Oxford Cognitive Therapy Centre
www.octc.co.uk

Course Outline

Practitioner Certificate in Dialectical Behaviour Therapy

Dr Fiona Kennedy

Introduction and Background

"*In Britain we have the remarkable phenomenon that large numbers of quite severely disordered*
people who require considerable therapeutic effort are deemed 'untreatable'.
[Gunn, quoted in *Breaking the Cycle of Rejection: The Personality Disorder Capabilities Framework.* National Institute for Mental Health in England (NIMHE), 2003, p.15].

Those whose presentations meet diagnostic criteria for personality disorders have a range of problems which are complex and long term.

Personality disorder is defined in DSM-IV (APA, 1994) as: 'an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment'.

Ten types of personality disorder are described: paranoid, schizoid, schizotypal, narcissistic, histrionic, borderline, anti-social, obsessive-compulsive, avoidant, and dependent.

The prevalence of personality disorder reported in the literature varies widely. This is probably because of differences in samples, diagnostic criteria, and assessment measures (Moran, 2002). Prevalence rates of 10–13% of adults have been reported in the community (de Girolamo & Dotto, 2000). In-patient services reported prevalence rates range from 36% to 67% (NIMHE,2003*b*; Hayward *et al.* 2006).

People with a diagnosis of personality disorder are more likely to have other mental health problems such as depression (Corruble *et al.* 1996), anxiety disorders (Sanderson *et al.* 1994), substance misuse/dependence (Robins, 1998) and eating disorders (e.g. Braun *et al.* 1994).

Ten percent of people with personality disorder complete suicide (Paris, 1993). Cheng *et al.* (1997) and Lesage *et al*. (1994) concluded that 47–77% of suicide cases studied retrospectively would have met criteria for at least one personality disorder.

Use of health-care services is high. In secondary care, this is particularly the case for people with borderline, histrionic, narcissistic, and antisocial personality disorder (Perry *et al.* 1987; Narrow *et al.* 1993). Bender *et al.* (2001) found people with personality disorder were hospitalized more often than those with depressive disorder; and used more psychiatric medication. A diagnosis of personality disorder predicts multiple psychiatric hospital admissions (Saarento *et al.* 1998).

Personality disorder predicts worse outcome for mental health problems such as depression, anxiety (Reich & Green, 1991) and schizophrenia (Tyrer & Seivewright, 2000).

Mental health services in the UK have not viewed personality disorder as part of their 'core business' (NIMHE, 2003*b*). In a 2002 survey study 28% of the health-care trusts in England who responded provided no identified adult mental health services to people with personality disorder (Fahy, 2002).

The revised Mental Health Act provides a broader definition of mental illness, which encourages the assessment and treatment of personality disorder as a legitimate role for mental health services (NIMHE, 2003*b*).

Psychiatric services in the UK have focused primarily on psychotic illnesses (Fahy, 2002), which have a prevalence of just 1–3% in the general population. People with personality disorder given another diagnosis such as depression or psychotic disorder may gain entry to mental health services but they are often ill-equipped to help.

Negative attitudes towards people with personality disorder are common in mental health services (NIMHE, 2003). This may be related to the view that personality disorder is not a 'mental illness', and an assumption that people with personality disorder can control their behaviour. Motives such as faking illness or seeking attention may be attributed, therefore they may be blamed for their problems.

Behaviours like self-harm and suicidal behaviour create anxiety for carers. Professionals can feel hopeless about the possibility of improvement and believe they have little to offer this client group.

Seven Randomized Clinical Trials with BPD (see Lynch, Trost, Salsman, Linehan, 2007 and NICE Guidelines for BPD, 2009), showed DBT reducing suicide attempts and self-injury, medical risk, premature drop-out inpatient/ER admissions and days, drug abuse, depression, hopelessness, anger, and increasing global adjustment and social adjustment.

NICE Guidelines for the treatment of personality disorders include recommending Dialectical Behaviour Therapy for the treatment of Borderline Personality Disorder.

