4 Tips for DBT Therapists About TIBs

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

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4 Tips for Overcoming Fear of Addressing TIB's

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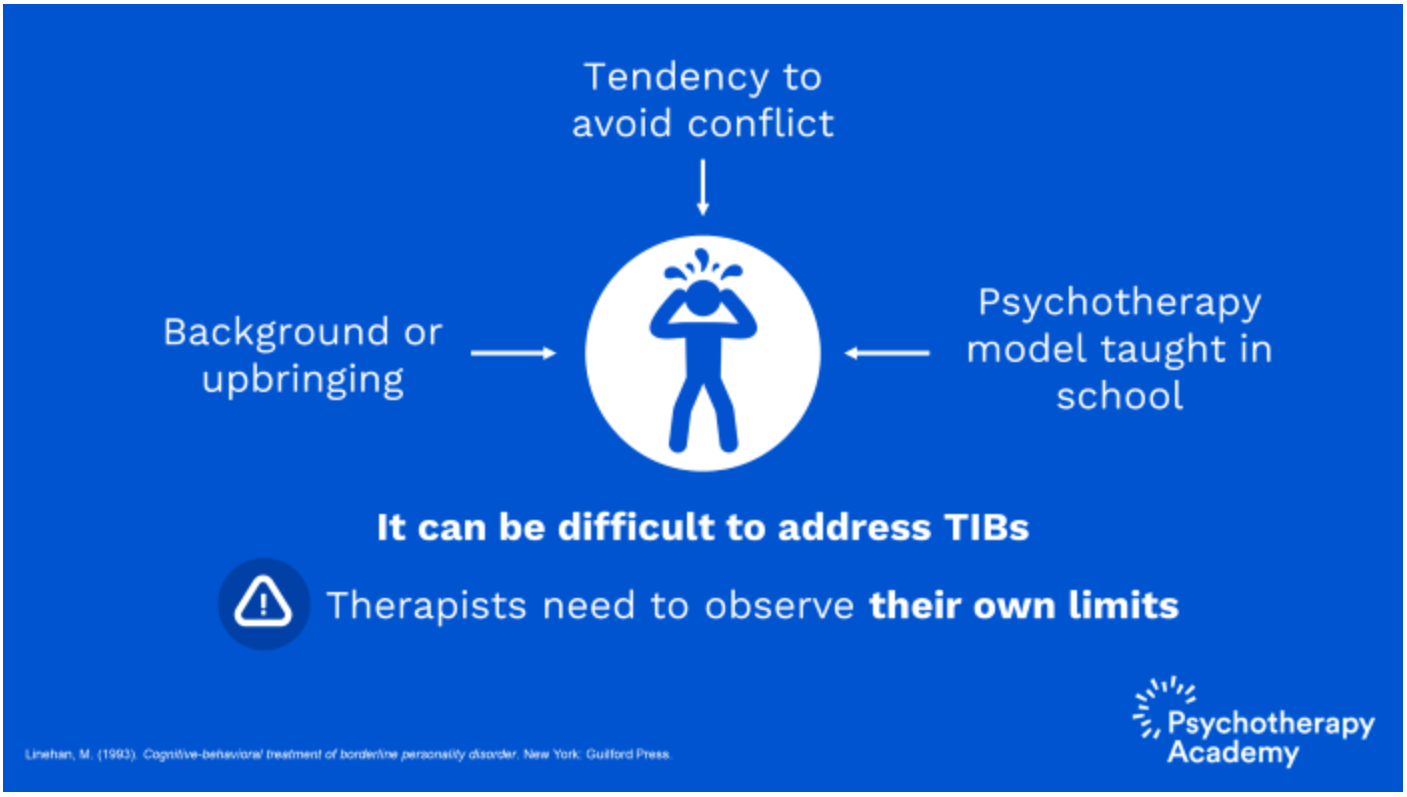
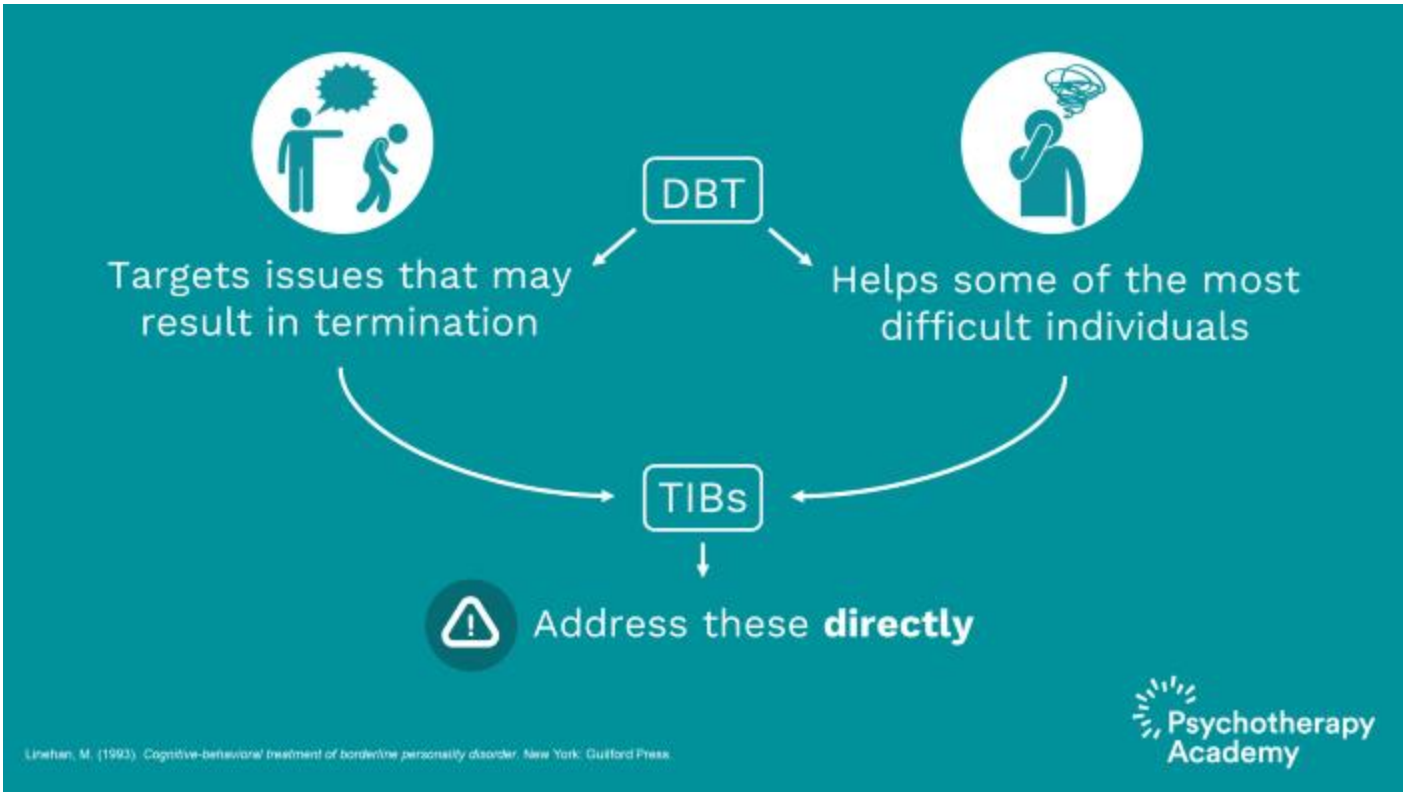


