

Dialectical Behavior Therapy

An Experiential Workshop on Engagement and Confrontation

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Characteristics of Difficult-to-Treat Dual Diagnosis Patients

- Multiple diagnoses on Axis I and II.
- Chronic and/or progressive conditions.
- Periods of well-being vs. relapse crises.
- Unremitting suffering.
- Difficult to like.
- Lack of personal or financial resources.

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Challenges for Caregivers of Difficult-to-Treat Patients

- Competency: having enough know-how to design a sound treatment plan.
- Keeping the patient in treatment.
- Efficacy: promoting change in patient's behavior.
- Maintaining therapist empathy and motivation.

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Dialectical Behavior Therapy (DBT)

Developed by Marsha Linehan, Ph.D.
and Colleagues
University of Washington, Seattle

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Dialectical Behavior Therapy

Originally developed to treat parasuicidal behaviors in patients who meet criteria for Borderline Personality Disorder.

Now also used to treat patients with poor impulse control, maladaptive behaviors, and dysregulated emotions.

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Cognitive-Behavioral Treatment of Borderline Personality Disorder

Marsha M. Linehan, Ph.D.
University of Seattle, Washington
Guilford Press, New York, NY, 1993
behavioraltech.org

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Skills Training Manual for
Treating Borderline
Personality Disorder

Marsha M. Linehan, Ph.D.
University of Seattle, Washington
Guilford Press, New York, NY, 1993

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Overview for Today's Workshop

- Experiential sampling of DBT techniques.
- Focus on Confrontation and Engagement.
- Chosen to be used as stand-alone tools.
- The tools are used in the context of a comprehensive treatment model.

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Biosocial Therapy of BPD

- A. Biological Vulnerability
Some are born with greater emotional sensitivity.
- B. Environmental Vulnerability
Some grow up in families that fail to validate private experience.

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C. Biology interacts with Environment and produces dysfunction:

- Emotional dysregulation
- Cognitive dysregulation
- Behavioral dysregulation
- Interpersonal dysregulation
- Identity dysregulation

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Biosocial Theory of SUDs

A. Biological Component

- Drug intoxication changes brain neurochemistry acutely.
- Prolonged drug use causes long-lasting changes in brain function.

B. Social and Environmental Component

- Developmental effects of growing up in substance abusing family.
- Prolonged drug use causes long-term changes in social and emotional functioning.

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C. SUDs are brain disorders but not JUST brain disorders

- Physiological and neurochemical dysfunction
- Emotional, cognitive, behavioral dysregulation
- Interpersonal and occupational dysfunctional

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As a result of chronic dysregulation in multiple areas of function, BPD and SUD patients exhibit maladaptive behaviors, poor problem-solving skills, little tolerance for physical and emotional distress, failure to trust their own intuitions, and impaired ability to see reality as-it-is.

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BPD and SUD Patients are Difficult Customers

1. Effective treatments are scarce.
2. Non-collaborative, non-compliant.
3. Often drop out of treatment.
4. Disliked by caregivers and by the public.
5. Associated with increased mortality.

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Goals of DBT Treatment

1. Stop using drugs and parasuicidal behaviors.
2. Increase ability to self-regulate emotions.
3. Replace maladaptive behaviors with skillful behaviors.
4. Improve dysfunctional cognition: irrational beliefs, black and white thinking, unrealistic expectations of the world and of the self.
5. Validate patient to strengthen identity.
6. Learn how to live skillfully in the world as it is.

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DBT Balances:

Skills Acquisition: teaching new behaviors

vs.

Validating and Reinforcing existing adaptive behaviors

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DBT Balances:

Standard behavior therapy techniques to promote **Change**

vs.

Acceptance strategies to promote the therapeutic alliance and keep patients in treatment

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Overview of DBT Treatment Model

- Weekly outpatient individual therapy.
- Weekly 2-hour skills training group.
- As-needed after-hours phone coaching within therapist limits.
- Team consultation (peer supervision) for therapists.