DBT has recently been conceptualized as a treatment with utility for intervening with
difficult-to-treat & multiply-disordered clients not just BPD (Linehan, Bohus, & Lynch, 2007; Lynch et al., 2006).

For **Eating Disorders**, Randomized Clinical Trials (Safer et al. 2001; Telch et al. 2001) found DBT superior to controls in terms of reducing binge and purge episodes/behaviours, weight concerns, shape concerns, eating concerns, urges to eat when angry and premature drop-out.

For **Treatment Resistant Depression** and Emotionally Constricted Personality Disorders, Randomized Clinical Trials (Lynch et al., 2003; 2006; Harley et al., 2008) found DBT Superior to Controls in reducing interpersonal sensitivity, interpersonal aggression, and depressive symptoms, and also producing quicker reductions in depression.

Because DBT consists essentially of a 'package' of several classic and innovative techniques ('strategies') each element can be learned and applied separately from the others and used in a wide variety of therapeutically challenging situations. For example, emotional self-regulation can be taught in group settings in many contexts where lack of emotional self-control is a concern; mindfulness techniques have a wide range of applications including in the treatment of anxiety and depression. Applied Behaviour Analysis approaches can be used to formulate and change challenging behaviour in forensic and learning disability settings as well as in adult mental health work.

Course Structure and Teaching Methods

The taught parts of the course delivered over two full-time weeks (80 hours).

The first week delivers the content below, using a variety of modalities including didactic teaching, demonstrations, role play, group and pair discussions, video and paper case studies, formulation of specific real therapeutic challenges, and DBT techniques such as contingency management, dialectical responses and mindfulness for both the course leaders and participants.

The second week embeds the learning through participant case presentations, role-plays, group discussions of the presentations, tests of participants' knowledge, assessments of participation, skills acquired and attitude to colleagues and clients. Participants are given individual feed back on each of these elements along with activities designed to remediate any deficits.

Sessions are also held on each team's progress on referral pathways, assessment practices and integration into existing service systems.

Refresher sessions on topics requested by participants are also held during the second week.

Between weeks one and two, a six month period of supervised clinical practice is used by participants to begin practicing DBT. Of necessity, service delivery models and issues also need addressing during this time. Course leaders are on hand to help advise on implementation.

Participants will be required to spend one day per week working in a DBT context (including supervision time) in the interval between weeks 1 and 2 (7 hours per day x 24 weeks = 168 hours), seeing individual patients, running DBT skills groups and attending consult (supervision) group.

In addition, participants will be required to read set texts, complete a DBT case study, familiarize themselves with assessments, referral pathways, recording forms, diaries, skills group materials, DSM-IV diagnoses and more (140 hours).

Participant time: 80 + 168 + 140 = 388 hours

Trainers will be required to present course content (35 hours per week) and meet for one hour each evening to review the day and plan detail for the next (4 hours). Trainer time is 39 hours per week x 2 weeks = 78 hours total teaching time. Preparation hours for teaching will be 10 hours. For two trainers this will be a total of 88 hours x 2 =176 trainer hours.

Trainers will offer one site visit per team per course, to take place in the period between weeks 1 and 2. This visit will be of 2 hours' duration and consist in supervision and consultancy. In addition, trainers will provide telephone consultancy and supervision to team leaders once per month. For a maximum of 5 teams this will mean 5 site visits of 2 hours =10 hours, and 5 x 6 one hour telephone consultations = 30 hours. This is a total of 40 trainer hours.

Trainers will also mark DBT case studies and complete assessment forms for participants, as well as check exam scores, time required is 20x2=40 trainer hours.

Total trainer time = 176 + 40 + 40 = 256 hours (128 hours per trainer).