Even when a therapist is able to accurately identify therapy-interfering behaviors, it can be extremely difficult to actually address them. There are several reasons for this. Some of those as therapists we can easily identify such as our background or upbringing, general tendency to avoid conflict but 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.



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.

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.

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.

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.

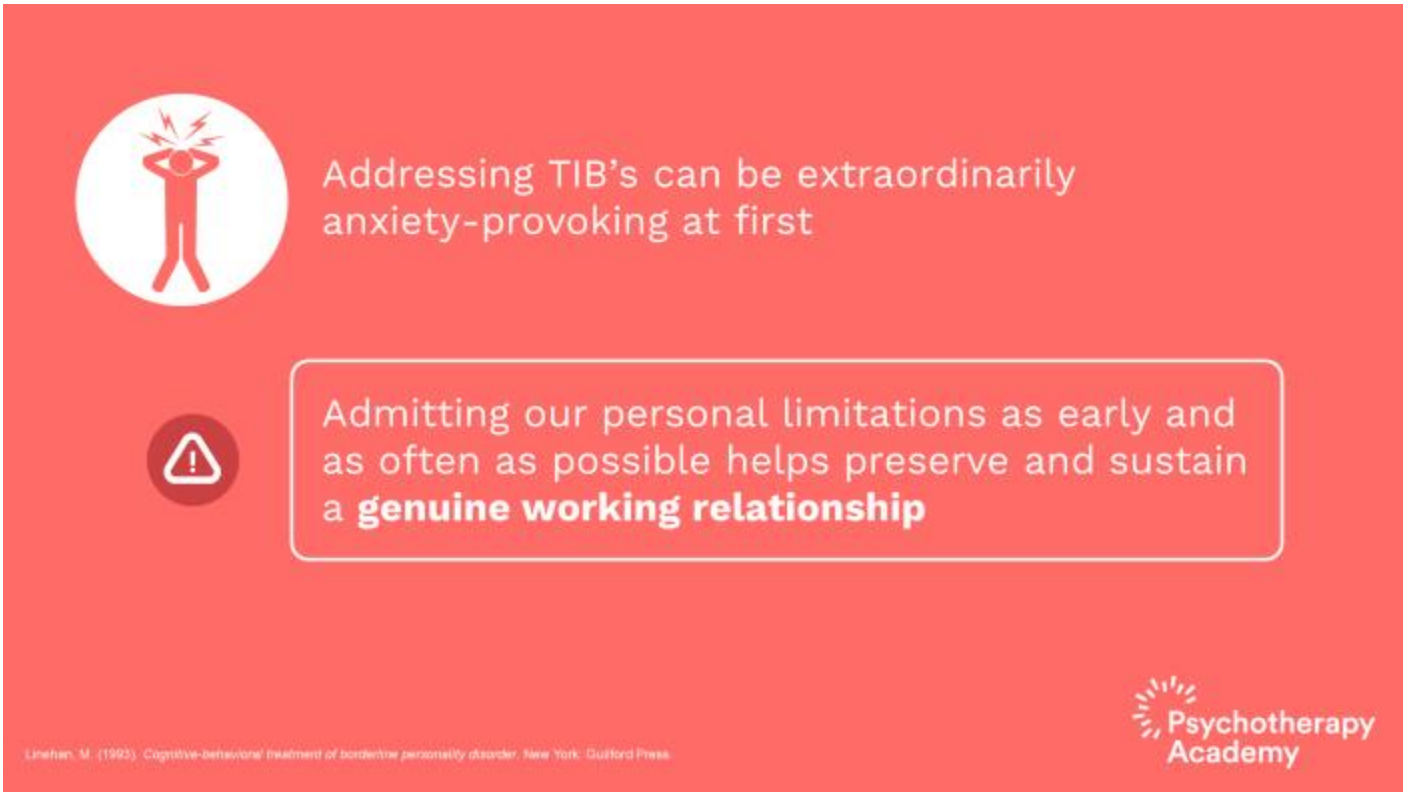
So some of the tips for dealing with these.

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.

