

Dialectical behaviour therapy in practice: A clinician's guide

Webinar attendee questions with answers from Dr Natalie Mastrogiovanni

Question: How can DBT be adapted for individuals with intellectual disability or cognitive decline?

While this is not my area of expertise you may find this manual helpful:

'The Emotion Regulation Skills System for Clients with Cognitive Challenges Second Edition (2026) A DBT-Informed Approach' by Julie Brown: [Books & Articles – Skills System](#)

Question: How can DBT be adapted for individuals with neurodevelopmental conditions such as autism, ADHD, or AuDHD, particularly where challenges with introspection, sensory processing, or communication may affect engagement with DBT skills?

Discussing with clients in pre-treatment how they learn best and what might affect their engagement and problem-solving from there. A cope ahead plan (a DBT skill) can be prepared ahead of group which can include how they know that they are becoming distressed, what works best if they become distressed, how others know they are becoming distressed and what they find helpful from others. This can be provided to facilitators.

Some adaptation suggestions largely based on following paper: Ritschel LA, Guy L, Maddox BB. A pilot study of dialectical behaviour therapy skills training for autistic adults. *Behavioural and Cognitive Psychotherapy*. 2022;50(2):187-202. doi:10.1017/S1352465821000370

- Relying on visual supports
- More practical activities
- Colour coding for different concepts
- Incorporate activities consistent with special interests
- Simplified handouts – not too wordy
- Predictability in group e.g. consistent break time
- More breaks and shorter sessions

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- Externalising reminders
- Modify diary cards to simplify
- Being aware of sensory sensitivities and how this may affect some skills e.g. self-soothing

I have come across this resource and haven't read it personally, however, you may find it helpful noting it's not licensed for multiple users or distribution:

[Neurodivergent Friendly Workbook of DBT Skills 2nd Edition - Digital Version — Lived Experience Educator](#)

Question: How can DBT be incorporated into treatment for people experiencing substance use concerns, particularly for clinicians working in smaller services or rural and regional settings?

Please see slides from 'DBT applied to substance use' and the webinar recording for an associated explanation

This paper may be helpful, suggesting telehealth as part of the solution: Walton, C. J., Gonzalez, S., Dunbar, A., & McGill, K. (2025). Telehealth and Collaboratively Delivered Dialectical Behaviour Therapy: An Opportunity for Increasing Access to Effective Treatment for People With Borderline Personality Disorder Living in Rural Areas. *The Australian journal of rural health*, 33(2), e70036. <https://doi.org/10.1111/ajr.70036>

Question: What evidence exists for adapting DBT for culturally and linguistically diverse populations, including migrant communities and people with English as an additional language?

Review suggests culturally adapting DBT is feasible but no controlled comparisons to standard DBT: Haft, S. L., O'Grady, S. M., Shaller, E. A. L., & Liu, N. H. (2022). Cultural adaptations of dialectical behavior therapy: A systematic review. *Journal of consulting and clinical psychology*, 90(10), 787–801. <https://doi.org/10.1037/ccp0000730>

Question: How can DBT be delivered through a cultural lens or adapted for non-mainstream populations or in non-clinical settings?

Suggestions recommended in the following review which I have also found helpful particularly interpersonal effectiveness skills and biosocial model: Haft, S. L., O'Grady, S. M., Shaller, E. A. L., & Liu, N. H. (2022). Cultural adaptations of dialectical behavior therapy: A systematic review. *Journal of consulting and clinical psychology*, 90(10), 787–801. <https://doi.org/10.1037/ccp0000730>

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- Using culturally relevant metaphors
- Considering cultural views of emotions
- Consider cultural context in the biosocial model – cultural values growing up but also how the individual may have felt ostracised growing up in a culture different to what they identify with
- Language translation
- Training members of the community in DBT
- Incorporating spiritual and cultural beliefs into components e.g. radical acceptance- ‘God’s will’
- Discussing appropriateness of interpersonal effectiveness skills based on cultural situation – pros and cons of using interpersonal effectiveness skills. Hierarchical relationships to be acknowledged and validated
- About doing what is effective for that individual’s context
- Consider the environment being more powerful than skills

Question: What strategies or adaptations are recommended when working with clients who may be reluctant to engage in therapy or who are not yet ready to recognise problematic behaviours?

- Motivational interviewing
- Reflect back consequences of problematic behaviours and how these might get in the way of their life worth living goals
- Discuss the unrelenting crisis cycle – see webinar recording on ‘distress tolerance skills’ slide
- Chain analysis on therapy interfering behaviours to understand what’s making it difficult to engage and problem solve

Question: Beyond BPD, what evidence exists for the use of DBT with other populations, such as older adults or individuals with generalised anxiety disorder?

Please see slide 'evidence' and recording for associated explanation.

