Slide 1

3 Types of Patient, Therapy Interfering Behavior.

Slide 2

According to the hierarchy of treatment targets, the second most important thing to address after life-threatening behaviors is what is referred to as therapy-interfering behavior. This is just what it sounds like, any behavior that gets in the way of therapy. Remember we treat life-threatening behavior first because as Linehan says, treatment can't work if the patient is dead. In the same way, we address therapy-interfering behavior because the patient can't receive treatment if they aren't there physically or psychologically or if they quit or if the therapist terminates treatment prematurely.

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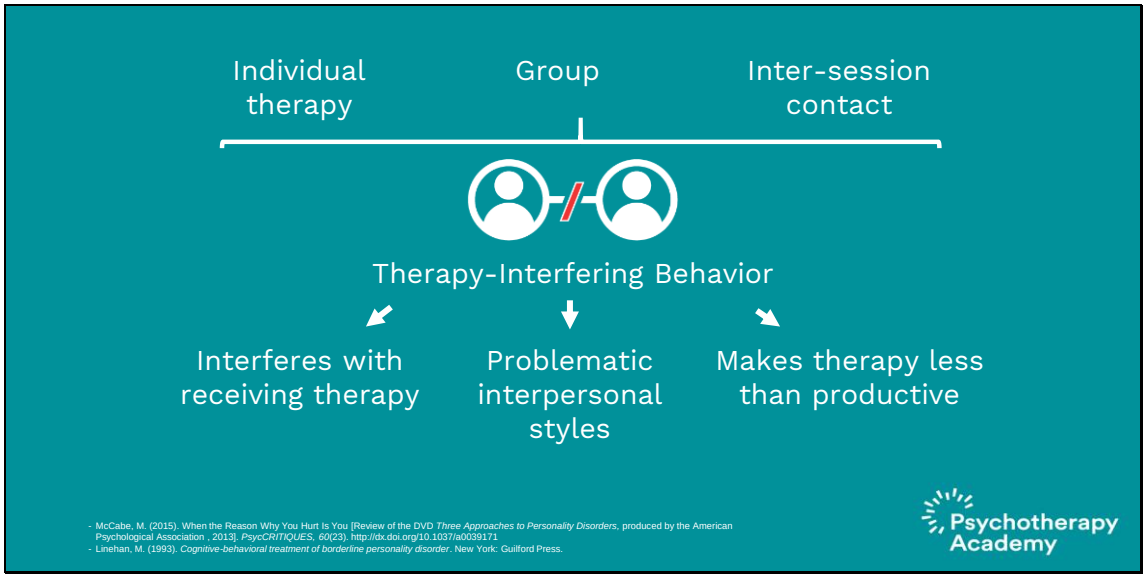

Therapy-interfering behavior can occur in individual therapy, in group or during intersession contact. Though we will primarily focus on how to address therapy-interfering behaviors of the patient, be sure to listen to the later discussion on those of the therapist. Therapy-interfering behavior may be behavior that literally interferes with receiving therapy such as missing sessions, problematic interpersonal styles such as blaming or other issues that make therapy less than productive such as not doing homework.

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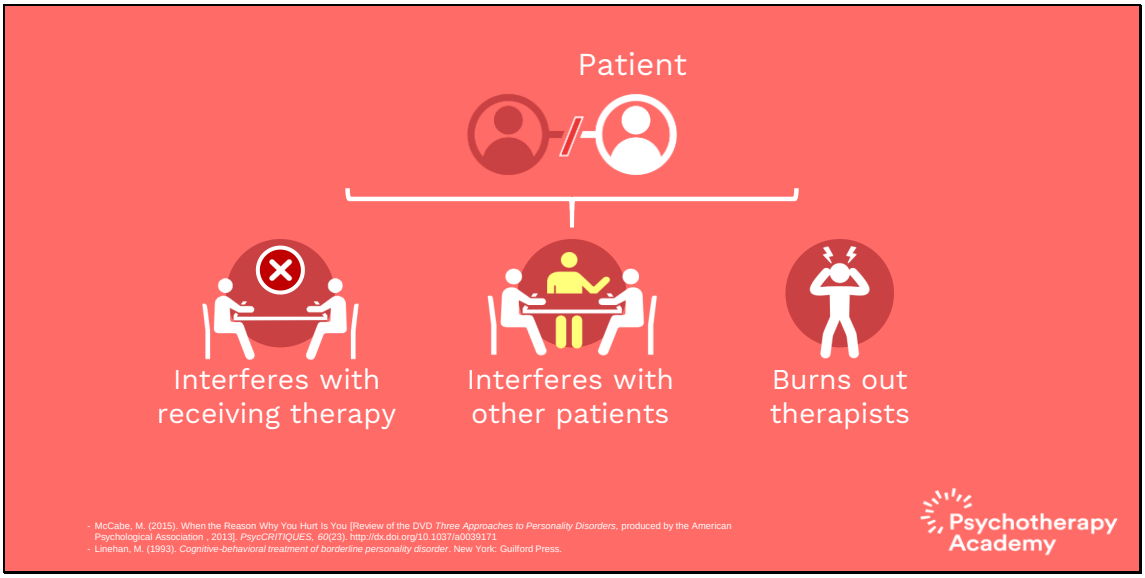

There are three categories of therapy-interfering behaviors of the patient. The first is behavior that interferes with receiving therapy and the next is behaviors that interfere with other patients and finally behaviors that burn out therapists.

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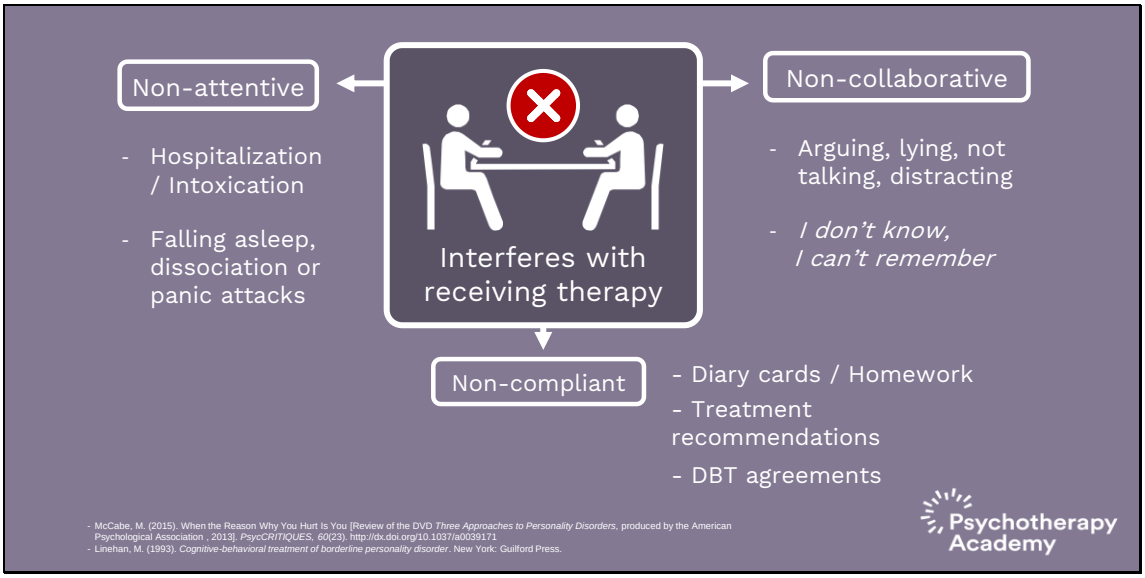

So when we're talking about those behaviors which interfere with receiving therapy, that would be things like not attending or not being psychologically present for a variety of reasons. That could be hospitalization, for example. That would be perhaps beyond a patient's control yet still they are not attending therapy. So keep in mind that this is not blaming the patient necessarily. This is just the facts of the matter. Another example would be intoxication. That would be a way that a patient would not be present in session fully. Falling asleep, dissociation or panic attacks, these are some examples. Other examples that would interfere with receiving therapy would be not working collaboratively, not working together as a team with the therapist, so things such as arguing, lying, not talking, distracting, answering I don't know or I can't remember to most questions. Other ways that the therapy might be interfered with would be not complying with the plan. So if there's a treatment plan in place and there's an agreement which there is in DBT, we've got those DBT agreements in the beginning but we have an agreement to bring a diary card, for example, so it would be not complying with the plan to bring a diary card or not doing homework, refusing to comply with recommendations or even with the initial DBT agreements. So those are all behaviors that interfere with receiving therapy.

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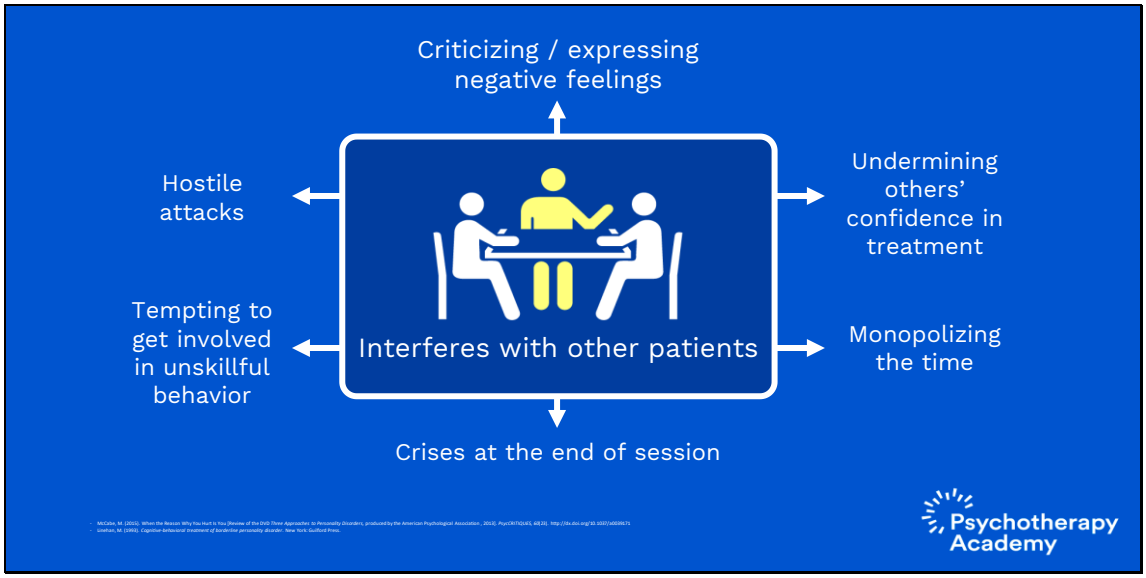

We've also got therapy-interfering behaviors that interfere with other patients and this could be things like criticizing or expressing negative feelings toward another patient, hostile attacks, starting rumors or conflicts which undermine other patient's confidence in treatment, tempting other patients or group members to get involved in unskillful behavior, monopolizing the time in group, having crises at the end of session which ends up taking the time of the next patient.

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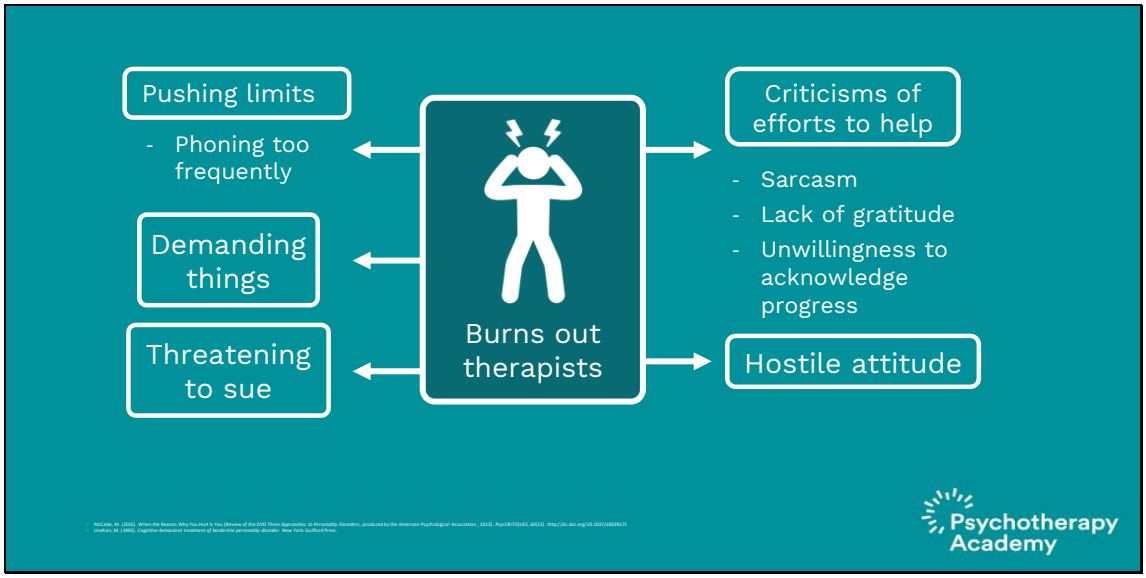

Finally, we have behaviors that burn out therapists. So traditionally, therapists sort of have this idea that people with borderline personality disorder burn out therapists. So this can be a major barrier to treatment. Some of the things that burn therapists out include things like pushing their personal limits or organizational limits and those that decrease their overall motivation for treating patients and doing a good job, things like phoning the therapist too frequently. We provide intersession contact but once that threshold has been crossed where the therapist feels that their limit has been crossed, then that is obviously a problem. Demanding things like extra session time or a solution to their problems. A recent example that I can give is a therapist who was on maternity leave and had discussed this with patients prior to going on maternity leave and one of these patients attempted to contact her regardless in spite of the fact that she was on maternity leave and this patient had been given alternate therapists to contact but chose to violate the agreement. So that would be a behavior that would burn out a therapist. Criticisms of efforts to help. So a therapist may be trying to help and they get a response of criticism or sarcasm, general lack of gratitude, unwillingness to acknowledge progress, so always being or very frequently being overly negative and denying when progress is met, threatening to sue a therapist, having a generally hostile attitude.

