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DBT Comprehensive Implementation and Training Intensive

Part I
Presented by:

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October 18 – 20 & 23 – 24, 2023
Virtual

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Dialectical Behavior Therapy Comprehensive Implementation and Training Intensive (DBT-CITI)

Virtual Training
October 18-20 & 23-24, 2023

Andrew White, PhD, ABPP &
Christopher Conley, DSW, RSW
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Why Do DBT-CITI or another intensive training?

- Motivate therapists to use evidence-based practices (EBPs) to treat complex, multi-diagnostic clients with severe problems.
- Teach effective use of DBT strategies
- Facilitate development of a DBT consultation team
- Facilitate adherent development of a DBT program

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Why Learn a New Treatment?

- Old one doesn't work
- New one has better outcomes
- New one has same outcomes, but…
  - More efficient, cost-effective
  - More preferred by clinicians
  - Is more humane to deliver

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Team Agreements

- To accept a dialectical philosophy.
- To consult with C on how to interact with other therapists and not to tell other therapists how to interact with C.
- Consistency of therapists with one another (even with same C) is not necessary or expected.
- Therapists are to observe their own limits without fear of judgmental reactions from other consultation team members.
- To search for non-pejorative, phenomenological empathic interpretation of C's behavior.
- Therapists are fallible.

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Training-Specific Agreements to Consider

- To throw self into learning & applying DBT throughout training phase
- To do DBT all-the-way (and not other approaches for DBT cases) in the service of learning DBT and building a DBT program.
- To stay on team for x months beyond the training phase.
- To apply DBT principles, strategies, and theory in all relevant treatment contexts.

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A DBT therapists acts from Wise Mind

Practices
- Observe (just noticing)
- Describe (put words on it)
- Participate (act intuitively from Wise Mind)

...and is
- Non-judgmentally (Neither good nor bad)
- One-mindfully (in the moment)
- Effectively (focus on what works)

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Mindfulness

- The quality or state of being mindful (attentive, thoughtful, intentional)
- A particular way of paying attention and directing one's focus, in the present moment, without judgment.
- Awake!
- The repetitive act of directing and redirecting one's attention to only one thing moment by moment.
- Attention control

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Overview of DBT

History, Philosophical Pillars, Research to Date, and Assumptions

DBT was developed by
Marsha M. Linehan, PhD for

multi-diagnostic, severe,
difficult-to-treat **chronically suicidal** individuals

with *both* Axis I
and Axis II disorders

DBT is a
principle-driven treatment
that includes **protocols.**

DBT is
Flexible, personalized, and
ideographic in approach.

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DBT is for People with Many Complex & Severe Problems

substance abuse
unrelenting crises
intimate partner violence
trouble making therapy work
medical problems
relationship problems
self loathing/self-disgust
dissociation
childhood sexual abuse
repeated suicide attempts
eating disorders
non-suicidal self-injury
extreme emotions
psychiatric hospitalization

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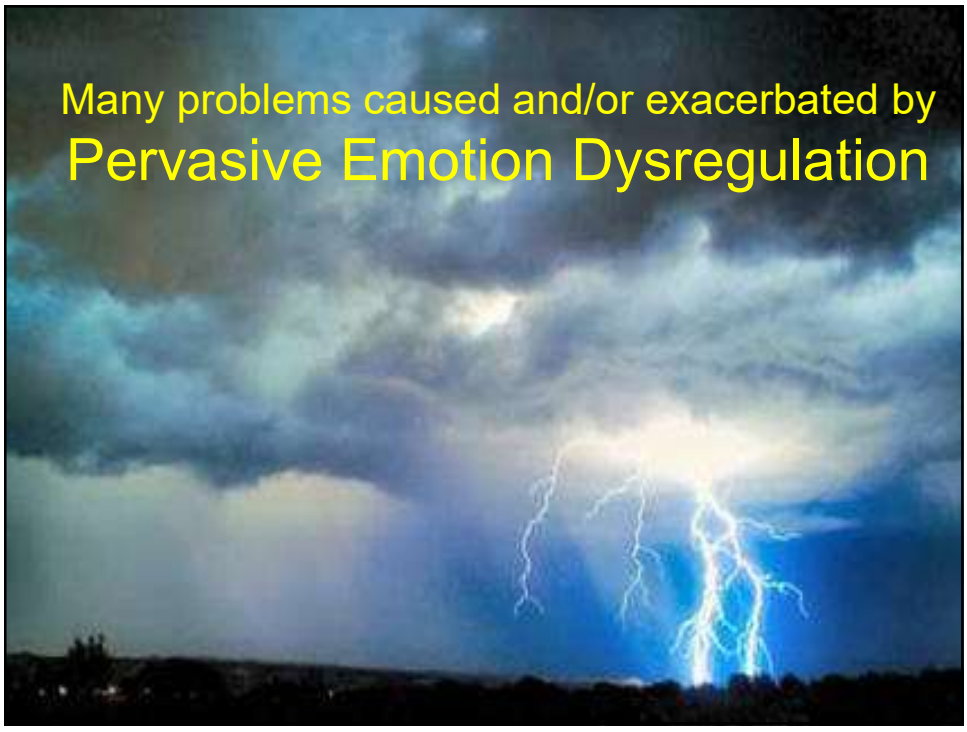

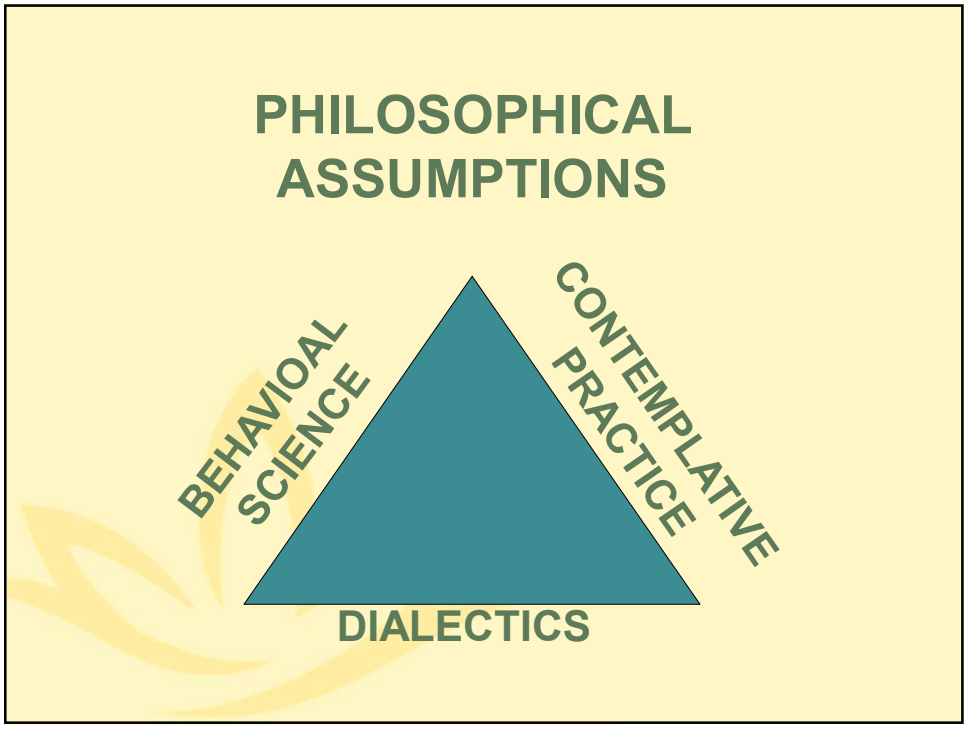

Standard Problem Solving Used in DBT

Behavioral Analysis
Insight
Solution Analysis
Troubleshooting
Skills Training
Cognitive Modification
Exposure
Contingency Management
Didactic
Orienting
Commitment

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Mindfulness & Reality Acceptance Skills

- Observe
- Describe
- Participate
- Non-judgmentally
- One-mindfully
- Effectively

Radical acceptance

Wise Mind

Willingness

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Dialectics as Persuasion

A method of logic or argumentation by disclosing the contradictions (antithesis) in an opponent's argument (thesis) and overcoming them (synthesis).

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Dialectics as World View

- Holistic, connected and in relationship
- Complex, oppositional, and in polarity
- Change is continuous
- Change is transactional
- Identity is relational and in continuous change

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Where Dialectics Show Up in DBT

Biosocial theory of BPD etiology

- Transaction between biology and environment over time.
- Systemic disorder

Treatment Strategies

- Balance of change vs. acceptance
- Search for "what is being left out", a synthesis, and function within dysfunction
- Emphasis on movement, speed, and flow
- Skills modules

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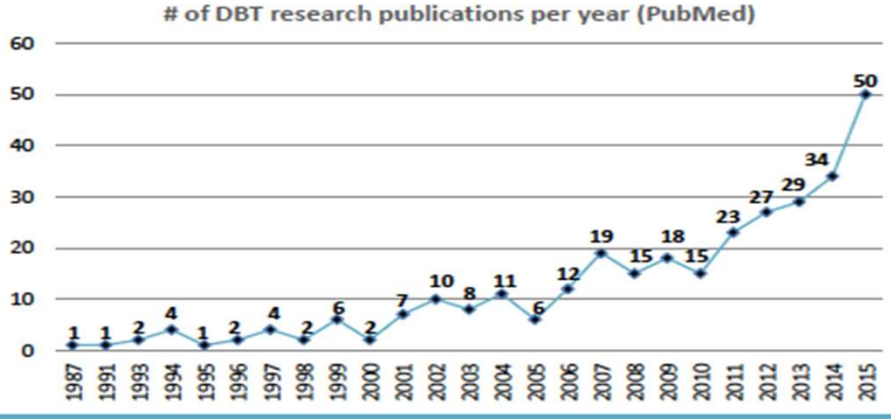
Empirical Basis for DBT:
What Do We Know?

Review of the Data to Date

DBT Research is Growing Rapidly



Get monthly updates at: http://www.linehaninstitute.org/research/latestResearch.php

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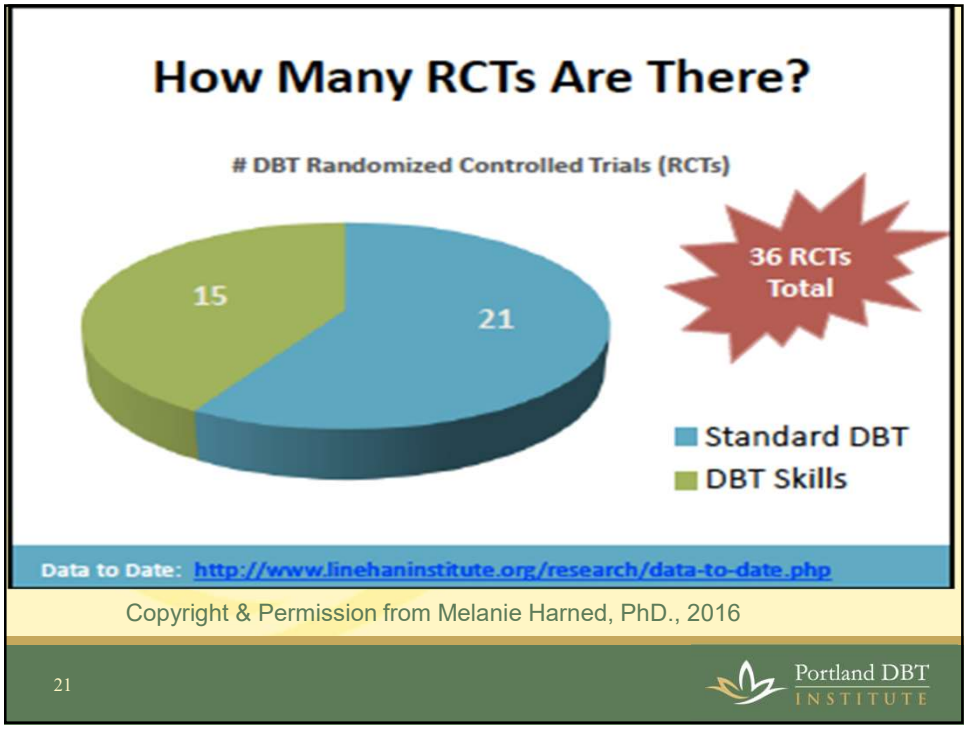

