

17

Dialectical Behavior Therapy for Deaf Clients: Cultural and Linguistic Modifications for Outpatient Mental Health Settings

AMANDA O'HEARN, ROBERT POLLARD, AND SHARON HAYNES

Dialectical behavior therapy (DBT) is a form of cognitive behavioral therapy originally developed for treating chronically suicidal women with borderline personality disorder (BPD) (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan, Heard, & Armstrong, 1993). DBT developed through Linehan's efforts to get her suicidal clients to stay in treatment. She found that when she focused too much on pushing her clients for change, they often felt invalidated and dropped out of treatment. When Linehan began to balance the treatment between pushing for change and accepting the client exactly where she was (i.e., validation), her clients were more likely to stay in treatment. She began to see clients improve where other therapies had failed them. Her motivation to work with a traditionally difficult-to-treat client population resulted in the development of a comprehensive treatment for BPD. She created treatment manuals (Linehan, 1993a, 1993b) based on what she had learned. The manuals detail protocols and strategies for working with individuals with BPD. DBT features elements of psychodynamic, client-centered, and gestalt therapy approaches, but its use of behavioral science, mindfulness, and dialectical principles sets DBT apart from other treatments (Koerner & Dimeff, 2007).

This chapter first describes the basic components of DBT and its efficacy with a variety of (hearing) patient populations and settings. We then describe modifications of DBT materials and methods that we have found effective in employing DBT in an outpatient setting with deaf individuals.

Dialectical Behavior Therapy Overview

More detailed descriptions of DBT can be found elsewhere, most notably in Linehan's original text (1993a). The following brief overview will help facilitate some understanding of this therapy approach and clarify the nature of the modifications needed to enhance DBT's applicability for a deaf clientele.

The DBT treatment approach balances acceptance with change, in relation to clients and their circumstances as well as therapists and their application of the treatment. Linehan's study of Eastern philosophy and Buddhism influenced her development of DBT, and Zen-like teachings are woven throughout the therapy (Kabat-Zinn, 2005).

The approach focuses on acceptance of clients exactly where they are, while simultaneously working toward changing behaviors that are harming their lives; this is the key “dialectic” in the treatment. For Linehan, understanding this dialectic (i.e., apparently opposing truths) and coming to a synthesis between them helps move the client away from “absolute thinking,” which tends to create an impasse and, instead, toward change and progress.

DBT was initially designed for clients diagnosed with BPD. Linehan views these individuals as emotionally vulnerable, a product of both biology and trauma experiences. Individuals with BPD often exhibit higher sensitivity to emotional stimuli, higher emotional reactivity, and a slower return to emotional baseline than the average person (Fruzzetti, Shenk, & Hoffman, 2005; Linehan, 1993a).

The developmental environment from which many people with BPD come is often invalidating. An invalidating environment is one in which an individual’s personal experiences, feelings, and viewpoints are discounted, disbelieved, or ignored. These individuals are not respected and their thoughts, feelings, and experiences are disregarded. An extreme example of invalidation would be chronic child abuse. In such environments, individuals do not learn to trust their own thoughts or feelings and do not learn how to regulate emotional arousal or tolerate distress. Linehan posits that BPD develops based on the interaction of invalidating environments and the individuals’ inherent emotional vulnerability. She refers to this as a transactional process in which each party (the at-risk individual and the environment) influences and reinforces the other. Because of this transactional cycle, even a slightly invalidating family and a slightly emotionally vulnerable child can, over time, evolve into a situation that is highly invalidating to both the family and the child (Fruzzetti et al., 2005). An invalidating environment over-simplifies problem solving (e.g., “you just need to try harder”) and often reinforces escalation of emotional responses (e.g., the child must display a temper tantrum to get a reasonable degree of attention).

The technique of validation in DBT treatment helps strengthen the client’s progress, serves as a balance to the stresses of making change, and serves to strengthen the therapeutic alliance. All clients benefit from validation, but Linehan believes it is particularly important for those prone to emotional dysregulation and sensitivity (Linehan, 1993a). Linehan describes six levels of validation. Validation can simply involve active listening (level 1) and reflection of what the client is saying (level 2); it can also be validation of the client’s unexpressed emotions or thoughts (level 3). Validation can involve understanding client behaviors in terms of past experiences or learning (level 4) or in terms of normative functioning (level 5). Considered the highest level of validation (level 6) the therapist is radically genuine with the client, responding to her as an equal. Clients (and therapists) often view the client’s behaviors as “invalid,” weak, or bad. Validation requires the therapist to search for the validity in any client perception, feeling, or response, thereby acknowledging the inherent effectiveness of these reactions whenever possible and, more importantly, teaching the client to self-validate (Koerner & Dimeff, 2007). A client who punches a hole in the wall because she is angry could be validated in that the physical pain she experienced provided an immediate decrease in her emotional pain (so it makes sense that she hurt herself in the context of trying to decrease her emotional pain), but at the same time, injuring herself isn’t valid in that it isn’t a normative response and goes against her goal of coping in more

effective ways. The case example at the end of the chapter provides an example of how the six levels of validation play out during therapy sessions.

STAGES OF DBT

DBT treatment is structured in stages that are behaviorally defined and have specific behavioral goals. Clients exhibiting the most severe symptoms of BPD require stage one treatment. In this stage, the goal is for the client to stabilize and achieve behavioral control. Target achievements in this stage include decreasing life-threatening behaviors (suicidal thoughts, suicidal behaviors, and self-harm such as “cutting”); decreasing therapy-interfering behaviors (such as quitting therapy, not doing homework, and not taking medications as prescribed); decreasing behaviors that interfere with quality-of-life (such as anger outbursts, missing work, sexual promiscuity); and increasing behavioral skills that can replace ineffective coping skills. DBT behavioral skills are typically taught through “skills groups” that provide detailed instruction on mindfulness, distress tolerance, emotion regulation, and interpersonal skills.

Stage two treatment commences when clients are no longer engaged in life-threatening behaviors. It focuses on replacing the experience of “quiet desperation” with full emotional experiencing. At this stage, posttraumatic stress disorder (PTSD) can be addressed since clients’ behaviors are under better control and they have also increased their behavioral skills. Traditional exposure work may be used as well.

Stage three treatment focuses on obtaining “ordinary” happiness and unhappiness and reducing ongoing problems with living. Clients who want more than ordinary happiness—they want a sense of connectedness to a greater whole—benefit from stage four treatment. The goal in this stage is to work on finding joy and freedom. The stage also focuses on resolving any sense of incompleteness.

