Remember DBT is not just skills training. A program or person who says they do DBT but only offers skills groups is not doing the comprehensive type of DBT that is effective (TARA, 2014).  

<table>
<thead>
<tr>
<th>Have you completed a 10 day intensive DBT training?</th>
<th>Yes, all of our DBT staff have completed a 10 day intensive DBT training.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you a member of a DBT consultation team?</td>
<td>Yes, all of our DBT staff participate weekly on a DBT consultation team.</td>
</tr>
<tr>
<td>Have you been supervised by an expert DBT therapist?</td>
<td>Our DBT program participates in consultation with a DBT expert/trainer on a regular basis.</td>
</tr>
<tr>
<td>Are you familiar with the main sets of DBT strategies (cognitive behavioral therapy, validation, dialectics)?</td>
<td>Yes, through therapy practice and intensive training.</td>
</tr>
<tr>
<td>Do you teach skills, practice behavior analysis, and review diary cards?</td>
<td>Yes, see below for additional details.</td>
</tr>
<tr>
<td>Do you do phone coaching?</td>
<td>Yes, phone coaching is offered 24/7 for DBT clients.</td>
</tr>
<tr>
<td>How many clients have you treated using DBT?</td>
<td>Our program was established in 2010. Approximately 30-40 clients (adolescents and adults) are served weekly in our DBT program.</td>
</tr>
</tbody>
</table>

What is DBT?

Dialectical Behavior Therapy (DBT) is treatment developed by Marsha Linehan, Ph.D., in the late 1970’s to treat individuals diagnosed with Borderline Personality Disorder (BPD) that were also struggling with suicidal and self-harming behaviors. DBT is recognized as an empirically supported treatment for BPD; that means that there have been clinical trials completed to determine it is effective. As DBT has evolved, it continues to treat BPD, as well as many other concerns, including depression, eating disorders, substance abuse and PTSD. DBT has been reorganized as a treatment to help those struggling with dysregulation in: 1.) emotions- ups and downs, anger problems, 2.) cognitions-
paranoia, extreme thinking, 3.) behaviors- impulsive behavior, intentional self-harm, 4.) relationships-chaotic relationships, 5.) self concept- difficulties with sense of self and strong feelings of emptiness.

Stages of DBT

• Stage 1: The goal of this stage is to become less miserable and to get problem behaviors under control. People often enter DBT with self-harming behaviors, anxiety or panic, anger, substance use, eating concerns, intense relationships, etc. This stage can take up to one year.

• Stage 2: The goal of this stage is to decrease internal suffering and increase emotional experiencing. This is the stage that helps people cope with the effects of a trauma or invalidation. Treating traumas can be done at the same time as the year of group and individual DBT mentioned above. A person is in Stage 2 if they are active in trauma treatment. DBT therapists at AFCS are using the evidence based Prolonged Exposure (PE) to treat trauma.

• Stage 3 Targets: The goal of this stage is to increase self-respect, achieve individual goals and cope with life problems. This stage helps people to live a life that includes ordinary happiness and ordinary unhappiness versus suffering.

• Stage 4 Targets: This stage is for people who are having a hard time finding spiritual fulfillment or meaning, even after living a life with ordinary happiness and unhappiness. The goal of this stage is to create freedom, joy, and completeness, continuing on a spiritual path of finding meaning and purpose.

Modes (Components) of DBT

In a best practice form, there are four modes of DBT, and all are offered by therapists at AFCS:

• Consultation team: DBT therapists meet weekly to increase competency, motivation and support for one another. This is an essential part of offering DBT.

• Skills training: Group is offered weekly and is psychoeducational. Clients learn new behavioral skills to increase capabilities of clients. Adolescent groups are 20 weeks and adult groups are 24 weeks. Therapists often recommend that clients participate in the full group cycle twice, making it a year of treatment.

