DBT and the Art of Engagement

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The Bell Curve

By Atul Gawande
Published in The New Yorker,
December 6, 2004

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Median life expectancy at "average" CF treatment centers vs. the "best" centers.

National
- 1964: 3 years
- 1966: 10 years
- 1972: 18 years
- 2003: 33 years

Best-Center
- 1964: 21 years
- 1972: 95% live > 18
- 2003: 47 years

Excerpted from "The Bell Curve", Atual Gawande, The New Yorker, December 6, 2004

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The top treatment centers continue to out-pace national averages even though:

- The median life expectancy for all CF patients has improved over time.
- All CF centers have comprehensive programs and highly specialized teams.
- The best-center treatment protocols have been adopted by all centers.

Excerpted from "The Bell Curve", Atual Gawande, The New Yorker, December 6, 2004

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Gawande's clinical vignettes suggest that the following caregiver variables had a significant impact on treatment outcome:

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- Persistent and detailed information gathering
- Empathy and respect for the patient's point of view
- Rigid team adherence to treatment protocols
- Unwavering insistence on excellence
- Tireless searching for a better margin of health
- Pushing through patient evasion and resistance
- Creative and flexible problem-solving
- Aggressive intervention at the first sign of a problem

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Shared characteristics of CF and Chemical Dependency

- Chronic and progressive
- Potentially life-threatening
- Many days of well-being interspersed with intermittent relapses
- Complex treatment protocol delivered by specialized team
- Treatment demands a high degree of motivation and compliance from patient

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What would it take to be in the top 5% of the bell curve?

- Know your science, offer state-of-the-art treatment.
- Demand a high standard of performance from patients and staff.
- Overtreat.
- Innovate.

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Caregiver variables associated with best outcomes may include persistence, consistency, ingenuity, and the ability to keep the patient in treatment.

- Can we aspire to develop those qualities?
- Can we teach them to each other?

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Dialectical Behavior Therapy (DBT)

Developed by Marsha Linehan, PhD
and Colleagues
University of Washington, Seattle

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DBT

A one-year comprehensive outpatient behavior therapy designed to reduce the frequency of impulsive and self-destructive behaviors in patients who suffer from emotional dysregulation.

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The essential dialectic in DBT

ACCEPTANCE
vs. CHANGE

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OVERVIEW: How does a therapist promote change?

- Confrontation: OBSERVE and DESCRIBE the problem to the patient.
- CHAIN ANALYSIS: examine how the problem occurs.
- SOLUTION ANALYSIS: ask for a more adaptive response.
- Get a COMMITMENT to try a new behavior.
- REHEARSE the new behavior in-session.
- PROBLEM-SOLVE, CHEERLEAD, persist through obstacles.

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CHAIN ANALYSIS

A moment-by-moment description of a behavior sequence that includes the thoughts, feelings, and consequences associated with each link in the chain.

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Start with a particular instance of a problem behavior:

- Determine the circumstances: when, where, who was there, how did it happen?
- What was the prompting event?
- "When did it first cross your mind?"
- What was the point of no return?
- What were the consequences; i.e. "What happened after you drank the alcohol?"
- Were there any pre-existing vulnerabilities?

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Be persistent.

- Get the sequence from prompting event >>>> problem behavior clearer and clearer.
- Focus especially on thoughts >> feelings >> behaviors >> external events and vice-versa.

Think and talk about BEHAVIOR

- Reduces emotional reactions and judgments.
- Increases precision in communication and understanding.

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Practice OBSERVING

- Just notice what is.
- No language to label the experience.

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Practice DESCRIBING what you observe.

- External events that other people can also OBSERVE (a flower, a sound, a speech).
- Private internal events that only you can OBSERVE (a physical sensation, a thought, an emotion)

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Notice: you cannot DESCRIBE what you did not OBSERVE:

- Someone else's private thoughts and feelings
- Other people's motivations (or lack thereof)
- Unconscious yearnings and conflicts
- Abstract concepts: "projection" "manipulation" "fair/unfair" "resistance" "splitting"

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Instead, try DESCRIBING what behaviors you did OBSERVE in the patient and what thoughts/feelings you OBSERVED in your mind about those behaviors.

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SOLUTION ANALYSIS

- Identify a maladaptive link in the chain.
- Ask what the patent needed at that moment.
- Ask for a more adaptive response.
- Be gently persistent.
- If the patient has no ideas, teach a better response. What would you have done faced with the same situation?

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GET A COMMITMENT

- "So, how about if you give this new behavior a try?"
- "Can I get a COMMITMENT from you?"
- Get specific.

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Asking for a commitment increases the likelihood of follow-through.

- COMMITMENTS are not the same as promises or guarantees.
- You are asking the patient if he/she is COMMITTED, in this moment, to performing the new behavior at an agreed upon time in the future.
- It's easier to make and keep a small specific COMMITMENT than a large global one.

