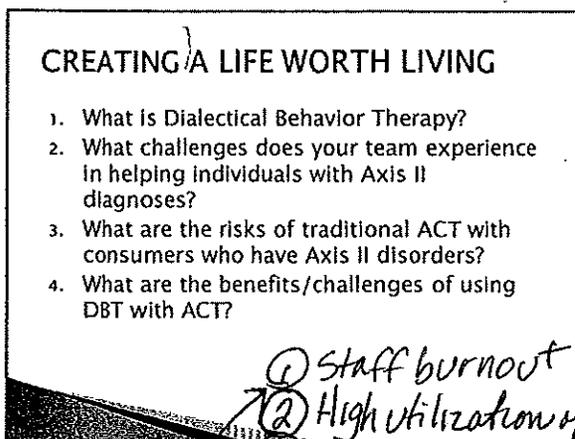


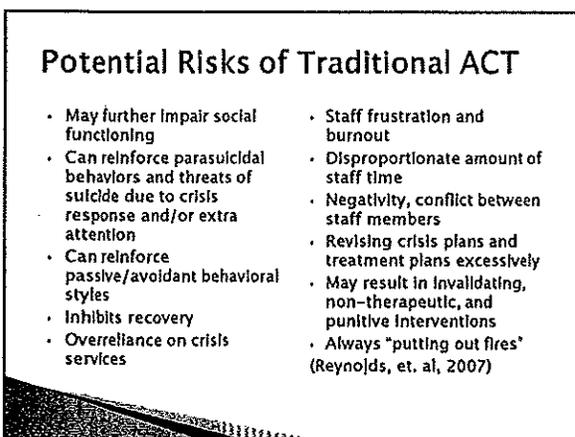
- ① ind skillbuilding
- ② ind. therapy
- ③ group therapy

* mindful exercise -



- Helps /c/ manage painful emotions
- ✓ Help available
- ✓ Tools, supports

- ① Staff burnout
- ② High utilization of Crisis line
- ③



Benefits of ACT with DBT Track

- › Dialectical Behavior Therapy is an Evidenced Based Model
- › Provides conceptual framework and treatment strategies
- › Efficacy for reducing suicidal, parasuicidal, and other behaviors that precipitate crises
- › Reduces "out-of-control" behaviors are often associated with emotional dysregulation
- › Helps individuals "create a life worth living"
- › Reduces staff frustration/burnout

Challenging Misconceptions

- › Persons with Borderline Personality may be perceived as:
 1. Manipulative
 2. Attention-Seeking, Needy
 3. "Upping the ante", "playing games"
 4. Like the "drama"; Play the victim
 5. Not trying; not wanting to get better
 6. "Splitting"; creating conflict with treatment providers
 7. Trying to start a fight; take out their frustration on everyone else

Assumptions of DBT

- | | |
|--|--|
| › Doing the best they can | › Lives are unbearable- "living hell" |
| › Want to Improve | › Solution is to create better lives |
| › Need to do better, try harder, be motivated to change | › Cannot fall, have deficits in motivation that must be overcome |
| › Have not caused all there own problems but need to solve them anyway | › Therapists need support! |
| › Need to learn new behaviors | |

Theoretical Basis

- ▶ From Cognitive Behavioral Treatment of Borderline Personality Disorder (Linehan, 1993)
- ▶ Biosocial Theory: results from biological predisposition, dysfunctional/invalidating environments, and interactions over time
- ▶ Adopt characteristics of invalidating environment, invalidate own emotional experiences, look to others to understand external reality, oversimplify solving life's problems leading to unrealistic goals
- ▶ Emotional regulation is primary dysfunction; high emotional vulnerability

TRAUMA, ABUSE, NEGLECT, TRUST

ACCEPTANCE/VALIDATION

Dialectical Approach

- ▶ Dialectics: "Reconciliation of opposites in a continual process of synthesis" (Linehan, 1993)
- ▶ Accepting patients just as they are within the context of helping them to change
- ▶ Believe in client's essential desire to grow and progress, inherent ability to change
- ▶ Validation: Frequent, sympathetic acknowledgement of emotional desperation
- ▶ Parasuicidal and other dysfunctional behaviors are part of learned problem solving
- ▶ Change by focusing on active problem solving; acceptance/validation of client's emotional, cognitive, and behavioral responses

look @ both sides ,

Therapeutic Targets

1. Suicidal Behaviors
2. Parasuicidal/self-harming behaviors (cutting)
3. Therapy Interfering Behaviors
4. Quality of Life Interfering Behaviors
5. Skills Deficits
6. PTSD Behaviors
7. Self-Respect
8. Individual Goals

Core Techniques

1. Problem Solving
2. Exposure
3. Skills Training
4. Contingency Management
5. Cognitive Modification
6. Behavioral Analysis
7. Validation
8. Dialectics

