

# **DBT-SP:** Adapted Dialectical Behavior Therapy for Special Populations

### CULTURE-SPECIFIC INFORMATION

Engagement	For which specific cultural group(s) (i.e., SES, religion, race, ethnicity, gender, immigrants/refugees, disabled, homeless, LGBTQ, rural/urban areas) is this treatment tailored? If none, please respond "not specifically tailored."  Youth with intellectual disabilities (developmental disabilities)
	Do clinicians, implementing the intervention, tailor engagement for specific cultural groups? If so, how? Please be as detailed as possible.  At this point, we have attempted to adapt DBT for use with youth who have ID, but we have not yet started working to address the needs of youth with intellectual disabilities (ID) who belong to specific other cultural groups. This work is planned for after our current adaptations have been researched.
	Are there culture-specific engagement strategies (e.g., addressing trust) that are included in the intervention?  The current engagement strategies are specific to working with youth who have ID. They include using simplified handouts for skills training, restructuring the balance between the individual and group therapy components of the model, providing more time for role play exercises and for repetition of material.
Language Issues	How does the treatment address children and families of different language groups? Not yet. Addressing different language groups is planned once our initial work on the English version is completed.
	If interpreters are used, what is their training in child trauma?  We have not yet used interpreters with DBT-SP.
	Any other special considerations regarding language and interpreters?  Not at this time.
Symptom Expression	Is there research or clinical evidence to suggest that the populations served manifest trauma symptoms in differential ways? If so, are there differences in the ways that symptoms are assessed for the various populations?  In our work, we have found that youth with ID tend to be more vulnerable to the effects of trauma. They are less likely to be resilient and to recover spontaneously.
	If there are differences in symptom expression, in what ways does the theoretical/conceptual framework of this treatment address culturally specific symptoms?  Following trauma, youth with ID tend to display increased difficulty with emotion regulation, distress tolerance and interpersonal relationships, which are addressed in the skill building components of the DBT-SP model.



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Assessment	In addition to any differences noted above, are there any differences in assessment measures used across cultural groups? If so, please indicate which measures are used for which cultural groups. Are there normative data available for the populations for which they are being used?  No, we are using an adapted daily diary sheet to assess all groups.
	If no normative data exists for assessment measures, how is the measure used clinically to make baseline or outcome judgments?  This measure is not used to make outcome judgments.
	What, if any, culturally specific issues arise when utilizing these assessment measures?  The daily diary sheet has been simplified for use with youth who have limited reading and writing skills.
Cultural Adaptations	Are cultural issues specifically addressed in the writing about the treatment?  Please specify.  Issues related to the challenges experienced by youth with intellectual disabilities are addressed.
	Do culture-specific adaptations exist? Please specify (e.g., components adapted, full intervention adapted).  Only the adaptation for youth with intellectual disabilities at this time.
	Has differential drop out been examined for this treatment? Is there any evidence to suggest differential drop out across cultural groups? If so, what are the findings? We have not examined this yet, due to the small size of our current sample.
Intervention Delivery Method/ Transportability & Outreach	If applicable, how does this treatment address specific cultural risk factors (i.e., increased susceptibility to other traumas)? N/A
	Is this a clinic-based treatment or is the treatment transportable (e.g., into home, community)? If the treatment is transportable, how is it adapted into the new setting? Is it still efficacious?  We have used it effectively in an outpatient clinic environment, but it would probably be difficult to transport into the home or community. However, homework assignments encourage youth to use the skills they learn at the clinic in other environments.
	Are there cultural barriers to accessing this treatment (i.e., treatment length, family involvement, stigma, etc.)? We don't have data on this issue yet.
	Are there logistical barriers to accessing this treatment for specific cultural groups (i.e., transportation issues, cost of treatment, etc.)?  The treatment is currently being provided primarily for clients who have Medicaid.  There are some barriers to accessing treatment due to limitations on treatment

placed by other insurance providers.



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Intervention	
<b>Delivery Method/</b>	
Transportability &	
<b>Outreach continued</b>	

Are these barriers addressed in the intervention and how? Not at this time.

What is the role of the community in treatment (e.g., local groups such as faith-based organizations, community groups, youth and/or parent organizations, first responders, schools)? We have not developed a community role.

### **Training Issues**

### What potential cultural issues are identified and addressed in supervision/training for the intervention?

We provide ongoing supervision for clinicians at our facility as they learn this model to ensure that they have the necessary skills for adapting their treatment interventions for use with youth who have intellectual disabilities in a way that is consistent with the DBT-SP model.

If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?

Cultural issues between supervisor and supervisee are addressed on an ongoing basis in training, but do not have a direct relationship to implementation of this adaptation, since the focus here is on adaptation for clients who have intellectual disabilities.

If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training? N/A

Has this guidance been provided in the writings on this treatment? No

Any other special considerations regarding training? No