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Tools for ACCEPTANCE: Overview

- OBSERVE and DESCRIBE
- NON-JUDGMENTAL THINKING
- VALIDATION
- RADICAL ACCEPTANCE
- IMPROVE THE MOMENT
- DIALECTICAL THINKING

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Practicing Acceptance With SUD Patients

- Think Dimension 4: Readiness to Change.
- Objective, measurable, quantifiable.
- Meet the client where they are.
- Assume target behaviors are a result of: skill deficit, motivation, and “What is missing?”

Assess. Ask questions. Be persistent.

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- ACCEPTANCE means taking the patient right now just as they are.
- ACCEPTANCE is profoundly important to patients and is a universal feature of psychological and spiritual therapies.
- ACCEPTANCE can melt patient resistance, promotes attachment, and enhances motivation.

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• ACCEPTANCE does not imply passivity, endorsement or preference. We can deeply object to a circumstance while acknowledging the reality of that circumstance. We can cease striving to make the undesirable reality be different than what it is. This does not require that we like it or forgive it or acquiesce to it.

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• ACCEPTANCE by the therapist can teach self-acceptance to the patient.

• ACCEPTANCE is probably *NOT* sufficient to promote change.

• To the extent that ACCEPTANCE means ceasing to struggle for some other reality, it is orthogonal to avoidance and to willful control

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Observe

• Just notice *what is*

• Moment-to-moment awareness

• Minimize language

• Beginner's mind

• Open, curious recognition

• Don't "jump ahead" to conclusions

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Describe

- Language-based
- Serves to communicate experience to self or others
- Only that which is *OBSERVABLE*
- Objective Data Points – not conclusions

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How to Observe and Describe:

NON-JUDGMENTALLY

The ability to OBSERVE and DESCRIBE, verbally or silently, what simply is, without reference to “good” or “bad”.

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- The judgments one seeks to minimize are those that label behaviors as good or bad, right or wrong, fair or unfair, worthy or unworthy.
- In our daily lives, the skill of judging is necessary and not intrinsically problematic.
- However, certain kinds of judgments are problematic because patients use them to globally define their self-worth and the “value” of various people and experiences.
- Therapists use judgmental thinking to blame or pathologize the patient, thereby decreasing patient and therapist motivation.

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WHY BOTHER WITH NON-JUDGMENTAL THINKING?

- Promotes self-acceptance and promotes empathy for others.
- Increases self-regulation of emotions.
- Increases tolerance for distressing situations.
- Opens the mind to previously discarded solutions.
- All these qualities make it easier for patients to stay in treatment and for therapists to avoid burnout.

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PRACTICE NON-JUDGMENTAL THINKING

- **OBSERVE** judgmental statements when they arise.
- **DESCRIBE** the judgment explicitly.
- **RESTATE** using non-judgmental language. Strive for specific and behavioral language.
- **OBSERVE** the after-effects of your non-judgmental restatement.
- Apply this practice to spoken statements, facial expression, tone of voice, body posture, and private thoughts.

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VALIDATION

Any response from the therapist that indicates that the patient's point of view is valid; i.e. appropriate to the situation and would make sense to the average person.

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Types of Validation:

- Verbal validation: articulate what is already sane and appropriate about a patient's response.
- Functional validation: act in a way that communicates your understanding of the patient's need and the seriousness of the situation. Your behavior is "in-tune" with the patient's communication.

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VALIDATE ONLY WHAT IS VALID

- Validation is not just support or kindness.
- Validation must always be authentic.
- Don't validate a behavior that you think is maladaptive.
- There is always a tiny kernel of valid truth buried in the most chaotic behavior: Look for that and speak to it!

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RATIONALE FOR ACCEPTANCE

- Emotional or physical pain + non-acceptance = suffering.
- Let go and stop fighting reality.
- Letting go transforms unbearable suffering into more ordinary pain, which is part of life.

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RADICAL ACCEPTANCE

- **RADICAL ACCEPTANCE** is a whole-hearted embrace of present reality, just as it is, in just this one moment.
- **RADICAL ACCEPTANCE** means letting go of trying to make it different; “nowhere else to go, nothing else to be.”

