Welcome!
Comprehensive Training in Dialectical Behavior Therapy
Part 1

Please sit with your team.

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Why Learn a New Treatment?
Why DBT?

• Better outcomes: empirically supported improvements across key outcomes
• More efficient: uses few resources (in any part of system)
• Provider preference: reduced burnout, more consistent with values, aesthetics; may increase mindfulness
Training Overview

- DBT is Evidence-based
- DBT modes & functions
- Diagnosis & assessment
- Biosocial/transitional model
- Understanding emotion
- Dialectics
- Levels of disorder & treatment target hierarchy
- Primary & secondary targets
- Behavioral assessment & chain analysis
- Change strategies
- Acceptance & validation

Parts 2-4
- Overview of DBT skills
- Building a skill curriculum
  - Skill training
  - Skill generalization/coaching
  - Crisis management
  - Consultation team
  - In-session TIB management
  - Case consultation
  - Building your program
  - Family interventions
  - Fidelity and adherence

DBT: Evidence-Based Treatment

- More than 100 studies, dozens controlled trials
  - Adults & adolescents, males & females
  - Mostly severe and/or refractory problems
  - Outpatient, inpatient, day programs, forensics, residential treatment programs; other disabilities
  - BPD, BPD features, antisocial, mixed PD; non-BPD
- Outcomes are consistent across studies
  - ↓Suicide attempts, self-injury, aggression, etc.
  - ↓Substance abuse, eating disorders, anger, depression, PTSD, family/relationship problems
  - ↓Dropout from treatment & relapse
  - Costs reduced 50% or more

DBT is the Standard of Care for BPD + Out-of-Control Emotions & Behaviors (multi-problem presentations)

Studies vary in length of intervention, follow-up, measurement, treatment population, severity, etc., but show consistent improvement across multiple domains (not only safety and behavior self-control, but also quality of life, independent living, etc)

Outcomes are consistent across studies.
Key Readings (optional)


What is DBT?

What is a DBT Program?

DBT Functions & Modes of Therapy

1. Enhance capabilities
   SKILLS TRAINING (Skills Acquisition), Pharmacotherapy
2. Improve motivation (Establish primary targets, do chain analysis & solution analysis, get commitment...with validation).
   INDIVIDUAL THERAPY, Group, or Family Therapy
3. Assure generalization to natural environment
   In vivo or Phone Consultation, After-hours & Crisis Service, Milieu, Systems Interventions, Generalization Planning
4. Enhance therapist capabilities and motivation to treat
   Therapists’ CONSULTATION TEAM MEETING, Supervision, Continuing Education, Staff Incentives
5. Structure the environment to allow progress
   Admin. or Treatment Setting, Family Interventions
DBT is a Comprehensive, Multi-component, Principle-driven Treatment

Mode of delivery of services are flexible, and data do not favor one mode over another. However, providing all functions is required to be “DBT” and, so far, data show decrements in outcomes if functions are not provided.

DBT Principles and Strategies are Employed in Every Mode of Treatment
Key Reading (team):


DBT for whom?

DBT is Transdiagnostic

In DBT

Borderline Personality Disorder is:

A Pervasive Dysfunction of the Emotion Regulation System

BPD is the prototype for emotion dysregulation disorders.

DBT treats disorders of emotion dysregulation.
Emotion Dysregulation Disorders

• Maladaptive behaviors *function* primarily to regulate emotions (or, are the natural consequences of chronic emotion dysregulation)
• Examples: cutting, drug use, restricting eating, aggression, suicide thinking or attempts

Emotion Dysregulation ≠ High Arousal or Being Upset

Form ≠ Function

Emotion dysregulation can *appear* as under-controlled or over-controlled.
Borderline Personality Disorder

Emotion Dysregulation
Affective lability
Problems with anger

Interpersonal Dysregulation
Chaotic relationships
Fears of abandonment

Self Dysregulation
Identity/difficulties with sense of self
Sense of emptiness

Behavioral Dysregulation
Suicidal and non-suicidal self-injury
Impulsive behavior

Cognitive Dysregulation
Dissociative behavior/transient paranoia

Arousal versus Performance

<table>
<thead>
<tr>
<th>Performance level</th>
<th>Difficult tasks</th>
<th>Easy tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Arsenal</td>
<td></td>
<td>Arsenal</td>
</tr>
<tr>
<td>High</td>
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</tbody>
</table>
Co-morbidity/Co-occurring Disorders

- Depression
- Substance use
- Eating disorders
- Panic disorder
- PTSD
- Social phobia
- GAD
- Dissociation
- Violence & aggression
- Bipolar disorder
- Attention deficit disorder
- Conduct disorder
- Oppositional/defiant disorder
- DD/MR
- Other Cluster B disorders
- Other Personality Disorders

Biosocial Theory, or Transactional Model

Theory:
Bio-social or Transactional Model for the Development and Maintenance of Borderline Personality and other Disorders of Emotion Regulation
Step 1: Develop a Comprehensive, Dialectical Perspective on Severe Disorders that is both Scientific and Empathic

Or, conceptualizing and thinking like a DBT therapist

Healthy Transactions and Emotion Regulation

- Low Emotion Vulnerability
- Event
- Modest Heightened Emotional Arousal
- Accurate Expression
- Validating Responses
- Consistent Validating Responses
Healthy Emotional Processing

- “Bump” into stimulus → primary emotional response
- Notice and allow the primary emotion
- Approach it with interest and self-validation
- Others validate, offer instrumental support
- Problem-solve the situation, if needed
- Arousal goes down (natural course)
- Go on with life; “negative” counter-balanced by “positive”
- “Bump” again, and again...

