DBT Certification by The Hirose Institute Session Two

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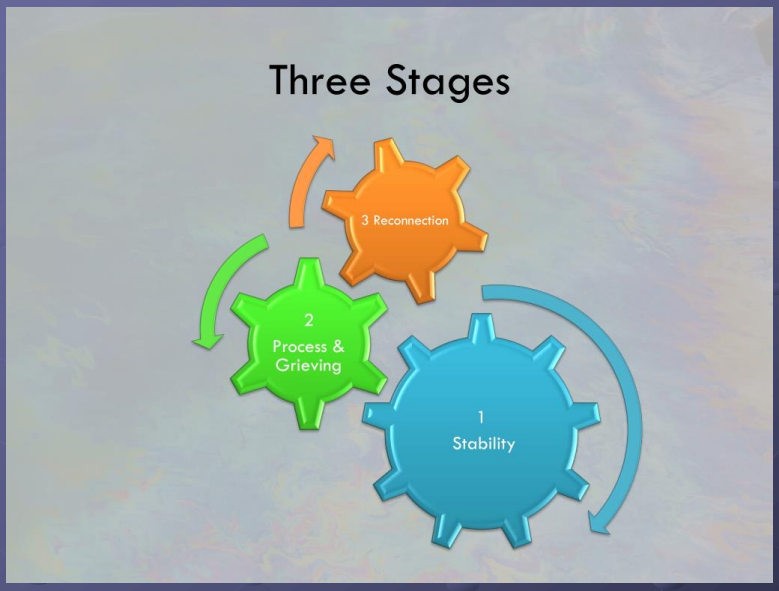
Welcome Back!

1. Mindfulness activity: Counting Breaths
2. Homework review:
   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

Triphasic Model of Treatment (Herman, 1992)



Getting Commitment

DBT Commitment Strategies:

1. Devil's Advocate (e.g. you tell me you've seen three therapists before, and you've always decided to continue with NSSI; what makes you think things will be different this time?)
2. Foot in the Door/Door in the Face (Asking for a tiny goal that almost anyone would agree to; asking for the moon so the client will readily agree to something less)
3. Freedom to Choose (highlighting that they are free to choose for themselves, but also highlighting the consequences of those choices; you might also highlight that you (the therapist) are also free to choose to observe your own limits)
4. Shaping behaviour (baby steps!)

Stages of Treatment

Stage 1 - Primary focus is on reducing:

1. Life-interfering behaviours
2. Therapy-interfering behaviours
3. Quality of Life-interfering behaviours (e.g. incapacitating or severe mental illness, extreme poverty or homelessness, domestic violence)
4. Increasing skills use to address targets and increase self-management

This stage addresses severe skills deficits and is about working toward STABILITY

Stages of Treatment
Stage 1 – Secondary Targets:

Increase:

- Emotion regulation
- Self-validation
- Emotional experiencing
- Active problem-solving
- Accurate expression

Decrease:

- Emotional reactivity
- Self-invalidation
- Emotional inhibition
- Active passivity
- Mood dependency