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Radical Acceptance

- We can practice Radical Acceptance by repeatedly **TURNING THE MIND** towards whole-hearted acceptance of reality.
- Turning the Mind is an active choice and requires an inner commitment, as well as mindful intention.

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Tolerating-Accepting Distress **IMPROVE the Moment**

- IMAGERY
- MEANING
- PRAYER
- RELAXATION
- ONE THING IN THE MOMENT
- VACATION
- ENCOURAGEMENT

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THE "D" IN DBT

Dialectics is a branch of philosophy that proposes that every phenomenon contains its opposite within. Ambivalence is described as the inability to choose between white and black. Dialectical thinking challenges us to hold both black and white in our minds simultaneously, valuing each color equally. The resulting tension is a vehicle for change and transformation when we seek to SYNTHESIZE the opposing poles of the dialectic.

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Dialectical Dilemmas

1. Change vs. Acceptance
2. Active passivity vs. Apparent competence
3. Unrelenting crisis vs. Inhibited grieving
4. Emotional vulnerability vs. Self- invalidation
5. Absolute abstinence vs. Harm reduction

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PRACTICAL APPLICATION of DIALECTICAL THINKING

- Identify the two poles of the dialectic.
- Treat both poles as equally valid realities.
- Try to find a solution that honors both (all) realities.
- Look for synthesis, not compromise.
- In compromise, some or all parties are dissatisfied.

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Tools for CHANGE: Overview

- Chain Analysis
- Solution Analysis
- Task Analysis
- Commitment Strategies
- Rehearsal
- Shaping
- Response to Egregious Behaviors

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CHAIN ANALYSIS

A moment-by-moment description of a behavior sequence that includes the thoughts, feelings, and consequences associated with each link in the chain.

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Chain analysis starts with a particular instance of a problem behavior:

- Determine the circumstances: when, where, who was there, how did it happen?
- What was the prompting event?
- “When did it first cross your mind?”
- What was the point of no return?
- What were the consequences; i.e. “What happened after you drank the alcohol?”
- Were there any pre-existing vulnerabilities?

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Be persistent.

- Get a clear and detailed sequence from prompting event to problem behavior.
- Focus especially on the sequence of thoughts > feelings > behaviors > events and vice-versa.

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Behavioral Formulation

1. Summarize the story.
2. Add any insights you have.
3. Identify dysfunctional links in the chain.
4. Identify reinforcers: what keeps this problem behavior going?
5. Identify function: how does this problem behavior serve the patient?

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CONFRONTATION with NO EDGE.

- THINK AND TALK BEHAVIOR.
- DESCRIBE, UNDERLINE, NOTICE.
- EASY MANNER.
- WARMTH.
- GENTLE HUMOR.
- GENTLY PERSIST: LIKE WATER RUNNING OVER A STONE.

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SOLUTION ANALYSIS

- Identify a maladaptive link in the chain to work on.
- Ask what the patient needed at that moment.
- Ask for a more adaptive response.
- Brainstorm for any and all conceivable solutions

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THE ONLY 4 TYPES OF SOLUTIONS

- Solve the problem.
- Feel better about the problem.
- Tolerate the problem.
- Be miserable.

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THE BIG DECISION

- Pick a solution to work on.
- If the patient has no ideas, teach an alternative response. What would you have done faced with the same situation?

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TASK ANALYSIS

- What will it take to succeed?
- Step-by-step list of each necessary component.
- “Chain analysis in reverse.”
- Identify deficits in current repertoire.
- Do one piece at a time, not the whole enchilada.

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GET A COMMITMENT

- “So, how about if you give this new behavior a try?”
- “Can I get a COMMITMENT from you?”
- Get specific.

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Asking for a commitment increases the likelihood of follow-through.

- COMMITMENTS are not the same as promises or guarantees.
- You are asking the patient if he/she is COMMITTED, in this moment, to performing the new behavior at an agreed upon time in the future.
- It's easier to make and keep a small specific COMMITMENT than a large global one.

