Terapia comportamental dialetica pdf

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This article or section does not provide reliable or independent sources. Help insert links. Unverified content can be removed.-Find Sources: Google (News, Books and Academic) (August 2018) Dialectical Behavioral Therapy (CDT) is a psychotherapy originally developed in the 1980s specifically to treat borderline personality disorder, and is now considered a first-line clinical intervention for this disorder. Due to its balanced component between adoption and change technologies, it is one of the first third generation of psychotherapy. More recently, this method has been clinically tested for other disorders, namely adaptation difficulties in adolescents, addictive behaviors, eating disorders, ADHD, depression, suicidal behavior, etc. lack of sources?. The name comes from a dialectical method that confronts two or more competing mises (and/or antithesis) and seeks to come to synthesis. In general, TCD follows this proposal and seeks to reconcile and/or resolve conflicts wisely through its direct impact, failing to prioritize the calmness and quality of life of the patient. Dialectics is present in several aspects of therapy, namely in the theoretical substrate (biological and social), conceptualization of problems (active passivity and seeming effectiveness), therapist style (call and verification), strategies and goals of psychological intervention (promoting acceptance and change), in that the therapist cannot change or accept the client without accepting or changing himself, among others. Proposed by Marsha M. Linehan, TCD has a component of individual psychotherapy, group skills training, telephone counseling (coaching) and therapists are constantly consulted by a group of advisory peers (interspecies group). Its theoretical basis, which underlies the strategies of change (regulating emotions and the effectiveness of interpersonal relationships) comes mainly from behavior with elements of cognitiveism. Adoption strategies are based in part on behavioural behaviour as well as on the philosophical principles of Eastern cultures (reasonableness and stress resistance), namely in the practice of zen (authored by a practitioner and master). Individual CdT therapy is usually a directive and based on the here and now, and seeks to address in a weekly session adaptive problems that the client can present. Priority is given to suicidal and self-destructive behavior, and then to behavior that interferes with the therapy itself. Here are the quality questions: and improving it. In the final phase of therapy, attention is paid to intervention in psychological trauma and encourage self-esteem. For some clients, it is necessary to find a deeper meaning for their existence, so for them, TCD contemplates the approach of subjects such as life with meaning and spiritual aspects, in particular, a sense of belonging to the universe. This is aimed at promoting sustainable capacity to prey on freedom and satisfaction. During individual therapy, we often discuss how to improve the skills or competencies that make up the TCD model, overcome obstacles to its development, and encourage the generalization of their practice in everyday life (using, for example, daily registration cards). It also identifies management skills that rarely work in groups, such as current analysis, in which triggers, underlying events and the effects of problematic behaviors are indexed to corrective behavioral skills to heal them. Most intervention training skills are done in a group and usually consist of a weekly session of two hours to two and a half hours focused on developing specific skills or experiences organized in four modules: Basic Mindfulness Examination Of Emotional Regulation Examination Stress Tolerance Examination Interpersonal Relationships Efficiency Four Module Learning Skills TCD MindFulness Is considered to be the basis for supporting other skills, mindfulness (or alert mind) , in zen), and consists of a broad and tolerant posture of attention aimed at all phenomena that manifest themselves in the conscious mind - i.e. all kinds of thoughts, fantasies, memories, sensations and emotions are perceived in the field of attention perceived and accepted as they are. Regulating emotional patients of borderline and suicidal personality disorders tends to experience intense and somewhat fluctuating emotions. For this reason they have many benefits from learning to regulate their emotions and express them at the most convenient moments. Among the dialectical skills aimed at emotional regulation included: identifying and classifying emotions identifying obstacles to changing emotions reduce vulnerability to emotional intelligence (uncontrollable emotions) increase and improve positive emotional events to realize emotions present at every moment to take action contrary to the undesirable emotional tendency to apply pressure tolerance techniques (described in the following paragraph) Stress tolerance Many mental health approaches leave tolerance to external pressure. CdT, however, is clearly engaged in this component of mental health. Tolerance to pressure involves the ability to take as they are now as an external situation that lives and the inner state of the patient himself to perceit him with clarity and calm without falling into an excruciating or violent reaction. It should be noted that accepting the reality of the situation does not mean that it is being respected or that it will be kept as it is. The goal is not in accordance, but calmness in the face of what actually exists. The behavior of pressure tolerance involves crisis tolerance and resistance and acceptance of life as it is at the moment. Four categories of Crisis Survival Strategies Teach: Distraction Self-Service Improvement Point Consider the pros and cons of Admission Skills include Radical Acceptance Holding The Mind to Contrast Acceptance of Receptive Will (Disposition) with an unreasonable definition (stubbornness) of interpersonal effectiveness of interpersonal efficiency of Interpersonal Efficiency TCD to include the development of assertiveness and the resolution of interpersonal problems. These include the ability to ask for what is