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REHEARSE THE NEW BEHAVIOR

- Ensures that the patient can actually perform the new behavior.
- REHEARSAL is a way to practice new behavior.
- Practice leads to improved skill and reduced anxiety.
- REHEARSAL often leads to trouble-shooting and refined planning.

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FOLLOW-UP

- If you give an assignment, make a contract, or elicit a commitment you MUST follow-up.
- Failure to follow-up suggests that you are not interested in the outcome.
- It teaches patients that there is no consequence for avoiding the assignment and no reward for completing it.

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ADDRESS THE OBSTACLES

- "Oh no, what happened? Let's take a look together at what got in the way."
- Brief CHAIN ANALYSIS.
- Remind patient of their prior COMMITMENT.
- Link the new behavior to the patient's GOALS.

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- Troubleshoot: PROBLEM SOLVE the obstacles that come up.
- Don't let the patient get away with doing NOTHING.
- SHAPING: give lots of partial credit.
- Be a CHEERLEADER.

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CONFRONT PROBLEM BEHAVIORS IN-SESSION

- "Are you noticing what I'm noticing?"
- DESCRIBE the behavior specifically and NON-JUDGMENTALLY.
- Assess the behavior by doing a small CHAIN ANALYSIS.
- Use SOLUTION ANALYSIS to generate alternative, more adaptive behaviors.
- REHEARSE the new behavior right there in-session.
- Get a COMMITMENT to work on this together.

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If you have no time for behavior analysis:

- Make a CONTINGENCY STATEMENT.
- Offer an alternative behavior, get the patient's agreement,and rehearse it.

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IS IT CONFRONTATION? OR JUST NOTICING?

- Confrontation is DESCRIBING reality as you see it.
- But confrontation seems to imply an aggressive, belligerent, or pushy edge.
- Can you CONFRONT without becoming adversarial?
- Try thinking of yourself as DESCRIBING, NOTICING, or UNDERLINING what you OBSERVE.
- An easy manner and gentle humor helps.

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How does a therapist keep patients in treatment?

Acceptance is the softer edge of engagement.

Instead of thinking that the patient is not motivated for treatment, consider that engaging the patient is always the first and most essential therapeutic challenge.

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- ACCEPTANCE means taking the patient right now just as they are.
- ACCEPTANCE is profoundly important to patients and is a universal feature of psychological and spiritual therapies.
- ACCEPTANCE can melt patient resistance, promotes attachment, and enhances motivation.

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- ACCEPTANCE by the therapist can teach self-acceptance to the patient.
- ACCEPTANCE is probably *NOT* sufficient to promote change.
- DBT actively tries to teach ACCEPTANCE skills to patients and therapists.

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- RADICAL ACCEPTANCE is a whole-hearted embrace of present reality, just as it is, in just this one moment.

- RADICAL ACCEPTANCE means letting go of trying to make it different; there is nothing else to do, there is no where else to go.

- To the extent that ACCEPTANCE means ceasing to struggle for some other reality, it is orthogonal to avoidance and to willful control.

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- ACCEPTANCE does not imply passivity, endorsement or preference. We can deeply object to a circumstance while acknowledging the reality of that circumstance. We can cease striving to make the undesirable reality be different than what it is. This does not require that we like it or forgive it or acquiesce to it.

- We can practice RADICAL ACCEPTANCE by repeatedly TURNING THE MIND towards genuine whole-hearted acceptance of reality.

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DBT techniques that help keep patients in treatment:

- RADICAL ACCEPTANCE
- NONJUDGMENTAL THINKING
- VALIDATION
- WHAT WILL IT TAKE? Suspend assumptions and prejudices.

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- Using DBT Assumptions to avoid blaming
- HONORING LIMITS
- Peer Consultation for Therapists

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NON-JUDGMENTAL THINKING

The ability to OBSERVE and DESCRIBE, verbally or silently, what simply is, without reference to "good" or "bad".

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- The judgments one tries to minimize involve labeling behaviors as good or bad, right or wrong, fair or unfair, worthy or unworthy.
- In our daily lives, the skill of judging is necessary and not intrinsically problematic.
- In therapy, certain kinds of judgments are problematic because patients use them to globally define their self-worth and the "value" of various people and experiences.
- Therapists use judgmental thinking to blame or pathologize the patient, thereby decreasing patient and therapist motivation.

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WHY BOTHER WITH NON-JUDGMENTAL THINKING?

- Promotes self-acceptance and promotes empathy for others.
- Increases self-regulation of emotions.
- Increases tolerance for distressing situations.
- Opens the mind to previously discarded solutions.
- All these qualities make it easier for patients to stay in treatment and for therapists to avoid burnout.

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HOW TO PRACTICE NON-JUDGMENTAL THINKING?

- OBSERVE judgmental statements when they arise.
- DESCRIBE the judgment explicitly.
- RESTATE using non-judgmental language. Strive for specific and behavioral language.
- OBSERVE the after-effects of your non-judgmental restatement.
- Apply this practice to spoken statements, facial expression, tone of voice, body posture, and private thoughts.

