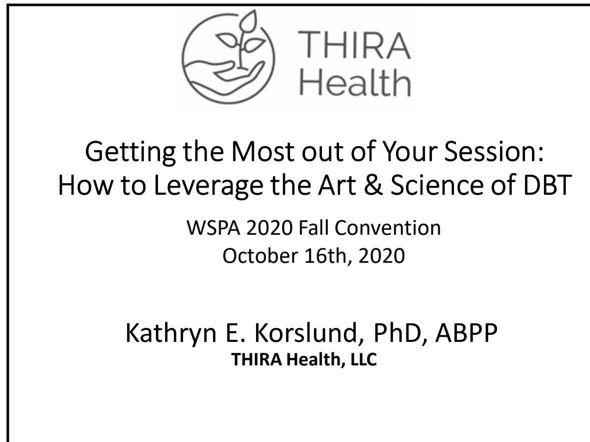

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FACULTY DISCLOSURE STATEMENT

Dr. Korslund:

- Receives payment to provide DBT consultation on federally funded studies of DBT.
- Receives payment to provide DBT training and clinical consultation.
- Receives salary support from THIRA Health, LLC a DBT based partial hospital and intensive outpatient program in Bellevue, WA.

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OBJECTIVES

- Understand DBT treatment philosophy, principles, and assumptions underlying DBT to leverage their delivery in other CBT approaches.
- Describe the research supporting DBT's evidence base and how to translate the science into practical intervention.
- Be able to apply key strategies used in DBT to maximize delivery of DBT sessions and/or facilitate other CBT approaches.

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FOUNDATIONS

- CBT is the most established evidence-based psychotherapy for depression and anxiety disorders
- Fewer than 20% of people seeking treatment for depression and anxiety receive CBT

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The Research to Practice Problem

- Clinicians rarely use treatment manuals
- Training in empirically supported treatments (EST) is necessary but insufficient for clinicians to implement ESTs
- Little information about the “key ingredients“ necessary for clinical outcomes in ESTs

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Theory-Practice Gap

(Pilecki & McKay, 2013)

- Disparity between knowledge of technique and associated theory
- IMPLICATIONS:
  - CBT encompasses diverse techniques with varying mechanisms of action
  - Ideographic application of treatment methods requires theory grounded case conceptualization
  - Knowledge of theory facilitates identification of indicator that treatment is not working or is contraindicated for an individual

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Clinician Drift

(Waller, 2009)

- Failure to deliver treatment despite training and sufficient resources
  - Underuse or omission of essential strategies; inclusion of model incompatible strategies
  - May be intentional or out of clinician awareness
- IMPLICATIONS:
  - Patients may not achieve benefit
  - Providers and patients may believe the patient was a non-responder

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What accounts for clinician drift?

- Beliefs & attitudes
- Emotions
- Personality
- Physiology/biology

(Waller & Turner, 2016)

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What accounts for *your* treatment drift?

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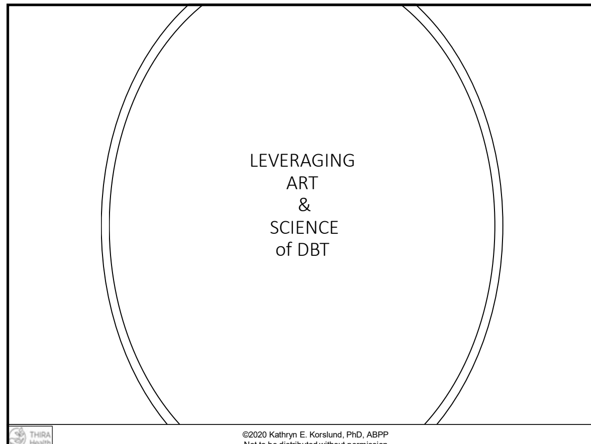