Course content

The course uses the Kolb-Lewin model of adult learning to facilitate effective teaching

- The theoretical underpinnings of DBT
- The structure of DBT as a service delivery model
- The evidence base for effectiveness of DBT
- How to assess clients for DBT
- How to commit clients to DBT
- How to contract with clients
- Structuring the therapy: treatment goals and targets
- DBT techniques: Applied Behaviour Analysis; Acceptance Strategies; Dialectical Strategies;
- Systemic Considerations: Consultation to the Client/Environment; Telephone Interventions
- DBT Therapist Styles
- DBT Skills Groups: content
- DBT Skills Groups: how to conduct
- DBT Supervision: peer supervision; other supervision
- Recursive practice of DBT

The theoretical underpinnings of DBT

DBT is a collection of pre-existing psychological models and theories including behavioural analysis, acceptance, paradoxical and systemic approaches. These understandings were gathered together by Marsha Linehan during her work with people with Borderline Personality Disorder, packaged and tested and found to be effective.

Linehan has several theoretical perspectives on Borderline Personality Disorder and other theorists have extended these to other disorders

The structure of DBT as a service delivery model

DBT takes a systemic perspective on the well being of clients, and so considers the social and physical environment as part of formulation. The need to establish a DBT service within a given context, such as hospital, prison or substance misuse services is key to the success of the training.

For this reason a DBT team of practitioners is trained (minimum three) who can take the training back to their service provider and implement the therapy.

The DBT Consult Group (Linehan 1993) is the main supervision delivery channel by which therapists receive tutor and peer supervision, and which enables therapists to stay valuing of clients with severely challenging behaviour.

Referral pathways appropriate to client need must be developed during this time along with specific assessment and commitment practices.

The evidence base for effectiveness of DBT

This is reviewed for Borderline Personality Disorder (for which DBT was developed) and for other conditions such as treatment-resistant depression, eating disorders, offending behaviour, substance misuse and emotionally constricted personality disorders. Relevant adaptations for each disorder are reviewed.

The NICE guidelines for treatment of personality disorders are reviewed.

How to assess clients for DBT

Sample assessment materials are presented along with their statistical validity and reliability as well as clinical utility. Participants practice using these assessments in session and are encouraged to use them for their week two DBT case study.

Assessments of personality disorder for research and for clinical screening are included, along with general mental health assessments and disorder-specific assessments such as for eating disorders and substance abuse.

How to commit clients to DBT

DBT places great importance on the need to commit clients to therapy, in order to address the high drop out rates among treatment resistant groups and in order to establish a collaborative relationship between client and therapist. This pre-DBT phase can last many weeks and involves a specific collection of strategies, including considering pros and cons, 'devil's advocate', 'foot–in-the-door/door-in-the-face' and others.

The techniques are presented with the rationale behind them and participants practice using them in supervised role plays.

Participants are themselves exposed to these techniques in order to 'commit' them to the training course, i.e. establish the reasons for them participating and maximise their motivation.

Commitment techniques are used throughout therapy (and training) when motivational issues threaten to affect progress.

How to contract with clients

At the outset of DBT client and therapist sign a contract specifying details of treatment, commitment to attend groups, use phone coaching, abstinence from suicidal behaviour. How to facilitate this process is taught using demonstrations and sample contracts as

well as a checklist ‘are we ready to sign a contract?’. This contract is referred to throughout treatment.

Structuring the therapy: treatment goals and targets

DBT uses life goals or values to inform therapy, identifying a list of ‘target behaviours’ to decrease and ordering these in priority: life-threatening, therapy-interfering and quality of life-interfering behaviours

Participants learn how to work with clients to identify and label these behaviours and how to structure sessions around these targets.

DBT techniques: Applied Behaviour Analysis; Acceptance Strategies; Dialectical Strategies;

Applied Behaviour Analysis is the ‘behaviour’ part of DBT, and is used collaboratively with clients to identify repetitive patterns of target behaviours. Problem solving techniques are used to develop plans to use new more adaptive behaviours in the next similar crisis.

Acceptance strategies are designed to make the client feel heard (validated), to address hopelessness, promote attachment and develop tolerance of distress. Participants are encouraged to use the same strategies to enable themselves to learn new skills during the training.