COMPONENTS OF DBT TREATMENT

A comprehensive DBT program includes five components: (a) individual therapy; (b) skills training group therapy; (c) a consultation team for DBT therapists; (d) between-therapy coaching calls when indicated; and (e) supplemental services as needed (e.g., pharmacotherapy, case management).

Individual therapy is typically offered on a weekly basis. Individual therapists help clients move through the stages of change described earlier. Therapists balance acceptance (validation) with encouragement toward change throughout DBT therapy. They motivate the client, reinforce skillful behaviors, and help extinguish unskillful behaviors and unhealthy behaviors. Clients may have been reinforced in the past for being symptomatic. Unfortunately, the mental health service system often withdraws support as clients get better. The opposite is often also true; as clients decompensate, support increases. This can be very problematic for clients who are not skilled at getting their needs met other than through dramatic and extreme measures.

For example, consider a client with poor coping skills and poor emotional regulation who says he wants to kill himself. His life may indeed be so miserable that he thinks he is better off dead. He may also have learned that in order to get people in his life to take him seriously, he needs to express his pain very loudly. His environment has

reinforced his need to be “loud” in order to get support, attention, or help in solving his problems. Feeling suicidal is not the central problem; rather, the problem is poor coping skills and the lack of problem solving skills which leaves suicide as an attractive possibility.

Therapists use “behavioral chain analysis” to help clients understand any problematic behaviors they wish to target for change (e.g., suicidal ideation, “cutting,” suicide attempts, “blowing-up,” etc.). Behavioral chain analysis defines the problem behavior and spotlights its antecedents and consequences (both behavioral and environmental). The goal of behavioral chain analysis is to create a relatively complete account of what happens before, during, and after the problem behavior. As client and therapist create the chain analysis, dysfunctional responses can be highlighted, emotions/thoughts are noted, and patterns can be discovered that relate to other problem behaviors for the client. Client and therapist together look for places in the chain where skillful behavior was used, as well as what skills need to be used next time to avert engaging in the problem behavior. Client and therapist may also find that other changes need to be made, such as working on cognitive restructuring, exposure to emotions, or managing contingencies (consequences). In the example of the suicidal individual, a behavioral chain analysis may show that when the client states he’s going to kill himself, his girlfriend drops everything and attends to him. In this case, in order to extinguish this behavior, the client might focus on contingency management and ask his girlfriend *not* to attend to him the next time he says this (or they may come up with another plan, such as the client contacting his therapist for skills coaching or going to the emergency room if he truly is at risk of harming himself). The client then works on getting his need for his girlfriend’s support in other ways (possibly by using his interpersonal skills).

Skills training groups are 90–120 minutes in length and occur weekly. Skills groups are more like classes than a therapeutic process-type group. Skills training has several distinct components or modules. Mindfulness skills help clients observe and describe their thoughts and feelings in a nonjudgmental way. The significance of mindfulness is that if clients can’t get control of their attention, it will be difficult to apply the other DBT skills. Distress tolerance helps clients learn to cope with problematic emotions and events without making their situation worse. These skills can be likened to a lifeboat—for use in emergencies but not for coping in the long-term. Emotion regulation skills help clients learn how to change emotions they wish to change. Interpersonal skills help clients become more assertive or more accepting of help through the application of social skills. Clients also learn how to say no to unreasonable requests and ask for help in skillful ways.

Each DBT skills training module typically lasts 8 weeks. The first half of each week’s session is dedicated to homework review, during which clients discuss the skill they have practiced from the previous week and the homework they have completed. Diary cards are used to monitor target behaviors and make note of skill use during the week. The second half of the session focuses on learning a new skill. Clients are assigned homework related to the new skill to work on during the next week. Ideally, two DBT skills trainers lead the groups.

Coaching calls between skills training sessions function to help the client generalize the skills they have learned. Clients are instructed on when they should or should not

contact their therapist for a coaching call. The metaphor that works here is of a basketball coach who isn't present for the game. In most public mental health settings clients generally visit their therapist 1 hour per week or less; the remaining 167 hours per week, they are out "on the field" applying what they are trying to learn through therapy. It is quite reasonable to anticipate that clients could use help "during the game," which is the purpose of encouraging coaching calls to the therapist outside of formal DBT sessions. Coaching calls are structured to focus on problem solving specific to the situation raised by the client and are explicitly not a minitherapy session. Clients are asked to describe what current skills they are using in the moment and are coached on other skillful behaviors they might try if they have exhausted their ideas. The purpose of the call is to help the client avoid engaging in self-harming behaviors or other problematic behaviors that make the situation or their lives worse. Encouraging the client to contact the therapist before engaging in problematic behaviors reinforces the client (through the therapist's positive attention) for trying to be skillful and extinguish previously dysfunctional but reinforcing behaviors (e.g., cutting).

Comprehensive DBT treatment also includes the utilization of a consultation team for therapists providing DBT treatment. The consultation team functions to decrease therapist burnout (which is not uncommon in working with BPD or other difficult-to-treat patient populations) and also helps therapists stay on track in providing effective treatment. Team members provide feedback to each other and are meant to be a form of treatment for the therapist.

Research Findings

When presented as part of a comprehensive therapeutic program, DBT reduces suicidal ideation (Koons et al., 2001; Linehan et al., 2006), and self-injurious behaviors (Koons et al.; Linehan et al., 1991; Linehan et al., 1993; Linehan et al., 2006). Frequency of emergency room visits decreases (Linehan et al., 2006); length of inpatient stays decreases (Linehan et al., 1991), and overall costs associated with mental health treatment decrease (Aos, Lieb, Mayfield, Miller, & Pennucci, 2004). Of all treatment for suicidal clients with BPD, DBT presently has the greatest degree empirical support.

Modifications have been made to DBT to accommodate different settings as well as different client populations, including:

- Elderly depressed individuals (Lynch, Morse, Mendelson, & Robins, 2003)
- Families (Hoffman, et al., 2005; Woodberry, Miller, Glinski, Indik, & Mitchell, 2002)
- Couples (Fruzzetti, 2006)
- Adolescents (Miller, Rathus, & Linehan, 2006; Rathus & Miller, 2002)
- Bulimia (Safer, Telch, & Agras, 2001)
- Binge eating (Telch, Agras, & Linehan, 2001)
- BPD with comorbid substance abuse disorders (Linehan et al., 1999; Linehan et al., 2002; van den Bosch, Verheul, Schippers, & van den Brink, 2002)
- Clients with intellectual disabilities (Lew, Matta, Tripp-Tebo, & Watts, 2006)
- Inpatient units (Bohus et al., 2000; Katz, Cox, Gunasekara, & Miller, 2004)

Adaptations also have been made for non-English speaking populations. The DBT skills manual has been translated into Spanish, French, German, and Dutch (Linehan, 1996a, 1996b, 2000, 2003a).

