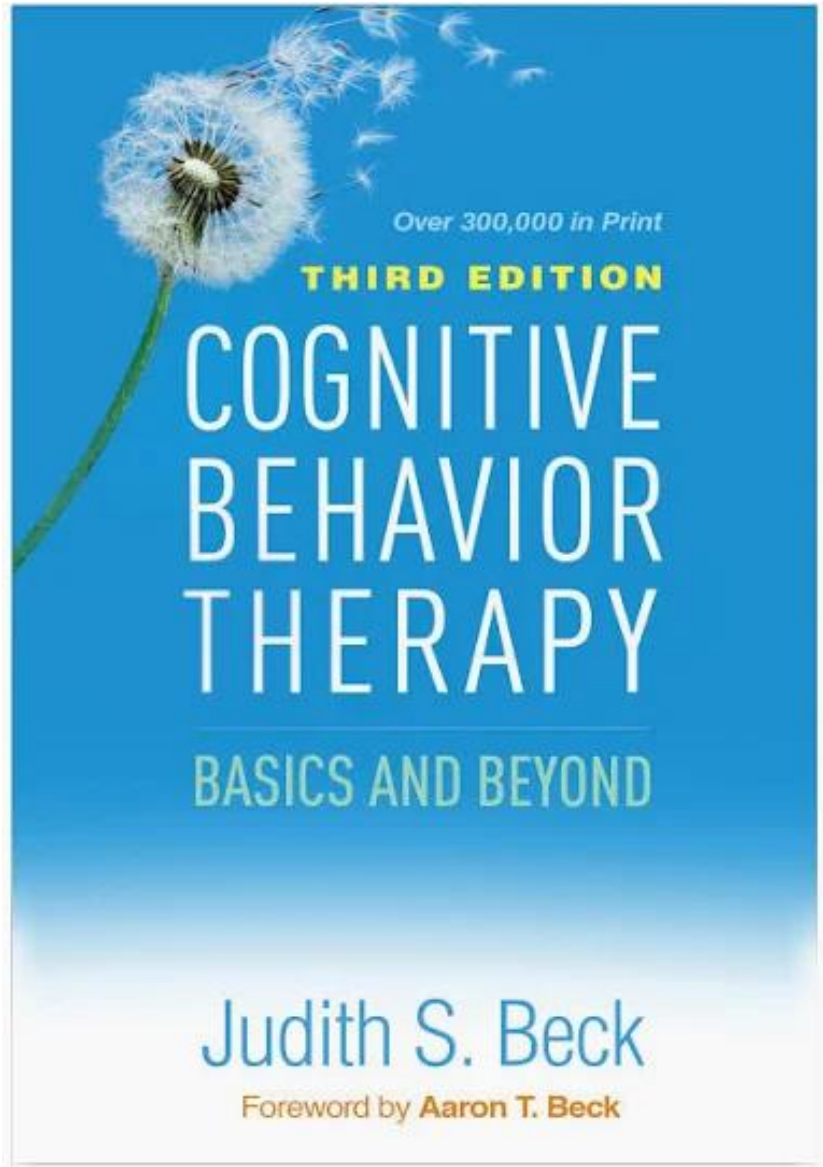
A CLINICAL SKILLS INTENSIVE

# The Clinical Power Couple

*Integrating CBT and DBT Strategies for Trauma, Addictions, Anxiety, Depression, OCD, and Chronic Pain*

Presented by **Carissa Muth, Psy.D., R.Psych**

July 7, 2026 • 12:45 PM – 4:00 PM


Over 300,000 in Print
THIRD EDITION
COGNITIVE BEHAVIOR THERAPY
BASICS AND BEYOND
Judith S. Beck
Foreword by Aaron T. Beck

# Therapy Model

1. Theory of personality and psychopathology backed by empirical evidence
2. Model of psychotherapy with sets of principles and strategies
3. Empirical findings of outcomes (including Randomized Control Trials)

# Example- Behavior Therapy

1. Personality is a result of interactions between the individual and environment (conditioning). Pathology is caused by maladaptive learning leading to unhealthy behavior.
2. To change a person, you must change their environment (Watson). Habituation, positive reinforcement, extinction (Skinner).
3. Exposure therapy for phobias (success rates up to 90%). Behavioral activation for depression treatment shown just as effective as medication

# Cognitive (Behavior) Therapy

1. Personality is established based on information processing activating a person's cognitive, affective, motivational, and behavioral responses to the physical and social environment (APA). Pathology is caused by maladaptive beliefs, behavioral factors, and maintaining factors (Beck).
2. People learn to evaluate their thinking in a more adaptive and realistic manner they experience a decrease in negative emotional and maladaptive behavior.
3. Considered the "gold standard" for many disorders

# Other treatments based on CBT

Emotional Behavior Therapy (Ellis, 1962)

Dialectical Behavior Therapy (Linehan, 1993)

Problem- Solving Therapy (D'Zurilla & Nezu, 2006)

Acceptance and Commitment Therapy (Hayes et al., 1999)

Exposure Therapy (Foa & Rothbaum, 1998)

Cognitive Processing Therapy (Resick & Schnicke, 1993)