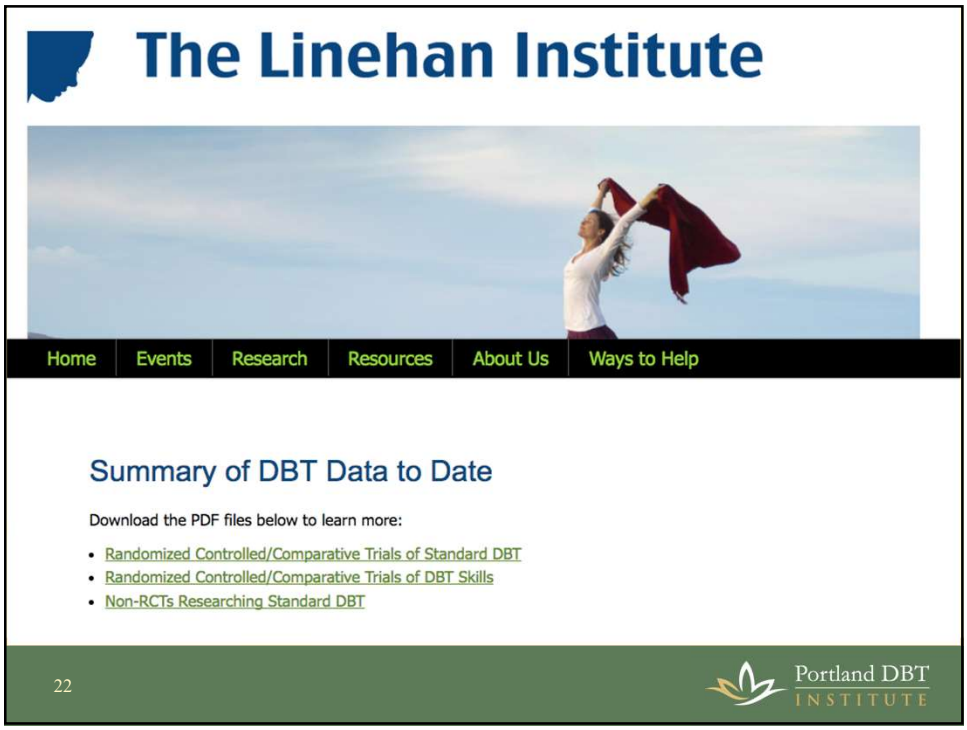

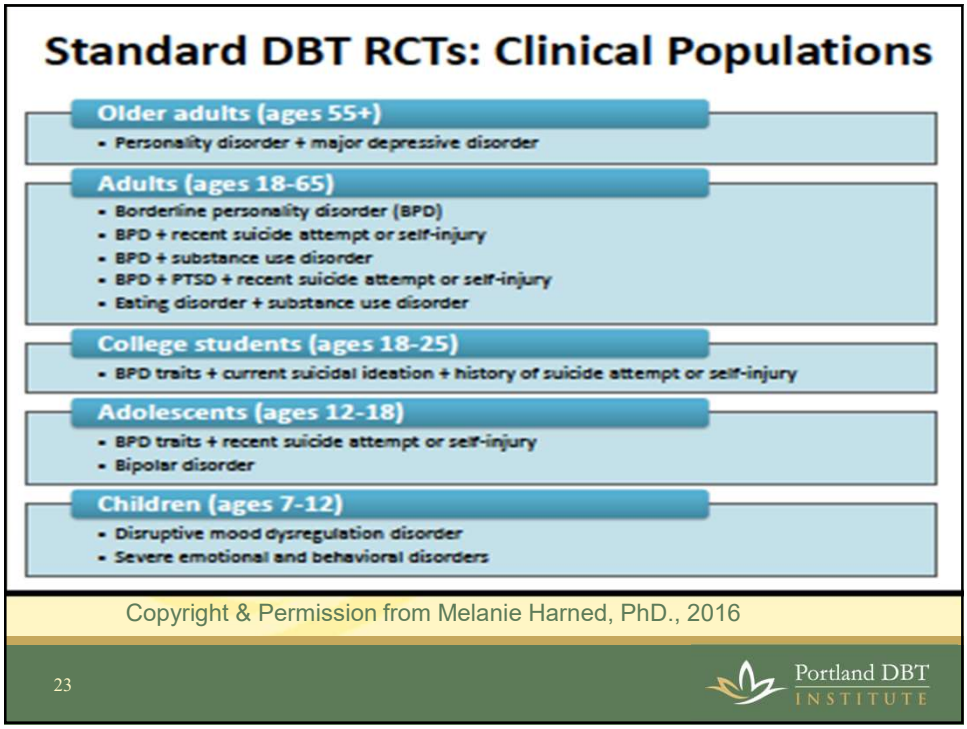

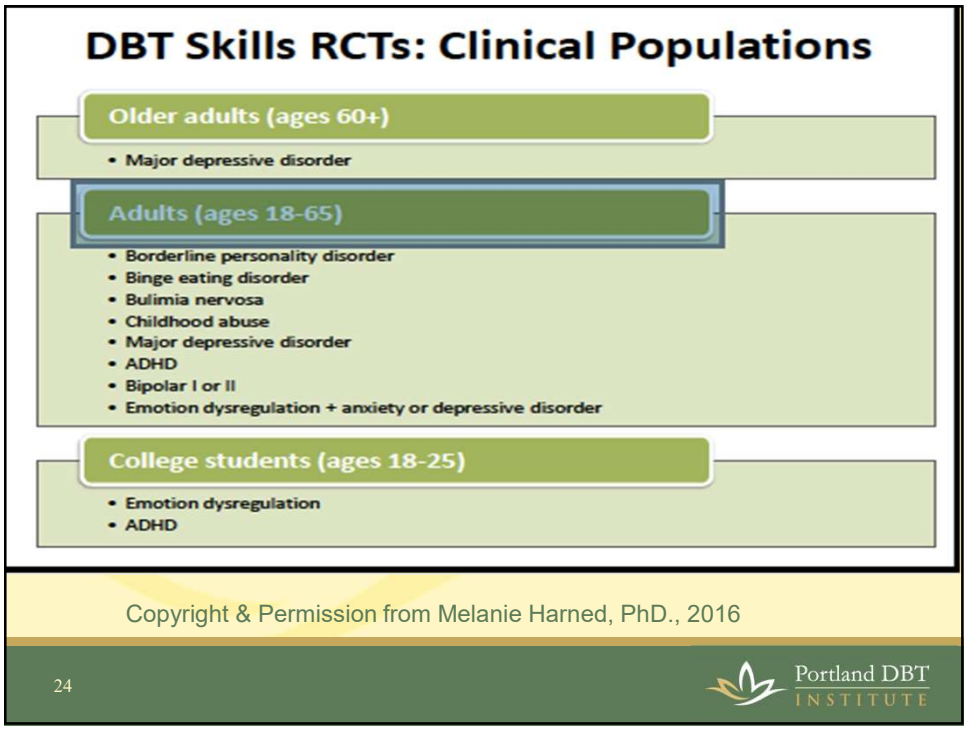

Adherence and Fidelity Matters: Suicide and Self-Harm

- For each standard deviation increase in therapist adherence, there was a 19.6% decrease in subsequent suicide attempts
- For each standard deviation increase in adherence, there was a 23.8% decrease in the odds of dropout
- No effect on NSSI [may be more related with replacement behavior of DBT skills training]. See component analysis.
- Higher therapist adherence significantly predicted fewer subsequent psychiatric hospitalizations among community therapists but not among research therapists
- Among community therapists, for each standard deviation increase in therapist adherence there was a 40.1% decrease in subsequent psychiatric hospitalizations (RR = 0.60, 95% CI = 0.45–0.81)

Harned, M. S., Gallop, R. J., Schmidt, S. C., & Korslund, K. E. (2022). The temporal relationships between therapist adherence and patient outcomes in dialectical behavior therapy. *Journal of Consulting and Clinical Psychology*. https://doi.org/10.1037/ccp0000714

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DBT Assumptions

About Patients and Therapists

DBT Assumptions about Patients

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

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DBT Assumptions about Therapy

1. The most caring thing a therapist can do is help patients change in ways that bring them closer to their own ultimate goals.
2. Clarity, precision, and compassion are of the utmost importance in the conduct of DBT.
3. The therapeutic relationship is a real relationship between equals.
4. Principles of behavior are universal, affecting therapists no less than patients.
5. DBT therapists can fail.
6. DBT can fail even when therapists do not.
7. Therapists need support

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BPD & Biosocial Theory

Diagnostic Criteria, BPD Reframed,
DBT Biosocial Theory of BPD

Prevalence Rates of BPD

- A large scale community survey in 2008 (SAMHSA, 2008) found a lifetime prevalence of 5.9% (18 million individuals) with no significant difference across gender in the United States.
- By comparison, the lifetime prevalence rate for schizophrenia is .4%, PTSD is 7.8%, and Bipolar Disorder is 1.4%

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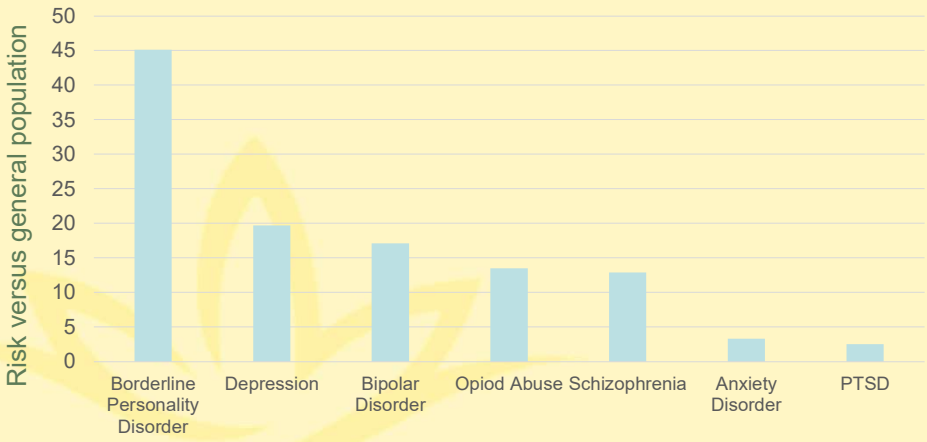
Suicide and Mental Health Diagnosis



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Challenges in Treating Persons with BPD

- Multiple diagnoses/problems
- Poor client retention
- Easily emotionally dysregulated in session
- Often non-compliant or quit treatment
- Engage (sometimes often) in life-threatening behaviors
- Don't demonstrate usual clinical progress

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People with BPD are High Utilizers of Health Services

- 8-11% of outpatients
- 14-20% of inpatients
- Up to 40% of highest utilizers

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Health Service Utilization Among Individuals Meeting BPD Criteria

- 97% receive outpatient treatment
  – From an average 6.1 therapists
- 72% receive inpatient treatment
- Compared to MDD, individuals with BPD receive:
  – 4.7 x individual, 2.7 x group, 2.8 x day treatment
  – 5 x inpatient treatment, 2.1x antidepressants
  – 6.2x mood stabilizers, 10.5 anti-psychotics
  – 2.2x anti-anxiety medications

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Outcomes of Treatment-as-Usual Health Service Utilization

Severe impairment in:

- Employment (52%)
- Global satisfaction (55%)
- Social adjustment (71%)
- Overall functioning (47%)

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TABLE 1. Studies examining various facets of employment in individuals with borderline personality disorder (BPD)

First Author/Year of Publication/Country	Sample Size/Description	Follow-Up Period (Years)	Comparison Group	Work Variable	Outcome
Pope/1983 United States[6]	33 BPD patients initially hospitalized	4–7	Patients with schizophrenia, schizoaffective, and bipolar disorder	Best occupational or academic functioning	BPD patients higher functioning than schizophrenic patients, but lower functioning than schizoaffective and bipolar patients
McGlashan/1986 United States[7]	81 BPD patients initially hospitalized	15	Patients with schizophrenia and unipolar affective disorder	Work time (4=all the time), level (1=most complex), and quality past year (4=very competent); further education	Means: BPD, schizophrenic, unipolars for work time: 2.7, 1.2, 2.5; work level: 2.9, 4.2, 3.3; work quality: 3.1, 2.0, 2.8; further education: 51%, 30%, 50%
Modestin/1989 Switzerland[8]	18 BPD patients initially hospitalized	4.6	Patients with other personality disorders	Work <20 hours per week and disability status	No differences between groups; 50% of BPD patients working <20 hours/week and 22% on disability
Mehlum/1991 Norway[9]	26 BPD patients initially in day treatment	2–5	None	Employment and self-supporting status	56% employed and 38.5% self-supporting
Najavits/1995 United States[10]	8 BPD patients initially hospitalized	3	None	Social Adjustment Scale	While there was no baseline data, work functioning did not significantly change from Year 1 (2.89) to Year 3 (2.33), but samples were not identical.
Trull/1997 United States[11]	35 college students with BPD features	2	30 college students without BPD features	Cumulative grade-point average; semesters on probation; % ineligible to enroll	BPD vs. non-BPD Grade-point: 2.34 vs. 2.91 Semesters on probation: 1.17 vs. 0.63 % ineligible to enroll: 20% vs. 0%
Paris/2001 Canada[12]	64 patients, average age 50, initially hospitalized	27	Community norms	Social Adjustment Scale	BPD patients' mean work score, 1.5; community norm work score, 2.1; 20% of BPD patients on long-term welfare
Stevenson/2005 Australia[13]	30 BPD patients initially seen as outpatients	5	None	Time off work	From baseline, patients experienced significant reduction in time off from work at follow-up
Yoshida/2006 Japan[14]	19 BPD patients initially hospitalized	17+	None	Employment status	54.2% employed
Zanarini/2009 United States[15]	249 BPD patients initially hospitalized	10	None	Social Security Disability	40.7% on Social Security disability at baseline and 44.2% at follow-up
Comtois/2010 United States[16]	30 BPD patients initially seen as outpatients	1	None	Employed or in school; employed at least 20 hours per week	Employed/school before treatment: 10% Employed/school after treatment: 50% 20 hours/week employed before: 3% 20 hours/week employed after: 37%

Sansone & Sansone, 2012, Employment in BPD

- Analysis of 11 studies btw 1983 & 2010
- Nearly half remained unemployed at follow up
- 20% to 45% subsisted on disability.
- Zanarini et al (2009): 40.7% on SSD at baseline; 44.2% at follow up.

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DSM-V Diagnostic Criteria for BPD

A pervasive pattern of instability of interpersonal relationships, self-image, and affect, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the diagnostic criteria.

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DSM-V Diagnostic Criteria for BPD

at least 5 of the following:

1. Frantic efforts to avoid real or imagined abandonment
2. A pattern of intense and unstable interpersonal relationships
3. Identity disturbance or problems with sense of self
4. Impulsivity that is potentially self-damaging

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DSM-vV Diagnostic Criteria for BPD

at least 5 of the following:

5. Recurrent suicidal or non-suicidal self-injurious behavior
6. Affective instability
7. Chronic feelings of emptiness
8. Inappropriate intense or uncontrollable anger
9. Transient stress-related paranoid ideation or severe dissociative symptoms

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BPD Criteria Reorganized

Emotion Dysregulation

- Affective lability
- Problems with anger

Interpersonal Dysregulation

- Chaotic relationships
- Fears of abandonment

Self Dysregulation

- Identity disturbance/difficulties with sense of self/sense of emptiness

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BPD Criteria Reorganized

Behavioral Dysregulation

– Suicidal behaviors

– Impulsive behaviors

Cognitive Dysregulation

– Dissociative responses, paranoid ideation

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BPD is a Systemic Emotion Regulation Disorder

BPD criterion behaviors function to regulate emotions or are a natural consequence of emotion dysregulation.