What Goes Wrong

- Too many big negative “bumps” (too few +) and/or very high vulnerabilities
- Increasingly avoid situations, ignore primary emotions/reactions (suppress, self-invalidate)
- Get judgmental about another, or self
- Jump to secondary emotion
- Others invalidate, increase demands
- Get stuck in primary or secondary emotion
- Get dysregulated... → helplessness, increased vulnerability, etc., & cycle escalates

Interactional Model:
Factors are Static, Independent

A ➔ B ➔ C
Transactional Model: Factors Influence Each Other (Reciprocal)

Individual Emotion Dysregulation

Invalidating Responses

Transactional Model for Emotion Dysregulation

Event

Heightened Emotional Arousal

Vulnerability - temperament - current biology - baseline now

Event

Heightened Emotional Arousal
Emotion Vulnerability Requires the Presence of All Three Factors:

1. High sensitivity
   - High level of discrimination of stimuli with an emotional valence
2. High reactivity
   - When discriminated, reactions are extreme
3. Slow return to baseline
   - Slow return leaves the individual vulnerable to the next emotional stimulus

Transactional Model for Emotion Dysregulation

Primary and Secondary Emotions

- Primary emotions: initial response, normative, typically adaptive, effective
- Secondary emotions: emotional response to primary emotion itself; through over-learning, secondary emotional responses may even become a problematic initial emotional response
- Goal or strategy: treat primary emotions; ignore/extinguish/refocus away from secondary emotions

(cf. Greenberg & Safran, 1989)
Secondary Emotional Reactions

Sadness  
Fear  
Guilt  
Jealously  
Shame  
Frustration  

Conditioned

Anger or Shame

Secondary Emotional Reactions

Sadness  
Fear  
Guilt  
Jealously  
Shame  
Frustration  

Judgment

Mediated by judgments

Anger or Shame

Transactional Model for Emotion Dysregulation

High Emotion Vulnerability  

Event  

Judgments  

Heightened Emotional Arousal  

Dysregulated Behaviors:
- Self-harm
- Suicide attempt
- Substance use
- Depression
- Eating disorder
- Angry outbursts
- Aggression
- Withdrawal
**Transactional Model for Emotion Dysregulation**

- **Event**
- **High Emotion Vulnerability**
- **Heightened Emotional Arousal**
- "Inaccurate" Expression
- Invalidating Responses

**High Emotion Vulnerability**

**Event**

**Judgments**

**Heightened Emotional Arousal**

"Inaccurate" Expression

Invalidating Responses

**Parent, Partner, etc.**

**Event**

**Judgments**

**Heightened Emotional Arousal**

"Inaccurate" Expression

Invalidating Responses

**Parent or Partner**

**Event**

**Judgments**

**Heightened Emotional Arousal**

"Inaccurate" Expression

Invalidating Responses

**Vulnerabilities**

Invalidating Responses

**Emotional Arousal**
Impact on Negative Emotional Arousal of Validating vs. Invalidating Responses

Transaction Model for Emotion Dysregulation

High Emotion Vulnerability

Event (relational)

Judgments

Heightened Emotional Arousal

"Inaccurate" Expression

Dysregulated Behaviors

Invalidating Responses
Event
High Emotion Vulnerability
Judgments
Heightened Emotional Arousal
“Inaccurate” Expression
Invalidating Responses
Pervasive History of Invalidating Responses

Big Part of the Problem: Dysfunctional Two-Step
1. Inaccurate Expression
2. Invalidating Responses

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47
48
Big Part of the Solution: Healthy Two-Steps

1. Accurate Expression
2. Validating Responses

Heightened emotional arousal
Inaccurate self-expression

Invalidating responses

Severe Distress is Predicated On:
1. Emotion Vulnerability (combination of all 5 factors)
   a) Sensitivity
   b) Reactivity
   c) Slow return to baseline
   d) Current biology
   e) Current baseline
   PLUS
2. Inability to modulate emotions (lack of skillful self-management)
   PLUS
3. Invalidating social/family environment
Invalidating Environment

*Pervasive* communication that valid responses of the individual, especially private ones (e.g., emotions, thoughts, wants) are incorrect, inaccurate, faulty, inappropriate or otherwise invalid

Validating Family Environment

• Legitimizes the experiences of the members of the family, especially private ones (emotions, wants & desires, thoughts, beliefs, sensations, etc.)
• Validates those experiences EVEN when they are quite discrepant from others’
• Accepts: tolerates/appreciates differences; does not try to change or control
• Does not use aversive control strategies
• Communicates acceptance and caring
• Facilitates problem solving and coping

Parent Responses to Adolescent Children (~BPD)