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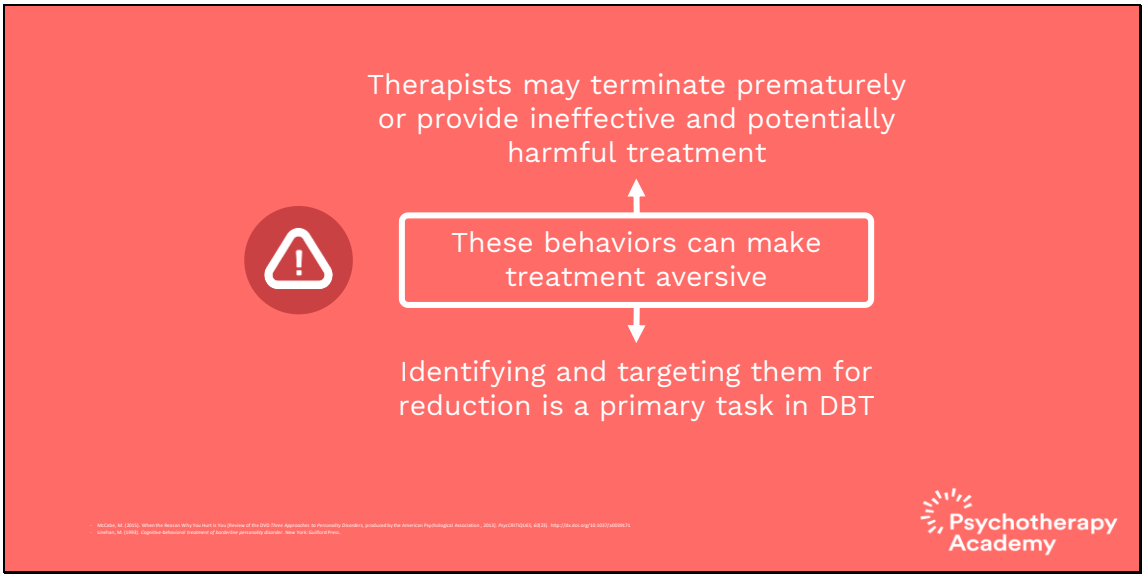

So the presence of these behaviors can really make treatment of the patient so aversive that therapist may terminate prematurely or end up providing treatment or responding in a way that is really ineffective and potentially even harmful to the patient. So the identification and targeting of these for reduction is a primary task in DBT.

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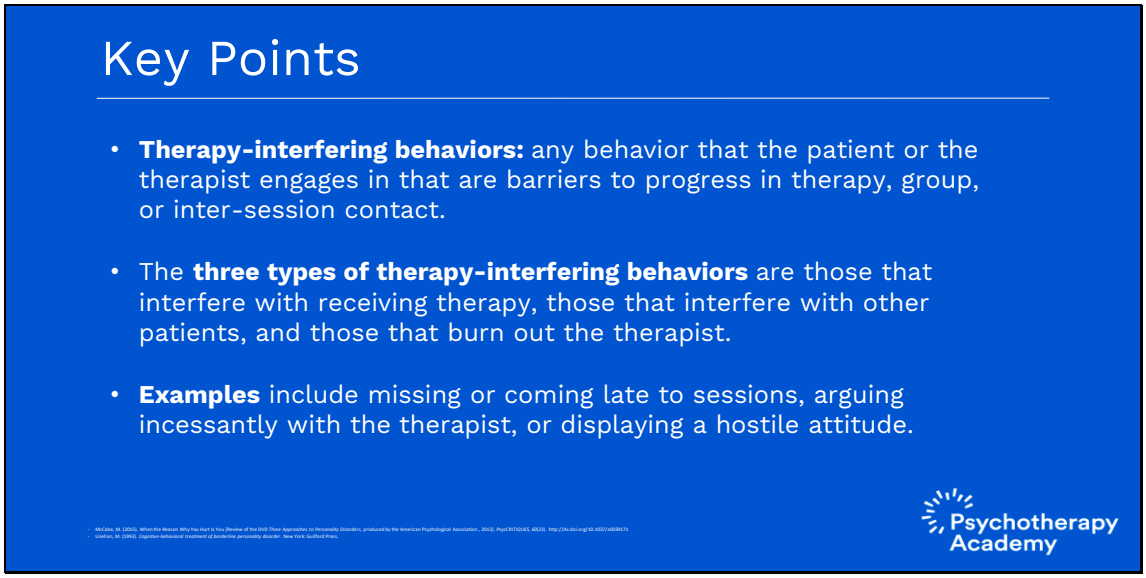
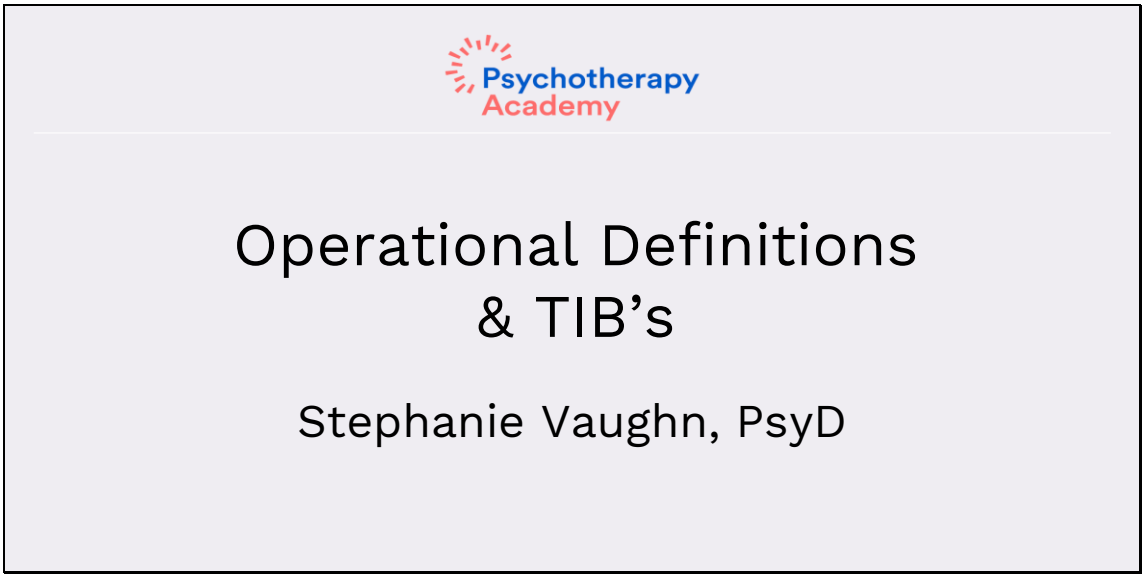


Key Points
Therapy-interfering behaviors refer to any behavior that the patient or the therapist engages in which are barriers to progress in therapy, group or intersession contact.
The three types of therapy-interfering behaviors are those that interfere with receiving therapy, those that interfere with other patients and those that burn out the therapist.
Examples of therapy-interfering behaviors include missing or coming late to sessions, arguing incessantly with the therapist or displaying a hostile attitude.

Slide 10

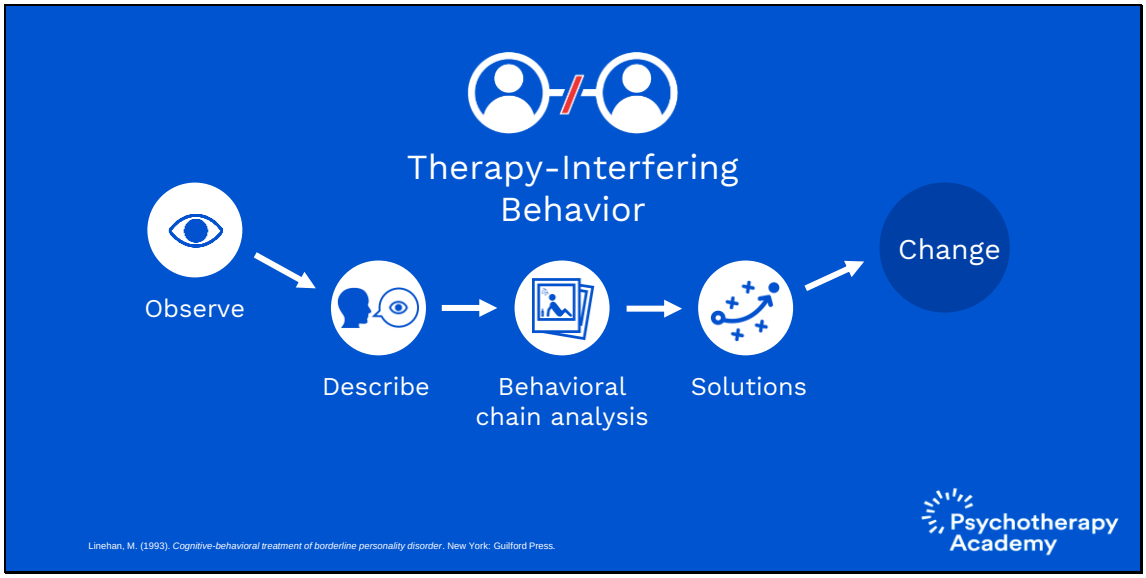

Next Presentation:
Operational Definitions
& TIB's
Psychotherapy
Academy

Slide 1



Operational Definitions & Therapy Interfering Behaviors

Slide 2



DBT clinicians work with therapy-interfering behaviors in the same way they do any other behavior, by observing it, describing it and then using what is discovered from conducting chain analyses to create solutions that will hopefully lead to change.

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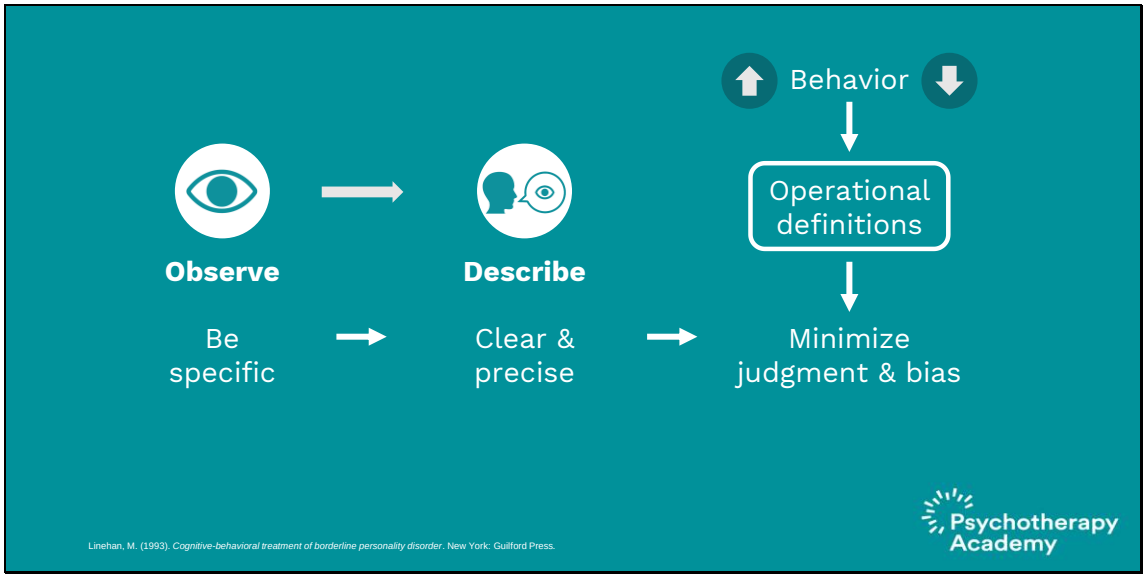

Creating operational definitions or workable descriptions of behavior is not possible without first observing. The clinician must be clear on what is actually occurring or not occurring rather than some theory about why things are the way they are. As Linehan notes, you cannot describe anything until you first observe it. So the first step is to use those observe skills. Now, when observing what's happening, let's say we're observing a behavior in therapy that's interfering, it's important to be specific. Because operational definitions help in the process of determining whether a behavior is increasing or decreasing, in order for them to be truly useful, they should be as clear and precise as possible. For example, rather than describing someone as not participating in therapy, the therapist might describe how the patient has not turned in a diary card for the past three sessions. This is a behavior anyone could observe and measure. Sometimes, we use catchphrases like not trying or not participating in therapy or not invested as a shorthand and this can be a real barrier when it comes to changing behavior.
So we start with observing a behavior then we move to describing it using operational definitions to minimize judgment and bias as much as possible.

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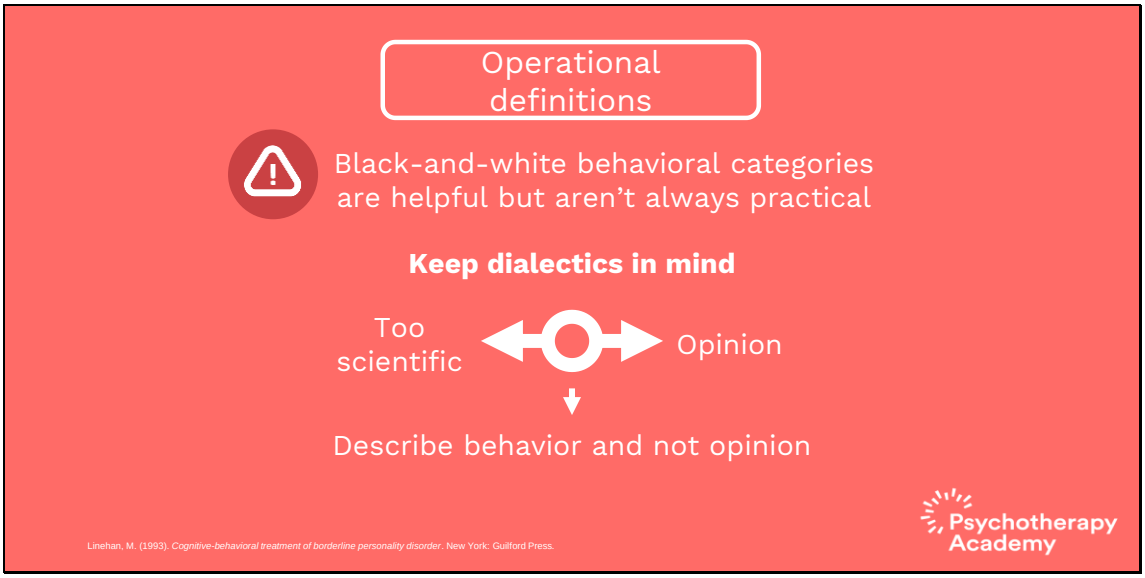

But of course, we don't want to go too far. Keep in mind that absolute, black and white behavioral categories are helpful but aren't always practical when defining some therapy-interfering behaviors. We want to keep dialectics in mind and we don't want to get so caught up in defining the behavior and being precise that we miss the forest for the trees. It's important to recognize that there is a balance, a dialectical balance between being ridiculously scientific in labeling behaviors on the one hand, for example, his voice began at a 60-decibel range and increased 10 to 20 decibels during a 12-second interval, that would be not a good example of setting a therapy-interfering behavior target, versus using some loosey-goosey therapist conjecture on the other. So an example of that might be oh, the problem is he's too defensive. We're typically more apt to use that sort of example. The problem is he's just too defensive. It's a quick shorthand way and we nod and smile at one another as therapists and think that we understand but the truth is we don't really understand why one therapist may have a problem with the patient and another one does not. Part of that is because each therapist has different limits. For example, one limit might be cussing. One therapist may not like cussing at all. It may seem very offensive to them. And another one doesn't mind it. And so that first therapist may interpret the language as being defensive or aggressive and the second therapist thinks that it's nothing, it's just fine. And so we need to be careful to make sure that we're actually describing behavior and not our opinion of the behavior.

