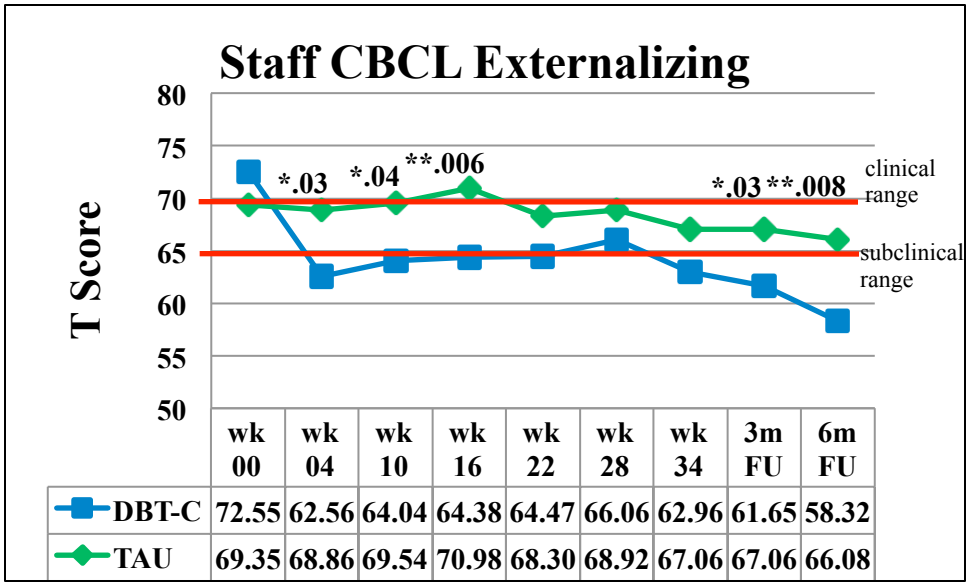
	wk 00	wk 04	wk 10	wk 16	wk 22	wk 28	wk 34	3m FU	6m FU
DBT-C	71.45	59.53	58.96	59.57	58.85	60.42	56.23	57.42	56.21
TAU	67.82	69.02	70.63	70.59	68.48	70.34	69.01	68.22	67.23



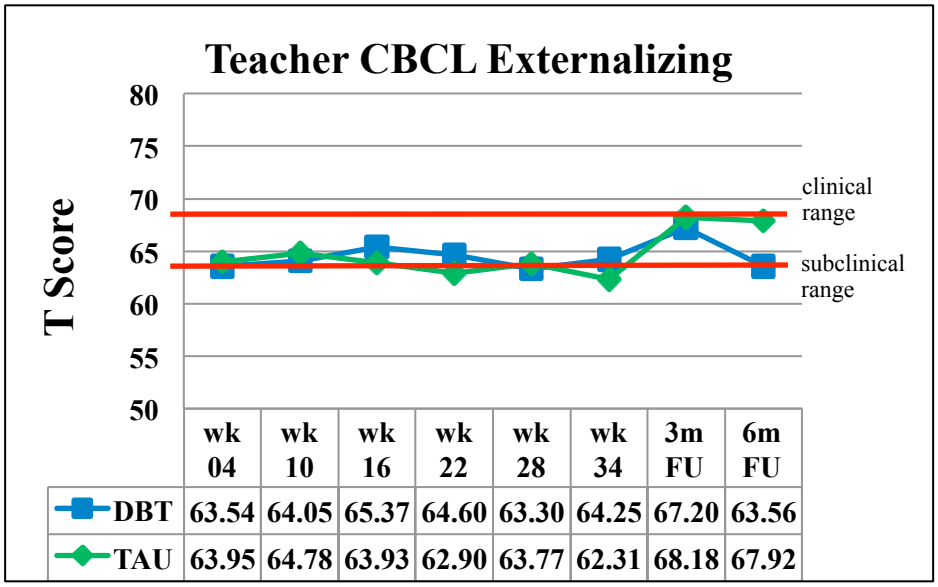
	wk 04	wk 10	wk 16	wk 22	wk 28	wk 34	3m FU	6m FU
DBT	63.15	61.04	61.62	62.08	60.56	61.46	59.8	60.72
TAU	59.16	62.16	61.93	60.01	62.66	59.47	57.59	56.33