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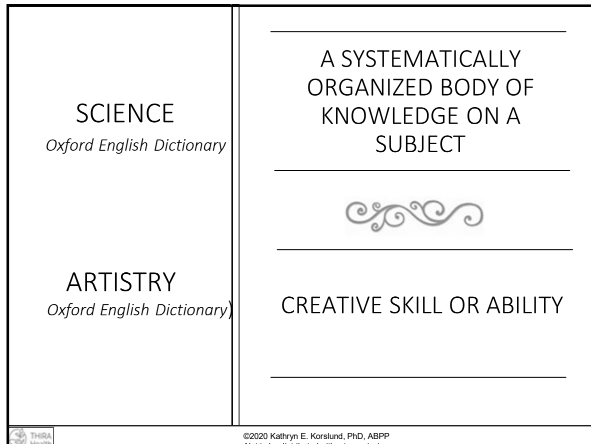

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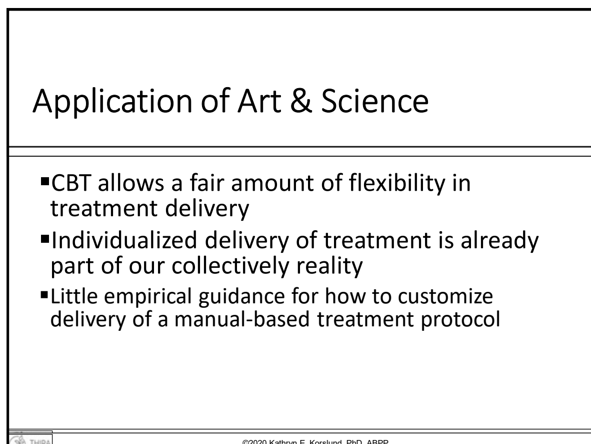

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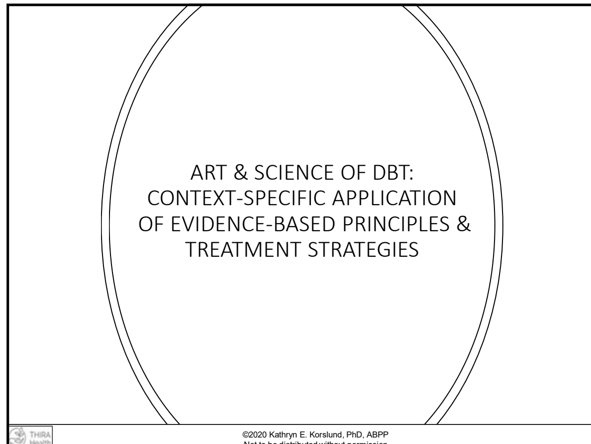

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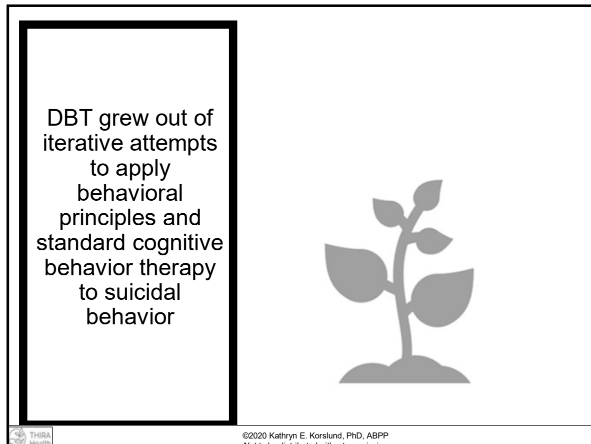

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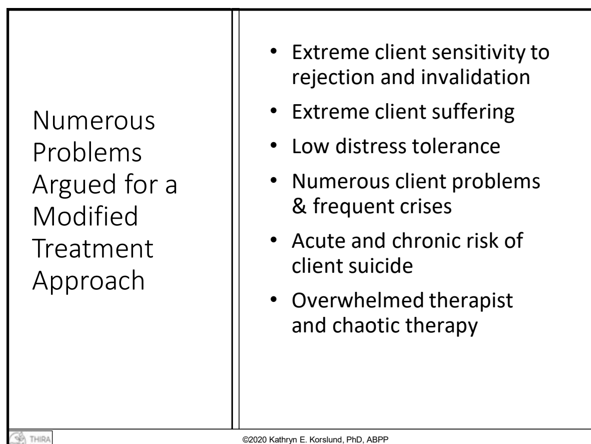

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DBT is a
comprehensive,
principle-driven treatment
designed for
individuals with complex
&
severe disorders