<table>
<thead>
<tr>
<th>Validation</th>
<th>Invalidation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents of Clinic Children</td>
<td>Parents of Non-Clinic Children</td>
</tr>
</tbody>
</table>

Shenk & Fruzzetti, 2014

*p<.05
Validating Behaviors

- Validate the “valid”
- *Invalid*ate the “invalid” (only occasionally, and gently, after validating the valid)
- Do not require agreement
- Are not necessarily without criticism
- Are not necessarily pleasant

Invalidating Social/Family Environment

- Is not necessarily:
  - Mean, cruel, abusive, or negative
  - Neglectful, uncaring, dysfunctional
  - Pathological
- What it does mean
  - Valid behaviors, especially wants, emotions, are regularly missed (not attended to), disregarded, misunderstood, criticized, pathologized, etc.
  - Invalid behaviors, especially passive or dangerous behaviors, are legitimized

Invalidating Social/Family Environment

- Employs high levels of aversive control
- Pervasively rejects/punishes valid behaviors, especially “self” behaviors
  - Intrinsically motivated or free-operant behavior
- Punishes “accurate” and/or normative expressions of emotion & pain
- May intermittently reinforce problem or pain escalation
- May minimize the difficulty of tasks or of tolerating pain, or over-simplify problem solving
Invalidation is More Likely When:

- Behavior communicates private experience
- Behavior is “self-generated” (i.e., not under control of the immediate social environment)
- Behavior puts demands on others above the level they prefer
- Others do not have the ability to meet the level of need communicated
- Individual has different wants, emotions, beliefs, activities, etc., from the others

Consequences of Pervasive Invalidation

- The individual does not learn to:
  - Label her or his private experiences in a normative way
  - Express emotions accurately
  - Communicate pain effectively
  - Seek help effectively
  - Tolerate distress en route to alleviating distress
  - Effectively regulate emotions
  - Solve moderate to difficult problems
  - Trust her or his own experiences as valid
  - Develop a coherent “self”

Key Readings (at least one of these three):


Dialectics (Part 1)

Dialectics

• As a theory of behavior change
  – Thesis
  – Antithesis
  – Synthesis
• As a method of persuasion
• As a philosophical world view or system
  – Non-linear
  – Multiple pathways
  – Premium on successful working
Foundations of DBT

- Behavioral science
- Mindfulness practice
- Dialectical philosophy

Core Dialectic

Acceptance/Validation

Change/Problem Solving

Dialectics

Behavior Therapy

- Change
- Problem Solving
- Rationality
- Logic
- Experimental

Mindfulness Practice

- Acceptance
- Validation
- Observing/Knowing
- Paradox
- Experiential
Assumptions: Why make assumptions about anything?

Dialectical Assumptions 1: Patients
- Patients are doing the best they can
- Patients want to improve
- Patients must learn and use new behaviors in all relevant contexts
- Patients cannot fail in DBT
- Patients may not have caused all of their own problems, but they have to solve them anyway
- Patients need to do better, try harder, and/or be more motivated to change
- The lives of suicidal, borderline individuals are unbearable as they are currently being lived

Dialectical Assumptions 2: Therapy
- The most caring thing a therapist can do is help patients change in ways that get them closer to their own goals (not just talk about it)
- Clarity, precision, and compassion are of the utmost importance in the conduct of DBT
- The therapeutic relationship is a real relationship between equal human beings
- Principles of behavior are universal, affecting therapists and patients alike
- Therapists treating BPD patients need support
- DBT therapists can fail
- DBT can fail even when therapists do not
Comprehensive Treatment Across Treatment Settings

DBT Program Structure
Functions and Modes of Treatment

DBT Functions & Modes of Therapy

1. **Enhance capabilities**
   - SKILLS TRAINING (Skills Acquisition), Pharmacotherapy

2. **Improve motivation** (Establish primary targets, do chain analysis & solution analysis; get commitment...with validation)
   - INDIVIDUAL THERAPY, Group, or Family Therapy

3. **Assure generalization to natural environment**
   - In vivo or Phone Consultation, After-hours & Crisis Service, Milieu, Systems Interventions, Generalization Planning

4. **Enhance therapist capabilities and motivation to treat**
   - Therapists’ CONSULTATION TEAM MEETING, Supervision, Continuing Education, Staff Incentives

5. **Structure the environment to allow progress**
   - Admin. or Treatment Setting, Family & Social Environment
Outpatient DBT

- Typically provides all 5 functions
- May be associated with DBT-compatible inpatient program
- Can manage crisis or on-call services internally or can train crisis service in skills and how to manage DBT clients
- Need clear inclusion & exclusion criteria
- Typically long-term treatment when successful

Brief Inpatient DBT

- Target solving the crisis that got the patient into the hospital
- Manage inpatient behavior problems
- Use abbreviated skill modules
- May be organized as a track within an acute-care unit or may be the standard treatment modality
- Discharge the client as quickly as possible, preferably to a connected outpatient DBT program

Day Treatment

- Opportunity for intensive skill acquisition and strengthening PLUS immediate generalization opportunities throughout the program
- Combination of inpatient (targets) and outpatient (comprehensive)
Residential/Long-Term In-Patient

