CHAPTER 15

An Overview of DBT for Preadolescent Children

Addressing Primary Treatment Targets

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Dialectical behavior therapy for preadolescent children (DBT-C) was developed to address severe emotional dysregulation and associated behavioral dyscontrol in a pediatric population (Perepletchikova, 2018; Perepletchikova, Axelrod, et al., 2011; Perepletchikova & Goodman, 2014; Perepletchikova, Nathanson, et al., 2017). DBT-C retains many of the theoretical model, principles, and therapeutic strategies of the adult DBT model, and includes most of its skills-training curriculum and corresponding didactics (Linehan, 1993). To accommodate developmental and cognitive levels of the target population (children ages 7–13), and the family-oriented treatment approach (children are seen in treatment together with their parents), the presentation and packaging of the information have been considerably modified, and an extensive parent training component has been added. Modifications (i.e., duration of treatment, engagement of parents) are made to accommodate the unique developmental and cognitive adaptations, as consistent with other evidence-based practices (EBP) for children (Becker et al., 2018; Dowell & Ogles, 2010; Fawley-King et al., 2013; Haine-Schlagel & Walsh, 2015; Noser & Bickman, 2000; Zima et al., 2005). In contrast to work with teens, young adults, and adults, a central goal of DBT-C, like other EBPs for children, involves strengthening both the motivation and capability of the child's *parent or guardian* to treat the child. This chapter has three main objectives: (1) to provide an overview of the DBT-C model, including adaptations to the DBT framework to address primary treatment targets; (2) to describe the target population; and (3) to detail the differences and similarities between DBT-C and standard DBT.

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Treatment Structure

The main goals of DBT-C are (1) to teach parents how to create a validating and change-ready environment; (2) to empower parents to become coaches for their child so as to promote adaptive responding during treatment and after therapy is completed; and (3) to teach parents and their children effective coping and problem-solving skills. In service of these goals, outpatient DBT-C retained all of the modes of the comprehensive DBT model, including individual therapy, skills training, consultation team meeting for therapists, and phone coaching between sessions, and has added a comprehensive parent training component. Further, DBT-C retained the five main functions of DBT. The corresponding functions of treatment are as follows:

1. *Improve client's motivation.* Although the goal of the treatment is to improve the child's level of functioning, the family as a unit is the client in DBT-C. Thus, motivation for engaging in therapy and continued participation is a target for all family members. The child and parents are provided with their own individual therapy time. The outpatient DBT-C model includes a 90-minute session once per week, done with families on an individual basis. The sessions are divided roughly into three main components: (1) a 30-minute individual session with the child, (2) a 20-minute parenting session, and (3) 40-minute skills training with both parent(s) and child present. Table 15.1 details the treatment structure of DBT-C.

2. *Enhance client capabilities.* In an outpatient setting, DBT-C provides skills training individually within each family unit, as opposed to a group format in standard DBT or a multifamily group done in adolescent DBT. This also means that in DBT-C, the individual therapist and skills trainer is one and the same. The developmental and cognitive ages of the children seen in DBT-C (ages 7–13 years) are too varied to have the children of various ages plus their parents seen for group skills training. Individual skills training also allows better tailoring of the material being presented to the developmental and cognitive levels of the child and family needs, including which material is covered and to what degree, the amount of time spent on specific skills, the presentation of didactics, and so on.

3. *Assure generalization.* Generalization is assured via homework assignments, mandated daily skills practice with parents in hypothetical situations, and phone coaching. In DBT-C, only parents are required to call the individual therapist between sessions. The child is invited to call the therapist, but is not required to make coaching calls. Instead, the child is instructed to use the parent as her skills coach. Of course, it cannot be realistically expected that a young child will call a therapist for coaching. Therefore, the main function of structuring phone coaching in this manner is to establish parents as the main coaches for the child. As these children grow, new developmental tasks and challenges will arise and parents need to become a consistent and reliable source of help long after treatment ends.

4. *Structure environment.* Structuring the environment is one of the most important functions of DBT-C. Working with children offers a significant advantage to targeting psychopathology, as the invalidating environment can be targeted directly and concurrently with treating the child. Indeed, parents are seen in treatment by themselves for the first 6 weeks to help create a validating and change-ready

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TABLE 15.1. DBT-C Treatment Structure

Assessment

Assessment with parents:

- Conduct assessment of the child's symptoms.
- Conduct assessment of parental readiness to engage in treatment.
- Start orientation of parents to treatment (e.g., your child's behavior is irrelevant until the environment is ready).
- Incorporate teaching parents 1–2 coping skills (give them a diary card).

Assessment with the child

Therapy phase (90-minute sessions)

Weeks 1–2: Pretreatment with parents only (2 sessions)

Weeks 3–9: Treatment with parents only (4–6 weeks to help them create a validating and change-ready environment, training on material up to ignoring); safety planning session with child, if child has suicidal ideation or NSSI

Weeks 10–12: Child starts therapy when parents are ready to support their child's progress:

- Biosocial theory (with child only)
- Orientation and commitment (with child only)
- Optional to see parents concurrently if needed for a portion of the child's session (separately from the child)

Weeks 13–18: Child and parents come together for therapy:

- Together, child and parent receive psychoeducation on emotions during the child's individual part of session (30 minutes).
- Parents receive individual counseling, focusing on the implementation of the learned techniques, feedback, and troubleshooting problems (20 minutes).
- Together, child and parents do skills training (start with the mindfulness module; 40 minutes).