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SOLUTION WAS TO DEVELOP A TREATMENT THAT BALANCED:
ACCEPTANCE
&
CHANGE

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A New Treatment

- Philosophy balancing acceptance & change
- Skills based intervention teaching reality acceptance & problem-solving skills
- Based on evidence-based principles of behaviorism, acceptance and dialectical philosophy
- Rooted in mindfulness
- Structured hierarchy of treatment targets
- Team based, emphasizing peer consultation

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Relevance to Treatment Delivery

- Acceptance of risk of drift and need for change
- DBT skills facilitate awareness of drift & skills to create change
- Treatment strategies anchored in evidence-base of CBT
- Principle-driven treatment structure gives flexibility within a structured hierarchy
- Team based treatment and peer consultation provides framework for monitoring and discussing problems related to drift

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DBT Principles & Philosophy

BEHAVIORAL SCIENCE

ACCEPTANCE STRATEGIES

DIALECTICAL PHILOSOPHY

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DBT is a treatment designed to for individuals with pervasive disorder of the emotion regulation system

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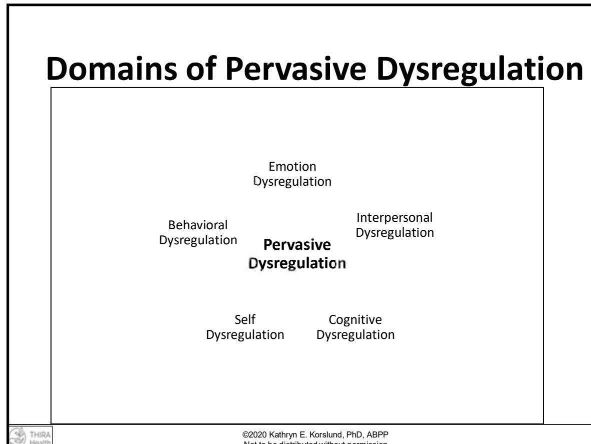

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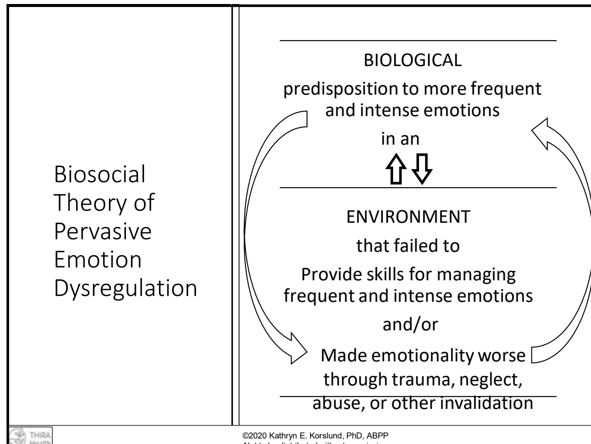

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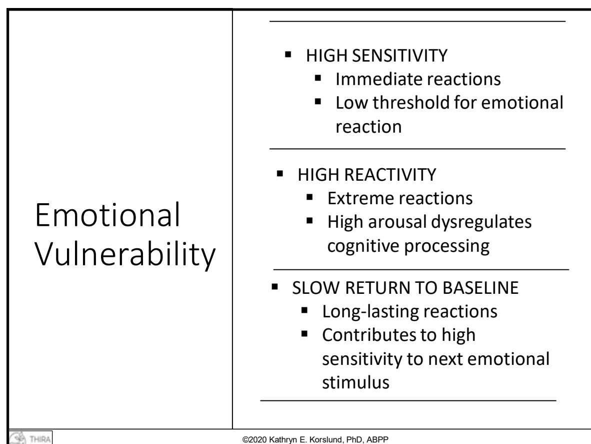

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Invalidating Environment

- INDISCRIMINATELY REJECTS communication of private experiences and self-generated behaviors
- PUNISHES emotional displays and INTERMITTENTLY REINFORCES emotional escalation
- OVER-SIMPLIFIES ease of problem solving and meeting goals