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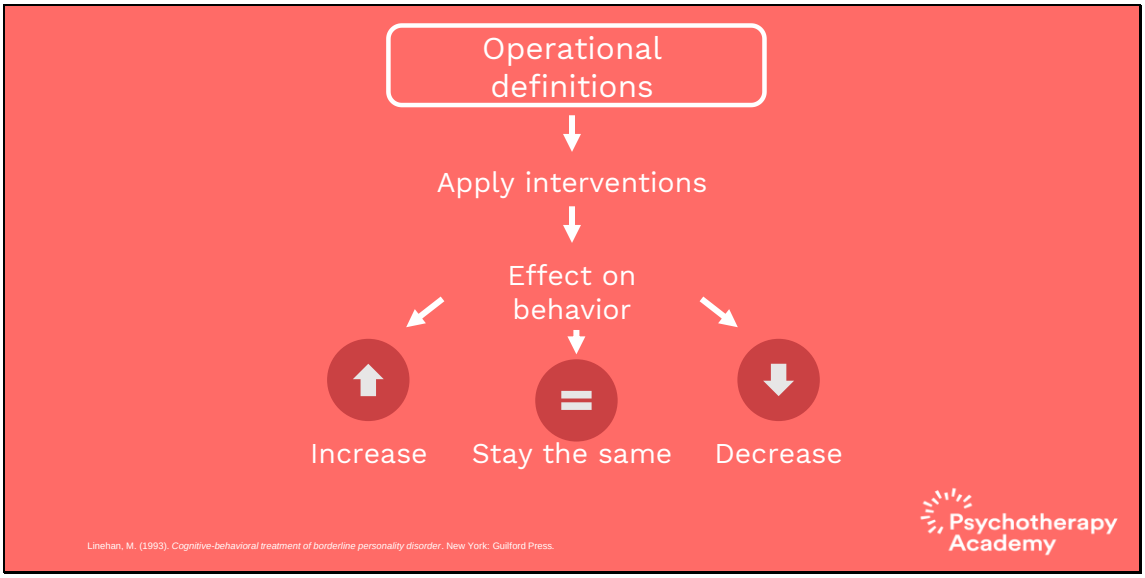

So the point of defining a behavior is not to be ridiculously scientific. The point is so that when we apply interventions, and that's what we do, we apply interventions, when we apply those interventions, we have some idea about what effect, if any, our interventions have. In other words, does the behavior increase, decrease or stay the same?

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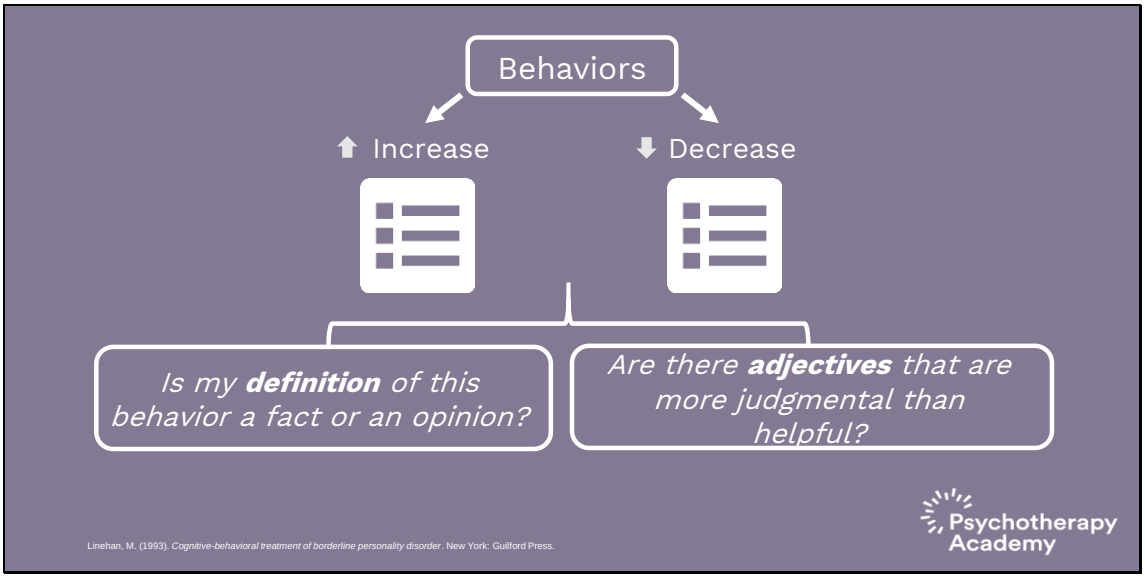

Sometimes, I will draw an arrow pointing up and another arrow pointing down when I'm training therapists to learn how to do this. And I will say, what behaviors are we trying to increase and what behaviors are we trying to decrease? And we have to get specific when we write down these behaviors next to the arrows. And we've got to keep that in mind. You may want to ask yourself a few questions. Look at the definition. When you're writing these down or when you're trying to come up with a target, when you're conceptualizing this therapy-interfering behavior, you want to look at the definition you've created and ask, is my definition of this behavior a fact or an opinion? When we were in elementary school, we used to have the fact or opinion test. You would see a list of phrases and then the teacher would want you to say whether it was fact or opinion. So we want to try to be as factual as possible. One way of doing that is to ask if it's fact or opinion. Another way is to look and to see are there any adjectives. And the more adjectives there are, the more likely it is that we're going to be judgmental. So are there adjectives that are more judgmental than helpful?

Slide 7

Another question is: Could I easily train someone to sit with a notebook and mark when or how long this particular behavior is occurring and the person could produce results with fairly decent accuracy? So could you train a student to sit down and if your description of the therapy-interfering behavior is clear enough, could they sit down and mark the frequency or the duration? Would they know when it was occurring? Or is this so broad that they're unsure?

Slide 8

Another question, is it possible that another therapist would disagree with my definition? Would they disagree with what I'm concluding? If you take the example of the client is too defensive and we try to write that down, we're trying to decrease defensiveness. Well, there's a problem because some therapists are going to define behavior as defensive and others are not. So we've got to make sure that we're very clear. Are we all able to look at this behavior or listen to this behavior, experience it in some way and regardless of our theoretical model that we're able to come to an agreement that this is what's occurring?

Slide 9

Another question, what would the devil’s advocate in your life say? We all have some devil’s advocate in our lives. They’re friends or family or employers or whomever. And what would the devil’s advocate in your life say about this definition that you’ve created? In DBT, we will ask team members when we’re in consult group, when we’re doing our peer consult group. We’ll ask team members to what we call bring up the other side. So when we’re all in agreement in team that a behavior is defensive, for example, then hopefully we are dialectic enough to be able to, somebody pipes up and says, can anybody please bring up the other side? And in that way, that can help with identifying what we might be missing.

Slide 10

Finally, another way of helping to clarify your definition or operationalize your definition of therapy-interfering behavior would be to ask yourself, if I were to role play this patient or be the director of a theater production, what behaviors would I have the patient's character perform? In other words, how would I write those into the blocking for a script? And that's going to help us to get really crystal clear about what's occurring. We can't just come up with a shorthand summation. We have to actually execute something.

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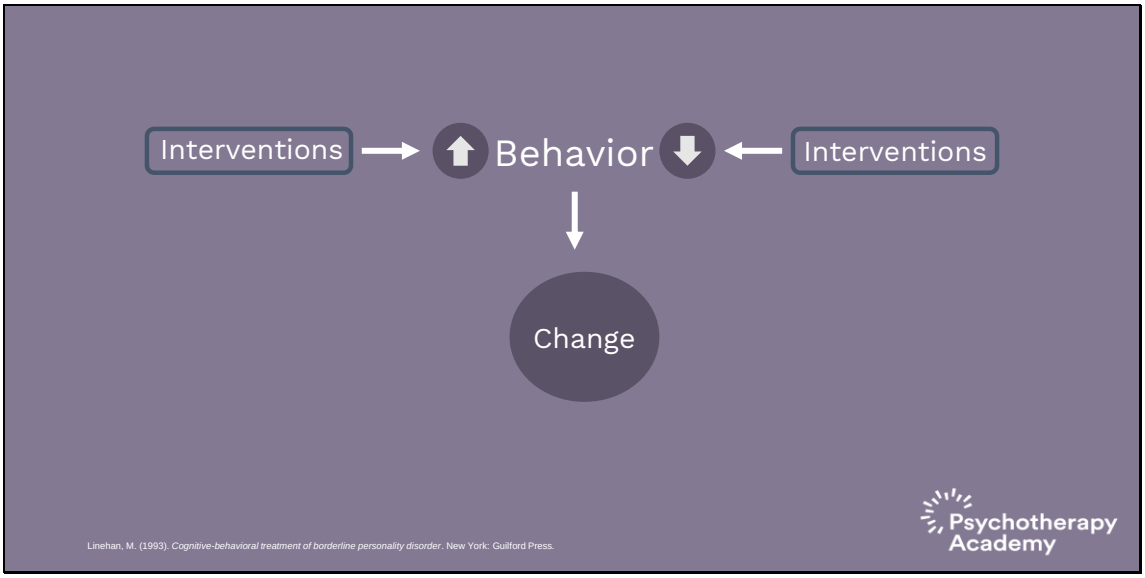

And so that's going to help to figure out what behaviors am I looking to decrease and what behaviors am I trying to increase. And all of this is done in order to bring about change and so we can discover whether our interventions actually have any effect.

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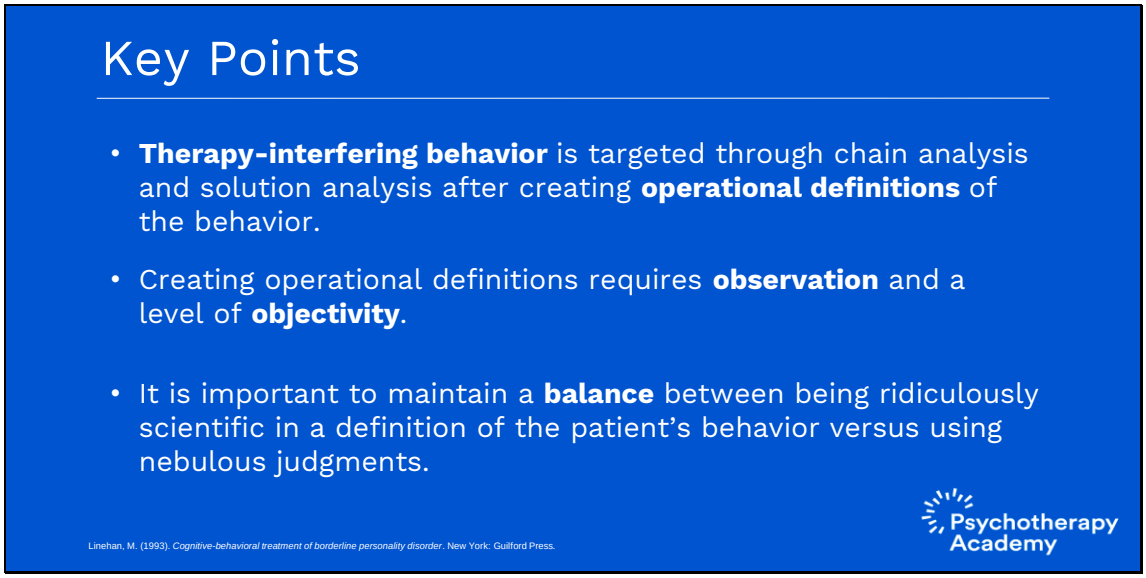

Key Points
Therapy-interfering behavior is targeted through chain analysis and solution analysis after creating operational definitions of the behavior.
Creating operational definitions requires observation and a level of objectivity.
It is important to maintain a balance between being ridiculously scientific in a definition of the patient's behavior versus using nebulous judgments.

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Next Presentation:
A Dialectical Stance in Defining
What is Therapy-Interfering
Psychotherapy
Academy

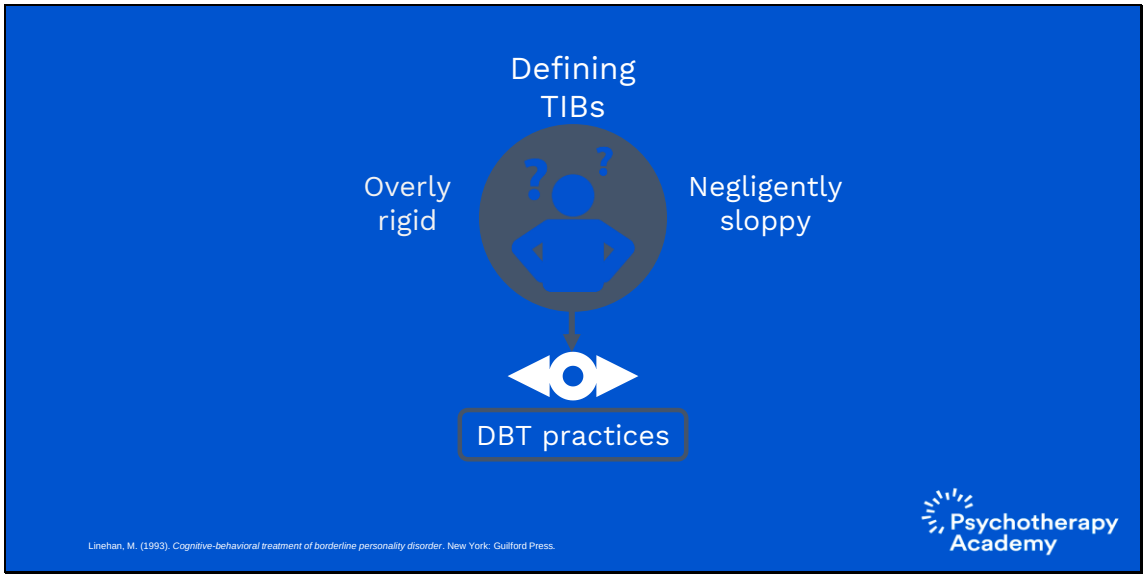
Slide 1

Psychotherapy Academy

A Dialectical Stance in Defining What is Therapy-Interfering

Stephanie Vaughn, PsyD

Slide 2



So how do you know whether you're being overly rigid versus being negligently sloppy when defining therapy-interfering behaviors? I find that a few DBT practices actually assist me in preventing myself from going too far in either direction.

