



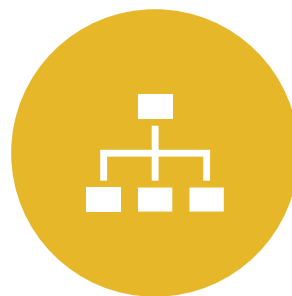
ESSPD DBT Workshop

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Conflicts of interest



I get paid to provide training and supervision in DBT by biDBT in the UK.



I am on the Board of Directors of the IBS GmbH a subsidiary of biDBT.



I am also the Chair of the SfDBT in the UK and Ireland.



I am on the board of the EDBTA.

Survey says:

Who has training in DBT?

- What kind of training?

If you leave this workshop having learned one thing, what would it be?

Workshop Plan



DIDACTIC
INFORMATION



EXERCISE



VIDEO 1 "BIGGER"
BEHAVIOURS



VIDEO 2 "SMALLER"
BEHAVIOURS

The VERY Basics of DBT



Stage based treatment ranging a focus on behavioural control to spiritual development.



When people talk about DBT, they are generally referring to stage one of DBT, which focuses on behavioural control.



This stage of treatment is focused on problem solving in the present.



It is skills based.

Targets of Stage One of DBT

- ▶ Target hierarchy:
 1. End Life Destroying Behaviour: including: suicidal, homicidal, and non suicidal self injurious behaviours. Reduces urges and ideation to a low level
 2. Work on Therapy Interfering Behaviours: Any behaviours: client or therapist that interferes with treatment
 3. Reduce seriously destabilising quality of life interfering behaviour
 4. Increase skills use
- ▶ In aid of helping a client move towards their life worth living

Highlighted Assumptions

- ▶ Treatment relationship is a real and equal relationship
- ▶ The principles of behaviourism apply to clients and therapists equally.
- ▶ DBT therapists need the support of their consultation team
- ▶ All behaviours are caused. Figuring out and changing the cause of behaviour is more effective than judging the behaviour.
- ▶ Client are doing the best that they can and need to try harder.



Dialectics of TIBs

- ▶ Principles of transaction:
 - ▶ All behaviours embedded in a web of transactions

Therapist Limits

Therapist limits centre on idea of how much they are willing to give of themselves in the treatment.

Delivering the treatment with fidelity and adherence is a non-negotiable. However, how present the therapist is willing to be or what a therapist will tolerate in terms of client behaviour is negotiable and context dependent.



Consultation Team often helps therapists BOTH identify their limits (and assert them) and to expand them for limited periods of time when the context calls for it.

So, what about the treatment relationship in DBT?

DBT IS JUST THE SKILLS, RIGHT?

Research on therapeutic relationship in DBT

- ▶ Bedic et al.'s (2012) examination therapeutic alliance variables as part of the RCT of DBT versus Community Treatment by Experts (CTBE)
 - ▶ found that DBT participants found their therapists more affirming, protecting, and controlling during therapy.
- ▶ A strong association was found between participants experience of therapist affirmation and protection and the reduction of self-harming behaviour.
- ▶ In 2015, Bedic et al. also concluded that patient reduction in self-harm led to higher ratings of the therapeutic alliance in the DBT condition as opposed to the CTBE condition.

