How to Apply Mindfulness to Your Life and Work

Dialectical Behavior Therapy -
A New Approach to Treating Extreme Emotions

the Main Session with
Marsha Linehan, PhD and Ruth Buczynski, PhD
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Dr. Buczynski: Hello everyone, and welcome. I am Dr. Ruth Buczynski, a licensed psychologist in the State of Connecticut and the President of the National Institute for the Clinical Application of Behavioral Medicine.

I am so glad that you are here.

We have a very special guest for this session. Dr. Marsha Linehan, is probably well-known to many, many of you. She is Professor of Psychology at the University of Washington with an appointment in the Department of Psychiatry and Behavioral Sciences. She is Director of Behavioral Research in Therapy Clinics, and the author of several books.

Marsha is most well-known as the inventor of dialectical behavior therapy.

This is a therapy that was first used with borderline personality disorder and is now being used with other kinds of conditions.

A lot of us will think of applications – perhaps some that Marsha hasn’t even thought of yet – because this is a brilliant approach to some really difficult, challenging conditions that people suffer with.

So let me just first say, Marsha, welcome. It is great to talk to you and to be here with you.

A Definition of Borderline Personality Disorder

Dr. Buczynski: To start with, people listening in represent a range in professions. Since we are going to spend some time on borderline personality disorder, can you give us just a definition of how you would describe borderline personality disorder?

Dr. Linehan: Borderline personality disorder, as a disorder, really started being looked at by the psychoanalysts back in the thirties. They saw a group of individuals with certain characteristic problems that their treatments were not very effective for at the time.

Over the years, people have been looking at a category of people who I am going to talk to you about in a
moment – but the way the name *borderline personality disorder* came about was due to how we used to think about disorders.

This was a treatment that was viewed as *on the borderline* between psychosis and neurosis. That is actually how the term came in.

But the term has never really identified exactly what the disorder is, and we no longer have these sorts of continuum categories of mental disorder that we used to have. However, the name has stuck.

I am going to first say to people, “Put the name to the side” – it is a technical name that we can’t get rid of right at the moment although a lot of people are trying to.

If you try to understand what is in front of you when a person meets criteria for borderline personality disorder – and I am not going to go through the criteria because people can look that up and read the criteria – but the problem is largely twofold.

First, it is a problem of severe and pervasive emotion dysregulation. What that means is it is not across one emotion like depression or anxiety or fear, but it tends to be across all of them.

So you have a group of individuals who present with sadness, anger, jealousy, envy, depression, et cetera. They have extreme and volatile up-and-down emotions – and not only that, but they are not able to regulate themselves.

There are a lot of people today who believe that if we could rename the disorder, it would be a disorder of pervasive emotion dysregulation.

Now, to understand *that*, you have to understand what is meant by pervasive emotion dysregulation, and you have to understand what is meant by “emotion.”

Within the purview of emotion are all the components of emotion. There is the physiology or biology to emotion. There is thought and interpretations that are part of emotion. There are actions to emotion. Emotions have a thought component, a biological component, and an action or expression component.

The problem with individuals who meet the criteria for borderline personality disorder is they can’t regulate any of these emotions.
They can’t regulate their thoughts. They can’t regulate their feelings – their physiology and how they feel – and they can’t regulate action. So there is a degree of impulsivity in the disorder.

From that point of view, most of the behaviors that get labeled “borderline personality disorder” are an outcome of emotion dysregulation – for example, the interpersonal conflict and difficulties that these individuals usually have.

It is very difficult to have a good relationship with a person whose emotions keep changing all the time – “I hate you today/I’ll love you tomorrow/I wanted to play golf with you today but now I hate golf and I want to go to a movie,” et cetera. It is very difficult.

Or, if they are not that, they are the solution to unbearable emotions – they see suicide – killing themselves – as the solution. There is an underlying belief that if they are dead, they will actually feel better, or at least they won’t feel as bad – not that there is a shred of evidence that this is true.

Also, there is definitely the belief that alcohol makes you feel better. We know that people believe that cutting makes them feel better.

There is a lot of impulse-controlled behavior, but the behavior functions to regulate your emotions only for the time being.

So, that is largely how I would describe “borderline personality disorder” – a group of people who, despite their best efforts, cannot regulate emotions or actions related to emotions.

**Zen, Contemplative Prayer, and Mindfulness**

**Dr. Buczynski:** Thanks – that is a good starting point.

Now, in your work to try to find something that could be helpful with these people, how did it come about that Zen and mindfulness are relevant and part of your work?

**Dr. Linehan:** You have to understand that I started out as a cognitive behavior therapist, and cognitive behavior therapy had just come into its ascent, right when I was starting to practice. (For short, from now on as we talk, I will call cognitive behavior therapy, behavior therapy.)
I came into the profession from being trained as a behavior therapist. No one in the universe was a bigger believer than I was about behavior therapy, and I figured it would just cure everybody – but I was most interested in helping people who were extremely suicidal.

I decided that I was going to do research and try to develop an effective treatment for people who not only wanted to kill themselves but people who often tried to kill themselves. At the time, I had never heard of borderline personality disorder.

So I got all these people who were extremely suicidal. It turned out later that almost all of them met criteria for borderline personality disorder.

Suicide is extremely high and prevalent in people who meet criteria for borderline personality – in fact the highest rate is in that disorder.

I went in with my behavior therapy – and behavior therapy is very focused on change. It is like this: “You’ve got this problem – let’s talk about a solution that you could do.”

Basically, that was the fundamental point: it was a catastrophic event. The client would say: “You’re saying I’m wrong. You’re saying I’m bad. You’re being critical of me.” They would hide behind the chair; they would get mad at me; they would storm out; they would decide to quit therapy – nothing went right.

