Dialectical Behavior Therapy

Dialectical Behavior Therapy:

Adaptations and new applications

Special Series

Cognitive and Behavioral Practice

The first article is:

Miller, A. L., & Rathus, J. H. (2000). Introduction. Cognitive and Behavioral Practice, 7, 420-425.

General Background

- Marsha Linehan (1993a). Cognitive Behavioral Treatment of borderline Personality Disorders. NY: Guilford Press.
- Marsha Linehan (1993b). Skills training manual for treating borderline personality disorder. NY: Guilford Press.
- Targets chronically parasuicidal adult outpatients diagnosed with BPD.
- Parasuicide: "…any acute, intentional, self-injurious behavior resulting in physical harm, with or without intent to die" (p. 420).

General Background

- Linehan et al (1991) reported significant reductions in anger and parasuicidal behaviors during inpatient stay in addition to improved social adjustment.
- Results were maintained at 1 year follow up.
- Other investigators have found good results with outpatients.
- DBT is suited for behavioral dyscontrol including substance abuse and violence.

Standard DBT Has a Dialectical Worldview

- DBT is based on dialectical philosophy.
  - Assumes opposing internal forces in continuous flux (very psychodynamic)
  - This entails multiple tensions and motives
- Pts are taught to accept this condition (cf. Hayes's Acceptance & Commitment Therapy)
- Explores contradictory emotions, cognitions, and behavior patterns.
- Attempts to find middle ground.
- [Like Freudian psychodynamic Ego functions. Freud was very dialectical: e.g., Id = Thesis vs. Superego = Antithesis, Ego = Synthesis]

Standard DBT Has a Dialectical Worldview

- Therapist uses dialectics in two ways:
- 1) Attempts to maintain a collaborative therapeutic relationship by balancing:
  - change & acceptance
  - flexibility & stability
  - challenging & nurturing
- 2) Teaches and models dialectical thinking and behavior by:
  - Highlighting contradictions in pts behavior and thinking.

Standard DBT Has a Dialectical Worldview

- By offering opposite or alternative positions.
- By maintaining that truth is not absolute but is constructed and evolves over time.
- Attempts to find synthesis of oppositions (Hegel: Thesis, Anti-thesis, Syn-thesis)
- [Freud's Id, Superego, and Ego system entails the dialectic as noted previously.]
- [Freudian psychotherapeutic interventions are pertinent here.]
- [Dialectics entail constraint satisfaction.]
- [Connectionism implements constraint satisfaction.]
- [Freud would have been a connectionist.]

Dialectical Dilemmas and Treatment Targets

- DBT, like Behavior Modification (operant oriented treatment) identifies behavioral excesses and deficits.
  - [[Tryon, W. W. (1996). Observing contingencies: Taxonomy and methods. Clinical Psychology Review, 16, 215-230.]
  - [Behavioral Dx implies behavioral Rx.]
- DBT seeks to decrease certain behaviors and increase others.
- These are expressed dialectically as follows:

Dialectical Dilemmas and Treatment Targets

Dilemma

- Emotional Vulnerability vs. Self-Invalidation

Treatment Target

- Increasing emotional modulation.
- Decreasing emotional reactivity.
- Increasing self-validation
- Decreasing self-invalidation.

Dialectical Dilemmas and Treatment Targets

Dilemma	Treatment Target
• Active Passivity vs. Apparent Competence	• Increasing active problem solving. • Decreasing active passivity. • Increasing accurate communication. • Decreasing mood dependency of behavior.

Dialectical Dilemmas and Treatment Targets

Dilemma

- Unrelenting Crisis vs. Inhibited Grieving

Treatment Target

- Increasing realistic decision making and judgment.
- Decreasing crisis-generating behaviors.
- Increasing emotional experiencing.
- Decreasing inhibited grieving.

Functional Assessment

- Is used to determine what triggers and maintains behavioral sequences (chains).
- [S-O-R model.]
- [Discriminative Stimuli (S^D) set the occasion for behavior.]
  - [Operant behavior is about choice.]
  - [Skinner is an R-S not an S-R psychologist.]
  - [Stimuli set the occasion for behavior but do not elicit behavior as in S-R psychology.]

Functional Assessment

- [O stands for Organism and is represented by the middle layer in three layered CNN models. It is where concepts are formed.]
- [R represents Response, observed behavior. It is maintained by its consequences.]
  - [Reinforcement ALWAYS strengthens behavior.]
    - [Onset of Positive stimulus = Reward C.]
    - [Offset of Negative stimulus = Relief C.]