Week 19: Child and parents come together for therapy:

- Child's individual therapy follows treatment target hierarchy (30 minutes).
- Parents receive individual training component (20 minutes).
- Skills training with child and parents takes place (40 minutes).

environment in preparation for the child entering treatment. During that time, they are provided with psychoeducation, and learn contingency management, validation, dialectics of parenting and emotion-regulation skills. Once parents cover this material and have sufficient emotion-regulation skills, the child starts treatment. Parents continue to be seen, to help them apply what they learned in the first phase and to improve their emotion regulation. Treatment is usually terminated *not* when all of the child's problems are addressed, but when the therapist is confident that the parents are able to consistently implement the learned strategies and procedures *and* can maintain their own emotional regulation to sustain the change-ready and validating environment.

5. *Enhance therapist capabilities and motivation.* Like standard DBT, DBT-C involves a community of clients and families receiving treatment from a community of therapists. Therapists participate in weekly consultation team that serves as a "therapy for therapists" and a forum for discussing aspects of their clients' treatment when needed.

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Target Population

DBT-C targets primarily children ages 6–13 years with severe emotional dysregulation and corresponding behavioral dyscontrol. As in standard DBT, DBT-C defines emotional sensitivity in terms of the following components:

1. *Emotional reactions have a low threshold for occurrence*. For these children, prompting events may involve just a thought, a memory, an association, or an external event so minute that others may not notice its occurrence.

2. *Emotional reactions are intense*. Children often describe their emotional reactions as tsunamis that are hard to withstand.

3. *Emotional reactions happen fast*. Parents and children alike describe these reactions as going from "0 to a 100" in a millisecond.

4. *Emotional reactions take a long time to subside*. Once an emotional reaction starts, it takes considerable time for the reaction to go back to baseline. At times, it may take hours before a child calms down.

Clinical observations indicate that emotional sensitivity frequently co-occurs with most of these patterns of behavior:

- Emotionally sensitive children frequently *look for ways to avoid effort*. These children are constantly overwhelmed by their own emotional experiences and may be less inclined to face more challenges. They need to withstand not only the impact of a challenge but also the impact of their intense emotional reaction to it. This is an important consideration for parents who might believe that their emotionally sensitive children are "lazy." Instead, parents need to remember that their children may be in a constant state of emotional overload.

- These children are usually *hyperreactive* and may exhibit behaviors such as anxiety attacks, physical aggression, verbal outbursts, temper tantrums, suicidality, and nonsuicidal self-injury (NSSI) like cutting.

- These children *generally dislike change*. They respond well to structure, sameness, and security. Anything new is met with reluctance; having to transition from one activity to the next is problematic for them.

- They are *more easily bored*. Although these children usually avoid engaging in difficult new activities, they require a high level of stimulation and need a constant source of enjoyable events. However, parents also must keep in mind that these children rapidly lose interest even in fun activities.

- These children tend to have *a lower tolerance for delayed gratification*. Because of their high excitability, they experience the inability to satisfy their wishes right away as painful.

- Frequently, these children have *more difficulty with concentration and rapidly shift their attention* compared to peers.

- Since emotionally sensitive children are overexcitable, they tend to have a *surplus of physical energy* and may be viewed as hyperactive.

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- They frequently display *impulsive behaviors*. Sensitive children may often do things without thinking. The intensity of their emotional reactions is so high that they may not be able to fully process their urges before they act on them. This may also be related to their difficulty with delayed gratification, and with feeling pain because they are being blocked from immediately achieving a goal.

- Emotional sensitivity is frequently associated with *sensory sensitivity,* or a low tolerance for sensory stimulation. Some or all of the senses may be affected (i.e., touch, smell, taste, sound, and vision). Even putting on a new pair of socks may cause a high level of discomfort for some of these children.

- These children frequently have *severe interpersonal difficulties* with siblings and parents, and may have problems with peers and friends. Their reactivity often greatly interferes with developing and maintaining stable relationships.

- They tend to have an *extreme thinking style,* such as black-and-white thinking and catastrophizing. They also tend to perseverate and ruminate. This is quite understandable, given that under high arousal, attention narrows down and thoughts become more rigid.

- These children often have *difficulty with personal hygiene,* such as brushing their teeth, taking showers, and the like. This may stem from such activities being perceived as unpleasant, boring, or demanding effort and, in some cases, from sensory processing problems. Sensitive children have difficulty with all of these, as discussed above.

A child who is emotionally sensitive brings unique demands to the environment, such as parents, teachers, and therapists alike. However, emotional sensitivity also brings with it certain unique advantages. DBT-C includes a standard psychoeducation on the dialectics of emotional sensitivity and discusses associated challenges alongside the advantages:

- Emotionally sensitive children can *experience positive emotions at a higher level*.
- Emotionally sensitive children are quite *adept at reading other people's emotions*.
- They are *empathic* and very likely to be caring, supportive, and understanding of other's pain.
- Emotional sensitivity has been linked to *increased creativity* (see Kaufman & Gregoire, 2015).