It became clear to me, “Wait a minute. This is a real problem.” So then I would say to the client, “No – you’re not the problem. You’re okay” – I tried to be soothing, at which point, they would even get angrier. They would say, “You mean you’re not going to help me? You’re supposed to help me. You’re saying everything’s all right – why aren’t you helping me?”

Then, I thought, “No – wait a minute. That’s a mistake, too.”

I had to pull back and say, “What is needed here?” Two things became completely clear to me over time. One was that, as a therapist, I had to learn to radically accept these clients – I had to radically accept a slow rate of progress.

In other disorders, we often have very effective treatments that actually work pretty fast – you can get results in twelve weeks.
But all of a sudden, I had a group of people that were taking a long time to change. They were engaged in behaviors that were very aversive to me, and they didn’t do any of the cooperativity and clarity I thought clients should be doing.

So, first, I realized that I myself had to learn to accept these clients and not demand that clients change immediately.

Two: it became clear to me, particularly after listening to their lives and the pain and suffering they were going through, and for many – not all, but many – had unbelievably tragic pasts, that they also had to radically accept the present.

They had to accept their life as it was, and they had to be able to accept their lives in the past.

I also realized that I somehow had to teach them to tolerate distress long enough for us to solve a problem.

They couldn’t be constantly going to cutting, or trying to kill themselves, or getting drunk or taking drugs, or overeating, or going to all the other impulsive- destructive behaviors that were so common in this particular group.

I became clear about what I had to do – what the problem was – it’s just that I didn’t know how to do that myself! I thought, “God, I’d better learn how to do this.”

It turned out that at the same time – I had been taking a class in spiritual direction, semi-online and traveling back and forth to Washington, DC from the University of Washington. I was getting trained to be a spiritual director, and that was completely independent of all this work.

I knew a lot of people who knew a lot of people, and I realized that one of the things that one finds in most spiritual approaches is an emphasis on acceptance.

Christianity says, “The will of God will be done...” So I figured, “Okay, I need a teacher. I have to get myself a teacher, and when I learn all this, I’ll teach the patients.”

I sent letters out to everybody and I said, “Who are the best teachers in the world?” I figured if I was going to do it, I might as well go to the best.

Two names came back, and one of them was from Shasta Abbey in California, and one of them was a Zen
teacher in Germany.

The Zen teacher was Catholic and the person at Shasta Abbey was Buddhist – but she was a woman. The other Zen teachers were Catholic priests. I had to say to myself, “What am I? Am I a woman or am I a Catholic?” I decided, “I’ll go to the woman first; I’ll go to the Catholic second.”

I went to Shasta Abbey, which is a Buddhist monastery in California that lets you come as a guest. I went there and, I would say by the second week, I knew I had found exactly what the patients needed.

Then I went to Germany and met the Catholic priest who was also a Zen master, and I realized that he was teaching the exact same thing that I had just learned at Shasta Abbey. I knew right away this was what the patients needed.

At that time, it was Zen in one place and it was Zen and Christian contemplative prayer in the other. I didn’t really have a name for it and I had never in my life heard of mindfulness.

I came home and started to teach all this to my clients, but it became absolutely obvious within a week that the clients couldn’t do what I had been taught. Primarily, I had been taught meditation.

I tried to get them to meditate, but, as one of them said when I said, “Watch your breath,” she said, “I don’t do breathing.” Another one said, “When I do that, I die, Marsha.” I said, “Okay – don’t do it.”

After that, I spent a lot of time going back and forth thinking, “What are they really teaching me?”

I knew they weren’t teaching me to watch my breath; they weren’t teaching me to take off my shoes; they weren’t teaching me to sit on the floor; they weren’t teaching me to watch the wall. So the question was: what were they teaching me?

I spent a lot of time trying to translate what I had learned into a set of very specific behaviors – which I did. I kept getting them approved by Zen teachers and contemplative prayer teachers – the Catholic priest.

What happened next is that I needed a name for what I was teaching.

I was somewhat “in the closet” – nobody knew I was doing this in the behavior therapy world.

But I needed a good name, and it needed to sound “psychological” so that people didn’t think I was teaching
some sort of religion – that was my problem – I didn’t want people to think I was teaching a religion.

I came across a psychology book called Mindfulness where there were studies on awareness versus non-awareness – when you do things and what is the impact?

For example: you are xeroxing and you are paying attention versus you are doing it automatically. So I said, “Oh, good – mindfulness is a psychological word. I can use that.”

Then I happened to read Thich Nhat Hanh’s book, The Miracle of Mindfulness, which had just come out, and I thought, “Oh, my gosh – mindfulness also could be a word for this Zen teaching – I’ve got a word.”

I got into all of this from something I developed and then needed a word to describe it, and I ended up calling it mindfulness.

But mindfulness, at that time – you have to remember, – was in no psychology book; there was no mental-health program that had mindfulness. It wasn’t everywhere like it is now. This was back in the early 1980s.

Jon Kabat-Zinn had developed mindfulness-based stress reduction, but that was for people with chronic medical problems. I had never read that because that is not a literature I track.

I had never actually heard of Jon Kabat-Zinn, and the only other study that had ever been done on meditation was by a faculty member here who was also “in the closet” – nobody knew what he was doing either.

This faculty member studied meditation, but his study was not effective – relaxation was more effective. You can just imagine, his study didn’t go anywhere, but he later did mindfulness-based relapse prevention, which is very effective.

So that is how I got into all of this – the technology of change that I had was a disaster. I needed the technology of acceptance.

