

STUCK?!
**ENHANCING TREATMENTS FOR ANXIETY
AND DEPRESSION USING PRINCIPLES FROM
DIALECTICAL BEHAVIOR THERAPY**

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“Here’s what I’ve tried: individual psychotherapy (three decades of it), family therapy, group therapy, cognitive-behavioral therapy, rational emotive behavior therapy, acceptance and commitment therapy, hypnosis, meditation, role-playing, interoceptive exposure therapy, in vivo exposure therapy, self-help workbooks, massage therapy, prayer, acupuncture, yoga, Stoic philosophy, and audiotapes I ordered off a late-night TV infomercial.

And medication. Lots of medication. Thorazine. Imipramine. Desipramine. Chlorpheniramine. Nardil. BuSpar. Prozac. Zoloft. Paxil. Wellbutrin. Effexor. Celexa. Lexapro. Cymbalta. Luvox. Trazodone. Levoxyl. Inderal. Tranxene. Serax. Centrax. St. John’s wort. Zolpidem. Valium. Librium. Ativan. Xanax. Klonopin.

Also: beer, wine, gin, bourbon, vodka, and scotch.

Here’s what’s worked: nothing.” -- Scott Stossel, *Surviving Anxiety*, *The Atlantic*
January/February 2014

PREVALENCE AND COMORBIDITY

- 40 million adults in the U.S. suffer from an anxiety disorder (NIMH)
- More than half of people with one anxiety disorder have another anxiety disorder (Brown et al., 2001)
- Among individuals who attempt suicide, 70% have an anxiety disorder (Nepon, Belik, Bolton, & Sareen, 2010)
- Major Depressive Disorder affects approximately 14.8 million adults
- Nearly half of the people who have a major depressive episode will also have an anxiety disorder (e.g. Reiger et al.. 1998)
- In BPD populations, lifetime prevalence of depression occurs in as many as 83% and anxiety disorders occur in as many as 88%

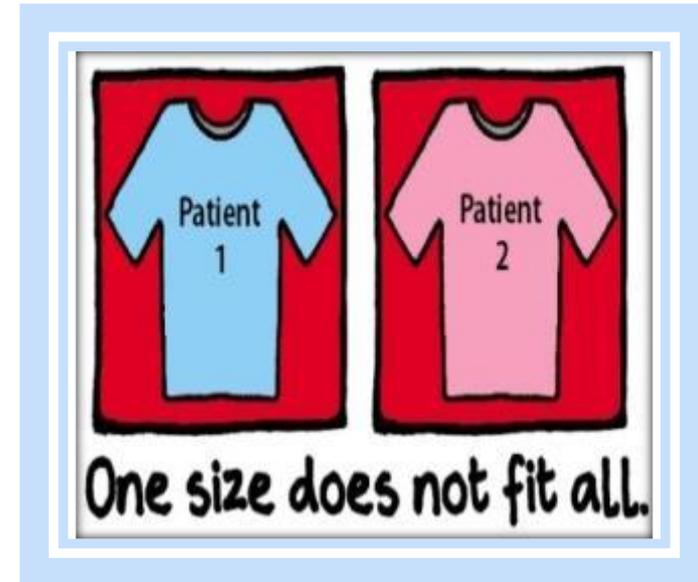
CURRENT CONCEPTUALIZATIONS

- Depression and anxiety share common factors (e.g. Fairholme, 2010)
- Research in affective science suggests moving toward examining broader shared constructs (e.g. Brown & Barlow, 2009)
- Common process =emotion dysregulation
- Empirically supported treatments target emotion regulation
- The mechanism of change in DBT is reducing ineffective actions associated with dysregulated emotions.

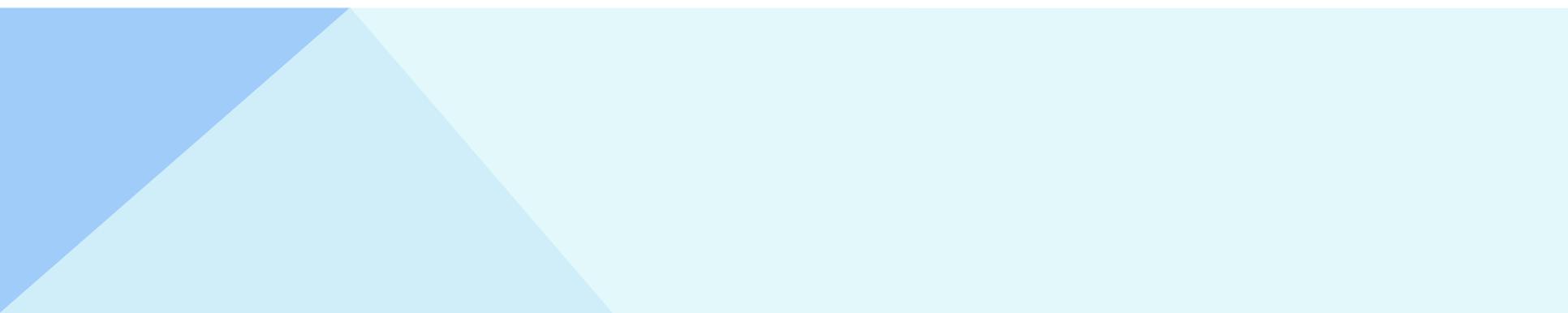


WHAT MIGHT BE GETTING US STUCK?