Unfortunately, the word "sensitive" has acquired the negative connotation of one being "touchy," defensive, uptight, paranoid, or neurotic. To avoid the common derogatory terms associated with sensitivity, in DBT-C, we use the expression "supersenser" to describe children and adults with emotional sensitivity. An analogue is the term "supertasters" that describes people with heightened sensitivity to sensory perceptions. When the challenges and advantages of the emotional sensitivity are discussed with parents and children, it is underscored that sensitivity has its challenge and advantages and, in itself, is not a problem to correct but a special ability that the child needs to learn to control. Communicating this point to the child is critical. This

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helps children feel understood, validated, and not judged, which decreases their self-critical thinking and increases their willingness and interest to learn what we term "superskills" to help control their "superabilities."

Biosocial Model

DBT-C retains the DBT strategies, procedures, and theoretical principles to address the needs of the target population. In her landmark *Cognitive Behavioral Therapy for Borderline Personality Disorder* (Linehan, 1993), Marsha Linehan outlined an etiological theory on how a person develops borderline personality disorder (BPD) throughout their life span. According to Linehan's biosocial model, BPD has its origins in a maladaptive transaction that occurs between a biologically emotionally vulnerable person and an invalidating environment that leads to pervasive emotional dysregulation. Emotional vulnerability is seen as an inborn dysfunction in emotional processing, where a person has a low threshold for emotional reactivity, reacts quickly and intensely to stimuli, and experiences a slow return to baseline.

It is quite a challenge to parent a supersenser. A poor match between the child's needs and parental ability to satisfy these needs may lead to the development of an invalidating environment. An invalidating environment is characterized by pervasive and indiscriminate rejections of the child's experiences (e.g., feelings, thoughts, behaviors) as invalid (e.g., "Stop acting like a baby, there is nothing to be scared about!"); oversimplification of the ease of solutions (e.g., "Just stop this!"); and intermittent reinforcement of escalations (i.e., the child learns that while lower levels of dysregulation are invalidated, the coveted support and care can be achieved by engaging in self-harm or threatening suicide; Linehan, 1993).

An invalidating environment is not necessarily abusive or neglectful. On the contrary, in most cases, parents are indeed caring and supportive, and attempt to deal with situations to the best of their ability. They may be quite competent in providing "good enough" parenting to other children in the family who may not be as emotionally sensitive. However, good enough parenting is simply not good enough for supersensers. The poor fit between the child's needs, and parental capacity to satisfy these needs, may lead to a pervasive transaction where the child's demands stretch the environment's resources, and the environment invalidates the child in response. This transaction dysregulates the child further, resulting in further demands on the environment, and so forth. As a result, these children fail to learn self-regulation, and often have problematic relationships with parents, siblings, peers, and teachers, and persistent difficulties in multiple settings. The negative feedback may lead to the development of negative self-concept in affected children; impede their emotional, social, and cognitive development; and increase the chance of psychopathology in the future (Althoff, Verhulst, Retlew, Hudziak, & Van der Ende, 2010; Okado & Bierman, 2015; Pickles et al., 2010).

As noted, for supersensers, "good enough" parenting may not be sufficient to meet their needs. *Supersensers require what can be called a superparent*. One of the most important goals of DBT-C is to help parents learn to become superparents. A superparent can be compared to a firefighter. Just like a firefighter:

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- A superparent does not start fires (e.g., does not model verbal or physical aggression, does not provoke or invalidate the child, does not retaliate, and does not use ineffective parenting techniques).
- A superparent is not afraid of fires (e.g., is not scared of the child's outbursts and does not accommodate the child in an effort to avoid problems).
- A superparent calmly and skillfully puts fires out and works on preventive measures (e.g., ignores their child's dysfunctional behaviors, validates the child's suffering, models skills use, prompts and reinforces adaptive behaviors, uses effective parenting techniques, helps the child to cope ahead of problematic situations, does daily reinforced practices with the child, and encourages the child's self-management).

Treatment Target Hierarchy

As detailed above, DBT-C is a family-oriented approach, where family as a unit is treated as the client. Parental involvement, participation, and commitment to the treatment are required, while a child's commitment is only preferred, regardless of the child's age. Commitment from a child is elicited *only* if a therapist is sure that the commitment will be given, after the initial orientation. Preadolescent children may not have sufficient cognitive and developmental maturity to fully understand commitment, so this aspect is less relevant for DBT-C than for standard DBT, for the function of treatment engagement.

In DBT-C, parental emotion regulation and ability to create an environment conducive to change are prioritized. To incorporate these goals, the hierarchy of primary treatment targets was greatly extended in DBT-C as compared to standard DBT and DBT for adolescents. In the original model, the treatment target hierarchy consists of three main categories, in order of priority: decreasing life-threatening behaviors, decreasing therapy-interfering behaviors, and decreasing quality-of-life interfering behaviors, all while simultaneously increasing skillful responding. DBT-C has a target hierarchy that includes 3 main categories, divided into 10 subcategories.

I. Decrease current severe psychopathology and risk of psychopathology in the future:
   1. Decrease life-threatening behaviors of the child.
   2. Decrease therapy-destroying behaviors of the child.
   3. Decrease therapy-interfering behaviors of the parents.
   4. Improve parental emotion regulation.
   5. Teach effective parenting techniques.

II. Target the parent–child relationship:
   6. Improve the parent–child relationship.

III. Target the child's presenting quality-of-life and therapy-interfering behaviors:
   7. Decrease risky, unsafe, and aggressive behaviors.
   8. Decrease quality-of-life interfering problems.