Unfortunately, none of these modifications or adaptations address the barriers that deaf clients face in accessing this useful form of treatment. The deaf client population often presents with limited English literacy skills, fund of information deficits (Pollard, 1998), and limited language skills, even in American Sign Language (ASL). These factors and unique cultural characteristics require considerable modification of DBT materials and methods in order to make the treatment accessible (O’Hearn & Pollard, 2008).

DBT APPLICATIONS FOR DEAF PEOPLE

DBT should be available to deaf people who have suicidal behaviors or have BPD, just as it is for hearing people. Several studies suggest that deaf people have a higher risk for suicide behaviors than hearing people (Boyeckko, 1992; Critchfield, Morrison, & Quinn, 1987; Dudzinski, 1998; Samar et al., 2007; Turner, Windfuhr, & Kapur, 2007) suggesting the potential value of DBT for this population. While empirical evidence regarding mental illness epidemiology in the deaf population is limited (Pollard, 1994), deaf people may be at higher risk for developing BPD (O’Hearn & Pollard, 2008). Researchers believe that deaf people experience higher rates of abuse in childhood (Embury, 2001; Sullivan & Knutson, 2000) and that abuse is associated with the development of BPD.

Also, as noted earlier, BPD is believed to result from the transaction of an invalidating environment and the biological vulnerabilities of the individual. Deaf people are usually born into hearing families, where their experiences and sense of self are often at odds with the language and culture of their parents, siblings, and extended family, which certainly may constitute an invalidating experience. The commonly described “dinner table syndrome,” in which the deaf individual is routinely left out of family conversation, laughter, and information sharing provides one example of invalidation that many deaf people experience. When asked what an animated dinnertime conversation is about, responses of “It’s not important” or “I’ll explain later” are common and would be invalidating to most people. Many deaf people also experience invalidation outside the family context—in school, at work, and in the community. Sign language, Deaf culture, and Deaf social norms and values typically are not valued by the dominant (hearing) culture, which can be experienced as invalidating or even oppressive. “Audism” is a term that is increasingly used to encompass this concept of oppression and invalidation at both the individual and societal levels, when based on one’s ability or inability to hear (Bauman, 2004). Because of its emphasis on validation, even in the absence of a diagnosis of BPD, DBT may be particularly salient for deaf clients (O’Hearn & Pollard, 2008).

DBT also may be particularly useful for deaf people because of the skills training group therapy component. In light of common fund of information gaps, as well as the aforementioned lack of communication within the family, DBT skills group can be a useful adjunct to other (non-DBT) types of treatment. It is common for deaf clients to present for mental health treatment manifesting deficits in coping and emotional regulation skills (even emotional vocabulary), regardless of their psychiatric diagnosis.

Glickman (2009) addresses this topic in great detail in his book on cognitive-behavioral therapies with deaf people with language and learning challenges.

Modifications in Using DBT with Deaf Clients

Normally, DBT skills groups are taught using a workbook (Linehan, 1993b) which includes diary cards. Given the wide range of reading abilities in the deaf population, particularly in the clinical population (Black & Glickman, 2006; Glickman & Gulati, 2003), modifications are needed to make written materials accessible. Furthermore, the videotapes used in the context of skills training groups with hearing people (e.g., Linehan, Dimeff, Waltz, & Koerner, 2000; Linehan, 2003b, 2003c) are not captioned. Even if they were, this would not be a suitable alternative for deaf clients with limited literacy. Even for clients with good English literacy, these videos are intended for hearing audiences and do not “speak to” the Deaf experience; clients may feel disengaged while watching these tapes. The deaf mental health client population often presents with more language and learning challenges than the general deaf population (Black & Glickman, 2006; Glickman, 2009, Glickman & Gulati, 2003). Accordingly, modifications to learning materials must take these factors into account in order for such modifications to allow optimal accessibility and learning for clients (Pollard, Dean, O’Hearn, & Haynes, 2009).

The DBT skills training workbook frequently uses mnemonics (Linehan, 1993b). Mnemonics are problematic because of the lack of 1:1 equivalence between words in English versus ASL as well as because mnemonics are not a technique used in ASL to aid memorization. For example “improve the moment” is a particular DBT distress tolerance skill. Each of the letters of the word “improve” stands for a specific distress tolerance skill that can be used by clients (e.g., using *imagery*, finding *meaning* for suffering, *prayer*, etc.). While mnemonics often help hearing, English-speaking clients, their relevance and helpfulness as a memory tool is questionable for ASL users.

Since fund of information gaps must be addressed in deaf skills training groups, more time is generally needed—especially for groups with greater than average language or learning challenges. ASL is a dialogic language (Metzger & Bahan, 2005; Pollard, Dean, O’Hearn, & Haynes, 2009) so more time may be needed for information exchange via group discussion. Allowing for more back-and-forth time in groups, both among members and with coleaders, is necessary to ensure that information gaps are being addressed and comprehension is maximized. Hearing DBT clients tend to summarize the skills they used without including a lot of detail. However, storytelling is a key cultural feature of ASL (Padden & Humphries, 1988) and details, not summarizing, are valued. For all these reasons, deaf skills training groups typically need more time, depending on the size and language/learning abilities of the group.

One of the core DBT skills is mindfulness. Several of the mindfulness practices taught to hearing clients through skills group include instructing clients to close their eyes and reorient to the sound of a bell. With deaf clients, mindfulness must be taught in ways that do not rely on auditory ability or require that members close their eyes while instruction is taking place.

The issue of confidentiality needs special attention in deaf DBT groups, in ways that are not as relevant for hearing groups. O’Hearn and Pollard (2008) provide particular details in this regard. Finally, therapist consultation teams, an important DBT provider

resource, may be difficult or impossible to form if an insufficient number of local clinicians work with deaf clients and use DBT.

USE OF INTERPRETERS

Engaging qualified sign language interpreters is, of course, a reasonable accommodation when no sign-fluent providers are available. However, the presence of an interpreter does not necessarily indicate that a deaf client has the same access to effective treatment as a hearing client. Glickman (2003) refers to this common presumption as the “illusion of inclusion.” O’Hearn and Pollard (2008) explain why the presence of interpreters does not result in equal access to DBT treatment. As mentioned previously, the clinical deaf population likely has fund of information deficits and lower literacy levels than the average deaf person. An interpreter does not typically have time, especially in a group setting, to fill these gaps or accommodate for literacy limitations. Particularly in the context of DBT treatment, which has its own jargon and metaphors, the interpreter would be faced with the “interpersonal demand” (Dean & Pollard, 2005) of attempting to bridge the “thought world” of the hearing group members/therapists with the thought world of the deaf client. Unless time is unlimited, this will not happen. Also, DBT metaphors, which make sense to hearing people, do not translate well into ASL or fit the average deaf client’s experience (Isenberg, 1996).

