DBT for Problems Other Than BPD

More and more research is being done on using DBT to treat illnesses other than BPD, and chronic suicidality and self-harm. DBT, either the full model or in a modified or adapted form, has also been studied and found helpful in the following contexts:

- other personality disorders (Springer et al, 1996 (and others))
- binge eating disorder (Telch et al, 2000)
- anger in male forensic patients (Evershed et al, 2003)
- people diagnosed with HIV/AIDS, substance use disorder and BPD (Wagner et al, 2004)
- oppositional defiant disorder (Nelson-Gray et al, 2006)
- bipolar disorder in adolescents (Goldstein et al, 2007)
- treatment-resistant depression (Harley et al, 2008)
- anorexia and bulimia (Salbach-Andrae et al, 2008)
- depression (Feldman et al, 2009; Lynch et al, 2003)
- family members of people with BPD (Rajalin et al, 2009; Hoffman et al, 2007)
- suicidality in intellectually disabled forensic patients (Sakdalan, Shaw, and Collier, 2010)
- trichotillomania (Keuthen et al, 2011)
- PTSD related to childhood sexual abuse (Steil et al, 2011)
- nonsuicidal self-harming behaviors and suicidal ideation in children (Perepletchikova et al, 2011)
- caregivers of family members with dementia (Drossel et al, 2011)
- ADHD (Hirvikoski et al, 2011)
- bipolar disorder in adults (Van Dijk, Jeffery, & Katz, 2013)
- intellectual disabilities and challenging behaviors (Brown, Brown &Dibiasio, 2013)
- breast cancer patients (Cogwell et al, 2013)
- family members of teens with symptoms and behaviors associated with borderline and externalizing pathology (Uliaszek et al, 2013)
- in a Disciplinary Alternative Education Program (Ricard, Lerma & Heard, 2013)
- in adolescent chronic kidney disease (Hashim, Vadnais & Miller, 2013)
- emotion regulation group in a college counseling service (Meaney-Tavares &Hasking, 2013)
- in post-disaster psychotherapy (Martin, 2015)
- for chronic pain related to gastrointestinal disorders (Sysko, Thorkelson & Szigethy, 2016)
- for marijuana use disorder (Davoudi et al, 2021)
- for Irritable Bowel Syndrome (Mohamadi et al, 2019)

Research has been conducted on the use of DBT in different contexts to treat adolescents, adults and the elderly; as well as in in-patient, out-patient, forensic settings and ACT teams. Many of these studies involved the full DBT model, but many are on the use of adapted models of DBT, especially for disorders other than BPD.

DBT Certification by The Hirose Institute Session One

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Objectives

By the end of this six-week course, participants will learn:

- The theories underlying DBT: Dialectics, the Biosocial theory, and Behaviour Theory; as well as strategies from these theories to help increase effectiveness with clients
- How to teach clients mindfulness and other DBT skills (Core Mindfulness, Emotion Regulation, Interpersonal Effectiveness, and Distress Tolerance) to reduce the impact of emotion dysregulation

Objectives

By the end of this six-week course, participants will learn:

- How to use a variety of dialectical strategies to help clients get unstuck and move toward healing
- Ways of reducing their own feelings of burn-out and ineffectiveness in therapy, including using DBT skills and working as part of a consultation team

What is DBT?

Dialectical Behavior Therapy is a treatment developed by Marsha Linehan in Seattle, Washington, to treat individuals with Borderline Personality Disorder (BPD)

Marsha and her team were using traditional Cognitive-Behavioral Therapy (CBT) to treat this difficult population and found that it was not very effective.

What is DBT?

Marsha and her team attributed this to three factors:

1. Clients with BPD receiving CBT found the unrelenting focus on change inherent to the treatment invalidating

What is DBT?

2. Clients punished therapists for effective therapy (e.g. responded with anger, emotional withdrawal, threatened self-harm, etc.); and rewarded therapists when allowed to change the topic from one they didn't want to discuss to one they did want to discuss.

What is DBT?

