



History of Dialectical Behavior Therapy

Stephanie Vaughn, PsyD

My name is Stephanie Vaughn and I'm a Clinical Psychologist in Nashville, Tennessee. I am a Dialectical Behavior Therapy–Linehan Board Certified Clinician and I own a private practice in Nashville in which we conduct DBT as much as possible to fidelity on adolescents, adults and families in addition to other cognitive behavioral therapies. I founded and continue to run the Vanderbilt University's Dialectical Behavior Therapy Peer Consult Team and serve as a consultant to a variety of hospitals and schools. I am an Affiliate Professor of Vanderbilt Psychiatry and an Associate Professor of Vanderbilt Counseling Program.

Dialectical Behavior Therapy



Founder:
Marsha Linehan, PhD



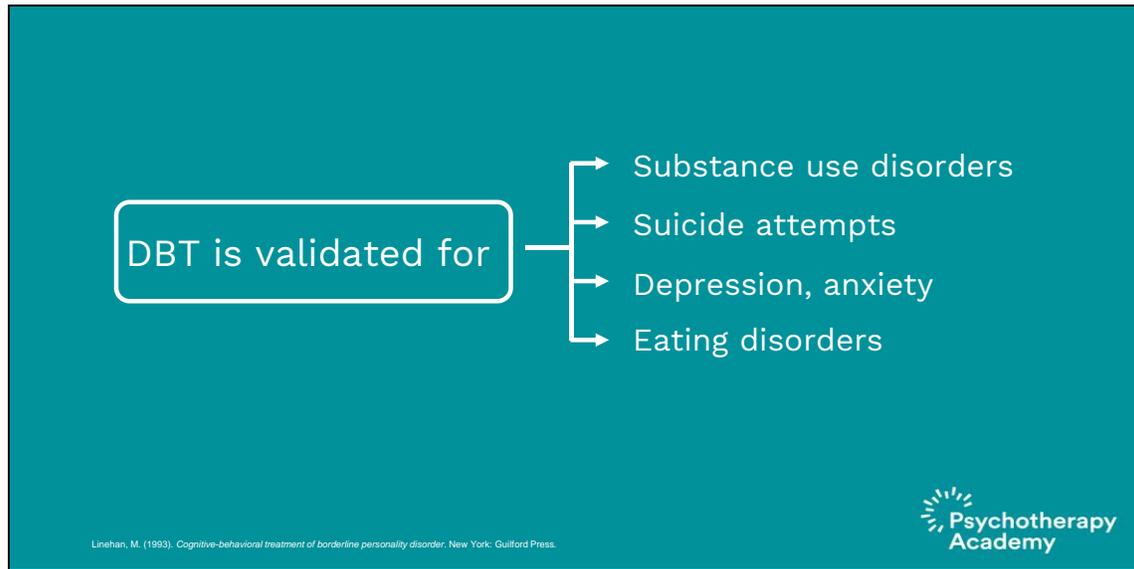
Effective for Borderline
Personality Disorder

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.



DBT was originally founded in the late 1970s by Marsha Linehan who was a suicide researcher at the time. She actually did not know anything about borderline personality disorder but came to find out about later.

DBT is well known for treating borderline personality disorder. Linehan found that there was support for the use of dialectical behavior therapy with borderline personality disorder but today it's almost a faux pas to suggest that DBT is only used to treat borderline personality disorder.



In fact, it's been empirically validated for a variety of different populations and issues including substance use disorders, suicide attempts, PTSD, self-harm, symptoms of depression and anxiety, eating disorders, that's including binge eating and bulimic tendencies. There is less evidence supporting anorexia.

Decrease in frequency rate and length of hospitalization

- Adults
- Adolescents

· Both genders

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Frequency rate and length of hospitalization have been shown to decrease repeatedly in different studies that have been conducted on DBT. And it's also been supported with not just adults but with adolescents. Women are the primary gender in which DBT has been supported with but there has also been some evidence that it's helpful with both genders. And so it's no longer associated just with borderline personality disorder in women.



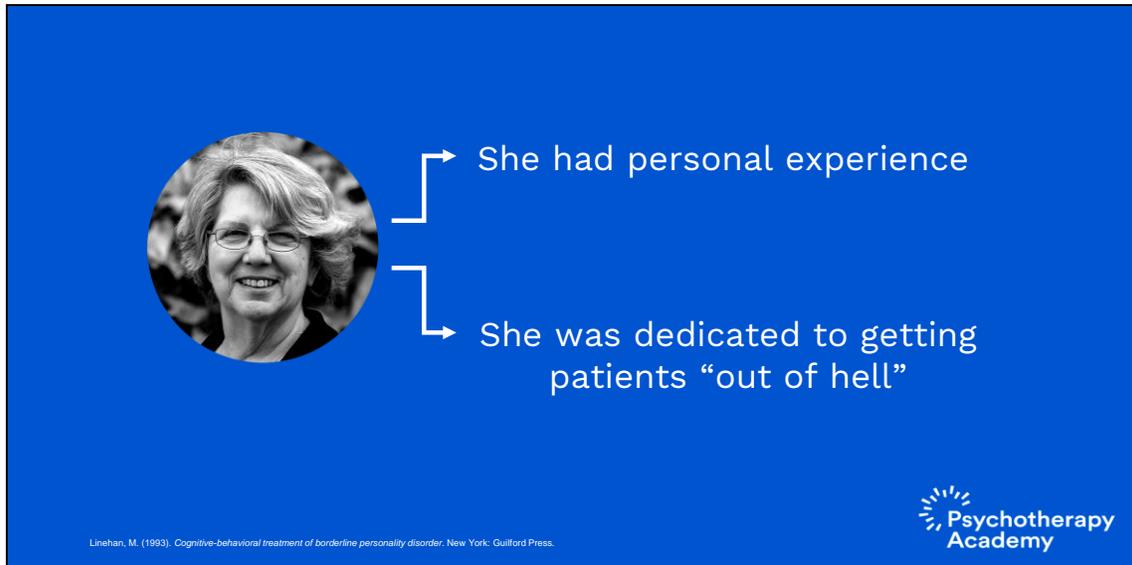
In the '70s when Linehan first started working with suicidal individuals, she tells about how it was easier to get grant money because she was the only one who was doing randomized controlled trials with suicidal individuals. Her research team would call the hospitals in the area and ask them to send her the most severely suicidal and self-injuring populations and they would do so.

And she would try to, as she says, cure them with behavioral therapy.

But what she found was not only it wasn't enough but oftentimes it was extremely aversive to the patient and they would quit treatment and they would get angry.

In the '70s and '80s, behaviorism was popular but also the humanistic approaches were also dominating at the time. And so she thought well, maybe there's something to this humanistic approach. Behaviorism has a reputation for being fairly sterile and cut and dried. She was willing to take a step back and consider that this other approach, humanism, would be more a appropriate stance. And so she tried it. And that didn't go well either.

If we look at humanism or the humanistic approaches as being at one end of the continuum and we look at behaviorism as being at the other end of the continuum, they're fairly opposite. And so she went from one treatment to another almost in a black and white fashion, from one end of the continuum to another and found that neither was effective.



She had personal experience

She was dedicated to getting patients “out of hell”

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.

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And so Linehan very much wanted to help this population. She had her own struggles with mental illness. She came out in the New York Times over the last few years and acknowledged that she had severe mental illness when she was in her late teens. And she’s one that had a personal interest in helping all of the patients that she saw. And so she was dedicated to, as she would say, getting them out of hell. She felt like the population she was working with was in hell and she wanted to be able to get them out any way that she could. So she wasn’t particularly tied to a model of psychotherapy.