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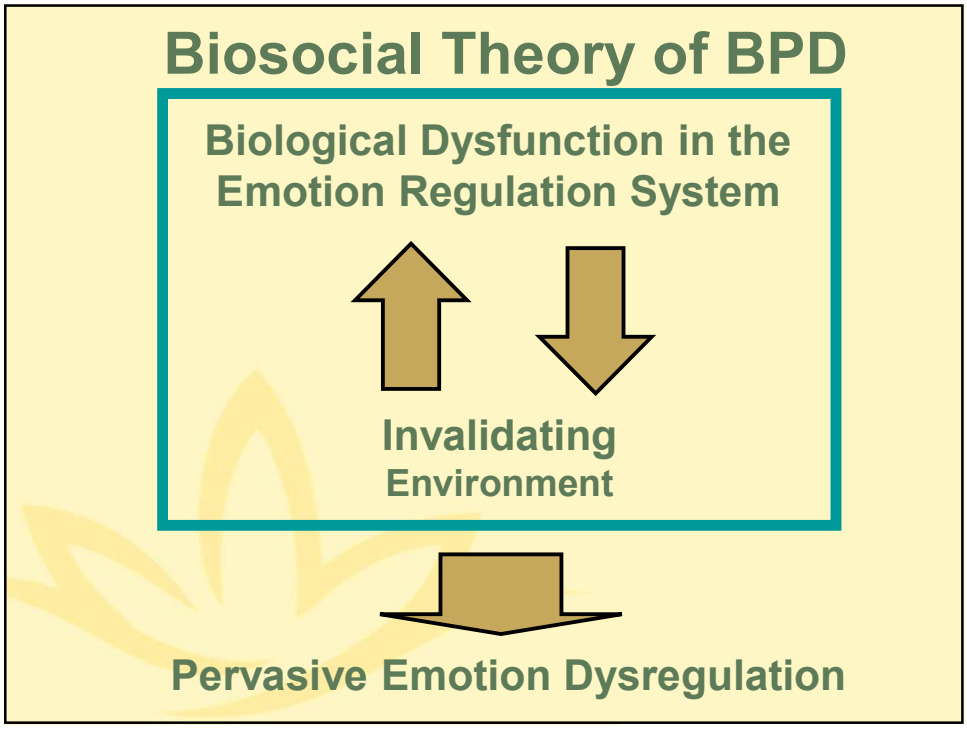

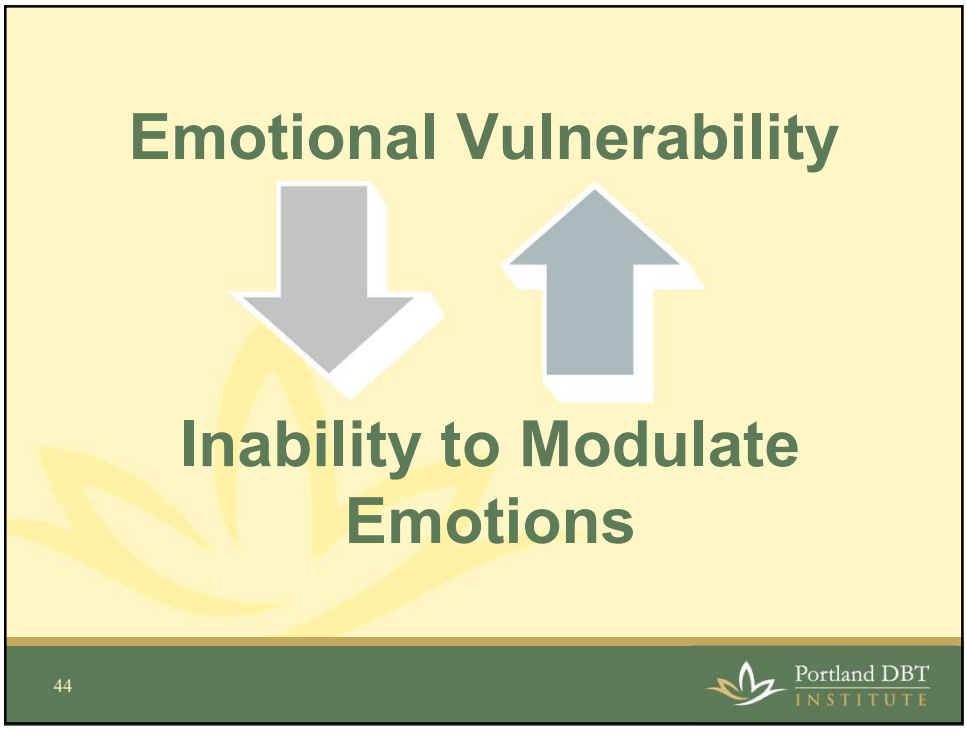

Emotion Vulnerability

- **High Sensitivity**
  - Immediate reactions
  - Low threshold for emotional reaction
- **High Reactivity**
  - Extreme reaction
  - High arousal dysregulates cognitive processing
- **Slow Return to Baseline**
  - Long lasting reactions
  - Contributes to high sensitivity to next emotional trigger

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Tasks in Emotion Modulation

1. Decrease or increase physiological arousal associated with emotion.
2. Reorient attention
3. Inhibit mood dependent actions
4. Organize behavior in the service of external, non-mood dependent goals.

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Linehan's Hypothesis

BPD results from **transaction** of biological vulnerability with invalidation over time.

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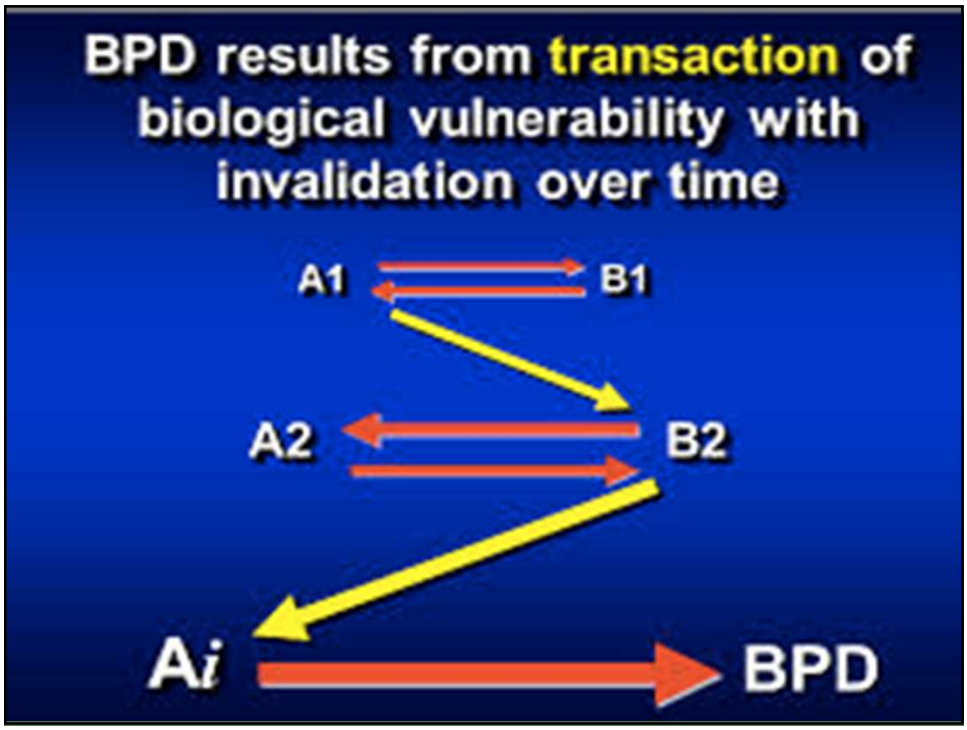

Invalidating Environment

***Pervasively* invalidates**

(punishes, negates, dismisses, ignores) behavior **independent of the actual validity** of the behavior

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Characteristics of an Invalidating Environment

1. INDISCRIMINATELY REJECTS communication of private experiences and self-generated behaviors
2. PUNISHES emotional displays and INTERMITTENTLY REINFORCES emotional escalation
3. OVER-SIMPLIFIES ease of problem solving and meeting goals

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Examples of Invalidating Responses

- Reject self-description as inaccurate
- Reject response to events as incorrect or ineffective
- Dismiss or disregard
- Directly criticize or punish

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Examples of Invalidating Responses

- Neglect
- Pathologize normative responses
- Reject response as attributable to socially unacceptable characteristic (e.g., over-reactive emotions, paranoia, naiveté, manipulative intent, lack of motivation, negative attitude, etc.)

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1. Consequences of Invalidating Responses

- Environment does not teach individual to:
  - Label private experiences in a manner normative in larger social community
  - Effectively regulate emotions
  - Trust experiences as valid responses to events
- Instead, environment teaches individual to:
  - Actively self-invalidate and search social environment for cues about how to respond

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2. Consequences of Intermittent Reinforcement of Escalated Emotional Displays

- Environment does not teach individual to:
  - Accurately express emotions
  - Communicate pain effectively
- Instead, environment teaches individual to:
  - Oscillate between emotional inhibition and extreme emotional styles

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3. Consequences of Oversimplifying

- Environment does not teach individual to:
  - –Tolerate distress
  - –Solve difficult problems in living
  - –Use shaping and other behavioral strategies to effectively self-regulate own behavior
- Instead, environment teaches individual to:
  - –Respond with high negative arousal to failure
  - –Form unrealistic goals and expectations
  - –Hold perfectionistic standards

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Factors That Increase Probability of an Invalidating Response

- Behavior is self-initiated (i.e., not under control of immediate environmental events)
- Behavior communicates private experience
- Behavior puts demand on environment above preferred level
- Environment has no readily available response to meet need communicated by emotional display and/or pain behavior
- Individual is different from others in environment

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Types of Invalidating Families

- Chaotic Family
- Perfect Family
- Ordinary Family

Think about a patient of yours

1. How might they have experienced pervasive invalidation in their home environment?

2. What are examples for how they may experience invalidation in treatment?

Rethinking BPD & the Biosocial Theory with Neuroscience

Implications for Case Conceptualization and Treatment Planning

What is DBT?

Dialectics

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Dialectical Philosophy

Teaches that:

- Everything and every person is connected in some way.
- Everything is made of opposing forces/opposing sides.
- Change is the only constant.
- Change is transactional

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Dialectics

Everything and Every Person is Connected in Some Way

- "What goes around comes around."
- The waves and the ocean are one.
- We are all connected to each other physically
- Each of us has parts (e.g., arms, legs, blood vessels, cells) and each of us is part of a greater whole
- Modern physics tells us that separation is an illusion

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Dialectics

Everything is Made of Opposing Forces or Sides

- "He who knows only his own side knows little of it."
- Balancing of opposites is walking the Middle Path.
- All people have unique qualities and different points of view
- It is important to let go of seeing the world in "black-or-white," "all-or-nothing" ways.
- Two things that seem like opposites can both be true

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Dialectics

Change is the Only Constant

- "You can't step in the same river twice."
- Even one vote changes the outcome.
- Meaning and truth evolve over time.
- Change is transactional.

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Dialectics

Change is Transactional

- "The doors we open and close each day decide the lives we live."
- When "A" influences "B" the change in "B" influences "A"
- We are allsimultaneously making (influencing) this moment.

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How a **Dialectical Perspective** helps

- Get unstuck during standoffs and conflicts with others
- Be more flexible and approachable
- Avoid blaming either ourselves or others for difficulties or problems
- Find the synthesis in opposing points of view
- Recognize that skills help learn how to "walk the middle path" in how we think and act.

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Dialectics in Action

- Looking for synthesis in apparent conflicts
- Requires finding something valid in other perspective (do not compromise or agree with invalid information)
- Opposite of adversarial
- NOT compromise and NOT autocratic
- Search for "what's left out"
- Agree on rules of the game (all players must agree to adopt dialectical position)

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A "How To" Guide for Thinking and Acting Dialectically:

Be Aware That You Are Connected

- Treat others as you wish them to treat you. Remember that if you are harsh, critical or invalidating, you will likely be treated the same way.
- Notice how your mood affects others around you, and how other people's moods affect you.

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A "How To" Guide For Thinking and Acting Dialectically:

Walk the Middle Path

- Fine tune and balance the opposites in your life e.g., balance accepting reality and working to change it; validating yourself and others and also pointing out errors; both working and resting.
- Practice looking at all sides of a situation. Find the kernel of truth in every side. .

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A "How To" Guide For Thinking and Acting Dialectically:

Walk the Middle Path

- Move away from extremes, such as "either-or" (to "both-and") "always," "never," (to sometimes) "you made me" (to concrete descriptions).
- Accept that different opinions can be valid even when you disagree.

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A "How To" Guide for Thinking and Acting Dialectically:

Embrace Change

- Allow those you care about to grow, develop, and change over time.
- Practice radical acceptance when people and relationships begin to change in ways you wish they wouldn't.
- Let go of clinging to the present; remember every moment is unique.
- Be patient with gradual changes; be prepared for sudden changes.

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A "How To" Guide for Thinking and Acting Dialectically:

Remember Change is Transactional

- Pay attention to the effect of what you do and say on others and how what they do and say affects you.
- Let go of blame by seeing your own and others' behaviors as arising from transactions occurring over time.

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Discussion

- Give one or two examples of when someone was operating from a non-dialectical perspective - that is, when they were "stuck" in an extreme way of seeing things.
  - Why was that a problem?
  - Can anyone generate an alternative position?

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Structuring Up DBT Treatment

DBT Treatment Modes & Functions
DBT Stages & Targets
Building a Life Worth Living

Structure the Treatment

Decide whom you will serve with DBT and where clients will receive it

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Standard DBT Modes

- Outpatient Individual Psychotherapy
- Outpatient Group Skills Training
- Telephone Consultation
- Therapists' Consultation Meeting
- Uncontrolled Ancillary Treatments
  - Pharmacotherapy
  - Acute-Inpatient Psychiatric

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DBT Treatment Functions

1. Enhance capabilities
2. Improve motivational factors
3. Assure generalization to natural environment
4. Structure the environment
5. Enhance therapist capabilities and motivation to treat effectively

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Residential Treatment Modes

- Individual DBT
- Group Skills Training
- Milieu Treatment
- Coaching on the Fly
- Consultation Team
- Egregious Behaviors Protocol
- Uncontrolled Ancillary Treatments
  - Pharmacotherapy

On an Index Card...

- Name of Team (at the top)
- Is your team DEVELOPING a new DBT program or STRENGTHING an existing team?
- What modes/functions does your team CURRENTLY offer?
- What modes/functions does your team plan to have in place by Part II?

If more than 1 program on team, do ONE CARD per program

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Structuring Treatment Team

DBT requires each **client to have one** (and only one) primary therapist.

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Role of Primary Therapist

Responsible for:

- Treatment planning
- Ensuring progress across treatment targets
- Ensuring success in other modes
- Consultation to patient on being effective consumer of care
- Management of suicide and other crises

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And every DBT therapist must have one primary DBT team

Team is responsible for:

- Helping plan/trouble-shoot treatment
- Monitor adherence to DBT
- Ensure progress toward DBT competence
- Consult to therapist on effective engagement with other MH networks, providers
- Provide support, particularly when limits stretched

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Function of
DBT Consultation Team

To enhance the capability and motivation of clinicians to treat complex, difficult to treat patients and to stay within the treatment frame through consultation practices.