Preventing Suicidal / Self-Destructive Behaviors

- › Assess frequency, intensity and severity of behavior
- › Conduct Chain Analysis with moment-to-moment detail (events, emotional and cognitive responses, overt actions, and consequences)
- › Discuss Alternative Solutions, tolerating negatives/consequences
- › Recognize negative effects of self-destructive behavior
- › Reinforce nonsuicidal/nonsel-injurious responses
- › Obtain commitment to non-suicidal behavioral plan
- › Validate pain
- › Relate current behavior to overall patterns

(Linehan, 1993)

Therapy Interfering Behaviors

Client TIB

1. Nonattentive
2. Noncollaborative
3. Noncompliant
4. Interfering with other patients
5. Pushing Therapist Limits
6. Lack of Progress

Therapist TIB

1. Creating therapeutic imbalance (Inflexible, overemphasis on change, not teaching skills, infantilizing)
2. Lack of Respect (cancelling, avoiding calls, taking calls during session, inattentive)

Addressing Therapy Interfering Behaviors

1. Actively work to reduce behaviors that will inhibit treatment/reduce motivation of the therapist
2. Point out that unconditional positive regard does not exist
3. Individual in treatment must be willing to engage in techniques essential to therapeutic effectiveness
4. Teach the individual to engage in therapy enhancing behaviors



→ Sometimes supporters have "HAD ENOUGH"

Treatment Orientation

1. DBT is a supportive, "life-enhancement program" not suicide prevention
2. Behavioral- behavioral analysis; learning and practicing skillful behavior
3. Cognitive- Examine and change thoughts to reduce extremes and judgments
4. Skill Development to enhance abilities
5. Balance acceptance and change
6. Collaboration- client and therapist function as a team (relationship is key!)

Therapy Enhancing Behaviors

1. Make progress toward goals
2. Avoid suicidal/parasuicidal behaviors
3. Trying out behavioral suggestions
4. Asking therapist when calling is acceptable- and accepting "No" as an answer
5. Keeping agreements
6. Accepting shorter phone calls as needed
7. Calling to cancel in reasonable time frame
8. Showing a sense of humor
(Must be taught; not expected!)



ASSERTIVE - ASK FOR WHAT YOU WANT & ACCEPT ANSWER

Quality of Life Interfering Behaviors

Suicidal and unhappy because of life; solution: Change Quality of Life!

1. Substance Use
2. High Risk Sexual Behavior
3. Extreme Financial Problems
4. Criminal Behavior
5. Extreme Dysfunctional Interpersonal Behavior
6. Vocationally Dysfunctional
7. Illness related dysfunctional behavior
8. Housing related dysfunctional behavior
9. Mental Health dysfunctional behavior
10. Behavioral patterns on Axis I./II.

Skills Training

1st Stage

1. Mindfulness
2. Interpersonal effectiveness
3. Emotional regulation
4. Distress Tolerance

2nd Stage

1. Decreasing Posttraumatic Stress
2. Increasing Respect for Self
3. Achieving Individual Goals

Skills Training Procedures

- › 1. Skills Acquisition: involves teaching new behaviors.
- › 2. Skill Strengthening: involves "fine-tuning" skills to increase the probability of use of skill.
- › 3. Skill generalization: involves discussing the similarities and differences in situations in which skills are used.

①

Core Mindfulness Training

- › Main foci:
 - Learning to go within to find oneself
 - Learning to observe oneself
- › Three "what" skills
 - Observing
 - Describing
 - Participating
- › Three "how" skills
 - Taking a nonjudgmental stance
 - Focusing on one thing in the moment
 - Being effective

②

Interpersonal Effectiveness Training

- › Main foci:
 - Learning to deal with conflict situations
 - Learning how to obtain what one wants and/or needs
 - Learning to say "no" to unwanted requests
 - Maintaining self-respect
- › Goals:
 - Decrease in interpersonal chaos
 - Maintenance of self-respect

Conflict resolution

assertive

learn to say "No"

③

Emotion Regulation Training

- › Main foci:
 - To enhance one's control of emotions, even is COMPLETE emotional control cannot be achieved
 - Becoming mindful of one's emotions and maintaining a nonjudgmental stance when describing them.
- › Goal:
 - To decrease labile affect, mood, and emotions

Distress Tolerance Training

- › Main foci:
 - Learning to tolerate and survive crises
 - Learning to accept life as it is in the moment
- › Crisis survival strategies:
 - Distraction, self-soothing, improving the moment, and thinking of pros and cons
- › Acceptance skills:
 - Radical acceptance, turning the mind toward acceptance, and willingness vs. willfulness

Individual Therapy

1. Convey expertise, credibility and efficacy
2. Begin with warm, inviting attitude
3. Recognize emotional state, topics important to client, agenda to address targets and topics of importance to both parties
4. Validate: acknowledge use of maladaptive solutions and emotional suffering; use strengths to help get out of misery and "to create a life worth living"