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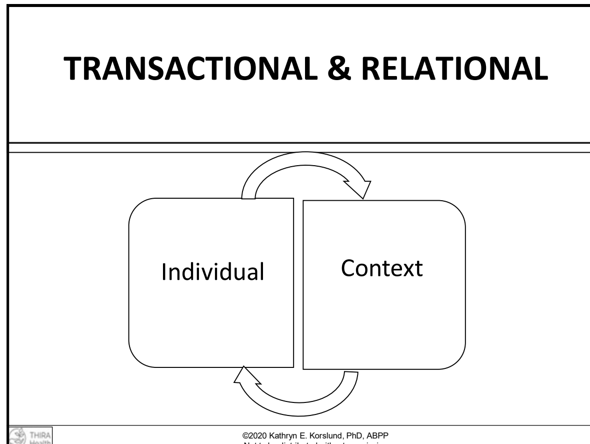

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In the context of pervasive emotion dysregulation, the DBT Model is

PROBLEM BEHAVIORS
FUNCTION to REGULATE EMOTION
-or-
Are a natural CONSEQUENCE
of being emotionally dysregulated

EXAMPLE
SUICIDE BEHAVIORS
are attempts to
ESCAPE painful emotions
-or-
Are the result of being
DYSREGULATED

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DBT BIOSOCIAL MODEL

- Based on a transactional model of biology and environmental factors
- Informs the treatment approach
- Engenders attitude of effective compassion
- Provides a framework for the provider in interacting with the client
- Defines relationship between presenting problems and treatment

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DBT HOLDS ARTICULATED
ASSUMPTIONS
ABOUT
PATIENTS
&
THERAPY
THAT SERVE TO KEEP PROVIDERS IN
THE MODEL

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ASSUMPTIONS ABOUT PATIENTS

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

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ASSUMPTIONS ABOUT THERAPY

1. The most caring thing a therapist can do is help patients change in ways that bring the client closer to their ultimate goals.
2. Clarity, precision, and compassion are of the utmost importance in the conduct of DBT.
3. The therapeutic relationship is a real relationship between equals.
4. Principles of behavior are universal, affecting therapists no less than clients.
5. Therapists treating suicidal clients need support.
6. DBT therapists can fail.
7. DBT can fail even when therapists do not.

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WHAT ARE *YOUR* ASSUMPTIONS
ABOUT
PATIENTS
&
THERAPY?

DO THEY SERVE TO KEEP YOU IN THE MODEL OF TREATMENT DELIVERY?

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DBT STRUCTURE
FACILITATES
TARGETED INTERVENTION

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DBT structures treatment around

FUNCTIONS

MODES OF DELIVERY

STAGE OF TREATMENT
&
HIERARCHY OF TARGETS

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5 FUNCTIONS OF COMPREHENSIVE TREATMENTS

1. Enhance capabilities
2. Improve motivational factors
3. Assure generalization to natural environment
4. Structure the environment
5. Enhance therapist capabilities and motivation to treat effectively

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MODES OF STANDARD DBT

Outpatient Modes: DBT
1. Weekly Individual Psychotherapy (60 min)
2. Weekly Group Skills Training (2 hrs)
3. As Needed Phone/Text/Milieu Coaching
4. Weekly Consultation Team (60 min)

Ancillary: DBT
- Pharmacotherapy
- Inpatient/residential
- Case Management

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STAGE OF TREATMENT

PRE-TREATMENT ⇨ COMMITMENT & AGREEMENT

DIALECTICAL BEHAVIOR PATTERNS, EMOTIONS & THINKING

Stage	
Stage 1	SEVERE BEHAVIORAL DYSCONTROL ⇨ Stability & Behavioral Control
Stage 2	QUIET DESPERATION ⇨ Non-anguished Emotional Experiencing
Stage 3	PROBLEMS IN LIVING / LESS SEVERE DISORDERS ⇨ Ordinary Happiness / Unhappiness
Stage 4	INCOMPLETENESS ⇨ Freedom & Capacity for Joy

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STAGE 1 PRIMARY TARGETS: INDIVIDUAL THERAPY

INCREASE DIALECTICAL PATTERNS

SEVERE BEHAVIORAL DYSCONTROL ⇨ *BEHAVIORAL CONTROL*

DECREASE
- Life-threatening behaviors
- Therapy-interfering behaviors
- Quality-of-life interfering behaviors