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Structure the
GOALS of Treatment
by **Levels of Disorder**

DBT's Overarching Goal is

a life worth living

The path to a "Life Worth Living"…

…all depends on where you start

Levels of Disorder Dimensions

- Imminent threat
- Disability
- Severity
- Pervasiveness
- Complexity

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Levels of Disorder

Level 1: **Behavioral Dyscontrol**

Level 2: **Quiet Desparation**

Significant Psychopathology

Level 3: **Problems of Living**

Level 4: **Incompleteness**

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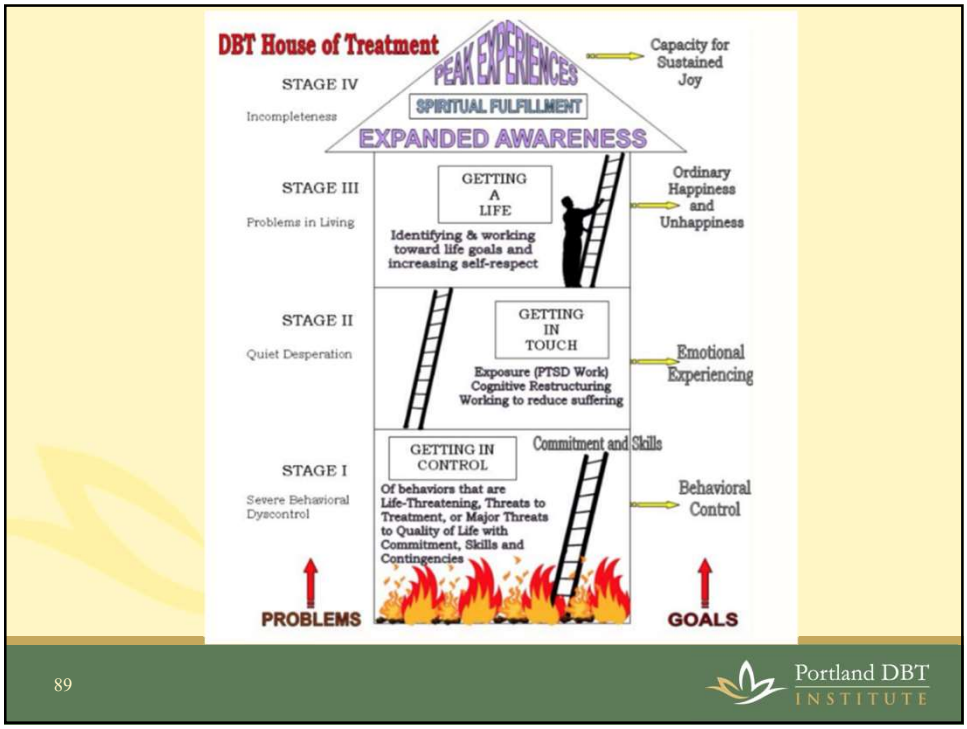

Level 1 Disorder: Behavior Dyscontrol

- Failures in survival and safety
- Severe disinhibition
- Severe "externalizing" disorders
- Incapacitating disorders
- Severe quality-of-life interfering behaviors

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Level 1 Disorder: **Behavior Dyscontrol**

Examples

- Life-threatening behaviors
  - Suicide attempt
  - Homicidal rage
- Florid psychosis
- Homeless heroin addict
- Catatonic depression

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Level 1 Disorder: **Behavior Dyscontrol**

- Imminent Threat
- Disability

} **One or both high**

- Complexity
- Pervasiveness
- Severity

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Level 2 Disorder: Quiet Desperation

–Severe neuroticism
–"Internalizing" disorders
–Sense of safety

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Level 2 Disorder: Quiet Desperation

Examples

–PTSD
–Maladaptive bereavement
–BPD

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Level 2 Disorder: Quiet Desperation

- Imminent Threat
- Disability
- Complexity
- Pervasiveness
- Severity

} **Low**
Low-Moderate
One or both high

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Level 3 Disorder: Problems in Living

Examples

- Uncomplicated, circumscribed Axis I disorder (e.g., *panic, OCD, depression, eating disorder*)
- Marital problems
- Career problems

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Level 3 Disorder: Problems in Living

- Imminent Threat
- Disability
- Complexity

} **Low**

- Pervasiveness — **Low-Moderate**
- Severity — **Low-High**

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Level 4 Disorder: Incompleteness

Examples

- "Existential" concerns
- Emptiness
- Malaise/meaninglessness
- Spiritual dryness
- Loneliness/non-attachment

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Level 4 Disorder: Incompleteness

- Imminent Threat
- Disability
- Complexity

} **None**

- Pervasiveness — **Low-High**
- Severity — **Low-High**

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Stages of Treatment

Pre-Treatment: → ***Commitment and Agreement***

Stage 1: Severe Behavioral Dyscontrol
→ **Behavioral Control**

Stage 2: Quiet Desperation
→ **Emotional Experiencing**

Stage 3: Problems in Living
→ **Ordinary Happiness /Unhappiness**

Stage 4: Incompleteness
→ **Capacity for Joy and Freedom**

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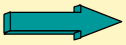
Structure the Primary Treatment Targets

in hierarchical order by importance and grouped by level of disorder

Stage 1 Primary Targets

Dialectical Synthesis

Pre-Treatment:  Commitment & Agreement

- Decrease
  - Life-threatening behaviors
  - Therapy-interfering behaviors
  - Quality-of-life interfering behaviors
- Increase behavioral skills using DBT skills (Mindfulness, Distress Tolerance, Emotion Regulation, & Interpersonal Effectiveness) as well as other behavioral skills.

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Suicidal and Life Threatening Behaviors

- **Suicidal and Life-Threatening Crisis Behaviors** (indicates risk of imminent suicide, suicide attempt, homicide, and serious aggression)
- **Non-suicidal self-injury (NSSI)**
  - Intent to cause harm to self
  - Deliberate action
  - Acute Injury (tissue damage, ingests poisons or drugs over reasonable prescription; serious risk without outside intervention)

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Therapy-Interfering Behaviors (Patient)

1. **Behaviors that interfere with receiving therapy**
   - Non-collaborative behaviors
   - Non-compliance
   - Non-attending behaviors
2. **Behaviors that interfere with other patients**
3. **Behaviors that burn out therapist**
   - Behaviors that push therapist's limits
   - Behaviors that reduce therapist's motivation to treat

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Therapy-Interfering Behaviors (Therapist)

1. **Behaviors that unbalance therapy**
   - Extreme acceptance or change
   - Extreme flexibility or rigidity
   - Extreme nurturing or withholding
   - Extreme vulnerability or irreverence
2. **Disrespectful behaviors**

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Quality of Life Interfering Behaviors

- Incapacitating DSM-V disorders
- Unemployment
- High risk or unprotected sex
- Extreme financial problems
- Criminal activities
- Severe interpersonal dysfunction
- Physical, medical problems
- Homelessness, unstable, unsafe housing
- Intimate partner violence

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Stage 1 Primary Targets: Order it Up

- Used cocaine 1x in past week (but didn't use meth, drug of choice)
- Urges to kill self (4 on 5 point scale)
- Threw up (intentionally)
- Parents burned out and are an inch away from sending client to rural south to be with grandparents
- Intentionally cut self ("just a scratch")
- Disruptive in group and rolls eyes when Client B is sharing
- Hit the wall causing physical damage when staff said "no" to request for cigarette break.
- Frequent flashbacks during the week (a janitor looks like client's perpetrator)
- The new resident and your client have a violent, extremely

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DBT Skills Training TARGETS

- DECREASE behaviors likely to **destroy** therapy.
- INCREASE skills acquisition & strengthening
  - Mindfulness, Emotion Regulation, Interpersonal Effectiveness, Distress Tolerance
  - Self-Management
- DECREASE therapy-interfering behaviors

(Question: How is this similar to/different from DBT standard targets for Stage 1 clients? What is the rationale?)

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DBT Phone Coaching Targets

- **INDIVIDUAL THERAPIST:**
  - DECREASE suicide crisis behaviors
  - INCREASE generalization of DBT skills
  - DECREASE sense of conflict, alienation, & distance with therapist.
- **SKILLS TRAINER**:
  - DECREASE therapy destructive behaviors
  - INCREASE immediate contacting of primary therapist

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Phone Coaching 101

DBT Secondary Targets
Stage I BPD Clients

Behavioral patterns that interfere with your ability to effectively treat the primary targets.

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DBT Secondary Targets
Stage I BPD Clients

DBT selects secondary targets by their positions and functions on the chain analysis of most significant problem behaviors.

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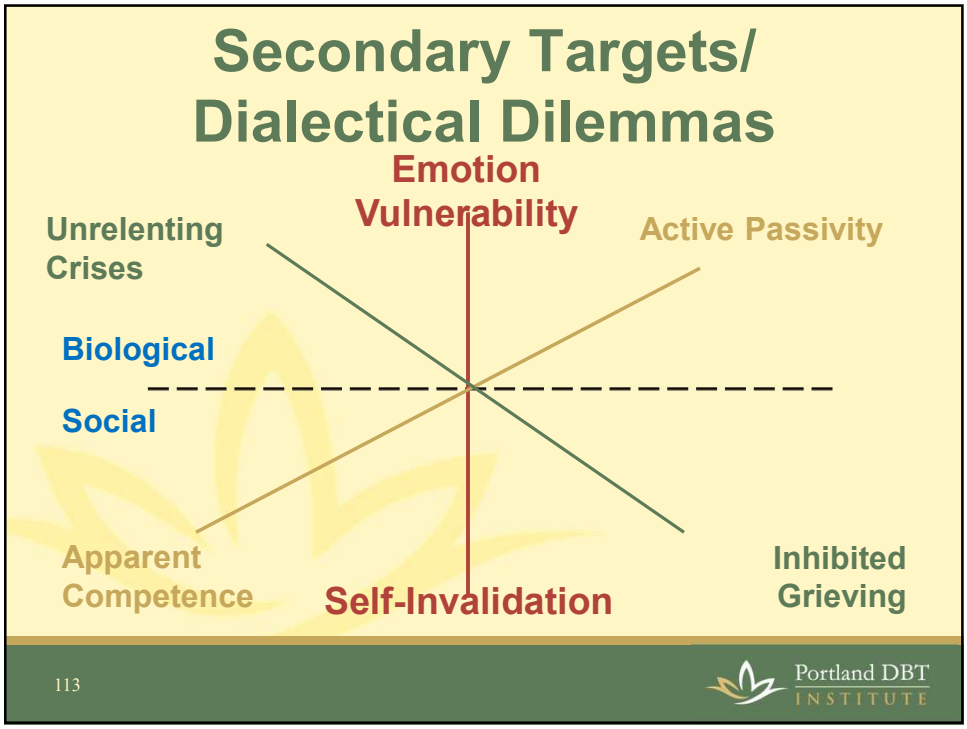

DBT Secondary Targets

INCREASE	DECREASE
• Emotional modulation • Self-validation	• Emotion reactivity • Self-invalidation
• Realistic judgment	• Crises generating behaviors
• Emotional experiencing	• Grief inhibition
• Active problem-solving • Accurate Expression	• Active-passivity • Apparent competence

Stage 2 Primary Targets
Dialectical Synthesis

Quiet Desperation → Emotional Experiencing

Primary Target: Decrease Post-Traumatic Stress Response

- Distortion/denial of facts of trauma
- Stigmatization, self-invalidation
- Denial/avoidance of traumatic cues
- Dichotomous response style

Goals:

- Non-traumatizing emotional experiences
- Connection to the environment

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Stage 3 Primary Targets
Dialectical Synthesis

Problems in Living → Ordinary Happiness & Unhappiness

Primary Target: Decrease Post-Traumatic Stress Response

- Increase respect for self
- Decrease individual problems in living

Goals:

- Self-respect (mastery, self-efficacy), sense of morality

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Stage 4 Primary Targets
Dialectical Synthesis

Incompleteness → Capacity for Sustained Joy

Primary Target:

- **Expanded Awareness** (self, past to present, self to other)
- **Peak Experiences/Flow**
- **Spiritual Fulfillment**

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Pre-Treatment:
Getting the Commitment & the First Four Sessions

Getting Started with Pre-Treatment

DBT requires clear, voluntary, and fully informed agreement before starting treatment of any sort.

1. Commitment to Change: Therapist & Client agree on treatment goals and approach
2. Agreement to Treatment: Therapist & Client agreements
3. Agreement to Therapist-Client Relationship

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Patients' Agreements in Standard DBT

- Stay in therapy for specified time period
- Attend scheduled therapy sessions
- Work towards changing targeted behaviors
- Work on problems that arise in therapy that interfere with its progress
- Participate in skills training for specified time period (Stages 1 & 2)
- Abide by clinic and financial policies

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Therapists' Agreements in Standard DBT

- Make every reasonable effort to conduct competent and effective therapy
- Obey standard ethical and professional guidelines
- Be available to patient for weekly therapy sessions, phone consultations, and provide as needed therapy back-up
- Respect the integrity and rights of the patient
- Maintain confidentiality
- Obtain consultation when needed.

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Motivation and Engagement Strategies

- Linking to Goals
- Validation
- Commitment Strategies

Commitment Strategies

pp. 284-291

- Selling commitment: evaluating the pros and cons
- Playing the devil's advocate
- Foot-in-door and door-in-the-face techniques
- Connecting present commitment to prior commitments
- Highlighting freedom to choose and absence of alternatives
- Shaping

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Commitment Tips for Your Back Pocket

- *All things being equal, if you could give up X, would you want to?*
- *If I have a magic wand in my pocket and could magically take away X, would you want me to?*

Remember:

1. **Take what you can get; get what you can take.**
2. **Shake it up with stylistic strategies; oscillate intensity**
3. **Movement, speed, flow**

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What's Needed in FIRST FOUR Sessions?

- Overall philosophy: *Skills over pills.*
- Introduce C to other modes, biosocial theory, BPD (if they have it).
- Orient to the DBT Diary Card and get them using it.
- And…Establish ***Treatment Expectations***
  - What are they?
  - Why do they matter?

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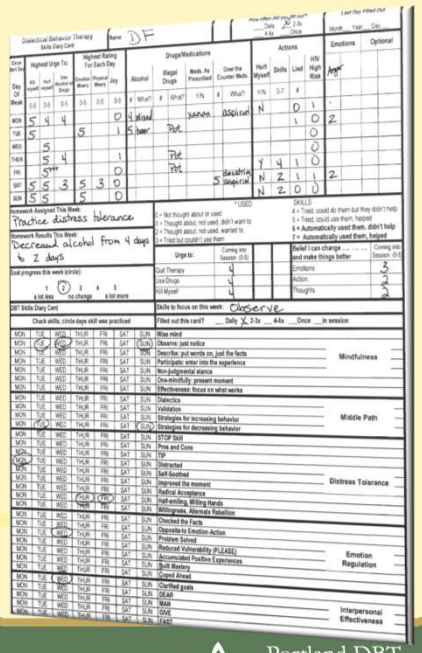
DBT Diary Card

DBT Diary Card

- What should be on it?
- What's it's value/purpose?
- How do you use it in milieu setting with youth?
- How do you overcome obstacles?



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DBT Diary Card Essentials

- Purpose
- What to include
- When and how do I use it?
  - Review out loud
  - Review strategically with eye to targets
  - Be mindful to YOUR behavioral response when

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Common Objections to Diary Card

- C doesn't want to use it.
- C can't use it (e.g., *it's too complex*; *C is too dysfunctional*)
- *I am tired of battling its use with my client.*

Others?

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Validation

Defining Validation

The action of validating or making valid; a strengthening, reinforcing, confirming; establishing something as valid.