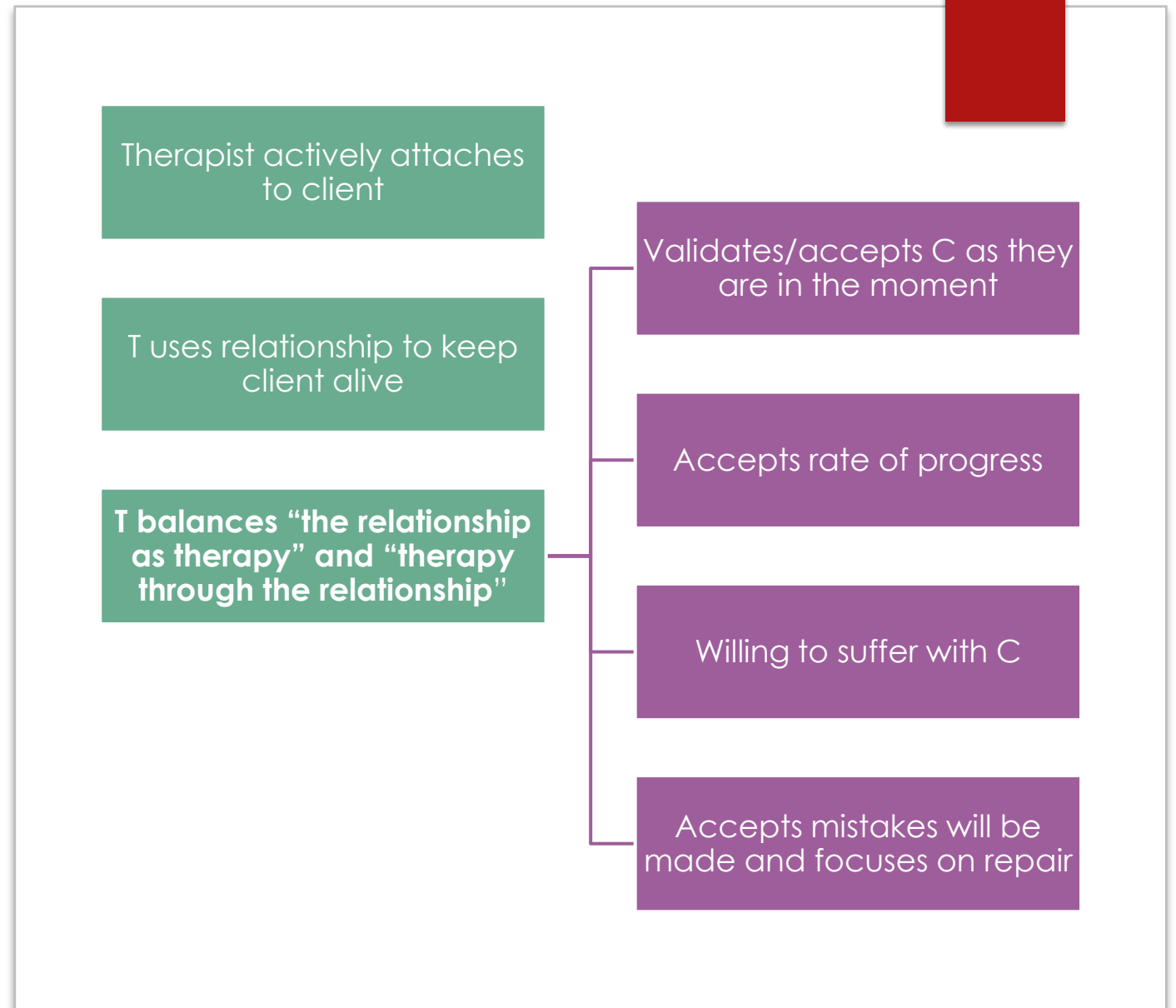


Research on therapeutic relationship in DBT Cont....



- ▶ Rudge et al. (2020) suggested that therapeutic alliance was as important as differences in therapy conditions in mediating symptom changes.
- ▶ Barnicot et al.'s (2012) systematic review of the literature concluded that symptom severity and therapeutic alliance predicted positive therapeutic outcomes.
- ▶ Hirsch et al. (2012) examined therapeutic alliance in RCT on DBT versus psychiatric management. They found that in the DBT condition, the more therapists perceived a client as agreeable, the higher the client rated the global alliance during treatment.