3. The complexity of problems experienced by clients made it impossible to use standard CBT - therapists simply did not have time to address all of the problems presented by clients (e.g. suicide attempts, urges to self-harm or quit treatment, etc.) AND have session time devoted to helping the client learn and apply more adaptive skills.

What is DBT?

In response to these key problems, Marsha and her team made modifications to CBT to balance accepting clients as they are with focusing on change and teaching skills needed to lead a life worth living, through the inclusion of mindfulness and acceptance techniques.

What is Mindfulness?

Focusing on one thing at a time, in the present moment, with your full attention, and with acceptance.

- Step out of automatic pilot
- Turn your attention to what is happening NOW, within yourself or within your environment.
- Adopt an attitude of curiosity, acceptance, and openness toward your experience

A Little Introduction to Mindfulness…

Why Practice Mindfulness?

Mindfulness skills are central to DBT and are the first skills taught in group. Mindfulness is helpful in MANY different ways:

1. Increasing self-acceptance
2. Reducing dwelling or rumination
3. Improving concentration and memory

Why Practice Mindfulness?

4. Increasing pleasurable emotions
5. Relaxation
6. Managing urges
7. Getting to know yourself

(it helps to get buy-in from your client if you personalize this skill for them)

Mindfulness Exercise

Introductory exercise:

Abdominal Breathing

- Posture
- Eyes
- Bowl/bells
- Four Steps

How to Practice Mindfulness

Four steps to mindfulness:

1. Choose a focus
2. Start to focus on that activity
3. Notice when your attention wanders
4. Gently, without judgment, bring your attention back

Repeat steps 3 & 4 over and over and over…

What is Mindfulness?

Two types of practice:

1. Formal: requires devoting a specific amount of time to being still in order to focus all of your attention on the exercise (e.g. breathing exercise, body scan, Zentangling)

Formal exercises help you to become more aware of internal experiences, increasing self-awareness and your ability to manage yourself more effectively.

What is Mindfulness?

2. Informal: can be practiced at any time during your day; incorporating mindfulness into your daily activities such as walking, driving, eating, etc.

Informal exercises help you to live your life more mindfully and to be in the present moment on a regular basis. Both types of practice are extremely important.

(DBT mindfulness vs. other MBT's)

Formal versus Informal Practice

- Hanley et al (2015) studied the effect of mindfully washing dishes and found partial increases in positive affect and partial decreases in negative affect.
- Hindman et al (2015) reported greater mindfulness and self-compassion in participants of a mindful stress management-informal group compared to a wait list control group
- Shapiro et al (2003) reported participants who practiced more informal mindfulness felt more rested after sleeping
- Cebolla et al (2017) found frequency of informal practice predicted the "observing" facet of mindfulness
- Study by Birtwell et al (2018) found that more participants were practicing informally than formally; and that frequency of informal mindfulness is more important for wellbeing and psychological flexibility than frequency or duration of formal practice

** more research still needed.

Reactive and Proactive Practice

Reactive Practice: how are clients often start practicing – i.e. when they feel they "need it"

Proactive Practice: how we want our clients to be practicing more often; the more they practice proactively, the less often they'll find themselves "needing" mindfulness

Tips for Teaching Mindfulness

- Practice what you teach! – you must be practicing mindfulness yourself
- Make it doable – short practices, choice of activities
- Do a variety of practices in group
- Emphasize *informal* as well as *formal* practices (DBT mindfulness vs. other)

Tips for Teaching Mindfulness

- Eyes open vs. closed
- Stay away from "meditation" and "Buddhism" (Contemplative Prayer)
- Repetition
- Examples – personalize these for your clients: TV, music, walking, kids & pets, work, hobbies, sports, etc.
- Give personal examples as well

Problems Clients Often Encounter

- "It makes me more anxious"
- "I don't have time"
- "I already focus on the task at hand"
- "I fall asleep"
- ("It's not scientificky" – observing & describing)

Problems Clients Often Encounter

- "I HAVE to multi-task!"
- "Isn't mindfulness just avoiding or repressing?"
- "But I have to plan for the future"
- "I just can't do it", "It's not working, I'm not doing it right, I can't stay focused" (Monkey Mind & Puppies)

Mindfulness Analogies

Monkey Mind…hear that voice chattering away in your head? That's your Monkey Mind. It's NORMAL!