Therapeutic Process

- › Problem-Solving:
 1. Behavioral analysis of targeted behaviors
 - a. Chain analysis, precipitants to maladaptive behavior
 - b. Functional analysis of reinforcing contingencies
 2. Solutions analysis for alternatives
 3. Orienting to proposed solutions and skills needed to engage in strategy
 4. Eliciting commitment
 5. Applying Procedure

Process integrates skills training, contingency management, exposures, reduction of inhibitions/fears, and cognitive modifications to address faulty/beliefs and assumptions (Linehan, 1993)

Telephone Calls and Phone Coaching

- › May decrease parasuicidal and suicidal behaviors
- › Increases the application of skills to everyday life - essentially, "coaching during the game" of life
- › Precipitates crisis management
- › May resolve interpersonal crises, alienation, or sense of distance between client and provider



"The person is not responsible for the way he/she is, but is responsible for the person they become." (Linehan, 1993) »

Using DBT with ACT

- › Target Population: Individuals with emotional dysregulation in 3 out of 5 areas: affective, behavioral, interpersonal, self, cognitive
- › Exclusions:
 1. Extreme psychosis
 2. Substance Use that prohibits treatment (unwillingness/inability to attend without extreme intoxication)

(Reynolds, et. al, 2007)

Similarities Between DBT/ACT

- › Presence of Severe, Chronic, Complex problems
- › Uses rehabilitation to help consumers reduce hospitalization, homelessness, and improve living skills
- › Alternative, less intensive services not effective
- › Team Based Treatment
- › Keeping consumers engaged emphasized
- › Present focused, problem solving approach to develop skills in real world context/situations
- › Works with family/community/natural supports
(Reynolds, et. al, 2007)

Differences of DBT Approach

1. Increased emphasis on behavior change
2. Consultant to the consumer case management model ("with" rather than "for")
3. Commitment to DBT
4. Time limited; skills to create "life worth living" outside the mental health system
5. Therapy vacation and potential for termination when not adherent
6. Phone coaching prior to crises

Getting Started

Training for Team:

- DBT Specialists:**
1. Individual/Group Therapists
 2. Online/Seminar trainings
 3. Should have training in skills training, exposure, contingency management, cognitive restructuring
 4. Prepare for Implementation: Weekly meetings about approach/orienting team

DBT Generalists:

1. Other Team Members
 - Educate about differences between models including phone coaching for on-call, interaction styles
- › Specialists provide initial and ongoing training
- › Role of Psychiatrists/ Prescribing Professionals
- › "DBT Informed" status



Selecting Participants

- 1. Select those who meet criteria.
 - 2. Participation is voluntary
 - 3. Demonstrate how client's goals may be achieved using DBT
 - 4. Orient to DBT and obtain commitment
- Establish Baseline Data:
- › Self Injurious Behavior
 - › Suicide attempts
 - › Crisis Contacts
 - › Drug/Alcohol Use
 - › Psychiatric Inpatient Days
 - › Medical Inpatient Days
 - › ER Visits
 - › Police Contacts
 - › Loss of Housing
 - › Loss of Job

Treatment Course

- › Individual Therapist
 1. Strong relationship; important reinforcer to stay engaged and working in treatment
 2. Contingencies enhance clinical growth
 3. Should avoid role confusion, but sometimes necessary in team
- › Skills Training
 1. Group
 2. Individual
- › Therapy Vacation- contingency used to elicit behavior change, reduce TIB, and reestablish commitment (may last 4-8 weeks)

Other Treatment Aspects

- DBT Consultation Group
1.
 - › Case Management utilizes "Consultation to the Patient" Strategies, avoid "doing for"
 - 1. "in vivo coaching, opportunity to generalize skills in real life"-does not reinforce passive problem solving
 - 2. Ex. Managing trip to grocery store, doctor visit, frustration in traffic, dealing with Social Security, etc.

wkly team mtg (DBT Tx Team)

References and Recommended Readings

1. Linehan, M. (1993). *Cognitive Behavioral Treatment of Borderline Personality Disorder*. New York: Guilford Press
2. Linehan, M. (1993). *Skills Training Manual for Treating Borderline Personality Disorder*. New York; Guilford Press
3. McKay, M., Wood, J.C., & Brantley, J. (2007) *The Dialectical Behavioral Skills Workbook: Practical DBT Exercises for Learning Mindfulness, Interpersonal Effectiveness, Emotional Regulation, and Distress Tolerance*. Oakland, CA: New Harbinger Publications.
4. Reynolds, S.K., Wolbert, R., Abney-Cunningham, & Patterson, K. (2007). Dialectical Behavior Therapy for Assertive Community Treatment Teams. In Dimelf, L.A. & Koerner, K. (Eds.) *Dialectical Behavior Therapy in Clinical Practice: Applications Across Disorders and Settings*. New York: Guilford Press

On-Line Resources

1. www.behaviortech.org
2. www.dbtselfhelp.com
3. www.anythingtostopthepain.com/tag/dbt/ (Self-injury alternatives with DBT)
4. <http://www.tara4bpd.org/dyn/index.php> (Treatment and Research Advancements)

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