- Opportunity for intensive skill acquisition and strengthening PLUS immediate generalization opportunities throughout the program
- “All DBT, All the Time”
  - Integrate skill strengthening & generalization (skill coaching) throughout milieu
  - All functions of treatment are delivered
  - Can “step down” care to day treatment or outpatient

Specialized Populations

- DBT principles and strategies throughout program
- Minor adaptations and additions that are consistent with DBT principles and strategies
  - No need to re-invent the wheel
  - Let’s not drive the client crazy with incompatible additive treatments; Commit to one treatment model & deliver it well

Optional Key Reading:


NB: 2nd edition of this book is due soon…
Nuts and bolts of treatment:
Start with organizing problems into treatment targets, and not get overwhelmed ourselves

Stages of Disorder, Stages of Treatment, and Treatment Targets by Stage

Overarching DBT Goal: Creating a Life Worth Living
Overarching goals are not:
- Keeping the client alive
- Keeping the client out of the hospital
- Reducing the overall cost of care for the client

Note: However, all these things must be accomplished in order to achieve a life worth living.

Levels of Disorder & Stages of Treatment

Pre-treatment: Assess, orient, agree, commit

Stage 1: Severe Behavioral Dyscontrol
Goal: Behavioral Self Control

Stage 2: Misery
Goal: Emotional Experiencing/Expression

Stage 3: Problems in Living
Goal: Ordinary Happiness & Unhappiness

Stage 4: Incompleteness
Goal: Capacity for Contentment & Intimacy

Pre-Treatment Assessment

- Inclusion/exclusion criteria
- Problem assessment (diagnostic, primary targets, secondary targets)
- Client expectations, goals and desires
- Contingencies affecting participation
- Capacity for DBT and other available treatments
- Analysis of problems in previous treatments (failures, dropout, prior therapy-interfering behaviors, etc.)
- Social/family/work environment factors
Getting Started in Pre-Treatment

- Do the treatment before starting the treatment (structure & process)
- Orienting and explicitly committing to:
  - goals
  - diary cards
  - skill training
  - assessments
  - treatment target hierarchy
  - time frame (e.g., 6 months, 1 year)
  - audio or video taping
  - contingencies for recommitment later on
  - therapist agreements

Examples of Therapist Agreements

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

Pretreatment Sessions

1. Brief history; description of current problems; formulate target hierarchy; orient to DBT; basic diary card as “homework”
2. Use diary card to demonstrate therapy (target, chain, validation, solutions); pros and cons of DBT; improved diary card
3. Continue pros and cons, identify what would get in the way; planning for blocking drop-out, addressing motivation; commitment; devil’s advocate; discuss with team
Primary Targets for Each Stage

Diary Card

Functions:
- Keeps targets clear and salient (daily)
- Assessment (interval/episode)
  - Monitor therapy progress on primary targets
  - Monitor secondary targets, skillful alternatives
- Used in session to set agenda (and improves chain analysis)
- Reminder to practice skills; blocks avoidance and escape
- Facilitates improvement (self-monitoring)

See Diary Card examples
Stage 1

Severe Behavioral Dyscontrol → Behavioral Control

Primary Targets

- **Decrease:**
  - Life-threatening behaviors: suicide, self-injury, homicide, aggression, child neglect
  - Therapy-interfering behaviors
  - Quality-of-life interfering behaviors

- **Increase Behavioral Skills & Self-Management**
  - Mindfulness
  - Interpersonal Effectiveness
  - Emotion Regulation
  - Distress Tolerance

Stage 1 Goals

- **Safety**
  - Elimination of suicidal and self-injurious behaviors, aggression, other life-threatening behaviors

- **Stability**
  - Treatment
  - Housing
  - One or more relationships
  - Meaningful daily activities (e.g., working, taking care of family, education)

Life-Threatening Behaviors

- Suicide-related behaviors
- Self-injurious behaviors
- Changes in suicide ideation and communication about suicide
- Aggressive and violent behavior
- Child abuse and neglect
- Other life-threatening behaviors...
Violence & Aggression

- Physical Aggression
- Sexual Aggression
- Damage to Property or Pets
- Threats of Aggression
- Other physical control


Therapy-Interfering Behaviors: Patient

- Behaviors that interfere with therapy process
  - Not attending sessions (individual, group, etc.)
  - Not collaborating in treatment
  - Not complying with agreements (e.g., agreed-upon solutions in chain analysis)
- Behaviors that interfere with other patients
- Behaviors that will likely burn out the therapist or other team members
  - Behaviors that push therapists' limits
  - Behaviors that reduce therapists' motivation

Therapy-Interfering Behaviors: Therapist

Some examples:
- Behaviors that unbalance therapy (e.g., too extreme acceptance or change)
- Judgmental behaviors
- Not attending to own motivation
- Providing too little or too much nurturance
- Reinforcing dysfunction
- Any disrespectful behavior
Remember:

In DBT, problem behaviors are assumed to function to regulate emotions, or are a natural consequence of emotion dysregulation. So, even those behaviors that push limits must be addressed within this assumption (chain analysis, solution analysis, commitment, practice), not primarily with aversive control or simple contingency clarification.

