UNC SCHOOL OF SOCIAL WORK CLINICAL INSTITUTE SERIES

Dialectical Behavioral Therapy (DBT)

DAY 1

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University of North Carolina at Chapel Hill

Day 1 Agenda

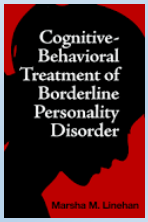
9:00 Welcome & Housekeeping
9:10 I. DBT: Introduction
10:15 Break
10:30 II. Nuts and bolts: How DBT works
12:00 LUNCH
1:00 III. DBT in action
2:30 Break
2:45 IV. Strategies during therapy
4:30 END

I. Introduction

To history, theory, and practice

Dialectical Behavioral Therapy

- Developed by Marsha Linehan
- Began as intervention for chronically suicidal women
- Combines behavioral principals with Buddhist practice of "mindfulness"



(1993)

History

Late 1970s, **Marsha Linehan** attempted to apply cognitive behavioral therapy (CBT) to adult women with chronic suicidal attempts and para-suicidal behaviors.

Formative history

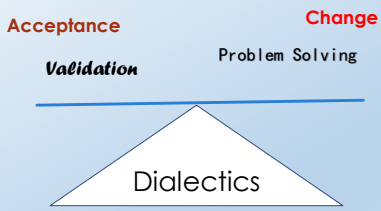
DBT created in response to problems Linehan noted:

- Reinforcement – little incentive to broach difficult topics

EXAMPLE: therapists back off when clients express anger or mention self-harm; clients respond with warmth to topic change

- Dilemma: How can therapist teach adaptive behaviors when client is in continuous crisis?
- Invalidating nature of "change" therapies

Balance Core Strategies



DBT Approach

1. CBT
2. *plus*: Acceptance strategies (validation & mindfulness)
3. *plus*: Dialectical worldview and strategies
   - both/and (not **all** or **nothing**)
     - opposites can both be true and be **synthesized**; change is inevitable and constant; everything is connected

Originally created for people with BPD

Borderline Personality Disorder
(BPD)

What comes to mind?

BPD (according to DSM-5)

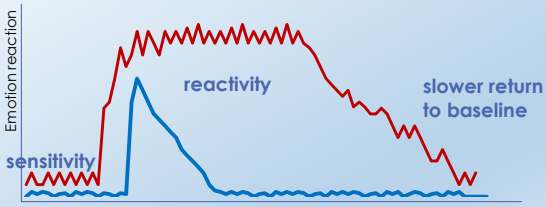
- Frantic efforts to avoid abandonment; pattern of unstable relations (vacillating between idealization and devaluation)
- Identity disturbance, unstable self-image or sense of self
- Impulsivity in self-damaging ways (sex, spending, eating, substance use, reckless driving)
- Recurrent suicidal behavior, gesture, threats or self-injuring behavior
- Affect instability; chronic feelings of emptiness; inappropriate anger or difficulty controlling anger
- Transient, stress-related paranoid ideation, delusions or dissociation

BPD (according to Biosocial Theory)

- BPD is a pervasive disorder of *emotional regulation system*
- Develops as a result of a ***genetic vulnerability*** in **transaction** with an ***invalidating environment***

Biosocial theory

1. **Genetic vulnerability**: (a) predisposition of high emotional sensitivity, (b) high reactivity, (c) slow return to baseline



Biosocial theory

1. **Genetic vulnerability**

+

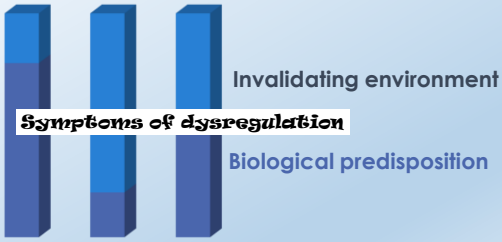
2. **Pervasively invalidating environment**

⇩

- Phobia of valid, natural responses to experience
- Self-invalidation / rejection of self
- Emotional overwhelm
- Maladaptive behaviors (all/nothing)

Emotional dysregulation

Biosocial theory



All BPD criteria are:

- ✓ Natural consequences of emotion dysregulation

OR

- ✓ Behaviors that regulate emotions

Borderline personality disorder (BPD)

Kiera Van Gelder

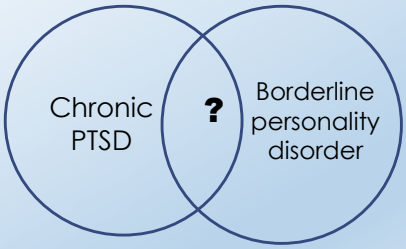
author of

The Buddha and the Borderline

https://vimeo.com/13606126

Notice **strength-based framework**

Trauma and diagnosis



Borderline Personality Disorder diagnosis, reorganized by DBT problem/skill area

Behavioral Dysregulation
- Self-harm or suicidal behaviors
- Impulsivity

Cognitive Dysregulation
- Slowed, confused, or paranoid thinking

Emotional Dysregulation
- Rapidly shifting feelings and moods
- Problems with anger

Interpersonal Dysregulation
- Chaotic relationships
- Fear of being left alone or abandoned

Self Dysregulation
- Fluctuating or absent sense of self
- Feelings of emptiness

DBT has become a trans-diagnostic approach

DBT: Evidence basis for

- Substance use disorders
- Eating disorders
- Bi-polar depression
- Suicidal adolescents
- Depressed elderly
- DBT- Family skills training
- Forensic population

Targets ***emotion dysregulation*** in general rather than disorders specifically

DBT-Prolonged Exposure (PE) Protocol

- Developed by Melanie Harned, PhD
- Concomitant and/or integrated **DBT + prolonged exposure**

Outcome:

- Reduction in dissociation, trauma-related guilt, shame, anxiety, depression, and increase in global social adjustment measures.

(Harned et al., 2012; Meyers et al., 2017)

II. Nuts & Bolts
How DBT Works

Goals of DBT

Overall goal:

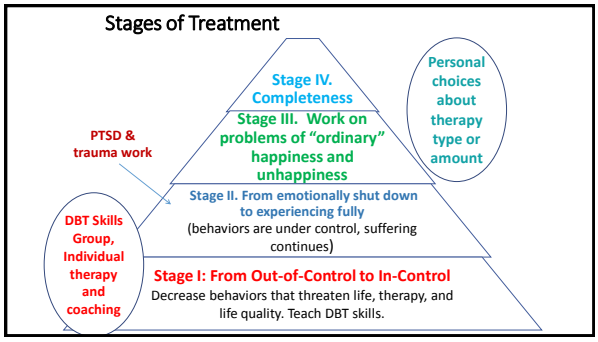
Helping clients create a "Life Worth Living"

DBT Framework

Acceptance
&
Change Skills
→ Middle Path

DBT Stages & Targets

- Includes four **stages of treatment** and a comprehensive framework
- Sessions are guided by structured yet flexible **target hierarchy**, which varies based on stage of treatment



DBT Primary Treatment Targets

Behaviors to Decrease

1. Decrease suicide and NSSI (non-suicidal self injury) - thoughts, urges, actions
2. Therapy interfering behaviors
3. Quality of life interfering behaviors

Hierarchy followed in each session

How is DBT Practiced?

1. Individual therapy
2. Coaching calls
3. Skills group
4. Consult team

1. DBT: Individual therapy

- Begins with review of diary card
  - Daily rating of target behaviors, urges, emotions
  - Review card *In session if necessary*
  - Set session agenda based on target hierarchy *Solicit client input*
- Behavioral shaping through "chain analysis" of "targets," structuring of session, & therapeutic strategies

Example Diary Card

Dialectical Behavior Therapy Diary Card | Initials | ID# | Filled out in session? Y N | How often did you fill out this side? ____ Daily ____ 2-3x ____ Once | Date Started

Day & Date	TARGETS			EMOTIONS				BEHAVIORS								
	Use	SI	S-H	Anger	Shame	Fear	Sad	Illicit		ETOH		Prescrip	S-H	Lying	Joy	Skills	R
	0-5	0-5	0-5	0-5	0-5	0-5	0-5	#	Specify	#	Specify	# Specify	Y/N	#	0-5	0-7	
Mon																	
Tues																	
Wed																	
Thur																	
Fri																	
Sat																	
Sun																	