- Problematic expectations-on both sides!
- Poor therapeutic alliance
- Premature dropout
- Patient hopelessness/low motivation
- Lack of generalization to real world
- Therapist burnout
- Too many problems to juggle



GOALS FOR TODAY

1. Increase familiarity with Dialectical Behavior Therapy (DBT)
 2. Target potential stuck points using DBT principles
 3. Learn at least 5 DBT strategies to employ with your clients
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OVERVIEW OF DIALECTICAL BEHAVIOR THERAPY

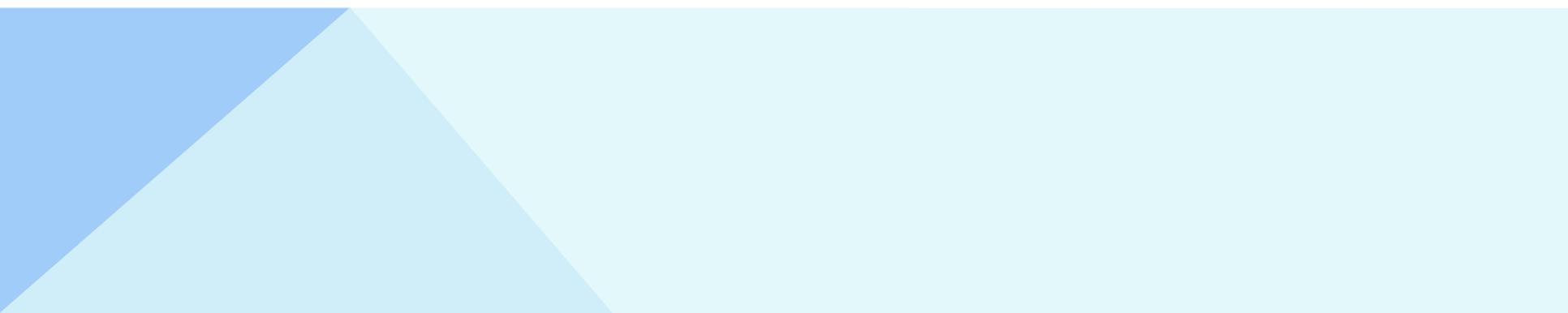
Comprehensive DBT includes:

1. skills training
2. individual therapy
3. coaching calls
4. team meetings

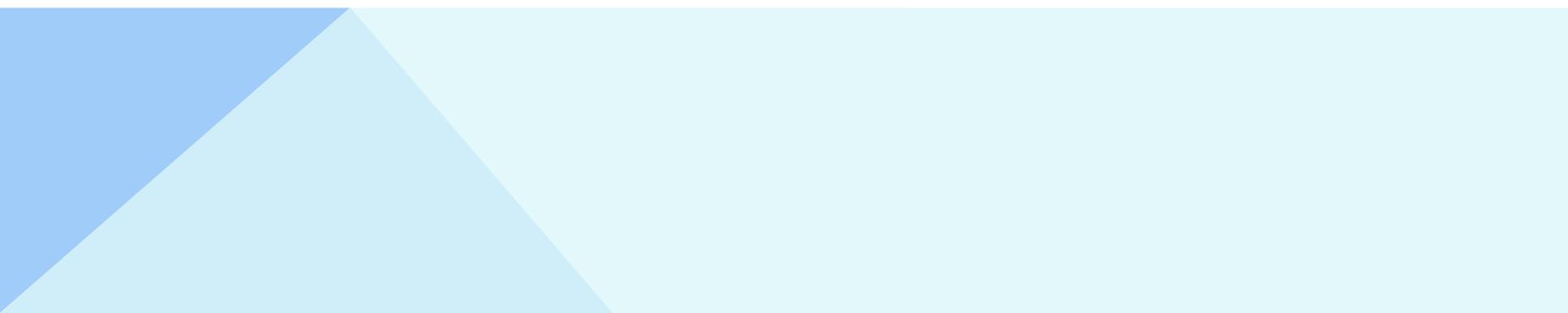
These components aim to:

1. enhance clients capabilities
2. structure the environment to support the client
3. generalize client gains
4. heighten therapist motivation and competence

DBT is principle-based, not protocol-based



EFFICACY OF DBT COMPONENTS BEYOND BPD

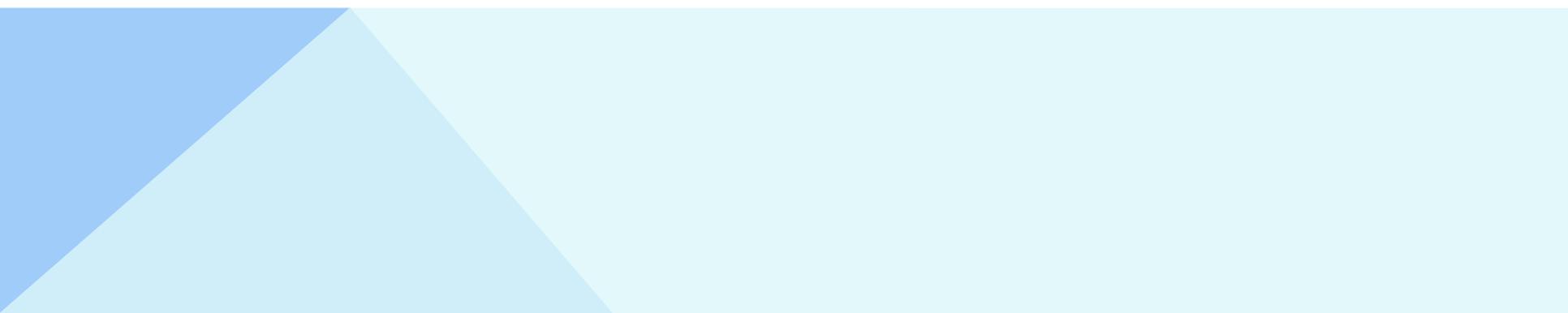
- Bulimia nervosa and binge eating disorder (e.g. Hill, Craighead, & Safer, 2011)
 - ADHD (Hesslinger, 2002)
 - Treatment resistant depression (Lynch et al., 2000, 2003; Harley, Sprich, Safren, & Jacobo, 2008)
 - Depression in the elderly (DBT+MED) (Lynch, Morse, Mendelson, & Robins, 2003)
 - Post-traumatic stress disorder (Bohus et al., 2013)
 - DBT-enhanced habit reversal for trichotillomania (Keuthen et al., 2011)
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DBT FOR DEPRESSION

- 34 depressed adults over the age of 60 (M age =66.0, S.D= 5.0) recruited from the Clinical Research Center for the Study of Depression in Late Life at Duke
- Participants were randomly assigned to either an antidepressant condition (MED) or medication+ 14 weeks of DBT skills training + 30 minutes/week DBT phone coaching
- At post-treatment, 71% of MED+ DBT patients were in remission at post-treatment compared to 47% of MED alone patients.
- At a 6-month follow-up, 75% of MED+DBT patients were in remission compared to only 31% of MED patients.