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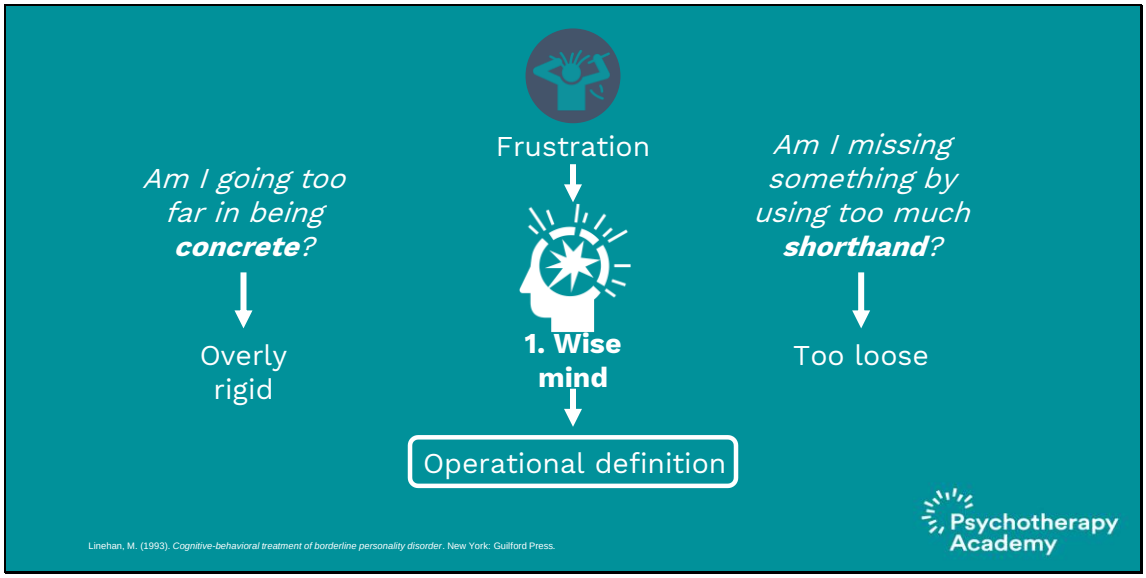

First, as with all DBT practices, wise mind is a great go-to skill. When you find yourself frustrated with a patient due to therapy-interfering behavior and you have come up with your operational definition, you will want to take a moment, step back and consult wise mind.
Inquire within yourself whether you're going too far in being concrete or whether you're missing something by using too much shorthand.
So when you use wise mind, you want to really inquire deeply as we say and be ready to hear the answer. I find that therapists tend to be overly scientific when they're attempting to explain a behavior to another DBT colleague. In my opinion, we need to have some shorthand and we also need to be as scientific as possible. So that's where wise mind comes in. And you ask yourself, am I being overly rigid or too loose with my definition?

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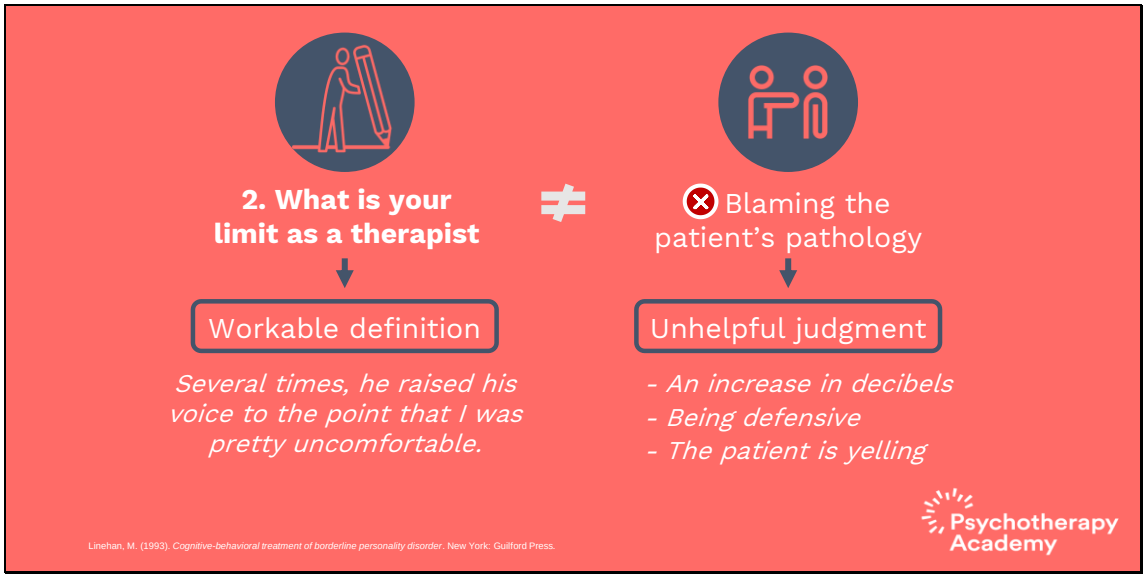

Next, defining behavior in terms of what is your limit as a therapist rather than blaming the patient's pathology can be the difference between an unhelpful judgment and a workable definition of behavior. So instead of being too rigid and attempting to define the behavior as an increase in decibels, for example, that I mentioned in a previous talk, being too broad and label the behavior as being defensive or just being judgmental and saying the patient is yelling, the therapist might define the behavior instead in this way. Several times, he raised his voice to the point that I was pretty uncomfortable. So as you could see, the several times, I mean, we're not saying the exact number of times. We have a descriptor here that's broader than a specific number yet at the same time, we get the gist of it. This also accounts for the voice level. He raised his voice to the point that I was pretty uncomfortable. So it ties it directly into a breach of the therapist's limits. So this allows for the possibility that the therapist could just be overly sensitive and acknowledges that if the patient wants the therapist to feel comfortable and therefore preserve the relationship which we would imagine that the patient would, the patient would need to adjust the volume to account for the therapist's limits.

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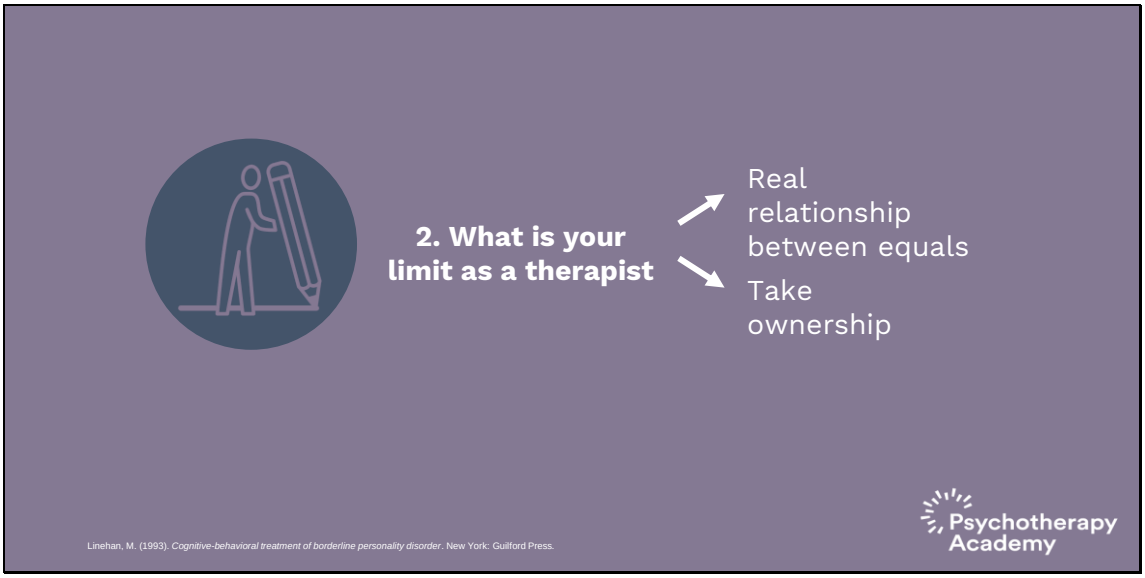

So the therapists take this upon themselves. And the more that we can own our limits as our limits and not for the patient's good which is a way of kind of copping out of what is really our limit, if we can define it in terms of what our preferences are and we don't have to be defensive about that, after all, this is relationship and you may recall in previous discussions that this is in DBT considered a real relationship between equals, between equals, so if we are in a real relationship between equals, then we're going to both be cognizant of how we impact the other. And really, the positive outcome of DBT in the relationship is because we're having open conversations about this and the therapist is taking their part. We're having some degree of disagreement here and we're not as a therapist trying to put it all on the patient as being their fault. We have to be able to take ownership of ours. So anytime that a therapy-interfering behavior can go back to what your limit is as a therapist, the better.

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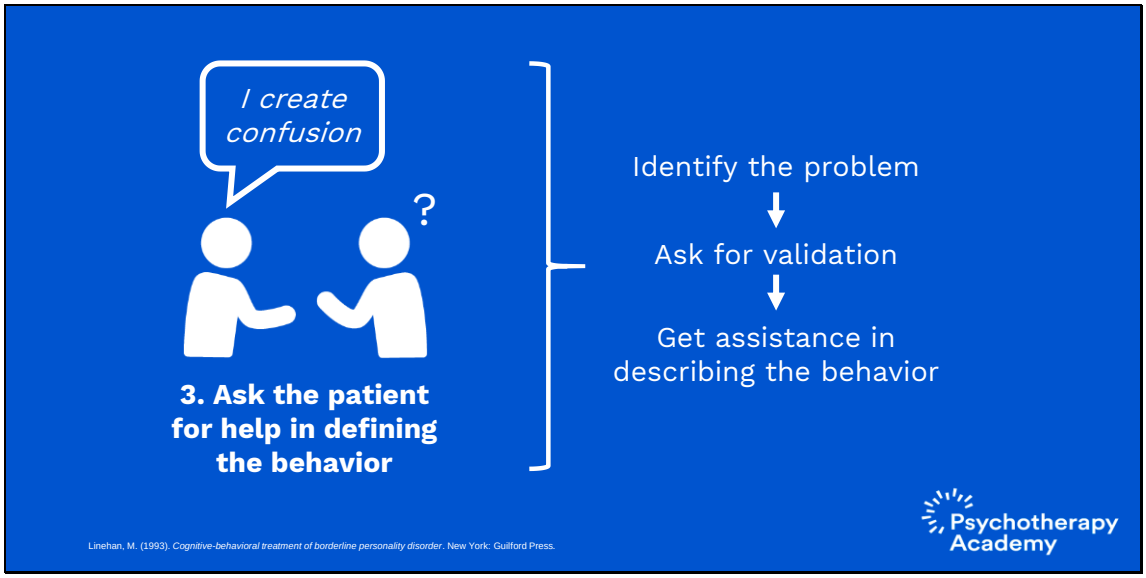

The third and one of my favorites is to actually ask the patient for help in defining the behavior. So sometimes, I found that I have difficulty really wrapping my head around what exactly the thing is that is rubbing me the wrong way or that seems to be a barrier. And so I'll ask the patient for help. I found that on a number of occasions when I approach the discussion of these therapy-interfering behaviors with the patient, and I don't actually use that phrase but then we can work together. I can help identify the problem as largely the results of my limits, not their deficiencies.
I can ask them for validation about what's bothering me and ask their assistance in helping to form a good description of what the behavior is. And what's interesting is I 99 out of 100 times have seen that they are more than happy to oblige and come up with far more creative terminology than I ever could on my own. So I've had clients label their behaviors. They take ownership for their part using phrases like oh yeah, I know exactly what you're talking about. I do this thing where I'll create confusion. So creating confusion becomes a way that we can, both the patient and I can recognize when a particular problem is occurring.

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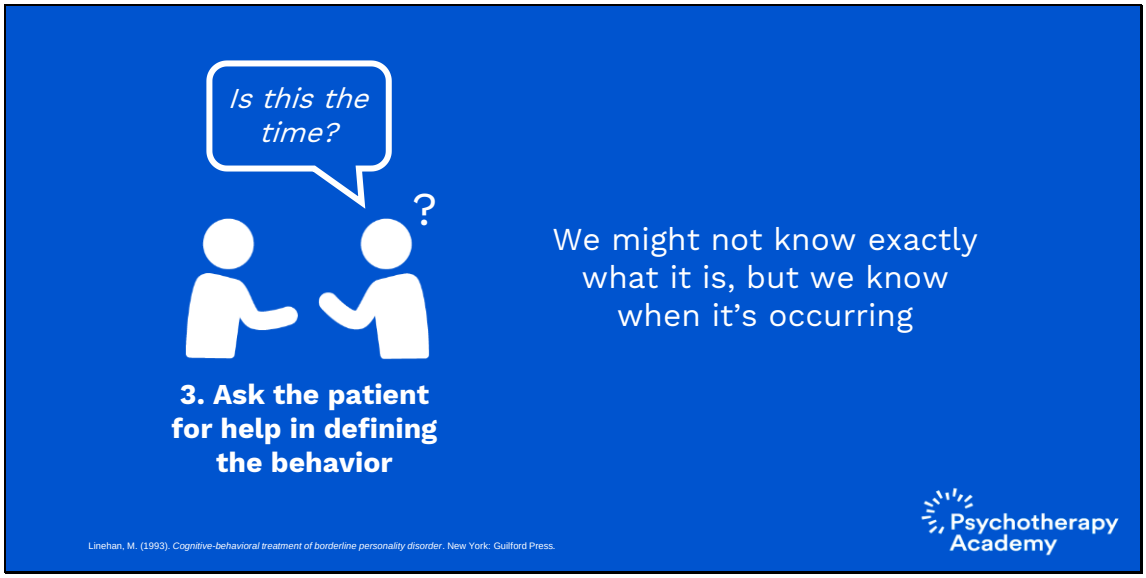

We might not know exactly what it is, we don't know how to define it exactly but we know when it's occurring. Other examples would be that I've had patients say things like oh yeah, when I'm getting pissy or I'm kidding myself. So then I can ask, hey, is this the time? I'm feeling like this might be a time where there's the creating confusion thing. Is it just me or is there maybe some of that creating confusion thing that you do? It's a really collaborative approach and can be super beneficial when you've got the patient working with you to help target that.