needed, to say no and to deal with interpersonal conflicts. Patients receiving CDT often have a good theoretical understanding of interpersonal skills, but need training to get used to applying it in their daily lives. This module focuses on situations where you try to cause changes (usually by asking someone to do something) and/or resisting the changes proposed by the medium (say no). The overall goal is to increase the chances that the patient's personal goals will be achieved, without compromising their self-esteem or the quality of their relationships with others. Received from In the last text published in this column, my colleague Tamares wrote about the use of metaphors in DBT. I have to thank you for explaining to you, in addition to the importance, of applying such a strategy because it will help me fulfill my goal in this article. Metaphors in DBT are part of a group of dialectical strategies used throughout treatment in order to work on the tension that exists between opposites, contradictions and polarization in therapy and in the patient's life (Linehan, 2010). These strategies help the DBT therapist remain dialectical. But after all, what is it like to remain dialectical in DBT? Many of the challenges faced by patients lead therapists need to think clearly about extreme situations. As we can imagine, in the face of complex problems, it is natural for people in general to tend to certainty, relying on old cognitive or behavioral patterns and thus becoming less psychologically flexible. This lack of flexibility can also occur in psychotherapy processes. When therapists and patients take forms of polarized thinking and action, i.e. less flexible and dichotomous, it is natural that tensions between them are created. Let's take it as an example when a patient says he will give up therapy because it doesn't work. The patient says he won't be back for the sessions. Faced with such a situation, it makes sense that the therapist's fears lead him to sharply focus on the idea that the patient cannot give up therapy and perform interventions based on such thoughts. Thus, the patient and the therapist are in two opposite poles: one is in the position that therapy is not the solution, and the other is the opposite, that therapy is the only solution. Let's try to talk about this with a metaphor used by Linehan (2010) to explain the tension and dialectical movements of DBT. Imagine a bamboo stalk balanced on a thin line at the top of the Grand Canyon. In therapy, it's like the patient and the therapist are at the ends of this rod. While the patient is constantly moving back and forth, from end to middle, and from middle to finish, the therapist is also moving, trying to keep the balance of the rod above the line and avoid falling, or that he breaks. The big difficulty is that if the patient and the therapist move continuously backwards, that is, taking opposing positions, in an attempt to maintain balance, the risks as the fall in the canyon increases. Thus, the task of the therapist is not only to maintain balance, but also to maintain it in such a way that both the patient and the therapist move in harmony in the environment, achieving an understanding of reality and more balanced and less polarized actions. If the therapist stays on the opposite end of this stem, trying to convince the patient that he cannot refuse therapy, there may be an important imbalance. In this scenario, remaining dialectical involves the ability to resist simplifications (for example, giving up therapy won't be good for you, or therapy doesn't work) and goes beyond fragile obligations (such as I would like your word that you will not give up therapy) and instead seek a combination of poles: problem solving and validation; Reason and emotion; acceptance and change. That is, it is necessary to understand and verify the patient's experience that the therapy does not work, accept it and understand it so that alternatives can be thought out to fix problems and solve difficulties. Another metaphor is here to help us. Present football field. At its core, a football match consists of dialectic, that is, tension between two teams with the same goal of victory, playing in opposite directions and against each other. However, in a DBT football match, a therapist and patient are not necessarily in opposing teams. Playing against the patient will not act dialectically; it requires the balance and courage of the therapist to play in both teams, sincerely trying to understand the wisdom in the experience of wanting to give up therapy, while promoting the patient's hope and participation in treatment (Swenson, 2016). To achieve this goal, the therapist remains dialectical in two ways: 1) embraces a worldview in which he maintains a position to fully accept what comes from the patient, as well as the moment moving toward change, and 2) seeing polarization as something natural and looking for reality in every pole and in general in which they are inserted (Koerner , 2011). That is to be dialectical in the face of the tension of giving up therapy means to recognize that the patient has experience discrediting the treatment, or wanting to abadonize it and, at the same time, suggest discussing problematic solutions so that this experience can be changed. It is about trying to determine what is valid in the patient's experience of wanting to give up therapy and recognizing how this experience can be used to strengthen, or enhance the therapeutic process. It is through dialectical posture that therapeutic movement is possible and that greater flexibility and balance are achieved when faced with dead ends and conflicts. Dialectics is the basis of DBT, expressed in the treatment of the therapist, who always informs the patient that the truth is neither absolute nor relative, but rather developed and built over time. Inquiries: Koerner, K. (2011). Conducting dialectical behavioral therapy: Practical Guidance (Guide to Individual Evidence Therapy). New York: The Guildford Press. Linehan, M.M. (2010). Cognitive-behavioral therapy of borderline personality disorder. Porto Alegre: Artmed. Swenson, C. R. (2016). DBT® principles in action: acceptance, change and dialectic. 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