Puppies… think of your brain as a puppy. Right now you're training your puppy to sit and stay, but you can't expect it to get it right away, it takes time.

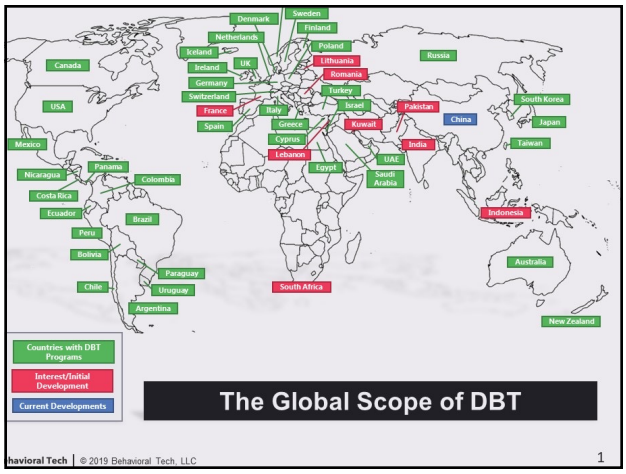
What is DBT?

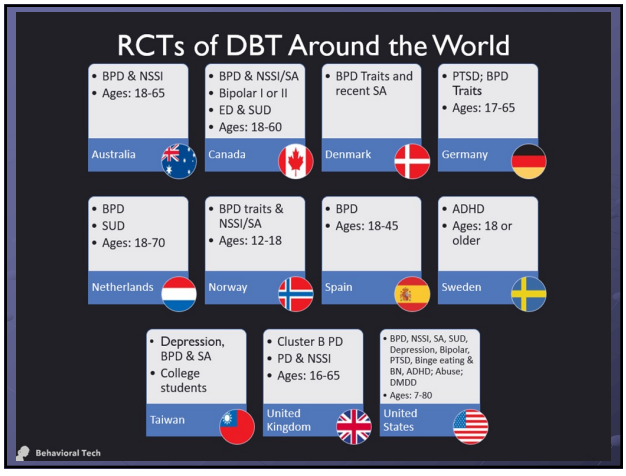
Some other differences between DBT and CBT:

- Mindfulness and acceptance
- Principle-driven vs. protocol-driven
- Contingency management
- (in individual DBT therapy there are other differences as well, including heavy emphasis on suicide assessment and commitment strategies)
- Mode of delivery

Standard DBT Model

1. Outpatient individual psychotherapy
2. Outpatient group skills-training
3. Skills Coaching
4. DBT team consultation





Modifying DBT

"In a study by Marsha's team, data showed no significant difference between Comprehensive DBT and a DBT Skills Condition on all major outcome variables during 12 months of treatment, and it looks like Comprehensive DBT begins to slightly outperform the DBT skills condition in the 12 month post-treatment follow-up on certain outcome variables." (The Skills Condition included a Consultation Team, and clients had case managers who were trained in the UWRAP and who assisted with suicide crises as they arose) – Linehan et al, 2015

Modifying DBT

A Canadian study (McMain, Guimond & Streiner – 2017) looked at 84 patients with BPD, aged 18 and older:

- Provided 20 weeks of skills training only, compared to a waiting list group
- At 3 months follow-up:
  - Significant reductions in self-harm and suicidal behaviour, anger, impulsivity, and BPD symptoms; and an increase in mindfulness, distress tolerance, and emotion regulation

Modifying DBT

In a recent 2-year study by McMain et al (2022), 12 months of full DBT was compared to 6 months of DBT. The authors concluded that both groups showed "significant improvement from baseline to month 24 on all primary and secondary outcome measures" (p. 12).