I knew that I couldn’t drop the technology of change because if you went to acceptance only, that was extremely invalidating. That communicates to the client: “I’ll just commiserate with you. You can tell me all of your suffering – I’ll be accepting of it and I’ll teach you how to accept your suffering.”

That communicates to a person that you have no idea how really terrible it is.

I had to keep the change in, but I had to get a balance.
Now, the word dialectical comes in because it is a synthesis of acceptance and change. That is where that term came from—and that is how it ended up being *dialectical behavior therapy*.

**How Dialectical Behavior Therapy Works**

**Dr. Buczynski:** Thank you. That is very interesting—to get that historical piece. I guess it just makes me want to get you to give us a little more.

Can you tell us a little bit about dialectical behavior therapy? What are some of the major concepts or approaches when you are working with borderline personality disorder?

I got the sense that it is a combination of change and acceptance, but this is a population of people that are highly reactive and very punishing if they don't find it helpful—or even if it is helpful but it isn’t what they are expecting.

How does it work? What are your thought on how to develop it beyond that?

**Dr. Linehan:** The fundamental core is intervention. First of all, dialectical behavior therapy is a modular treatment. That means that there are all sorts of parts that you bring in or take out, depending on who you are treating.

For example, you don't have to keep doing the suicide module if you have a non-suicidal person.

The core strategy—that overshadow of the dialectics—means that you are always balancing acceptance with change. You always continue that.

But the mental core strategy, from the behavior of the therapist, is problem-solving with balance by validation.

Validation is when you communicate to the individual an actual understanding of their behavior—where they are and the causes of their behavior. In other words, all behavior is caused.

When you are paying attention to them, you are listening to them. You are reporting, “What you say is important to me.”

You are reflecting back accurately—you would be amazed how many therapists are inaccurate when they...
reflect back.

I have listened and watched many therapists: the client says one thing and the therapist says, “So you mean this...”

The client says, “No, I don’t” and the therapist continues to say, “Yes, you do.” You don’t do that in DBT. You try to read what is actually going on with them.

You look at how their behavior makes sense in terms of causes – in other words, “You have major depression, so it is understandable that you would be thinking in this way and doing this. It is due to the major depression, in other words, you aren’t a jerk. You aren’t terrible, or you are not this/you are not that.”

It is also finding what is valid. Therapists in DBT are required in all interactions to find something that is valid – you want to validate.

You don’t validate invalid behavior – although you can validate invalid behavior’s cause. In other words, all behavior is caused – it always is.

On the other side of this is acceptance and change – essentially, the therapist uses standard cognitive behavioral evidence-based interventions for problem-solving.

Now, you also have to teach the client acceptance and change.

We have a set of skills. Half of the skills are primarily acceptance – those are the mindfulness skills and we have a lot of those. We have mindfulness now in our new version – mindfulness that is straight psychological intervention and mindfulness from a spiritual perspective.

Then we have distress tolerance – and distress tolerance is how you tolerate things without changing them. How do you get through a crisis without making things worse? How do you radically accept the life that is not the life you want?

Many people, most people really, have to do that to a certain extent. There are parts of your life you just have to accept – you are not going to be able to change them.

From here, we teach two major sets of change skills. One set of change skills is emotion regulation, and the other is interpersonal effectiveness.
As I always say to therapists, the key for the treatment is this: if a client has a problem, you have to always remember to balance and give them a way to accept what is going on and a way to change what is going on.

We have some therapists who never give acceptance – they always give change. We have other therapists who never give change – they always give acceptance. So we say, “Look – you’ve got to do both.” There are always two things you can do with any problem.

We have a concept called “wise mind,” which comes straight out of both my belief that borderline patients in general are often treated as if they really are crazy – as if they have no capacity for wisdom, or as if they are somehow fatally flawed. I want to communicate to them how that is not true – they have the capacity for wisdom.

I made up the term “wise mind” – which I have to admit I made up – and that means that we all have the capacity of wisdom, and that means the clients do, too. I want to communicate that to them.

It is also very compatible with Zen and contemplative practices in mindfulness, which is that we all have access, at the center of our being – to wisdom, to the universe as a whole.

This is the idea that we are not separate – we just think we are. It is just an illusion that we are all separate.

“Wise mind” is a way to help them get in touch with, in effect, their true self – “Come home.”

There are a million poetic words for DBT. The mindfulness part of DBT has a lot of poetry, is behavioral, and uses a lot of technology.

We have a technology of acceptance and a technology of change – and DBT is all about putting them together, for both sides. The therapist has to do this every bit as much as the client.

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**How to Tolerate Distress**

**Dr. Buczynski:** I’d like to circle back to distress tolerance. Certainly from the borderline patients that I have treated, that is a critical area. What have you found that is helpful with teaching them how to tolerate
Dr. Linehan: I am sure you might be shocked by this if you don't know DBT, but one of the best ways to tolerate distress is to distract.

We actually teach— we are the only therapists I know of who don't tell them all the time to quit distracting, even though they often overly distract.

“But in a crisis, when you have an enormous urge to hurt yourself, kill yourself, cut yourself, use drugs or do something else, distraction can be extraordinarily valuable. So, we teach distraction.”

We teach self-soothing, which a lot of our patients have a lot of difficulty with because they have a belief that they don't deserve it.

We have another emotional skill which we call “opposite action.” We say, “You've got to practice opposite action. You must soothe yourself. You will never feel soothable unless you do it. You are not going to change these thoughts up there just by talking to yourself – this does not work.”

We teach how to imagine that the universe is different; in other words, it is where you imagine you are floating out in Hawaii on a beautiful day on a float...

Essentially, we have a lot of skills that psychologically take you out of the pain until it goes down.