Confirming

Authenticating

Verifying

Substantiating

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Important Constructs to Validate

Particularly for those with BPD

Problem Importance

Task Difficulty

Emotional Pain

Sense of Being Out-of-Control

Self-Dysregulation

Location Perspective

Wisdom of Ultimate Goals

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Functions of Validation

- To strengthen clinical progress
- To dialectically balances change
- To strengthen self-validation
- As feedback
- To strengthen the therapeutic relationship
- ***To strengthen individual's capacity to see, know, & rely on inner wisdom (i.e., Wise Mind).***

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Types of Validation

Explicit (verbal)

Implicit (functional)

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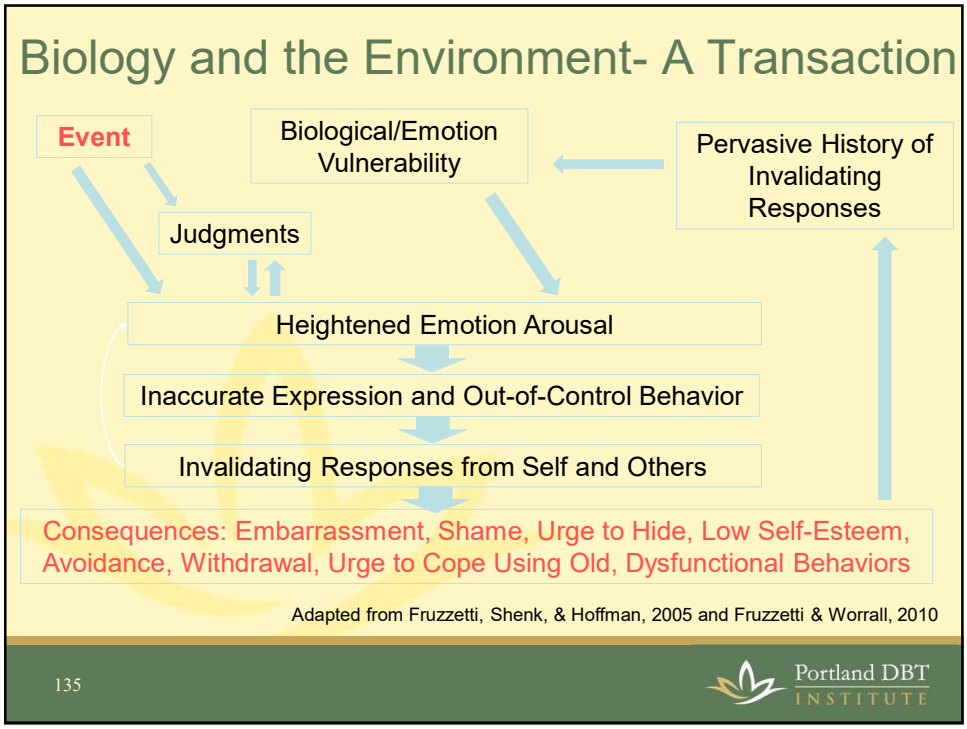

Validation Strategies

3. **Cognitive**
   - Elicit and reflect thoughts & assumptions
   - Find the "kernel of truth"
   - Acknowledge "Wise Mind"
   - Identify and respect one's own values

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Cheerleading Strategies

- Assume the best
- Actively encourage
- Focus on strengths/capabilities/successes
- Contradict/modulate external criticism
- Be realistic
- Stay near

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Levels of Validation

1. **Staying Awake**: Unbiased listening & observing
2. **Accurate Reflection**
3. **Mind-Reading**: Articulating the unverbalized thoughts, emotions, behavioral patterns
4. Validation in terms of **past** learning or biological dysfunction.
5. Validation in terms of **present** context or **normative** functioning
6. **Radical Genuineness**

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What Makes Validation Difficult?

- Severe individual distress and disorder
- Bad habits, patterns, etc.: forgetting that this is a person you actually care about
- Judgments (right/wrong, should/shouldn't)
- Negative emotions (anger!)
- Poor (inaccurate) self-expression
- Lack of understanding
- Poor conflict management skills
- Lack of acceptance

DBT as Cognitive Behavioral Therapy & Problem Solving

Standard Problem Solving Used in DBT

Behavioral Analysis
Insight
Solution Analysis

Skills Training

Contingency Management

Exposure

Cognitive Modification

Didactic
Orientation
Commitment

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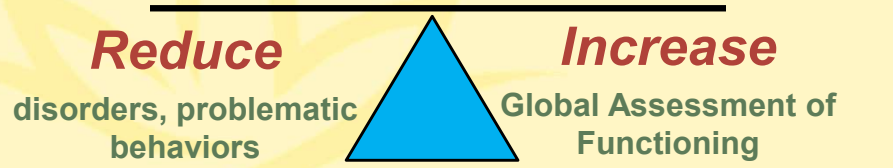
DBT Treatment Plan

1. Solves the problems that interfere with C having/keeping a LWL,
2. Works strategically & systematically to help C build a LWL.



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The Game Plan

Chain Analysis = *Moment by Moment Analysis of Events Over Time*

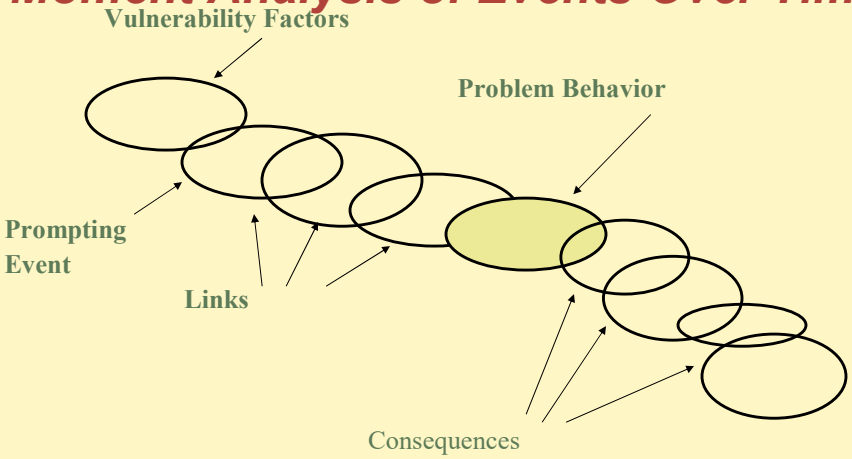

Figure out the problem: **Behavioral Analysis**

- Define problem as behavior (with focus on emotion)
- Conduct chain analyses

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Fundamentals for Behavioral Analysis

- ***What is a behavior?*** Anything a person does (public or private) including thinking, feeling, acting.
- ***What are the elements used to describe a behavior?*** Frequency, intensity, duration, topography
- ***How can you define a behavior?*** Excess, deficit, faulty stimulus control (e.g., behavior shows up in wrong context, or doesn't show up in context where it's needed).

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• Define problem behavior • Behavioral chain analysis • Hypothesis generation • Insight • Solution analysis • Orienting strategies • Didactic strategies • Commitment Strategies	Lacks needed skills	Skills training
	Emotions interfere	Exposure
	Contingencies interfere	Contingency management Observing limits
	Cognitive content or processes interferes	Cognitive modification

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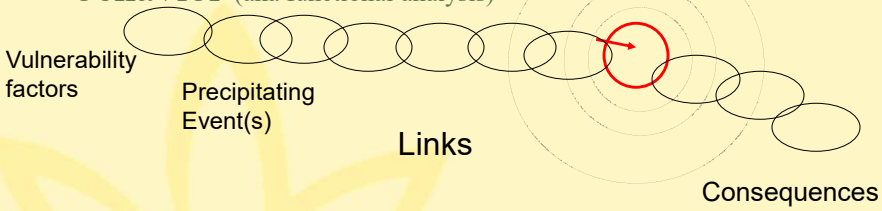
Treating the Primary Behavioral Targets

A chain analysis is conducted each time a target behavior occurs

- Identify controlling variables for targeted behavior (aka functional analysis)



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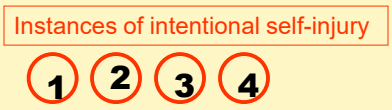
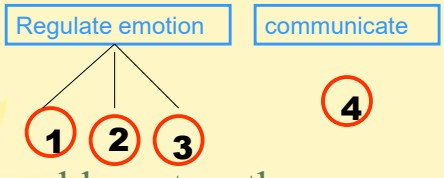
Building an Understanding in order to SOLVE the Problem(s)

- **Chain Analysis:** specific instance of behavior



- **Behavioral Analysis**: classes of behavior



- **Case Formulation** link problems together

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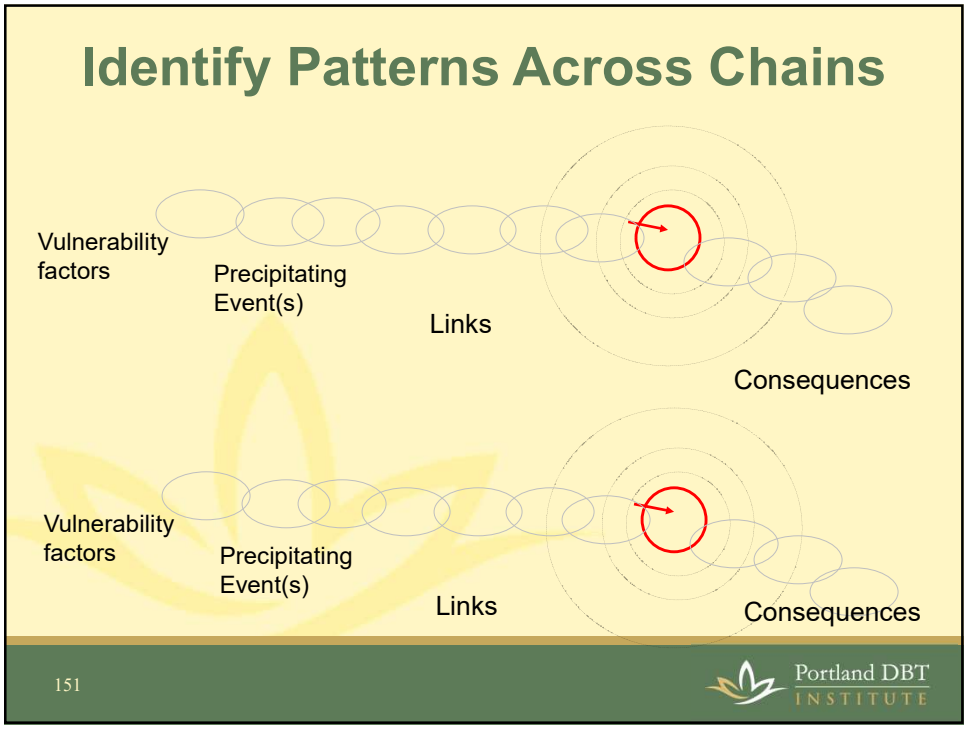


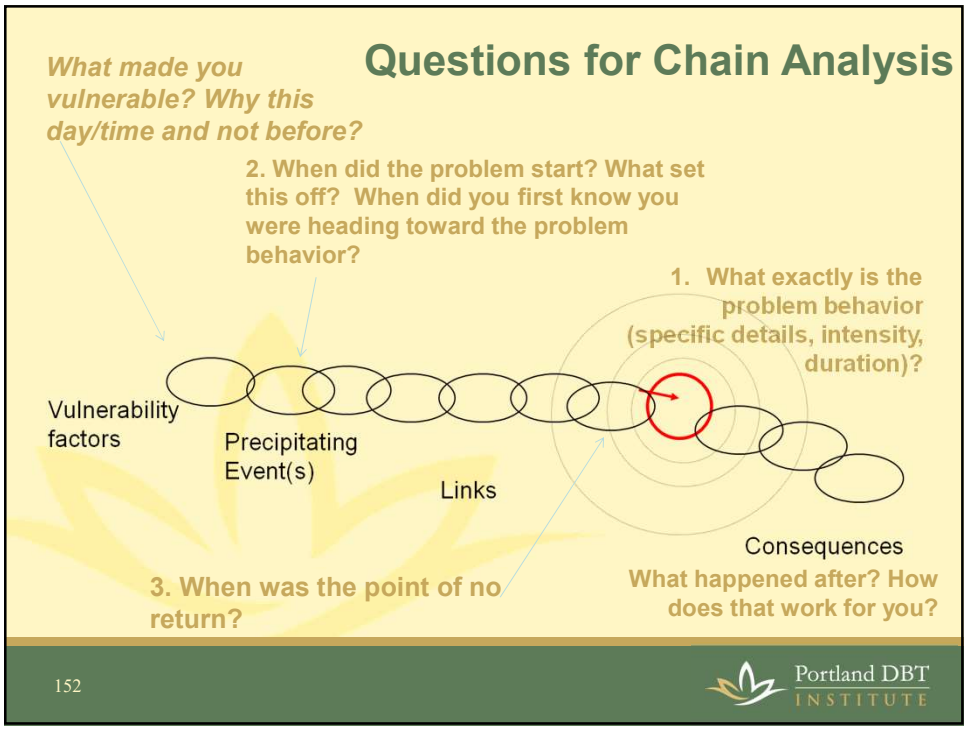
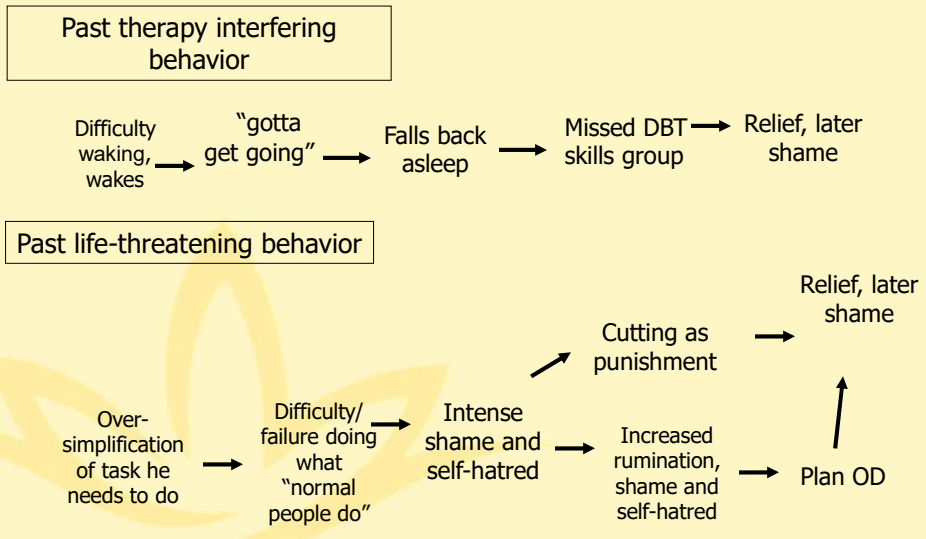


Figure 3.1 "Michael": past functional analyses of target behaviors (Koerner, 2011)



Which Variables Control the Behavior?

- **Classically conditioned** (respondent) behaviors?
  - Behaviors learned under the control of the stimulus (i.e., a conditioned stimulus).
- **Instrumental (Operant)** behavior?
  - Learned behaviors that are under the control of the consequences.

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Classical Conditioning Examples

Attack	Alley	Fear
Drugs	Bathroom	High
Nurturing	Hospital	Seeking
Nausea	Bathroom	Vomiting
Urge to cut	Razor	Cutting
Car accident	Car	Fear

Examples of S-S Problems

- A neutral stimuli (e.g., men in baseball caps) is associated with an aversive stimuli (e.g. physical abuse).
  - Max avoids men in baseball caps.
- A positive stimuli (e.g., being with son) is associated with an aversive stimulus (e.g., intensive guilt).
  - Lisa avoids contact with son.
- An aversive stimuli (involuntary hospitalization) is associated with a positive stimuli (e.g., nuturance).
  - Maria works to get into the hospital.

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Instrumental/Operant Conditioning

Learned behavior that is under the control of the consequence.

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Instrumental/Operant Conditioning

A Antecedent/Trigger/Cue

B Behavior

C Consequence

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Principles of Learning: REINFORCEMENT

Consequences that in general result in an INCREASE in a behavior in a particular situation.

Positive Reinforcement

Increases probability of a behavior by providing positive consequence.

Negative Reinforcement

Increases probability of a behavior by removing or stopping an aversive stimulus.