The conclusion was that "there was no additional benefit of long-term over short-term DBT for the treatment of a severe, polysymptomatic clinical sample with BPD pathology" (p. 12)

Modifying DBT

- A RCT on the 12-week DBT skills group for Bipolar Disorder I developed demonstrated a reduction in depressive symptoms, an increase in self-efficacy, and an increase in one's ability to manage one's emotions; hospitalizations and ER visits were also reduced in the 6 months post-group compared to 6 months prior to group (*Journal of Affective Disorders*, March 2013)

Research continues to be conducted on adaptations of DBT, and on using DBT for other disorders

(see handout)

Biosocial Theory of BPD

Clients with BPD have pervasive emotional dysregulation. This is the result of two main factors:

1. A biological predisposition to emotional vulnerability:
   - A person who is emotionally vulnerable has a baseline of higher than average emotional pain; reacts emotionally to things others wouldn't typically react to; has more severe emotional responses than what is warranted; and takes longer to return to baseline.

BioSocial Theory: Emotional Vulnerability

Biological factors implicated in emotional vulnerability:

1. Genetics: work done by E. Aron has pointed to the possibility that up to 30% of individuals are born "highly sensitive", physically & emotionally
2. Trauma: severe emotional or physical trauma causes changes in the brain to make it more vulnerable to intense feeling states (e.g. attachment).

BioSocial Theory: Emotional Vulnerability

Biological factors implicated in emotional vulnerability (continued):

3. Mental illness: Psychiatric disorders, especially when not well controlled by medications, lead to further emotional suffering.

BioSocial Theory: **The Invalidating Environment**

2. The second factor contributing to emotion dysregulation is a ***Pervasively Invalidating Environment***: the tendency to deny or respond unpredictably and inappropriately to the individual's private experiences (e.g. the child expresses an emotion and is judged or punished for this; is told that their experience is incorrect; the experience is minimized or ignored; and so on).

BioSocial Theory: The Invalidating Environment

Examples of an invalidating environment include:

- The Abusive Home: physical, emotional, sexual or verbal abuse or neglect is the epitome of the invalidating environment
- The Poor Fit: e.g. the creative child in a family of "rational-thinkers"; the emotionally sensitive child in a family without this sensitivity

BioSocial Theory: The Invalidating Environment

Examples of an invalidating environment include:

- The Chaotic Home: e.g. parents who had an invalidating childhood; who have a mental illness or addiction; who are financially unstable
- Other Invalidating Environments: e.g. school, social media clubs, extra-curricular activities; ***Societal contributors – discrimination and oppression based on race, ethnicity, religion, culture, gender, sexuality, etc…

BioSocial Theory: The Invalidating Environment

Consequences of the invalidating environment:

- The child doesn't learn to label or trust their private experiences, including emotions; instead, they learn to search the environment for cues on how to think, feel, and act (as an adult, this is experienced as "emptiness" or a lack of self-awareness).

BioSocial Theory: The Invalidating Environment

- An extension of not being able to label or trust their experience is that the child doesn't learn to modulate emotional arousal; or how to respond appropriately to distress
  - These emotional problems are not recognized by caregivers, and the child is told to control their emotions without being taught the skills to help them do this.

BioSocial Theory: The Invalidating Environment

- By punishing communication of painful emotions and intermittently reinforcing displays of extreme emotions, the environment teaches the child to oscillate between emotional inhibition and extreme emotional states.
- In this way, individuals with emotion dysregulation learn extreme ways of getting others to take them seriously (e.g. self-harm, suicidal behaviours and threats)

BioSocial Theory: The Invalidating Environment

- As adults, these clients have difficulty modulating their emotions because they have **not learned** to trust their reactions and to use healthy skills to regulate their feelings and behaviour.