Using interpreters in a group setting also makes it difficult for the deaf client to feel like part of the group. The lag time necessary for translation means that the deaf person is always receiving information a bit later than the rest of the group, which makes equal participation difficult. Additionally, it is impossible to read the workbook materials or diary card while simultaneously watching the interpreter, a barrier that hearing clients do not face. Simply having a third party in the room for therapy, especially when the deaf client knows the interpreter from other contexts, can be uncomfortable.

MATERIALS MODIFICATIONS THAT MAKE DBT ACCESSIBLE

O’Hearn and Pollard (2008) provide details and examples of DBT written materials (workbook and diary cards) that have been modified to accommodate several deaf DBT group skill levels. Minimal modification is made for clients who are fluent in English. A modest number of modifications are needed for clients who are comfortable with a basic, but not advanced, level of English. Finally, major modifications are needed for clients who require materials involving little reading. These materials include more iconic images to represent skills and concepts (O’Hearn & Pollard, 2008). See Figures 1 and 2, which depict diary cards that have been modified for limited readers and for skilled readers, respectively. Note that Figure 1 only shows seven skills and Figure 2 includes all 20 skills that clients are expected to learn over the entire course of DBT skills training. Including all 20 skills in one module might be overwhelming for limited readers, so these groups utilize several diary cards. Therapist can use only skills cards that focus on the current module.

Modifications of DBT materials should not only focus on English-related changes, but should also incorporate material specifically relevant to the Deaf sociocultural

Mindfulness Diary Card

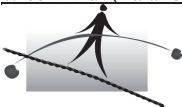






Day of the week → Skill ↓	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
<p>Wise Mind- (Balanced Mind)</p>  <p>Think, feeling, know do right</p>							
<p>Observe</p>  <p>Stop, Pay Attention to Your Feelings</p>							
<p>Describe</p>  <p>Tell others about your feelings</p>							
<p>Participation</p>  <p>Join Group</p>							
<p>Nonjudgmental</p>  <p>See real things and accept</p>							
<p>In the Moment</p>  <p>Pay Attention to one thing</p>							
<p>Do Your Best</p>  <p>I can do better</p>							

Figure 1. Example of Diary Card for Limited Readers

experience to foster learning and increase the relevance of such materials for deaf clients (O’Hearn & Pollard, 2008). The DBT interpersonal skill termed “DEAF CAN” provides an example of one such modification. Each letter of this mnemonic stands for a different skill needed to either ask for something or to say no to an unwanted request.

DBT Skills Diary	Use this diary to learn and practice skills everyday. Write how you used your skill.						
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
<p>1. Wise Mind: Use calm and wise thoughts. Balance Emotional Mind and Reasonable Mind.</p> <p>2. Observe: Just see the experience happen. “Non-stuck-pan mind.” (Not thinking too much about one thing.)</p> <p>3. Describe: Use fact words to describe to yourself what is happening. (Don’t use critical words.)</p> <p>4. Participate: Get involved. Act positively.</p> <p>5. Nonjudgmental: Don’t criticize yourself or other people. Use facts (not opinion).</p> <p>6. In the moment: Do one thing at a time. Don’t worry about the past or the future.</p> <p>7. Do Your Best: Use your skills. Let go of revenge and useless anger.</p> <p>Interpersonal Effectiveness</p> <p>8. DEAF CAN Describe. Express. Ask/Say no. Focus. Confidence. Add Reward. Negotiate/Suggest.</p> <p>9. Take Care of Relationships: GIVE: Gentle/soft talking. Interested. Value other person. Easy approach.</p> <p>10. Self-respect: FAST: Fair. No Apologies. Stay with your Beliefs. Be Truthful.</p> <p>Emotion Regulation</p> <p>11. “Be Strong”: plan “B”, sleep well, take medications/take care of illness, reject drugs/alcohol, once a day do something that makes you feel in control, nutritious eating, get Exercise.</p>							

Figure 2. DBT Skills Diary for Fluent Readers

DBT Skills Diary	Use this diary to learn and practice skills everyday. Write how you used your skill.						
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
12. Do positive experiences: Do enjoyable things. Pay attention to positive experiences.							
13. WAIT: Watch emotion, action is not necessary, internally experience emotion, think of it as helping you.							
14. Emotions as a wave: Experience your emotion, don't think too much or block it. Practice loving emotions.							
15. Opposite-to-emotion action: Change emotions by acting opposite of it.							
Crisis Skills:							
16. Distract: Do Activities. Help Others. Compare. Opposite-Emotions. Push away. Think other thoughts. Strong feelings.							
17. Self-soothe with the 5 senses. Enjoy sights, sounds, smells, tastes and touch.							
18. IMPROVE the moment: Imagery. Meaning. Prayer. Relaxation. One thing in the moment. Vacation. Encouragement.							
19. Pros and cons: think about the +/- of using skills and the +/- of losing control							
20. Acceptance: Choose to see and accept reality.							


Figure 2 (continued). DBT Skills Diary for Fluent Readers

In an effort to associate each of these skills with an ASL sign that would translate easily, we modified the mnemonic to become “DEAF CAN.” Not only does this mnemonic relate to a useful, parallel translation of the same DBT concepts, it capitalizes on positive Deaf self-perceptions. (See Figures 3 and 4 for examples of a DEAF CAN worksheet for those with lesser and greater English fluency, respectively.)

One of the DBT distress tolerance skills is referred to as “half smile.” This is a “Mona Lisa” type smile that clients can use to help boost their mood (researchers believe that the change in facial expression causes physiological changes in the brain). Even good deaf readers initially had difficulty comprehending this skill because the words “half smile” don’t make sense at a literal level. Deaf clients often thought it meant that half of your mouth should smile while the other half should frown. We therefore changed the wording to “little smile,” which increased comprehension of this term in the written materials without changing the fundamental meaning or impact of the skill itself.

Two DBT skills training films have been modified to be more relevant to deaf clients (Pollard & Dimeff, 2006, 2007). The films utilize an all-deaf cast and include many deaf-specific references, such as content regarding Deaf values and Deaf culture. The films also feature a dialogic style of information exchange, repetition of key learning points, and the use of deaf people as experts and authority figures. To make these adapted films accessible to the widest audience (including hearing and hard of hearing

Guidelines for Goals



A way to remember these skills are the words “**DEAF CAN**”:

- D**escribe
- E**xpress
- A**sk/Say No
- F**ocus

- C**onfident
- A**dd Reward
- N**egotiate/Suggest

1. **Describe** what happened. Only the facts.
 “When _____”
2. **Express** your feelings using “I feel...”
 “I think it’s good/bad _____”
3. Asking for what you want or **Saying NO** clearly.
 “What I want is... _____”
 Or “I won’t do that because _____”
4. **Focus** on your goal. Don’t change your mind. If the other person attacks, threatens or tries to change the subject, ignore them.
5. Appear **Confident**. Make good eye contact. No looking at the floor.
6. **Add Rewards**. Tell the person why it will be good if they do what you want.
7. **Negotiate**. Think of what you can give to get what you want. Or ask the person what ideas they have to solve the problem.