Behavioral therapy

Model of change

*"This is **my** fault?"*

Humanistic approach

Reflection and validation

Being supportive

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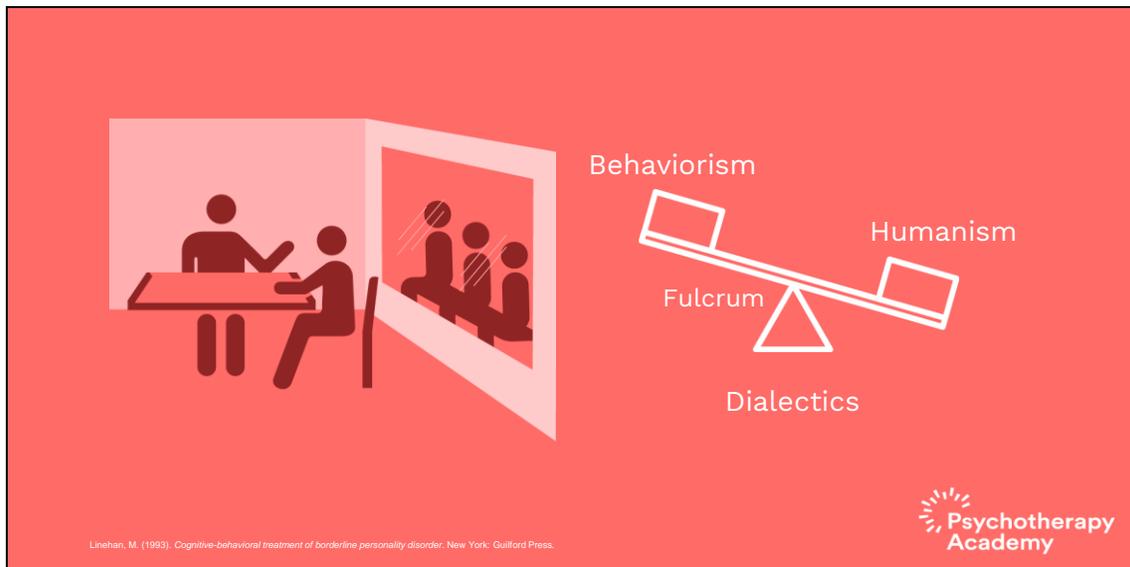
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When she was trying behaviorism, the patients would respond feeling like the therapist was saying that they were the problem.

Behaviorism is the model of change.

When she would give feedback about ways that they could change and improve their symptoms, they felt like she was saying that it was all their fault. So the response was: What are you saying? This is my fault? What about my employer? What about my kids? What about my spouse? What about the environment that I'm living in that makes it extremely difficult for me to get better?

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And in trying to figure out what works, she had her research team watch through a one-way mirror so they could see in and Linehan and the patient couldn't see them. And they would take notes. Linehan would just try to do what worked. So she would do a little of this and a little of that and the team would take notes. And what they found was with certain things that she would say or do the patient would get upset and then other things seemed to be more regulating. What they found wasn't a third theory. It wasn't something totally different. It was more of a movement or a blend of the two. So instead of doing just behaviorism, instead of doing just humanism, we were moving back and forth between the two. But the fulcrum between the two, the thing that helped to balance those two seemingly opposite theories was dialectics.

Non-pejorative stance



Zen influence

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The origins of the theory involved a non-pejorative stance. Instead of painting the patient as the problem or calling them manipulative which is a typical pejorative term that's used with individuals with borderline personality disorder, the approach was one of equals between therapist and client.

Her balance between CBT and humanism was also influenced by her Zen training. DBT was actually almost called Zen behavior therapy. Linehan is now a Zen master. And when she was training back then, she found that a lot of the principles she was learning in Zen and in her meditation were applicable to her population and mindfulness being one of them.

Key Points

- DBT was developed in the 1970's
- Marsha Linehan had personal experience with mental illness
- DBT was the first psychotherapy to formally incorporate mindfulness
- DBT is not just for severe populations
- DBT balances CBT and humanism with dialectics

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.



The key points are as follows: DBT was developed in the 1970s. Linehan had personal experience. DBT was the first psychotherapy to formally incorporate mindfulness. DBT is not just for borderline personality disorder or severe populations. DBT combines strategies from cognitive behavioral therapy and humanism. DBT balances CBT and humanism with dialectics. There is a heavy zen influence in DBT.

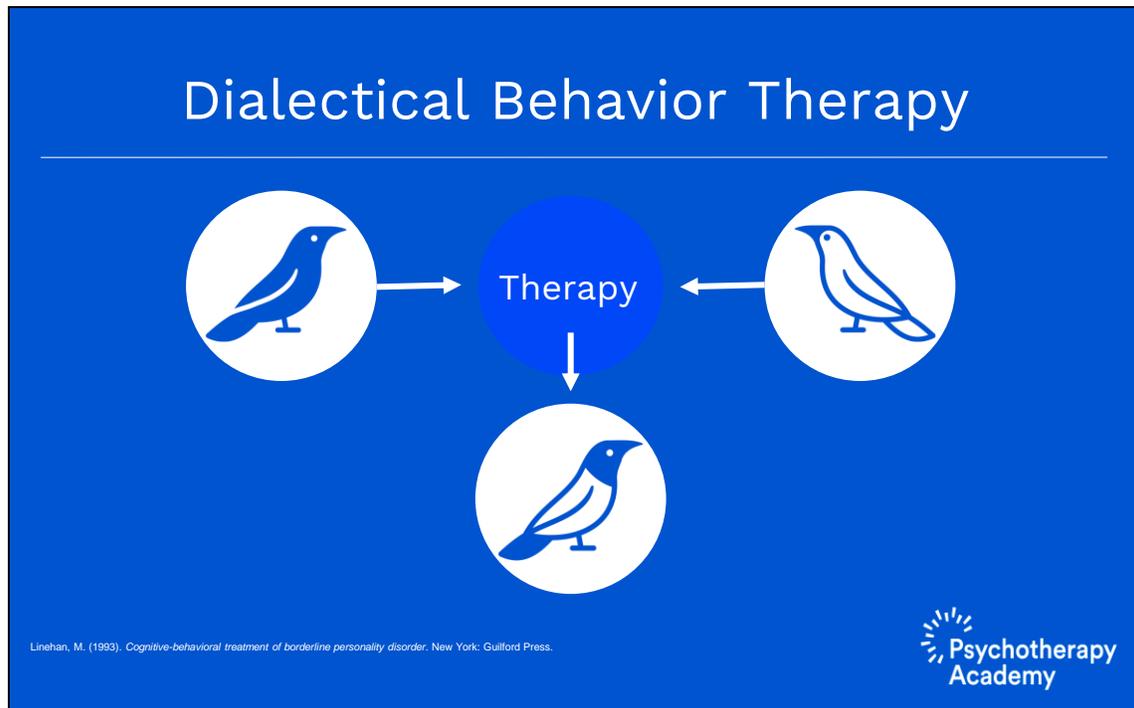


Next Presentation: What is the Meaning of Dialectics in DBT?



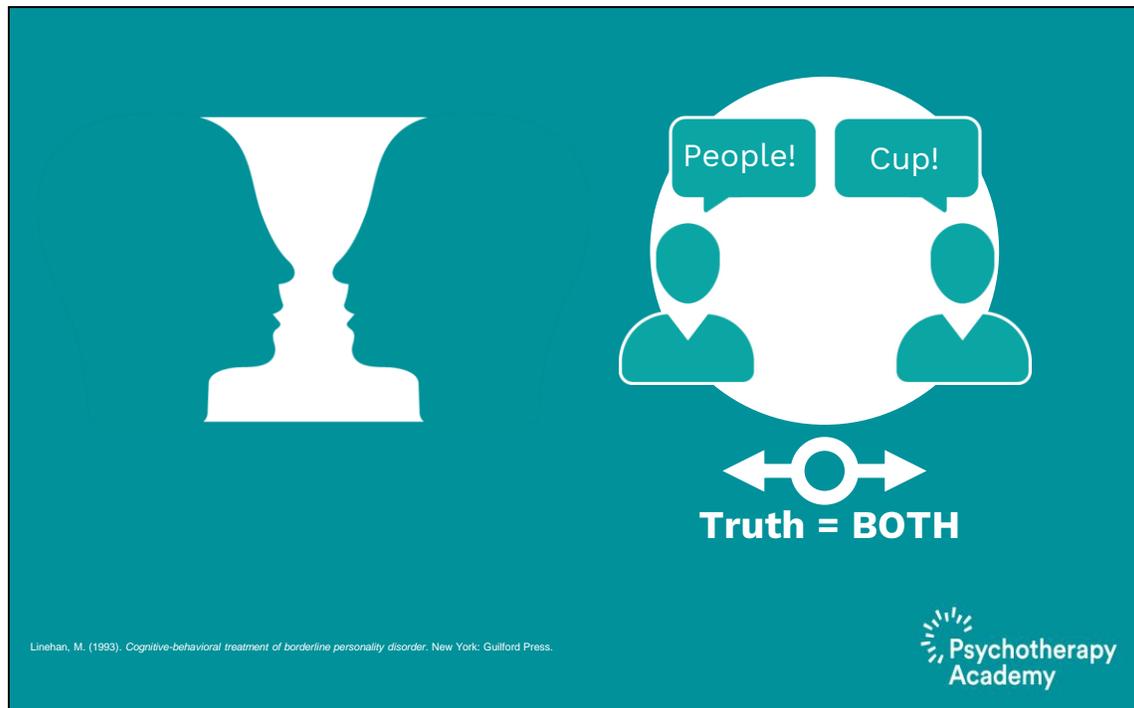
What is the meaning of Dialectics in DBT?