# Cognition Levels

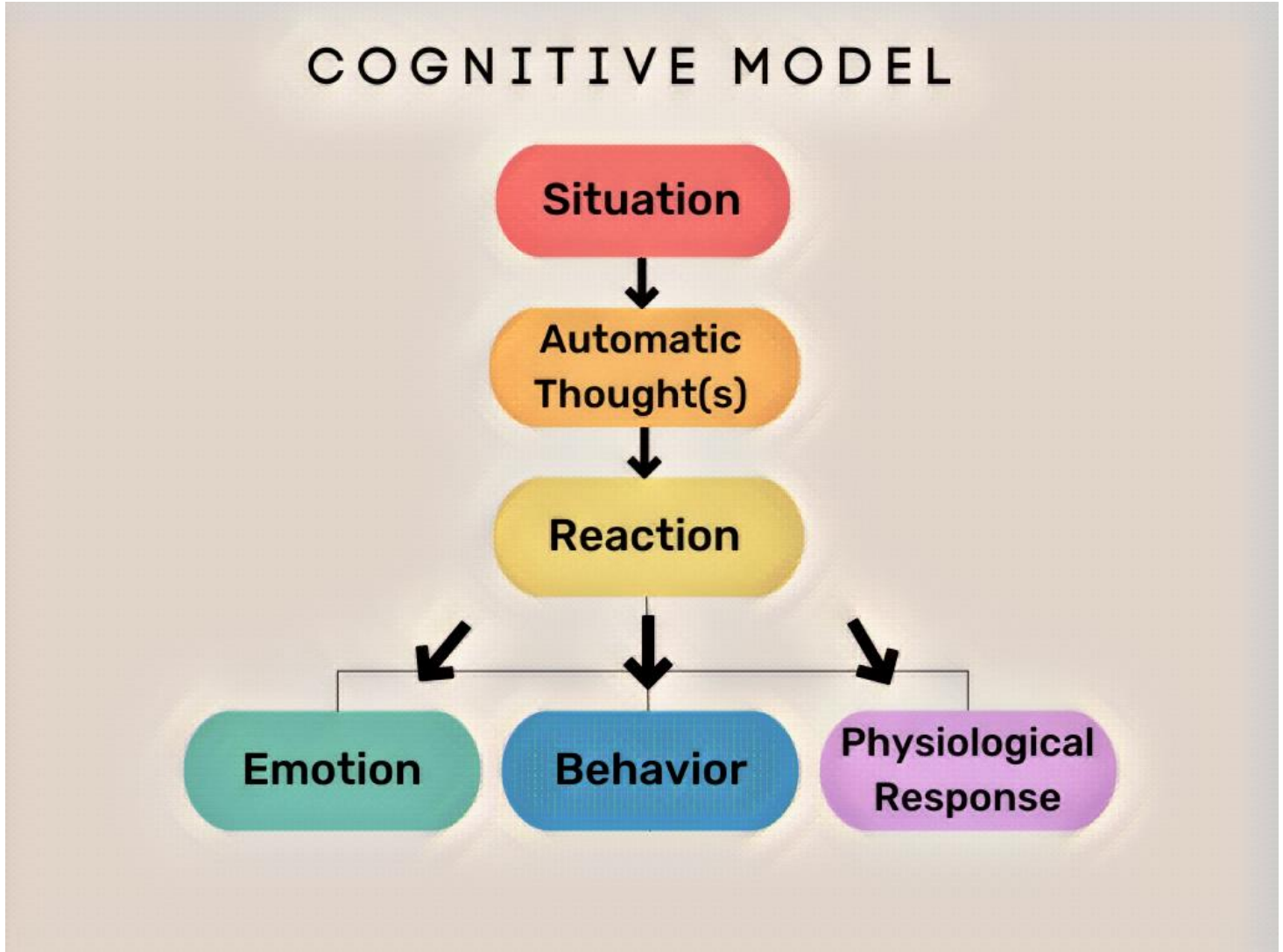
1. Automatic thoughts- Most superficial level

2. Intermediate beliefs – Underlying assumptions

3. Core beliefs- Beliefs about yourself, others, and the world

# Principles of Treatment

1. CBT Treatment Plans are based on an ever-evolving cognitive conceptualization
   - Cognitive formulation (key cognitions, behavioral strategies, and maintaining factors that characterize disorder)
   - Incorporate strength, positive qualities, and resources
   - Identify behavioral obstacles, precipitating factors, developmental events, and enduring patterns of interpreting