(Lynch, Cheavens, Cukrowicz, Thorp, Bronner, & Beyer, 2007)

TREATMENT INNOVATIONS WE'LL COVER TODAY

- ✓ Commitment strategies
 - ✓ Validation
 - ✓ Concrete skill instructions in distress tolerance and emotion regulation
 - ✓ Extensive self-monitoring of emotions and skills
- 

DIFFERENTIATING

BEHAVIOR THERAPIES

- Exposure and response prevention
- Skills training
- Reinforcement
- Cognitive restructuring/distancing

DBT

- Commitment strategies
- Validation as a skill set
- Mindfulness as a set of skills- e.g. wise mind, participate
- Dialectical focus
- Emotion regulation and opposite action skills
- Distress tolerance skills
- High therapist self-disclosure
- Telephone consultation

DBT ASSUMPTIONS

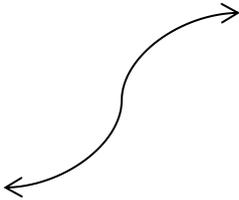
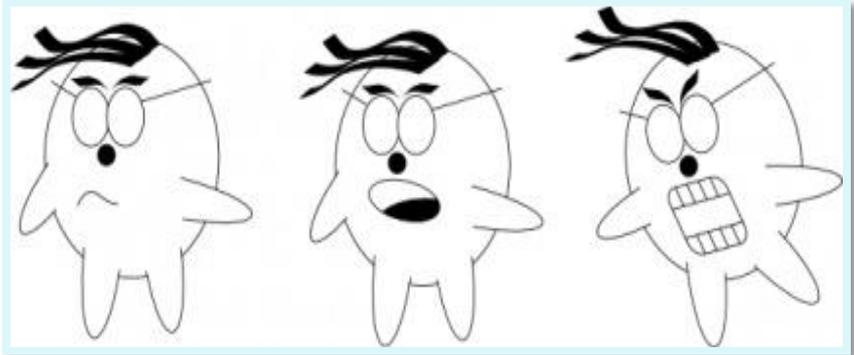
ABOUT THERAPY

- The most caring thing a therapist can do is to help bring patients closer to their ultimate goals
- Clarity, precision, and compassion matter
- Principles of behavior affect both therapists and clients-they are universal
- The therapeutic relationship is a real relationship between equals

ABOUT PATIENTS

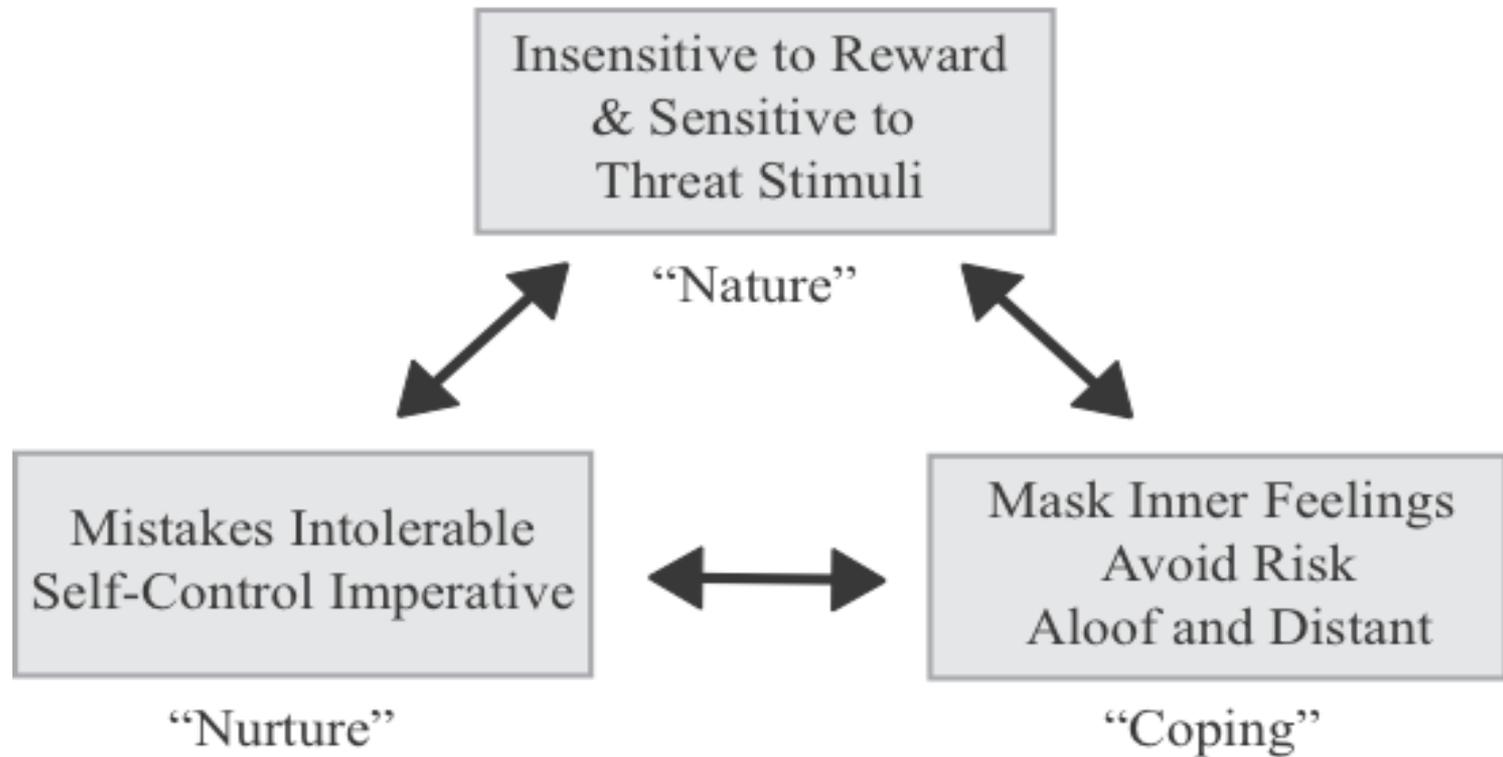
- Patients are doing the best they can (and cannot fail in therapy)
- Patients want to improve
- Patients need to do better, try harder, be more motivated
- Patients may not have caused their problems, but need to solve them
- Patients must learn new behaviors in all relevant contexts