Quality-of-Life Interfering Behaviors

- Severe dysfunctional behaviors that interfere with employment, education, etc.
- Health related dysfunctional behaviors
- Lack of stable housing
- Severe mental health problems (eating, substance use, depression, anxiety, other disorders)
- High risk sexual behavior
- Extreme financial problems that interfere with nutrition, safety, or life stability
- Criminal behaviors that increase the risk of prison
- Extreme dysfunctional interpersonal behaviors

Stage 2

Quiet Desperation, Misery, and Truncated Emotions

Primary Targets

- Decrease PTSD-related problems (Stage 1 if severe)
- Decrease general avoidance of emotion cues
- Decrease secondary emotional reactions/misery
- Decrease self-invalidation
- Decrease relationship conflict

Goals

- Increased emotional identification, experiencing, and expression; self-validation
- Connection to family member(s) & others
- More validating social/family environment
Levels of Disorder & Stages of Treatment

Pre-treatment: Assess, orient, agree, commit

Stage 1: Severe Behavioral Dyscontrol
Goal: Behavioral Self Control

Stage 2: Misery
Goal: Emotional Experiencing/ Expression

Stage 3: Problems in Living
Goal: Ordinary Happiness & Unhappiness

Stage 4: Incompleteness
Goal: Capacity for Contentment & Intimacy

Treatment Targets

Secondary Targets
Identified by Chain Analysis

Precise Targeting in All Stages

• Primary Targets:
  – Behaviors that interfere with a life worth living
  – Behaviors at the end of the chain

• Secondary Targets:
  – Behaviors that lead to the primary targets
  – Links on the chain
Behavioral Chain Analysis

VULNERABILITIES

PROMPTING EVENT

PRIMARY TARGET
(PROBLEM BEHAVIOR)

SECONDARY TARGETS

REINFORCING CONSEQUENCES

Awareness is of descriptive reality...not reifying concepts

Examples of Secondary Targets and Skillful Alternatives

1. Emotional vulnerability and reactivity
   (skill: emotion regulation)
2. Self-invalidation (skills: self-validation, mindfulness)
3. Crisis generating behaviors (skills: realistic judgment, self-management)
4. Emotion inhibition (skills: emotion identification, experiencing and expression)
5. Active-passivity (skills: problem solving)
6. Apparent competence (skills: accurate expression, self-validation)
Chain Analysis: Steps in Detail

1. Identify primary target (accurate assessment, including diary card)
2. Do chain (behavior) analysis to identify secondary (treatable) targets and understand determinants of behavior
3. Identify acceptance & change solutions
4. Use behavior therapy strategies to incorporate solutions collaboratively
5. Employ teaching, orienting strategies
6. Get commitment to new behavior(s)

Example: Chain Analysis of Cutting*

TRIGGER: INVALIDATION
VULNERABILITIES: LONELY, TIRED, REACTIVE
CUTTING, Thursday at 4:30
RELIEF
JUDGMENTS or SELF-INVALIDATION "I'M WORTHLESS"
SECONDARY EMOTION: SHAME

Behavioral Chain Analysis: Changing Behavior & Breaking the Old Pattern

VULNERABILITIES
PROMPTING EVENT
PROBLEM BEHAVIOR
REINFORCING CONSEQUENCES
SKILLFUL BEHAVIORS
Example: Solutions

Key reading:


Understanding Emotion
Components of Emotions

- Prompting Event 1 (inside or outside)
- Interpretation of Event
- Brain Change (neurochemical)
- Face and Body Change (physical)
- Sensing (experience)
- Action Urge

- Prompting Event 2
- Face and Body Language (e.g., posture, face)
- Expression with Words
- Action (do something)

- After-effects
- Emotion Name

Primary and Secondary Emotions

- **Primary emotions:** initial response, normative, typically adaptive, effective
- **Secondary emotions:** emotional response to primary emotion itself; through over-learning, secondary emotional responses may even become a problematic initial emotional response
- **Goal or strategy:** treat primary emotions; ignore/extinguish/refocus away from secondary emotions

Examples: Anger or Shame

- **Anger or shame as a primary emotion**
  - when normative, justified

  **VERSUS**

- **Anger or shame as a secondary emotion**
  - non-normative or unjustified (or destructive)
  - escape response from a different (primary) emotion
Change Negative Emotions

- Use anger or shame as a “signal” for missing a primary emotion (self-invalidation)
- Identify the primary emotion (from the antecedent chain)
- “Treat” the primary emotion (e.g., identification, labeling, self-validation, description, acceptance or change skills)
- Acknowledge the secondary emotion, then ignore it...focusing instead on the primary

Maladaptive Learning and Secondary Emotions: Bambi

Treating Emotions on the Chain

See handout
Example: Sadness (depression)

Problems
- Urges: passivity, deactivate, avoid
- Anhedonia
- Social isolation
- Self-invalidation
- Lethargy
- Irritability
- Escape into secondary emotions

Solutions/Treatment
- Soothing (from self or others)
- Allowing emotion (1st)
- Validation (from self or others)
- Activation (physical, mental, social, etc.)
- Mindfulness
- (see examples for specific skill handouts)

Key Readings:


Change Strategies:
Behavior Therapy
MODERN BEHAVIOR THERAPY

IT MAY NOT BE WHAT YOU THINK!