COGNITIVE MODEL
Situation
Automatic Thought(s)
Reaction
Emotion
Behavior
Physiological Response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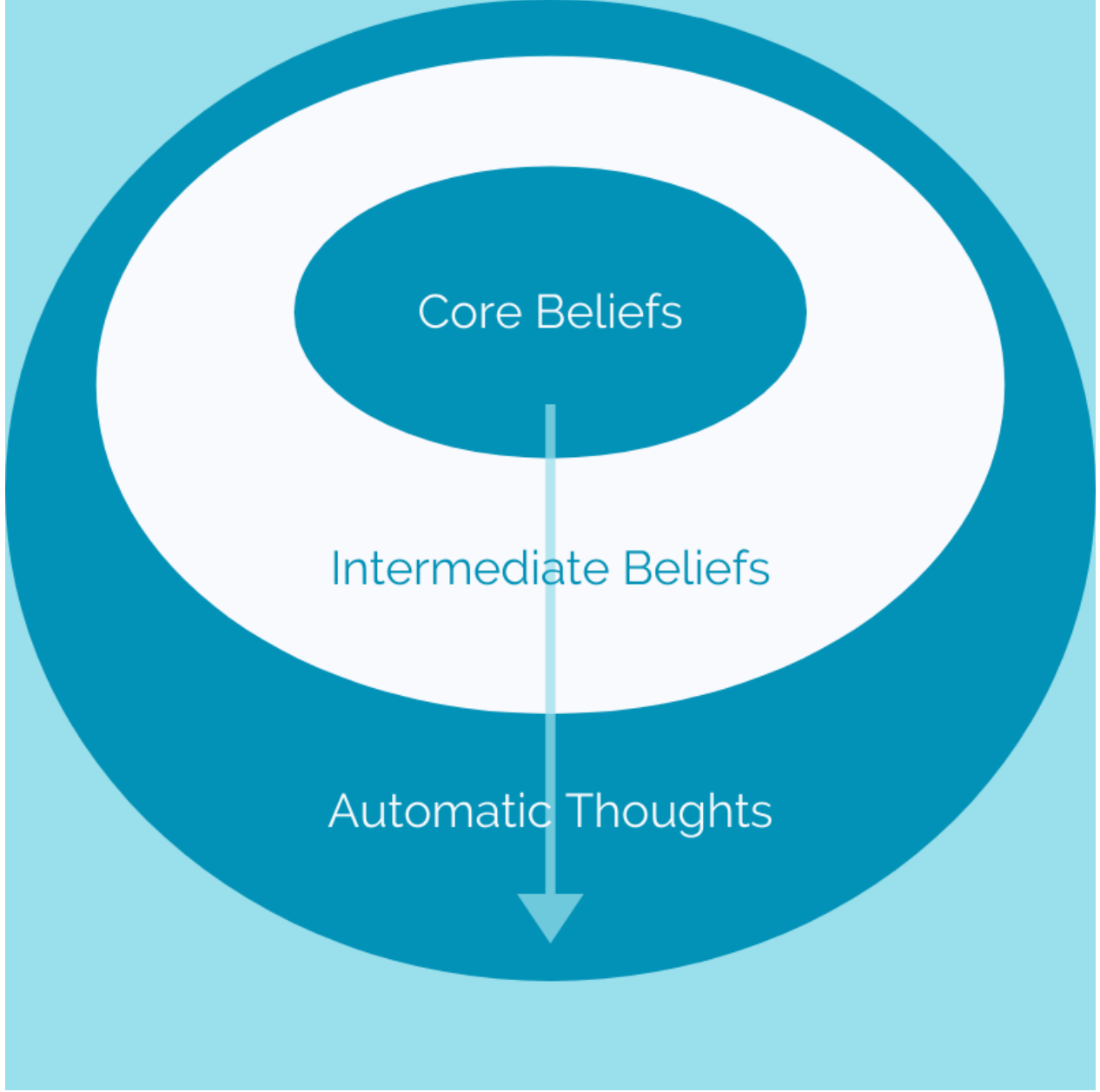
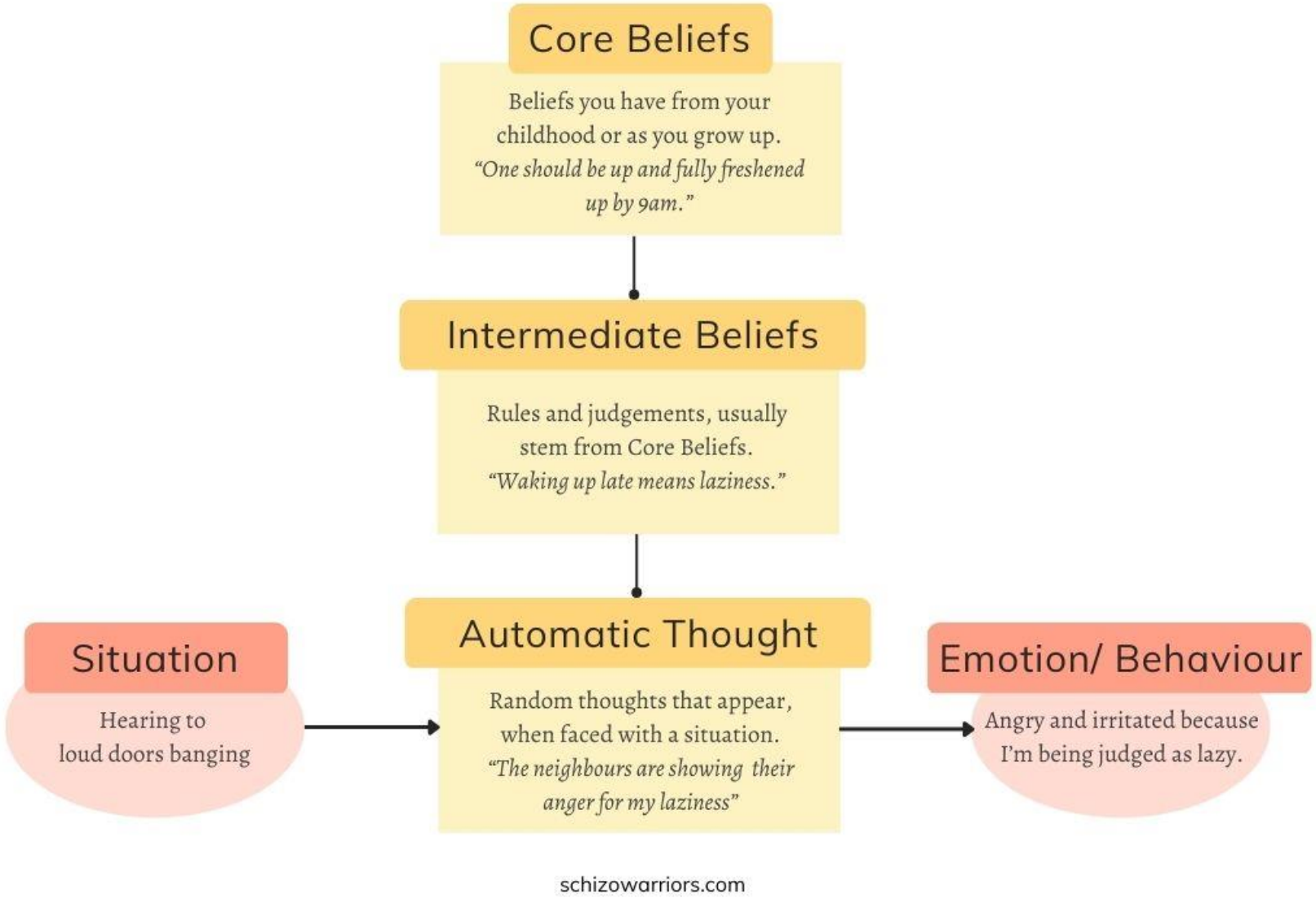

