DIALECTIC BEHAVIOUR THERAPY (DBT) FOR CHALLENGING BEHAVIOUR IN PATIENTS WITH LEARNING DISABILITY (LD).

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INTRODUCTION

DBT is generally used for the management of borderline personality disorder in general population. Conventionally, challenging behaviour in people with LD is managed by restrictive practices which may socially isolate and have negative impact on the quality of life the person. The enhanced reactive attention may calm the patient in short term but reinforce the behaviour in long term. By using the DBT approach, patients not only learn how to deal with their negative emotions but also learn the skills of independent living in their own community by social skills training. This intern provide a better quality of life for patient, reduce burden of stress for staff and financial savings for the service providers.

DBT was originally introduced to deal with challenging behaviour in borderline personality disorder in general population. There is emerging literature on the use of modified DBT in patients with learning disabilities and borderline personality disorder. These reports show some promising early outcomes. However, it is clear from these reports that the central DBT skills are taught, for example how to regulate emotions, tolerate distress, use mindfulness and interpersonal effectiveness. This is taught in group or individual sessions with use of visual aids, simplified language, more repetition and longer modules. The use of diary cards, with pictures for patients with intellectual impairments, to use as basis of behavioural analysis and coaching of patient to use skills, is a key component of DBT. Crisis coaching is used to support patient to use skills learnt to behave more adaptively when distressed.

Although the DBT approach has been recommended in North American literature for the management of challenging behaviour in people with LD, the evidence of its practical use is very limited. We have tried this approach in one of our learning disability services in Ireland for a limited number of patients with LD who presented with challenging behaviour with and without borderline personality disorder. We found this approach as holistic, which deals with challenging behaviour proactively and provide support in crisis; it also builds patients' capacity to live an independent, meaningful and responsible life. The author therefore recommends the DBT for challenging behaviour for people with learning disability with and without borderline personality disorder.

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LITERATURE REVIEW

Learning disability (mental retardation) is defined as significantly reduced ability to understand new or complex information and to learn new skills with a reduced ability to cope independently, which started before adulthood and have lasting effect on development[1].

The term challenging behaviour has been defined as culturally abnormal behaviour(s) of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities[2].

The assessment of borderline personality disorder can be overlooked by clinicians in patients with LD due to diagnostic overshadowing and therefore the challenging behaviour may be attributed to the LD only[3]. Mental health problems, in particular personality issues, are often linked to external rather than internal factors[4]. Apart from overshadowing some criteria for emotionally unstable personality disorder ('marked tendency to act unexpectedly and without consideration of the consequences', 'difficulty in maintaining any course of action that has no immediate reward') may be satisfied by a substantial proportion of people with LD

The management of challenging behaviour in the LD context without understanding the emotional needs of the patients with borderline personality disorder may inadvertently reinforce the problem behaviour[5].

DBT, developed by professor Marshal Linahan is favoured among other therapies for challenging behaviour in BPD and has been found to significantly reduce self-injury, suicidal behavior, impulsivity, self-rated anger and the use of crisis services among borderline patients[6,7].

DBT is based on biosocial model of the person with BPD who have problem with emotions regulations (bio) and early experiences of invalidating (dysfunctional) environment (social)[8]. An emotionally invalidating environment is any environment in which a person's emotional experiences are not responded to appropriately or are responded to inconsistently[9]. The child may learn that crying will not elicit sympathy from the family but a threat to self-harm may do so. This pattern of learned behaviour in early childhood tend to be repeated in later life and often drawing out an invalidating response which reinforce the behaviour.

The ultimate aim of DBT is teaching individuals to solve their own problems and navigate skilfully within their own environments. In other words, DBT teaches individuals to do for themselves, rather than have others do for them.

Individuals with LD that possess personality disorders and particularly BPD are an extremely challenging population. They are at high risk for restrictive treatment and their treatment is complicated by helplessness, confusion, and hostility held by those providers responsible for their care[10]. Most of the individuals with LD and BPD are treatment resistant and often results in team discord among service providers. They often take a lot of resources of acute services and develop reputations that result in difficulty obtaining community mental health services[11].

DBT approach is considered very appropriate for LD population as it is a skills-based model. Second, DBT is fundamentally non-pejorative in its language and positive in its aspirations, without blaming the victim. Third, DBT has a strong focus on teaching individuals to advocate for themselves that is consistent with principles of assertiveness, independence, empowerment, and self-advocacy[12].

It has been pointed out that standard DBT for LD faces challenges as people with LD have poor cognition and may not be able to engage in meaningful dialectic therapy, they may not be ready to engage in group sessions and may have difficulty to practice their skills in clinical set up therefore practice in the real world is encouraged[13].

CONCLUSION

Restrictive strategies for challenging behaviour may reinforce the maladaptive behaviour.

DBT can, not only help with problem behaviour, but, also improve the quality of life of the patient with LD by capacity building, which enable the person to live an independent, meaningful and responsible life.

DBT should be considered for all patients who present with significant and lasting behaviour issues, particularly with mild and moderate LD.

DBT cannot be used in its standard form for people with LD, instead an individual rather than group approach and practical instead of theoretical training should be more appropriate for people with LD.

REFERENCES

1. World Health Organization. The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines. Geneva: WHO; 1992.
2. Emerson E, Bromley J. The form and function of challenging behaviours. J Intellect Disabil Res 1995;39:388-98.
3. Mason J, Scior K. Diagnostic overshadowing amongst clinicians working with people with intellectual disabilities in the UK. J Appl Res Intellect Disabil 2004:17:85-90
4. Jopp DA, Keys CB. Diagnostic overshadowing reviewed and reconsidered. Am J Ment Retard 2001:106:416-33.
5. Dunn B, Bolton W. The impact of borderline personality traits on challenging behaviour: implications for learning disabilities services. Br J Forensic Pract 2004:6;3-9.
6. Verheul R, Van Den Bosch LM, Koeter MW, De Ridder MA, Stijnen T, Van Den Brink W. Dialectical behaviour therapy for women with borderline personality disorder. Br J Psychiatry 2003;182:135-40.
7. Linehan MM, Comtois KA, Murray AM, Brown MZ, Gallop RJ, Heard HL, et al. Dialectical behaviour therapy vs. therapy by experts for suicidal behaviours and borderline personality disorder. Arch Gen Psychiatry 2006:63:757-66.
8. Linehan MM, Armstrong HE, Suarez A, Allmon D, Heard HL. Cognitive behavioural treatment of chronically parasuicidal borderline patients. Arch Gen Psychiatry 1991:48:1060-4.
9. Thomas A, Chess S. Genesis and evolution of behavioural disorders: from infancy to early adult life. Am J Psychiatry 1984;141:1-9.
10. Murphy ET, Gunderson J. A promising treatment for borderline personality disorder [Online]. 1999 [cited on 2007 Sep 07]. Available from URL: http://web.archive.org/web/19991014032825/http://www.mcleanhospital.org/psychupdate/psyupl-3.htm
11. Wilson SR. A four-stage model for management of borderline personality disorder in people with mental retardation. Mental Health Aspects Dev Disabil 2001;4:68-76.
12. Lew M, Matta C, Tripp-Tebo C, Watts D. Dialectical behaviour therapy (DBT) for individuals with intellectual disabilities: a program description. Mental Health Aspects Dev Disabil 2006;9:1-12.