Relationship Strategies (pg. 516)



Relationship Strategies (pg. 516) 2

T focuses Problem Solving when problems arise

Assumes both are motivated to work on relationship problems

Dialectical approach and transaction

T uses consult and other forms of supervision

T attends to generalisation of behaviours learned in therapy relationship to other relationships

Possible Causes of T-TIBs (Linehan 1993 pg 138-141)

- ▶ Personal problems impacting work: home or work stress
 - ▶ Lack of sleep
 - ▶ Illness
 - ▶ Too many demands
 - ▶ Compartmentalising clinical work such that requests/contact outside of the “clinical” time experienced as intrusion
- ▶ Insecurity about one’s own skills
- ▶ Comparisons to other therapists
- ▶ Comparison of my clients’ progress to the progress of other therapists’ clients
- ▶ Anger, hostility and frustration towards the client



Possible
Causes of T-
TIBs Cont'd
(Linehan
1993 pg 138-
141)

- ▶ “Blaming the victim” attitude
- ▶ Sense of being pushed to the wall by the client
- ▶ Sense of losing control of the therapy situation
- ▶ Fear of being sued, struck off or disciplined in some way
- ▶ Anxiety about the client dying by suicide
- ▶ Unrealistic beliefs about what is possible
- ▶ Unreasonable expectations of the client



Therapist TIBs

Can be divided into behaviours related to imbalance in the following areas:

- ▶ Pushing for change versus fostering acceptance with clients/self
- ▶ Being too flexible or too rigid in application of DBT
- ▶ Lack of balance in nurturing clients versus demanding change from client

- ▶ Behaviours that interfere with receiving therapy
 - ▶ Nonattentive
 - ▶ Non-collaborative
 - ▶ Noncompliant
- ▶ Behaviours that interfere with other clients
- ▶ Behaviours that burn out the therapist
 - ▶ Pushing therapist's personal limits
 - ▶ Pushing organizational limits
 - ▶ Behaviors that decrease therapist's motivation

Client TIB Categories

Some can
be
Therapy
Destroying!

Conceive of the behaviours as patterns

COGNITIVE
REFRAME: THE
CLIENT IS GIVING
THE GIFT OF
SHOWING UP AS
THEMSELVES! AND
WHILE BEHAVIOUR
MAY MAKE IT
HARDER TO DO
THERAPY, IT MIGHT
NOT REALLY BE A
TIB

Video then Exercise

TIB Behaviour Strategies Checklist (pg 496)

- ▶ Behavioural definition of TIB
- ▶ Chain analysis (emphasis on analysis of the function of the behaviour)
- ▶ Problem Solving Plan
 - ▶ If client unwilling T to discuss goals of therapy
 - ▶ Avoids a power struggle (is there another way to approach the issue? Are you moveable?)
 - ▶ Considers vacation or change of therapist



Anti-DBT TIB Tactics

- ▶ Therapist blames the client
- ▶ Therapist infers, without assessment, that client does not want to change or progress
- ▶ Therapist is rigid in interpretation of client's behaviour
- ▶ Therapist places all responsibility for change on client
- ▶ Therapist takes a position and refuses to move
- ▶ Therapist is defensive
- ▶ Therapist fails to see their own contribution to behaviour


A vacation? That sounds fun! No!

- ▶ Based on idea that client is connected to therapist
- ▶ Used when a therapist is burnt out and has exhausted all of their resources and clients won't change their behaviour
 - ▶ Therapist has assessed that desired change is within the client's behavioural repertoire.
- ▶ Applied only after consultation with their team (no unilateral: therapists have emotions too and can be reactive)
- ▶ For a specific period of time to accomplish a specific task or motivation to change behaviour
 - ▶ May necessitate referral to someone else to support client in interim



Use of consult

- ▶ Balance and perspective:
 - ▶ Accepts therapist in the moment
 - ▶ Helps them think more dialectically about the client, situation and yourself.
 - ▶ Find phenomenological empathy for client
 - ▶ Engage in problem solving
 - ▶ Hold and stretch limits
 - ▶ Take over treatment of the client when therapists or client burnt out



Thank you so much for your
participation.

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