Figure 3. DEAF CAN Skill Sheet for Limited Readers

Getting What I Want



A way to remember these skills is the phrase “**DEAF CAN**”:

Describe
Express
Ask/Say No
Focus

Confident
Add Reward
Negotiate/Suggest

1. **Describe** the current situation. Tell the person *exactly* what you are reacting to. Use *facts*, not judgments.
2. **Express** your feelings and opinions about the situation. Assume that the other person has no idea what you’re feeling. (No mind-reading). Say “I want ___,” or “I don’t want ___” instead of “I need___,” “You should ___,” or “I can’t.”
3. **Ask** for what you want or **Say “no”** clearly. People won’t give you what you want unless you ask. Don’t expect others to know how hard it is for you to ask.
4. **Focus** on the point of what you want and stay mindful. Don’t change your mind.
 - a. Don’t get distracted. Keep asking, saying no, or expressing your opinion over and over. Keep calm while you are talking.
 - b. If the other person gets upset, threatens or tries to change the subject, ignore it and keep to your point, gently.
5. **Confident appearance.** Make good eye contact. No slouching, looking at the floor.
6. **Add Rewards.** Reinforce to the person by saying the benefits if they do what you want. Tell the person the negative effects if they don’t do what you want.
7. **Negotiate.** Suggest other solutions. Say no, but offer to do something else. Focus on what will work. Ask the other person to help think of solutions to the problem.

Figure 4. DEAF CAN Skill Sheet for Fluent Readers

viewers), an English language vocal track and open-captions were added. In-depth descriptions of recommended practices for adapting educational material for deaf audiences have been described by Pollard, Dean, O’Hearn, & Haynes (2009) and, regarding DBT in particular, by O’Hearn & Pollard (2008).

SKILLS GROUP MODIFICATIONS

As noted earlier, all-deaf DBT skills groups need additional time for the variety of reasons detailed. DBT skills modules with hearing groups span 8 weeks, which is usually not enough time for deaf groups. Depending primarily on the language characteristics of the group and how much extra time is needed to address fund of info gaps and literacy limitations, 1 to 4 additional weeks are typically needed. Depending on the size of the group, even more time may be needed to allow for the dialogic and storytelling aspects of ASL.

Mindfulness practices that involve “going inward” and counting breaths, or observing internal sensations, may be too challenging for some deaf clients who have never

been exposed to this concept or who need more overt or guided mindfulness practices. In such cases, other “active” mindfulness activities can be used, such as studying a penny in great detail (without the mind wandering to other topics), playing a game within the group while fully attending to the game, eating a raisin mindfully, or taking a mindfulness walk. Then, as clients become more familiar and comfortable with mindfulness, internal and “quiet” mindfulness practices can be introduced with more success.

PHONE COACHING

As noted, being available to coach DBT clients outside of sessions is necessary to help them avoid engaging in undesirable behaviors that have been targeted for change. Coaching deaf clients can be done via videophone, TTY, and/or pagers and cell phones, depending on what technologies the client and therapist have access to. For phone coaching to be effective, clients must be oriented as to the purpose and the format of coaching, as described above.

FORMATION OF GROUPS

Similar to forming therapy groups in small towns or rural areas, issues regarding confidentiality need to be considered when planning the formation of all-deaf therapy groups (O’Hearn & Pollard, 2008). Forming all-deaf groups, regardless of the rural or urban setting, usually means that some, if not all, of the prospective deaf members will know at least one other person in the group. If at all possible, care should be taken to avoid placing romantic partners, relatives, coworkers, or other persons who are in current, close contact with each another in the same group. Despite such efforts, it can be nearly impossible to completely avoid clients knowing each other. Therefore, the DBT therapist must make judgment calls regarding what types of preexisting relationships will be acceptable for placing associated members in the same group. This is best done on a case-by-case basis, based on information gathered through a private, individual conversation with each of the prospective members. In general, clients who know each other from church or clients who used to be in a class together often are fine to place in the same DBT group. All prospective group members should be coached on handling the discomfort that might result in seeing familiar faces, especially on the first meeting of the group. Because the Deaf community is small, clients frequently need to utilize this skill in the real world as well. DBT clients are also encouraged to avoid socializing with one another until after the group sessions have ended, in order to minimize the potential for outside conflicts or the emergence of cliques that might cause problems with broader group cohesion. Clients are encouraged to focus on skills acquisition in the group: DBT skills groups are not psychotherapy process groups; they function more like a classroom than a therapy session.

Once the issue of preexisting relationships has been addressed, the next important step involves creating a group where clients have similar learning and language styles. This allows members to acquire the skills at a similar pace. As mentioned above, DBT learning and practice materials may need to be modified to fit different language and learning levels.

CONFIDENTIALITY

Deaf clients' biggest fear in joining an all-deaf group is that their confidentiality will not be maintained. Before clients attend their first group meeting, we orient them individually on the necessity of maintaining confidentiality. During this conversation, their fears about breaches of confidentiality are validated. Knowing that other group members are just as worried as they are about confidentiality usually makes clients feel somewhat relieved. As well, clients are reminded that they are free to share as little or as much as they like about their personal lives when in group sessions. While they will be encouraged to share examples of DBT skills they have used during group sessions, there is no need to go into detail about the target behavior(s) they are working on or why they are in treatment.

During the first group meeting, confidentiality is again discussed, this time with the group as a whole. The diary card, which clients complete each day, includes a place to note if they had any urges to break confidentiality or if confidentiality was broken. A confidentiality challenge could be as simple as encountering a fellow group member at the grocery store and, when a third party asks how the two of them know each other, a client replies, "I can't tell you; it's confidential." While truthful, the response only superficially keeps the confidentiality rule; it invites further inquiry or speculation that is counter to the confidentiality goal. Another problematic answer might be, "We go to DBT together." We discuss examples like this in group and engage in confidentiality role-plays so clients will feel prepared if they find themselves in situations where they need to maintain confidentiality skillfully.