Older adults is not my area of expertise but this chapter outlines 2 studies finding evidence for DBT + medication (compared to a medication only group) on various outcomes including depression in older adult participants: Cheavens, J.S., Lynch, T.R. (2008). Dialectical Behavior Therapy for Personality Disorders in Older Adults. In: Gallagher-Thompson, D., Steffen, A.M., Thompson, L.W. (eds) Handbook of Behavioral and Cognitive Therapies with Older Adults. Springer, New York, NY. https://doi.org/10.1007/978-0-387-72007-4_12

Regarding generalized anxiety disorder, there are other evidence based approaches that would be more indicated (eg CBT). However, DBT skills could be incorporated based on a formulation-based approach. Mindfulness skills in particular would be useful to stay in the present moment and the check the facts skill would be useful for making sure the emotion (anxiety), duration and intensity, fit the facts. This paper may also be helpful: Malivoire BL. Exploring DBT skills training as a treatment avenue for generalized anxiety disorder. Clin Psychol Sci Pract.2020;27:e12339. <https://doi.org/10.1111/cpsp.12339>

Question: Can DBT interpersonal effectiveness skills be used in group programs supporting individuals experiencing complex psychosocial stressors, such as long-term unemployment, family stress, mental health concerns, and substance use?

They can be useful, particularly exploring how such stressors / presenting difficulties impact on their interpersonal relationships and how they might be able to ask what they need or say no to loved ones (DEARMAN skill), improve their relationships (GIVE skill), maintain their self-respect (FAST skill) and what barriers might get in the way of effective interpersonal skills.

Question: Can individuals be referred or diverted into DBT programs through court or justice pathways?

This isn't my area of expertise however, it appears that Youth Justice NSW use DBT across Youth Justice NSW settings: [Dialectical Behaviour Therapy use across Youth Justice settings | Department of Social Services](#)

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Question: In your experience, which DBT skills are most helpful for clients with co-occurring substance use and trauma?

It would depend on what the specific behaviours are, however these are some skills which may be relevant:

- Radical acceptance: because we can't change the past, we have to accept it (doesn't mean we approve of it) because acceptance leads to change *this can be a difficult skill to teach and can be a process over a long period of time. I would recommend reading the DBT manual for more information.
- Dialectic: I might not have been the one to cause my problems AND I need to be the one to solve them anyway
- Mindfulness: coming back to the present moment and facts of the current situation especially when pulled back to the past with trauma symptoms

Question: How do you decide which DBT skills to prioritise early in treatment?

In individual sessions, it's less about what skills to prioritise early on in treatment, rather, what behaviours they are exhibiting and where those behaviours fit on the hierarchy – life threatening behaviours prioritised first, followed by treatment interfering and quality of life interfering. Then you would discuss the skill that is most relevant to prevent each of those behaviours (with the assistance of a chain analysis to figure out what led up those behaviours).

For group, if possible it can be useful to structure modules in the following order: mindfulness + distress tolerance, mindfulness + emotion regulation and mindfulness + interpersonal effectiveness. However, it is often the case that clients start with the module that is running at the time of them joining the program.

Question: What are some common challenges clinicians face when implementing DBT in alcohol and other drug (AOD) settings, including managing therapy-interfering behaviours?

Please refer to slide 'DBT hierarchy applied to substance use' and the webinar recording for the associated explanation.

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Question: How can DBT be adapted in services that do not have the capacity to deliver a full DBT program?

Please refer to slide 'DBT in clinical settings' and the webinar recording for the associated explanation.

Question: How do you approach emotional dysregulation in clients with complex trauma backgrounds?

From a DBT perspective, you would lean into the biosocial model to discuss this.

Refer to slide 'Biosocial theory' and the webinar recording for the associated explanation.

Some examples of how emotion dysregulation can be formed when a client has a complex trauma background:

- Growing up, if the client discloses trauma, caregiver might deny it happening, or just never talk about it after → clients learn to suppress emotions or escalate to get needs met.
- Growing up, when abuse is perpetrated towards the client and they express understandable distress OR abuse happens as a result of expressing an emotion → client can learn to suppress because showing emotions results in danger

Other concepts:

- Principles of trauma informed approach – creating safety, choice, slowing things down, checking in if that fits with their experience
- Dialectic: I might not have been the one to cause my problems AND I need to be the one to solve them anyway

Question: What advice would you give clinicians who are new to DBT, including small practical strategies they could begin using immediately in AOD practice?

Have a team around you or at least really good supervision – clients who are most suited to DBT can present with complex difficulties so it's important to have a space to debrief and seek further advice.

Having a read of the DBT distress tolerance skills in the DBT manual – the manual makes everything relatively easy to understand but the distress tolerance skills are a good starting point because they are quite useful for most clients and relatively easy to implement in sessions particularly when managing risk.

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