Targets
Emotions
Behaviors
Skill use and reinforcement

*USED SKILLS
0 = Not thought about or used
1 = Thought about, not used, didn't want to
2 = Thought about, not used, wanted to
3 = Tried but couldn't use them
4 = Tried, could do them but they didn't help
5 = Tried, could use them, helped
6 = Didn't try, used them, didn't help
7 = Didn't try, used them, helped

	Before	After	Belief in control of . . .	Before	After
Urge to use (0-5):			Emotions:		
Urge to quit therapy (0-5):			Behaviors:		
Urge to harm (0-5):			Thoughts:		

DBTC Diary Card
Copyright 1999 Marsha M. Linehan, Ph.D.

Example Diary Card (cont.)

Dialectical Behavioral Therapy DIARY CARD | Instructions: Circle the days you worked on each skill | Filled out in session? Y / N | How often did you fill out this side? __Daily __2-3x __Once

1. Wise mind	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
2. Observe (Urge Surfing)	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
3. Describe: put words on, non-judgmentally					Fri	Sat	Sun
4. Participate: enter into the experience					Fri	Sat	Sun
5. Non-judgmental stance					Fri	Sat	Sun
6. One-mindfully: in-the-moment					Fri	Sat	Sun
7. Effectiveness: focus on what works	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
8. Objective effectiveness: DEAR MAN	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
9. Relationship effectiveness: GIVE	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
10. Self-respect effectiveness: FAST	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
11. Reduce vulnerability: PLEASE	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
12. Accum. positives, Build mastery, Cope ahead	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
13. Opposite Action	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
14. Mindfulness of Emotion	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
15. Loving the Emotion	Mon	Tues					
16. TIP Skills	Mon	Tues					
17. Problem Solving	Mon						
18. Distract: "Wise Mind ACCEPTS"	Mon	Tues					
19. Self-Soothe using Five Senses	Mon	Tues					
20. IMPROVE the Moment	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
21. Observe the Breath	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
22. Pros and Cons	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
23. Radical Acceptance and Willingness	Mon	Tues	Wed	Thurs	Fri	Sat	Sun

List of Skills
Days of week to circle

2. DBT: Phone consultation

- Therapist is "coach" on the use of skills
- Can only call *before* acting out (24 hr rule)
- Focus on skills: "what have you tried already?"
- Client must be willing to accept help
- Call should be brief: 5 or 10 minutes

* Some therapists will use text rather than calls
Remember, you set the guidelines.

3. DBT: Skills training group

- More like "class" than "group therapy"
- Meets weekly for 2 hours
- Format
  - Mindfulness practice
  - "Business"
  - Review homework
  - Teach and practice new skill
  - Closing awareness

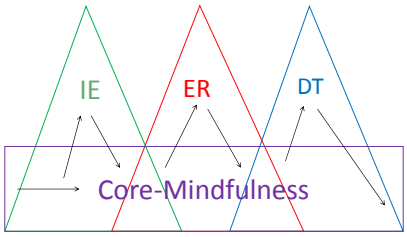
DBT: Skills group
4 Modules

1. Core Mindfulness
2. Interpersonal effectiveness
3. Emotion Regulation
4. Distress Tolerance

35

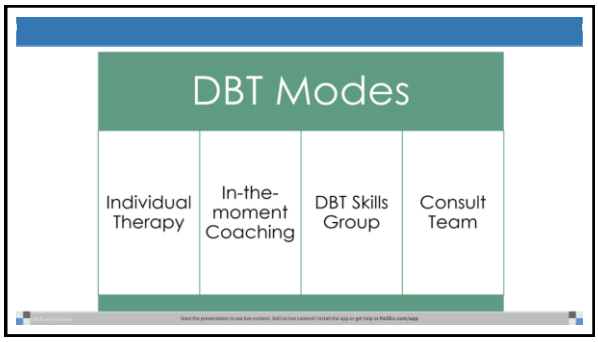
DBT: Skill Modules

2 full cycles = ~ 1 year, but varies



4. DBT: Therapist Consultation Team

- Focus on therapist behavior not client's
- Addresses therapy interfering behaviors of therapist
- Provides support to therapist to decrease burn-out and enhance motivation
- Often begins with mindfulness exercise