If confidentiality is breached, the DBT cotherapists should meet with the clients involved and make a decision about what should be done. In less serious cases, it might be decided that the offending client can make amends to the group as well as the individual whose confidentiality was broken in some manner agreed upon by the therapists and clients involved. In more serious cases (such as ones with malicious intent, or where significant personal details have been shared), the offending group member may need to be terminated from the group.

Once deaf clients overcome any fears regarding confidentiality, they typically benefit from the group in ways that are uniquely linked to the group experience and include benefits that they likely would not experience if they had joined an interpreted group with hearing clients. Deaf clients often remark that they are relieved to know they aren't the only ones with problems, and often benefit more from the feedback of fellow group members than input from the coleaders.

THERAPIST CONSULTATION TEAMS

As noted, DBT consultation teams function to provide DBT therapists with support (to decrease burnout) as well as to enhance the therapist's skill set in working with hard-to-treat clients. Consultation teams also function to help the therapist remain adherent to the tenets of DBT treatment. Ideally, a therapist treating deaf clients would have access to a consultation team composed of other therapists treating deaf clients. In the absence of this, a DBT therapist could join a hearing consultation team. If interpreters are needed because the therapist is deaf, similar interpreting issues as mentioned

above will need to be addressed, including educating the team on how best to work with interpreters and the challenges and limitations of interpreted meetings. Joining a consultation team that doesn't understand Deaf culture or the relevant language issues involved in providing DBT treatment to deaf individuals may be less helpful to the deaf-specialist therapist. An alternative might be to join a "virtual" team of providers working with deaf clients by using technology to link providers who live in geographically diverse areas.

Case Example

Sara¹ is a deaf, 40-year-old single, White female who has struggled for years with symptoms related to BPD including intense fears of abandonment, lack of sense of self, and instability in interpersonal relationships (both family and partners). She had chronic suicidal ideation as well as frequent self-mutilating behavior (cutting), impulsivity with spending and sexual exploits (often with men she'd just met), and frequent anger outbursts, which resulted in negative consequences for her (such as being arrested).

Sara's parents and siblings are hearing. She was raised orally but later learned ASL when she attended a deaf college. She describes a conflictual relationship with her family members and is closest to her older brother. However, even that relationship vacillates in her eyes between being great and being awful. Sara had been jumping from job to job, usually quitting because of an interpersonal conflict or being fired for inappropriate behavior (anger outbursts). She was on public assistance at the time of treatment.

Sara had been in and out of therapy for depression, anxiety, and BPD for the past 20 years. She came to our clinic from a hearing clinic where all services were provided through the use of a sign language interpreter. She had attended DBT skills group and was working with a DBT trained individual therapist. However, both she and the therapist felt she would make better progress in a clinic where she could receive direct services.

Initial treatment involved targeting Sara's cutting behaviors (several times per week) and suicidal ideation. Treatment had to be structured around these behaviors as a priority to minimize Sara's wanting to talk about the crisis de jour (e.g., the fight she'd had with her boyfriend, her lack of happiness with her life in general, her feeling like she'd never find the career she wanted). DBT treatment is structured to attend to life-threatening behaviors (as mentioned earlier) before anything else for the reason alluded to here: Putting out fires week after week for a person whose life is chaotic and painful is tempting to do (the therapist wants to feel helpful to the client, and the client wants to talk about what feels most relevant), this makes it difficult to make any real progress. Both Sara and her therapist had to stay on track with the stages of treatment. Diary cards that Sara completed during the week (recording skills used, target behaviors engaged in) allowed both Sara and her therapist to see exactly where the treatment needed to be for each session.

1. This is a composite of a real case, with identifying information changed.

Early in treatment, Sara came to her session with her diary card indicating she cut herself. Sara and her therapist conducted a behavior analysis of the target behavior (cutting) and determined that Sara had been sitting around the table at dinner and misunderstood a joke that her mom was telling her sister. Sara's family did not try to clarify the joke. Sara began feeling hurt and sulked off to her room. She began thinking about all the other rejections she has experienced in her life and became very upset. She tried to calm herself down by paging a friend, but the friend wasn't available. To stop the unbearable feelings she was experiencing, Sara got a razor she kept in the back of her drawer (even though she'd agreed to throw this out) and cut her forearm. Her sadness immediately decreased. Soon afterwards, she felt guilty since she had promised to work on not cutting to cope with her emotions. Her friend finally replied on her pager and gave Sara the support she needed.

Sara's therapist had several options for validation in this situation.

Level 1: Actively listening while Sara tells the story of the events. At this level, the therapist basically stays awake and aware for Sara and communicates interest in what Sara has to say.

Level 2: Reflecting back to ensure the therapist understands Sara accurately. Sara can clarify if something she's said has been misunderstood or misrepresented. This happens naturally in ASL discourse.

Level 3: The therapist would make interpretations or guesses about what Sara doesn't overtly communicate to show that she "gets" Sara. "You must have been feeling like your family didn't care about you when they wouldn't explain the joke?"

Level 4: The therapist would point out why Sara's behavior makes sense in terms of her history. "You've told me that you never developed good coping skills because of the lack of communication at home, so I can see why you felt you had so few options of dealing with your sadness."

Level 5: At this level, the therapist points out that Sara's responses make perfect sense given the situation: "Anyone would have felt sad being excluded like that!" and to be more specific the therapist could say, "Many deaf people have the same experience feeling left out like that."

Level 6: The therapist could say, "I know just how you feel, that happened in my hearing family as well." Here the therapist is being radically genuine, and the therapist-client power differential is not apparent.

The therapist validated Sara in many different ways in this one behavior chain analysis. Additionally, the therapist will also point out the invalid, being careful not to validate the cutting behavior. (Never validate the invalid.) The therapist might say, "I completely understand why you were so hurt and angry since that would make anyone angry (level 5), but Sara, we've got to work on the cutting behavior. Where could you insert skills that would have avoided you cutting yourself?" A question along these lines would be asked to go back through the chain analysis and create a plan for dealing with her emotions in a more effective, skillful way the next time they arise.

The therapist worked closely with her consultation team in making sure she was on target with her treatment with Sara. Several times throughout the treatment, the team noted that the therapist had veered from providing DBT and would inadvertently

provide “bad” treatment because Sara would reinforce her. For example, Sara stopped bringing her diary card to session: “I just didn’t have time, but you know I’m working on the skills.” The therapist was reluctant to say anything for fear of upsetting Sara when she’d seen such good progress to date. When the team pointed out that the therapist was treating the client as fragile and slipping away from providing effective treatment, the therapist was able to recognize this pattern and return to the use of diary cards (even though Sara grumbled about doing them). This returned the treatment to focusing on target behaviors and resulted in gradual symptom improvement.