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VALIDATION

Any response from the therapist that indicates that the patient's point of view is valid; i.e. appropriate to the situation and would make sense to the average person.

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Types of Validation:

- Verbal validation: articulate what is already sane and appropriate about a patient's response.
- Functional validation: act in a way that communicates your understanding of the patient's need and the seriousness of the situation. Your behavior is "in-tune" with the patient's communication.

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VALIDATE ONLY WHAT IS VALID

- Validation is not just support or kindness.
- Validation is always authentic, don't use psycho-babble.
- Don't validate a behavior that you think is maladaptive.
- There is always a tiny kernel of valid truth buried in the most chaotic behavior: Look for that and speak to it!

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WHAT WILL IT TAKE?

Open-minded approach to keeping patients in treatment.

What does the patient need?

What will it take to get the patient to stay?

How can the patient/therapist/agency/program respond?

- DESCRIBE the problem that the patient is having.
- Generate possible SOLUTIONS.
- Make a TASK ANALYSIS: i.e. a step-by-step pathway to achieving the solution that takes into account every needed step, action, skill, event.

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“AW, JUST LET ‘EM GO, THEY’RE NOT READY FOR TREATMENT”

- If the patient drops out of treatment, you have no opportunity to help them improve.
- They still have their problem and they now have no treatment.
- The patient is exhibiting the problem that he/she needs help with and is now being asked to leave treatment???

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- Patients who seem non-compliant may be trying to become more active and self-determining in their care. Don’t overlook or punish these efforts. Search for that kernel of truth to validate!
- If you solve the obstacle in treatment, the patient will learn a great deal and so will you.
- Often there are rules or assumptions that get in the way of thinking up creative solutions.

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- Blaming and judgmental thinking of the therapist can also result in rigidity.
- Is there a solution that honors your policy while still keeping the patient?
- Is your policy so rigid and restrictive that it needs to be changed?

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DBT makes assumptions about patients:

- Patients do want to change but need help to do so.
- Patients are doing their best right now, but need to do better.
- Treatment can fail the patient, but patients cannot fail treatment.

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HONORING LIMITS

- DBT does not recommend an infinitely permissive stance.
- Patients and therapists and agencies need to HONOR THEIR LIMITS.

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- A LIMIT is already there inside you, something that you can't or won't do.
- OBSERVE your limit: notice what your private experience is telling you.
- DESCRIBE your limit by making a clear and specific communication.
- HONOR your limit with self-validation and by acting in ways that keep you within your limits.
- Find SOLUTIONS with patients that stay within your limits and your agency's limits.

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DBT does not promote SETTING LIMITS: this is often arbitrary, presented as if it's good for all patients, and does not reflect the moment-to-moment reality that limits change.

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Rather, DBT invites therapists (and patients) to be mindful of their own limits, to communicate about them in a non-blaming way, and to problem-solve about how to deal with the situation within one's limits.

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It is sometimes necessary and appropriate for therapists (or patients) to briefly extend beyond their limits. This should be seen as a temporary exception and requires much support.

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Another Important Dialectic in DBT:

WHAT WILL IT TAKE? vs. HONORING LIMITS

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Therapist Behaviors that Increase Patient Motivation and Attachment

- ORIENT the patient to everything.
- Link new behaviors to patient GOALS.
- Coaching Model: 3-10 positive statements for every request for change.
- POSITIVE REINFORCEMENT: praise, smile, positive comments, increased time, gifts.

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- LEVEL 5 VALIDATION: tell the patient what you admire and celebrate about them as a human being.
- Transparency: warm, RECIPROCAL COMMUNICATION style.
- Send birthday or holiday cards to current patients and drop-outs.
- Go and find lost patients and ask, "What will it take to get you back?"

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PEER CONSULTATION: TEAM SUPPORT FOR THERAPISTS

- Consistency: maintains high level of adherence to treatment protocols.
- Practice/Rehearsal: DBT therapy for the DBT therapist.
- Validation and Positive Reinforcement: maintains therapist motivation.
- Support: peers give assistance whenever needed, even after hours.

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IN OUR EXPERIENCE, NO ONE CAN DO THIS WORK ALONE.

IT IS ALSO OUR EXPERIENCE THAT, WITH TEAM CONSULTATION, THIS WORK IS HIGHLY REWARDING AND EMINENTLY DO-ABLE.

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SUMMARY

- Keeping difficult-to-treat patients enrolled in a complex treatment program requires active engagement by the caregivers.
- Engagement demands a balance of persistent but gentle confrontation and genuine acceptance of the moment as it is.
- Ways to learn these skills are all around us: mindfulness training, spiritual direction, sports coaching, used car dealers, psychotherapies that operationalize technologies of change and acceptance.
- Whatever you practice, you'll get better at that!

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