DBT – Assumptions about clients

1. Clients are doing the best they can.
2. Clients want to improve.
3. Clients need to do better, try harder, and/or be more motivated to change
4. Client must learn new behaviors in all relevant contexts
5. Clients cannot fail DBT.
6. Clients may not have caused all of their own problems, but they have to solve them anyway.
7. The lives of BPD individuals are unbearable as they are currently being lived.

DBT – Assumptions about therapy

1. The most caring thing a therapist can do is help clients change in ways that bring them closer to their ultimate goals.
2. Clarity, precision, and compassion are of the utmost importance in conduct of DBT.
3. The therapeutic relationship is a real relationship between equals.
4. Principles of behavior are universal – affecting therapists no less than clients.

DBT – Assumptions about therapy continued

5. DBT therapists can fail.
6. DBT can fail even when therapists do not.
7. Therapists treating BPD clients need support.

Another note about assumptions

- Assumes: each person is capable of wisdom with respect to her own life, though this capability isn't always obvious or accessible
- What is not assumed is: ***INTENT***

  *Discourages use of terms such as "manipulating, triangulating, needy, splitting, not trying," etc. to describe clients.

DBT – Limitations

- Client must be extremely motivated and willing to make a significant time commitment
- The approach may be too relentless and strict for some clients
- Client needs to have at least average I.Q. (unless the approach and homework are modified)
- Financial issues

5 Ways to fix anything

1. Solve the problem
2. Change your perception of the problem
3. Radically accept the problem
4. Stay miserable
5. Make things worse

Case Study - Samantha

- 24 yr old referred from psych hospital
- Extreme binge/purge led to heart problem and hospitalization
- Struggled w/ bulimia and cutting since 16
- Accident with drunk driver at 21, passenger died
- Takes opiates for chronic back pain from accident
- Since accident SI, SH & eating disorder worsened
- Cuts and burns arms & legs
- Overdoses on pain killers ("if it happens it happens; like Russian roulette")
- Hospital staff "moved mountains" to arrange for Samantha to live with aunt and participate in DBT

Case Study - Samantha (continued)

- Reactions? What are your thoughts and feelings about starting work with Samantha?
- Any evidence of: emotional sensitivity? invalidating environment?
- What stage of treatment is she in?

Case Study - Samantha (continued)

- I. Risk from life-threatening behavior?
- II. History of therapy-interfering behavior?
- III. Behaviors that seriously impair quality of life?

III. DBT in Action

Role plays of early and subsequent session

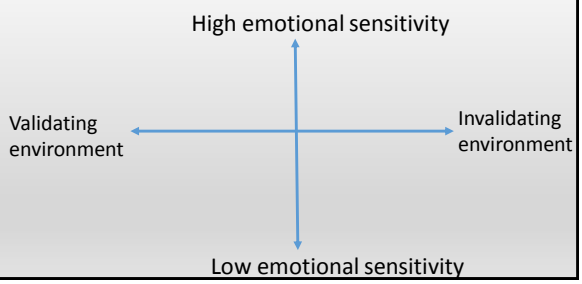
Intake interview

- Assessment
- Goals

Diagnostic interview and psychosocial history

- "Let your standard intake assessment questions be guided by the framework of stages and primary targets" (Koerner, 2012, p.35)
- "Target hierarchies guide you from the first moments of contact to determine the focus of treatment and how comprehensive treatment may need to be" (Koerner, 2012, p.41)
  1. Risk from life-threatening behavior?
  2. History of therapy-interfering behavior?
  3. Behaviors that seriously impair quality of life?