Initially it was clear that Sara lacked effective skills for dealing with her emotions. She was reluctant to join a deaf DBT skills group (as most clients are) because of fears of lack of confidentiality. She eventually joined and as she got comfortable with the format of the group and her ability to share as little or as much detail as she wanted about her skills practice, the more she relaxed in the group (and the more she shared). She remarked to her therapist that for the first time, she didn’t feel like the only one with the problems she had, feelings she had not experienced in the hearing, interpreted group. She also stated that the skills took on a whole new meaning when presented in ASL (her preferred language). Having a chance to see how other deaf clients understood the skills and feeling free to ask questions made all the difference. Once Sara had the skills down, target behaviors began to reduce. Sara became very good at doing behavioral chain analyses of her own behaviors. She began to see what her triggers were for engaging in a target behavior and choosing the right combination of skills to decrease these behaviors. Sara’s cutting stopped altogether as her skill use increased. Her suicidal ideation went from being a chronic, daily state of mind, to an infrequent thought (less than once per week). As she began to develop emotion regulation and interpersonal skills, she became better able to handle work relationships, and at the end of treatment had held a job for over 1 year (a record for her).

Near the end of treatment, Sara stated that had she not found direct access to DBT, she probably would not be alive today. Both Sara and her therapist reported that they felt DBT was the most effective treatment she had experienced with the greatest gain. Sara went from being a chronic client to a client who built a decent life and who only required occasional episodes of treatment (usually around major life stressors).

In summary, DBT can be an effective therapy for use with many populations. To be useful for most deaf clients, materials need to be modified to fit the learning level of the individual (or group) and methods need to be modified to be culturally relevant.

References

- Aos, S., Lieb, R., Mayfield, J., Miller, M., & Penucci, A. (2004). Benefits and costs of prevention and early intervention programs for youth. Olympia, WA: Washington State Institute for Public Policy.
- Bauman, H-D. (2004). Audism: Exploring the metaphysics of oppression. *Journal of Deaf Studies and Deaf Education*, 9, 239–246.
- Black, P., & Glickman, N. S. (2006). Demographics, psychiatric diagnoses, and other characteristics of North American Deaf and hard of hearing inpatients. *Journal of Deaf Studies and Deaf Education*, 11, 303–321.

- Bohus, M., Haaf, B., Stiglmayr, C., Pohl, U., Boehme, R., & Linehan, M. M. (2000). Evaluation of inpatient dialectical behavioral therapy for borderline personality disorder: A prospective study. *Behaviour Research and Therapy*, *38*, 875–887.
- Boyechko, V. (1992). *Suicidal behaviour and its correlates among hearing impaired college students*. Doctorial dissertation, University of South Dakota, Vermillion. (UMI No. 1992—98p.)
- Critchfield, A. B., Morrison, F., & Quinn, W. M. (1987). Suicide intervention with hearing impaired adolescents. In G. B. Anderson & D. Watson (Eds.), *Innovations in the habilitation and rehabilitation of Deaf adolescents: Selected proceedings of the second national conference on the habilitation and rehabilitation of Deaf adolescents* (pp. 187–203). Little Rock, AR: American Deafness and Rehabilitation Association.
- Dean, R. K., & Pollard, R. Q. (2005). Consumers and service effectiveness in interpreting work: A practice profession perspective. In M. Marschark, R. Peterson, & E. Winston (Eds.), *Interpreting and interpreter education: Directions for research and practice* (pp. 259–282). New York: Oxford University Press.
- Dudzinski, E. F. (1998). *An analysis of administrative response patterns to suicide ideation among deaf young adults*. Unpublished doctoral dissertation, Gallaudet University, Washington, DC.
- Embury, R. (2001, July). *Examination of risk factors for maltreatment of deaf children: Findings from a national survey*. Paper presented at the 7th International Family Violence Research Conference, Portsmouth, NH.
- Fruzzetti, A. E. (2006). *The high conflict couple: A dialectical behavior therapy guide to finding peace, intimacy, and validation*. Oakland, CA: New Harbinger Publications.
- Fruzzetti, A. E., Shenk, C., & Hoffman, P. D. (2005). Family interaction and the development of borderline personality disorder: A transactional model. *Development and Psychopathology*, *(17)*, 1007–1030.
- Glickman, N. S. (2003). Culturally affirmative mental health treatment for deaf people: What it looks like and why it is essential. In N. S. Glickman & S. Gulati (Eds.), *Mental health care of deaf people: A culturally affirmative approach* (pp. 1–32). Mahwah, NJ: Lawrence Erlbaum Associates.
- Glickman, N. S. (2009). *Cognitive-behavioral therapy for deaf and hearing persons with language and learning challenges*. New York: Routledge.
- Glickman, N. S., & Gulati, S. (2003). *Mental health care of deaf people: A culturally affirmative approach*. Mahwah, NJ: Lawrence Erlbaum Associates.
- Hoffman, P. D., Fruzzetti, A. E., Buteau, E., Neiditch, E. R., Penney, D., Bruce, M. L., et al. (2005). Family connections: A program for relatives of persons with borderline personality disorder. *Family Process*, *44*, 217–225.
- Isenberg, G. (1996). Storytelling and the use of culturally appropriate metaphors in psychotherapy with deaf people. In N. S. Glickman & M. A. Harvey (Eds.), *Culturally affirmative psychotherapy with deaf persons* (pp. 169–183). Mahwah, NJ: Lawrence Erlbaum Associates.
- Kabat-Zinn, Jon. (2005). *Coming to our senses: Healing ourselves and the world through mindfulness*. New York: Hyperion.
- Katz, L. Y., Cox, B. J., Gunasekara, S., & Miller, A. L. (2004). Feasibility of dialectical behavior therapy for suicidal adolescent inpatients. *Journal of the American Academy of Child and Adolescent Psychiatry*, *43*, 276–282.
- Koerner, K., & Dimeff, L. (Eds.). (2007). *Overview of dialectical behavior therapy in dialectical behavior therapy in clinical practice: Applications across disorders and settings*. New York: Guilford Press.