Stephanie Vaughn, PsyD



What is the meaning of Dialectics in DBT?

Dialectics as it applies to dialectical behavior therapy involves the therapist's stance in helping the patient bring together seemingly opposites throughout therapy reconciling some of the conflict that happens both within themselves and in the therapeutic relationship.



Dialectics is if you've ever seen any of the visuals, the optical illusion pictures where you can see multiple pictures in one, sometimes you can see two, sometimes you can see three, that would be a dialectic. The reason is because if one person looks at the picture, they might see two people looking at one another. And if another person looks at the picture, they might see a cup in the middle. But the truth lies somewhere in the middle or more so of a combination.

So there may be both a couple looking at one another and a cup in the middle and then there is the gestalt of the entire picture. So it's not two people looking at one another. It's not a cup in the middle. It is both at the same time. And so an optical illusion like that would be an example of a dialectic.

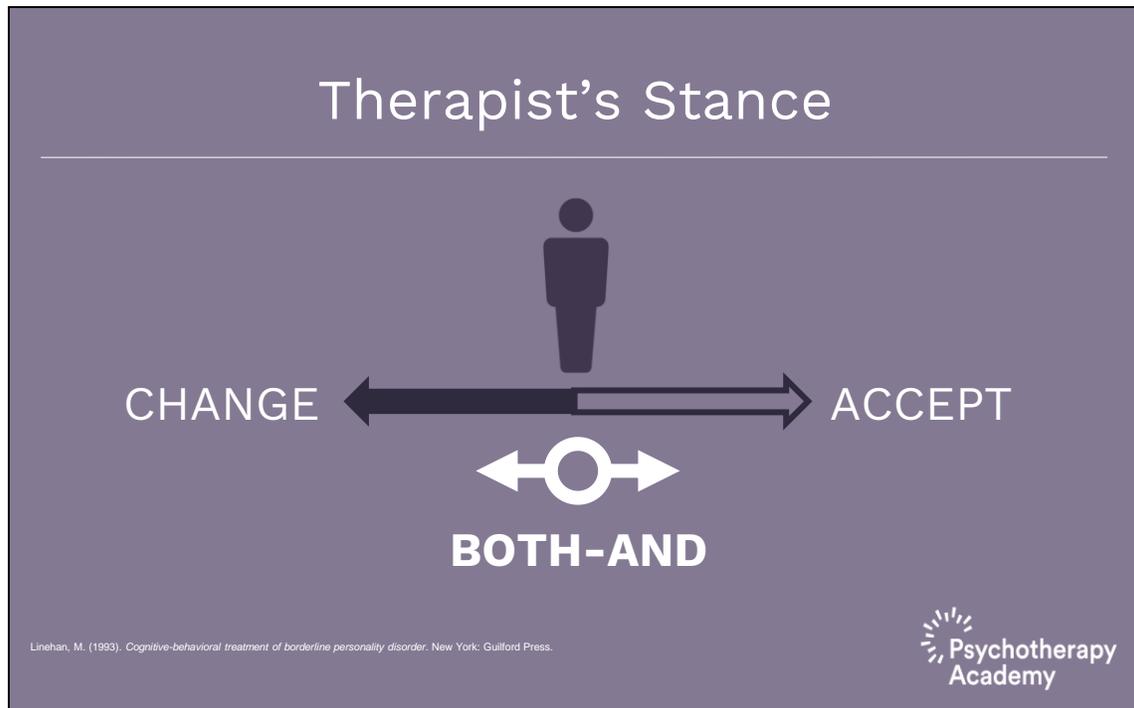
How does that apply in therapy?



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So how does that apply in therapy? Some of the common dialectics with DBT clients would be the client seeming to want to die and seeming to also not want to die. Some of the mistakes that non-DBT therapists will make -and DBT therapists also- are trying to figure out which it is. Does the client want to live? Or does the client want to die? And that's not taking a step back and looking at the entire picture. The client both wants to live and to die at the same time. How can that be? If you have ever wanted to get in shape, if I were to ask, "Do you want to get in shape?" you might say yes and no. So we can recognize those dialectical dilemmas within ourselves. Part of being a DBT therapist involves identifying when we get fixed on one end where perhaps we're saying the couple looking at one another, and our client gets fixed on the other end, they see a cup. And then we're arguing between ourselves about whether it's a cup or two people looking at one another. Is the dress blue and black or is it gold and white? Those are examples of dialectics because it's in the eye of beholder or in the ear of the beholder as to which you hear or which that you see. But the truth, it exists. There is truth in both sides.



The therapist's stance again fluctuating between change, trying to change the patient and trying to accept the patient at the same time. Those seem to be at opposite ends of the spectrum.

Well, which is it? Are we trying to change the patient? Or are we accepting them as they are in this moment? It's both-and.

Both-and is a common refrain in dialectical behavior therapy. We replace the term but with and. You may see DBT patients who have been in treatment for a little while revise a statement that they've made using "but" and replace it with "and" because there's been so much practice of that.

Dialectical Dilemmas

Under-regulation



EMOTIONS



Over-regulation



Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.



The dialectical dilemmas are behavioral patterns that are recognized in therapy. The therapist will notice certain dilemmas that are common for patients with borderline personality disorder and other patients as well that come up in therapy that need to be resolved. It involves both over and under regulation of emotional expression. Resolving these is the task of therapy. The dialectical dilemmas are one of those things that are more difficult to explain and thus would need to be gone into more depth in another section.

Key Points

- Dialectics and DBT involve bringing together **opposites** in considering what's being left out.
- **Dialectical dilemmas are behavioral patterns noticed in individuals with BPD. The patient fluctuates between two ends of each dilemma.**
- Balancing the dialectical dilemmas is a task of **therapy**.

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Our key points are that dialectics and DBT involve bringing together opposites in considering what's being left out.

Dialectical dilemmas are behavioral patterns noticed in individuals with BPD. The patient fluctuates between two ends of each dilemma.

Balancing the dialectical dilemmas is a task of therapy.



Next Presentation:
Biosocial Model in
DBT
How Symptoms Arise and Are Maintained

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Biosocial Model in DBT

How Symptoms Arise and Are Maintained

Stephanie Vaughn, PsyD

Biosocial Theory in DBT

The diagram illustrates the biosocial theory in DBT. On the left, a key labeled "Symptoms" points to a box labeled "Problems" which contains a person and a maze. On the right, a person with a DNA helix is labeled "BIO: INBORN", with "Emotional sensitivity" written next to it. Above the person are five icons representing different emotions.

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Biosocial theory in DBT is the underlying theory which explains how symptoms arise and how problems continue not just with borderline personality disorder but in a variety of different psychopathologies within DBT.

Biosocial model, the bio part of biosocial model involves the idea that emotional sensitivity is inborn. We all have different sensitivities in terms of our skin. We are more or less sensitive to the sun, more or less sensitive to detergents, perfumes, etc. We have biologically born sensitivities when it comes to our digestion, what we can eat and what causes us more difficulty. The same is thought to be true with our emotions.

We are born more or less sensitive emotionally and that is not something that can be necessarily changed. That's something that is part of your genetic makeup. That alone is not enough to cause difficulties.

Invalidating Environment

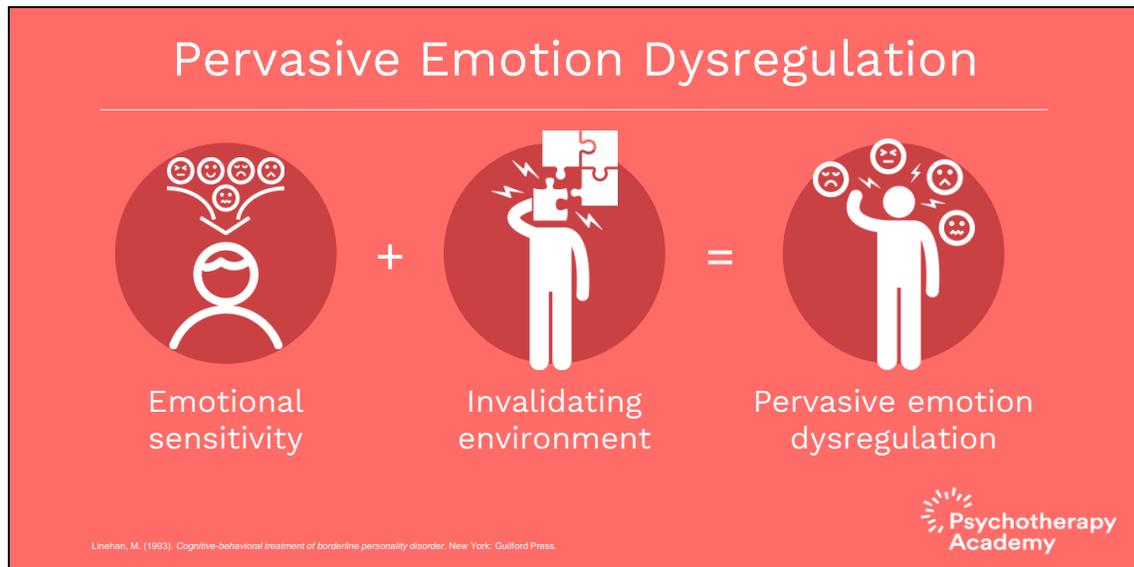


- Transactions over **time**
- Individual does **not fit**
- May or may not be **abusive**

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So in DBT, the idea is it's the transactions over time with what is referred to as an invalidating environment that causes the trouble.
An invalidating environment is one in which the individual doesn't fit. An invalidating environment can be abusive, but doesn't have to be abusive.