BioSocial Theory

In individual DBT work, understanding the client's early experiences of attachment, relationships with parents/siblings, and temperament, are very important in understanding the client's skill deficits and strengths; the bulk of the work, however, focuses on the here-and-now

The Valuable Aspects of the BioSocial Theory of BPD

It directs our focus to helping clients acquire skills:

- to **modulate** extreme emotions (they become experts at identifying their emotions and choosing behaviours that will reduce their intensity)
- to **reduce** emotional vulnerability (they become experts at being mindful of themselves and their environment, and at making healthier lifestyle choices)

The Valuable Aspects of the BioSocial Theory of BPD

It directs our focus to helping clients acquire skills:

- to reduce **mood-dependent** behaviours (they learn skills that disconnect emotions from behaviour, reducing impulsive drinking, parasuicidal behaviours, etc.)
- to **validate** their own thoughts, feelings, and behaviours (resulting in raised self-esteem/self-respect/self-efficacy)
- locus of control shifts from external to internal

The Valuable Aspects of the BioSocial Theory of BPD

- It facilitates psychoeducation by identifying inadequate **learning** experiences (normalizing maladaptive behaviours learned in childhood)
- The BioSocial Theory reduces the therapist's sense of helplessness and frustration when relapse occurs – it helps us to not to take it personally!

The Valuable Aspects of the BioSocial Theory of BPD

- Considering the fact that over 85% of DSM diagnoses involve emotion dysregulation (Werner & Gross, 2010), it makes sense to look at applying Linehan's (1993) biosocial theory to disorders other than BPD
- Think about your own clients (without BPD)?

Core Mindfulness Skills: Nonjudgmental Stance

Video

Core Mindfulness Skills: Nonjudgmental Stance

Judgments often increase the intensity of emotions – we need to watch for the judgments that stick to us! reducing these judgments will help us to reduce the painful emotions we're experiencing

**Note that this isn't about stuffing emotions or opinions, but rather helps us express these things more assertively

Core Mindfulness Skills: Nonjudgmental Stance

This skill is about semantics!

Think "inflammatory language" – if you can reduce the use of this language, you can reduce the intensity of emotions

The "How" Skills…

1. Nonjudgmentally:
   - Takes the short-form out and says what we really mean
   - Won't make the pain disappear, but will prevent extra emotions from arising
   - Will be more effective in interpersonal situations

Core Mindfulness Skills: Nonjudgmental Stance

- Judgments versus Evaluations
- What about positive judgments?
- The challenge of self-judgments
- Non-verbal judgments
- Sometimes judgments are hard to catch
- Awareness = Choice – this isn't about eradicating judgments!

Core Mindfulness Skills: Nonjudgmental Stance

Examples:

"I'm lazy" versus "I didn't get everything done I wanted to today and I'm feeling disappointed in myself"

"He's an idiot" versus "He hurt me and I'm feeling angry with him"

Core Mindfulness Skills: Nonjudgmental Stance

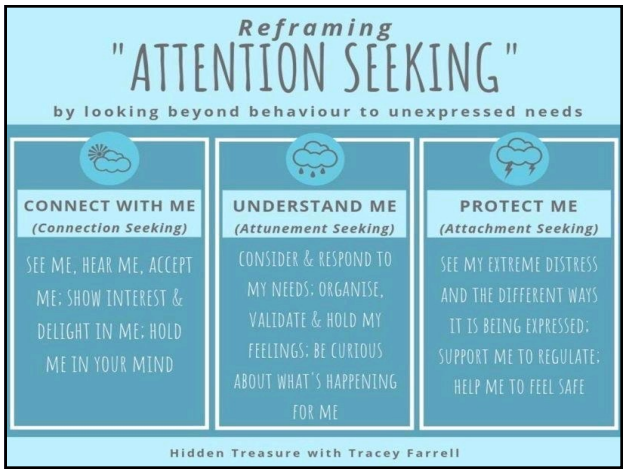
What nonjudgmental stance isn't:

- It's not rationalizing or excusing behaviour (e.g. "I didn't get everything done that I wanted to because I didn't sleep well last night" or "he said hurtful things because he had a hard day at work")
- It's not providing reassurance (e.g. "it's okay that I didn't get everything done today, I can work on it tomorrow")

Core Mindfulness Skills: Nonjudgmental Stance

Some helpful (nonjudgmental) words to consider:

- Helpful versus unhelpful
- Effective versus ineffective
- Safe versus unsafe or dangerous
- Satisfying versus unsatisfying
- Healthy versus unhealthy



Assumptions about Clients

1. They're doing the best they can.
2. They want to improve
3. They must learn new behaviours, both in therapy and in the context of day-to-day life.
4. No one can fail in DBT
5. They may not have caused all of their problems, but they have to solve them anyway.
6. They need to do better, try harder and be more motivated to change.
7. The lives of people who are suicidal are unbearable as they are currently being lived.