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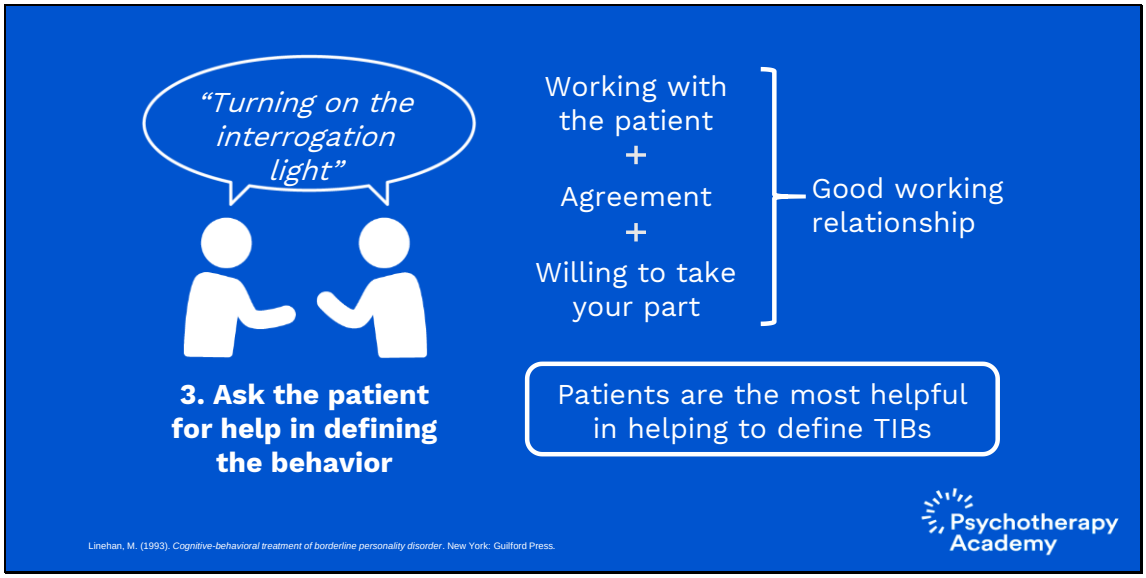

Another example is I have a patient who would call it turning on the interrogation light. So whenever we would be having a discussion and maybe I would ask a question and then she would respond in a way that I felt like I had had an interrogation light turned around on me. I couldn't quite really objectively define it as much but as soon as I point it out, my experience, she was very quickly able to own her part of the experience. And from that point on, we were consistently in agreement of when that happened even though we couldn't exactly quantify or qualify an eyebrow raised or a tone of voice or any other type of body movement or phrases. We both were consistently in agreement of when that happened. And so then she started to notice precursors to that behavior within herself that I couldn't see. So if you're able to get the patient on board with helping to define the behavior, you are 10 steps ahead in being able to target it.
So I mean, even if you have to come up with something as seemingly vague as: Are we doing that thing? Am I doing that thing? Are you doing that thing? Doing that thing is something that could seem if you're just looking at it from the outside far too broad. But as long as you're working with the patient on it and you're both in agreement and you as the therapist are willing to take your part and willing to be wrong and willing to take their word for it, if they say no, no, that's not, I'm not doing that thing, then we can take a step back and try to further clarify or objectively define what it is if it's not that. Then we've really got a good working relationship going on and the patient and the therapist can be clearer on what's happening because we've discussed it at length. So the patients themselves are actually the most helpful in helping to define this, giving an operational definition of behavior when it comes to therapy-interfering behaviors.

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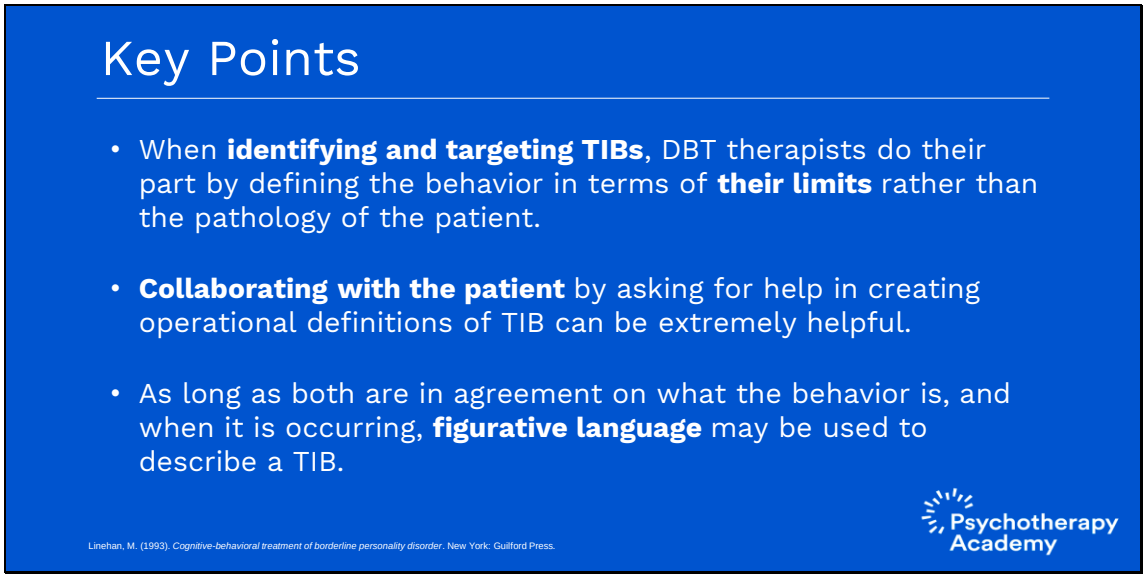

Key Points
When identifying and targeting therapy-interfering behaviors, DBT therapists take their part and define the behavior in terms of their limits rather than the pathology of the patient whenever possible.
Collaborating with the patient by asking for help in creating operational definitions of therapy-interfering behavior can be extremely helpful.
As long as you and the patient are both in agreement on what the behavior is, when it is occurring and so on, figurative language such as getting pissy may be used to describe a therapy-interfering behavior.

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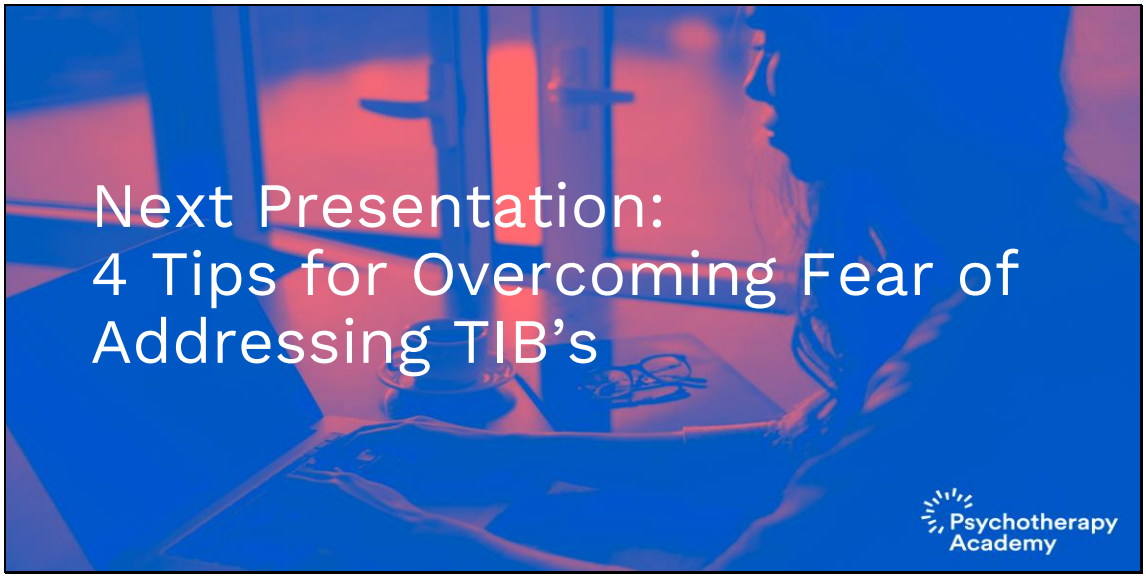
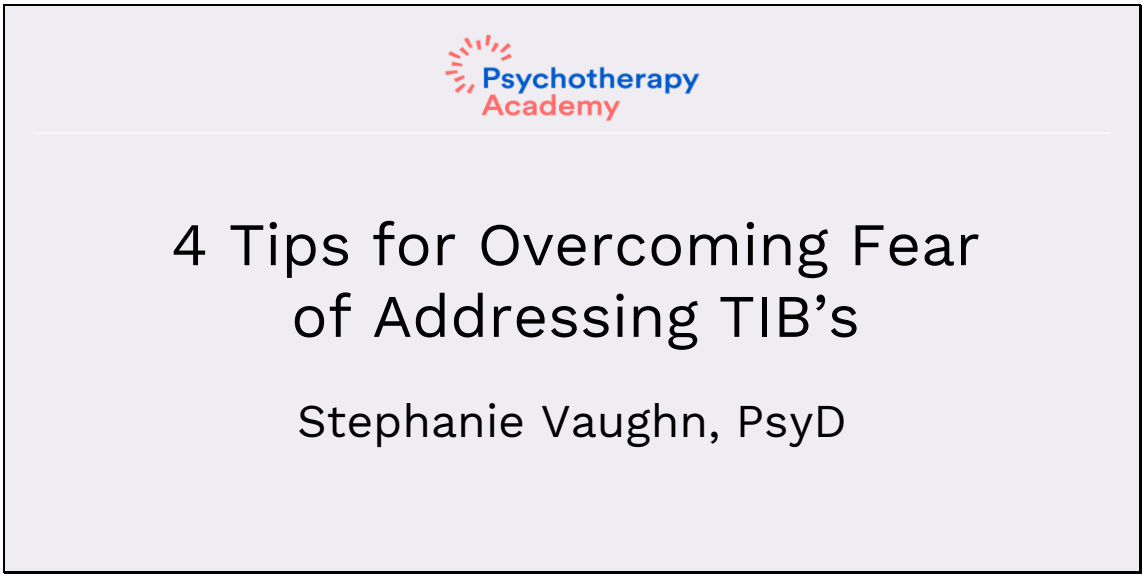

Next Presentation:
4 Tips for Overcoming Fear of Addressing TIB's
Psychotherapy Academy

Slide 1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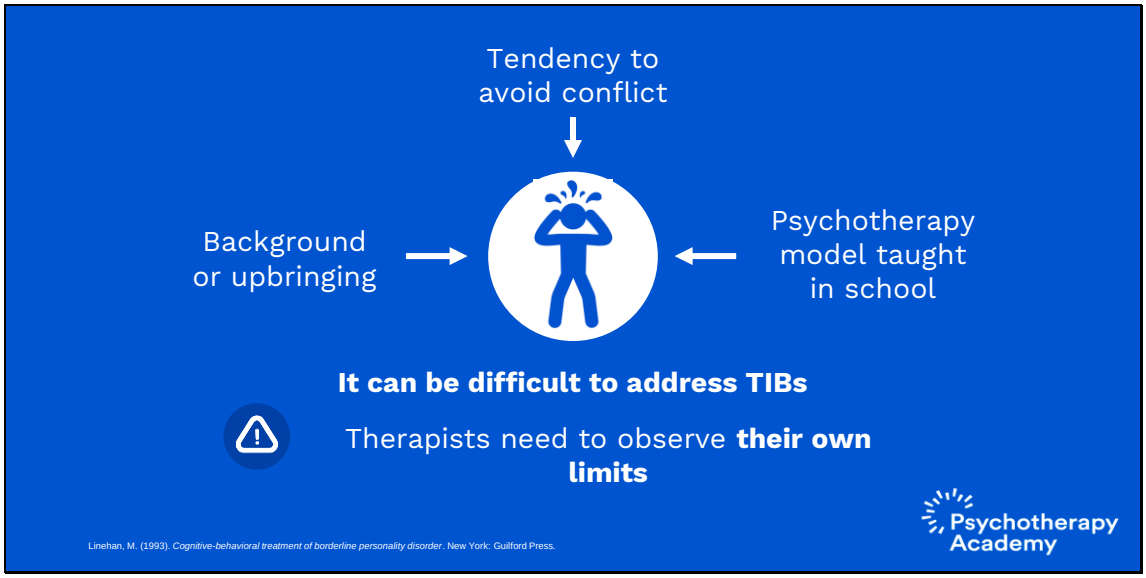
4 Tips for Overcoming Fear of Addressing TIB's
Stephanie Vaughn, PsyD

Slide 2



Even when a therapist is able to accurately identify therapy-interfering behaviors, it can be extremely difficult to actually address them. There are several reasons for this.
Some of those as therapists we can easily identify such as our background or upbringing, general tendency to avoid conflict but there are others such as our psychotherapy model that we have been taught in school. We may have been taught in school or during training that addressing things directly is wrong somehow or is not going to be beneficial or that it's selfish in some way or based on what the therapist wants and the therapy is supposed to be all about what the patient wants. So within DBT, it's very important for the therapist to actually observe their own limits because no one else is going to necessarily. And for us to expect that someone else particularly someone that we're treating is going to observe our limits is expecting too much of anyone. And so we're also trying to model communication, effective communication. We're trying to model self-care. We're trying to not pretend like we're someone that we're not also. We're not made of steel and we're not from some other planet. We have thoughts and feelings.

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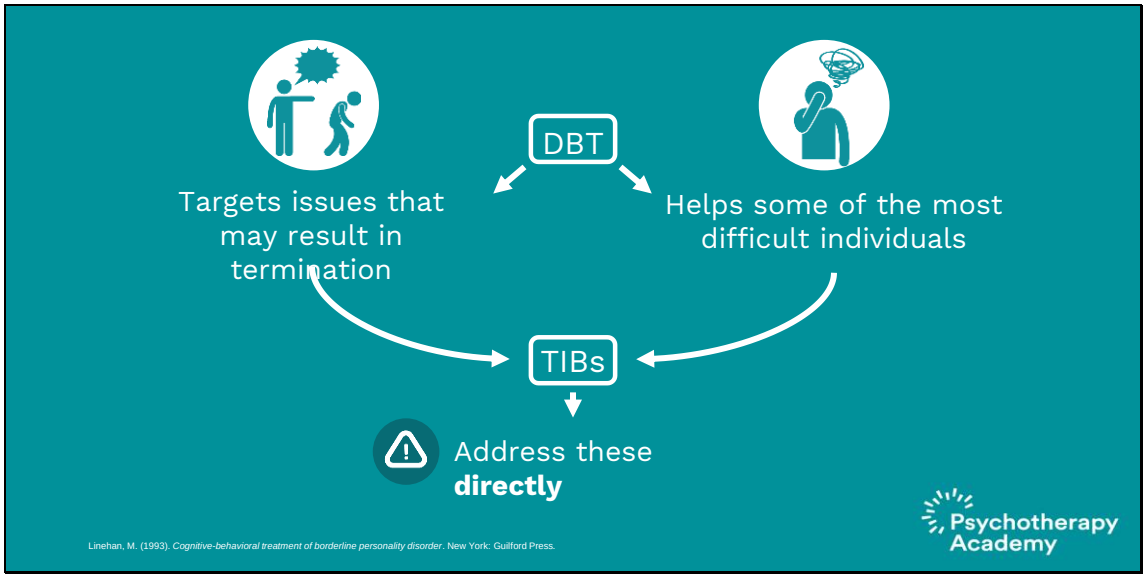

And so DBT is different in that we're directly targeting these issues that may end up in termination if we don't reduce them. So DBT was created as a therapy that was helping some of the most difficult individuals to get better. And these individuals often went from therapist to therapist and burned out one therapist after another and sometimes were not allowed back into a hospital or not allowed to come back and see a therapist that they had seen for a long time because of the therapy-interfering behaviors that were happening. And so it's so important to address these directly because what will end up happening is the therapy wouldn't work, the patient will drop out or you will terminate the patient for these behaviors. So DBT is a different therapy. And the other therapy models that we were taught in school may not be effective when it comes to doing therapy with the patient who has a lot of these behaviors.