Skills are taught in the following areas:

- Mindfulness: awareness in the present moment, paying attention on purpose to just the moment
- Distress Tolerance: how to survive crisis and accept painful situations
- Emotion Regulation: how to experience and change emotions.
- Interpersonal Effectiveness: being assertive while also keeping good relationships and self-respect
• Individual therapy: Therapy is offered weekly to increase client’s motivation. AFCS has individual therapists that are intensively trained in DBT and adhere to the DBT model during sessions. Individual sessions include a review of a diary card that tracks feelings and behaviors. There are different strategies used to create change: behavior analysis and solution analysis of the problem, improving cognitions or thoughts, exposure to the situation or the feelings that may be creating discomfort or pain, and skills training. There are often multiple problems for clients entering DBT, and problems will be addressed in a progression.

The following is the order of priority for individual sessions:

▪ Decrease life threatening behavior: suicidal or self-harming behaviors are the top priority in treatment
▪ Decrease therapy interfering behavior: includes problems that get in the way of doing therapy effectively or make it so that treatment will end abruptly. Can be behaviors of the therapist or the client (i.e., coming to sessions late, not doing homework, withdrawing in session).
▪ Decrease quality of life interfering behavior: includes any behaviors that interfere with clients building a life worth living (i.e., financial problems, relationship chaos, anxiety or depression).
▪ Increase skills: learning and applying new behaviors in all relevant contexts

• Phone coaching: Clients are offered in the moment coaching through a 24 hour phone coaching line with DBT therapists. This helps clients generalize or apply information learned in DBT to their environments.

*This information was summarized/paraphrased from:

**Suggested Resources:**

• **National Education Alliance for Borderline Personality Disorder** - www.borderlinepersonalitydisorder.com

• **National Alliance on Mental Illness** - Founded in 1979, NAMI has become the nation’s voice on mental illness. As the nation’s largest grassroots mental health organization, it is dedicated to improving the lives of persons living with serious mental illness and as well as their families, through advocacy, research, support, and education. www.nami.org

• **National Institute of Mental Health** - The National Institute of Mental Health is the leading Federal agency for research on mental and behavioral disorders, and is one of 27 components of the National Institutes of Health (NIH). The NIMH is actively involved in strategic planning and priority-setting for the Institute as a whole as well as for specific research areas. www.nimh.nih.gov
Borderline Personality Disorder Demystified - This web site is intended for people with borderline personality disorder, for their families, and for psychiatrists and other mental health care providers. Selected information provides an understanding of the symptoms, history, causes and nature of BPD. Also presented are the various methods of treatment now available as well as of their effectiveness and risks. Locating resources is also outlined. www.bpddemystified.com

DBT Self Help - This site was written primarily by PEOPLE WHO HAVE BEEN THROUGH DBT, not DBT professionals. For this reason, consider the source of any given document. We cannot give advice, but we can talk about our experiences on our DBT journey. In this regard, I hope we can help one another. www.dbtselfhelp.com

Behavioral Tech – Marsha Linehan’s website, the creator of DBT. http://behavioraltech.org

An Explanation of the DSM-IV TR Criteria

For a patient to be diagnosed with Borderline Personality Disorder, he or she must experience 5 out of the 9 criteria (see page 2) as set forth in the DSM-IV TR. Establishing the diagnosis is complicated by the fact that the presence of many of these criteria fluctuate. Here is a more detailed explanation of these symptoms:

Abandonment Fears. These fears should be distinguished from the more common and less severe phenomena of separation anxiety. The perception of impending separation or rejection, or the loss of external structure, can lead to profound changes in the BPD patient’s self-image, affect, cognition, and behavior. Individuals with BPD are interpersonally hypersensitive and may experience intense abandonment fears and inappropriate anger even when faced with criticisms or time-limited separations. These abandonment fears are related to an intolerance of being alone and a need to have other people with them. Frantic efforts to avoid abandonment may include impulsive actions such as self-injurious or suicidal behaviors. It was originally postulated that fear of abandonment developed as a result of failures in a child’s development during the rapprochement phase (from age one-and-a-half to two-and-a-half). However, empirical evidence has not borne this out.