Stages of Treatment

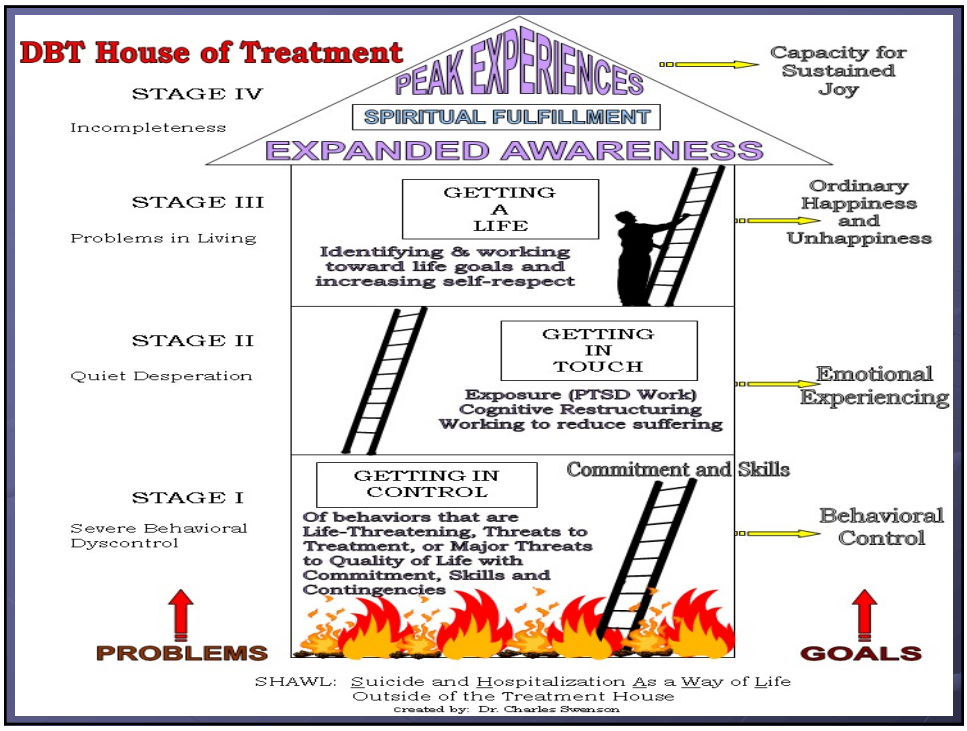
Stage 2: reduce feelings of misery and "quiet desperation" more evident once behaviours are relatively under control

- increase emotional experiencing and expression
- address PTSD symptoms with evidence-based treatments if applicable (e.g. DBT-PE by Melanie Harned; DBT-PTSD by Bohus)
- in this stage, treatment targets are identified by the client

Stages of Treatment

Stage 3: client is stable; focus is on the more "ordinary", less pathological problems in living (e.g. mild-severity disorders, increasing self-respect and QOL, difficulties with setting and achieving life-goals or problem-solving); treatment targets as identified by client

Stage 4: increasing awareness of self, feelings of incompleteness, spiritual fulfillment, etc. (the least developed/standardized of DBT's stages; highly personalized to the individual, with the main goal being to find deeper meaning in life through spiritual existence with mindfulness retreats, radical acceptance, etc.)



Stages of Treatment

Discussion:

What Stage is your client in?

Structuring the Therapy Session

Diary Card (PsychSurveys)/Behaviour Tracking Sheet and structuring the individual session:

1. Life-interfering Behaviours (e.g. Suicide attempts or thoughts; self-harming)
2. Therapy-interfering Behaviours (e.g. Late for sessions, homework incomplete)
3. Quality of Life-interfering Behaviours (i.e. Everything else – symptoms of depression, anxiety, substance use, etc.)

This involves some evaluations by therapist regarding where a specific behavior fits, depending on the client and the situation

Sample DC

Dialectics

DBT is based on a dialectical philosophy:

- "Walking the middle path" (Miller et al, 2007)
- A more balanced way of thinking – getting away from Black & White and moving toward the Grays
- The only thing constant about reality is change! – being dialectical means being flexible

How a Dialectical Worldview Informs Treatment Strategies in DBT

- There are no absolute truths (perspectives); each position has its own wisdom or truth, even if it's only a kernel of truth
- Opposites are interconnected and defined by each other; synthesizing these opposites is what leads to change (e.g. we need to accept the way things are AND move to change them)

How a Dialectical Worldview Informs Treatment Strategies in DBT

- Searching for what is left out in order to thoroughly analyze behaviours, thoughts and feelings
- Highlights oppositions (e.g. good/bad, right/wrong) in order to reduce interpersonal conflict; helps us to see the others' perspective
- Sometimes we need to hold two (or more) truths, without having to make one "right"

Dialectics

Video

"All that we share"

Dialectics

Dialectical thinking moves away from all or nothing thinking (e.g. "expressing emotions is good"; or "controlling emotions is good"), and toward a more synthesized, balanced perspective (e.g. "expressing *and* controlling emotions are both good")

And instead of *But*

Dialectics in Therapy:

Activity:

- Acceptance versus Change
- Your goals for your client versus their goals for themselves
- Learning to tolerate versus problem-solving
- Observing limits and being available to clients

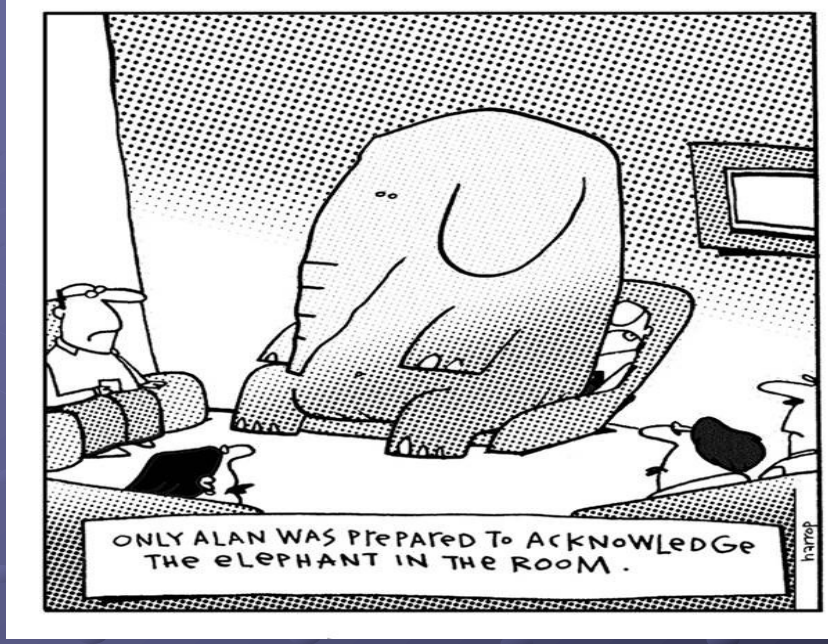
Dialectics

Dialectical strategies are used in DBT to help keep this balance between acceptance and change.

These strategies help to counter the tendency, found in treatment with clients diagnosed with BPD, to become mired in arguments, polarizing positions, and extreme positions (power-struggles)

Dialectical Strategies: Reciprocal vs. Irreverent Communication

- Reciprocal Communication:
  - Give and take; equality
  - Warmth and genuineness; validating
  - Use of self-disclosure
    - To validate or normalize an experience
    - To problem-solve
    - To model for the client how to self-disclose
    - Self-involving self-disclosure
    - Guidelines



Validation

What is validation?

- Communicating to the client that their responses make sense and are understandable within their current life context or situation
- Communicating acceptance of the client, taking the client's responses seriously and not discounting or minimizing them

Why validate?

- *Invalidation* increases emotional arousal, which makes it difficult for clients to process information
- Validating the emotionally aroused client (e.g. “I know you’re angry”) helps to reduce the intensity of emotions, allowing for new learning and therapeutic change (balances the push for change)

Benefits of Validation

Video

Benefits of Validation

- Enhances the therapeutic relationship
- Strengthens your empathy toward the client
- Encourages the client to keep going when they're ready to quit
- Teaches the patient through modeling, how to trust and validate themselves

How to Validate

- Only validate the valid! – e.g. you need to validate the extreme emotional response without validating the problematic behaviour
- Be descriptive and nonjudgmental in articulating how the client's response isn't effective or doesn't make sense

Levels of Validation (Linehan, 1997)

1. Listening & Observing (listen mindfully, active listening)
2. Accurate Reflection (so what you're saying is…)
3. Articulating the Unverbalized (I would imagine you'd be feeling…)
4. Validate the current state based on history or biology (e.g. of course you don't want to walk down the dark alley, you were assaulted in an alley)

Levels of Validation

5. Communicate the person's behaviour makes sense and is reasonable for anyone (e.g. Of course you don't want to walk down the dark alley, dark alleys are scary and dangerous; example with my cousin)

Levels of Validation

6. Radical Genuineness: treating the person as valid (matter of fact, not treating patient as fragile, direct and challenging)
   - This level of validation must come from the therapist's genuine self; at this level, almost any response by the therapist can be validating
   - Notice your natural, spontaneous reaction (versus the "Twilight Zone" therapist)
   - Not just verbal, but facial expressions and behaviour as well

Levels of Validation

Carson-Wong, A., Hughes, C. D., & Rizvi, S. L. (2018). The effect of therapist use of validation strategies on change in client emotion in individual DBT treatment sessions.