• Behavior is *anything* a person does, public or private, including thinking, feeling, and acting
• Includes ACCEPTANCE and CHANGE

LEARNING THEORY

• OPERANT behavior is learned through reinforcement (i.e., learned through it’s consequences).

• RESPONDENT behavior is also learned, but through conditioning (repetitive pairing, or association) with an antecedent stimulus.

INCREASING TARGET BEHAVIORS

• Reinforcers: consequences that strengthen behavior, resulting, on average, in an increase in the behavior they follow
  – *Positive Reinforcement*: providing a positive consequence, or applying a positive stimulus after a given behavior
    • In-session, this is likely to be arbitrary and temporary
  – *Negative Reinforcement*: removing, stopping, or decreasing a negative or aversive stimulus after a given behavior
    • This is where all the change (↑ skills) must start...
DECREEASING TARGET BEHAVIOR

- Punishment: consequences that result, on average, in a reduction in the behavior they follow (+/− punishment) – used rarely in DBT
- Extinction: reductions in a given behavior that has been reinforced before by no longer allowing reinforcement – relevant occasionally
- Reduce antecedent stimuli for dysfunctional behavior (or use mindfulness of alt. stimuli)
- Increase antecedent stimuli for alternatives
- Reinforce skillful alternative behaviors

BEHAVIORAL or CHAIN ANALYSIS

The relationship among:

$S^D \rightarrow B \rightarrow C$

Context
(Setting, events, Behavior antecedents) Consequence

KEY CONCEPTS:

- Shaping
- Satiety or Satiation of a Reinforcer
- Discriminative Stimulus
- Reinforcement Schedule
- Fixed (steady) vs. Intermittent Reinforcement
- Escape Behavior
- Reinforcement or Punishment Gradient
- Extinction Burst
- Natural vs. Arbitrary Reinforcers
Modern Behavior Therapy

- Behavioral Assessment/Chain Analysis
- Skill Training
- Stimulus Control
- Contingency Management
- Exposure & Response Prevention
- Cognitive Restructuring

In the service of changing links on the chain: weaving in skillful alternatives to dysfunctional behaviors and dysfunctional behavioral patterns; commitment

Behavior Change (Replacing Dysfunctional with Functional Responses)

- Chain analysis of primary target
- Inductive understanding (identify secondary targets)
- Solution analysis: Skills as solutions
  - Mindfulness, Emotion Regulation, Distress Tolerance, Interpersonal Effectiveness, and others
- Behavior therapy & acceptance/validation strategies facilitate implementation of skills
- Strengthen commitment/anticipate and remove blocks to the solution

Skills as Solutions: Use Behavior Therapy To Implement Solutions
Skills Training (teaching and learning) is Necessary When the Solution is Not in the Patient’s Repertoire (much more in Part 2)

Stimulus control strategies are necessary when stimuli in the patient’s life are maladaptive

- problem behaviors are at least partially under the control of antecedents, or, skillful alternatives should be under control of existing stimuli

Stimulus Control Strategies

Changing behavior by:

• Altering the presentation of particular stimulus conditions
• Altering the rate of the presentation of particular stimulus conditions (schedule)
• Altering the properties of particular stimulus conditions (i.e., changing the stimulus properties themselves)
• Altering attention focus (mindfulness)
Contingency management strategies are necessary when problem behaviors are under the control of reinforcers that can be altered, or when skillful behaviors are not at sufficient strength to “take over” (or when the ratio of positive to negative consequence favors the dysfunctional behavior).

Contingency Management

Changing behavior by:

- Altering the *presentation* of reinforcing vs. punishing vs. non-consequences (extinction) following specific behaviors
- Altering the *rate* of the consequence (matching law)
- Altering the *properties* of the consequence
- Reinforcing incompatible or competing behaviors (if goal is to decrease)
- Use the *reinforcement gradient* (remember, reinforcement ≠ positive)

Contingency Management, continued

- Shaping: using positive or negative reinforcement to build/strengthen difficult or complex behaviors
- Contingency Clarification
- Blocking Dysfunctional Behaviors and Redirecting Toward Skillful Alternative (eliciting skillful behavior to reinforce)
- Self-Managed Contingencies in the natural environment
Contingency Clarification

- Clarification of current contingencies
  - Highlighting consequences as they occur
  - Self-involving self-disclosure
- Clarification of future contingencies in therapy
  - Highlighting limits

Dialectics of Behavior Change

Example: stimulus control strategies are also contingency management strategies:

- Every consequence for one behavior is a discriminative stimulus for another
- Every new S² is (in principle) a consequence for antecedent behavior(s)
- Consider the analysis both ways
- Also true for synthesis of other change strategies

Exposure and response prevention is necessary when an escape behavior (target) was previously extremely adaptive but now extremely problematic.
Exposure and Response Prevention

- Orienting
- Providing non-reinforced exposure
- Blocking action tendencies associated with problem emotion
- Blocking expressive tendencies associated with problem emotion
- Must achieve at least some habituation
- Enhancing control over aversive events

Habituation Vs. Escape

Cognitive restructuring or modification is useful when irrational or maladaptive cognitions are common antecedents of problem behaviors.