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9. Provide skills training.
10. Decrease therapy-interfering behaviors of the child.

The following sections briefly describe each target category and how each target is addressed in treatment.

Decrease Current Severe Psychopathology and Risk of Psychopathology in the Future

Children with severe emotional dysregulation are at high risk to develop psychopathology. Irritability and impulsivity that are highly prevalent in this population are associated with poor functioning and severe impairment during childhood and adolescence, as well as in adulthood (Althoff et al., 2010). These include significantly impaired functioning at home, school, and with peers; clinical-level anxiety and depression; attention-deficit/hyperactivity disorder (ADHD); impulsive–aggressive behavior; negative affect; and cognitive problems (Althoff et al., 2010; Roy et al., 2013). Further, emotional dysregulation and irritability symptoms are associated with adult personality disorders, substance abuse, and mood disorders (Althoff et al., 2010). These behaviors are also a significant predictor of suicidality in adulthood (Stringaris, 2011). Thus, the main goal of DBT-C is to target the present psychopathology and to reduce the risk of psychopathology in the future.

Target 1: Decrease Life-Threatening Behaviors of the Child

As has been stated, the priority in DBT-C is to reduce the risk of severe psychopathology now and in the future. To that end, the highest target remains the same as with standard DBT: life-threatening behaviors. These include suicidal and NSSI acts, urges, communications, ideations, expectations, beliefs, and affect. In the preadolescent population, suicidal and NSSI behaviors are less common than in adult or adolescent populations. However, risk assessment and safety planning are integral parts of treatment from beginning to end. A therapist must continue to assess the level of risk that a child presents to inform their decisions. For example, it is quite common for emotionally sensitive children to make remarks such as "I wish I were dead!" or "I'm going to kill myself!" during a verbal outburst. Whether these communications are actively ignored or attended to depends on the risk level of the child, and the function that these comments serve. In most cases, such verbalizations are ignored in the moment, followed by processing of a situation, when the child is in a neutral state, to figure out how to handle a similar situation in the future. It is often very difficult for adults to ignore a child threatening to cut themself, yet most often that is precisely what is needed to preclude reinforcement of the behavior with attention.

Target 2: Decrease Therapy-Destroying Behaviors of the Child

As will be discussed later, DBT-C is very tolerant of behaviors on the part of the child, in and out of session, that may be therapy-interfering (e.g., yelling, cursing). However, children can engage in behaviors that may destroy the treatment process. In session, therapy-destroying behaviors are those threatening the safety of participants

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or the therapist, such as physical aggression, property damage, or running away from the office (unless it can be safely assumed that the child will remain in the vicinity of the office and will return shortly). As a general rule, any physically aggressive acts in a session are treated as therapy-destroying and are typically addressed with a time-out procedure (administered by a parent). Measures can also include ending the session or, if possible, ending just the child's portion of the session. Ending a session may be particularly problematic as there is a risk of reinforcing such behaviors, if the function of a behavior is to end a session. Yet, ensuring participants' safety takes precedence. Such matters are best resolved by prevention as opposed to intervention, including building a strong therapeutic alliance, use of reinforcement of opposite desirable behaviors, and coping ahead strategies.

Therapy-destroying behaviors on the part of the child that occur between sessions include dangerous levels of aggression or destruction at home, school, or elsewhere, such as choking a sibling or breaking windows. Such behaviors are therapy-destroying, as they preclude the effective use of behavior modification techniques like planned ignoring and, therefore, progress cannot be achieved. Therapy-destroying behaviors that are frequent and interfere with progress may necessitate the consideration of medication management to reduce reactivity. In severe cases, a higher level of care may be needed before beginning a course of outpatient DBT-C.

Target 3: Decrease Therapy-Interfering Behaviors of Parents or Therapists

While therapy-interfering behaviors of the child are considered a lower priority in DBT-C (Target 10), therapy-interfering behaviors of parents or caregivers are placed high on the hierarchy. Significant and lasting treatment gains cannot be achieved without parental engagement. Therapy-interfering behaviors on the part of caregivers may include frequently missing or re-scheduling sessions; failing to follow the therapist's recommendations; and continued use of prolonged, harsh, or unnecessary punishment techniques.

To help reduce such occurrences, parental orientation to the treatment begins at the first point of contact. Often, orientation starts at the introductory phone call, outlining the requirements in a direct and clear manner: This treatment involves a lot of work on the part of caregivers. Parents are expected to learn and model the use of coping skills and elicit them from their children. They are expected to ignore annoying behaviors. They are expected to provide validation and praise adaptive behaviors. Also, frequently the therapist will be asking parents to do what may be counterintuitive or contrary to the expectations of how a parent and child "should" interact (e.g., don't reprimand your child during an outburst when he is swearing at you). From the very beginning, parents are oriented to the complex structure of the treatment, and to the idea that it will take time before they understand the treatment model and appreciate how different components are designed to address the specified targets. Thus, parents are instructed to "act as if" they trust the method before they fully understand it and begin seeing therapeutic gains. As mentioned above, parental commitment to treatment is necessary, while the child's commitment is just preferred, and providing parents with full disclosure of what may be involved before such a commitment is elicited helps decrease the risk of therapy-interfering behaviors.