- Depression
- Anxiety disorders
- Substance abuse
- Life problems

- INCREASE behavioral skills
  - Mindfulness
  - Distress Tolerance
  - Interpersonal Effectiveness
  - Emotion Regulation
  - Self-Management

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Consultation-to-the-Therapist

- Facilitate adherent delivery of intervention
- Encourage and support each other
- Provide dialectical balance
- Confer on treatment plans and review of patient progress

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DBT CONSULTATION AGREEMENTS

1. To accept a dialectical philosophy
2. To consult with the client on how to interact with other therapists and not to tell other therapists how to interact with client
3. That consistency of therapists with one another (even across the same client) is not necessarily expected
4. That all therapists are to observe their own limits without fear of judgmental reactions from other consultation group members
5. To search for non-pejorative, phenomenologically empathic interpretations of clients' behavior
6. That all therapists are fallible

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Research Summary

Science to date supports DBT as the front-line treatment for individuals at high-risk for suicide and those with multiple, complex and difficult to treat disorders

DBT is a transdiagnostic intervention and shows targeted outcomes across multiple co-occurring disorders

DBT treats more than "symptoms" with demonstrated outcomes pertaining to quality of life

DBT skills are a key component of DBT and may be sufficient for less complex and lower suicide risk individuals

DBT is an intervention well suited for disorders of emotion dysregulation and difficult-to-engage patients

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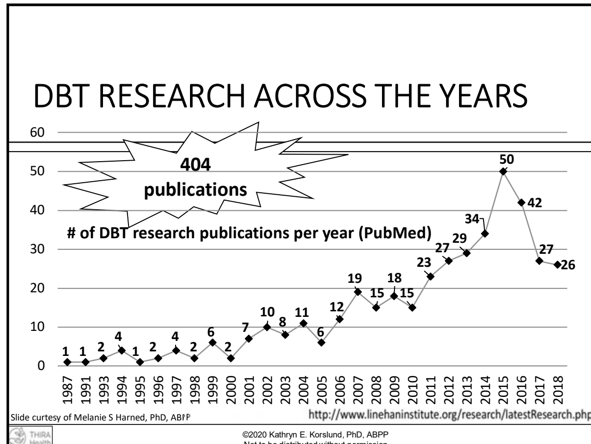

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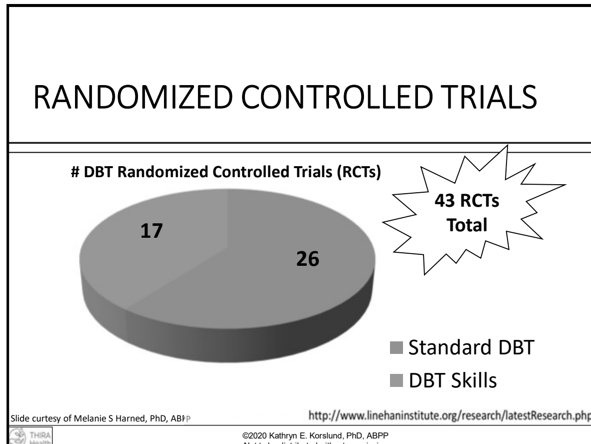

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FINDINGS FROM STANDARD DBT RCTS: A BROAD RANGE OF OUTCOMES

- Suicide Attempts
- Non-Suicidal Self Injury (NSSI)
- Psychiatric Admissions/ Days
- Depression
- Hopelessness
- Anger
- Anxiety
- Substance use
- PTSD symptoms
- Dissociation
- Impulsive behaviors
- Interpersonal problems
- General psychopathology
- General & social adjustment
- Positive self-esteem

https://behavioraltech.org/research/evidence/

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Morgenstern & McKay, 2007

Translating Research into DBT Practice

Koerner, 2013

PSYCHOTHERAPY TECHNOLOGY MODEL

- Based on dose-response theory as driver for obtaining outcomes
- Strategy is to maximize treatment adherence & competence

MODULAR COMPETENCY & CLINICAL DECISION-MAKING MODEL

- Based on evidenced-based competencies that recombine across CBT protocols
- Strategy is to combine modular competencies and apply via a clinical decision-making framework