We have urge-surfing, for example, which we picked up from Alan Marlatt (Professor of Psychology and Director of the Addictive Behaviors Research Center at the University of Washington).

Urge-surfing is a strategy to remind yourself that everything changes – everything goes away. I always tell clients, “You have never had an emotion that didn’t end – not even once in your whole life.”

This is the crisis survival part, and we also teach paced-breathing as a strategy.

“We have a lot of skills that psychologically take you out of the pain until it goes down.”

“We have some psychological methods of changing biology is what it boils down to – these are rapid interventions to bring down arousal. That is for when you are so upset you can’t process information.

When patients can’t process information, they can’t use the skills that we
have taught them, so we need a rapid way to get arousal down. We have a whole set of strategies for that.

**Dr. Buczynski:** Can you tell us one?

**Dr. Linehan:** One strategy is paced-breathing, which I think is one of the reasons why meditation works. With paced-breathing, you change your biology by breathing— you breathe in and then you breathe out longer than you breathe in.

When you breathe in, the sympathetic nervous system fires and arousal goes up. When you breathe out, the parasympathetic system kicks in and arousal goes down.

The trick is to do belly breathing so that you hit the vagal nerve, which jumps in the sympathetic nervous system. Then, you breathe out slowly, which brings in the parasympathetic nervous symptom.

You can get an app on your iPhone—probably on others, too, but definitely on the iPhone—called “Breath-Pacing.” It has an indicator that will tell you exactly how long to go up and how long to go down.

I don’t teach it that way—I have people look at a second hand and learn how to count. For example, my count is five in and seven out.

People learn how to count. I had one of my teenagers, who had gotten through our whole program and was really doing wonderfully just tell me when I asked, “What’s your favorite skill?”

She said, “Oh, paced-breathing, Marsha—I do it every day! I do it in meetings if I think people are going to say things that I don’t want to hear or I disagree with but I don’t really want to say too much. I get through all these difficult moments with paced-breathing.”

I have had clients—one, especially—who brought someone with her to a treatment session and she went outside at a break. Right as she did that, a car ran right into the other person’s car and crashed it.

She came back in just totally out of control, and I just said, “Sit down—paced-breathing.” I went with her right through her breathing, and she was down very quickly. It is very effective.

We have a number of these strategies that are very, very effective. They’re rapid-fire methods. That is just one of them and it’s easy to do—you can go and look it up on an app.
Another part is how to live a life that is not the life that you want, and that’s reality acceptance skills.

The only way to live a life that is not the life that you want is to radically accept what you have.

We teach radical acceptance – we teach willingness, we teach willing hands and we teach half-smiling, which came from Thich Nhat Hanh.

There are a lot of strategies that help you radically accept what is going on in your life. We didn’t used to have this, but we have started a whole list of, “Here are the things to do – to practice.”

What’s most important is that everybody has to know about acceptance and radical acceptance.

Radical acceptance means acceptance totally, from the top to the bottom. It is not superficial acceptance, which many of us can do. But the real problem with acceptance is to remember that you can’t make yourself be accepting.

If someone says to you, “Just accept it,” you can’t do it – you cannot make yourself do that. It is unbelievably invalidating to tell someone to accept.

It is also invalidating because it implies that you have no understanding whatsoever what they are going through.

What you have to say is: “Practice.” In fact, for all of our skills – and DBT is primarily a skills-training treatment – we say, “Practice your skills.”

Now, of course, therapists are practicing all the time. At my clinic, we are always saying, “What skills are you practicing?” or someone will say, “Practice your willingness, Marsha! Practice your willingness” when they know I am not going to like something.

We all go around saying, “What are you practicing?”

“Oh, I’m practicing this skill/I’m practicing that.” We practice our mindfulness – we practice all of our skills.

It is really important for me to communicate that telling people what to do is often experience-invalidating, but suggesting and telling people to practice is not – so you say, “Practice.”
If someone’s loved one dies, telling them to accept it is really problematic. But saying, “You know, you are really going to have to practice radical acceptance. I know that’s going to be hard.” That recognizes that it can take a really long time – so that is why we have another skill called “Turning-the-mind.”

Here’s what I mean by turning-the-mind. Have you ever noticed when you practice radical acceptance, you think you accept something and then about ten minutes later you are not accepting it?

A good example – mundane but nonetheless good – is when you look in your pocket for your keys and they are not there.

You start looking in other places, and about twenty minutes later, you look in your pocket again. In other words, you are not accepting that they are not there – you are back to thinking they could be there.

Dr. Buczynski: They should be there!

Dr. Linehan: Yes – they should be there, therefore you look again, but it doesn’t matter how many times you look – they are not going to be there when they are not there.

For everything in acceptance, that is how it often goes. You accept and then you are not accepting – you are accepting, and then you are not.

What it means is that you have to keep turning-the-mind back to acceptance.

Acceptance can take a really long time – and this is one of the important things that therapists with this population have to do. They have to recognize that they, too, have to radically accept – not only themselves as the therapist but they have to radically accept the client as they are and the pace as it is.

That doesn’t mean you don’t try to improve the pace and make things work better, because of course you have to.

Another characteristic of DBT is that it requires you to be on a team. The function of the team is to keep the therapist in an evidence-based treatment manual or to keep them in effective treatment.
Exposure Technique: Being Mindful of One’s Own Emotional Response

**Dr. Buczynski:** You have said that mindfulness to one’s own emotional responses can be thought of as an exposure technique. Tell us more about that – what do you mean by that?

**Dr. Linehan:** Many of our clients are phobic of their own emotions so they try to avoid them at all times. This is where cutting, trying to kill yourself, or overeating comes in – all these behaviors function to avoid emotions.