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Target 4: Improve Parental Emotion Regulation

Attempting to help the child achieve emotion regulation in a dysregulated environment is a rather futile task. Parental emotion regulation is critical in all aspects of treatment. Parents need to have a vast repertoire of emotional coping skills to model effective coping, reinforce adaptive behaviors, ignore dysfunctional behaviors, and suppress dangerous behaviors, all while validating a child's distress. Thus, bolstering parental emotional coping capacity is one of the main goals of treatment. Thus, during the initial 4 to 6 weeks of therapy, only caregivers are seen in treatment to help establish a change-ready and validating environment. This includes parents learning emotion-regulation skills themselves.

Target 5: Teach Effective Parenting Techniques

Closely related to increasing parental emotion-regulation ability is the goal of increasing effective parenting skills. Typically, when families seek DBT-C, the child's maladaptive behaviors are at a severe level, and parents rely mostly on punishment to force compliance and to regulate their own distressing emotions. Instead, they need to learn how to rely primarily on reinforcement of desired behaviors, validation, behavioral shaping paradigms, and planned ignoring. Parents are instructed to use punishment techniques very sparingly and strategically to suppress only potentially unsafe behaviors of their child.

Target the Parent–Child Relationship

Families often enter into therapy with high-conflict households, where the parent–child relationship is characterized by active opposition and hostility rather than compassion. The high-conflict relational pattern is usually a result of a poor fit between the child's needs and parental capacity to satisfy these needs, as discussed above. In such households, parents frequently use retaliation to achieve perceived vindication and also to regulate their own emotional distress. Unsurprisingly, children respond in kind to their parents, so the cycle continues. When the parent–child relationship has been corroded to this point, any meaningful changes can hardly be expected of the child. Parents are the main tools of therapeutic change in DBT-C, and a loving relationship between children and parents is the driving force for the desired changes.

Target 6: Improve Parent–Child Relationship

Having a healthy and loving relationship between children and parents is the foundation on which change can be built. Therefore, parents are instructed to take active steps toward building, mending, and maintaining the relationship with their children. Heavy reinforcement schedules, validation, and building reciprocity between members of the family are the main methods for addressing this target. To build reciprocity, parents are instructed to actively participate in joint activities with their children. The choice of activities is driven by the child's, not the parents', interests and frequently includes watching videos or playing video games. The goal is for parents to be involved in what their child likes to do and promote their child feeling happy, loved, and accepted.

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A positive parent–child relationship serves several important functions toward ameliorating the child's problem behaviors. It models a relationship that is based on trust, reinforcement, shared interest, and mutual respect. It helps instill in the child a sense of self-love, safety, and belonging that are necessary for adaptive, independent, and prosocial functioning. It increases the child's desire to spend time with their parents, which in turn means that parents have more time to elicit, model, and reinforce adaptive coping behaviors, and practice the use of skills with their child. A positive relationship also augments the child's motivation to behave in a way that will please their parents and make them proud, as opposed to making them miserable. Indeed, reinforcement from parents becomes more effective if the child wants to make their parents happy, which cannot be taken for granted. Finally, a healthy parent–child relationship helps to build pathways in the child's developing brain that are associated with adaptive behaviors.

Target the Child's Presenting Problems

The third major category on the hierarchy consists of problems that usually bring families to treatment, yet they are relatively low on the target hierarchy as meaningful and lasting changes cannot be achieved in an environment that is dysregulated, invalidating, and unable to support the child's progress.

Target 7: Decrease Risky or Unsafe Behaviors of the Child

Target 7 includes physical aggression and property destruction at home, school, and other settings. These behaviors are mild to moderate in severity (e.g., kicking, pushing, shoving), as compared to the Target 2 therapy-destroying behaviors (e.g., choking a younger sibling, or using a heavy object aggressively). Parents are instructed to use punishment techniques to suppress Target 7 behaviors (e.g., reprimands or a time-out). Although responses in Target 7 also represent quality-of-life interfering behavior, they are placed in a separate category, as they have to be addressed before targeting other quality-of-life interfering problems and events. It is frequently countertherapeutic to address them simultaneously with some of the Target 8 behaviors. For example, when physical aggression is placed on a shaping paradigm, there is frequently a temporary increase in verbal aggression.

Target 8: Decrease Quality-of-Life Interfering Events or Behaviors of the Child

Target 8 includes the quality-of-life interfering behaviors of the child and events that affect the child's functioning. This category subsumes a broad array of behaviors, including comorbid disorders such as ADHD, anxiety, verbal aggression, interpersonal difficulties, impulse control issues, and struggles maintaining personal health and hygiene. Further, this category includes addressing school problems and parent/family issues (e.g., divorce).

Level 8 behaviors usually happen more frequently than life-threatening behaviors, therapy-destroying behaviors, or risky and unsafe behaviors. However, it may take time before they are consistently targeted as such might be countertherapeutic to address them at the same time as higher-level issues. For example, targeting a decrease in physical aggression (Target 7) may temporarily trigger an increase in

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verbal aggression (Target 8). Parents can easily agree that targeting a risk of self-harm or suicide is more important than addressing school refusal or that hitting a sibling is more problematic than cursing at him. However, due to the sheer frequency of the level 8 behaviors and their impact on family life, it is usually quite difficult for parents to continue to accept the need to tolerate these behaviors until more pressing issues are addressed. Therefore, continued validation of parental struggles balanced with increasing their mindfulness of therapeutic priorities is a leitmotif of parent sessions.