However, these are typically only useful under moderate emotional arousal states, and therefore have limited utility in DBT in Stage 1.
Key Reading:


Examples of Behavior Therapy in Session

• Positive Reinforcement
  – Attention, warmth

• Negative Reinforcement
  – Help client regulate, feel relief, decrease arousal

• Extinction
  – Ignore dysfunction, block dysfunction

• Elicit
  – Elicit or facilitate improvements (& reinforce)

• Classical conditioning/reconditioning
  – Exposure, pairing warmth/validation with skills

Commitment Strategies

• Sell commitment: evaluate the pros and cons
• Anticipate blocks: avoid or problem-solve in advance (e.g., “What might get in the way?”)
• Play the devil’s advocate
• Use foot-in-door and door-in-the-face techniques
• Connect present commitments to prior commitments
• Highlight freedom to choose and absence of alternatives
• Shape stronger commitment over time
### Pros and Cons

<table>
<thead>
<tr>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skill</td>
<td>Automatic</td>
</tr>
<tr>
<td>No Skill</td>
<td>Automatic</td>
</tr>
</tbody>
</table>

### Commitment

- Not the same as wanting
- Requires the capability to do the skill or behavior as needed
- Mindfulness of the target is the key
- Willingness to maintain target
- Is on a continuum (from weak to strong)

### Behavioral Chain Analysis: Changing Behavior & Breaking the Old Pattern
Example 1: Therapy interfering behavior in session

Managing In-Session Dysregulation

- **Stimulus control:** e.g., change focus of attention, change physical stimuli
  - Distract to reduce arousal, then return to evocative topic/stimulus if relevant (i.e., do NOT reinforce escape/escalation)
- **Validation PLUS blocking and redirecting**
  - Soothe emotion to reduce arousal, then return to topic/stimulus
- **Skill instruction:** e.g., “do ___”
  - Coach on how to reduce arousal, then return to topic

Managing In-Session Dysregulation

- **Exposure & response prevention:**
  - Practice bringing up the evocative stimulus (habituation)
- **Contingency management:**
  - Do NOT reinforce dysfunctional behavior; DO reinforce improvements (+ or – reinforcement)
- **Problem solve the dysfunctional behavior:**
  - Identify target, describe chain & consequences
  - Elicit alternative or instruct client in alternative
  - Orient & commit to alternative
  - Rehearsal with coaching & feedback
  - Reinforce, anticipate recurrence, recommit
Example 2: Egregious Behavior

Example 3: Primary target, client

Example 4: Therapy interfering behavior, therapist

Example 5: other targets...

Acceptance and Validation Strategies

What is Acceptance?

- **Acceptance** is *not* putting energy into changing the person or his/her experience *per se* (at least not *right now*); not fighting the “reality” of the moment

- Instead:
  - Tolerate
  - Appreciate context
  - Observe or notice
  - Understand
  - Participate or allow the experience
Validation

- Validation is the communication of acceptance, understanding, or legitimacy, of the person or his/her behavior & experience
- We only validate those things that are valid, of course (actions, thoughts, emotions, wants, etc., in the ways that they are, indeed, valid)
- The timing, method, and targets of validation may be different in DBT (Fruzzetti et al., 2012)

Basic Research on Validation and Invalidation

- Validation ➔ Decrease in emotional arousal
- Invalidation ➔ Increase in emotional arousal
- Self-verification ➔ Decrease in emotional arousal
  - Self-verification involves validation of self and “self constructs”
  - Invalidating self & self-constructs ➔ escalation
- High emotional arousal ➔ out-of-control behavior (including information processing)
- High emotional arousal ➔ interrupts learning

Validating vs. Invalidating Responses

- Sherk & Fruzzetti (2011)
  J. Social & Clinical Psychology
Self-Verification Theory
Validation ~ Self-Verification

INVALIDATION OF SELF-CONSTRUCT \rightarrow\text{ INCREASED AROUSAL \& SENSE OF BEING OUT OF CONTROL}

HIGH arousal
\text{ OUT-OF-CONTROL}

Failure to Process New Information

Example:
Client:
“I’m completely worthless…
I don’t deserve to live.”

Validation, continued
Behaviors may be valid according to:
• Previous learning, history
• Antecedent events or behaviors
• What’s needed to achieve goals

Therefore, one behavior may have both valid and invalid parts, depending on criteria
• It is essential to sort both out with the client
Roles of Therapist Validation

• As a stimulus for improvement (S^2 or ES)
• To balance change strategies (dialectically)
• Reinforce progress (shaping, skillfulness)
• Potentiate skill use
• Strengthen self-validation
• Keep session moving/prevent getting stuck
• Communicate acceptance and strengthen the therapeutic relationship
• Assessment
• Bring arousal down

Levels or Types of Validation (Linehan, 1997)