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Principles of Learning: PUNISHMENT

Consequences that in general result in a DECREASE in a behavior in a particular situation.

Positive Punishment

Decreases probability of a behavior by providing an aversive consequence.

Negative Punishment

Decreases probability of a behavior by removing or stopping a positive stimulus.

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More Operant Conditioning

	Increase Behavior	Decrease Behavior
Positive Stimulus	Positive Reinforcement Add Positive	Response Cost Remove Positive
Negative Stimulus	Negative Reinforcement Remove Aversive	Punishment Add Aversive

Unpacking Negative Reinforcement

Example 1: Distracting yourself with your car radio

Negative stimulus: A scary warning light (or sound) on your dashboard

Behavior: You turn up the radio which distracts you from the light (or sound)

This is *negative reinforcement*- you are being rewarded for a behavior (turning up the radio) by the removal of something you don't like (the warning light/sound). You are now more likely to use the radio again when a warning light comes on

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Unpacking Negative Reinforcement

Example 2: Ruminations and suicidal ideation

Negative stimulus: A text message from your partner rejecting or breaking up with you which prompts a strong abandonment response

Behavior: You think over and over again about suicide (or another rumination)

This is *negative reinforcement*- you are being rewarded for a behavior (suicidal ideation/ruminating) by the removal of something you don't like (feeling abandoned). You are now more likely to use suicidal ideation or rumination when feeling abandoned in the future

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Unpacking Classical Conditioning

Example 1: The stomach flu and cherry cough drops

Unconditioned Stimulus

Stomach flu

Unconditioned Response

Nausea

Conditioned Stimulus (taking cough drops a lot while having the stomach flu)

So then… after the flu is over…

Conditioned Stimulus

Conditioned Response

Nausea

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Unpacking Classical Conditioning

Example 2: Therapy and diary cards

Unconditioned Stimulus

Previous therapy

Unconditioned Response

Dysregulation

Conditioned Stimulus (diary card presented frequently during dysregulation)

So then… after therapy is over…

Conditioned Stimulus

Conditioned Response

Dysregulation

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Principles of Learning

Extinction

Reduction in the likelihood of a behavior because reinforcement is no longer provided in a particular situation.

Extinction Burst

Temporary INCREASE in frequency & intensity of a behavior when reinforcement is withdrawn.

Shaping

Process of reinforcing successive approximations in the direction of the desired behavior.

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Insight Strategies

- Highlight clinically relevant variables.
- Observe & describe reoccurring patterns.
- Comment on implication(s) of behavior.

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Understanding and insight into a behavior is unlikely to change it.

Standard Problem Solving Used in DBT

Behavioral Analysis

Insight

Solution Analysis

Skills Training

Contingency Management

Exposure

Cognitive Modification

Didactic

Orientation

Commitment

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Solution Analysis Strategies

- Identify goals, needs, desires.
- Generate solutions
- Evaluate solutions
- Choose solution to implement
- Troubleshoot the solution
  - Identify where it will break down, not work.
  - Then solve that problem.

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Task Analysis: From Goals to Solutions

Identify specific behaviors required to skillfully achieve a goal; break it down into specific steps or components.

1. Identify desired behavior/outcomes
2. Identify required behaviors to achieve outcomes
3. Identify behaviors necessary for adapting to obstacles along the way.

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Task Analysis: Finding the Information You Need

1. **Models**
   - Identify people who have met the goal, have the behavior.
   - In social environment, books, films
2. **Psychology**

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Options for Responding to Problems

1. Solve the problem
2. Change emotional reaction to the problem
3. Tolerate/accept the problem
4. Stay miserable

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Skills Training Procedures

Skills acquisition
Skills strengthening
Skills generalization

Skills Acquisition Procedures

- Instruct
- Model
  - Therapist models
    - Self-involving modeling
    - Demonstrating; role-playing
    - Self-disclosure modeling
  - Participant modeling
  - Models in social environment, books, media, stories

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Skills Strengthening Procedures

- Rehearse behavior
  - Describe new behavior
  - Covert rehearsal
  - Role playing
  - Staging a practice
- Reinforce new skills
  - Natural
  - Arbitrary

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Skills Generalization Procedures

It is your responsibility to ensure that your client can use the new skill in all relevant contexts.

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Skills Generalization Procedures

- Program generalization
  - Relate in-session behavior to outside life.
  - Troubleshoot obstacles that may interfere with transfer.
- Consult to C in between sessions.
- Provide audio recordings of sessions to review *in vivo.*
- Assign C homework that involves behavioral rehearsal.
- Change the environment
  - Community reinforcement approach

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Contingency Management

Contingency Management

- Positive reinforcement
- Negative reinforcement
- Extinction
- Punishment

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Manage Contingencies Well

- Reinforce target-relevant adaptive behavior (clinically relevant behaviors)
  - Immediate vs. delayed
  - Continuous vs. intermittent

  } How do you decide which to use when?
- Extinguish target-relevant maladaptive behaviors
  - Find an alternative response to reinforce
  - Soothe
- Provide aversive consequences *with care.*
  - Withdraw warmth
  - Correction/Over-correction
  - Vacation from therapy
  - Termination as a last resort

  } In collaboration with consultation team.

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Use Contingency Management Strategically

- Assess the potency of consequences.
- Pay attention to satiation.
- All things being equal, select natural over arbitrary consequences; if arbitrary reinforces *are* used, transition them to natural.
- Shape new behaviors.

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Observe Your Own Limits

- Be mindful of and monitor your limits.
- Be honest to C and team about your limits.
- Strategically extend your limits, if needed, and temporarily.
- Be consistent and firm with respect to your limits.
- Soothe, validate, & problem-solve when your limits cause your client anguish or frustration.

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Correct/Overcorrect

Start correction/over correction:

What was the harm of the behavior and how can you go about correcting it?

Some ideas: a letter of apology, making commitments and following through and repairing what was damaged, or completing a project that has been created by staff.

Egregious Behaviors Protocol

A special application of
contingency management

Egregious Behavior Protocol (EBP) Steps

1. Programming stops until EBP is completed.
2. Resident undertakes work on BCA
   - Uses worksheet
   - Works on it alone for 2 hours
3. Resident presents to staff, including solutions generated.
   - Resident practices skills with staff
   - Resident makes commitment to use

Egregious Behavior Protocol (EBP) Steps

4. Staff evaluates BCA/EBP. If acceptable, signs off.
5. Resident resumes regular programming.
6. Behavioral analysis is covered in detail in next counseling session.
7. Target behaviors (to decrease and increase) are identified and added to the youth's treatment plan.

Exposure Principles, Procedures & Therapy

Working with Classically Conditioned Responses

- Change the Cue
  - Problem solving (get rid of the cue)
  - Stimulus Control (modify presentation of the cue)
- Change the Response to the Cue
  - Non-reinforced exposure
  - Response prevention
  - Opposite Action

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Exposure Principles in a Nutshell

Cue Exposure

Response Prevention

Opposite Action

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Exposure Principles

- Orient:
  - Will feel worse before feeling better; validate how difficult it is; distinguish between masking emotions and changing emotional expression.
- Provide non-reinforced exposure:
  - Present & do not remove the cue.
- Block action tendencies & use of safety cues associated with the problem emotion:
  - Leaving topic or session when emotion increases; using drugs before session).

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Exposure Principles

- Block expressive tendencies associated with the problem emotion
  - Client experiences intense shame, so slumps in chair, avoids making contact.
  - Clients yells at and verbally attacks therapist when T encourages continued engagement with the stimulus.
- Enhance control over aversive events using Opposite Action
  - Reinforce using skills
  - Improving Quality of Life

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Cognitive Modification

Clarify Contingencies

- **Clarify current contingencies**
  - Highlight consequences as they occur
  - Use self-involving self-disclosure
- **Clarify future contingencies in life**
  - Provide realistic, accurate information
- **Clarify future contingencies in therapy**
  - Highlight/observe your own limits.

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Clarify Restructuring

- **Teach cognitive self-observations**
  - Self monitoring
- **Identify and confront maladaptive or erroneous cognitive content and style**
  Cognitive distortions, irrational beliefs; interpretations without checking the facts.
- **Generate alternative adaptive cognitive content and style**
- **Develop guidelines for when to trust perception and when to suspect myopic/inaccurate cognitions**
  - Highlight/observe your own limits.

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Basis for Cognitive Restructuring

- **Empirical Evidence**
  - Develop experiments to evaluate accuracy of beliefs.
- **Logical consistency**
  - Examine beliefs for logical consistency/inconsistency.
- **Consistency with true beliefs (i.e., Wise Mind)**
  - *Is this belief what I believe when I am calm and in Wise Mind?*
- **Effectiveness**
  - Is it effective for me to hold this belief?

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Didactics, Orienting, & Commitment

Didactic Strategies

- Provide facts
- Give reading materials
- Give information and resources to family members

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Orienting Strategies

Communicate treatment plan, rationale, & approach so C can make an informed decision & fully collaborate.

- **Role Induction**
  - Describe the general task
  - Link rationale/necessity to C's goals
  - Link to specific expectations/behaviors required by C.
- **Rehearse new expectations**

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Commitment Strategies

pp. 284-291

- Selling commitment: evaluating the pros and cons
- Playing the devil's advocate
- Foot-in-door and door-in-the-face techniques
- Connecting present commitment to prior commitments
- Highlighting freedom to choose and absence of alternatives
- Shaping

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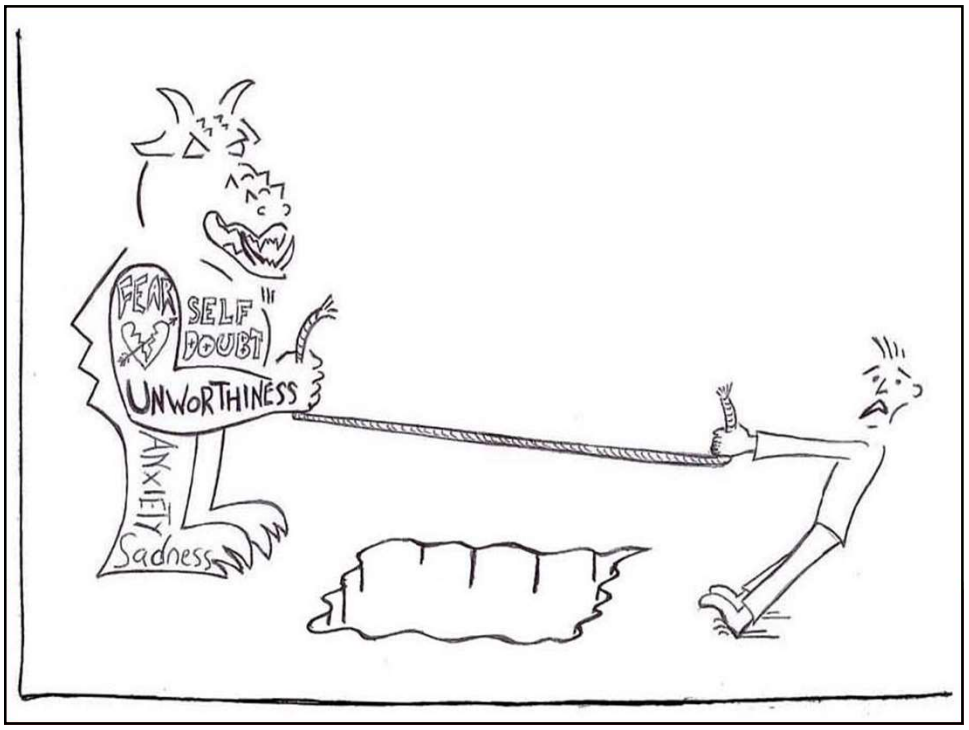
Dialectical Strategies and Stylistic Strategies



Dialectical Strategies

- Balances treatment strategies
- Entering the paradox
- Metaphor
- Devil's advocate
- Extending
- "Wise Mind"
- "Lemonade out of lemons"
- Allowing Natural Change
- Dialectical Assessment

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Stylistic Strategies

Define *how* we apply all treatment strategies

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Irreverent Communication

- Reframing communication in an unorthodox, off-beat manner.
- Plunging in where angels fear to tread.
- Using a confrontational tone.
- Calling client's bluff.
- Oscillating intensity
- Expressing omnipotence and impotence.

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Reciprocal Communication

- **Responsive**
  - Staying awake
  - Taking Cs agenda seriously
  - Responding to the "manifest" (vs. latent) content of C's communication
- **Self-Disclosure**
  - Orients C to T's use of personal disclosure
  - Self-Involving Self-Disclosure
  - Personal disclosure
- **Warm engagement**
- **Genuineness**

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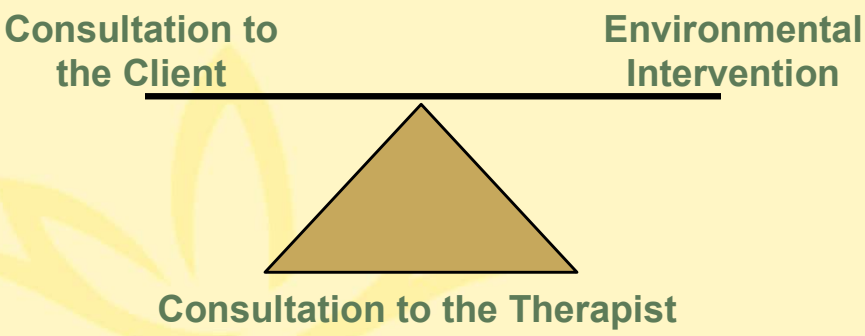
Consultation Strategies vs. Intervening in Environment



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When to Intervene in the Environment

Intervene in the environment

when the short term gain is worth the long term loss in learning.

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Conditions Mandating Environmental Intervention

- When C is unable to act on his/her own behalf and the outcome is very important.
- When the environment is intransigent & high in power.
- To save C's life or avoid substantial risk to others.
- When it is the humane thing to do & will cause no harm.
- When C is a minor.

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Environmental Intervention Strategies

- Provide information to others independent of C.
- Advocate for C.
- Enter C's environment to provide assistance, as is needed.

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Consultation to the Patient

The DBT therapist's primary role is to consult to C about how to effectively manage his/her environment (e.g., social, professional, personal), and *not to consult to the environment about how to manage the client*.

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Consultation to the Patient Strategies

- Orient C and network to this approach.
- Consult to C about how to manage other professionals
- Consult to C about how to manage others within his/her environment.

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Corollaries of Consultation to the Patient

- Give other professionals generic information about DBT and the therapy program.
- Do not discuss C or C's treatment without C present (except on the team or in supervision).
- Within the team, share information as needed while honoring spirit of this strategy.
- Do not tell other professionals how to treat C.
- Teach C how to act as his/her own agent.
- Do not intervene or solve problems for C with other professionals.
- No not defend other professionals.

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DBT Consultation Team

A community of clinicians treating a community of clients

Behavior Therapy	Zen Practices
• Change	• Acceptance
• Problem solving	• Validation
• Rationality & empiricism	• Intuition
• Logic	• Paradox
• Experimental	• Experiential
• Doing	• Being

Principles of Zen Practice

- All individuals and reality as a whole are one; boundaries are a delusion.
- Everything is as it should be.
- Attachment is at the root of suffering
- Reality as a whole are impermanent
- All individuals have an inherent capacity for enlightenment and truth.
- The essential experience is that form is empty, and therefore self is empty (and at the same time one).