Core Beliefs
Intermediate Beliefs
Automatic Thoughts


Core Beliefs
Beliefs you have from your childhood or as you grow up.
"One should be up and fully freshened up by 9am."
Intermediate Beliefs
Rules and judgements, usually stem from Core Beliefs.
"Waking up late means laziness."
Situation
Hearing to loud doors banging
Automatic Thought
Random thoughts that appear, when faced with a situation.
"The neighbours are showing their anger for my laziness"
Emotion/ Behaviour
Angry and irritated because I'm being judged as lazy.
schizowarriors.com

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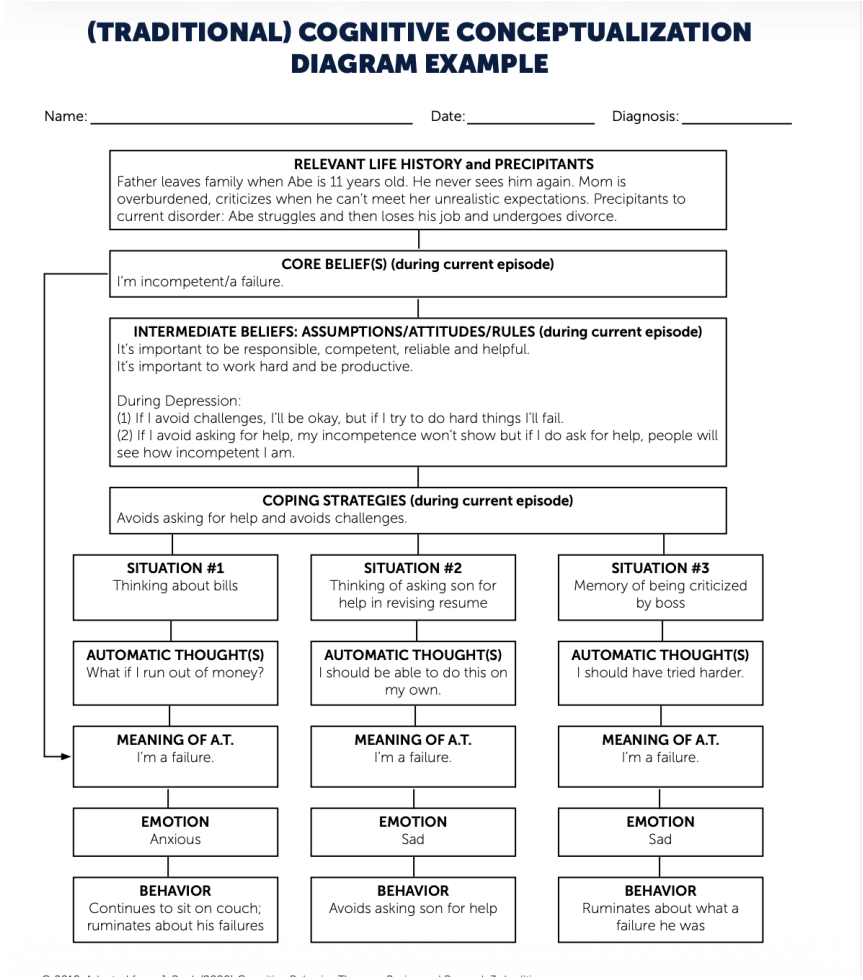

## (TRADITIONAL) COGNITIVE CONCEPTUALIZATION DIAGRAM EXAMPLE

Name: _____ Date: _____ Diagnosis: _____

**RELEVANT LIFE HISTORY and PRECIPITANTS**
Father leaves family when Abe is 11 years old. He never sees him again. Mom is overburdened, criticizes when he can't meet her unrealistic expectations. Precipitants to current disorder: Abe struggles and then loses his job and undergoes divorce.

**CORE BELIEF(S) (during current episode)**
I'm incompetent/a failure.

**INTERMEDIATE BELIEFS: ASSUMPTIONS/ATTITUDES/RULES (during current episode)**
It's important to be responsible, competent, reliable and helpful.
It's important to work hard and be productive.

During Depression:
(1) If I avoid challenges, I'll be okay, but if I try to do hard things I'll fail.
(2) If I avoid asking for help, my incompetence won't show but if I do ask for help, people will see how incompetent I am.