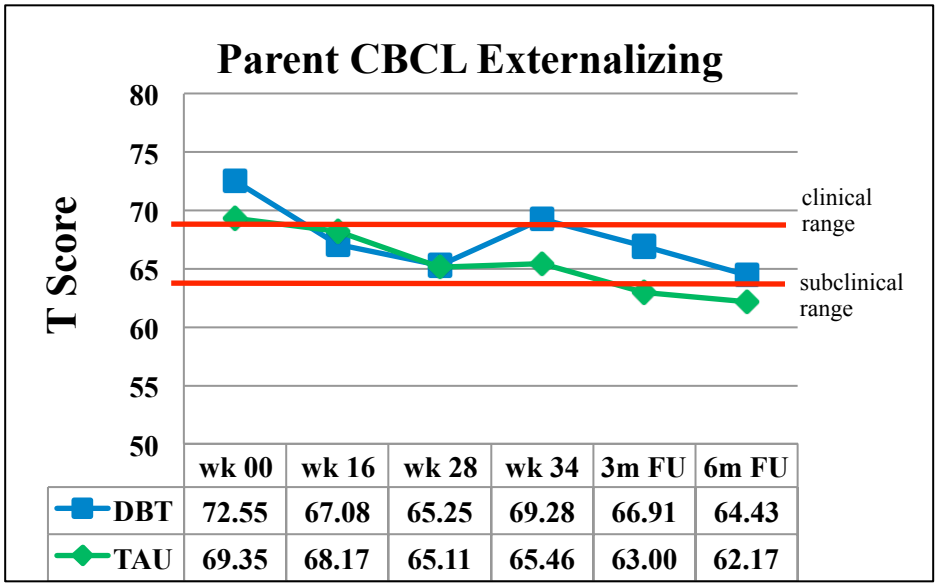
	wk 00	wk 16	wk 28	wk 34	3m FU	6m FU
DBT	71.45	67.12	66.32	68.63	67.58	64.21
TAU	67.82	66.13	64.65	64.20	61.50	61.58



	wk 00	wk 04	wk 10	wk 16	wk 22	wk 28	wk 34	3m FU	6m FU
DBT-C	72.55	62.56	64.04	64.38	64.47	66.06	62.96	61.65	58.32
TAU	69.35	68.86	69.54	70.98	68.30	68.92	67.06	67.06	66.08



	wk 04	wk 10	wk 16	wk 22	wk 28	wk 34	3m FU	6m FU
DBT	63.54	64.05	65.37	64.60	63.30	64.25	67.20	63.56
TAU	63.95	64.78	63.93	62.90	63.77	62.31	68.18	67.92



	wk 00	wk 16	wk 28	wk 34	3m FU	6m FU
DBT	72.55	67.08	65.25	69.28	66.91	64.43
TAU	69.35	68.17	65.11	65.46	63.00	62.17

Summary: DBT-C residential care

- Results of this trial indicate that DBT-C was acceptable for pre-adolescent children (7-12 years of age), including a population with a mean IQ (M=88.9) that is one SD lower than the average.
- Further, it is feasible to implement DBT-C in residential care settings. Therapists were able to demonstrate adherence to the model. Staff training and supervision was an integral part of the treatment.
- DBT-C was significantly more effective than TAU in decreasing a broad spectrum of psychiatric symptoms, as measured by CBCL staff report.
- Results were clinically significant.
- Lack of a significant difference for CBCL teacher and parent reports between groups on most scales highlights the importance of involving parents in treatment to help generalize and sustain therapeutic gains.

Thank you

For further information, please contact me at

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