SYNTHESIS

- DBT adherence requires context-dependent, principle-driven application of evidence-based strategies

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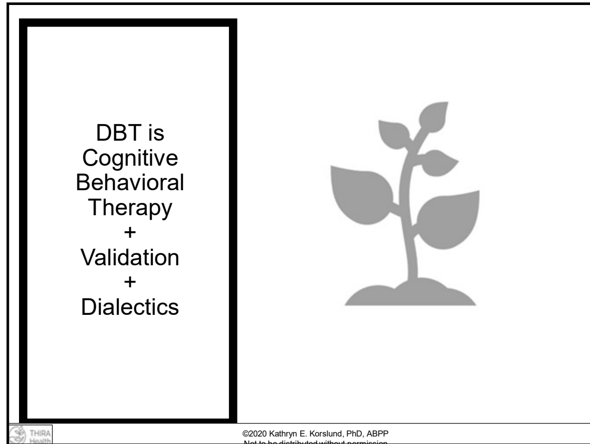

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DBT TREATMENT STRATEGIES

CHANGE

ACCEPTANC

COMMUNICATION STRATEGIES

IRREVERENCE **RECIPROCITY**

CORE STRATEGIES

PROBLEM SOLVING **VALIDATION**

DIALECTICS

CASE MANAGEMENT STRATEGIES

CONSULTATION -TO-CLIENT **ENVIRONMENTAL INTERVENTION**

CONSULTATION TEAM

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TARGET THE PROBLEM: Conduct a Chain Analysis & Implement a Solution

- DEFINE the problem in behaviorally specific terms
- TRANSLATE problem into behaviors to increase or decrease
- Determine the CONTROLLING VARIABLES for the problem behavior
- Identify SOLUTIONS & practice new behaviors
- Get COMMITMENT & TROUBLESHOOT

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CONDUCT:
BEHAVIORAL CHAIN ANALYSIS

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THE GAME PLAN:
BREAK LINKS TO PROBLEM BEHAVIOR & FIND NEW PATH TO EFFECTIVE BEHAVIOR

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ENGAGE THE PATIENT

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Acceptance & Engagement

VALIDATE

- Emotions, thoughts & behaviors

FACILITATES

- Down-regulation of emotion
- Engagement in problem-solving
- Informal exposure to one's own experience

FACT BASED

- NOT validation of the invalid
- NOT empathy or positive regard

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LEVELS OF VALIDATION

1. Staying Awake: unbiased listening and observing
2. Accurate reflection
3. Articulating the unverbalized emotions, thoughts, or behavior patterns
4. Validation in terms of past learning or biological dysfunction
5. Validation in terms of present context or normative functioning
6. Radical Genuineness

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DIALECTICS

- Holistic, connected, and in relationship
- Complex, oppositional and in polarity
- Change is continual
- Change is transactional
- Synthesis occurs through integration of seemingly disparate opposites
- Identity is relational and in continuous change
- Truth is neither Universal nor Relative but emerging

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Dialectics

PHILOSOPHY

BALANCES TREATMENT STRATEGIES ACROSS ACCEPTANCE & CHANGE

TREATMENT STRATEGIES
- MAGNIFY TENSION
- WORKS FOR SYNTHESIS
- USE OF METAPHOR
- MOVEMENT, SPEED & FLOW

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QUESTION:
What will you do differently on Monday?

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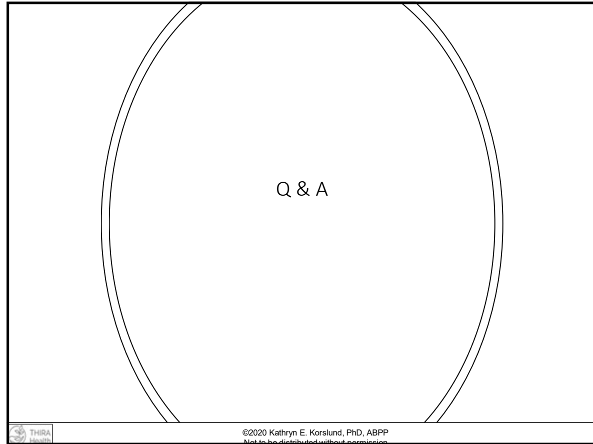

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