When you have a person who is biologically born to be emotionally sensitive and you have them in an environment in which they don't fit, the transactions that happen over time lead to emotion dysregulation due to the reinforcement patterns that occur.

The core issue in DBT is pervasive emotion dysregulation. One of the ways that you can identify a patient that DBT is going to benefit is if their core characteristic is that they have emotion dysregulation.

I think of emotion dysregulation as being a thermostat that wouldn't hold steady, so particularly sensitive to distressing circumstances, seem to feel things more intensely than others. When a person is in an invalidating environment, it's almost like being born gluten intolerant and being born into a family of bakers. That would be a very difficult situation to be in. The person could not help that they were gluten intolerant or gluten sensitive. And the bakers, they're not abusive or there's no problem with being a family of bakers. But the problem comes in the combination of the two.



When we have families or spouses who would ask, “Whose fault is it? Or why is it this way?” DBT considers it a no-blame model. It’s not the person who is coming in for treatment that’s to blame. It’s not the family that’s to blame. It is the transactions between the two that cause a problem. Invalidation in the environment maintains and may exacerbate the biological sensitivity of the individual. And patterns tend to arise between the two so that when they come in to treatment part of the treatment itself involves identifying and changing up these patterns that have led to the exacerbation of symptoms.

Key Points

- DBT's biosocial model is the theory of how symptoms arise and are maintained. It is a **no-blame model**.
- Equation for the biosocial model: **emotional sensitivity** plus an **invalidating environment** equals pervasive emotion dysregulation.
- Emotional sensitivity is **inborn**.
- An **invalidating environment** is one in which a person does not fit. It does not have to be an abusive one.
- The biosocial model is **transactional** in nature.

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.



The key points for this talk are that DBT's biosocial model is the theory of how symptoms arise and are maintained. It is a no-blame model.

The equation for the biosocial model is emotional sensitivity plus an invalidating environment equals pervasive emotion dysregulation.

Emotional sensitivity is inborn. An invalidating environment is one in which a person does not fit. An invalidating environment does not have to be an abusive one.

The biosocial model is transactional in nature.



Next Presentation:
Structure of Standard DBT



Structure of Standard DBT

Stephanie Vaughn, PsyD

Pre-Treatment

2-3 sessions



- 1 year in therapy (adults)
- No self-harm / suicide

DBT ≠ Other Therapies

- Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.
- Miller, A. L., Rathus, J. H., & Linehan, M. (2007). *Dialectical behavior therapy with suicidal adolescents*. New York: Guilford Press.



The structure of standard DBT involves a pre-treatment period of time.

This is when the patient and the therapist determine whether they can work with one another and whether the patient is willingly entering into a DBT plan.

The first two to three sessions, the therapist and the client are discussing the terms of DBT, how it's different from standard therapy or CBT and they're discussing the DBT's patient and therapist agreements.

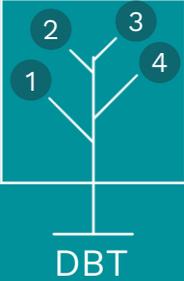
The most significant parts of those agreements involve the one-year term gentlemen's agreement to stay in therapy. One year is the minimum requirement for engaging DBT with adults.

Another significant agreement involves the client taking self-harm and suicide off the table for a period of time. Taking it off the table does not imply that a client will be terminated if they do engage in self-harm or have a suicide attempt. More clarification on the therapist and patient agreements will come later.

Stage 1



Behaviors
under control



DBT

- Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.
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Once pre-treatment has passed and the agreements are signed, then the patient would enter into stage one.

Stage one is the most well-known phase of DBT. It's the one that's most talked about and it involves getting the patient's behaviors under control.

There are four modes of therapy or there are four modes in DBT. One involves individual therapy.

Individual Therapy


1



- Weekly
- Homework – Diary cards
- Behavioral chain analysis
- Targets
- Formal assessments



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- Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.
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So individual therapy is just a part. It involves weekly sessions, is structured. It requires the most training for the therapist. To be a group leader does not require as much training but for an individual therapist, they need to be well versed in a variety of different parts of the DBT and CBT. In an individual session that's structured, there is homework every week and the diary card, the DBT diary card being one of those.

The individual therapist will be engaged with the client in conducting behavioral chain analysis repeatedly during each session in stage one. The individual therapist will be prioritizing targets. What's most important to address and whether or not we're able to discuss with the client who brings in as much detail as they would like to talk about it is determined by a hierarchy of targets that we'll discuss later.

In addition, we want to, in individual therapy, be conducting formal assessments and doing data tracking. For example, in an individual session with a client who might have increased their suicidal thinking, we would do a formal assessment called the Linehan Risk Assessment Protocol. So that would be an example of a formal assessment that DBT requires.

Group Skills Training





- Weekly
- Psycho-educational
- 3 to 10 individuals
- 4 Modules
 - Mindfulness



- Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.
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The next component after individual therapy is group skills training. This is absolutely required. In fact, more research has come out suggesting that group skills training is helpful in and of itself independent of individual DBT. Group skills training is a weekly one-and-a-half hour to two-and-a-half hour psychoeducational group.

You would have in a DBT group between three and 10 individuals and that would determine how long your group was. If it was between an hour and a half to two and a half hours is somewhat determined by the amount of patients that you have in that group. There are four modules in group and mindfulness is the most popular and most well known of those. But there are also three other ones that we can discuss in more detail later on down the line.

Inter-session contact



- Set limits
- Therapy-interfering behaviors

- Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.
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Another component, we have individual, group, another component is intersession contact. Now, intersession contact can exist in different forms. That could be telephone coaching. It could be if the patient had an individual therapist and they were on a residential unit, then they would have access to someone in between their sessions at any point in time. This is a 24-hour intersession contact possibility. If you were doing individual therapy, that client would have your personal cell phone number. They might call. They might text. They might email. Being able to manage and set limits around that is a key feature in DBT. Any violation or problems that arise around that would be treated as what's called a therapy interfering behavior. Therapy interfering behaviors are another concept that we can go into more detail at another point. So observing limits for the therapist is extremely important when it comes to intersession DBT contact and that is partially why an individual therapist needs to be well versed in all of the DBT principles in theory and practices.

Peer Consultation Team Meetings



- Weekly
- Support
- Discuss & apply DBT
- Learn

- Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.
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The final component in DBT is what's referred to as peer consultation team meetings. And these are weekly meetings that last between an hour and two hours between all members of a team which are treating the patient. And within the DBT perspective, the treatment of a patient in DBT requires a team. And so your team might be the individual therapist, the group leader, the group co-leader, the medication provider and/or possibly a nutritionist or anybody who is willing and able to join in the group that is treating the patient. And the purpose of this is partially to support the providers who are treating the client. And oftentimes, providers who are conducting DBT need extra support. So it's partially a support for the therapists. It's also a forum for being able to discuss cases and to apply DBT principles to the case. And it's also a way to learn more about DBT and reinforce some of the practices from group that each and every provider needs to actually practice for themselves.