Biosocial Assessment



Orientation to Treatment

- Raising DBT as treatment
- Targets and hierarchy
- Diary card
- Coaching calls
- Skills Group
- Agreements

Subsequent appointments with Samantha

Samantha Diary Card

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Day & Date	TARGETS			EMOTIONS				BEHAVIORS								
	SI	Self Harm	Dis. Eating	Phys. Misery	Angrr	Shame	Sad	S-H Cut	S-H Burn	Restrict	Purge	Pills	Argue / yell	Joy	Used Skills*	R
	0-5	0-5	0-5	0-5	0-5	0-5	0-5	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	0-5	0-7	
Mon	2	2	2	4	4	3	5	N	N	N	N	N	Y	1	3	
Tues	2	3	2	4	3	3	5	N	N	N	N	N	Y	1	4	
Wed	3	3	3	4	3	3	5	N	N	N	N	N	Y	4	0	
Thur	1	1	5	5	4	5	5	N	N	N	Y	N	Y	4	0	
Fri	2	3	5	5	5	5	5	N	N	Y	N	N	Y	4	5	r
Sat	5	5	5	5	4	5	5	Y	N	Y	N	N	Y	0	3	
Sun	4	5	5	5	5	5	5	Y	N	N	Y	Y	Y	0	4	

Is the door to suicide/self-harm open? Yes

Homework assigned and results this week: States of mind
- looked for wise mind

*USED SKILLS
0 = Not thought about or used
1 = Thought about, not used, didn't want to
2 = Thought about, not used, wanted to
3 = Tried but couldn't use them
4 = Tried, could do them but they didn't help
5 = Tried, could use them, helped
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Session	Before	After	Belief in control of . . .	Before	After

Samantha Diary Card (cont.)

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Behavioral Chain Analysis

DEMONSTRATION WITH SAMANTHA

Behavioral Chain Analysis

Thorough, collaborative, step-by-step assessment of problem behavior

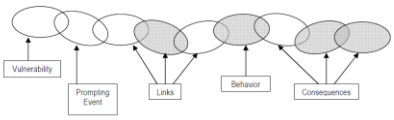
Conducted in almost every session in initial phase of treatment

Helps keep crises from undermining motivation to engage, understand, and move forward.

Steps in BCA

1. Choose a focus behavior
   - Orient the client
   - Get specifics
2. Conduct the chain analysis
   - Start with prompting event
   - "Naïve observer"
3. Generate Hypotheses
   - Be willing to abandon hypotheses if they don't fit
   - Use previous BCAs
4. Weave solutions into BCAs
   - Where could they have been used
   - Recommend (or agree on) a solution for next time
5. Summarize and highlight important links

Behavior Chain Analysis



Behavior? _____

Prompting Event?

Cascade of thoughts, feelings, actions.

Places for skillful intervention.

Possible Types of Links
A = Actions
B = Body Sensations
C = Cognitions
E = Events
F = Feelings

Pieces in Chain Analysis

1. Start with **specific problem behavior** (most severe and best remembered) – use specific language about events, thoughts, feelings, intensity.
2. Describe **prompting event**
3. Identify **vulnerabilities** (more than usual)
4. **Chain of events** that led up to behavior (in excruciating detail) include thoughts, feelings, behavior, reactions
5. Identify **consequences** (to self, to others)
6. **Solutions**?
   1. Where could you do something different?
   2. Anything you could have done to prevent from starting?
   3. Repairs that you can make?

Learning from BCA's

- ✓ Understand patterns – what elicits and maintains behavior & effective alternatives?
- ✓ Identify and change **problematic contingencies**, CONDITIONED RESPONSES and **ineffective cognitive processes**
- ✓ Reinforce skill use
- ✓ Also functions to shape behavior

IV. Strategies during therapy

Therapeutic Strategies

- Acceptance strategies
- Dialectic strategies
- Change strategies

Start with

Validation

Acceptance/Validation

- Rationale
- How & What to Validate

Validation → Change

- Strong, accurately worded, emotionally evocative validation
  - Reduces physiological arousal
  - Down-regulates emotions
  - Increases adaptive responses

- Allows for new, adaptive emotions, which reorganizes client's whole system

It can be tricky!!