Mindfulness of emotions is a skill in our emotion regulation group. Mindfulness of emotions is when, if you are emotional, you try to pay attention and sense them.

Emotions are physiological sensations – there is a reason that they are called *feelings* – so mindfulness of emotions is to pay attention.

The real problem with individual criteria for borderline personality disorder is if you ask them to do that early in treatment, it is often more harmful than helpful because they can’t pay attention – they end up in all sorts of problematic behavior.

This is why DBT did not include meditation as a primary practice of mindfulness – in fact, that is how meditation got dropped. We discovered many of our clients could not do it.

In my Emotion Regulation program, it makes sense to do mindfulness of current emotions before you try to change them. When I first started this program, I found out that clients couldn’t do that until they could regulate their emotions, so I made that part last.

But now that I am rewriting my manual and doing a revision, which I am almost finished with, I thought, “Oh, well – I must have been wrong.”

I moved it back to the beginning again and the same thing happened! I had a person flat on the floor – just out of control. I said, “Okay, okay – stop this... I’ll move it to the end, back to when we do core mindfulness regulation of current emotion.

That is a good example of the problem with this particular population – they often cannot do mindfulness.

It is a shaping process: you have to give them other skills before you get them to this. It is like exposure in the sense that they have to be exposed to their emotions, meaning that they learn to tolerate them. They learn
that their emotions are not dangerous — they are not going to be hurt by them.

Most important, to be honest with you, is learning that if you pay attention to your emotions, they actually come and go — and our clients have a lot of trouble believing that.

“Most important is learning that if you pay attention to your emotions, they actually come and go.”

That is how I came up with the concept of “emotion mind,” which is when your emotions are totally in control. It doesn’t mean intense emotion because you can be very intensely emotional, but not be controlled by the emotion.

It is not so much how intense the emotion is, but whether it is in control instead of you — or, as we would say in DBT, instead of wise mind.

**Dr. Buczynski:** Do your patients end up believing that emotions can come and go?

**Dr. Linehan:** Oh, yes. The training is very effective, and what it is especially effective for is emotion regulation.

Also, the training is extremely effective for the expression of emotion. DBT is best at treating any out-of-control person because it regulates suicidal behavior, aggressive behavior, substance abuse, and eating disorders. It not only improves your emotions — a lot of treatments do that — but it improves your emotions and improves your action, the action component.

DBT essentially reduces avoidance of emotions, and in fact, once you stop avoiding, you discover that emotions come and go.

**The What and How Skills of DBT**

**Dr. Buczynski:** You have divided the core of mindfulness skills that you teach in DBT into “What” and “How” skills. Can you talk more about that?

**Dr. Linehan:** Yes. The first skill is “wise mind,” which is the notion of going with emotions and the notion that you are open to the universe if you do that. So that is the first one.

“What” and “How” have come from me thinking, “What are those teachers teaching me? If they are not
teaching me meditation, how to stare at the wall and how to walk slowly around a room, what are they teaching? I started trying to figure out, “What have I learned?”

I realized that I learned at least three skills. One is to observe, which is to notice, pay attention, and to be aware.

In meditation, you are often noticing your breath – there are many other things to notice, but noticing is observing. It is like contemplating – it is like looking at art – you are just looking at your mind.

You are looking at sensations; you are looking at what is going on. You are looking, and just as when you walk, you pay attention to your feet, you’re paying attention – observing.

You could be observing within, like in your body, which is primarily what you are doing in meditation or you could be observing outside of your body, which is not so much in Zen meditation – but it is in contemplative prayer. You can be observing a cross, or you can be observing a crucifix...

I divided observing into these parts, and that is the first skill – just learning how to observe.

And this is wordless observing, which is very hard! It took me four years to be able to observe without immediately saying what it was.

The second skill is describing. You learn describing in a spiritual world because you have either a teacher or a spiritual director who you then describe your experience to.

You have to describe the actual factual experience and no analysis of it – no interpretation and no getting into the meaning of it. My teacher used to say to me all the time, “Concepts, Marsha, concepts,” and he would ring the bell and I would leave.

I finally got to where I could actually describe. It turns out, loads of problems in life have to do with not describing – you’re interpreting, but you think you are describing.

For example, “My boyfriend hates me,” I’d say, “You can’t observe anyone’s emotions. No one can observe another person’s emotions.”

“Yes, I can. He does hate me.” I’d say, “Okay – what did he do that made you think he hates you?”
“I asked him for money and he wouldn’t give it to me.”

“I asked my boyfriend for money and he wouldn’t give it to me” is a description of what you observed. You could also say, “Then I observed the thought that was in my mind: my boyfriend hates me.”

Now, you have two things you could observe, but nobody has ever observed another person’s thoughts, feelings or motives.

“We teach people how to observe and how to describe what they observe.”

So we try to teach people how to observe and how to describe what they observe. That means you can describe, “I had a thought that you hate me/I had the thought that you don't like me/I had the thought that you’re angry.” That is the skill of describing.

You learn that at least in Zen with your teacher – but also in spiritual direction you learn that skill.

The third skill comes straight out of Zen, which is the question of participating. A participating skill is the skill of becoming one with. It is really based on the idea that we are all connected but our problem is that we don’t experience ourselves as connected.

Now, physicists – thank God for physics – can tell us we are absolutely right – we are all connected. It is not like you are teaching something religious here – the fact is: we are connected.

“We are all connected but our problem is that we don't experience ourselves as connected.”

But borderline patients, in particular, almost always feel unconnected. I always think of them as the ultimate outsiders – they experience themselves as outsiders. But the fact is they are not really outsiders – because there is no inside or outside. There is only one.