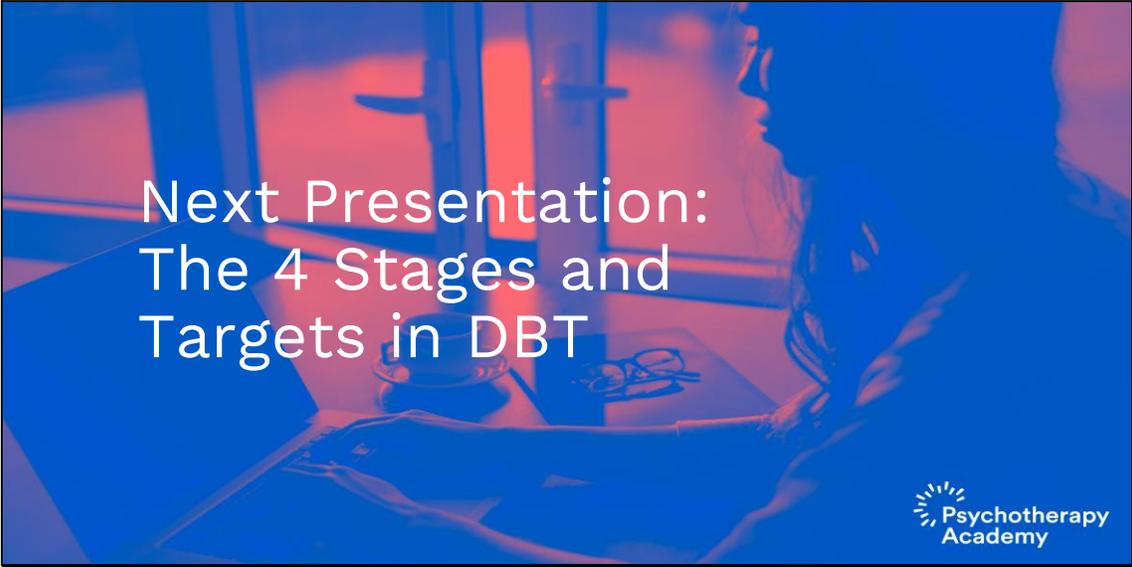
Key Points

- **Pre-treatment: therapist and the client agreeing to work together**
- **Weekly individual and group sessions. Diary cards, behavioral chain analysis, prioritizing targets and formal assessments are included in individual DBT.**
- **Four modes in DBT: individual therapy, group skills training, peer consultation team meetings and intersession contact between therapist and patient.**
- A typical **DBT agreement** is one year for adults

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The key points for this talk are: All patients begin in pre-treatment. Pre-treatment involves the therapist and the client agreeing to work with one another. There are no involuntary patients. There are weekly individual therapy and weekly group. Diary cards, behavioral training analysis, prioritizing targets and formal assessments are included in individual DBT. There are four modes in DBT – individual therapy, group skills training, peer consultation team meetings and intersession contact between therapist and patient. A typical DBT agreement is one year for adults and the structure is different for adolescents.

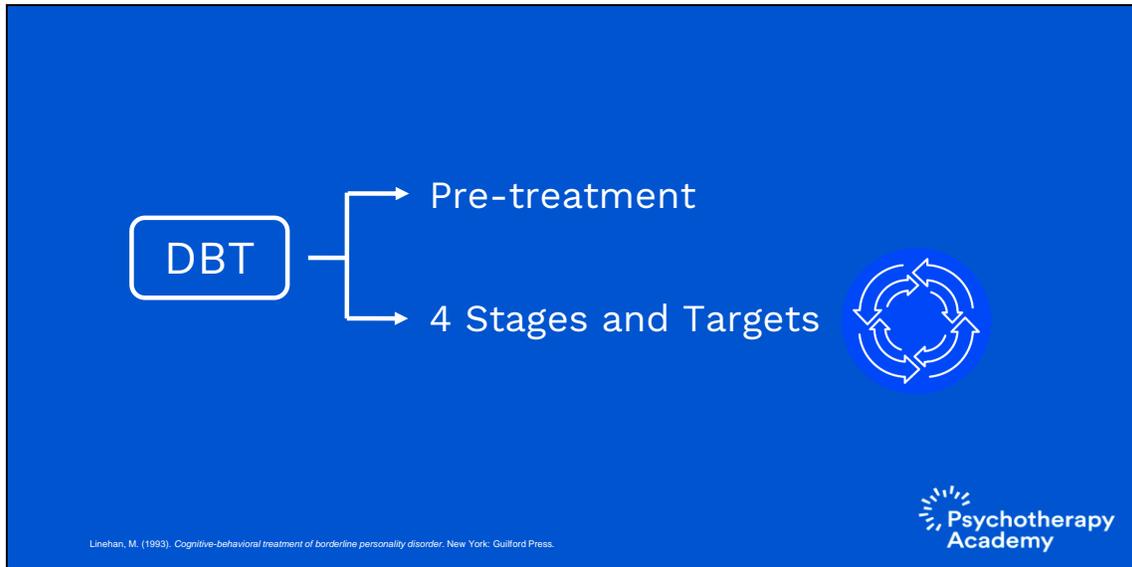


Next Presentation:
The 4 Stages and
Targets in DBT



The 4 Stages and Targets of DBT

Stephanie Vaughn, PsyD



There are four stages and targets in DBT treatment. The four stages and targets do not include the pre-treatment phase which is the phase that every potential DBT client needs to participate in. Once passing through the pre-treatment phase when the therapist and client determine that they can work together, they typically enter stage 1.



Stage 1 is when the therapist and the client work together to get behavior under control reducing problem behaviors, life-threatening behaviors, therapy-interfering behaviors and increasing skills-based practice. The patient will be learning skills in stage 1.

Slide 4

- Stages are not chronological
- Same issues may repeat



It's important to understand that the stages are not chronological. They're actually circular, meaning that there are certain issues in each stage that the therapist and the client may have to work through repeatedly. So it is not uncommon for a patient to finish stage 1, enter stage 2 and then go back to stage 1 again.

Stage 2



- Reduces **trauma**-related symptoms
 - PTSD
 - Traumatic emotional experiences
 - Invalidating experiences in childhood
- Turns up the heat
 - Processing trauma and intensifying emotions



Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.

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Stage 2 involves reducing any trauma-related symptoms including formal diagnoses of posttraumatic stress disorder and other traumatic emotional experiences that may not fit the criteria for PTSD.

In addition, invalidating emotional experiences that clients may have experienced when they were in childhood can be discussed here as well. It is important to not turn up the heat in therapy as much until you are in stage 2. I think of stage 2 as turning up the heat because we're processing traumatic histories and intensifying emotion. It is essential not to intensify the patient's already difficult emotional experiences from stage 1.

How to Determine the Stage?



- Behaviors exhibited in treatment
- Often Stage 1:

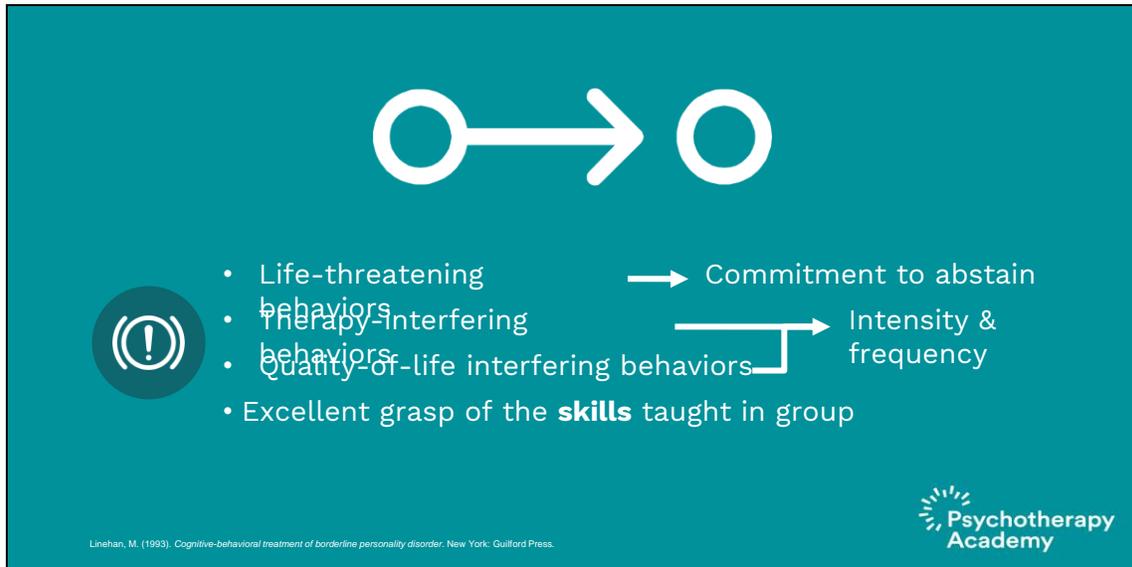
Difficulties in creating a life worth living

- Self-harm
- Suicidal behavior or ideation
- Quality-of-life interfering behaviors

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So how you determine the stage that a client is in DBT depends upon the behaviors that they exhibit when they come to treatment. Most often, patients will come to therapy with a tendency to begin in stage 1. They may have self-harm that's present. They may have suicidal behavior or ideation that's significant. They may also have what DBT refers to as quality of life interfering behaviors, significant quality of life interfering behaviors such as substance abuse or very dysregulated romantic relationships, anything that contributes to the difficulties in creating their life worth living. So if they are exhibiting any of these problem behaviors, then they would begin in stage 1.



