

**Dialectical Behavior Therapy in Integrated Dual Disorder Treatment Settings:
The Science and the Practice**



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DBT Originated With CBT

- Linehan began work with suicidal and self-injurious clients in the 1980's, using CBT; Linehan used her expertise to adapt CBT based on client needs and preferences
- Linehan's Cognitive-Behavioral Treatment of Borderline Personality Disorder was published in 1993
- Numerous RCTs established DBT as an empirically-supported treatment (EST), also referred to as an evidence-based treatment (EBT)
- DBT places greater emphasis on behavioral interventions compared to cognitive interventions, and is guided by a different theory than CBT
- DBT is directive and change-oriented

DBT Balances Its Change Orientation with Client-Centered Elements

- Belief in clients' capacity to grow and change
- View of acceptance/self-acceptance as a prerequisite to change
- Empathic understanding of clients' internal frame of reference with non-judgmental, positive regard
- Emphasis on the therapist being authentic and genuine
- Present focus over past and/or future

DBT Borrows From Many Approaches

- DBT shares commonalities with CBT, client-centered, psychodynamic, gestalt, paradoxical, and strategic approaches among others (Heard & Linehan, 1994; Marra, 2005)
- Mindfulness has been around awhile
- Dialectics go back to ancient philosophers
- Dialectically, DBT is both innovative and derivative

“There is no new thing under the sun” -Ecclesiastes 1:9

Remembering Contextualism: What Works in Therapy

“Over the past 30 years, a series of clinical trial research studies have compared treatments from very different theories to see which one was superior to the others. This ‘horse race’ research design has not found a single specific treatment for substance abuse that consistently does better than all the others” (Conners et al., 2001, p. 214-215)

This is because therapy largely works due to common therapeutic factors

Remembering Contextualism: What Works in Therapy

- Structured therapy models delivered with mutual believe and expectancy will be effective
- Stay focused on the common therapeutic factors that most account for change
- Apply treatments that are convincing to clients coherently, favoring a degree of flexibility over high adherence. **There are better approaches and interventions for individuals.**
- Seek and incorporate client feedback at all stages of therapy

Evidence-Based Practice (EBP)

- Psychology has moved away from overly prescriptive applications of Empirically-Supported Treatments (ESTs, now commonly called Evidence-Based Treatments, or EBTs)
- EBP is a process that applies research in a manner that includes clinical expertise and client culture, characteristics, and preferences
- EBP includes the ongoing monitoring of clinical outcomes

Avoid being a “model maniac” and doing overly prescriptive therapy applications (that lack external validity). Instead think of customization of approaches

So Why DBT for SUDs (called DBT-S)?

- Therapists find DBT philosophies of acceptance and non-judgment to be a natural fit
- DBT offers a breadth of interventions, many of which speak to the treatment alliance
- DBT is a teachable, learnable, and practical approach
- DBT is a “privileged” approach (i.e., perceived to be superior, leading clients, payers, and policy-makers to advocate its use)
- Strong belief and expectancies in DBT may enhance outcomes (through allegiance effects)

Essential Elements of DBT-S

- Knowledge of IDDT/DBT Philosophy and Strategies
- Allegiance to the Approach
- Structured Therapy (Treatment framework/service delivery/treatment agreements)
- Treatment Hierarchy/Stages
- Validation Balanced with Behavioral/Cognitive Interventions
- Integration of Dialectics and Mindfulness
- Consultation
- Skills Training

Essential 5 Functions of DBT-S

- Improve clients' motivation for change (**MI techniques**)
- Enhance clients' capabilities (**Skills Training**)
- Help clients generalize skills/behaviors to their natural environments (**Behavioral Activation Plans**)
- Enhance the motivation and skill of therapists (**Consultation**)
- Structure the treatment/program and environment

The 5 functions can be applied in any treatment framework/service delivery

Dialectical Philosophy

- Dialectics originated with early philosophers
- No position is absolute; each position has its own wisdom or truth (if only a kernel at times). Dialectics allow for subjective truth
- Opposite tensions are interconnected, interrelated, and defined by each other
- The synthesis of opposites, through understanding varying contexts and seeking a workable balance, leads to change
- Change is continual, so dialectics require fluidity
- Dialectics allow for subjective truths that do not need to hold up to logical analysis