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STRENGTHEN THE COMMITMENT

- Link the new behavior to patient's goals.
- Review pros and cons.
- Remind patient of earlier commitments.
- Devil's advocate: argue against the change.
- Freedom to choose vs. Absence of alternatives.

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REHEARSE THE NEW BEHAVIOR

- Ensures that the patient can actually perform the new behavior.
- REHEARSAL is a way to practice new behavior.
- Practice leads to improved skill and reduced anxiety.
- REHEARSAL promotes trouble-shooting and refined planning.

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FOLLOW-UP

- If you give an assignment, make an agreement, or elicit a commitment you **MUST** follow-up.
- Failure to follow-up suggests that you are not interested in the outcome.
- It teaches patients that there is no consequence for avoiding the assignment and no reward for completing it.

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- Troubleshoot: **PROBLEM SOLVE** the obstacles that come up.
- Don't let the patient get away with doing **NOTHING**.
- **SHAPING**: give lots of partial credit.
- Be a **CHEERLEADER**.
- **REWARD** positive steps with warmth, praise, attention, time, gifts.

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Response to Egregious Behaviors

1. Describe the problem behavior to the patient.
2. Patient writes a chain analysis on the problem behavior (alone).
3. Patient reviews chain analysis with therapist for behavioral formulation.
4. Patient presents chain analysis to community, gets feedback.

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5. Patient and therapist identify the damage done by the problem behavior.
6. **Correction**: an amend that returns the situation back to baseline.
7. **Overcorrection**: an amend that actually improves the situation, making things better than they were to begin with.
8. **Correction-overcorrection procedure** is strengthened by therapist withholding some goody (warmth) until patient successfully completes the overcorrection.

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Ultimate Aversive Sanction: Vacation from Therapy

1. Describe the problem behavior to the patient.
2. State that failure to stop this behavior is leading to vacation.
3. Give patient a chance to escape the vacation (by solving the problem).

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4. Place patient on vacation. Patient may resume therapy when problem is solved.
5. Give appropriate referrals for continuity of care.
6. Maintain non-demand contact with patient ("pining for his/her return").

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Contingency Management: Requires no co-operation from the patient

1. Reinforce desired behaviors (surprising how we forget this).
2. Stop reinforcing maladaptive behaviors: extinction.
3. Punishing maladaptive behaviors will only suppress behaviors.

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TOOLS TO DECREASE CAREGIVER BURNOUT

- HONOR LIMITS
- RADICAL GENUINENESS: irreverent and reciprocal communication
- Confronting Therapy-Interfering-Behaviors
- DBT ASSUMPTIONS
- PEER SUPPORT

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HONORING LIMITS

- DBT does not recommend an infinitely permissive stance.
- Patients and therapists and agencies need to HONOR THEIR LIMITS.

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- A LIMIT is already there inside of you; something that you can't or won't do.
- OBSERVE your limit: notice what your private experience is telling you.
- DESCRIBE your limit by making a clear and specific communication.
- HONOR your limit with self-validation and by acting in ways that keep you within your limits.
- Find SOLUTIONS with patients that stay within your limits and your agency's limits.

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DBT does not promote SETTING LIMITS: this is often arbitrary, presented as if it's good for all patients, and does not reflect the moment-to-moment reality that limits change.

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Rather, DBT invites therapists (and patients) to be mindful of their own limits, to communicate about them in a non-blaming way, and to problem-solve about how to deal with the situation within one's limits.

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It is sometimes necessary and appropriate for therapists (or patients) to briefly extend beyond their limits. This should be seen as a temporary exception and requires much support.

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OWN YOUR LIMITS

- Identify personal limits and agency limits for what they are.
- Limits are choices, not facts.
- Avoid hiding limits:
 - “It’s in your best interest...”
 - “This is the way it’s done...”
 - “You made me do this...”

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RADICAL GENUINENESS

HOW DO YOU TREAT YOUR BEST FRIEND?

HOW DO YOU EXPECT YOUR FRIENDS TO TREAT YOU ?

WHY SHOULD IT BE ANY DIFFERENT FOR PATIENTS?

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IRREVERENT COMMUNICATION:
humorous, informal, slightly outrageous.