It's not really possible to have a patient fully resolve all stage 1 behaviors prior to moving on to stage 2. However, the most important thing to get under control is the suicidal behaviors and self-harm behaviors. The amount of time that DBT therapists will recommend for having a patient abstain from life-threatening behavior before moving in to stage 2 is variable. Patients must have a commitment to abstain from life-threatening behavior prior to moving on to stage 2. And when considering therapy-interfering behavior or quality of life interfering behavior, the therapist will want to consider the intensity and frequency of both of those. By the time a client moves in to stage 2, they should have an excellent grasp of the skills which are taught in group skills training.

Target-Based Agenda



- Relevance to the patient's daily behaviors
- Relevance to the session



- Individual session
- Group session
- Inter-session

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.



For each stage, there are targets which are prioritized depending upon the relevance to the patient's daily behavior and the relevance to the session at hand. So this is a target-based agenda in individual therapy. The targets differ for individual and for group as well as for intersession contact such as text messaging the patient, emailing the patient or calling the patient. There are different targets for each of these which we can go over in a later section.

Stages 3 & 4



Stage 3

- Living life
- Trusting the self
- Reaching individual goals

Stage 4

- Deeper meaning through spiritual existence

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.



Beyond stage 2, the stages 3 and 4 are not as developed as stages 1 and 2 in DBT theory. In fact, not much has been written about stage 3 which involves living life, trusting the self and reaching individual goals or stage 4 where the patient obtains deeper meaning through spiritual existence. Most of the work that is done in DBT that has been studied is on stages 1 and 2.

Key Points

- Standard DBT includes **four stages** and a **pre-treatment** phase.
- There is **no timeline** for moving through these stages.
- **Targets differ in each stage.**
- Most patients begin in stage 1, which involves **behavioral stabilization.**
- Childhood history and histories of **trauma** are not addressed until stage 2.
- Very little information exists for treatment in **stages 3 and 4.**

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.



Key points. Standard DBT includes four stages and a pre-treatment phase. All patients begin in pre-treatment. There is no timeline for moving through these stages. The targets differ in each stage. Most patients begin in stage 1. Stage 1 is the most frequently discussed and involves behavioral stabilization. If with life-threatening behaviors, self-harm or significant therapy-interfering behavior or quality of life interfering behavior, the patient should remain in stage 1. Childhood history and histories of trauma are not addressed until stage 2. And finally, very little information exists for treatment in stages 3 and 4.



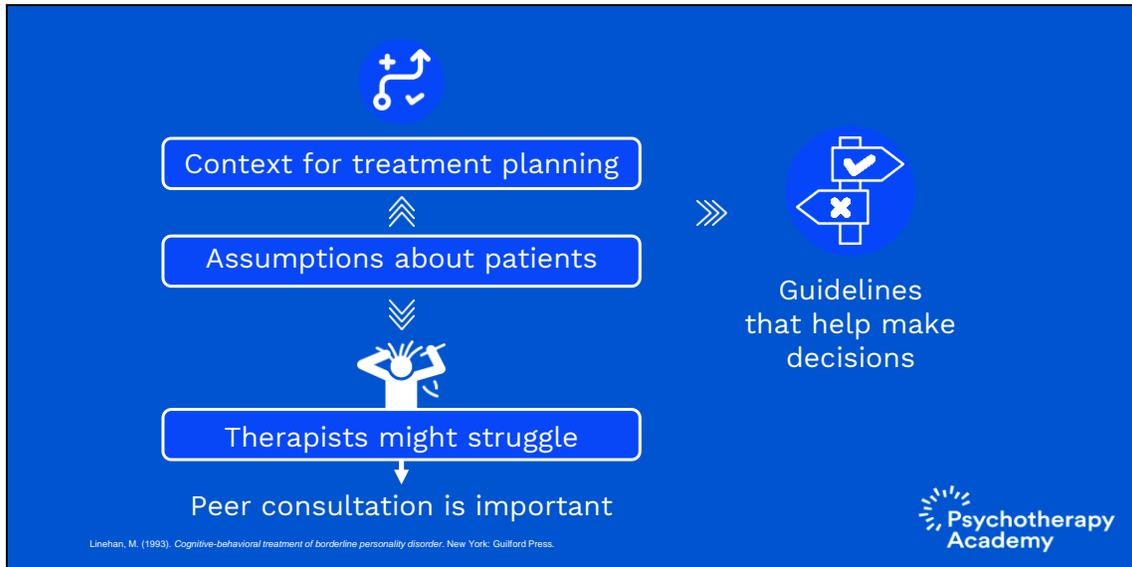
Next Presentation:
DBT Assumptions
About Patients



DBT Assumptions About Patients

Stephanie Vaughn, PsyD

Slide 2



DBT therapists go into therapy with assumptions about patients
This helps to form a context for treatment planning and generally helps make treatment go more smoothly.
Assumptions, of course, are not proven. They're just guidelines and sort of a foundation that will allow us to make decisions and dictate to some degree the choices that we make in any given moment. So some of the assumptions about patients are more difficult to wrap one's brain around than others.
And typically, therapists will find that they struggle with one or two of these assumptions. So it may be helpful to bring each of these assumptions up in team from time to time and ask colleagues in your peer consultation team which ones they struggle with from week to week.

Patients are doing the best they can

- Avoid invalidation
- In this particular moment - Mindfulness

They need to do better, try harder, and be more motivated to change

- In the next moment, we need to do better

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.

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So the first assumption is patients are doing the best they can. When we are thinking about an assumption, we have to take for granted that no matter how we feel the facts are as they are. So this particular assumption, patients are doing the best they can, is an essential one in order to avoid invalidating the patient by suggesting that they are not trying. So doing the best that they can does not mean that they cannot do better in the next moment.

So mindfulness is a part of DBT and Zen principles are a part of DBT. And part of the implication with this assumption is that from moment to moment we are all doing the best we can, the best we can given what we had for breakfast, the best we can dependent upon our childhood histories, the best we can dependent upon the individual we're interacting with or whether it's raining, etc. So doing the best they can is in this moment.

This is juxtaposed against one of the other assumptions that patients need to do better, try harder and be more motivated to change. One can see the dialectic in patients are doing the best they can and they need to do better, try harder and be more motivated to change. They seem almost contradictory but in fact they go together because in this moment we're doing the best that we can and in the next moment we need to do better.

Patients want to improve



People Want
To Feel Good



The Lives of Suicidal
Borderline
Individuals Are
Unbearable



*I don't think
she wants to
get better*

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.



So another assumption is that patients want to improve. Again, in order to avoid invalidation, severe invalidation of the patient, we want to go in with the idea that people want to feel good. Everyone wants to feel good. And so that leads to the conclusion that since patients are miserable, in fact, one of the assumptions is the lives of suicidal borderline individuals are unbearable as they're currently being lived, so if that is true that the lives of suicidal borderline individuals are unbearable then it naturally leads to the idea that they would want to improve, that they would want to feel better. The nature of things being unbearable is that we would want them to be bearable. So patients want to improve. We would never say in DBT "I don't think she wants to get better." That doesn't mean that we cannot look at the contingencies which might make it more difficult for him or her to get better. But it means that deep down in their core they want to improve, they want to feel better.

Patients may not have caused all their problems
but they have to solve them anyway



- Radical acceptance
 - *It is not possible to solve a problem we have not accepted*
- Puts blame aside 

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.



The next assumption, patients may not have caused all their problems but they have to solve them anyway. I like this one in particular. It involves what in DBT we refer to as radical acceptance. It doesn't say radical acceptance in the assumption but it implies it. So radical acceptance is when we radically, meaning drastically, fully, 100% embrace reality as it is, not liking it necessarily but accepting it as fact so that then we can solve the problem. So it's not possible to solve a problem that we have not first accepted. So this assumption, patients may not have caused all their problems but they have to solve them anyway, puts blame aside and acknowledges both that the patient did not cause all of them, that some of them involve no fault of their own, from the environment and that they have to solve the problems that they were given as well as the problems that they made themselves.

Patients must learn new behaviors in all relevant contexts



- Inter-session contact → Generalization of skills
- Skills & new behaviors → Reinforced in all contexts

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.



Our next assumption is patients must learn new behaviors in all relevant contexts, in other words, not just in individual therapy, not just in group skills training. The whole point of intersession contact is generalization of the skills to relevant contexts so that they have coaching in the moment that they're in. As therapists, I think all therapists have the tendency to back off or to have the urge to back off of a patient, of pressuring a patient to use skills or to make change during difficult times, for example, when that patient is feeling sick, when they've had a death in the family, when there's a breakup or some other life situation arises. However, this assumption brings home the point that these skills that they're learning and the new behaviors that they're working on cannot just be emphasized or reinforced in certain contexts. They have to be reinforced in all contexts in order for the patient to fully integrate the skills, in order for them to change their lives.