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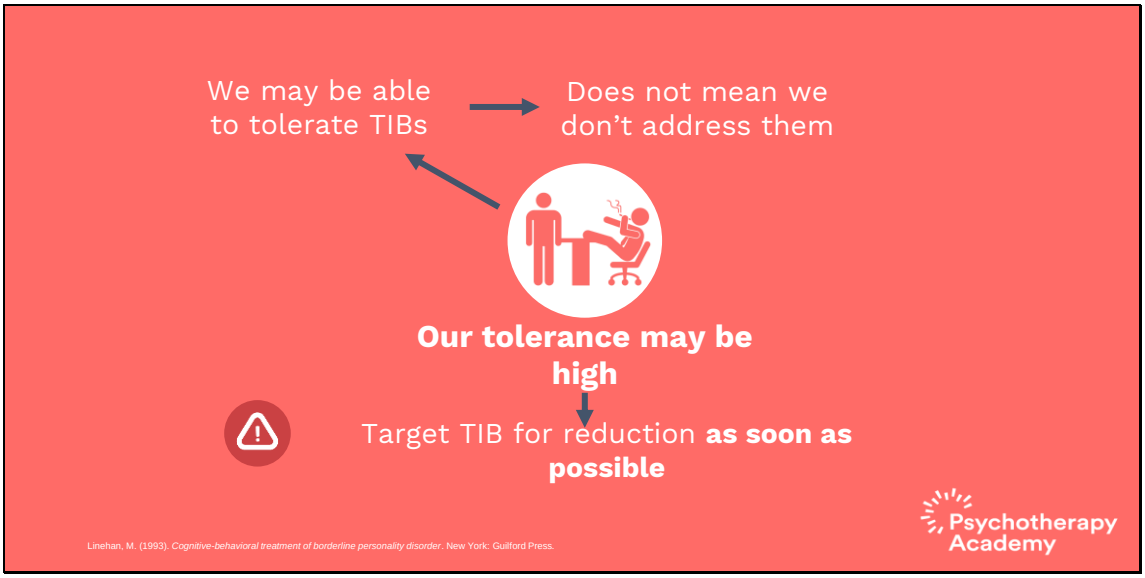

Another reason we might be hesitant to address these is because our tolerance may be high. So we may be able to tolerate yelling. We may be able to be okay with a person being late or not completing homework or being critical, calling too frequently or any number of these what we might consider therapy-interfering behaviors. And just because we can tolerate them doesn't mean that we don't address them. So one of the keys is to bring therapy-interfering behavior to light, target it for reduction as soon as possible. The longer it's allowed to build up, the more problematic it can be.

Slide 5

Another reason that dovetails with high tolerance is sometimes we will ignore how we feel. We will challenge ourselves to stretch farther and we will tell ourselves that if we're a really good therapist or we're really okay with ourselves then we would put our needs aside, we wouldn't feel the way that we feel, we wouldn't be frustrated or irritated. And that's really ridiculous because we're human beings just like every other human being, nothing particularly special about us to the point that we should be able to tolerate so much more. And really from a DBT perspective, we're not doing the patient any favors by pretending that we don't feel the way that we feel. We're trying to encourage them to articulate emotions and thoughts and do it in a skillful way. And so we can't really expect that from a patient if we're not willing to do that ourselves. And I think it really has to be disturbing to a patient to see someone act as though something doesn't bother them that any other human being on earth who is not a therapist would respond in a negative way. And so just because we tolerate something doesn't mean the outside world is going to tolerate it. And so we're not doing them any favors by pretending that the outside world is going to respond in the way that we are if we're letting things go too far.

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Finally, as therapists sometimes especially when a patient is at risk for suicide or just seems to be fragile, which in DBT one of the things we have to keep in mind is we're not supposed to treat the patient as fragile but that's another story right now but we have this fear of making them worse. So we end up tiptoeing and walking on eggshells. The irony is the time to set those limits, it's never a convenient time to do that. Most of the time when you need to identify a therapy-interfering behavior targeted for change or reduction, the patient is clearly struggling. They're not calling you too much because they're not struggling. They're calling you more frequently than you would like because they are struggling. So the timing of it never really fits. It never feels like it's a good time to bring things up when they're a problem. We have this terror that we're going to make things worse.

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So some of the tips for dealing with these.

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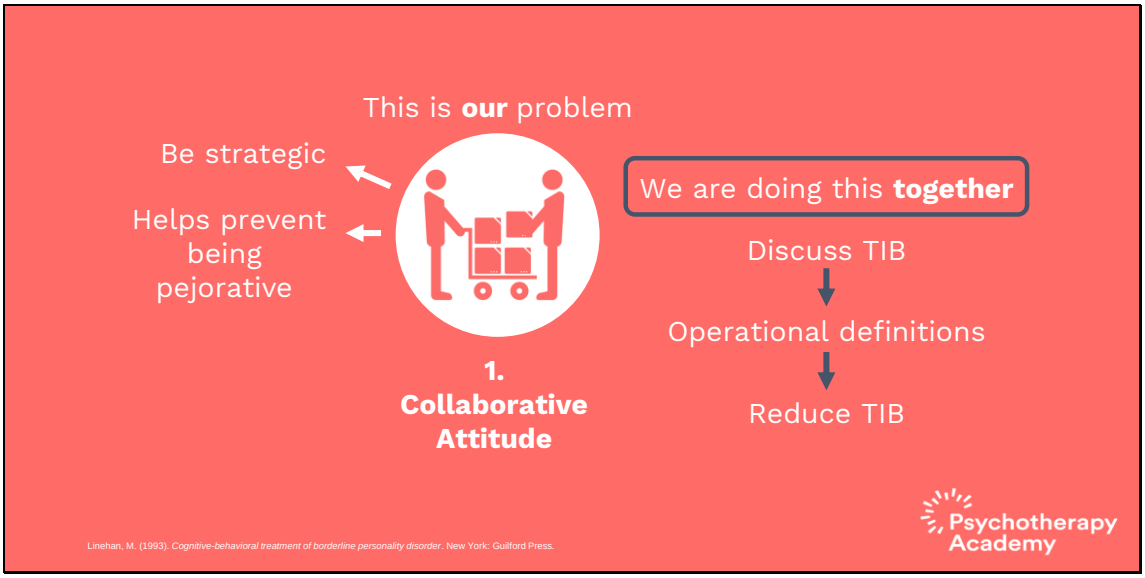

First off, remember to have a collaborative attitude. I can't reiterate this enough. Working together with the patient, take the time to remember that we work collaboratively rather than presenting ourselves as the all-knowing expert on them. I like to remember that I'm working for them. Focusing on the idea of working collaboratively helps prevent or minimize being pejorative, talking down to the patient or scolding them with some sort of passive-aggressive therapy speak. We're a team, us and the patient. And teams work together on problems. This is not their problem. It's not my problem. It's our problem. Sometimes, I will be doing supervision with a therapist, a new therapist and they're describing therapy-interfering behavior and they will say, well, how do I address this? And most of the time, I will say just like you just did. The way you just described this would be wonderful for you to share with the patient in that you just shared what was going through your mind at the time, the questions that you had. Do I say this? Do I say that? Why did you not say that out loud? That would be a great thing to say because it's a collaborative effort. We're not holding back and keeping things in, being the most manipulative person in the room.

One of the things that Linehan describes is using the term manipulative in a pejorative way. Manipulative involves skill. And part of the problem is that the patient lacks skills. So we want to be strategic. We don't want to be manipulative in a negative or a pejorative sense. We do want to be strategic but we don't want to be withholding information that if we were to let it out and just sort of talk it through with the patient that would lead to an improvement and would lead to change. They are your best bet, your best friend, your best collaborator in working on these problems.

So discussing therapy-interfering behavior is not about blame or reprimands but rather it's a way to conceptualize behavior using these operational definitions so that we can reduce them, make sure that we're getting the therapy, we're giving the therapy, there's nothing getting in the way, keeping them in treatment, improving the relationship, making it so that the helper wants to help which is so important in DBT. And we're doing this together. It's not all on you as the therapist. You have another person in the room who can be of help and they are the experts on themselves. So ask them.

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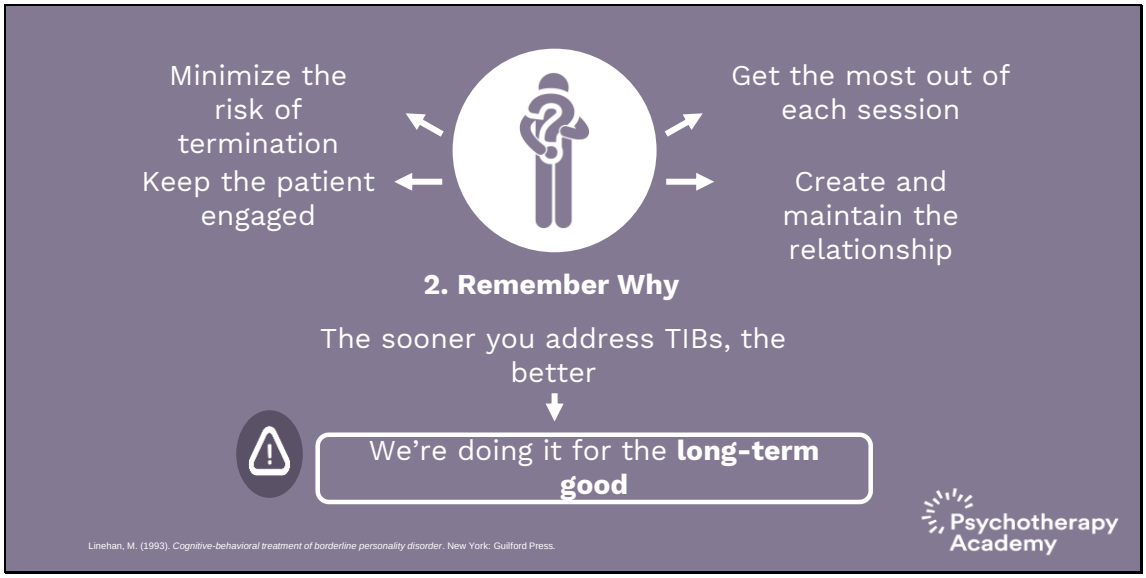

Next tip, remember why. So the why is important as well. If therapists do not believe that addressing therapy-interfering behaviors is beneficial, they wouldn't do it because it's often uncomfortable in the short term. I mean, it's super uncomfortable in the short term sometimes. As therapists, we're willing to do lots of uncomfortable things if we believe that it's for the long-term good. And the problem is if we don't believe or we're not sure that it's for the long-term good. So remember the why. The why is to keep the patient engaged in therapy, to minimize the risk of early or abrupt termination, to help them get the most out of each session and to create and maintain a relationship between therapist and patient in which the therapist wants to continue helping. So in short, this is done for the long-term good of both the patient and the therapist although short term, avoiding discussion of therapy-interfering behaviors may preserve the relationship. That's the short term. It may preserve. Long term, it's going to be detrimental. The sooner you do it, the better off both of you will be.

And I have taken many patients on after even DBT therapists will terminate with them. And it comes as a surprise to the patient who thought things were going along just swimmingly but the therapist was holding resentment, wasn't addressing these problem behaviors, did not communicate effectively with the patient in letting them know that they were at risk of being terminated. And in DBT, we use unilateral termination as a last resort. And so it's another example of how that fear of abandonment actually comes about. They actually are abandoned. So we want to make sure we are blowing the whistle early. We're communicating together. We're letting them know when there's a problem. Remembering the why. We're doing it for the good long term.

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Next, we've got to have radical acceptance of our own limits. As therapists, we have got to have that radical acceptance of limits. I once had a patient who called much more frequently than I was okay with. And this was earlier on in my career as a DBT therapist. The problem was I had let it go on so long that when I saw the phone light up with the name of this patient I was at the point where I literally flinched. I would then answer the phone with a voice that reflected a feeling I did not feel which was openness and a desire to help. And so I'm sort of putting on this mask. I was in short basically deceiving the patient because I'm pretending to feel a way I did not feel. I didn't feel like a helper but I found myself set on preserving this image that I was. I needed to. I felt like oh, I need to make them think that I'm open and willing and feeling the desire to help. It was this image of being a helper. So I could have rationalized that this persona mask was necessary to help the patient but the truth was the patient was getting worse. I was aware that at least in part I had contributed to this by taking too many calls and too many calls for me, so maybe not too many calls for one of my colleagues because everybody's limits are different but taking too many calls for me. And thus, I inadvertently reinforced this patient's anxiety. But I was afraid of hurting the patient's feelings or being considered rude.

I have a habit of saying this ain't no tea party. I'm a therapist. I'm supposed to be a therapist. This is DBT therapy. We're doing treatment on people with life-threatening, high-risk behavior. So I'm supposed to be a therapist, not a hostess. Many times, therapists need to come to terms, we have to be able to come to terms with ourselves and recognize that maybe we're not as laid back as we would like to be. I'm not as laid back as I'd like people to think I am. If you're a therapist, I can almost guarantee that this applies to you. So we have to have that radical acceptance of as much as I would like to, and I actually told my patient this at this time, I said, I would very much like to if I could press a button and make myself not feel irritated or make myself feel endlessly open to taking phone calls from you but the truth is that is not the case as much as I wish that it was. I'm like a rat or a dog or any other organism that with enough aversive experiences I'm going to have a conditioned response to flinch. So that's the radical acceptance that we have limits. And the sooner we recognize those limits, the better.

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So this leads into the next tip which is self-disclosure and DEAR MAN, so the practice of DEAR MAN in DBT. So once I had come to terms and radically accepted my limits, I was able to move to self-disclosure and labeling the behavior. I told my patient the truth that I was embarrassed I have these limits. I was. And just like I said if I could push a button and make them increase I would but I couldn't. I asked for help and I took responsibility for the fact that I had not addressed this sooner. I asked for help from the patient. I described how I found myself flinching when the phone rang and how I didn't want it to be the case. I modeled DEAR MAN with an emphasis on the E, expressing emotions and thoughts, and the R, reinforcement of the patient in letting them know I wanted to feel differently. With the A in DEAR MAN, I asserted what I wanted. I wanted no phone calls or texts for two weeks and then only positive contact for the first week, only the good things. We would continue talking about it in sessions. And suffice to say, this all went shockingly well. I remember how shockingly well that it went in spite of the fact that the patient was obviously calling more frequently because the distress was higher.