**COPING STRATEGIES (during current episode)**
Avoids asking for help and avoids challenges.

| SITUATION #1 | SITUATION #2 | SITUATION #3 |
|---|---|---|
| Thinking about bills | Thinking of asking son for help in revising resume | Memory of being criticized by boss |
| **AUTOMATIC THOUGHT(S)** What if I run out of money? | **AUTOMATIC THOUGHT(S)** I should be able to do this on my own. | **AUTOMATIC THOUGHT(S)** I should have tried harder. |
| **MEANING OF A.T.** I'm a failure. | **MEANING OF A.T.** I'm a failure. | **MEANING OF A.T.** I'm a failure. |
| **EMOTION** Anxious | **EMOTION** Sad | **EMOTION** Sad |
| **BEHAVIOR** Continues to sit on couch; ruminates about his failures | **BEHAVIOR** Avoids asking son for help | **BEHAVIOR** Ruminates about what a failure he was |

# Principles of Treatment

2. CBT requires a sound therapeutic relationship
   - Rogerian skills
   - Alliance on treatment plan
   - Collaborative decisions
   - Eliciting feedback

# Principles of Treatment

4. CBT is culturally adapted and tailors treatment to the individual
   - Clients have better outcomes when their therapist appreciates the significance of cultural and ethnic differences, preferences, and practices.
   - Address the client's and family's needs, emphasize culturally respectful behavior, identify culturally related strengths and supports, validate client's experiences of oppression.

# Principles of Treatment

5. CBT emphasizes the positive
   - Emphasize positive emotion and cognition in treating depression
   - Inspire hope

# Principles of Treatment

6. CBT stresses collaboration and active participation
   - Therapy as teamwork
   - Might start with therapist being more directive with treatment plan and homework
   - Move toward client helping to decide steps toward goals, problem solving potential obstacles, evaluating dysfunctional cognitions, summarizing important points, and devising homework

# Principles of Treatment

7. CBT is aspirational, values based, and goal oriented
   - Ask clients about their values, aspirations, and specific goals in the first session

# Principles of Treatment

8. CBT initially emphasizes the present
   - For most clients- involves a strong focus on the skills they need to improve their mood (and their lives)
   - Shift focus to the past in 3 circumstances
     1. When the client expresses a strong desire to do so
     2. When work toward current problems and future aspirations produces insufficient change
     3. Helping to understand how past events and patterns shape current dysfunctional thinking and behavior

# Principles of Treatment

9. CBT is educative
   - Goal of treatment (and important to alliance) make therapy understandable
   - Discuss expectations of treatment, structure of sessions
   - Present treatment plan, conceptualization and incorporate feedback
   - Explain techniques

# Principles of Treatment

10. CBT is time sensitive
    - Many clients with anxiety or depression require between 6 to 16 sessions
    - Make it as short as possible while fulfilling objectives
        1. Help client recover from their disorder
        2. Work toward fulfilling their aspirations, values, and goals
        3. Resolve their most presenting issues
        4. Promote satisfaction and enjoyment in life
        5. Learn skills to promote resilience and avoid relapse

# Principles of Treatment

11. CBT sessions are structured
    1. Aim is to conduct therapy as efficiently as possible
    2. Reestablish therapeutic alliance
    3. Review homework
    4. Prioritize session agenda
    5. Discuss goals or issues on agenda
    6. Summarize session
    7. Establish homework
    8. Elicit client feedback

# Principles of Treatment

12. CBT uses guided discovery and teaches clients to respond to their dysfunctional cognitions
    - Ask clients questions to help them identify their dysfunctional thinking
    - Evaluate validity and utility of their thoughts
    - Devise a plan of action (cognitive restructuring- process of assessing and responding to maladaptive thinking)

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# IDENTIFYING THOUGHTS WORKSHEET

**PART 1:**

**REMEMBER: JUST BECAUSE I THINK SOMETHING, DOESN'T NECESSARILY MEAN IT'S TRUE. WHEN I CHANGE MY UNHELPFUL OR INACCURATE THOUGHTS, I'LL LIKELY FEEL BETTER.**

Instructions: When my mood gets worse or I'm engaging in unhelpful behavior, ask myself: ***"What was just going through my mind?"*** Write down my thoughts below.

**PART 2:**

**REMEMBER: IT'S IMPORTANT TO CATCH MYSELF THINKING IN A HELPFUL WAY.**

Instructions: When I'm engaging in helpful behavior, ask myself, ***"What was I thinking that allowed me to do this?"*** Write down my thoughts below.

# Cognitive Distortions

| | |
|---|---|
| All-or-nothing thinking | Example: "If I'm not a total success, I'm a failure." |
| Catastrophizing (fortune telling) | Example: "I'll be so upset, I won't be able to function at all." |
| Disqualifying or discounting the positive | Example: "I did that project well, but that doesn't mean I'm competent; I just got lucky." |
| Emotional reasoning | Example: "I know I do a lot of things okay at work, but I still feel like I'm a failure." |
| Labeling | Examples: "I'm a loser." "He's no good." |
| Magnification/minimization | Example: "Getting a mediocre evaluation proves how inadequate I am. Getting high marks doesn't mean I'm smart." |
| Mental filter (selective abstraction) | Example: "Because I got one low rating on my evaluation [which also contained several high ratings], it means I'm doing a lousy job." |
| Mind reading | Example: "He's thinking that I don't know the first thing about this project." |
| Overgeneralization | Example: "Because I felt uncomfortable at the get-together, I don't have what it takes to make friends." |
| Personalization | Example: "The repairman was curt to me because I did something wrong." |
| "Should" and "must" statements | Example: "It's terrible that I made a mistake. I should always do my best." |
| Tunnel vision | "My son's teacher can't do anything right. He's critical and insensitive and lousy at teaching." |