So, the skill of participating is to get people, instead of going to parties and standing over here, is to get them to throw themselves in.

Throwing yourself into things and becoming one with what you are doing gives you the experience of flow and that feeling of flow leads to peak experiences.

So that is the “What” when we’re talking about skills.

Then the question is, “How do you do all this?” In other words, how do you observe? How do you describe? How do you participate?
Now, the first is non-judgmentally. Now, observing non-judgmentally in the present is in every mindfulness book that exists – so DBT has this also.

Non-judgmentality, though, is extremely radical because it is saying there is no good or bad inherent in anything – good and bad is always in the mind of the observer. There is what is and then there is good and bad when we observe it.

So non-judgmental means to drop the good and bad – to describe what you observe and also say whether you like it or don't like it, whether you think it has dangerous consequences or not.

Judgment is shorthand, really, for a description of consequences. “This food is bad because the consequence, if you eat it, you will get sick.” Or, “Guns are good because the consequence of having a gun is that you can protect yourself if you get attacked,” or, “Guns are bad because the consequence of having a gun is that you will kill somebody that you shouldn’t have killed.”

It is always in the mind of whoever is watching. It is probably the most radical part of DBT and also the most radical part of Zen – although I always tell people, “If you are Christian, judge not lest you be judged.”

The idea, though, of being non-judgmental has nothing to do with being approving. In other words, if you don't judge something, it doesn’t mean you approve of it. It doesn’t mean you say it is good. You are not going from bad to good – the idea is not to go from bad to good; the idea is to give up good and bad and describe.

In the moment – I love this part of mindfulness– is my favorite. I love in the moment, because when you think about it, there is nothing but the present.

If you think about it and all the people watching this think about it, if you just think this moment, there is nothing except this moment. In the very moment that I said that, that moment is gone.

So, yes, eternity is now – because this is everything that exists, and it exists right now. Always this moment exists – that is everything. I love thinking about this because it is like a miracle.

We teach that and we also teach the notion of not only being in the present but doing one thing at a time – in other words, no multitasking.

Actually, it doesn’t work well with anyone I teach. The teenagers want to text everyone in their group all the
time, and the parents want to multitask because they believe it is more efficient.

The research data states that multitasking is not more efficient – it is less efficient. However, I wouldn’t say we make huge progress.

But we make a lot of progress with the idea that, “Don’t suffer the past in the future.” As I say to my clients, “You’ve got enough suffering now. Adding past suffering and future suffering on, this is too much.” So you can get that one across.

To non-judgmental and in the moment, I added the concept of effectiveness.

Now, effectiveness came from Zen, and Zen talks all about enlightenment, where you get enlightened and you are joyful and it’s all wonderful. There’s a story in Zen that you then go sit on top of a flagpole and are just luxuriating in this experience.

But the problem is, of course, you can’t do that – you have to eventually come down, go to the grocery store, buy groceries, go home and cook some food.

Ultimately, that means that you have to be effective...What we taught was the concept of being effective over being right – it is the notion of “Be careful about being right when it interferes with being effective.”

Now, I have another skill – this one, effectiveness, pretty much has to do with you being effective, and there is another skill in reality acceptance, which is willingness.

Willingness is when you throw yourself into the universe as a whole – you are worried about the whole universe being effective, so you are willing to do what is needed for the universe’s whole.

Effectiveness is more focused – not completely – but more focused on effectiveness for yourself. Just because the other person is wrong doesn’t mean you have to stop being effective. The idea is to give up having to be right.

Those are the fundamental mindfulness skills that then go together with reality acceptance, willingness, half-smiling, willing hands – I should teach you all willing hands because it is one of my most fabulous skills.

“Willing hands is when you put your hands like this – you put your palms up. Everyone should just try this – it turns out that it is extraordinarily hard to be angry with willing hands.”
We haven't done a research study on it, but we have had so many people tell us it’s hard to be angry with willing hands. So, I say, “Just do willing hands when you get angry.” Willing hands is the opposite of angry hands, which is a clench.

We teach all our clients, “If you get angry, and you try to control yourself – just do willing hands. You can put them on your thighs; you can stand up and put them next to you if you are lying down.” It is just palms up – it is a very interesting skill.

It goes along with our skills of opposite action, which is if you want to change your emotion, act opposite to the emotion.

Dr. Buczynski: Can you give us an example?

Dr. Linehan: Here’s one: “I’m afraid to go to school/to take a test because I might fail it.” If it is likely that you are going to fail it, then the strategy would be problem-solving, which is to study a lot.

But let’s say you have already studied a lot, but you are just nervous and anxious. Then the thing to do is go take the test.

It all depends on whether or not your emotion fits the facts. If your emotion fits the facts, is a little bit like if there is a deadly snake in your office and you are afraid to go in, your fear fits the facts – you don't go in. You call an exterminator to come and get the snake.

On the other hand, if there was a snake in your office yesterday and you know there is not a snake there today, but you are still afraid to go in, then you go in.

This all comes from the strategies of prolonged exposure treatments where you do the things you are afraid of so that your brain gets the information.

You can go through all of the emotions: the opposite action for anger is to treat people a little bit nicer or leave softly – don't slam the door in other words. You start acting kinder and trying to understand the other person.

We have opposite actions for all the emotions. We have a number of skills that are extremely effective, and that is one of them.

Our data is beginning to suggest that the most important part of our treatment besides the therapist using all
the strategies of DBT is the skills training.

To do skills training, you have to do acceptance and change – you have to be able to validate, problem-solve, and use all the strategies of DBT.