BIOSOCIAL THEORY



Linehan, 1993

THE BIOSOCIAL MODEL FOR DISORDERS OF OVER CONTROL



Lynch, Hempel, Dunkley, 2014

CASE EXAMPLES

“Allison”

At intake (November, 2013, BDI 35, BAI 56) four months later- BDI 9, BAI 17)

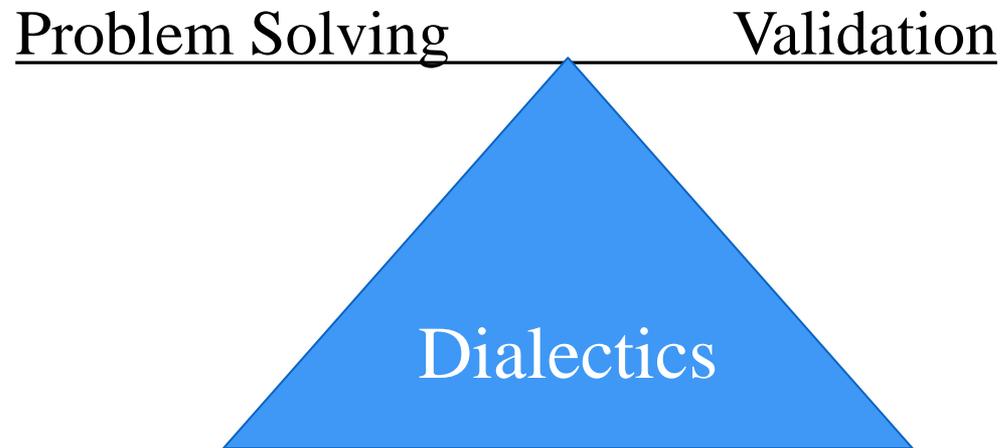
28-year-old female, longstanding history of generalized anxiety, social anxiety, and perfectionism. Developed panic disorder and was concurrently notably depressed and on medical leave from work.

“Mark”

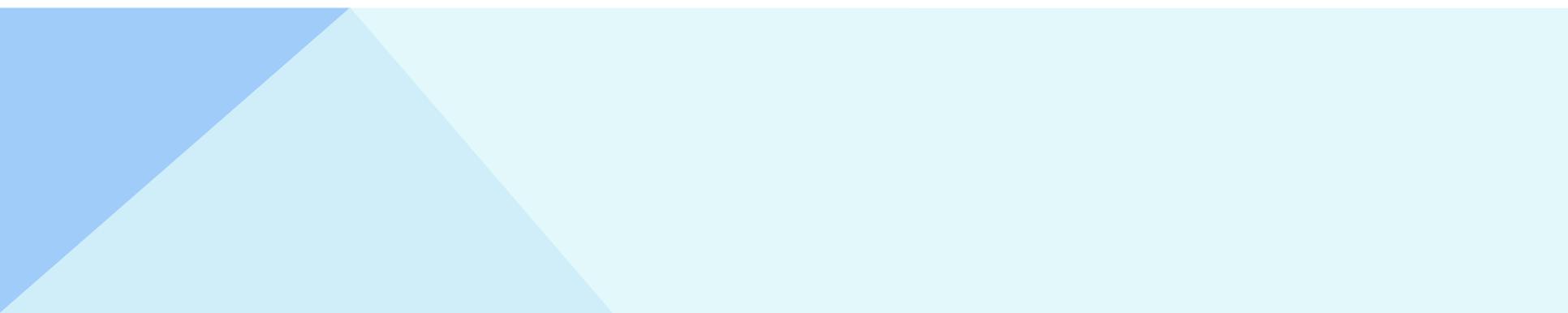
27-year-old male, long standing history of GAD, BDD, social anxiety, MDD, OCPD, and physical pain. Presented on medical leave, referred to me from prescribing psychiatrist to target SI.

BEHAVIOR THERAPY

- Change your thinking and your behavior →
Intense arousal, sense of invalidation
- What happens to the therapeutic relationship?