1. Staying Awake: unbiased listening and observing, paying attention
2. Accurate reflection (verbal & non-verbal), acknowledgement of the experience (reality)
3. Articulating the patient’s unverbalized emotions, thoughts, or behavior patterns
4. Validating in terms of previous learning or biological dysfunction
5. Validating in the present context; experience is normative, completely legitimate (normalize)
6. Radical Genuineness: patient is not fragile, but is an equal human being; treat as equal person

Types of Validation

• Explicit and verbal (validation as a verbal response)
• Implicit and functional (validation clear by responding to the situation/needs of the other person)
Applications of Validation in DBT

- Therapist validation of patient
- Therapist self-validation
- Teaching patient validation of others
  - interpersonal skills
- Teaching patient self-validation
- Therapist validation of other therapists

Dialectics of Validation

- Validation as shaping (reinforcement)
  - Reinforcing
  - Blocking and redirecting (“yes and…”)
- Validation as eliciting stimulus
  - S^a
  - S^a
  - Establishing operation (ES)
- Validation as discrimination training
  - Fosters mindfulness/acceptance and emotion regulation

Key Therapist Responses

- Valid the valid
- Block the invalid
  - With soothing, while validating the valid
- Redirect and facilitate (teach, strengthen) skills as alternatives, as solutions
- Use warmth, soothing to promote skill acquisition, strengthening & generalization
Key Reading:

Optional:


Next (Parts 2, 3, 4)
• Skills, skills training and skill coaching
• More on crisis intervention & management
• Case consultation
• System of care issues
• Program development
• More dialectical strategies
• Consultation on team functioning
• Family interventions
• DBT applications & implementation
A little more on dialectics

Balance Communication

- Reciprocal communication
- Irreverent communication

- Dialectically balanced: speed, movement in the service of behavioral self-management and reduced suffering
- Dialectics: strong reciprocal and strong irreverent communication

Reciprocal Communication

- Reciprocal “vulnerability”
- Responsive to client
  - Awake to client
  - Take client’s manifest content seriously
- Appropriate therapist disclosure
  - Self-involving self-disclosure
  - Personal self-disclosure
- Providing warmth
- Genuineness
Comprehensive DBT Training Part 1 – Las Vegas
September 2019

Observing Limits

- Genuineness
- Dialectically balancing therapist and patient benefits
  - sometimes must stretch limits
  - sometimes must tighten limits
- With consultation
- Deal with limits in session
  - provide rationale (dialectical validation)
  - provide soothing
- Remember consultation team agreements

Therapeutic Relationship

- Real relationship: equal human beings
- Genuine reactions, communication (within therapeutic context)
- Dependence on someone dependable within the domain of treatment
- No a priori limits based on fear, pejorative labels, judgments about clients with BPD, etc.
- NOT a target per se in treatment (data!)
- Rather, must facilitate/not interfere with treatment progress (necessary, not sufficient mechanism for change)

Irreverent Communication

- Unexpected, unorthodox response (form of response not necessarily expected)
- Change-oriented, but without being in a typical change-oriented style
  - Reframing (including humor)
  - Matter-of-fact
  - Confrontational/pushy (tone, suggestion)
  - “Plunging in where angels fear to tread”
  - Changing intensity, warmth, attention
  - Alternating omnipotent/impotent expressions
  - Calling the patient’s “bluff”
Dialectic: Strong Reciprocal and Strong Irreverent Communication
Not the average, not tepid
(at least not regularly)

Balance Consultation Strategy With Intervening in the Environment
Consultation with the Patient:
• Teach the patient to be effective on his/her own behalf with
  – Social network
  – Professional network
Environmental Intervention:
• Intervene on her/his behalf when the short-term gain is greater than the short-term + long-term loss

Environmental Intervention
Necessary when:
• The patient cannot do what is needed on her/his own behalf (or the environment will not accept it from the patient) and the outcome is very important
• The life of the patient or another is at stake
• The patient is a minor (legal/ethical)
• It is humane to do so and unlikely to cause harm to the patient
Dialectical Strategies

- Balance validation and problem solving
- Use metaphors and stories
- Get to “wise mind”
- Make “lemonade out of lemons”
- Do dialectical assessment (e.g., “what’s missing?”)
- Allow natural change
- Notice or enter the paradox
- Play “devil’s advocate” (genuinely)
- Use acceptance- and change-oriented skills
- Balance communication style (minimize neutrality)

Key Reading:

Treatment Team
Consultation-to-the-Therapist

Consultation with therapists to enhance their treatment skills and their motivation to treat

- Targets acceptance (support, validation) and change (targeting, problem-solving, effective learning)
Starting Your Consultation Team

- Meet weekly (at least)
- Training/Study/Practice → Treatment Team
- Use current cases to practice DBT strategies
- Limit administrative discussion
- Focus on doing more, “talking about” less
- Circumscribe program development time
- Team leader marshals the agenda
- Everyone is a “supervisor”/consultant
- “What do you need?” focuses on therapist

Team & Individual Practice

“Deliberate” Practice

(aka “homework”)

Mindfulness

- Paying attention, on purpose, in the present moment, without judgment
- What:
  - Observe
  - Describe
  - Participate
- How:
  - Non-judgmentally
  - One-mindfully
  - Effectively