Dialectical strategies such as the use of metaphor, dialectical thinking, entering the paradox, are used to help clients understand complex and hard to accept facts and help therapists get ‘unstuck’ in treatment-resistant presentations. Rehearsal and role play are the main ways these skills are taught.

Systemic Considerations: Consultation to the Client/Environment; Telephone Interventions

Participants are invited to consider the effects of the wider system upon the client’s behaviour. In general the therapist will prefer to ‘consult to the client’ i.e. coach the client to manage the people and help-giving systems around them, although should the client be unable to do so, the therapist will ‘consult to the environment’ on the client’s behalf.

Telephone consultation is offered to clients to provide coaching on reducing target behaviours at the point of crisis, and also to allow clients to repair relationships with therapists if necessary. The use of telephone consultation is often a source of anxiety to participants and discussion is held around when it is appropriate to offer such help and how to maintain good limits and therapist self-care.

DBT Therapist Styles

Therapists are supposed to have preferred natural styles of interacting with clients, some tending towards the warm/nurturing style, some more change-driven and demanding. Participants reflect on their own preferred styles and practice extending their repertoire to include the whole spectrum. Consideration is given to when different styles might be most helpful, and effects of switching styles in response to client positions.

Skills Groups: Content

DBT basic skills groups are delivered weekly in 'modules': mindfulness, interpersonal skills, emotion regulation and distress tolerance. This content is taught by pairs of DBT therapists to groups of up to eight clients. Familiarity with this content is important.

DBT Skills Groups: how to conduct

Demonstration and role play is used to model how to conduct a typical skills group, involving teaching the content whilst monitoring the reactions of clients on the group and using DBT techniques to problem solve and to motivate clients.

DBT Supervision: peer supervision; other supervision

Supervision for DBT practitioners is usually peer supervision in the form of the 'Consult Group'. This peer supervision group meets weekly and works within a DBT framework to validate therapists' reactions to clients, analyse and problem solve therapist behaviour, and provide insight into cases.

During the interval between week 1 and week 2 training, participants are expected to attend a consult group and use it to assure quality work is being carried out.

Trainers visit consult groups twice during the six months to provide external supervision, and also consult by telephone to the team leader of each group to provide guidance for the remainder of the time.

Recursive practice of DBT

Participants and trainers are expected to use DBT strategies to manage themselves during training, for example tolerating judgmental thoughts about the course or their own performance,
Tolerating sitting for long periods, deficits in the environment or equipment which might arise, doing difficult tasks, analysing their own behaviour, turning up on time, giving validating feed back.

This recursive practice is most useful in terms of producing an optimal learning environment and in generalising DBT skills to daily life.

Course Leaders

The course leader is Dr Fiona Kennedy

Dr Kennedy received an award from BUPA for clinical excellence and her DBT service received a recommendation as an example of good practice from the National Audit Office.

A BABCP Accredited Trainer, she has been providing training since 1985 and since leaving a NHS Head of Psychology post in 2006 has specialised in training, supervision and management consultancy.

She edited a book on CBT approaches to dissociation, published by Routledge, 2013.

Dr Kennedy works pro bono in India where she trains Indian volunteers in the basics of DBT so that they can mentor rescued street children. She has a first hand understanding of cultural, equality and diversity issues.

Supervision

Supervision is provided along the lines described above, through site visits and telephone consultation, each team receiving two visits and six one hour telephone consultations.

Supervision for the trainers is provided through the Oxford Cognitive Therapy Centre.

Assessment of Competence

Participant competence to adequately deliver DBT is assessed in the following ways:

- Trainer ratings of understanding, participation and skills
- A DBT exam
- Before and after questionnaire measuring attitude, confidence and knowledge
- A marked DBT case study (average 25 pages)

Feed back is given individually to each participant at the end of week 2.

If the candidate has satisfactorily completed all assessments s/he will be given a certificate of competence. If not, s/he will be offered advice and if necessary assistance to complete further work to establish competence in the identified areas, with a time limit for completion.