Assumptions about Therapists

1. The most caring thing a therapist or treatment provider can do is help people change in ways that bring them closer to their ultimate goals.
2. Clarity, precision and compassion are of the utmost importance.
3. The treatment relationship is a real relationship between equals.
4. Principles of behaviour are universal, affecting clinicians no less than clients.
5. Treatment providers need support
6. Treatment providers can fail.

The Consultation Team

Functions of the consultation team:

- To enhance therapists' skill and motivation
- To validate therapists' emotions
- To help problem-solve
- To recognize and reduce burn-out
- To build effective therapeutic responses and reduce ineffective ones
- To encourage therapists to remain patient, nonjudgmental and flexible
- To help therapists observe their limits

The Consultation Team: Agreements

1. Dialectics: We'll do our best to remember that there is no absolute truth – we are not RIGHT. We'll look for the truth in both positions and try to synthesize the two by asking questions such as "What's being left out?"

2. Consultation to the Patient: The primary goal of a consultation team is to improve our own skills as DBT therapists, and not serve as a go-between for clients. We agree to not treat clients (or each other) as fragile; and with the belief that they have the ability to speak on their own behalf.

The Consultation Team: Agreements

3. Consistency: Because change is natural and inevitable, we will accept diversity and change as it arises; we don't have to agree with each other about how to respond to specific patients, and we don't have to change our behaviour to be consistent with everyone else.
4. Observing Limits: We will each observe our own limits; and we will not judge or criticize other for having limits different from our own.

The Consultation Team: Agreements

5. Phenomenological Empathy: We agree to look for non-judgmental interpretations of peoples' behaviour. We assume that everyone is trying their best and wants to improve. We will strive to see the world through the eyes of the other person; and will practice being non-judgmental with our clients and one another.
6. Fallibility: We acknowledge that we all make mistakes; we'll work on letting go of defensiveness. Because we're fallible, we will inevitably violate all of these agreements, and when this happens, we'll rely on each other to point out the polarity and move to a synthesis.
7. Stretch Limits.

The Consultation Team

Structure:

- Mindfulness exercise
- Ratings of ineffectiveness & burnout
- Team members request amount of time
- Agenda is set based on therapists' needs and hierarchy of treatment targets: suicide, high risk of drop-out, burned-out therapist, then everything else
- Team members are expected to bring a clear question to the team; Team needs to stick to that question!
- Team provides validation, help with problem-solving, awareness of polarisations, challenge therapist if not adhering to DBT
- Rotating Roles: team leader (reviews agenda, monitors time), watchdog (rings bell to draw attention to lack of mindfulness, judgments, polarizations), note-taker

Reducing Therapist Burn-Out

Limit-Setting

- Traditionally, we've been taught about the importance of "setting boundaries", especially with our BPD clients
- Try to change your way of thinking about this to be more flexible:
  - observe your limits, rather than expecting someone else to "respect your boundaries"

Reducing Therapist Burn-Out

Limit-Setting

- Neither the client nor the therapist is pathologized for having "inappropriate boundaries" (perhaps there is a poor fit between what one person wants and what the other is willing to give)

Reducing Therapist Burn-Out

- Observing limits procedures:
  - Monitor your limits (burn-out)
  - Be honest about your limits (not for the good of the patient, but of the therapist)
  - Temporarily extend limits when needed (e.g. in response to client's important needs)
  - Be consistently firm (e.g. don't extend limits in response to behavioural escalation; don't respond punitively)

Reducing Therapist Burn-Out

Observing limits procedures:

- Importance of observing program limits as well as each individual's own limits, although the program limits trump individual limits

Reducing Therapist Burn-Out

Homework:

1. Practice mindfulness (informally or formally); be on the look-out for how mindfulness will help clients
2. Notice judgments – write down one judgment and if possible nonjudgment

Thank You!!!

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