# THOUGHT RECORD: SIDE TWO WORKSHEET

| Date/time | Situation | Automatic Thought(s) | Emotion(s) | Adaptive Response | Outcome |
|---|---|---|---|---|---|
| | 1. What event (external or internal) is associated with the unpleasant emotion? Or what unhelpful behavior did you engage in? | 1. What thought(s) and/or image(s) went through your mind (before, during or after the event or unhelpful behavior)?<br><br>2. How much did you believe the thought(s)? | 1. What emotion(s) (sad/ anxious/ angry/ etc.) did you feel (before, during or after the event or unhelpful behavior)?<br><br>2. How intense (0–100%) was the emotion? | 1. (optional) What cognitive distortion did you make?<br><br>2. Use questions below to compose a response to the automatic thought(s). Indicate how much you believe each response. | 1. How much do you now believe each automatic thought?<br><br>2. What emotion(s) do you feel now? How intense (0–100%) is the emotion?<br><br>3. What would be good to do? |
| | | | | | |

# When Cognitive Restructure doesn't work

- There are more central automatic thoughts
- The evaluation of the automatic thought is implausible, superficial, or inadequate
- The evidence that supports the automatic thought has not been adequately expressed
- The automatic thought is actually a core belief
- The client understands intellectually the thought is distorted but not on an emotional level
- The automatic thought is part of a dysfunctional thought pattern

# Mindfulness

1. Mindfulness of Thought- for clients who excessively ruminate, worry, or try to suppress intrusive thoughts or images

2. Mindfulness of Internal Stimuli- for intense emotion and other distressing internal experiences

3. Mindfulness for self-compassion- for clients who experience a great deal of self-criticism

# Principles of Treatment

13. CBT includes Action Plans (a.k.a. Homework)
    - Consist of
        - Identifying and evaluating automatic thoughts that are obstacles to client's goals
        - Implementing solutions to problems and obstacles that could arise in the coming weeks, and/or
        - Practicing behavioral skills learned in session

# Examples of Action Plans

1. Reading therapy notes
2. Monitoring automatic thoughts
3. Evaluating and responding to automatic thoughts
4. Doing behavioral experiments
5. Disengaging from thoughts
6. Implementing steps toward their goals
7. Engaging in activities to lift affect
8. Credit lists

# Increasing adherence

- Tailor to the individual
- Provide the rationale (link to goals and/or values)
- Collaboration
- Identify barriers
- Be practical with likelihood of follow through

# Principles of Treatment

14. CBT uses a variety of techniques to change thinking, mood, and behavior
    - Adapt strategies from many psychotherapeutic modalities within the cognitive framework

COMMON NEGATIVE

# Core Beliefs

**I'M NOT GOOD ENOUGH**

I'm a failure, I can't change, I will never succeed, everyone else is better than me, there is no point in trying in life

**I'M UNSAFE**

You can't trust anyone or anything, you have to be in control to survive, you should never be vulnerable or let your guard down