DIALECTICAL PHILOSOPHY

- According to Hegel, truth as a process that develops when opposing, valid positions integrate into a finer truth...
 - Assumption there is no single truth.
 - Effective use of dialectical strategies allow a provider to circumvent a rigid argument, allowing a client to move towards goals.
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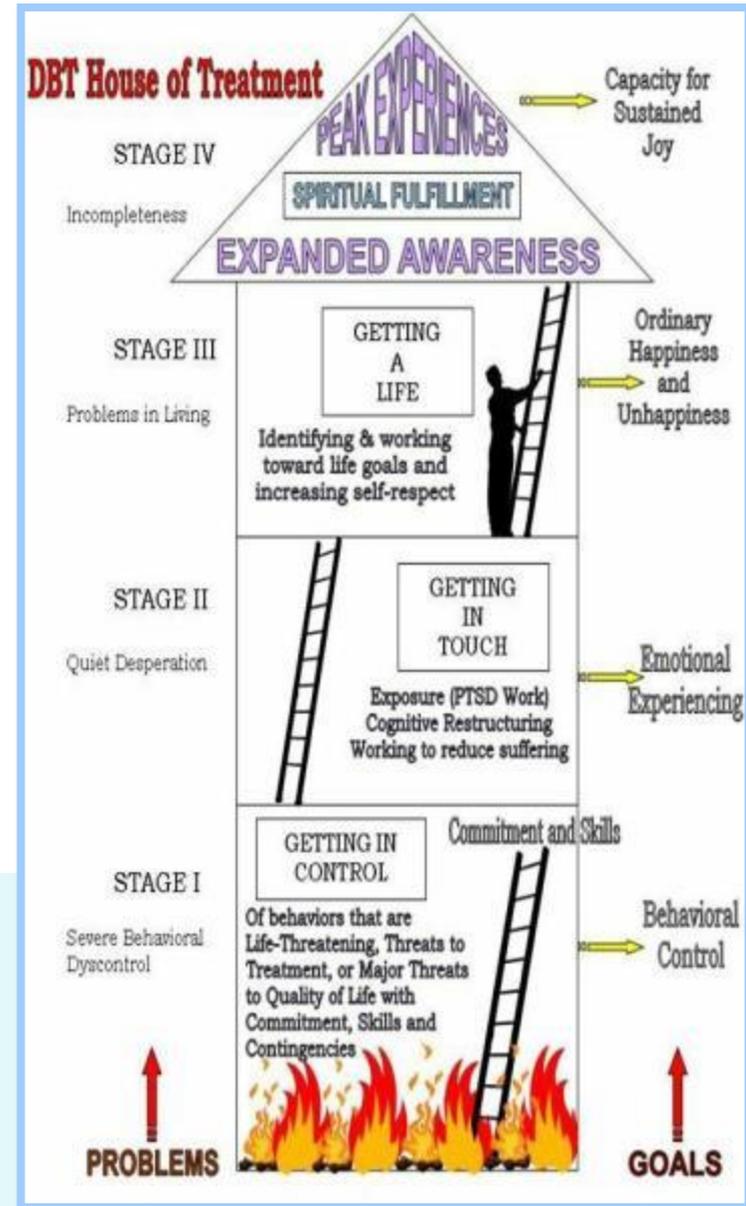
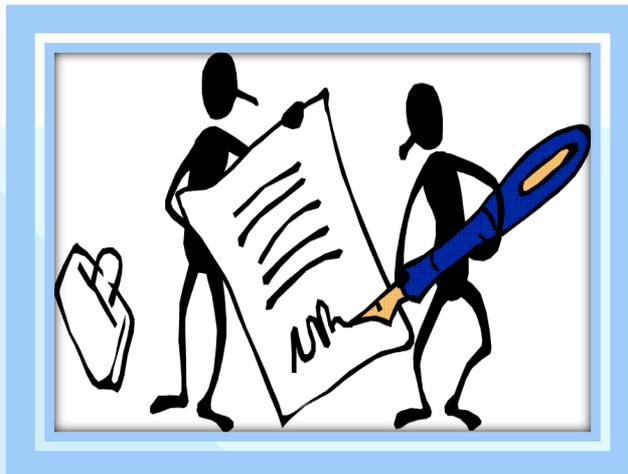
DIALECTICS IN DBT

- Dialectics is both a theory and a stylistic approach aimed to target dichotomous tendencies.
- Example of dialectical assumption in DBT: Clients are doing the best they can and they need to do better...
- The need to simultaneously accept and change
- Dialectical philosophy also addresses a system as a whole
- DBT aims to treat whole patient rather than just the disorder. Also whole emotion system is targeted- all elements seen as interrelated.

Linehan, 1993

ORIENTATION

- Ultimate treatment aim:
 - “A life worth living”
- Informed consent to treatment/
shared agreement on investment
- Treatment hierarchy:
 - Life threatening
 - Therapy interfering
 - Quality of life-interfering



COMMITMENT STRATEGIES

1. Evaluating the pros and cons of making a change
2. “Foot in the door/Door in the face”
3. Connecting present commitments to previous commitments
4. Underscoring freedom to choose and the absence of alternatives
5. Shaping
6. Cheerleading
7. Devil’s advocate
8. Agreement on homework



Linehan, 1993, p. 286-291

VALIDATION, DEFINED

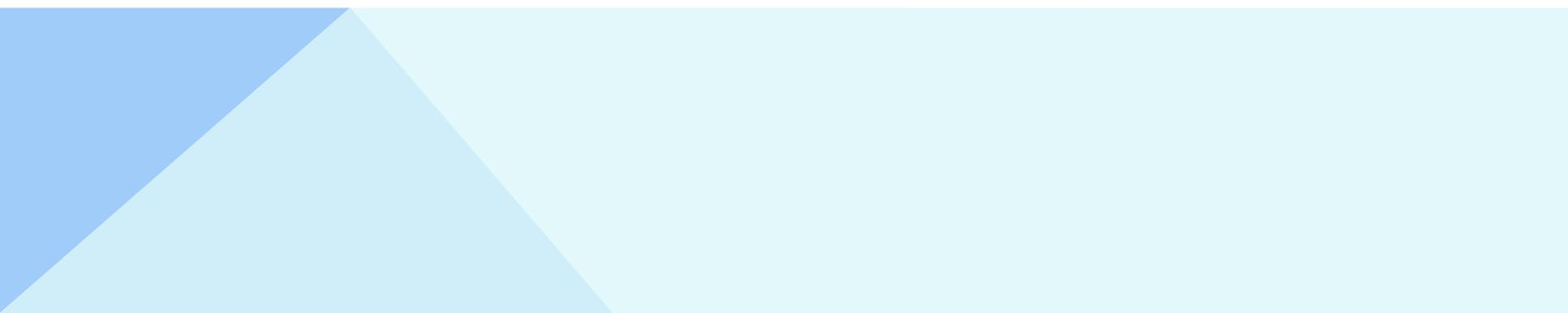
“The therapist communicates to the patient that her responses make sense and are understandable with her current life context or situation.”

“The therapist actively accepts the patient and communicates this acceptance to the patient.”

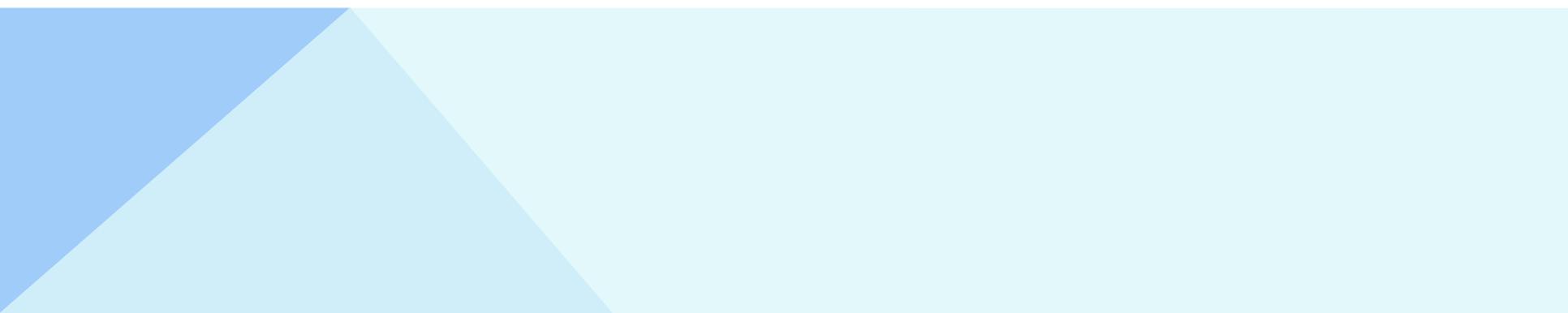
“The therapist takes the patient’s responses seriously and does not discount or trivialize them”

--Linehan, 1993, *Cognitive Behavioral Treatment of Borderline Personality Disorder*, p. 222-223

WHY VALIDATE?