Unstable, Intense Relationships. Individuals with BPD are frequently unable to see significant others (i.e., potential sources of care or protection) as other than idealized (if gratifying), or devalued (if not gratifying). This is often referred to as “black and white thinking,” and in psychological terms, reflects the construct of “splitting.” When anger initially intended toward a loved one is experienced as dangerous, it gets “split” off to preserve the loved one’s goodness. Relationship instability is thought to be a symptom of early insecure attachment characterized by both fearful distrust and needy dependency.

Identity Disturbance. The disorder of self which is specific to borderline patients is characterized by a distorted, unstable or weak self-image. Borderline patients often have values, habits, and attitudes which are dominated by whomever they are with. The interpersonal context in which these identity problems get magnified is thought to begin with not learning to identify one’s feeling states and the motives behind one’s behaviors.

Impulsivity. The impulsivity of the borderline individual is frequently self-damaging, in its effects if not in its intentions. This differs from impulsivity found in other disorders such as manic/hypomanic or antisocial disorders. Common forms of impulsive behavior for borderline patients are substance or alcohol abuse, bulimia, unprotected sex, promiscuity, and reckless driving.

Suicidal or Self-injurious Behaviors. Recurrent suicidal attempts, gestures, threats, or self-injurious behaviors are the hallmark of the borderline patient. The criterion is so prototypical of persons with BPD that the diagnosis rightly comes to mind whenever recurrent self-destructive behaviors are encountered. Self-destructive acts often start in early adolescence and are usually precipitated by threats of separation or rejection or by expectations that
the BPD patient assume unwanted responsibilities. The presence of this pattern assists the diagnosis of concurrent BPD in patients whose presenting symptoms are depression or anxiety.

**Affective (Emotional) Instability.** Early clinical observers noted the intensity, volatility and range of the borderline patient’s emotions. It was originally proposed that borderline emotional instability involved the same problems of affective irregularity found in persons with mood disorders, particularly depression and bipolar disorder. It is now known that although individuals with BPD display marked affective instability (i.e., intense episodic depression, unrest, anger, panic, or despair), these mood changes usually last only a few hours, and that the underlying dysphoric mood is rarely relieved by periods of well-being or satisfaction. These episodes may reflect the individual’s extreme reactivity to stresses, particularly interpersonal ones and a neurobiologically-based inability to regulate emotions.

**Emptiness.** Chronic emptiness, described as a visceral feeling, usually felt in the abdomen or chest, plagues the borderline patient. It is not boredom, nor is it a feeling of existential anguish. This feeling state is associated with loneliness and neediness. Sometimes their experience is considered an emotional state and sometimes it is considered a state of deprivation.

**Anger.** The anger of the borderline patient may be due to temperamental excess (a genetic vulnerability) or a longstanding response to excessive frustration (an environmental cause). Whether the cause is genetic or environmental, many individuals with BPD report feeling angry much of the time, even when the anger is not expressed overtly. Anger is often elicited when an intimate or caregiver is seen as neglectful, withholding, uncaring, or abandoning. Expressions of anger are often followed by shame and contribute to a sense of being evil.

**Psychotic-like Perpetual Distortions (Lapses in Reality Testing).** Borderline patients can experience dissociation symptoms: feeling unreal or that the world is unreal. These symptoms are associated with other disorders, such as schizophrenia and Post Traumatic Stress Disorder (PTSD), but in those with BPD the symptoms generally are of short duration, at most, a few days, and often occur during situations of extreme stress. Borderline patients also can be unrealistically self-conscious, believing that others are critically looking at or talking about them. These lapses of reality in the BPD patient may also be distinguished from other pathologies in that generally the ability to correct their distortions of reality with feedback remains intact.

*For more information about DBT, please contact AFCS at (920) 437-8256.*