Dialectic Synthesis in DBT-S

- Acceptance/validation and change/challenge
- The serenity prayer (acceptance and change)
- Balancing emotion and reason (Wise Mind)
- Doing one's best and needing to do better (a primary assumption)
- Active client and active therapist (collaboration)
- Goals of therapy (and/or program) and goals of client
- Integrating research and practice (per EBP)

Dialectical Dilemmas with Dual Disorders

- Wanting yet resisting change
- Using even when it actively causes harm
- Taking a minor lapse to an extreme relapse
- Having goals or values conflict with behaviors
- Removing triggers AND dealing with triggers
- Balancing self with others, and desires with responsibilities
- Treatment being both supportive and accountable

Dialectical Abstinence

- 100% (undialectical) commitment to cease substance use (or another harmful behavior)
- When a setback happens, you get back on your horse and ride rather than compounding the mistake
- Use of acceptance and nonjudgment helps in learning (**SLIP: Skills Learning Improves Progress**)

DBT View of Abstinence

- Not all clients can be abstinent at the beginning of treatment, yet abstinence is a primary goal of treatment
- Not all clients entering treatment have the skills to maintain abstinence
- Commitment to abstinence happens with realistic timeframes that will be re-upped
- Therapists take a nonjudgmental approach to relapse
- Clients with high comorbidity can only change so much, so fast
- For polysubstance use, the most problematic substance(s) is targeted first
- Medications are an accepted part of the treatment protocol

DBT Theory: The Biosocial Model

- Clients suffer from emotional vulnerabilities
- Emotional vulnerabilities can come from many sources (e.g., attachment issues, loss, trauma), but is often assumed to be biological
- Chronic and consistent invalidation exacerbates emotional vulnerabilities
- An ongoing, reciprocal relationship exists between emotional vulnerabilities and environments

DBT Theory: The Biosocial Model

- Emotional vulnerabilities are characterized by:
 - Emotional sensitivity
 - Emotional reactivity
 - Slow return to emotional baseline
- Over time emotions get sensitized, leading to a "kindling" effect
- This emotionality (and associated invalidation) is associated with many problems (disorders)
- Emotionality leads to escape and avoidance behaviors

Common Types of Invalidation

- Abuse and neglect
- Open rejection of thoughts, feelings, and behaviors
- Making "normal" responses "abnormal"
- Failing to communicate how experience "makes sense"
- Expecting behaviors that one cannot perform (e.g., due to developmental level, emotionality, or behavioral deficits)

Biosocial Theory Coherently Guides Treatment Targets and Strategies

- **Validation** is a primary intervention to:
 - Reduce acute emotionality
 - Provide gentle exposure to emotions
 - Provide a corrective validating environment (and new learning)
 - Create a bridge to learning self-validation
 - Open the client up to change interventions
- **Emotion regulation** is taught to:
 - Understand how emotion happen
 - Reduce vulnerability to intense emotions
 - Increase opportunities for positive emotions
 - Assist in stepping out of ineffective mood-congruent behaviors

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Biosocial Theory Coherently Guides Treatment Targets and Strategies

- **Mindfulness** (non-judgment and acceptance) is taught to:
 - Reduce amplifying emotions
 - Reduce escape and avoidance of emotions
 - Create qualitatively different and effective experience of emotions
- **Distress Tolerance** is taught to:
 - Provide healthy ways of coping with emotions when needed
- Use the theory to conceptualize the purpose of the interventions used

DBT (and other) Theories of SUDs

- DBT: emotional vulnerability leads to mood congruent behavior AND/OR escape and avoidance behaviors (alcohol and/or drug use)
- Behaviorally, alcohol and drug use is reinforced in a variety of ways, maintaining the behaviors
- Environmental contingencies cue and maintain alcohol and drug use
- Traditional chemical dependency treatment often focuses on a disease model. DBT recognizes biological contributions to SUDs, and managing disease requires skill use
- **To the extent possible, be open to each client's theories of etiology and change**