- increase in frequency of high VLs was associated with an increase in positive affect (PA) and a decrease in negative affect (NA)
- increase in frequency of low VLs was associated with a decrease in PA and no change in NA.
- increase in frequency of VL 4 was associated with increase in NA.
- VL 6 was associated with an increase in PA and a decrease in NA.

Validation Exercise

Marianne

Validation

- Pushing for change in the emotionally vulnerable client will likely be perceived as invalidating ("you don't understand how difficult it is if you expect me to change")
- But it will also be perceived as invalidating if all that occurs is validation with no effort to change ("you don't understand how awful it is if you're not helping me to change")

Dialectical Strategies: Reciprocal vs. Irreverent Communication

- Irreverent Communication: an unexpected, somewhat "off the wall", "edgy" response to a client; straight-shooting
  - Blunt, confrontational, honest, challenging
  - Off-beat sense of humor; irony
  - Relies on a good relationship with client; needs to be a good fit for you, and must be surrounded with validation
  - (Marsha's example)

Dialectical Strategies

- Devil's Advocate: e.g. You say you want to stop bingeing, but you're not using skills; I'm not so sure you're really committed to working on this.

- Making lemonade out of lemons: e.g. So you're finding it hard to tolerate being in group listening to others talk about their problems – that's great, you can practice being nonjudgmental!

Dialectical Strategies

- Activating WM – help clients find their WM and respond from this place of wisdom (we'll come back to this with States of Mind)
- Use of metaphors (or teaching stories) – helps clients be more objective; sometimes "safer"
- Extending – taking the client more seriously than they're taking themselves (and more seriously than they want to be taken!); take the client's "resistance" and extend it further (VIDEO)

Dialectical Strategies

- Dialectical abstinence – client needs to commit to change, with the understanding that they won't be perfect (e.g. SUD, disordered eating behaviour)
- Dialectical assessment: what's missing?

Dialectical Strategies

Entering the paradox: highlight the paradoxical nature of the therapeutic relationship, the client's behavior, or reality in general. This strategy works best when the client is stuck in rigid beliefs or engaging in black and white thinking.

- "If you're not willing to experience anxiety, you'll be stuck with it forever."
- "You have to work harder at not working so hard!"
- "Can you radically accept that you're not willing to accept?"

Dialectical Strategies

Allowing natural change – the natural change and inconsistency that occurs in any environment is simply allowed to happen.

- The idea is that, while acknowledging how difficult change can be for clients, experiencing change in a safe environment can be therapeutic
- The only consistency required is that behavioural progress be reinforced, and dysfunction not be reinforced; and that the therapist is consistently on the side of the client

Behaviour Theory: Definitions

- Respondent Conditioning: behaviour isn't learned, but is an automatic response; the unconditioned stimulus (US) requires no learning to elicit the unconditioned response (UR); the response is natural
  - E.g. the smell of food (US) causes our mouths to water (UR); a loud noise (US) causes us to flinch (UR)

Behaviour Theory: Definitions

- Operant Conditioning is when our behaviour comes under the control of consequences, and is therefore learned
- A previously neutral stimulus, that doesn't *naturally* elicit a response, now triggers a learned response (conditioned stimulus triggers a conditioned response)
  - For example: first time going to the dentist (US) causes pain (UR); next time going to the dentist for a routine check-up (CS) causes stress (CR); example of Oliver

Behaviour Theory: Definitions

It's important to determine if a behaviour is respondent versus operant because this will determine which interventions we'll use:

- If suicidal thoughts are Respondent, they're coming up automatically – e.g. for many clients a certain emotion (e.g. shame, loneliness) is so aversive the urge to suicide pops up; the client has no control over this. If this is the case, the intervention will be exposure therapy – helping the client learn to tolerate the emotion rather than having to do something about it; if you don't indulge the thoughts, they will be extinguished over time

Behaviour Theory: Definitions

- If suicidal thoughts are Operant, we don't use exposure, but contingency management – these thoughts are "indulgent", so we work on managing the reinforcers and punishers in order to extinguish the behaviour
- What is the client getting out of indulging the thoughts? How can we help them meet that need in another way?