Patients cannot fail in therapy



- Therapy can fail
- If the patient fails it is not his fault

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.



Next, patients cannot fail in therapy. So what this means is – It does not mean that the therapy cannot fail because the therapy certainly can fail. DBT does not work for everyone. It doesn't mean that the therapist can't fail because the therapist can fail to apply DBT treatment effectively. What this means is that even if DBT is applied 100% treatment to fidelity and the therapist is doing a fantastic job, if the patient fails, it is not their fault. It means that DBT may not be the treatment for them and perhaps the treatment for them has yet even to be developed. So one of the examples or metaphors that's used is a diagnosis of cancer. If a patient receives chemotherapy for a cancer diagnosis and the cancer does not go in to remission and in fact worsens, one does not blame the patient. They blame the treatment. The patient did not fail; the treatment failed them. So while this may seem to be a semantic argument, it makes all the difference in the world to the patient who has to be terminated from DBT because it's not working.

DBT therapists need support

The diagram features a red background. At the top center is the title 'DBT therapists need support'. Below the title, on the left, is a circular icon of four hands clasped together. To its right is a bulleted list: 'Peer consultation team meetings' and 'Therapy for the therapist'. Below this list is a circular icon containing a magnifying glass over a scene of a person in distress with various objects. To the right of this icon are two arrows: one pointing right labeled 'Change Life' and one pointing left labeled 'End Life'. A central arrow labeled 'Therapy' points from the 'Change Life' arrow to a rectangular box on the right labeled 'Life worth living'. In the bottom right corner is the logo for the Psychotherapy Academy.

- Peer consultation team meetings
- Therapy for the therapist

Change Life Therapy Life worth living

End Life

Psychotherapy Academy

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.

Another assumption is that therapists treating borderline individuals and individuals with pervasive emotion dysregulation need support. And DBT therapists get this support through peer consultation team meetings. More on peer consultation team meetings in another talk. So one function of team meetings is therapy for the therapist, support for the therapist. And those using DBT cannot do so in isolation. You have to be part of a team if you are a DBT clinician. So finally to circle back, the assumption, the lives of suicidal borderline individuals are unbearable as they're currently being lived, may sound rather dire but if we look at it through the lens of if a life is unbearable we can either choose to end life or we can choose to change life. So we go in with the assumption as therapists that the lives of these individuals we are treating are unbearable. In fact, Linehan refers to the patients as being in hell. And so one way out from the patient's perspective oftentimes is suicide, that is to end life. And this assumption implies that rather than ending life we can change life and may help to create that life worth living.

Key Points

- DBT assumptions are **beliefs** that DBT clinicians must ascribe to in order to effectively treat patients.
- 1. Patients are doing the **best** they can and want to **improve**.
- 2. Patients need to do **better**, try **harder**, and be more motivated to **change**. They may not have caused all their **problems**, but they have to solve them anyway.
- 3. The lives of suicidal borderline individuals are **unbearable**.
- 4. Patients must learn new behaviors in all relevant **contexts**, and **cannot fail** in therapy.
- 5. Therapists need **support**.

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.



Key points.

DBT assumptions are beliefs that DBT clinicians must ascribe to in order to effectively treat patients. The DBT assumptions are as follows:

1. Patients are doing the best they can.
2. Patients want to improve.
3. Patients need to do better, try harder and be more motivated to change.
4. Patients may not have caused all their problems but they have to solve them anyway.
5. The lives of suicidal borderline individuals are unbearable as they are currently being lived.
6. Patients must learn new behaviors in all relevant contexts.
7. Patient cannot fail in therapy.
8. Therapists treating borderline individuals and those with pervasive emotion dysregulation need support.

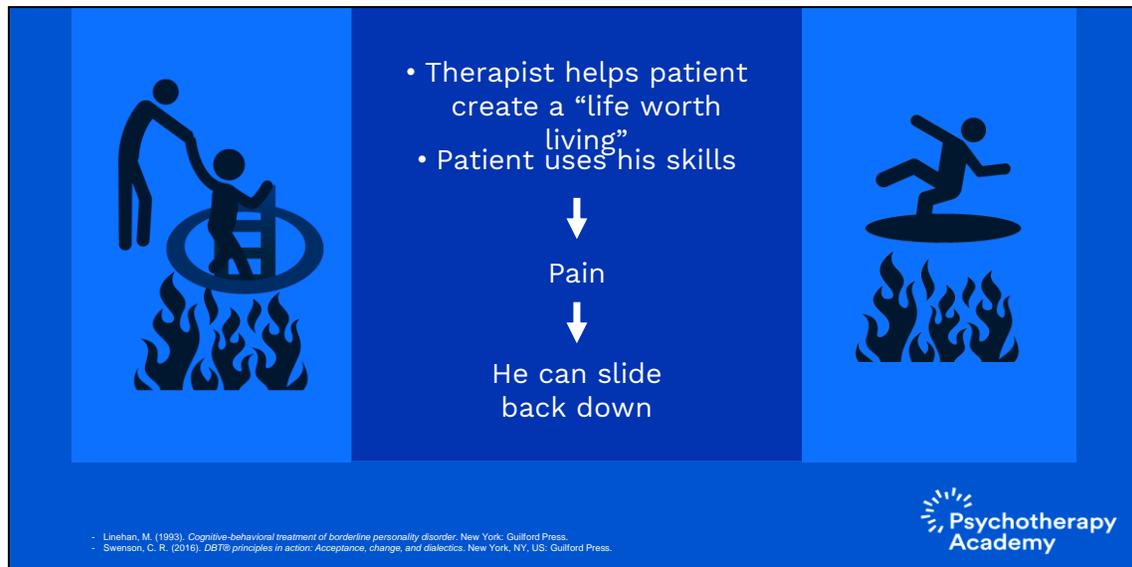


Next Presentation:
Targets & Goals of DBT



Targets & Goals of DBT

Stephanie Vaughn, PsyD



The targets and goals of DBT differ for each stage of treatment but the overarching goal in DBT is to help the patient create their life worth living. This goes along with the idea that patients' lives are unbearable as they're currently being lived. And it is the therapist's job to help them develop their life worth living rather than ending life or simply bearing the unbearable existence that they have. As Linehan says, the therapist's job is to help the patient find a way out of hell. She often describes the experience of patients first coming in to DBT as that of being in hell and having only a metal ladder to stretch out beyond hell and the therapist is there to help coax the patient onto the hot ladder and out of the hell that they're in. The problem with helping someone get out of a hot place using a metal ladder is obvious. As the patient starts to climb out using his or her skills, it is not uncommon for them to slide back down due to the pain involved in using the skills themselves.

What does the patient view as being a life worth living?

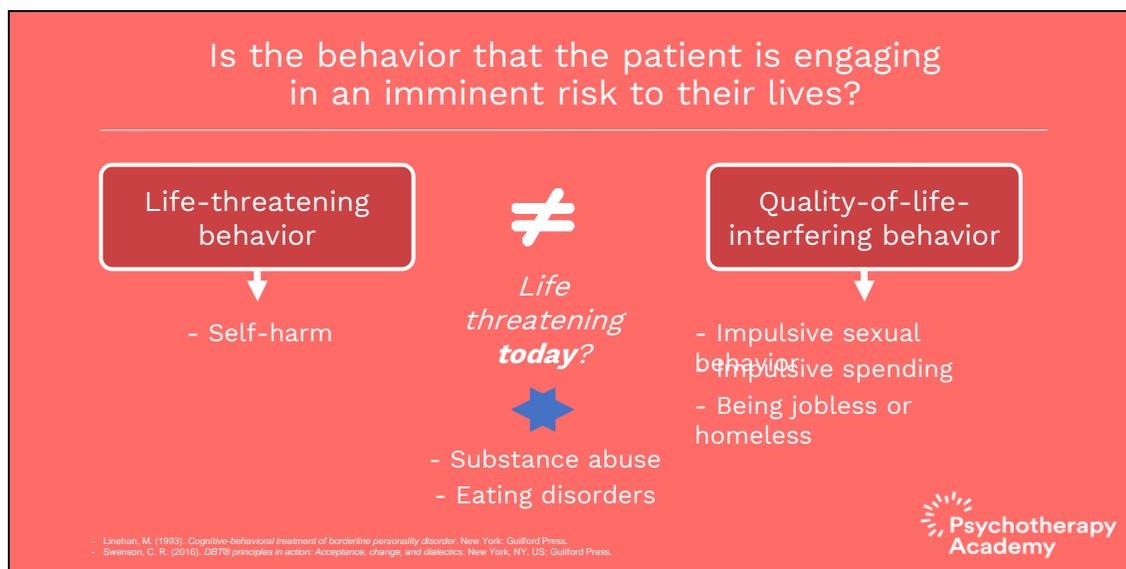
- That exploration can be dysregulating
- Patients may be able to list 1 or 2 things
- Stage 1:
 - Life-threatening behavior → Suicide
 - Therapy-interfering behavior
 - Quality-of-life-interfering behavior



- Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.
- Swenson, C. R. (2016). *DBT® principles in action: Acceptance, change, and dialectics*. New York, NY, US: Guilford Press.