Cue → Dysregulation

Inadvertent Invalidation

How to Validate

1. Express empathy (other's perspective)
2. Communicate that their experience and responses "*make sense …*" →

Levels of Validation

1. Awake, alert, aware
2. Reflection
3. Nonverbalized
4. Past learning or biology
5. Current circumstances
6. Radical genuineness

→ Self validation

Dialectical challenge

Align with client goals and remain open to what's valid, without:

- Reinforcing dysfunctional behavior
- Dropping focus on needed change

Helping clients change often requires **actively and repeatedly invalidating responses** that are incompatible with long-term goals

What can you always validate?

1. The experience of emotion, thought, behavior (kernel of truth)
2. Problem importance
3. Task difficulty
4. Wisdom in ultimate goals
5. Ultimate ability to meet goals

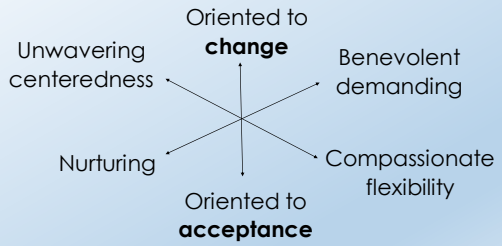
Validation Exercise

How to validate while holding dialectic?

Validation Exercise

Samantha calls to say that she wants to quit therapy. Last session she talked about the accident. She left feeling unsettled and dissociated and almost got hit by a car leaving your office. Then she went drinking and blacked out.

Therapist: dialectical stance



Dialectical Strategies

- Bring awareness of dialectical tensions to all interactions
- Hold dialectic of both/and (not: either/or)

1) Use metaphors and stories (to show other point of view)
2) Devil's advocate
3) Extending
4) "What do you know in your wise mind to be true?"
5) Lemons to lemonade: "gift" or opportunity to practice

- Stylistic: irreverence, vulnerability, radical genuineness

Additional Dialectical Strategies

6) Entering the paradox
7) Refusing right and wrong
8) Dialectical Assessment
9) Allowing natural change
10) Prescribing feared behavior
11) Exception rule (from solution-focused brief therapy)
12) Role reversal

Change Strategies

- Identify ***factors*** that contribute to primary target behaviors:
  - Skill deficits
  - Invalidation
  - Emotion vulnerability
  - Problematic conditioned emotional responses and contingencies
  - Cognitive "stories" (splitting)
- Then use behavioral theories to guide interventions to strengthen more effective responses

Change Strategies

1. Exposure
2. Cognitive modification
3. Contingency management & observing limits
4. Skills

1. Exposure

"What if allow discomfort to arise?"

Experience without avoidance or escape (**with corrective component**)

- Target behaviors often function to avoid emotion
- Extends exposure for fear/anxiety to: shame, guilt, anger, sorrow, etc.
- Formal and informal practices

2. Cognitive modification

emotion/problems ←→ "distortions"

✓Validation first!
- 1st = find and reinforce valid and functional beliefs, expectations, rules, interpretations

✓With cognitive restructuring, blend in more **validation** than **modification**

✓Normalize: "all people bias and distort"

3. Contingency management and observing limits

When you do "A," I feel "B"
When you do "X," "Y" happens

✓Reinforcement shapes behavior, emotions, thoughts
✓Explore "if-then" rules
- What is being communicated directly and indirectly?

✓Practice mindful reinforcement in tx
✓Be explicit about your limits

Reinforcement vs. punishment

	Reinforcement (to increase behavior)	Punishment (to decrease behavior)
Positive (add in)	Praise, "bribe," reward, treat, warmth, appreciation, turn towards (if perceived as desirable)	Chastise, reprimand, deliver painful consequence, "No!"
Negative (remove)	Stop nagging when clean room, etc.	Time out, remove attention or warmth, exclude

4. Skills

- Assess
  - What's getting in the way (i.e., skill deficit, emotions, environment) ?
- Teach
- Model
- Strengthen
- Generalization

Accumulate Positives
(an emotion regulation skill)

- Short-term
- Long-term
- Be unmindful of worries

- serenity
- love
- gratitude
- peace
- pleasure
- connection
- forgiveness
- compassion
- joy
- tenderness
- openness
- gratitude
- connection


Closing
awareness