- To facilitate self-validation
 - To reduce emotional arousal
 - To strengthen the therapeutic relationship
 - To balance change
 - As feedback
- 

LEVELS OF VALIDATION

1. Staying awake- undivided listening and observing
 2. Providing accurate reflection
 3. Articulating the unarticulated emotions, thoughts, or behavior patterns
 4. Validating in terms of past learn or biology
 5. Validating in terms of present context or normative functioning
 6. Radical genuineness
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RADICAL ACCEPTANCE

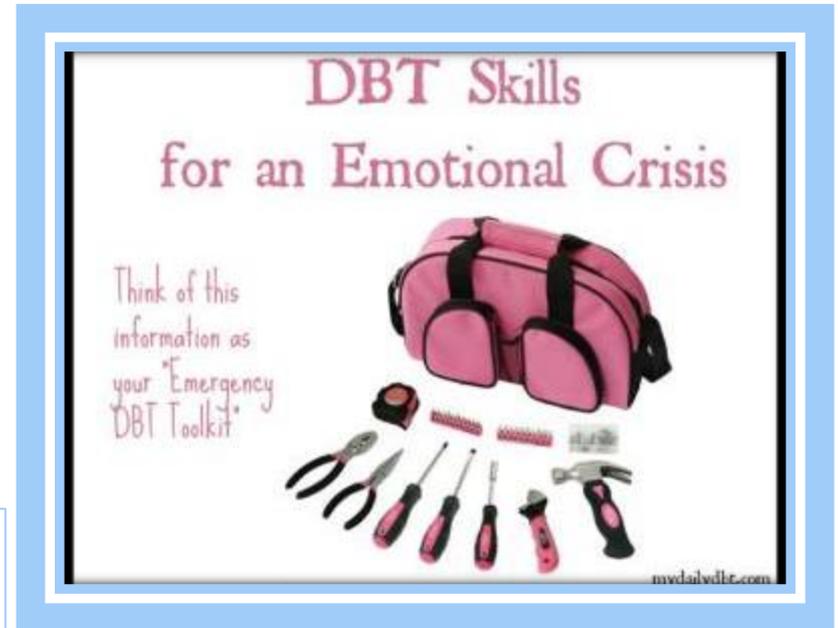
“To be fully open to what is, just as it is, at this very moment...”

- Half-smiling
- Willingness
- Turning the mind
- Mindfulness of thoughts



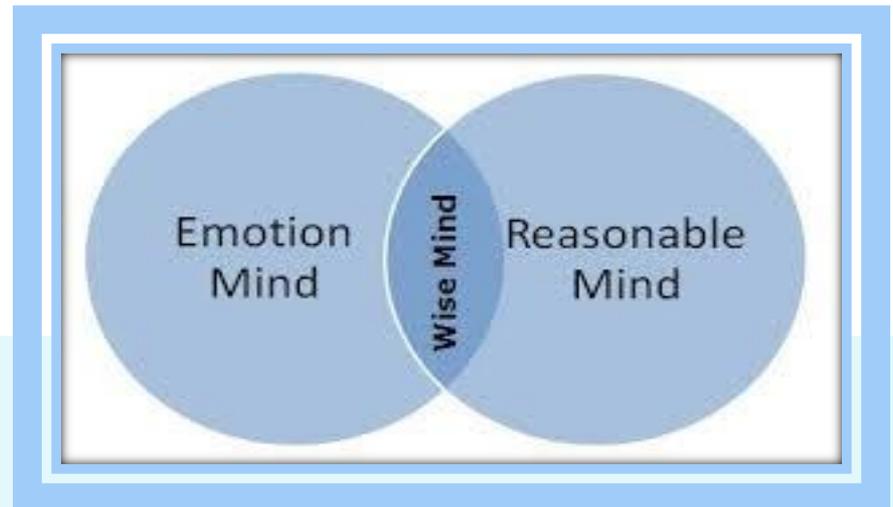
CRISIS SURVIVAL

- A pit stop, not a destination
- Self soothing with the senses
- Activities, contributions,
making meaning...



MINDFULNESS

- Present, nonjudgmental, awareness
- Includes ability to differentiate between
Emotion Mind, Reason Mind, Wise Mind
- What skills: observe, describe, participate
- How: nonjudgmentally, one mindfully, effectively