Target 9: Provide Skills Training

DBT-C, as in all forms of DBT, offers a variety of coping skills that can be used to replace maladaptive behaviors that supersensers display. The skills are presented in an animated, simplified, child-friendly way. Parents learn all the didactics that their child is learning, as they need to use these same skills to regulate their own emotions, as well as model, elicit, and reinforce the skills use of their child. Skills-training sessions are ideally done with all participants (parents and children) together. With some families, this may be problematic, particularly at the beginning of therapy, if the child cannot tolerate their parents being present. In such cases, skills training is done separately with parents and the child until the parent–child relationship has been sufficiently improved for cotraining to occur.

Target 10: Decrease Therapy-Interfering Behaviors of the Child

Therapy-interfering behaviors (as distinguished from therapy-destroying or risky/unsafe behaviors described above) are the lowest on a target hierarchy in DBT-C. These include in-session verbal aggression, threats, cursing, screaming, attempts to distract parents or the therapist, being distractible oneself, devaluing treatment, among many other behaviors. Sometimes the entire session can consist of the child screaming, yelling, and threatening. These behaviors are hard to tolerate, yet they are target-relevant and informative of what happens outside of sessions.

Target 10 behaviors are addressed primarily with contingency management (e.g., ignoring maladaptive and reinforcing adaptive behaviors in session). They provide great opportunities to refine the use of parental emotion-regulation skills and parenting techniques in the moment (Targets 4 and 5). The therapist also has a chance to observe and assess parent–child interactions for further interventions (Target 6). Further, the therapist can continue to teach skills to parents while a child is having an outburst (Target 9), assigning the parents to later discuss the learned techniques with the child. These behaviors additionally allow the therapist to model effective coping (Target 9) and application of contingency management procedures (Target 5). Finally, ignoring a child's disruptive behaviors in sessions as well as at home helps to extinguish such responses in multiple settings (Target 8).

Pretreatment Phase

In DBT-C, pretreatment is usually conducted over 2 sessions separately with the child and 2 sessions separately with the parent(s). The same topics are covered. During this phase, the therapist discusses the biosocial model and assumptions about clients who

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need DBT-C, orients the family to the treatment model, sets treatment goals, and connects how treatment components will address the specified targets. As has been referenced above, in DBT-C, parents are asked to commit to treatment at the outset of therapy, while children are not required to formally make such a commitment. The child's commitment is only elicited if a therapist is confident that the child will commit. This may require the child to have sufficient experience with therapy to trust that the treatment might indeed help.

Individual Therapy

Individual therapy with the child consists of two phases: psychoeducation on emotions and therapy following DBT-C targets. Psychoeducation on emotions includes a discussion of what emotions are, their functions, myths about emotions, the emotion wave, the emotion-regulation model, the behavior change model, radical acceptance, willingness and willfulness, and the STOP skill. DBT-C introduced the emotion-regulation model to help elucidate how one's emotion is amplified, sustained, and transformed into a mood. This model indicates that there are three main sources that fuel emotions: doing what an emotion wants us to do, thinking what an emotion wants us to think, and maintaining tension (or energy) that an emotion brings with an action urge. To stop experiencing an unwanted emotion, all three sources have to be cut off. The behavior change model is also unique to DBT-C. It includes three components: *awareness* (i.e., an ability to catch an action urge or thought before it is realized in action); *willingness* (i.e., motivation to not follow an urge if it is not justified by a situation); and *capability* (i.e., adaptive coping skill, problem solving, cognitive restructuring, self-management). Willingness is the most important aspect, as without motivation to engage in a competing response, knowledge of skills and other strategies becomes useless. A lot of time is devoted to enhancing the child's motivation during individual sessions with the therapist and in-between sessions with parents.

In DBT-C, chain analysis is simplified by following the sequence of emotion wave steps: vulnerabilities, event, thought, feeling, action urge, action, aftereffects. A three-headed dragon of chain and solution analysis game is used for younger children to motivate engagement and help sustain their attention. Children write about events, feelings, thoughts, and behaviors on specifically designated cards or links in a chain, and place them on a drawing of a three-headed dragon. The middle neck of the dragon represents what actually happened, and the other two necks are used to discuss what other actions could have been taken instead. Once alternative responses are developed, the child and the therapist role-play the use of generated adaptive solutions.

Individual treatment with the child following DBT-C targets includes regular DBT tasks, such as the application of learned skills, development of self-management, problem solving, cognitive restructuring, behavioral activation, exposure, modeling, coaching and shaping behaviors, and consultation to the client. In DBT-C, the main tasks during an individual session are to improve motivation for change; conduct thorough assessments of emotions, thoughts, and actions to understand functions of responses; and help clients effectively use change strategies (e.g., skills, problem solving, cognitive restructuring

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Skills Training

DBT-C retains the vast majority of the skills used in standard DBT, with many of the skills having been condensed, and only a few completely omitted. The mindfulness module has been retained completely, while other modules have experienced significant modifications. For example, in the standard DBT interpersonal effectiveness skills module, there are three sets of skills used to balance and maintain one's wants, relationships, and self-respect when dealing with others. These are the DEAR MAN, GIVE, and FAST skills, respectively, with each letter in the acronym standing for an aspect of the skill used. In, DBT-C, these skills have been concentrated into the DEAR and FRIEND skills (be **F**air and **R**espectful, act **I**nterested, use an **E**asy manner, **N**egotiate, and be **D**irect).