Biosocial Theory of BPD

- Primary problem in BPD is pervasive emotional dysregulation.
- Results from:
  - A predisposed individual (temperament)
  - An environment that is a poor fit with this vulnerability
    - Invalidating environment: Your responses are incorrect, faulty, inappropriate or otherwise invalid.
    - Sometimes PBD patients elicit invalidation from their environment.

Biosocial Theory of BPD

- Parasuicidal behaviors are seen as:
  - Failures to self-regulate and
  - Dysfunctional attempts to regulate
    - The behaviors of others.
    - Painful affective states.
  - [We know that depression results from a lack of control. See Seligman's work]

Biosocial Theory of BPD

- Valuable clinical features of this theory are:
- 1) It avoids “blaming the victim”
- 2) It facilitates psychoeducation by identifying inadequate learning experiences.
- [Learning & Memory are the two (one?) fundamental psychological processes.]
- 3) It helps pts acquire skills
  - to modulate extreme emotions,
  - to reduce emotional vulnerability
  - to reduce maladaptive mood-dependent behaviors
  - to validate their own thoughts, feelings, and behaviors.

Treatment Functions and Modes

- The following FIVE treatment functions are provided in several modes.
- 1) Enhancing the pts capabilities.
- 2) Improving the pts motivations.
- 3) Generalizing new skills to daily life.
- 4) Enhancing the therapists capabilities and motivation to effectively treat pts with BPD
- 5) Structuring the environment to support what has been learned.

Multiple Functions

- Function 1: Pts commit to 12 months of psychoeducation skills training.
- Function 2: Each pts has an individual therapist.
- Function 3: Generalization is promoted by telephone or in vivo sessions.
- Function 4: DBT therapists provide weekly supervision to other DBT therapists.
- Function 5: Structure the environment via family, school and other consultations. Be the pts advocate so they do not have to get worse to get help.

Weekly Group Meetings

- Concentrate on Behavioral Skills in Four areas:
- 1) Mindfulness skills
- 2) Distress tolerance skills
- 3) Emotion-regulation skills
- 4) Interpersonal effectiveness skills

Weekly Individual Therapy

- Focus is determined by treatment target hierarchy (discussed latter on) and
- Patient's behavior since the last session.
  - Pts use diary cards to self-monitor
  - Maladaptive behaviors (e.g., self-cutting, drug use).
  - Adaptive behaviors (use of specific skills).
- Therapists use functional analysis to identify S-O-R sequences regarding specific events.
- Behavioral chains identify what to work on.

Weekly Individual Therapy

- Therapists actively teach and reinforce specific adaptive behaviors while extinguishing maladaptive behaviors. [This is shaping].
- Pts call therapist in between sessions on an as needed basis to manage crises.
- Therapists meet in a supportive group to ensure that they are providing DBT to the best of their abilities.

Stages of Disorder

- Pretreatment Stage: Addresses pts agreements and commitment to treatment.
- Stage 1: Severe behavioral dyscontrol
- Stage 2: Quiet desperation
- Stage 3: Problems in living
- Stage 4: Incompleteness
- Research to date has been on Stage 1 pts.

Hierarchy of Treatment Targets

- A) Decrease life-threatening homicidal, suicidal, and parasuicidal behaviors.
- B) Decrease noncompliance and premature dropout.
- C) Decrease depression, drug abuse, school dropout, criminal behavior, and all other behaviors requiring in-patient care.
- D) Increasing behavioral skills.

Hierarchy of Treatment Targets

- Therapists address hierarchy in order (A-->D) that is relevant at the moment.
- This is a “principled” rather than “manualized” approach to treatment.
- The skills training groups are manualized.
- Other manualized treatments may be used.
- [Behavior modification has always been principled in that:
  - Functional assessment determined the problem.
  - Behavioral Dx determined behavioral Rx.]

Hierarchy of Treatment Targets

- [Tryon, W. W. (1996). Observing contingencies: Taxonomy and methods. Clinical Psychology Review, 16, 215-230.]
- Secondary Treatment Targets are woven into the above mentioned treatment targets.
  - Decreasing crisis generating behavior.
  - Increasing self-validation.

Integration of Acceptance With Change Strategies

- DBT pioneered integration of acceptance with change strategies.
- Acceptance and Commitment Therapy (ACT)
  - Hayes, S. C., Jacobson, N., Follette, V. M., & Dougher, M. (1994). Acceptance and change: Content and context in psychotherapy. Reno, NV: Context Press.
  - Jacobson, N. S., & Christensen, A. (1998). Acceptance and change in couple therapy: A Therapist's guide to transforming relationships. NY: W. W. Norton & Co.