Behaviour Theory: Exercise

1. Positive Reinforcement
2. Negative Reinforcement
3. Intermittent Reinforcement
4. Positive Punishment
5. Negative Punishment
6. Positive Consequence
7. Negative Consequence
8. Shaping
9. Modeling

Behaviour Theory: Definitions

- Something is *reinforcing* if it makes it more likely the behaviour will happen again (reinforcers can be internal or external).
- *Positively Reinforcing* a behaviour means that something the client sees as positive happens after a certain behaviour occurs.

Behaviour Theory: Definitions

- *Negatively Reinforcing* a behaviour means that something the client finds unpleasant is removed after a certain behaviour occurs
- *Intermittent Reinforcement* is when the positive or negative reinforcement occurs occasionally rather than every time the behaviour takes place; it is one of the most successful ways of reinforcing a behaviour, since the individual never knows when she'll be reinforced (e.g. the gambler)

Behaviour Theory: Definitions

- Non-contingent Reinforcement: providing reinforcement regardless of behaviour you want to decrease; the behaviour then decreases because it's not necessary to receive the reinforcement (e.g. Providing warmth and caring to your client just because that's you want to, not just to shape behaviour)

Behaviour Theory: Definitions

- Punishment – something is taken away (negative) or added (positive) in order to reduce a behaviour (e.g. no more video games; detention)
  - It's important to consider that punishment can be harmful to relationships, and doesn't teach new behaviour, although it may be necessary at times
  - Punishment may also have the result of causing the client to hide a behaviour, suppress it when the punisher is around, or become self-punishing

Behaviour Theory: Definitions

- Extinction – reinforcers are discontinued in order to reduce/extinguish a behaviour
- Extinction Burst (behavioural burst) – generally occurs when reinforcers are discontinued

Behaviour Theory: Definitions

- Consequence: The outcome of something that occurred earlier. In other words, when looking at the consequences of an individual's behaviour, we're asking the question "what happened after the person acted?"
- Consequences can be positive or negative
- Natural consequences tend to work best – e.g. if a client engages in a TIB a natural consequence is that I withdraw warmth and engagement and feel angry

Behaviour Theory: Definitions

- Shaping: By reinforcing behaviours that are close to the desired, end behaviour, you can shape an individual's behaviour (e.g. eliminating physical aggression with anger; self-harm replaced with physical pain).
- Modeling: demonstrating a behaviour for someone else to imitate (e.g. validation!)

Behaviour Theory: Definitions

- A *contingency* is when there is a relationship between two events, so that if one event takes place, the other event is more likely to also occur
- *Contingency management* requires the therapist to organize their behaviour strategically, so that client behaviours representing progress are reinforced, and unskilful or maladaptive behaviours are extinguished or punished (main contingencies are often disapproval, interpersonal distance)

Behaviour Theory: Definitions

- We want to help clients learn to manage their own contingencies (e.g. “once I’ve done this, I’ll allow myself to do that…”; reinforcing behaviours we want to increase, etc.)

Behaviour Theory: Contingency Management

For example: the 24-Hour Rule

If a client self-harms, the DBT therapist will not increase therapeutic contact for 24 hours (will keep any previously scheduled contact)

This is meant to increase the client's motivation to seek contact when she needs help to not engage in these behaviours; and to ensure the therapist doesn't reinforce the self-harm

Behaviour Theory

We always have to be considering:

1. Are we (or others) reinforcing behaviours we don't want?

2. Are we (or others) providing negative consequences or punishers to behaviours we do want?

3. How can we shape or model positive behaviours so that the client will eventually engage in these behaviours on her own?

(we also have to remember to consider context – just because something might have an unwanted effect, doesn't mean we don't still do it)

Homework

1. Take a dialectical perspective
2. Practice validating

Thank You!!!