In DBT-C, the differences in the distress-tolerance and emotion-regulation modules are discussed functionally from the perspective of the emotion-regulation model. Distress-tolerance skills function to reduce the risk of making the situation worse without the goal of changing how the person feels or the situation. Thus, the majority of these skills are designed to cut one or two foods for an emotion. For example, the DISTRACT skill (a combination of standard DBT wise mind ACCEPTS and IMPROVE the moment) includes **D**o something else (cuts *the doing food* from the emotion), **T**hink about something else (cuts *the thinking food*), and so on. Emotion-regulation skills, on the other hand, function to modulate an emotional experience and are thus designed to cut all three food sources from an emotion. For example, the opposite all the way skill includes opposite action, opposite thinking, and opposite tensing. As mentioned, some skills are omitted from the DBT-C distress-tolerance and emotion-regulation modules on the basis that they are less relevant for a pediatric population, such as sticking to values, comparing oneself to others less fortunate, finding meaning in suffering, and using prayer. For a more complete summary of DBT-C skills curriculum, please refer to Table 15.2.

Parent Training Component

DBT-C, as compared to standard DBT, has a unique advantage: an ability to directly intervene in the environment to stop the dysfunctional transaction described in the biosocial model. Parents have to learn everything the child is learning (i.e., didactics on emotions and skills), plus additional components (i.e., creating a change-ready and validating environment, behavior modification techniques, and the dialectics of parenting).

DBT-C maintains an emphasis on training parents to become therapists for their children, with the goal of promoting the parents' ability to model, elicit, and reinforce skills use and problem solving with their children long after therapy ends. From the very beginning, parents are given a message that their child's behaviors are *irrelevant* until parents are able to create a stable, change-ready, and validating environment. However, the tasks of the parent training component are not limited to just helping parents attain their own emotion regulation and teaching them how to reinforce, ignore, validate, and model adaptive responding. Adequate and consistent application of these strategies is just the foundation for helping parents promote in their child a sense of self-love, sense of safety, and

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TABLE 15.2. DBT-C Skills

	Mindfulness
Introduction	Meaning, importance, and goals of mindfulness skills.
Emotion mind and reasonable mind	"Emotion mind" occurs when thoughts and behaviors are controlled mostly by emotions and it is hard to think straight. "Reasonable mind" occurs when thoughts and behaviors are controlled by logic and rules, and emotions are not considered.
Wise mind	"Wise mind" occurs when we take into account information from our feelings and thoughts. and add intuition when making decisions. Steps to connect to wise mind are discussed.
What skills	Observing, describing, and participating with awareness.
How skills	Don't judge; stay focused and do what works.
Review	Review and discussion of the learned mindfulness skills.
	Distress tolerance
Introduction	Meaning, importance, and goals of distress-tolerance skills.
DISTRACT	Controlling emotional and behavioral responses in distress using the acronym DISTRACT: **D**o something else, **I**magine pleasant events, **S**top thinking about it, **T**hink of something else, **R**emind yourself that feelings change, **A**sk others for help, **C**ontribute, **T**ake a break.
TIP	When at a breaking point, use TIP skills: **T**ense and relax, **I**ntense sensation, **P**aced breathing.
Self-soothe	Tolerating distress by using the five senses: vision, hearing, taste, smell, and touch.
Review	Review and discussion of the learned distress-tolerance skills.
	Emotion regulation
Introduction	Meaning, importance, and goals of emotion-regulation skills.
Surfing your emotion	Decreasing the intensity of emotional arousal by attending to sensations the emotion produces in the body without distracting or ruminating.
Opposite all the way	Changing an emotion by acting and thinking opposite to the action urge and releasing tension that emotion brings into the body.
PLEASE skills	Reducing emotional vulnerability: Attend to **P**hysica**L** health, **E**at healthy, **A**void drugs/alcohol, **S**leep well, and **E**xercise.
LAUGH skills	Increasing positive emotion: **L**et go of worries, **A**pply yourself, **U**se coping skills ahead of time, set **G**oals, and **H**ave fun.
Review	Review and discussion of the learned emotion-regulation skills.
	Interpersonal effectiveness
Introduction	Meaning, importance, and goals of interpersonal effectiveness skills.
Worry thoughts and cheerleading	Goals of interpersonal effectiveness: what gets in the way of being effective and cheerleading statements.
Goals	Two kinds of interpersonal goals: "getting what you want" and "getting along."
DEAR skills	How to "get what you want": **D**escribe the situation, **E**xpress feelings and thoughts, **A**sk for what you want, **R**eward or motivate the person for doing what you want.
FRIEND skills	How to "get along": Be **F**air, **R**espect the other person, act **I**nterested, have an **E**asy manner, **N**egotiate, and be **D**irect.
Review	Review and discussion of the learned interpersonal effectiveness skills.

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sense of belonging. Parental vulnerability in these senses is also explored and targeted during sessions.