**An Interesting Study Using DBT**

**Dr. Buczynski:** Tell me about an interesting study that has been done with DBT.

**Dr. Linehan:** There are a lot of them. One of our best ones was a study by Alan Fruzzetti and Pistorello. They did a study of college students who were suicidal.

They compared DBT to a psychodynamic therapy. The graduate students were doing the treatments, but in both of them, there was very good supervision.

They found that DBT was superior and we do suicidal behavior much more, with hospitalizations...

But the most interesting part of it was they also looked at the difference in validation, and they found that both treatments validated equally, but DBT validates only the valid – in other words, only behavior that really fits the facts. They gave feedback, corrective feedback, on others.

In the psychodynamic therapy, there was not the corrective feedback; they validated both valid and invalid, without giving corrective feedback.

So what it means is: don't validate everything – we really learned from that. The secret is not to validate everything, but a lot of therapists think, “Okay, I’ll validate everything – I can’t tell them anything’s wrong – I can’t correct them on anything.” But the study shows that you really have to – it makes a call for dialectics where you have to put the validation and the invalidation in.

**Correcting the Facts with DBT**

**Dr. Buczynski:** Tell me, how do you language that? How do you correct the facts?
Dr. Linehan: You can certainly say, “That doesn’t fit the facts in the slightest.” DBT is very blunt, but it can also be very soft. It can say, “Do you really think that fits the facts? Have you checked the facts?

Check the facts is another skill. Have you checked the facts?” You could ask them in that way. Or you can say, “That’s nonsense. That no more fits the facts than the man in the moon!” The DBT therapist might say that as well.

It’s all in your tone of voice and how you say things – if you are sarcastic or mean-spirited, then no – you can’t say it.

Dr. Buczynski: Have they already been taught to check the facts?

Dr. Linehan: Yes. Everybody learns how to check the facts. They learn how to say, “Does my emotion fit the facts?”

Often emotions do fit the facts, and when they fit the facts, you want the emotion – it’s useful. You just don’t want the emotions that don’t fit the facts if they are causing you harm. If they are not causing you harm, they’re okay.

The main treatment study we have is DBT – we did this here at the University of Washington. It was published in 2006, but it is probably our most important study. We compared dialectical behavior therapy to treatment by experts in the community.

We got all the top clinics to nominate for us the most expert therapists in Seattle, and they became the therapists. We told them to do expert therapy – whatever they wanted and as much as they wanted.

They could see patients as often as they wanted, they could do any therapy they wanted, but we wanted them to do what they thought was the best therapy. We compared that to DBT.

DBT cut suicide attempts by fifty percent. It cut in-patient hospitalizations by over seventy percent. It also cut going to emergency rooms for suicidal behavior by fifty percent. It was more effective in reducing substance dependence and a number of other disorders.

DBT gets behavior under control and it saves money by keeping people out of healthcare services.
Dr. Buczynski: DBT has now been used not just with borderline personality disorder, but also with people who are substance abusers. When did you start developing or broadening it to other conditions?

Dr. Linehan: My research primarily has been borderline personality disorder. Other people have done most of the research on broadening it, and I am really happy that they have.

To be honest with you, people don’t even like talking to me in a grocery store because someone might think they have borderline personality disorder!

I have people who say, “I don't want anyone knowing I’m seeing you for therapy – they are going to think I have borderline personality disorder.” I say to them, “You know, I treat a lot of other things.” But they say, “Oh, no, no – I don't want anyone to find out.”

Borderline personality disorder has the most prejudice aimed at it. It is the most stigmatized disorder we have.

What is really good now is that DBT is being looked at for other disorders.

DBT skills have been shown to be effective for treatment-resistant depression. We have a version now that is effective for anxiety disorders. It is effective for straight emotion regulation problems without borderline personality disorder.

DBT is moving further and further into other disorders and that is good because it takes a lot of the stigma out of getting the treatment.

The skills themselves we are now teaching to friends and family – people without any disorder. The skills are going into the school systems and they are really moving. We have people wanting to bring them into the business environment.

It is a little like the way mindfulness is going everywhere – into business and medical schools and all over the place. DBT skills – not the entire treatment, but the skills – are beginning to move in the same way that mindfulness has.

We don't have lots and lots of research – there may be ten or fifteen studies, something like that but not a
lot. I would like there to be more – although obviously there are a lot compared to other treatments.

Adapting the Skills of DBT to Treat Obesity

Dr. Buczynski: Our country is facing almost an epidemic of people who are overweight and what is now being referred to as “diabesity.” Yet those are behaviors that are so, so hard to change especially when we throw in a sedentary lifestyle along with it.

If you looked at people with those behaviors or conditions, they would probably all agree that they should change and yet somehow find it very challenging and difficult to do so.

I was wondering what you thought about someone adapting DBT to that kind of suffering?

Dr. Linehan: The good thing about DBT for that group is that DBT incorporates validation as a core strategy.

What you have to do with people who are obese is put a lot of validation into the treatment. All disorders are biological and behavioral – none of them are behavioral alone.

Part of the problem of those with weight problems is the prejudice against them – the beliefs that they just don't care, they don't want to lose weight, and they are not trying. Being asked, “What don't you do it?” makes it even more difficult to make an effort.

DBT definitely has the behavioral aspect of treating the disorder of obesity, but it doesn’t have the biological part.

For some people, a behavioral part would be sufficient, but there are many people, for whom we are going to have to come up with new solutions, and I don't think DBT will be the solution – but it can be is helpful on the behavioral arena.

DBT skills certainly can be taught anywhere really – and the person who has to learn the skills is the care provider. Once you know them, you can teach them.