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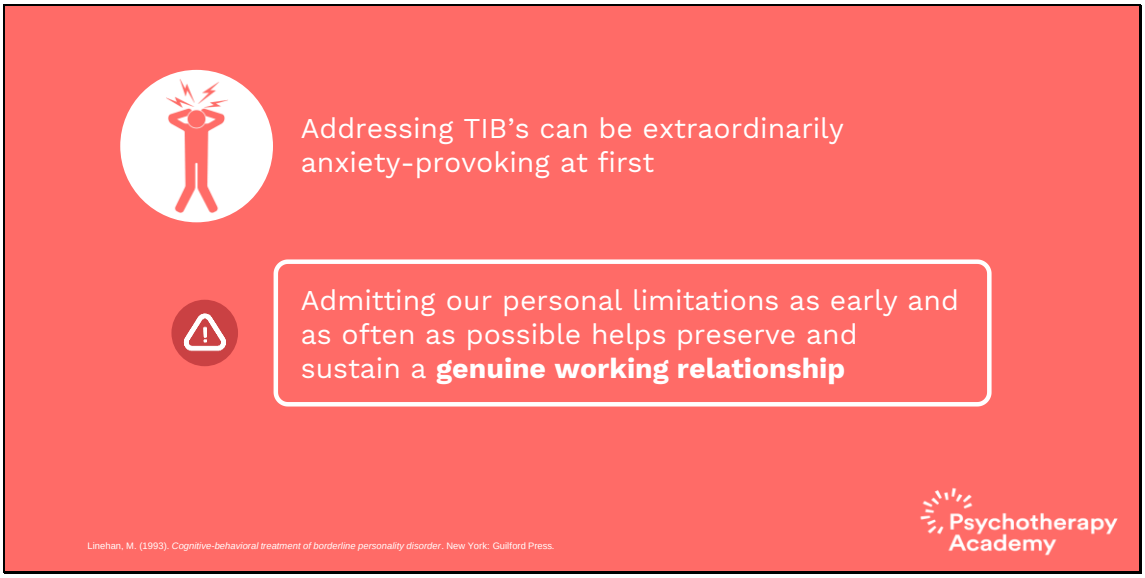

In short, if you're waiting until it feels like a good time to bring up therapy-interfering behavior, you will most likely not ever do it. So although addressing therapy-interfering behavior can be extraordinarily anxiety provoking at first, with practice, therapists find that there is a way to move away from negativity and instead of smiling at the patient to their face and eye rolling behind their back to instead acknowledge our own humanity and admit to our personal limitations as early and as often as possible in order to preserve and sustain a genuine working relationship.

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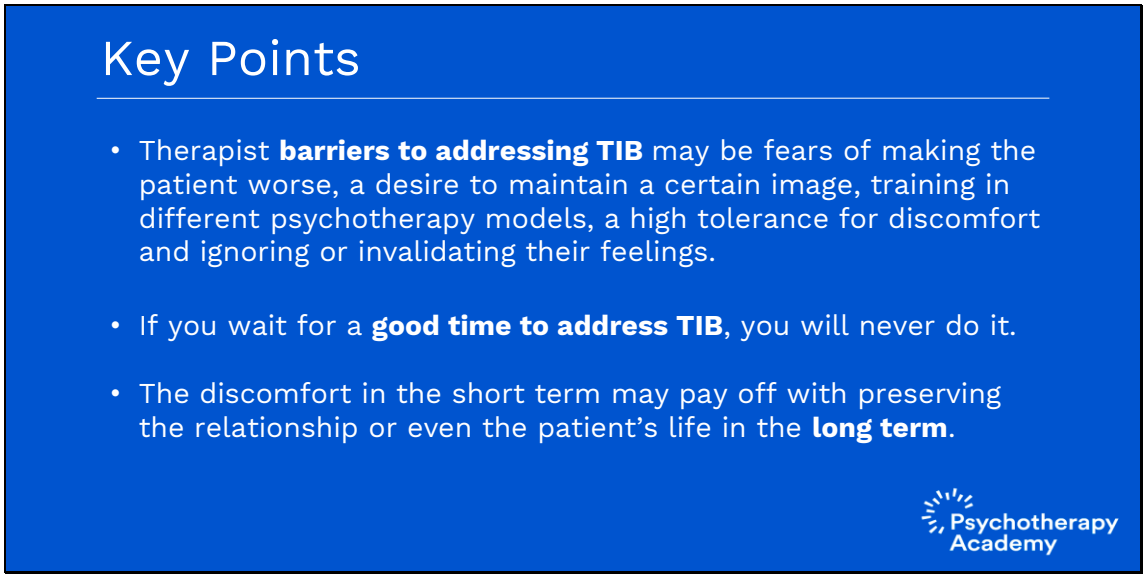

Key Points:
Therapist barriers to addressing therapy-interfering behavior may be fears of making the patient worse, a desire to maintain a certain image, clinical training in different psychotherapy models, a high tolerance for discomfort and ignoring or invalidating therapist's true feelings. If you wait for a good time to address therapy-interfering behavior, you will never address it. The discomfort of addressing therapy-interfering behavior in the short term may pay off with preserving the therapy relationship or even the patient's life in the long term.

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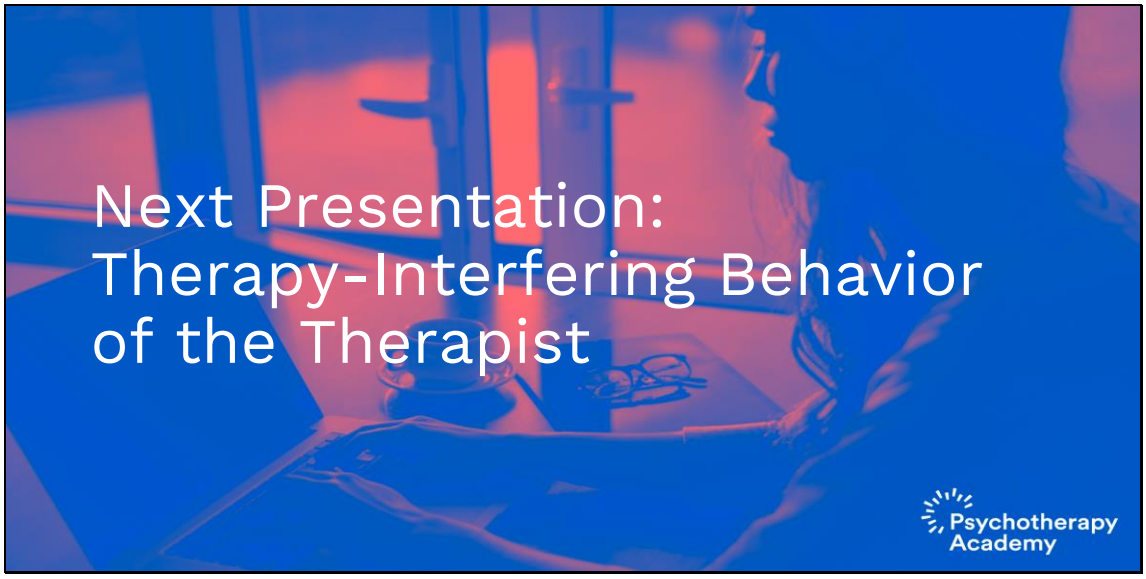
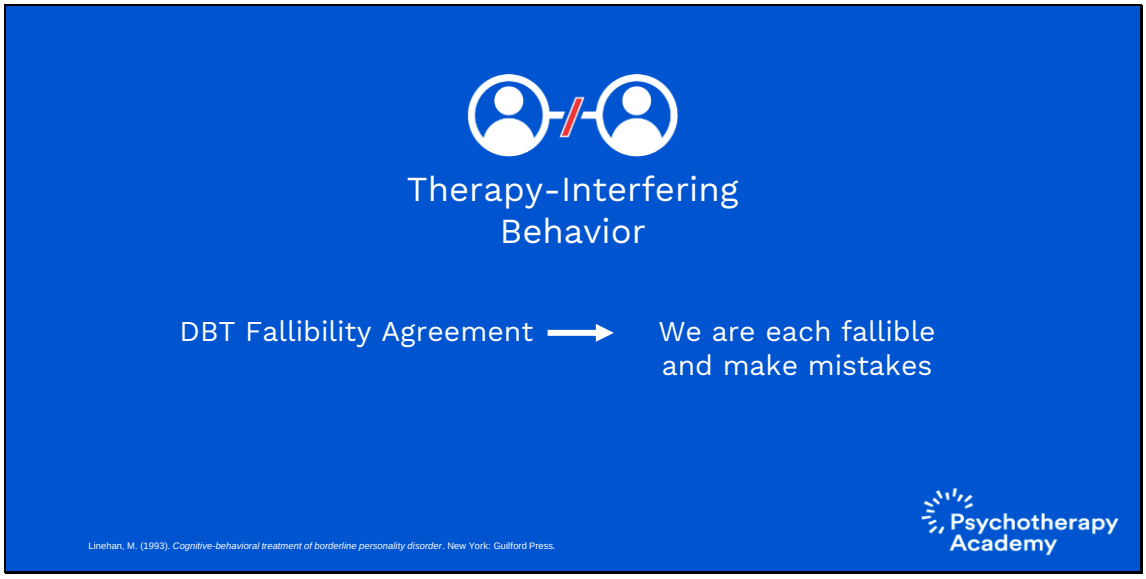

Next Presentation:
Therapy-Interfering Behavior
of the Therapist
Psychotherapy
Academy

Slide 1


Psychotherapy
Academy
Therapy-Interfering Behavior
of the Therapist
Stephanie Vaughn, PsyD

Slide 2



Patients aren't the only ones who can engage in therapy-interfering behaviors. Therapists are human too. And as the DBT Fallibility Agreement states we agree ahead of time that we are each fallible and make mistakes, that we have probably either done whatever problematic things we're being accused of or some part of it so that we can let go of assuming a defensive stance to prove our virtue or competence.

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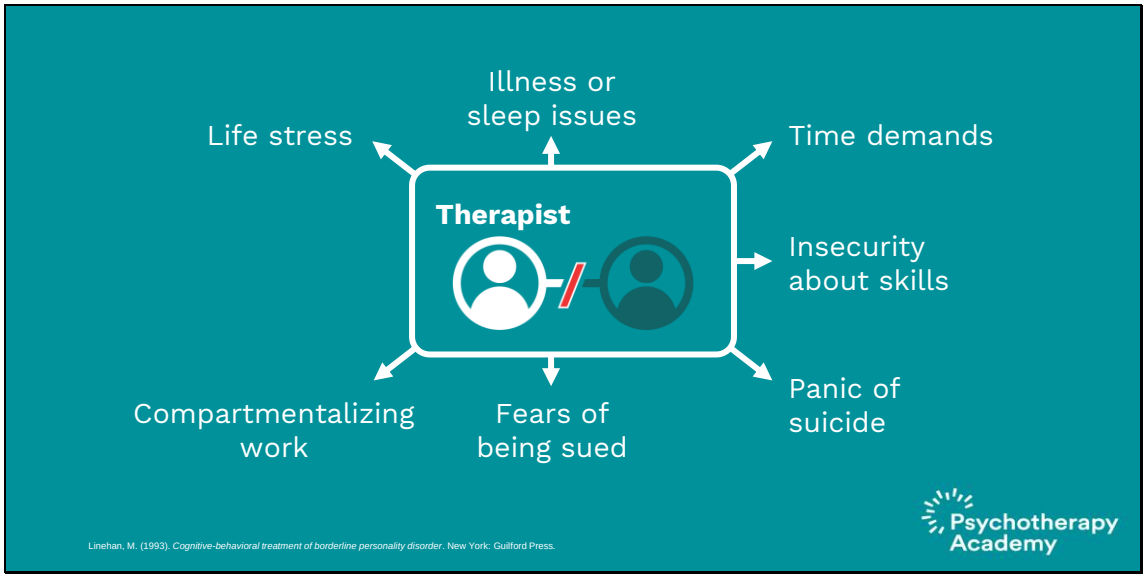

Some factors that contribute to therapy-interfering behavior of the therapist are life stress at home or work, illness or sleep issues, time demands, compartmentalizing clinical work so that the therapist is trying to do clinical work on certain days and perhaps research work on other days so that intersession contact or clinical duties feel intrusive, insecurity about one's skills as a therapist, fears of being sued and panic that a patient will commit suicide. So each of these things can lead to therapy-interfering behaviors of the therapist.

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So what are some of the most common problematic things?

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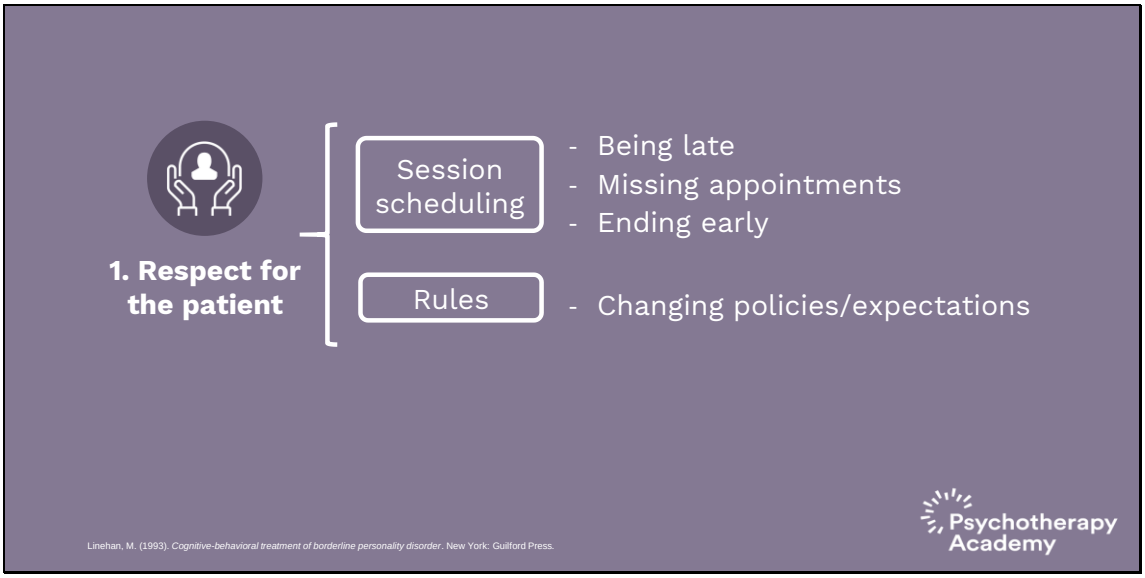

Well, these can be things that concern respect for the patient. That may be session scheduling. If a therapist is late, forgets or misses appointments, ends sessions early. So we want to make sure that we are demonstrating respect for the patient by being on time, starting and ending on time, appearing prepared. We want to have our policies and expectations as consistent as possible. So if the rules are changing a lot, those rules with phone coaching or payment, etc., those things need to be in place as much as possible.