Integration of Acceptance With Change Strategies

- Learn to distinguish and accept what you cannot change from what you can change.
- Similar to the alcoholic's creed that asks for strength to change what can be changed, to accept what cannot be changed, and to know the difference.
- Dialectical tension and resolution (synthesis) between accepting things the way they are (thesis) and working for change (antithesis).

Multiproblem Patients in Long-Term Treatment

- CBT is usually given for 8 to 16 weeks.
- Efficacy has been evaluated in “pure” samples.
- DBT was developed as a long-term treatment (2 or more years) for highly comorbid patients.

Emphasis on Therapeutic Relationship

- A strong working alliance is crucial when treating suicidal and borderline patients.
- Behaviors (by the therapist as well as the patient) that interfere with therapy have the highest priority after suicidal behavior.
- The therapeutic relationship:
  - Is a vehicle by which therapy is administered.
  - Is also considered therapeutic by itself.

Creating a Therapeutic Relationship

- **Trust** and **attachment** are augmented:
- Through warmth (e.g., Rogerian stance)
- Through appropriate self-disclosure (cf. Jourard)
  - [Freudian therapists would never do this.]
- By validating the patient's experiences.
  - Including negative feelings about therapy.
  - Explicitly identifying such feelings.
- Anticipating therapy-interfering behaviors.
- Being available by phone in between sessions.
  - [Freudian therapists would never do this.]

Dialectical Behavior Therapy:

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Special Series

Cognitive and Behavioral Practice

The second article is:

Rathus, J. H. & Miller, A. L. (2000). DBT for adolescents: Dialectical dilemmas and secondary treatment targets. Cognitive and Behavioral Practice, 7, 425-434.

DBT Modifications to Treat Adolescents

- Shorten first phase from 1 year to 12-16 weeks.
- Including parents in the skills training groups to enhance generalization and maintenance.
  - Parents serve as coaches.
  - Reduce invalidating home atmosphere.
- Including family into individual sessions when familial issues are paramount.
- Reducing the number of skills taught
  - to save time and
  - learn each skill better

DBT Modifications to Treat Adolescents

- Simplifying language on skills handouts.
- Formation of secondary behavioral treatment targets and corresponding adolescent dialectical dilemmas.
- The following three slides contain dialectical dilemmas and corresponding secondary treatment targets that have been modified for working with adolescents and families.

Dialectical Dilemmas and Treatment Targets

Dilemma	Treatment Target
• Excessive Leniency vs. Authoritarian Control	• Increasing authoritative discipline. • Decreasing excessive leniency. • Increasing adolescent self-determination. • Decreasing authoritarian control.

Dialectical Dilemmas and Treatment Targets

Dilemma

- Normalizing Pathological Behaviors vs. Pathologizing Normative Behaviors

Treatment Target

- Increasing identification of pathological behaviors.
- Decreasing normalization of pathological behaviors.
- Increasing recognition of normative behaviors.
- Decreasing pathologizing of normative behaviors.

Dialectical Dilemmas and Treatment Targets

Dilemma	Treatment Target
• Forcing Autonomy vs. Fostering Dependence	• Increasing effective reliance on others. • Decreasing excessive autonomy. • Increasing individuation. • Decreasing excessive dependence.

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Cognitive and Behavioral Practice

The third article is:

Fruzzetti, A. E., & Levensky, E. R. (2000). Dialectical behavior therapy for domestic violence: Rationale and procedures. Cognitive and Behavioral Practice, 7, 435-447.

Domestic Violence

- 1.8 million wives are assaulted by their spouses each year (Straus & Gelles, 1990).
- Partner abuse occurs in from 2.5 - 4.0 million homes each year (Feld & Straus, 1989).
- 20% of all women's emergency room visits result from battering (Houskamp & Foy, 1991).
- Dropout from standard treatment is high.
- Outcome from standard treatment is poor.
- Recidivism is high.
- New treatment (DBT) is therefore needed.

Emotion-Dysregulation Model

- A subgroup of batters have Borderline Personality Disorder.
- Battering is a consequence of BPD.
- DBT is an empirically supported treatment for BPD.