When someone comes into your office and they say they've got this or that kind of problem, you can say, “Try this” and you can give them a handout.

My revision, which has all the new skills, should be out in about a year, and you will, I think, be able to get for
I tell therapists all the time—“Get the skills and the training handouts. Put them in your office, and then when someone comes in, when a skill is relevant, you just pull out the handout, and you give it to them. You have one yourself, and you go over it in five minutes.”

All of them—if you know them—are very easy to teach. Most of the skills are very effective. I say all the time, “There is no skill that works for everyone and there is no one that a skill won’t work for.” Every skill works for someone.

**DBT and Its Impact on Living Our Lives**

**Dr. Buczynski:** Let’s for a moment take DBT out of conditions and look at how it might affect living our lives. For example, how might DBT deal with the issue of procrastination or people hoping to achieve goals that they never seem to do? Would DBT be a way to help them make these kinds of changes in their lives?

**Dr. Linehan:** Yes—and that is because it has such good behavior therapy. If you know how to do behavior therapy, it is very effective for procrastination…

The real problem with behavior therapy, to be honest with you, is many people have taken rather superficial courses—maybe just one course—and they don't learn to think like a behaviorist.

If you can think like a behaviorist and do behavior therapy, it will work for procrastination.

DBT brings in validation. DBT was unique when I developed it, but it is not unique now. Validation is in every therapy now, as far as I know.

Everybody now realizes the importance of validating the other person. A lot of people are afraid to validate—parents in particular, and a lot of therapists, too. That is because they think, “If I validate your crying, you will cry more.” But in fact, if you validate the crying, they will cry less.

*Everyone* listening to this can learn validation.
Procrastination can be treated with behavior therapy and you don't need a whole program like DBT. You don't even need all the skills – what you need is just the behavioral components.

DBT is like a little set of blocks – like twenty blocks. You just pick the blocks and take them...

**Dr. Buczynski:** You can take two or three or more or less...

**Dr. Linehan:** You take two or three blocks here and twelve blocks there, or this block there, and that block there. It is very modular. It is an in-and-out sort of treatment. That is what I think makes it very flexible, and that’s what you need – a flexible treatment in the real world.

### Apps for DBT

**Dr. Buczynski:** We don't have a lot of time left, but I know that some smart phone apps have been made... Can you tell us what they do?

**Dr. Linehan:** Actually, we are developing a lot of them. I haven't tracked other people, but I’m sure other people may have developed some, too. We are definitely developing ones that are skill coaches.

Generally, the apps that are going to be useful to people are skill coaches, skills tracking, and diary cards. DBT very much focuses on tracking behavior over time.

We are finding out in all treatments, and this isn’t just with DBT, that if you are tracking outcomes and talking about progress every week, and you show the patient their progress, you get better outcomes than if you ignore whether the person is changing or not.

So, we are putting out a number of apps. I am not so aware of other people’s, but I think probably one new app a day is going to be developed somewhere by somebody.

The trick here is to try them to see if they are helpful. If they are, use them. I think that’s great!

“**The apps that are useful to people are skill coaches, skills tracking, and diary cards.”**

The military is trying to develop some, too, and those are always great because they are free – and they are very good at developing those. This is one of their great talents.

**Dr. Buczynski:** There’s the multiplication factor – they are able to
multiply the impact – try it here and then it goes to a regiment and further.

**Dr. Linehan:** Yes, exactly. There is a lot out there. In fact, the best place to find a zillion things on DBT is simply to go online and look up *DBT*.

There are all kinds of websites with skills coaching. A lot of them are *really* wonderful. I love some of them! They tell you how to use the skill, and they have new ideas for using skills.

For people listening, go look at what is there and encourage your clients to go as well.

I don’t run any of these websites, but former clients – not of mine, but of other therapists who have gone through DBT and really liked it – put things up.

With most of it, there is very little that could be a problem... Just about everything I have seen most clients would find creative, useful, helpful, and sometimes funny. It is all on the skills of DBT, primarily, and the skills are the core of the treatment.

**Dr. Buczynski:** I’m sorry, we are out of time. There is so much more I would love to ask you about this and about applications that have been or could be done.

You are a creative person who has really developed some very, very important and precious skills/approaches. They really have made a difference to a *lot* of people who suffer, and whose suffering causes suffering for other people.

I just want to say thank you for all your work and your contribution to our field and to helping us find better ways to treat borderline personality disorder.

You are right – there is a lot of prejudice, and you have found a way to help people and your teaching of others about how to help patients is a huge, huge contribution.

So thank you very much. I appreciate the time today.
About the speakers . . .

**Marsha Linehan, PhD** is a Professor of Psychology and adjunct Professor of Psychiatry and Behavioral Sciences at the University of Washington and is Director of the Behavioral Research and Therapy Clinics, a consortium of research projects developing new treatments and evaluating their efficacy for severely disordered and multidiaagnostic and suicidal populations. Her primary research is in the application of behavioral models to suicidal behaviors, drug abuse, and borderline personality disorder.

She has written four books, including Cognitive-Behavioral Treatment for Borderline Personality Disorder and Mindfulness and Acceptance: Expanding the Cognitive-Behavioral Tradition.

**Ruth Buczynski, PhD** has been combining her commitment to mind/body medicine with a savvy business model since 1989. As the founder and president of the National Institute for the Clinical Application of Behavioral Medicine, she’s been a leader in bringing innovative training and professional development programs to thousands of health and mental health care practitioners throughout the world.

Ruth has successfully sponsored distance-learning programs, teleseminars, and annual conferences for over 20 years. Now she’s expanded into the ‘cloud,’ where she’s developed intelligent and thoughtfully researched webinars that continue to grow exponentially.