RECIPROCAL COMMUNICATION:
transparent, self-disclosing, heart-to-heart.

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CONFRONT THERAPY- INTERFERING BEHAVIORS

- “Are you noticing what I’m noticing?”
- DESCRIBE the behavior specifically and NON-JUDGMENTALLY.
- Assess the behavior by doing a small CHAIN ANALYSIS.
- Use SOLUTION ANALYSIS to generate alternative, more adaptive behaviors.
- REHEARSE the new behavior right there in-session.
- Get a COMMITMENT to work on this together.

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If you have no time for behavior analysis:

- Make a CONTINGENCY STATEMENT.
- Offer an alternative behavior, get the patient’s agreement, and rehearse it.

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DBT Assumptions

1. Difficult behaviors represent maladaptive solutions.
2. Engaging reluctant patients is a therapeutic task, not a pre-requisite for enrollment.
3. Patients are doing the best they can *and* patients need to do better and try harder to change.
4. Patients want to have lives worth living
5. When patients say their lives are unbearable, this is a valid statement.

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- Patients may not have caused their problems, but they do need to solve them.
- Patients need to demonstrate adaptive behaviors in all relevant contexts.
- Safety and security in therapy is not necessarily valued, in so far as it does not reflect the real world.
- Patients cannot fail in treatment.
- Therapists who conduct DBT need consultation.

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**PEER CONSULTATION
SUPPORT FOR THERAPISTS**

- Consistency: maintains high level of adherence to treatment protocols.
- Practice/Rehearsal: DBT therapy for the DBT therapist.
- Validation and Positive Reinforcement: maintains therapist motivation.
- Support: peers give assistance whenever needed, even after hours (while honoring limits).

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**IN OUR EXPERIENCE, NO ONE
CAN DO THIS WORK ALONE.**

**IT IS ALSO OUR EXPERIENCE THAT,
WITH TEAM CONSULTATION,
THIS WORK IS HIGHLY REWARDING
AND EMINENTLY DO-ABLE.**

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ADDITIONAL TOOLS

WILLINGNESS VS. WILLFULNESS
ATTACHMENT STRATEGIES
DBT SKILLS FOR SUBSTANCE ABUSERS

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Willingness

Doing just what is needed in the moment.
Listening. Responding. Allowing.
Effective. Unpretentious. Aware.

Willfulness

Refusing to do what is needed in the moment.
Refusal to tolerate what is happening in the moment.
Sitting on your hands. Giving up. Fixing.
Ineffective. Stubborn. Rigid.

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- “Are you, by any chance, being willful just now?”
- “What would you do differently if you were willing?”
- “What would it take to practice willingness in this one moment?”
- “How about if you give it a try?”
- “What was that like for you?”

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Attachment Strategies

1. Educate Patient about butterfly problem.
2. Increase session frequency initially.
3. Use voicemail, e-mail, or drop-ins as additional contacts.
4. Conduct therapy in patient's environment.
5. Shorten or lengthen therapy sessions.

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- Support meetings with family and friends.
- Phone patients who are avoiding therapy.
- Find lost clients.
- Send birthday and holiday cards to current patients and to drop-outs.
- Have a fabulous waiting room/reception area.

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Therapist Behaviors that Increase Patient Motivation and Attachment

- ORIENT the patient to everything.
- Link new behaviors to patient GOALS.
- Coaching Model: 3-10 positive statements for every request for change.

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- **USE POSITIVE REINFORCEMENT:** praise, smile, be attentive, give more time, gifts.
- **LEVEL 5 VALIDATION:** tell the patient what you admire and celebrate about them as a human being.
- **Transparency:** warm, **RECIPROCAL COMMUNICATION** style.
- Go find lost patients and ask, "What will it take to get you back?"

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Skills Added to DBT for Substance Abusers

- Urge Surfing (Observing Skill).
- Alternate Rebellion (find a way to rebel that does not harm you).
- Burning Bridges: eliminate options to use drugs and eliminate access to drugs.
- Avoid and eliminate cues or reminders of drug use.
- Build a life worth living: Structure and Mastery.

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