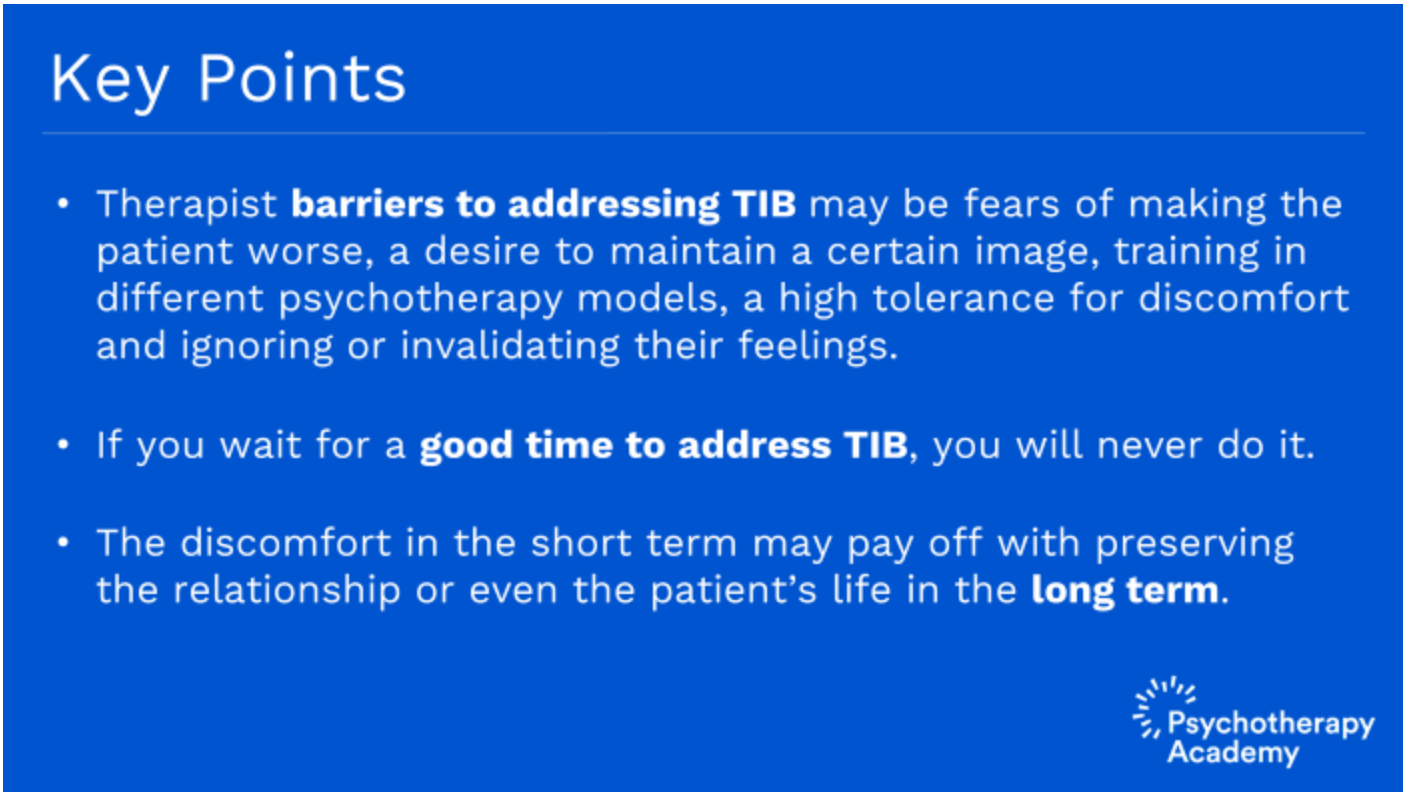
Next tip, remember why. So the why is important as well. If therapists do not believe that addressing therapy-interfering behaviors is beneficial, they wouldn't do it because it's often uncomfortable in the short term. I mean, it's super uncomfortable in the short term sometimes. As therapists, we're 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.

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.

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.



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.



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.