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In addition, assessment in the beginning of “What does the patient view as being a life worth living?” in and of itself, that exploration can be dysregulating. At the outset of treatment, patients may only be able to list one or two things that they would like to have present in a life that they could see themselves living in, for example, a house of their own, a job or a small white cat. In stage 1 which is the most frequently discussed and studied DBT stage, we are looking at eliminating life-threatening behavior, reducing and potentially eliminating therapy-interfering behavior and reducing what is referred to as quality of life interfering behavior. So life-threatening behavior would be things like suicide attempts, suicidal thoughts and urges and any kind of behaviors that are absolutely associated with suicide, anything that would make it more likely that the patient would be at risk for dying or substantial harm to themselves.



It is important to differentiate between life-threatening behavior and quality of life interfering behavior. And sometimes, that can be difficult for therapists to determine. Quality of life interfering behaviors would be things like substance abuse, impulsive sexual behavior, impulsive spending, being jobless, being homeless and other very difficult but not life-threatening behaviors such as eating disorders. It is not uncommon for a new DBT therapist to accidentally label a quality of life interfering behavior as a life-threatening one. The key to determining what is a life-threatening behavior is to ask the question “Is the behavior that the patient is engaging in imminently a risk to their lives?” So in the case of substance abuse or eating disorders, we would characterize them as life threatening if they were in fact imminently life threatening today. So for example, smoking or drug use would not be considered an imminent life-threatening behavior although it does potentially risk the patient’s life in the long term. So we want to eliminate life-threatening behaviors. Self-harm is also subsumed under this category because of the risk that the patient has to accidentally harming themselves to the point that their life is at risk. In addition, the correlation between self-harm and completed suicide is significant.

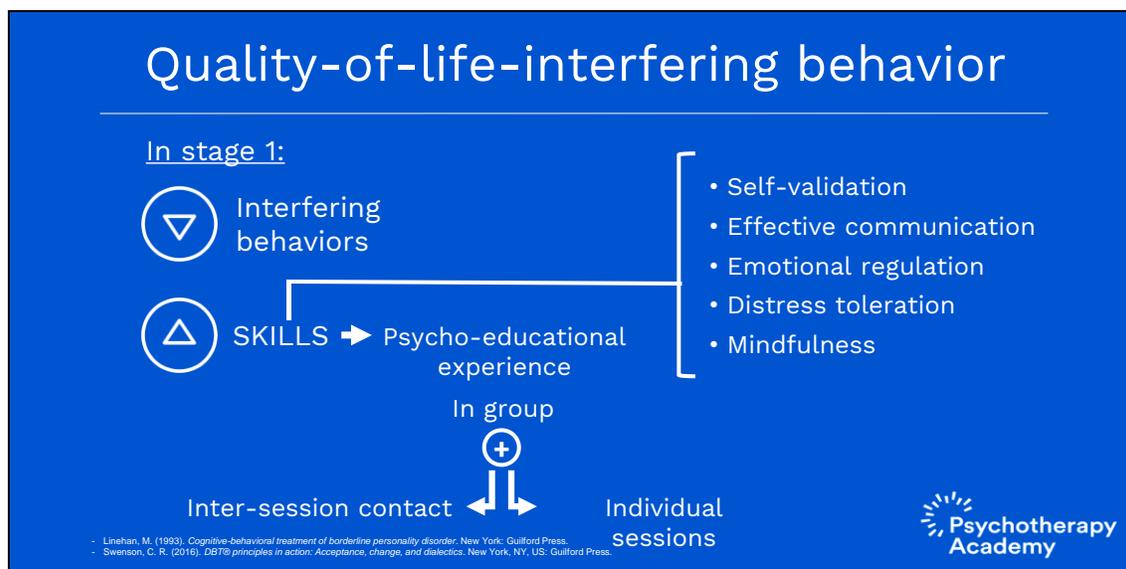
Therapy-interfering behavior

	Interferes with the therapy process	<ul style="list-style-type: none">• Missing therapy sessions• Arriving late
	Increases the risk of drop out or having therapy terminated	<ul style="list-style-type: none">• Interfering with the process• Interpersonal styles• Failing to follow treatment recommendations
	Issues with inter-session contact	<ul style="list-style-type: none">• Calling too frequently• Pushing limits

- Lichstein, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.
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So beyond life-threatening behavior, we want to reduce therapy-interfering behaviors. And there is a variety of therapy-interfering behaviors that we can work on. Some are behaviors which literally interfere with the process of therapy, for example, missing therapy sessions or arriving late to therapy sessions. Those would literally interfere with receiving therapy. We want to also work on behaviors which increase the risk that the patient is either going to drop out or be terminated from therapy. And that may be arriving late. It may also be things which literally interfere with therapy such as arriving late but can also include interpersonal styles of the patient which interfere with the therapist's willingness to treat them. It can also be behaviors such as failure to bring homework or follow through on other treatment recommendations that the therapist finds extremely important or concludes to be extremely important. Therapy-interfering behaviors would also include any issues with inter-session contact such as a patient calling too frequently or pushing or challenging the therapists limits



Our third set of behaviors is the quality of life interfering behaviors that were mentioned earlier. And we are not looking at completely eliminating quality of life interfering behaviors but we are looking at reducing. In stage 1, we are also looking at increasing skills. So not only are we trying to reduce things but we're also trying to increase things as well. And in group, this is where it happens that the patient gets a psychoeducational experience and skills. So they are going to be learning how to self-validate, how to communicate effectively, ways in which they can regulate their emotions and how they can tolerate distress. In addition, they will be learning the formal practice of mindfulness. So the skills that they're learning in group are reinforced by the individual therapist both in individual sessions and in inter-session contact.

Keep the patient in the environment that they are in

 False environments 

 Help them use these skills in the environment that they are in

• DBT patients go to the hospital → Not always recommended

- Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.
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Another of the goals of DBT is to keep the patient in the environment that they are in rather than to create a false environment. Sending a patient to a residential facility or hospitalizing them would be an example of an environment that was not a natural one. So we want to try to help them use these skills in the environment that they are in rather than withdrawing them and putting them in a structured environment that does not exist in the outside world. That being said, it is also not uncommon for DBT patients to go to the hospital. It's just important to recognize that that is not always a recommendation when a patient is suicidal.

Help the patient stay motivated

Help them stay with the skills and keep going



The illustration shows a therapist on the left with arms raised, saying "You can do it!" in a speech bubble. On the right, a patient is climbing a ladder that is being heated by flames from below, representing a difficult and painful challenge.

- Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.
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Another goal of DBT is to help the patient stay motivated. So it is the role of the individual therapist particularly in the beginning and at various periods throughout treatment to help motivate the patient and cheerlead him or her in to staying with the skills and to keep going. So again, if we go back to the ladder analogy, the therapist would coax, cheerlead, cheer for and remind the patient why it is so important despite how difficult it is to climb out of hell using a hot metal ladder, how important it is to keep going because the only alternative is to continue staying on in the unbearable environment that they are in.

Key Points

- DBT's main goal is to help patients create a **"life worth living"**.
- There are **three targets** for an individual DBT therapist in stage 1:
 1. To eliminate **Life-threatening behavior**
 2. Reduce **Therapy-interfering behavior**
 3. Reduce **Quality-of-life-interfering behavior**

- Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.

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Key points. The key points to video 7 include: DBT's main goal is to help patients create a life worth living. There are three targets for an individual DBT therapist in stage 1: To eliminate life-threatening behavior, reduce therapy-interfering behavior and reduce quality of life interfering behavior. Life-threatening behavior includes suicidal thoughts, urges and attempts as well as self-harm. A behavior is life threatening if it imminently threatens a patient's life. Therapy-interfering behavior is anything that gets in the way of the patient receiving therapy or makes it more likely treatment will end prior to completion. Examples of therapy-interfering behavior include missing sessions, not completing homework, calling a therapist too frequently and arriving late for session. Quality of life interfering behaviors are anything which interferes with the patient creating their life worth living. Examples of quality of life interfering behavior include substance abuse, impulsive sexual behavior, impulsive spending and eating disorder behavior.