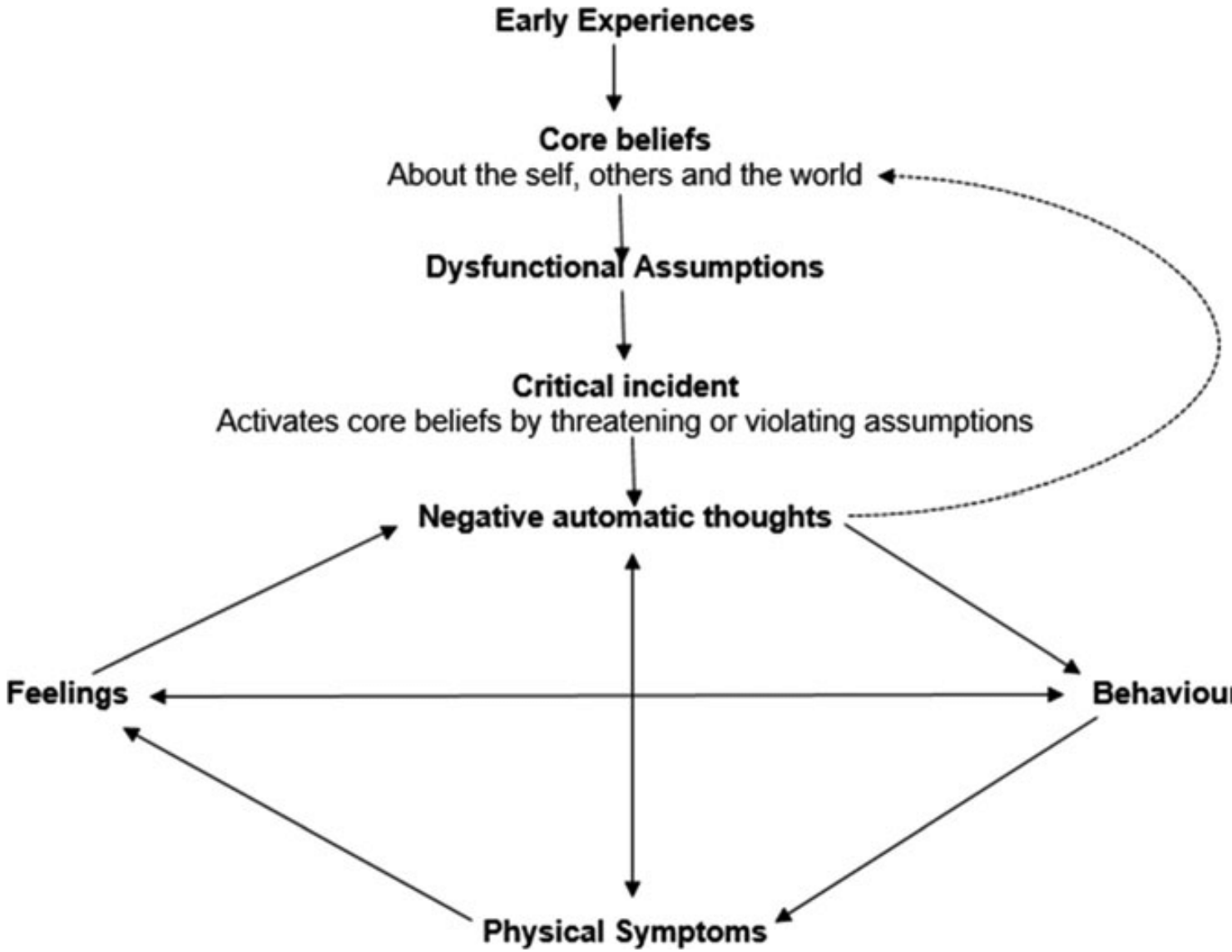
**IT'S MY FAULT**

I always get it wrong, I need to try harder, I have to help everyone, I am selfish to think about myself, I have to be perfect

**I'M UNLOVABLE**

Nobody wants me, nobody understands me, I bore others, people hate me, I'm better off alone

Credits: P&G Clinical Services.


Early Experiences
Core beliefs
About the self, others and the world
Dysfunctional Assumptions
Critical incident
Activates core beliefs by threatening or violating assumptions
Negative automatic thoughts
Feelings
Behaviour
Physical Symptoms

@mysoulbalm

# The Downward Arrow

Technique for discovering core beliefs

Start here, with a problematic thought

"I'm going to totally fail this job interview!"

keep asking yourself questions like "why does it matter if I fail?"

Because it would mean I don't get the job

And questions like "what does this say about me as a person?"

It means I didn't try hard enough to prepare and that I'm not good enough to have a good job like this.

Keep questioning Eventually you'll get to your core belief

It says that I'm a lazy failure at life

# Concepts about beliefs (p. 297)

- Beliefs are ideas, not truths and can be tested and changed
- Beliefs are learned, not innate.
- Beliefs can be rigid and “feel” as if they are true
- Beliefs originated through the meaning clients put to their experiences, often during developmental years
- When relevant schemas are activated, clients recognize data that support their core beliefs, while discounting data to the contrary.

# Exploring beliefs

1. Pose a hypothesis about the belief
2. Use a metaphor to explain information processing
3. Determining when the belief originated or became maintained
4. Explain beliefs using diagram

# Strengthen positive beliefs (p.304)

- Elicit positive data and drawing helping conclusions about their experiences
- Elicit the advantages of believing adaptive beliefs
- Pointing out the meaning of positive data
- Referencing other people
- Using a chart to collect evidence
- Inducing images of current and historical experiences
- Acting as if

# Modifying maladaptive beliefs (p.309)

- Socratic questioning
- Reframing
- Behavioral experiments
- Stories, movies, and metaphors
- Cognitive continuum
- Using others as a reference point
- Self-disclosure
- Intellectual- emotional role plays
- Historical tests
- Restructuring the meaning of early memories

# Principles of Treatment

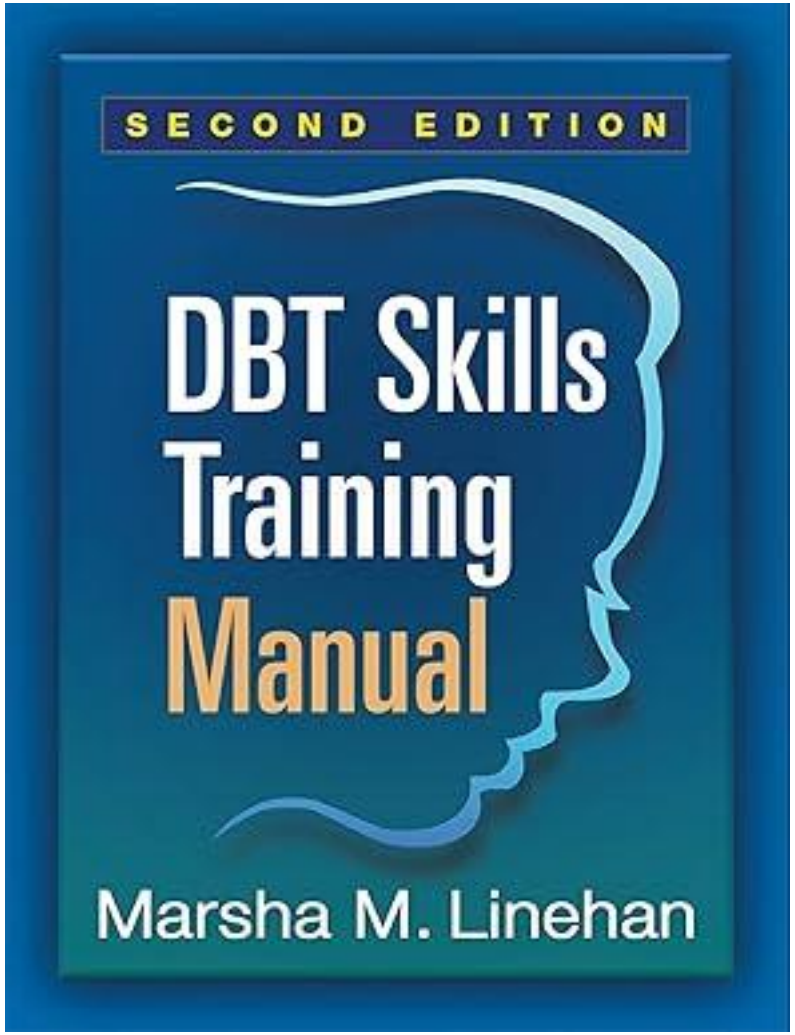
3. CBT continually monitors client progress
   - Routine monitoring improves outcomes
   - Measure progress toward goals, general functioning, therapeutic alliance