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Zen Practice

- Be mindful to the present moment.
- See reality as it is without delusions.
- Accept reality without judgment.
- Let go of attachments that obstruct seeing and accepting reality
- Use skillful means
- Find the middle path

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Zen Community

- Conducted within a context of a community and in relationship with a teacher.
- A student only practices alone after essential experiences are validated by a recognized master of Zen.
- Students return to the teacher and community for retreats.

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DBT is the Treatment of a **Community of Clients** by a **Community of Therapists**

Function of DBT Consultation Team

Function

To enhance therapists' motivation and capabilities to effectively treat DBT clients & to stay within the frame.

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Team Agreements

- To accept a dialectical philosophy.
- To consult with C on how to interact with other therapists and not to tell other therapists how to interact with C.
- Consistency of therapists with one another (even with same C) is not necessary or expected.
- Therapists are to observe their own limits without fear of judgmental reactions from other consultation team members.
- To search for non-pejorative, phenomenological empathic interpretation of C's behavior.
- Therapists are fallible.

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DBT Consultation Team BASICS

- Team leader vs. meeting leader vs. no leader.
- Roles
- Logistics
  - Who should attend?
  - How often should you meet?
- Depth vs. breadth
- How do we bring on new people to team?

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DBT Consultation Team BASICS

- Team leader vs. meeting leader vs. no leader.
- Roles
- Logistics
  - Who should attend?
  - How often should you meet?
- Depth vs. breadth
- How do we bring on new people to team?

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DBT Consultation Team BASICS

- Strategies for Consulting
  - Determine what specifically T needs (e.g., help figuring out the treatment plan, needs validation/emotional support).
  - Define and assess the problem behaviorally.
  - Once there is agreement on the problem, treat it using the same DBT strategies, principles used with clients (e.g., problem-solving, validation, acceptance).
  - Be mindful of time.

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DBT Consultation Team BEYOND the Basics

- Look for & address “Elephants in the Room”.
- Know your team mates’ Clinically Relevant Behaviors (CRBs)
- Take an active approach doing those activities that nurture and help maintain capacity for honesty & intimacy on your team.

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DBT Consultation Team BEYOND the Basics

- When is the problem one that must be addressed individually by the clinician (vs. in team)?
- What do you when a client is not improving (or is deteriorating), but your colleague is not seeking help?
- What do you do if you have reason to believe your colleague is behaving unethically with a client and/or is impaired?

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Consultation-to-the-Therapist Strategies

- Meet to confer on treatment.
- Keep supervision and consultation agreements.
- Cheerlead each other.
- Provide dialectical balance.

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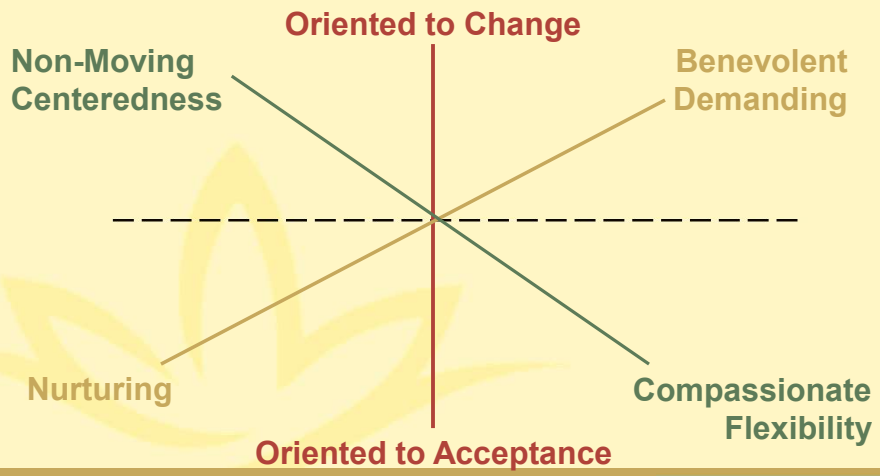
Therapist Characteristics



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Free Write Exercise

My Inner Most Thoughts & Feelings about…

1. Fully participating (i.e., being emotionally vulnerable) with my consultation team?
2. Whether there are "elephants-in-the-room"? (if there are elephants, what are they?).
3. My greatest aspirations for my consultation team.
4. What's needed to achieve my greatest aspirations.

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DBT Skills Training 101

Basics for Running an Effective DBT Skills Class

Rule #1

Structure Up Your DBT Skills Training Class & Stick to It

(even if you don't want to).

DBT Skills Training TARGETS

- DECREASE behaviors likely to **destroy** therapy.
- INCREASE skills acquisition & strengthening
  - Mindfulness, Emotion Regulation, Interpersonal Effectiveness, Distress Tolerance
  - Self-Management
- DECREASE therapy-interfering behaviors

(Question: How is this similar to/different from DBT standard targets for Stage 1 clients? What is the rationale?)

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Practical Issues to Consider

- Co-leader Selection
- Individual vs. Group Format
- Open vs. Closed Group
- Treatment Module Cycle
- Order of Modules
- Heterogeneous vs. Homogeneous Group
- Role of Individual Therapy & Therapist in Skills Training

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Scheduling/Planning Group

- Plan to have 2 rotations through skills
  - Six months each rotation x 2 rotations = 1 year!
- One Module = 8 weeks total
  - Two weeks of mindfulness
  - Six weeks of primary topic (ER, IPE, DT)
- Open group to new members the first 4 weeks of a new module, then close for 4 weeks.
- Know/communicate clearly end of group date.

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Tips for Starting a DBT Skills Training Group

- Individual therapist first orients C to mode & purpose and introduces C to group leader.
- Group leader meets with C individually before starting gets group-specific commitments from C using DBT Commitment Strategies
  - Come to group on time, every week.
  - Do homework between sessions
  - Be solid citizen as member of the group
  - Orients C to four-miss rule.
- Orients C to group logistics: location, time/date, structure of group

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Rule #2

Prevent problems by establishing & maintaining group norms & expectations early on.

- Show up on time; communicate when you can't.
- Do assigned homework.
- Act with kindness & compassion toward others.
- ***Use your skills often throughout the day, and every day.***

Tips for Starting a DBT Skills Training Group

- Encourage norm of alerting group of absence/tardiness
- Structure environment to promote skills training targets
- Give members a skills training notebook with extra homework sheets
- Have loaner notebooks, pens and pencils in the classroom

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Tips for Starting a DBT Skills Training Group

- For therapists, group begins 15 minutes before start time, 15 minutes after group ends, and breaks.
- Establish group norm for functional behavior early on
- Manage group tone proactively
- Consider technology tools to augment
  - DBT Coaching App, DBT Skills Online Training, MML DVDS

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Standard DBT Skills Training Group Format (2.5 hours)

- **Getting Started** (5 minutes)
- **Homework Review** (60 minutes)
- **Break** (10-15 minutes)
- **Didactic/New Teaching** (60 minutes)
- **Homework Assignment/Wind Down** (10-15 minutes)

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Getting Session Started

- Account for/track down members who are not yet present.
- Call missing members and coach attendance (typically co-leader)
- Do and debrief mindfulness exercise.

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Structuring Homework Review

- Review homework assigned last week.
- Ask for a volunteer to start.
- Set pace so that each member more or less gets same amount of time.
- Look for opportunities to highlight other skills member used, reinforce skills use, and teach/highlight self-management strategies applied.
- Therapists and other members provide feedback to further strengthen behavior or practice

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Effectively Manage the Group Break

Overarching Goal

- To facilitate emotion regulation before moving onto next (didactic) portion.
- To discuss topics with specific member that are not easily addressed in the whole group.

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Tips for Delivering Didactic

- Weave in self-management
- Balance focused discipline with ease of pace (e.g., a fancy dinner party).
- Speak (***indirectly***) to C's dysfunctional patterns &/or problems.
- Make explicit how the skill is relevant to C's problems & how it will help C get a life worth living.

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Tips for Assigning Homework

- Assign one (max two) ***doable*** more extensive homework that will strengthen the new skill.
- Clearly and explicitly define the homework; write homework on board. If using handout, go over the handout with group.
- After assignment given, ask/address questions about the assignment.
- Identify/address barriers that may interfere with completing assigned homework.

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Group Wind Down

Function

To ensure that clients are sufficiently *emotionally regulated before leaving group.*

- Process wind-down by offering observation about themselves, one another, the leader, or the group as a whole.
- Lead clients through relaxation, visualization, meditation, or breathing exercise.

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Rule #3

All problems that arise are ***grist for the mill*** & simply problems to solve.

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Supplement
Importance of Employment

Linda A. Dimeff, PhD
5200 SW Macadam Portland OR 97239 | (503) 290-3282

Goals Guiding This Training

- Reflect on how employment matters.
- What do we know from research literature?
- Lessons learned from DBT-SUD and Clinical Observations about Employment
- Brass Tacks: How do you work on work with Stage 1 BPD patient?

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What do you *mostly* think/believe?

Choice A	Choice B
My client's problems are really severe and complex. They are simply not stable enough to work. I've got to first address their (PTSD, depression, social anxiety, drug abuse, emotion dyscontrol, _____) before they can work.	*My client's problems are really severe and complex. The only/fastest way to get them stable is through creating structure and routine through normative avenues, like work. The time to start working is now.*

Why Do We Work?

Why *do* we work?

For many of us, work provides central focus of our lives

- Economic sustenance
- Role identity
- Social interactions
- Meaning

Shirley M. Glenn, PhD
PracticeGround, May 2, 2018

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What other *functions* does work fulfill?

- **Structures up**:
  - where we go
  - what we behaviorally do
  - who we interact with
- **Creates a rhythm/tempo for our lives**
- **Distraction**/takes our mind off our problems
- Mastery, meaning

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Recovery from Psychiatric Illness Defined:

President's New Freedom Commission on Mental Health (2003)

"The process by which people are able to **live**, **work**, **learn**, and **participate fully** in their communities. For some individuals, recovery is the ability **to live a fulfilling and productive life** despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having **hope** plays an integral role in an individual's recovery".

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"Recovery" Defined

Zanarini, Frankenburg, Reich, & Fitzmaurice (2010)

- No longer meets BPD criteria

and…

- Has good social relationships

and…

- Performing well in a vocational realm

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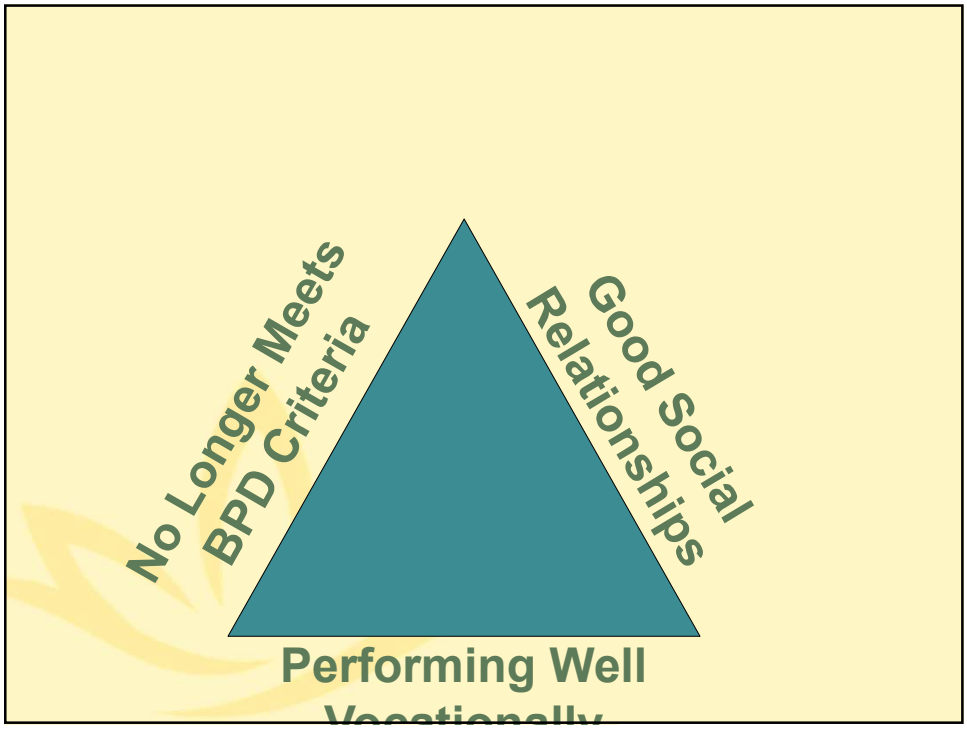

Functional Impairments in People with BPD

Article

Dialectical Behavior Therapy Compared With General Psychiatric Management for Borderline Personality Disorder: Clinical Outcomes and Functioning Over a 2-Year Follow-Up

Shelley F. McMain, Ph.D.
Tim Guimond, M.D.
David L. Streiner, Ph.D.
Robert J. Cardish, M.D.
Paul S. Links, M.D.

Objective: The authors conducted a 2-year prospective naturalistic follow-up study to evaluate posttreatment clinical outcomes in outpatients who were randomly selected to receive 1 year of either dialectical behavior therapy or general psychiatric management for borderline personality disorder.

Method: Patients were assessed by blind raters 6, 12, 18, and 24 months after treatment. The clinical effectiveness of treatment was assessed on measures of suicidal and nonsuicidal self-injurious behaviors, health care utilization, general symptom distress, depression, anger, quality of life, social adjustment, borderline psychopathology, and diagnostic status. The authors conducted between-group comparisons using generalized estimating equation, mixed-effects models, or chi-square statistics, depending on the distribution and nature of the data.

Results: Both treatment groups showed similar and statistically significant improvements on the majority of outcomes 2 years after discharge. The original effects of treatment did not diminish for any outcome domain, including suicidal and nonsuicidal self-injurious behaviors. Further improvements were seen on measures of depression, interpersonal functioning, and anger. However, even though two-thirds of the participants achieved diagnostic remission and significant increases in quality of life, 53% were neither employed nor in school, and 29% were receiving psychiatric disability support after 36 months.

Conclusions: One year of either dialectical behavior therapy or general psychiatric management was associated with long-lasting positive effects across a broad range of outcomes. Despite the benefits of these specific treatments, one important finding that replicates previous research is that participants continued to exhibit high levels of functional impairment. The effectiveness of adjunctive rehabilitation strategies to improve general functioning deserves additional study.

(Am J Psychiatry 2012; 169:650–661)

While several studies have established the effectiveness of cognitive-behavioral and psychodynamic treatments of borderline personality disorder, relatively few have addressed the long-term effects of these treatments. With a few exceptions (1–3), the duration of follow-up in these treatment studies has been short (<1 year). Conclusions about effectiveness require information on the sustained effects of treatment. Although dialectical behavior therapy is a multimodal cognitive-behavioral approach that has the largest empirical base of any psychosocial treatment for borderline personality disorder, the follow-up time frames in the five controlled trials evaluating the lasting effects of this treatment were 1 year or less (4–8). The available long-term data reveal a mixed picture, with some evidence suggesting that the strength of the treatment effects on some outcomes diminishes by 6 months after discharge (4, 6, 8).