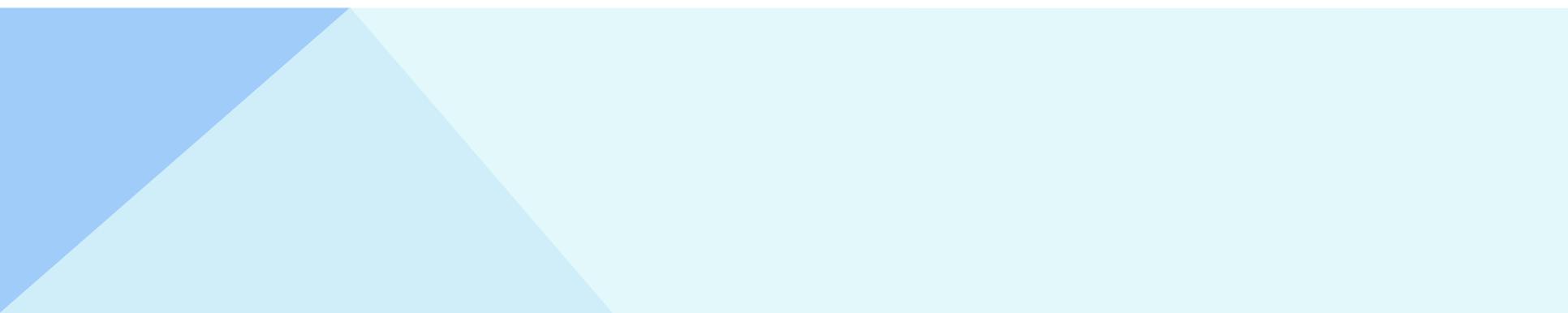


OPPOSITE ACTION

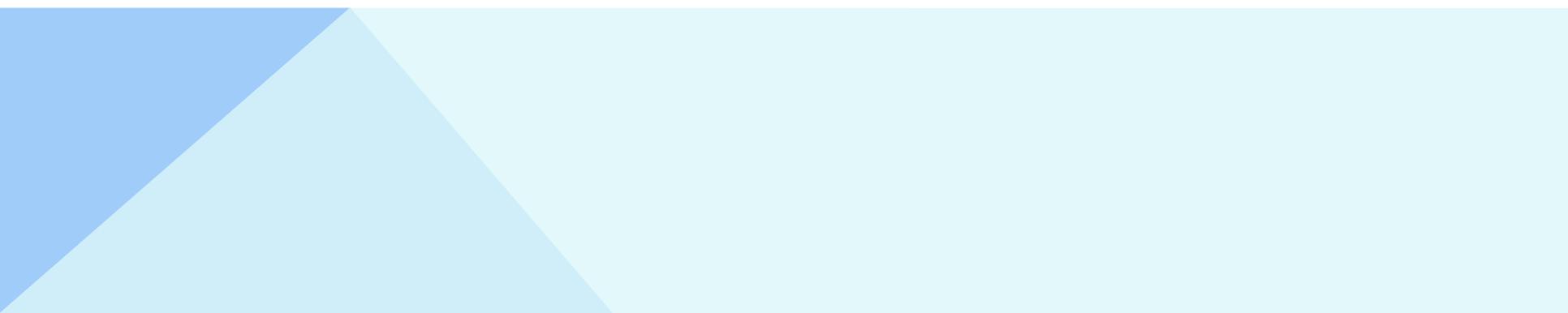
1. Identify emotion
2. Identify intensity of emotion
3. Is emotion justified (fit the facts) in terms of the emotion and the intensity?
4. Decide if you'd be willing to act opposite
5. Do opposite action all the way, mind and body

→ Aim is not to feel better, but to live bigger

EMOTION REGULATION

- Functions of emotions
 - Motivate actions
 - Communicate to self
 - Communicate to others
 - Understand the model of emotions
 - Differentiate between primary and secondary emotions
 - Reduce emotional vulnerability: Avoid avoiding!
 - Challenge beliefs about emotions and interpretations
 - Change an emotion by acting opposite
 - Values exploration
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INTERPERSONAL EFFECTIVENESS

- Attend to relationships, challenge interpersonal assumptions
 - Learn to make requests, say no effectively
 DEAR MAN GIVE FAST
 - Prioritize among:
 Objective
 Relationship
 Self respect
 - Practice validation
 - Learn flexibility in way in which you make requests, say no
- 

COMPREHENSIVE MONITORING

| Day & Date | | | | | | | | | | | | | | | | | | | | | | |
|------------|-----|---------|-----|------|-----|-------|-------|------|---------|---------|------|---------|----------|---------|-----|---------|-----|-------|-----|--------|---|--|
| | Use | Suicide | S-H | Pain | Sad | Shame | Anger | Fear | Illicit | | ETOH | | Prescrip | | OTC | | S-H | Lying | Joy | Skills | R | |
| | 0-5 | 0-5 | 0-5 | 0-5 | 0-5 | 0-5 | 0-5 | 0-5 | # | Specify | # | Specify | # | Specify | # | Specify | Y/N | # | 0-5 | 0-7 | ✓ | |
| Mon | | | | | | | | | | | | | | | | | | | | | | |
| Tues | | | | | | | | | | | | | | | | | | | | | | |
| Wed | | | | | | | | | | | | | | | | | | | | | | |
| Thur | | | | | | | | | | | | | | | | | | | | | | |
| Fri | | | | | | | | | | | | | | | | | | | | | | |
| Sat | | | | | | | | | | | | | | | | | | | | | | |
| Sun | | | | | | | | | | | | | | | | | | | | | | |

***USED SKILLS**

- 0 = Not thought about or used
- 1 = Thought about, not used, didn't want to
- 2 = Thought about, not used, wanted to
- 3 = Tried but couldn't use them

- 4 = Tried, could do them but they didn't help
- 5 = Tried, could use them, helped
- 6 = Didn't try, used them, didn't help
- 7 = Didn't try, used them, helped

| | | | | | | |
|-----------------------------|---------------|--------------|-----------------------------------|---------------|--------------|--|
| | Before | After | Belief in control of . . . | Before | After | BRTC Diary Card Copyright 1999 Marsha M. Linehan, Ph.D. |
| Urge to use (0-5): | | | Emotions: | | | |
| Urge to quit therapy (0-5): | | | Behaviors: | | | |