Frequently, parents are seen in treatment without the child for the first month or two to give parents the necessary training to be able to model, reinforce, and shape the adaptive responding of the child and develop sufficient emotional regulation to withstand the unavoidable increase in maladaptive behaviors once the child starts therapy. DBT-C, like most therapies, disrupts the established ways in which parents and children interact with each other and changes patterns of responding. Children and their parents need time to adjust to such changes, and lack of parental preparation can make the situation for the family worse. For example, if parents don't yet have sufficient emotional regulation and start to implement planned ignoring, there is a very good chance that they may not be able to withstand extinction bursts and will attend to a behavior (e.g., scream back at the child) at the height of escalation. Thus, rather than extinguishing a maladaptive behavior, a higher severity level of this behavior will be reinforced with attention.

Research on DBT-C

The outpatient study examined the provision of DBT-C and treatment-as-usual (TAU) to 43 children diagnosed with disruptive mood dysregulation disorder (DMDD; Perepletchikova et al., 2017). In this sample, 55.8% of children had active suicidal ideation and 37.2% engaged in nonsuicidal self-injurious behaviors. The study demonstrated the feasibility and efficacy of DBT-C, with no dropouts from therapy in the DBT-C condition as compared to 36.4% in the TAU condition, and families in DBT-C expressed higher treatment satisfaction. Further, 90.4% of children in the DBT-C condition responded to treatment, a rating of "much improved" or "very much improved" by blinded clinicians on the Clinical Global Impression Scale (Guy, 1976) as compared to 45.5% in TAU. These outcomes were demonstrated despite three times as many children in TAU as compared to DBT-C receiving psychiatric medications. The outcomes were clinically significant and sustained at follow-up.

An adaptation of DBT-C for a residential setting was also examined as compared to TAU in a sample of 47 boys ages 7–12 (Perepletchikova et al., 2020). The sample exhibited severe and diverse psychiatric problems, with the majority being diagnosed with ADHD, disruptive behavior disorders, and mood disorders and 61.8% engaging in suicidal behaviors and/or experiencing suicidal ideation. DBT-C was shown to be significantly more effective than TAU in reducing externalizing and internalizing psychiatric problems on all subscales of the Child Behavior Checklist staff report (Achenbach, 1991), with the differences being clinically significant. There were no significant differences, however, recorded in the parent and teacher reports. This could result from the fact that the milieu staff at the residential program were trained in DBT-C in the same manner as caregivers in the outpatient DMDD study, described above, while teachers were not trained in the approach (as they were in contact with both groups) and the majority of parents failed to consistently participate in trainings (on average, attending less than a third of prescribed sessions). Thus, the significant difference between groups was only observed with the caregivers (i.e., milieu staff) who were trained in the model, highlighting the importance of caregiver involvement in treatment to elicit and maintain treatment gains.

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Conclusion

DBT-C retains the main therapeutic strategies and procedures of standard DBT. Yet, the implementation of these procedures varies between the models. For example, providing psychoeducation, conducting extensive behavioral chain analyses, and doing consultation to the client are not emphasized in therapy with children as much as with adult patients. On the other hand, contingency management (e.g., use of a heavy reinforcement schedule, ignoring, shaping); stylistic strategies (e.g., validation, irreverence); and environmental interventions take center stage.

Dialectical strategies (e.g., magnifying tension, using a balanced style, dialectical thinking, speaking in metaphors, as well as movement, speed, and flow) bear particular salience to the therapeutic process within DBT-C. Moving with speed and flow to keep the client slightly off balance is key to sustaining the child's attention. Therapists have to be alert to changes in the child's mood and levels of engagement, as they happen frequently and usually quite abruptly. For example, the higher the severity of the child's behavioral outburst, the more relaxed the therapist has to be; the more withdrawn the child, the more enthusiastic, lively, bubbly, and funny the therapist has to become so as to bring and maintain momentum in the session. To encourage the child's participation, a therapist has to be prepared to play games, watch cartoons, sit on the floor in a lotus position, learn how to plié, eat a lot of candy, and become a comedian and a magician (if nothing else works, performing some sleight of hand for a mindfulness exercise can do the trick). A DBT-C therapist needs to have an ability to use a variety of strategies and switch swiftly between them, depending on the requirement of the situation. A rapid-fire delivery of validation, irreverence, reinforcement, and ignoring within each brief segment of a session is a rule, rather than exception, when doing therapy with children.

A therapist also has to be vigilant about parents' responses in session to ensure that they are able to tolerate the child's outbursts, maintain their own emotion regulation and engagement, learn skills, and assist the therapist during the session, as opposed to contribute to escalations. Orientation to the treatment model, goals, hierarchies, strategies, and parental role in therapy is paramount in DBT-C. Of similar importance is training parents (ahead of starting therapy with the child) on behavior modification and validation techniques, and having them practice coping skills to be able to withstand behavioral escalations. Parents have to be prepared to function as co-therapists during the interactions with the child in sessions and as the main therapists outside of sessions.

Further, there are significant differences between DBT-C and standard DBT in the treatment targets' hierarchy, individual therapy, skills training, and treatment structure, as well as the addition of an extensive comprehensive parent training component.

Marsha Linehan (1998) compared providing DBT to playing jazz, where a therapist must adapt and react to a patient in the same way a musician's fingers do when they fly rapidly over the keys of an instrument in response to what notes were just played a moment before. DBT-C can be compared to an interactive theater performance, where the therapist is at once the director, an actor, a props master, and a stagehand. A DBT-C therapist has to combine a scripted performance with spontaneity and improvisation, while setting the stage and closely monitoring, instructing, and directing other players to ensure that the performance unfolds collaboratively yet within the boundaries of the session's goals.

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