We report the results of a 2-year naturalistic follow-up study of 180 individuals enrolled in a randomized controlled trial in Toronto between 2003 and 2006. The design, procedures, and treatment outcomes of the original study are described elsewhere (9). Briefly, patients diagnosed with borderline personality disorder were randomly assigned to receive 1 year of outpatient treatment consisting of either dialectical behavior therapy or general psychiatric management. After discharge, participants in both groups showed significant improvements on a broad range of clinical outcomes, including suicidal and nonsuicidal self-injurious behaviors, health care utilization (emergency department visits, inpatient days, and psy-

This article is featured in this month's AJP Audio and is discussed in an Editorial by Dr. Bateman (p. 560).

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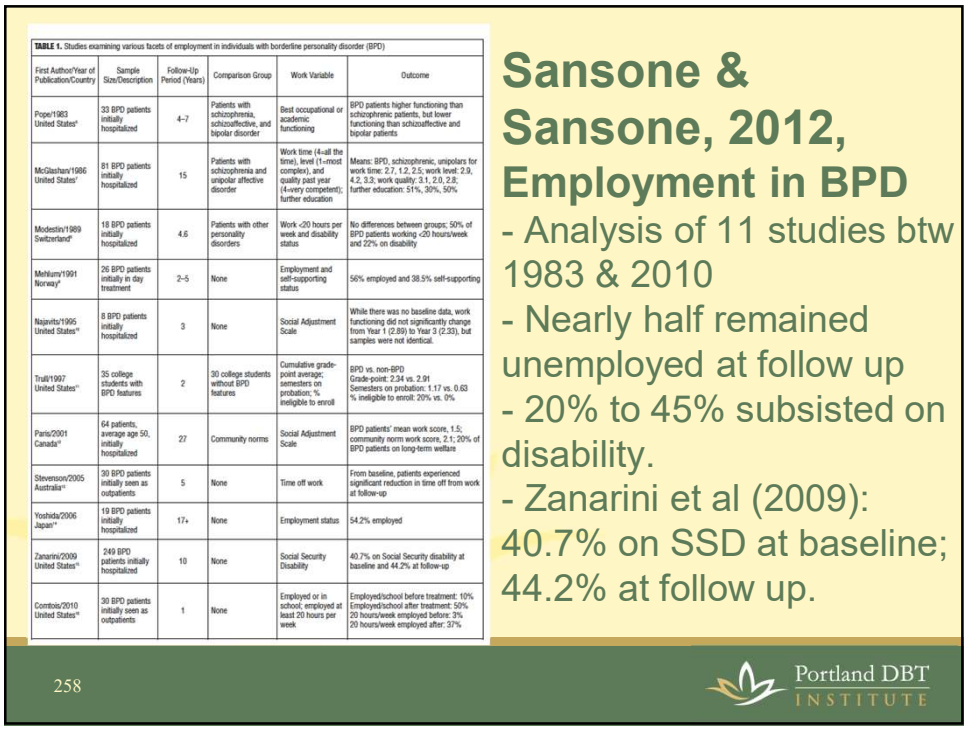

TABLE 1. Studies examining various facets of employment in individuals with borderline personality disorder (BPD)

First Author/Year of Publication/Country	Sample Size/Description	Follow-Up Period (Years)	Comparison Group	Work Variable	Outcome
Pope/1983 United States[a]	33 BPD patients initially hospitalized	4–7	Patients with schizophrenia, schizoaffective, and bipolar disorder	Best occupational or academic functioning	BPD patients higher functioning than schizophrenic patients, but lower functioning than schizoaffective and bipolar patients
McGlashan/1986 United States[c]	81 BPD patients initially hospitalized	15	Patients with schizophrenia and unipolar affective disorder	Work time (4=all the time), level (1=most complex), and quality past year (4=very competent); further education	Means: BPD, schizophrenic, unipolars for work time: 2.7, 1.2, 2.5; work level: 2.9, 4.2, 3.3; work quality: 3.1, 2.0, 2.8; further education: 51%, 30%, 50%
Modestin/1989 Switzerland[d]	18 BPD patients initially hospitalized	4.6	Patients with other personality disorders	Work <20 hours per week and disability status	No differences between groups; 50% of BPD patients working <20 hours/week and 22% on disability
Mehlum/1991 Norway[e]	26 BPD patients initially in day treatment	2–5	None	Employment and self-supporting status	56% employed and 38.5% self-supporting
Najavits/1995 United States[m]	8 BPD patients initially hospitalized	3	None	Social Adjustment Scale	While there was no baseline data, work functioning did not significantly change from Year 1 (2.89) to Year 3 (2.33), but samples were not identical.
Trull/1997 United States[n]	35 college students with BPD features	2	30 college students without BPD features	Cumulative grade-point average; semesters on probation; % ineligible to enroll	BPD vs. non-BPD Grade-point: 2.34 vs. 2.91 Semesters on probation: 1.17 vs. 0.63 % ineligible to enroll: 20% vs. 0%
Paris/2001 Canada[o]	64 patients, average age 50, initially hospitalized	27	Community norms	Social Adjustment Scale	BPD patients' mean work score, 1.5; community norm work score, 2.1; 20% of BPD patients on long-term welfare
Stevenson/2005 Australia[q]	30 BPD patients initially seen as outpatients	5	None	Time off work	From baseline, patients experienced significant reduction in time off from work at follow-up
Yoshida/2006 Japan[r]	19 BPD patients initially hospitalized	17+	None	Employment status	54.2% employed
Zanarini/2009 United States[s]	249 BPD patients initially hospitalized	10	None	Social Security Disability	40.7% on Social Security disability at baseline and 44.2% at follow-up
Comtois/2010 United States[t]	30 BPD patients initially seen as outpatients	1	None	Employed or in school; employed at least 20 hours per week	Employed/school before treatment: 10% Employed/school after treatment: 50% 20 hours/week employed before: 3% 20 hours/week employed after: 37%

Sansone & Sansone, 2012, Employment in BPD

- Analysis of 11 studies btw 1983 & 2010
- Nearly half remained unemployed at follow up
- 20% to 45% subsisted on disability.
- Zanarini et al (2009): 40.7% on SSD at baseline; 44.2% at follow up.

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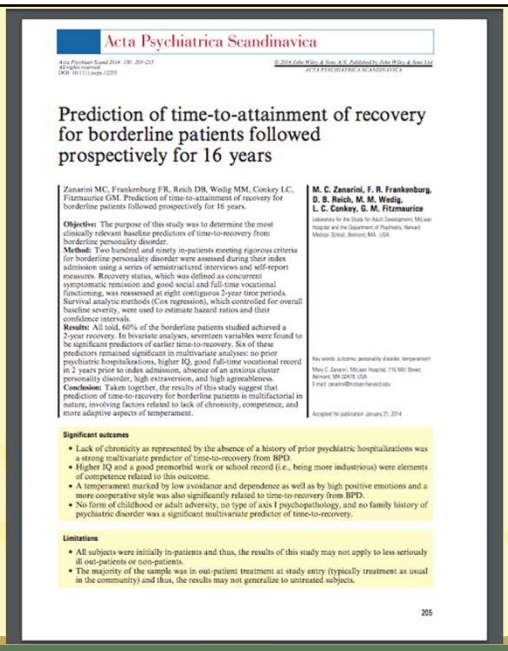

Acta Psychiatrica Scandinavica

Prediction of time-to-attainment of recovery for borderline patients followed prospectively for 16 years

Zanarini, et al., 2016, 2010

N=290 BPDs assessed at baseline & every two years.

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Predictors of BPD Time to Recovery

Zanarini, et al., 2014

N=290 BPD patients admitted to McLean's inpatient unit reassessed every two years after index hospitalization for 16 years.

"***Recovery***" = concurrent symptomatic remission **+** good social functioning **+** full time vocational functioning.

Findings: 60% achieved a two-year recovery.

Positive Predictors: no prior psychiatric hospitalization, higher IQ, good full-time vocational record in two years prior to index admission, absence of anxious cluster PD, high extraversion, high agreeability.

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Global Level of Functioning

Global Assessment of Functioning (GAF) Scale

(From DSM-IV-TR, p. 34.)

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

Code	(Note: Use intermediate codes when appropriate, e.g., 45, 68, 72.)
100 | 91	**Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.**
90 | 81	**Absent or minimal symptoms** (e.g., mild anxiety before an exam), **good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns** (e.g. an occasional argument with family members).
80 | 71	**If symptoms are present, they are transient and expectable reactions to psychosocial stressors** (e.g., difficulty concentrating after family argument); **no more than slight impairment in social, occupational or school functioning** (e.g., temporarily failing behind in schoolwork).
70 | 61	**Some mild symptoms** (e.g. depressed mood and mild insomnia) **OR some difficulty in social, occupational, or school functioning** (e.g., occasional truancy, or theft within the household), **but generally functioning pretty well, has some meaningful interpersonal relationships.**
60 | 51	**Moderate symptoms** (e.g., flat affect and circumstantial speech, occasional panic attacks) **OR moderate difficulty in social, occupational, or school functioning** (e.g.. few friends, conflicts with peers or co-workers).
50 | 41	**Serious symptoms** (e.g.. suicidal ideation, severe obsessional rituals, frequent shoplifting) **OR any serious impairment in social, occupational, or school functioning** (e.g., no friends, unable to keep a job).
40 | 31	**Some impairment in reality testing or communication** (e.g., speech is at times illogical, obscure, or irrelevant) **OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood** (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).
30 | 21	**Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment** (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) **OR inability to function in almost all areas** (e.g., stays in bed all day; no job, home, or friends).

1. Where is your client now?
2. Where will they be in 1 year?
3. Add five (or 10?) to it.
4. What exactly do you need to do in order to get them there?

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Borderline Personality Pathology and Physical Health: The Role of Employment

Patrick J. Cruitt, Michael J. Boudreaux, Joshua J. Jackson, and Thomas F. Oltmanns
Washington University in St. Louis

Employment functions as buffer against negative effects of BPD on physical health

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What's Gotten in Our Way?

- TAU is an "inside out" model of change.
- "Not my job"; "I'm not a vocation counselor."
- Don't know how to help a client get a job and don't often seek out consultation.
- `Hands are more than full when treating Stage I BPD clients.

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But if not YOU, then whom?

Assess Prior Work, Vocation, School History

- Highest degree – what kind of a student were they? What were they able to accomplish?
- Do they currently work? If no, when did they last work?
- What happened to cause them to stop/quit?
- Where did they thrive as employee? What was it about the circumstances?

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Assess Barriers That May Impede Getting Job

PS: Note they overlap with those that will interfere with treatment

- No (recent) job history.
- History of getting fired.
- Criminal record.
- Sleep is dysregulated.
- Won't pass drug screening.
- Avoidance, perfectionism, **emotions**

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Barriers That May Impede Keeping a Job

- Interpersonal problems with boss or coworkers.
- Sleep is dysregulated.
- Won't pass drug screening.
- Avoidance, perfectionism, **emotions**

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DBT	SUD & 12 Steps
Building Structure	**Address…**
Love	People
Time	Places
Place	Things

Lessons from
Behavioral Activation

If you **are what you do**, then what you do **really** matters.

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Ergo…

If what Ted does **really** matters, **then what** does Ted need to do?

(to increase functionality and hit recovery goals?)

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What might a BPD-specific *vocation-focused* intervention look like?

What would you do if you cared as much about work as suicide?

DBT Skills:
Crash Course, Part I

DBT Skills Training Modules

1. Mindfulness
2. Distress Tolerance
3. Emotion Regulation
4. Interpersonal Effectiveness

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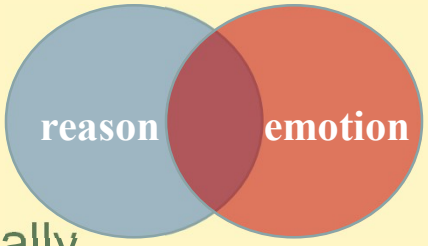
Mindfulness Skills

What
- Observe
- Describe
- Participate

How
- Non-judgmentally
- One-mindfully
- Effectively



wise mind

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Distress Tolerance Skills

- Crisis Survival Strategies
- Guidelines for Accepting Reality

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Crisis Survival Strategies

STOP Skill

Stop

Take a step back

Observe

Proceed mindfully

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TIP Skills

When You are Too Distressed to Figure Out a Better Skill

- Temperature
- Intense Exercise
- Paced Breathing
- Paired Muscle Relaxation

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Crisis Survival Strategies

Wise Mind *ACCEPTS*

Activities
Contributing
Comparisons
(with different) Emotions
Pushing away
Thoughts
Sensations

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Crisis Survival Strategies

SELF-SOOTHE the FIVE SENSES

Vision
Hearing
Smell
Taste
Touch

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Reality Acceptance

- Radical Acceptance
  - Turning the Mind
  - Willingness (over willfulness)

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DBT Skills:
Crash Course, Part II

Interpersonal Effectiveness Skills

- **Objectives Effectiveness** (DEARMAN)
- **Relationship Effectiveness** (GIVE)
- **Self-Respect Effectiveness** (FAST)

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Getting Your Objective

DEAR MAN

Describe the current situation
Express feelings and opinions
Assert by asking or saying no
Reinforce the person ahead of time
Mindful of objectives without distraction
  – Broken Record, Ignoring Attacks
Appear effective and competent
Negotiate alternative solutions
  – Turn the Tables

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Keeping the Relationship

GIVE

Gentle manner without attack or threat

Interested in the other person

Validate other person without judging

Easy Manner with humor or a "soft sell"

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Keeping Your Self-Respect

FAST

Fair to myself and others

(No) **A**pologies for being alive

Stick to values

Truthful without excuses or exaggeration

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Reducing Emotion Vulnerability

Accumulate Positive Emotions

Build Mastery

Cope Ahead

PLEASE

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Reducing Emotion Vulnerability

Build Mastery

- Do at least one thing each day to build a sense of accomplishment
- Plan for success
- Gradually increase the difficulty over time
- Look for a challenge

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Reducing Emotion Vulnerability

Cope Ahead

1. Describe the situation
2. Decide what skills to use
3. Imagine the situation
4. Rehearse in your mind coping effectively
5. Practice relaxation after rehearsing

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Reducing Emotion Vulnerability

PLEASE

- Treat **P**hysica**L** illness
- Balance **E**ating
- Avoid mood-**A**ltering Drugs
- Balance **S**leep
- Get **E**xercise

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Opposite Action

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Additional Skills

- **+1 Rule** (Julie Brown, PhD)
  - Assess Emotion Intensity: 0 – 5
  - Add 1 to your number
  - That's how many skills you need to get through hard situation.
- **5 Minute Rule**
  - Make inner commitment to cope for ONLY five minutes.
  - Make another commitment for another 5 minutes at end of initial 5 to get through high risk situation.

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