Treatment Targets: Decrease

- Life-threatening behavior
- Violent thoughts and urges
- Child neglect
- Therapy-interfering behaviors
- Criminal behaviors
- Promiscuity
- Illness-related dysfunctional behaviors
- Housing-related dysfunctional behaviors

Treatment Targets: Increase

- Mindfulness
- Distress tolerance
- Emotion regulation
- Interpersonal effectiveness
- Validation and empathy

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Cognitive and Behavioral Practice

The fourth article is:

McCann, R. A., & Ball, E. M. (2000). DBT with an inpatient forensic population: The CMHIP forensic model. Cognitive and Behavioral Practice, 7, 447-456.

Forensic Populations

- Are incarcerated against their will.
- Are about 97% males.
- Have engaged in antisocial behaviors.
- 67% have been adjudicated no guilty by reason of insanity.
- 50% - 80% have Borderline Personality Disorder.

Why Use DBT With Forensic Pts?

- 50% - 80% have Borderline Personality Disorder
- DBT has clear behavioral target hierarchy
- Managing aggressive or life-threatening behaviors on a forensics unit is crucial.
- DBT supports therapists and minimizes staff burnout.
- Hospital accreditation organizations favor empirically supported treatments.

Biosocial Model Confirmation

- Twin studies indicate that antisocial behavior is moderately heritable (McGuffin & Thapar, 1998).

Steps for Changing Emotions by Acting Opposite to Apathy or Detachment

- Make a list of prior wise-mind commitments. Do them.
- Commit Random acts of kindness. Again and again.
- Listen mindfully to another person.
- Participate in a group activity, even though you do not feel like it.

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The fifth article is:

Dimeff, L., Rizvi, S. L., Brown, M., & Linehan, M. M. (2000). Dialectical behavior therapy for substance abuse: A pilot application to methamphetamine-dependent women with borderline personality disorder. Cognitive and Behavioral Practice, 7, 457-468.

Overview

- 12-month treatment.
- Small pilot study using standard DBT methods.
- Promising results with a treatment resistant population.
- Further research is needed.

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The sixth article is:

Lynch, T. R. (2000). Treatment of elderly depression with personality disorder comorbidity using dialectical behavior therapy. Cognitive and Behavioral Practice, 7, 468-477.

Geriatric Treatment

- Depression in the elderly is treatable.
  - Psychotherapy
  - SSRIs
  - ECT
- Borderline Personality Disorder persists into old age.

Dialectical Dilemmas for Depressed Elderly

- Bitter Attachment vs. Mindless Approval
  - Always being right; regardless of consequences vs.
  - Giving up via mindless approval.

- Problem brooding vs. Problem Avoidant
  - Obsessing on problem solutions vs.
  - Solving problems through avoidance.

Dialectical Dilemmas for Depressed Elderly

- Withdrawal from others when stressed (apparent autonomy) vs. rigidly seeking and demanding nurturance from others and getting them to solve your problem (active passivity)[Passive Aggressive].

- Self-verifying by proving that one is truly distressed vs. I must be perfect and life should be easy.

DBT Diary Sheet

- Alcohol/Drug use
- Over-the-counter medications
- Rx meds taken as ordered
- Suicidal ideation
- Self-invalidation ideation
- Dysregulated emotion
- ACTIVITY LEVEL
- Fatigue
- Appetite
- Sleep [NOCTURNAL ACTIVITY LEVEL]
- Skill usage

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Cognitive and Behavioral Practice

The seventh article is:

Linehan, M. M. (2000). Commentary on innovations in dialectical behavior therapy. Cognitive and Behavioral Practice, 7, 478-481.

- DBT is based on the view that suicidal behavior is problem-solving behavior.
- The most consistent problem suicide solves is unregulated painful emotion.
- BPD behavior is viewed as:
  - A consequence of emotional dysregulation.
  - Efforts to regulate out-of-control aversive emotional states.
- DBT targets the dysfunctional behavior patterns that are functionally linked to emotional arousal.

- The DBT modifications presented in this series entail greater specification of specific behaviors targeted for change.
- Primary DBT targets entail behaviors that need to
  - Decrease or be eliminated (e.g., suicide)
  - Increase (communication skills)
- Secondary DBT targets are response patterns that are functionally linked to emotional states.
  - I behave in certain ways because I feel like doing so.

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The eighth article is:

Robins, C. J. (2000). Response: Expanding applications of Dialectical Behavior Therapy: Prospects and pitfalls. Cognitive and Behavioral Practice, 7, 481-484.

Major Headings Include

- Strengths of DBT adaptations
- Data before dissemination
- Can DBT be disseminated?
  - Can DBT be done effectively in clinical settings?
- Which aspects of DBT for which disorders?


The End