DBT-S and Other Approaches

- Motivational Interviewing is compatible with DBT-S (and called for by IDDT guidelines). Both have strong Rogerian aspects and use dialectical concepts. DBT-S is more directive, can be more protocol driven, **and rests on skills training as essential**
- DBT-S has substantial overlap with Relapse Prevention. Both embrace concepts of acceptance, learning from setbacks, and developing action plans to prevent future setbacks
- DBT-S has greatest contrasts with Traditional CD treatment and Twelve-step. However, aspects of both approaches can be thoughtfully combined
- DBT-S supports harm reduction practices **while not waivering from promoting abstinence as a treatment goal**

The DBT-S Hierarchy In Detail

- The Treatment Hierarchy determines "what to treat when" and sets the following priorities (i.e., treatment targets):
 - Suicidal behaviors and intense suicidal urges
 - Self-injurious behaviors (SIB) and Substance Use Behaviors (SUB)
 - Treatment-interfering behaviors (TIB) and Recovery-interfering behaviors (RIB)
 - Quality-of-life-interfering behaviors (QIB)

The hierarchy is a set of guidelines that can be adjusted based on expertise and client needs

Note: The Hierarchy is Especially Used During the 1st Stage of Treatment that is focused on **Abstinence and Stability**

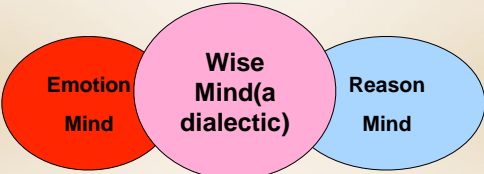
DBT Skills...

- Provide a common language for effective behaviors
- Help clients label, remember, and use effective behaviors
- Teach new behaviors to reinforce (one of the most benevolent ways of changing behaviors)
- Replace unhealthy and harmful ways of coping
- **Help clients move beyond abstinence to sustained recovery**

Mindfulness Skills

- Emphasize nonjudgemental and acceptance-based experience in the moment
- Provide a structure for attending to experience in an effective manner
- Build the ability to collect, focus, and sustain attention to then participate in responsive, not reactive, behaviors (awareness, and then choice)
- Mindfulness is its own "container"

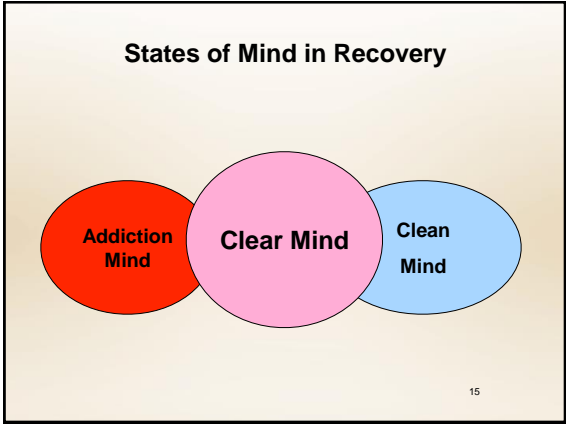
States of Mind



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Two Steps to Wise Mind

- **Step One:** Observe and Describe Non-judgmentally and One-mindfully
- **Step Two:** Participate Effectively



Distress Tolerance Skills

- Replace unhealthy and harmful behaviors
- Help to survive crisis without making it worse
- Include a couple dozen component skills along with skills like **Radical Acceptance** and **Willingness**
- **These skills must be learned and practiced proactively**

Emotion Regulation Skills

- Teach how emotions work
- Emphasize self-care to decrease emotional vulnerability
- Include skills such as **Build Mastery**, **Build Positive Experience**, and **Opposite to Emotion**

Interpersonal Effectiveness Skills

- Increase self-respect (**FAST**)
- Build and maintain relationships (**GIVE**)
- Increase assertiveness, saying "no", and setting boundaries (**DEAR MAN**)

DBT "Power" Tools

- **The Diary Card:** For Self-monitoring
- **Behavioral Analysis:** To Recognize Patterns and Use Skills to Change Behaviors

In Summation...

- DBT-S has been shown to be efficacious in research, and it can be expected to be effective in practice when applied with belief and expectancy in a structured and coherent manner
- A strength of DBT-S is *teaching skill sets to help people overcome deficits, achieve abstinence, and then move into sustained recovery*
- **DBT-S can be used as a stand-alone treatment, or thoughtfully combined with other structured approaches**

Thank You!



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