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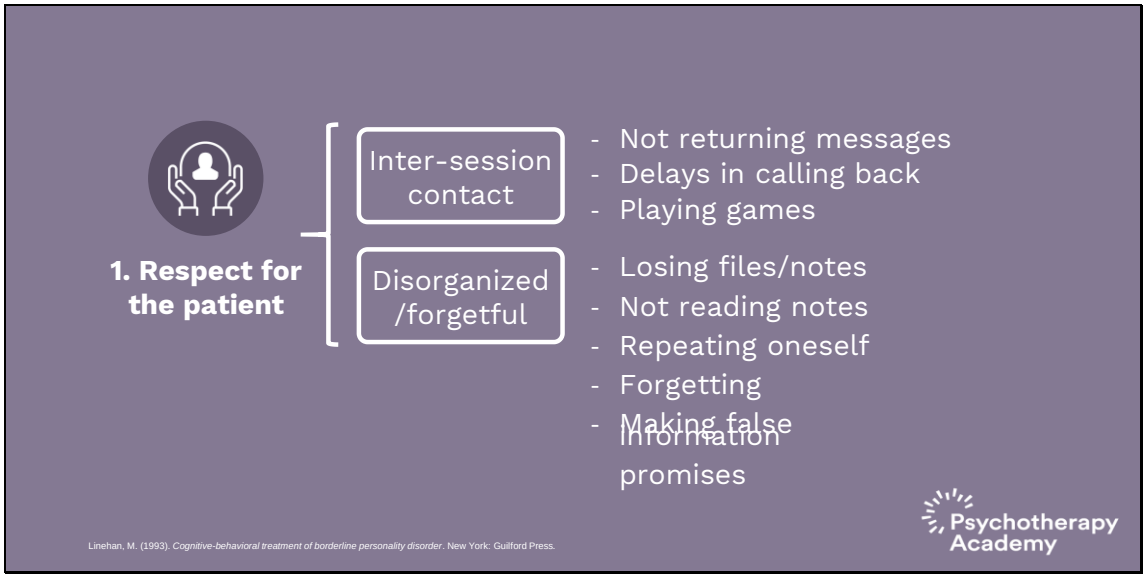

Intersession contact issues. If a therapist doesn't return messages, delays in calling back, plays games with the patient in just sort of punishing them not in a behavioral sense, not in a clinical sense but just to get back at them or something.
A disorganized appearance or being disorganized or forgetful, that's by losing files or notes, failure to read notes, repeating one's self as a therapist, forgetting really important information, making promises that you don't keep when you say that you're going to send something or you're going to email or you're going to call, you're going to check up and that not happening. Be careful what you promise. Don't make promises in session that you can't keep, you know, as much as possible.

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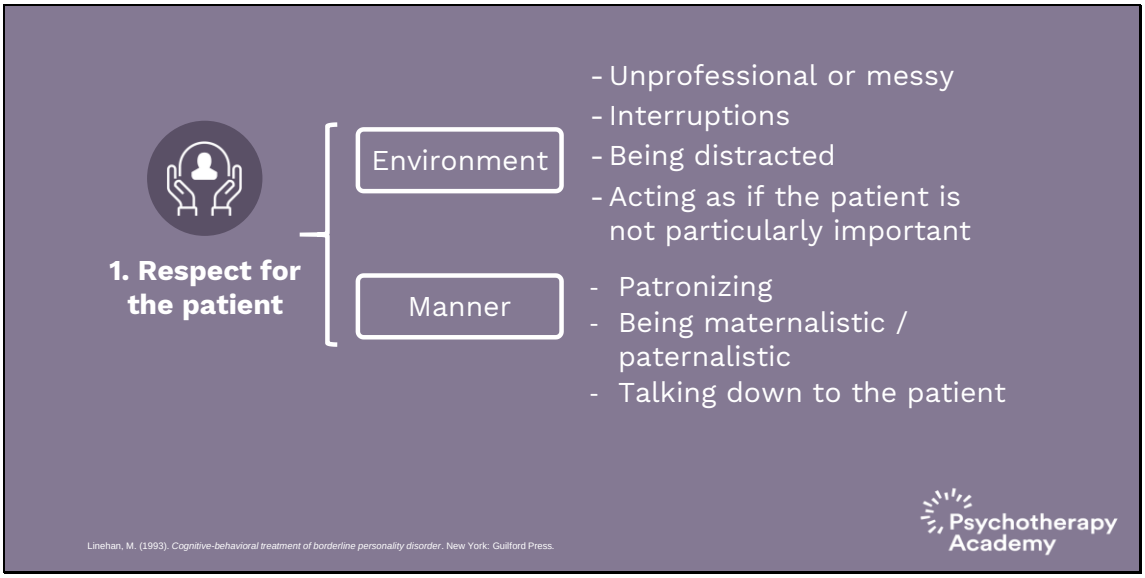

In the environment. So having an unprofessional or messy environment, not closing the door or having an area that's loud and there are interruptions, doing other work or taking calls or messages while you're supposed to be doing therapy, being distracted, watching the clock a lot. I've even heard of therapists falling asleep, appearing tired, having an appearance that the patient is not particularly important.

And finally, other issues that concern respect for the patient are having a manner that's patronizing or maternalistic or paternalistic, talking down to the patient. I've seen therapists or heard about therapists continually revamping the plan and having patients write their own notes, talking about therapy-interfering behaviors like it's the patient's fault, seeming like the expert on them, basically demonstrating a lack of respect for the patient.

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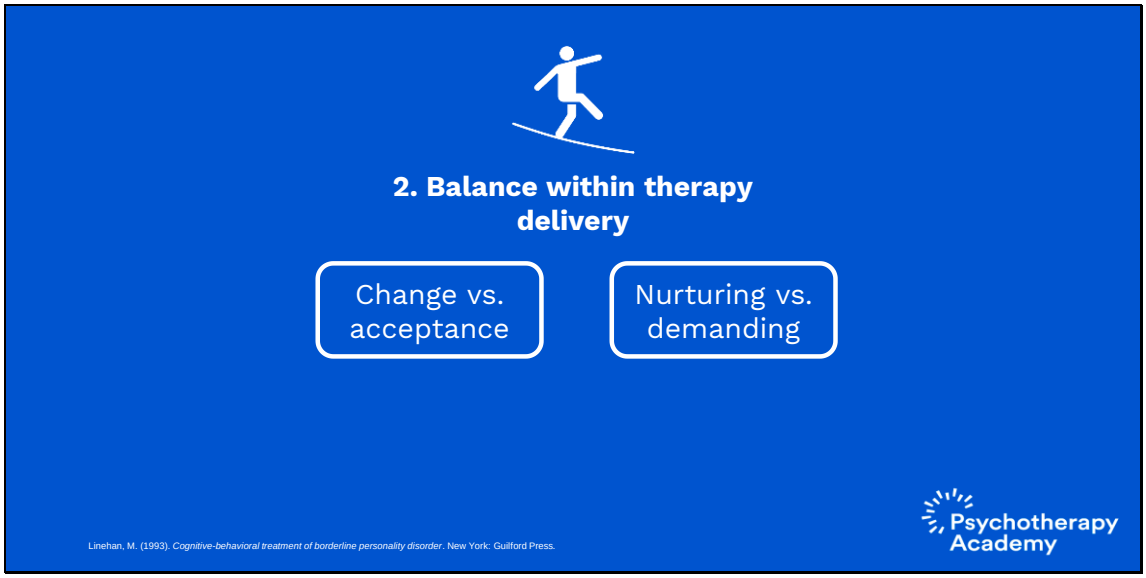

So other types are those that concern balance or maintaining the balance within the therapy delivery. So we want to keep that dialectical balance between change and acceptance. And as cognitive behaviorally trained clinicians, we often can weigh far too heavy on the change side at times and we're pressing the patient for change and we're not doing enough of the acceptance. So we're trying to make sure we're balancing between both of those in session. We may lean too heavily on the side of acceptance and not challenge a patient on something because it's just too uncomfortable for us or we're not feeling well that day and so we're just going to do a heart-to-heart session and we're going to do some heart-to-heart talks instead of sticking to the plan. Not doing a good job of balancing that reciprocal communication where we're validating with the irreverent communication and we're throwing the patient off track and not taking ourselves too seriously and not tiptoeing around, so weighing too heavy on one or the other of those. Not balancing the nurturing versus demanding characteristics. We need to be able to provide a balance of compassionate and caretaking and being nurturing in moments when it's necessary versus really challenging the patient to continue expecting more of themselves and challenging themselves.

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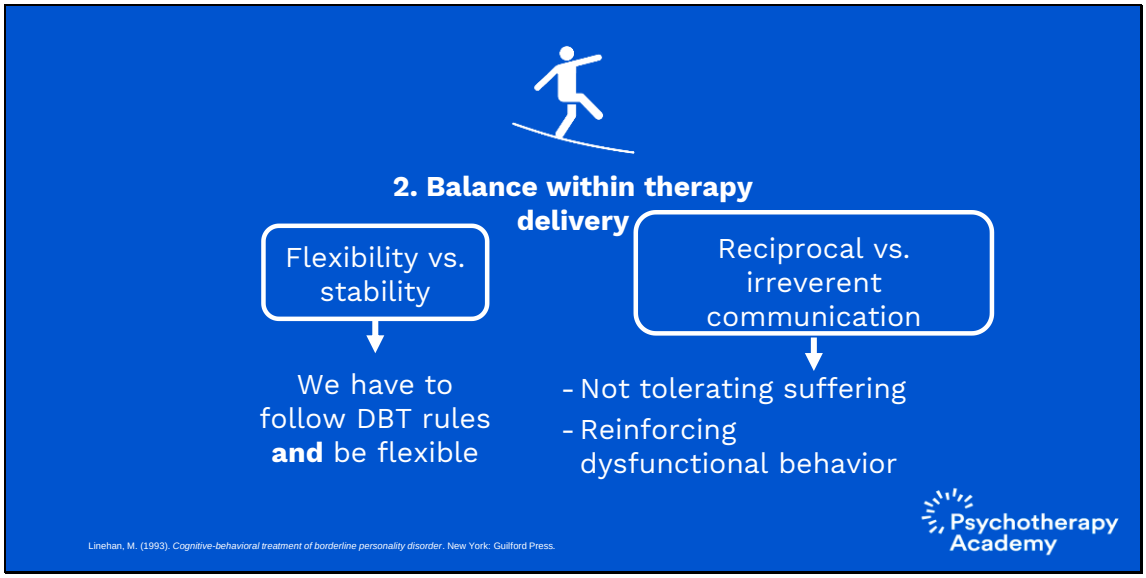

We also want to maintain a balance between flexibility and stability. So we do have those rules, those DBT rules like we need to bring a diary card and we need to talk about life-threatening urges and actions. We need to do behavioral chain analysis. There are rules about attending and all of that. And we need to also be able to be flexible. So take the example of a patient who comes in and she's not filled out her diary card and the therapist finds out she's not filled out her diary card. And the immediate response is okay, well, you're going to need to fill this diary card out here in session. That may be an intervention that's helpful and I can certainly imagine that it would be and I have done something similar before. But let's say that this patient has had a history of never bringing a late diary card and today she shows up without it or she's extremely tearful. And instead of being a human being and asking, hey, what's going on? I've never seen you like this when I first saw you and you always bring your diary card, instead of being a human, then we just go back to robotics of you need to fill this diary card out. And it turns out that the patient has just got in a car wreck or just found that her mother had died or her house had burned down or something. And so we've got to keep in mind that we need to be able to maintain that flexibility and adhere to these principles at the same time. We want to go with the spirit of the law as much as possible instead of always with the letter of the law so to speak.

I'm definitely guilty of this. Another way that therapists have therapy-interfering behavior is the inability to tolerate a patient's communication of suffering in the present. So it's very difficult when a patient is continually expressing lots and lots of emotional distress, lots and lots of emotional pain and that happens repeatedly, session by session. We can inadvertently, accidentally reinforce dysfunctional behavior. We can accidentally make things worse if we're not able to tolerate their suffering in the present, if we're jumping into change things or we're providing more session time or we're taking more phone calls. And there are a lot of different ways that we can accidentally reinforce dysfunctional behavior.

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So we've got to be able to have that team approach, that peer consultation team and bounce things off of them and be open to our peers in questioning. Is it possible that the way that you're responding to the patient is actually making things worse? So we've got to be open to looking at our own behavior and considering whether we're not being dialectic, whether we're engaging in behavior that shows a lack of respect for the patient and be open to discussing that and changing it. So we can have therapy-interfering behaviors too.

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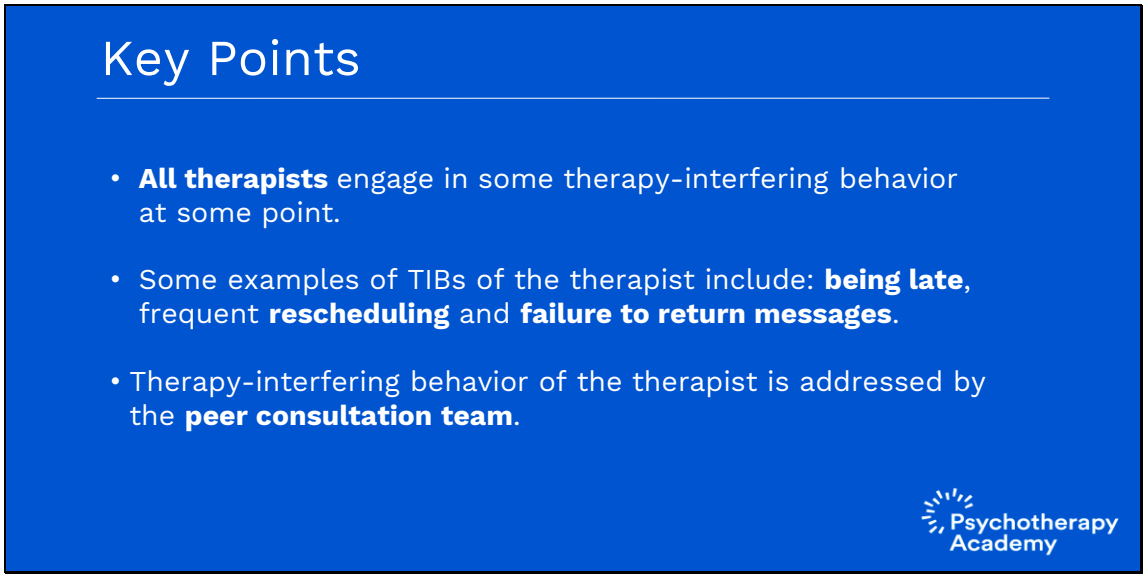

Key Points
All therapists engage in some therapy-interfering behavior at some point.
Some clear examples of therapy-interfering behaviors of the therapist include being late for sessions, frequent rescheduling of sessions and failure to return messages.
Therapy interfering behavior of the therapist is addressed by the peer consultation team.