- Koons, C. R., Robins, C. J., Tweed, J. L., Lynch, T. R., Gonzales, A. M., Morse, J. Q., et al. (2001). Efficacy of dialectical behavior therapy in women veterans with borderline personality disorder. *Behavior Therapy, 32*, 371–390.
- Lew, M., Matta, C., Tripp-Tebo, C., & Watts, D. (2006). Dialectical behavior therapy (DBT) for individuals with intellectual disabilities: A program description. *Mental Health Aspects of Developmental Disabilities, 9*(1), 1–12.
- Linehan, M. M. (1993a). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.
- Linehan, M. M. (1993b). *Skills training manual for treating borderline personality disorder*. New York: Guilford Press.
- Linehan, M. M. (1996a). *Borderline persoonlijkheidsstoornish Handleiding voor training en therapie*. Amsterdam: Swets & Zeitlinger Publishers.
- Linehan, M. M. (1996b). *Dialektisch behaviorale therapie borderline der persönlichkeitsstörung trainingsmanual zur*. Munich, Germany: CIP-Medien.
- Linehan, M. M. (2000). *Manuel d'entraînement aux compétences pour traiter le trouble de personnalité étai-limite*. Zurich, Switzerland: Medicine & Hygiene.
- Linehan, M. M. (2003a). *Manual de tratamiento de los trastornos de personalidad límite*. Barcelona, Spain: Ediciones Paaidós Ibèrica, S.A.
- Linehan, M. M. (2003b). *Practicing reality acceptance*. Seattle, WA: The Behavioral Technology Transfer Group.
- Linehan, M. M. (2003c). *This one moment: Skills for everyday mindfulness*. Seattle: The Behavioral Technology Transfer Group.
- Linehan, M. M., Armstrong, H. E., Suarez, A., Allmon, D., & Heard, H. L. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry, 48*, 1060–1064.
- Linehan, M. M., Comtois, K. A., Murray, A. M., Brown, M. Z., Gallop, R. J., Heard, H. L., et al. (2006). Two-year randomized controlled trail and follow-up of dialectical behavior therapy vs. therapy by experts for suicidal behavior and borderline personality disorder. *Archives of General Psychiatry, 63*, 757–766.
- Linehan, M. M., Dimeff, L. A., Reynolds, S. K., Comtois, K. A., Shaw Welch, S., Heagerty, P., et al. (2002). Dialectical behavior therapy versus comprehensive validation plus 12-Step for the treatment of opioid dependent women meeting criteria for borderline personality disorder. *Drug and Alcohol Dependence, 67*, 13–26.
- Linehan, M. M., Dimeff, L., Waltz, J., & Koerner, K. (2000). *DBT skills training video: opposite action*. Seattle: The Behavioral Technology Transfer Group.
- Linehan, M. M., Heard, H. L., & Armstrong, H. E. (1993). Naturalistic follow-up of a behavioral treatment for chronically parasuicidal borderline patients. *Archives of General Psychiatry, 50*, 971–974.
- Linehan, M., Schmidt, H., Dimeff, L. A., Craft, J. C., Kanter, J., & Comtois, K. A. (1999). Dialectical behavior therapy for patients with borderline personality disorder and drug-dependence. *American Journal of Addiction, 8*, 279–292.
- Lynch, T. R., Morse, J. Q., Mendelson, T., & Robins, C. J. (2003). Dialectical behavior therapy for depressed older adults: A randomized pilot study. *American Journal of Geriatric Psychiatry, 11*, 33–45.
- Metzger, M., & Bahan, B. (2005). Discourse analysis. In C. Valli, C. Lucas, & K. Mulrooney (Eds.), *Linguistics of American Sign Language* (4th ed.), (pp. 490–515). Washington, DC: Gallaudet University Press.

- Miller, A. L., Rathus, J. H., & Linehan, M. M. (2006). *Dialectical behavior therapy with suicidal adolescents*. New York: Guilford Press.
- O'Hearn, A. M., & Pollard, R. Q. (2008). Modifying dialectical behavior therapy for Deaf individuals. *Cognitive and Behavioral Practice, 15*, 400–414.
- Padden, C., & Humphries, M. (1988). *Deaf in America*. Cambridge, MA: Harvard University Press.
- Pollard, R. Q. (1994). Public mental health service and diagnostic trends regarding individuals who are deaf or hard-of-hearing. *Rehabilitation Psychology, 39*, 147–160.
- Pollard, R. Q. (1998). Psychopathology. In M. Marschark & D. Clark (Eds.), *Psychological perspectives on deafness, Vol. 2* (pp. 171–197). Mahwah, NJ: Lawrence Erlbaum, Associates.
- Pollard, R. Q., Dean, R. K., O'Hearn, A. M., & Haynes, S. L. (2009). Adapting health education material for deaf audiences. *Rehabilitation Psychology, 54*, 232–238
- Pollard, R. Q., & Dimeff, L. (Executive Producers.) (2006). *Opposite action: An adaptation from the Deaf perspective*. [Motion picture.] (Available from Behavioral Tech, LLC, 2133 Third Avenue, Suite 205, Seattle, WA 98101.)
- Pollard, R. Q., & Dimeff, L. (Executive Producers.) (2007). *Practicing radical acceptance: An adaptation from the Deaf perspective*. [Motion picture.] (Available from Behavioral Tech, LLC, 2133 Third Avenue, Suite 205, Seattle, WA 98101.)
- Rathus, J., & Miller, A. L. (2002). Dialectical behavior therapy adapted for suicidal adolescents. *Suicide and Life-Threatening Behavior, 32*, 146–157.
- Safer, D. L., Telch, C. F., & Agras, W. S. (2001). Dialectical behavior therapy for bulimia nervosa. *American Journal of Psychiatry, 158*, 632–634.
- Samar, V. J., Pollard, R., O'Hearn, A., Lalley, P., Sutter, E., Klein, J. D., et al. (2007, March). *Deaf young adults' self-reported suicide attempt rate: role of reading and gender*. Paper presented at the Pacific Rim Disability Conference, Honolulu, HI.
- Sullivan, P. M., & Knutson, J. F. (2000). Maltreatment and disabilities: A population-based epidemiological study. *Child Abuse and Neglect, 24*, 1257–1274.
- Swenson, C. R., Sanderson, C., Dulit, R. A., & Linehan, M. M. (2001). The application of dialectical behavior therapy for patients with borderline personality disorder on inpatient units. *Psychiatric Quarterly, 72*, 307–324.
- Telch, C. F., Agras, W. S., & Linehan, M. M. (2001). Dialectical behavior therapy for binge eating disorder. *Journal of Consulting and Clinical Psychology, 69*, 1061–1065.
- Turner, O., Windfuhr, K., & Kapur, N. (2007). Suicide in deaf populations: A literature review. *Annals of General Psychiatry, 6*, 1–15.
- van den Bosch, L., Verheul, R., Schippers, G., & van den Brink, W. (2002). Dialectical behavior therapy of borderline patients with and without substance use problems: Implementation and long-term effects. *Addictive Behaviors, 27*, 911–923.
- Woodberry, K. A., Miller, A. L., Glinski, J., Indik, J., & Mitchell, A. G. (2002). Family therapy and dialectical behavior therapy with adolescents: Part II: A theoretical review. *American Journal of Psychotherapy, 56*, 585–602.