| | | | | | | | |
|---|-----|------|-----|-------|-----|-----|-----|
| 2. Observe: just notice (Urge Surfing) | Mon | Tues | Wed | Thurs | Fri | Sat | Sun |
| 3. Describe: put words on | Mon | Tues | Wed | Thurs | Fri | Sat | Sun |
| 4. Participate: enter into the experience | Mon | Tues | Wed | Thurs | Fri | Sat | Sun |
| 5. Nonjudgmental stance | Mon | Tues | Wed | Thurs | Fri | Sat | Sun |
| 6. One-mindfully: in-the-moment | Mon | Tues | Wed | Thurs | Fri | Sat | Sun |
| 7. Effectiveness: focus on what works | Mon | Tues | Wed | Thurs | Fri | Sat | Sun |
| 8. Objective effectiveness: DEAR MAN | Mon | Tues | Wed | Thurs | Fri | Sat | Sun |
| 9. Relationship effectiveness: GIVE | Mon | Tues | Wed | Thurs | Fri | Sat | Sun |
| 10. Self-respect effectiveness: FAST | Mon | Tues | Wed | Thurs | Fri | Sat | Sun |
| 11. Reduce vulnerability: PLEASE | Mon | Tues | Wed | Thurs | Fri | Sat | Sun |
| 12. Build MASTERY | Mon | Tues | Wed | Thurs | Fri | Sat | Sun |
| 13. Build positive experiences | Mon | Tues | Wed | Thurs | Fri | Sat | Sun |
| 14. Opposite-to-emotion action (Alt. Rebellion) | Mon | Tues | Wed | Thurs | Fri | Sat | Sun |
| 15. Distract (Adaptive Denial) | Mon | Tues | Wed | Thurs | Fri | Sat | Sun |
| 16. Self-soothe | Mon | Tues | Wed | Thurs | Fri | Sat | Sun |
| 17. Improve the moment | Mon | Tues | Wed | Thurs | Fri | Sat | Sun |
| 18. Pros and cons | Mon | Tues | Wed | Thurs | Fri | Sat | Sun |
| 19. Radical Acceptance | Mon | Tues | Wed | Thurs | Fri | Sat | Sun |
| 20. Building Structure// Work | Mon | Tues | Wed | Thurs | Fri | Sat | Sun |
| 21. Building Structure// Love | Mon | Tues | Wed | Thurs | Fri | Sat | Sun |
| 22. Building Structure// Time | Mon | Tues | Wed | Thurs | Fri | Sat | Sun |

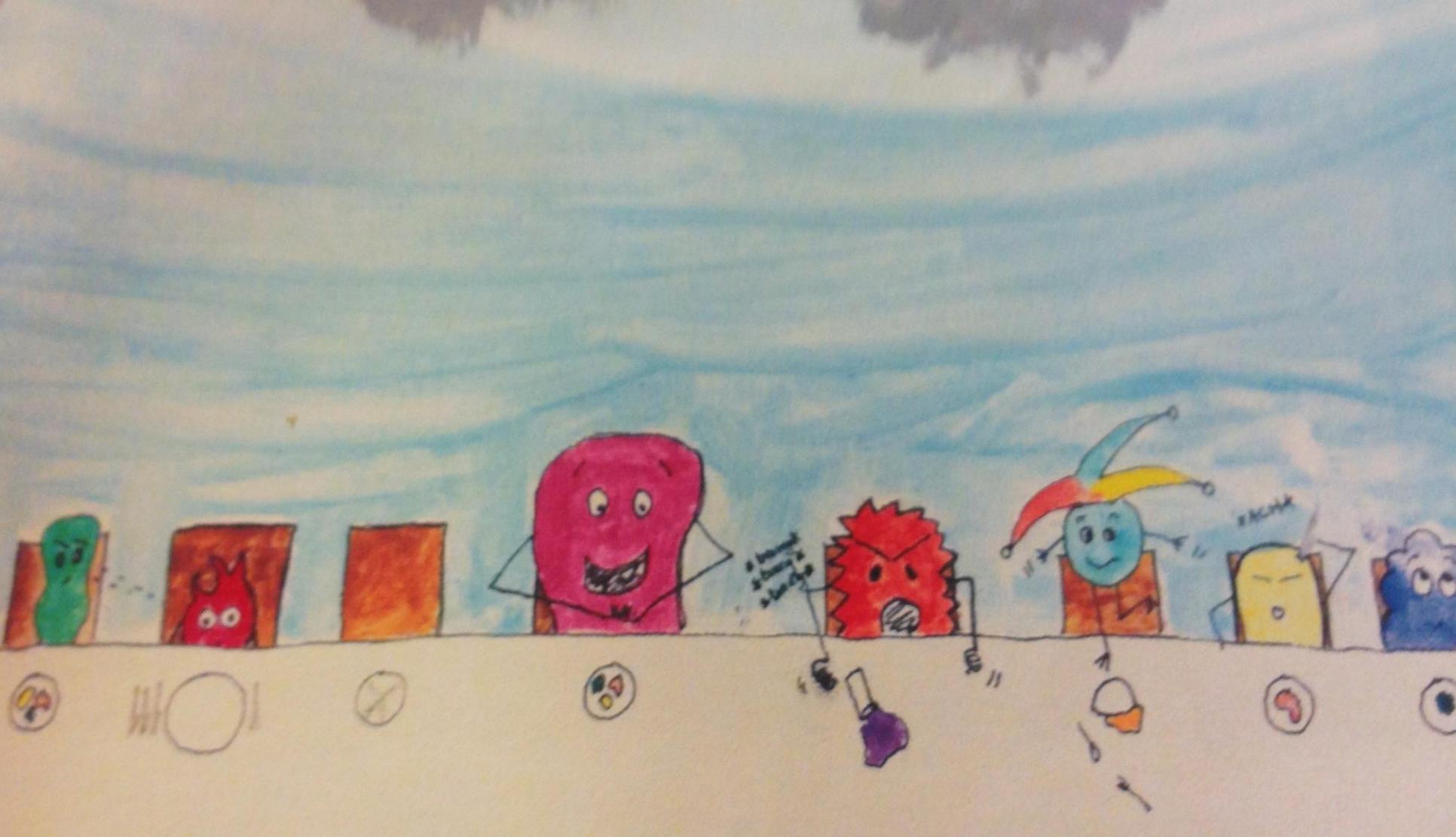
GETTING UNSTUCK

POTENTIAL OBSTACLES

- Problematic expectations
- Premature dropout
- Poor therapeutic alliance
- Patient hopelessness/low motivation
- Lack of generalization to real world
- Therapist burnout
- Too many problems to juggle

POSSIBLE DBT INTERVENTIONS

- Orientation, commitment strategies
- Validation, radical genuineness, therapist disclosure
- Skills monitoring, validation, commitment strategies, crisis kits, coaching calls
- Skills monitoring, distress tolerance skills, coaching calls as needed
- Nonjudgmental stance, teams, appropriate disclosure
- Hierarchy, skills training and monitoring



RECOMMENDED RESOURCES

www.behavioraltech.org

www.practiceground.org

www.dbtselfhelp.com