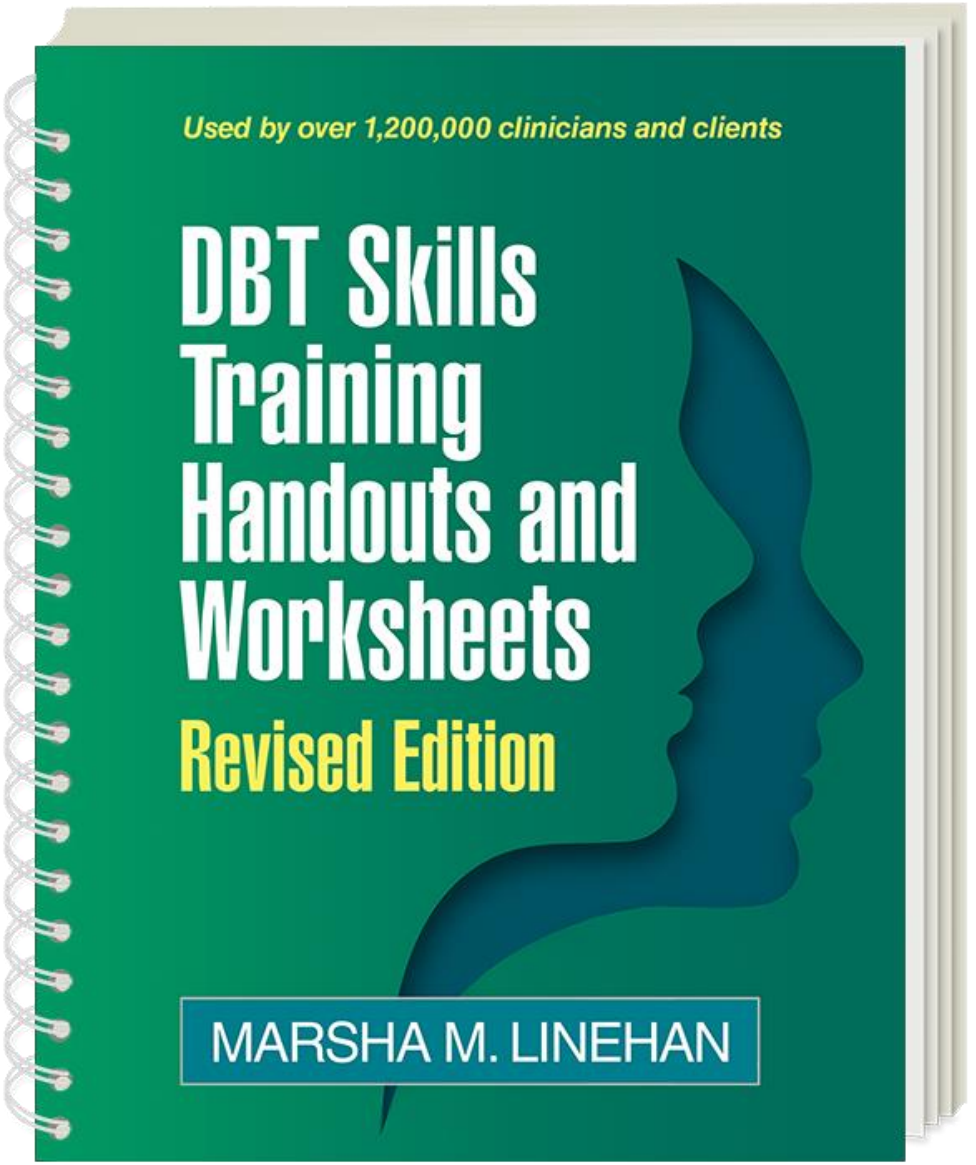
COURSE DESCRIPTION

# One transdiagnostic toolkit, two evidence-based traditions

| Where CBT struggles | Where DBT struggles | The bridge |
| --- | --- | --- |
| CBT offers powerful tools for cognitive change and exposure — but often struggles with clients who lack the emotional-regulation capacity to tolerate that work. | DBT offers excellent stabilization — but on its own may not sufficiently address the core schemas that drive chronic disorders. | This workshop bridges that gap with a "Stabilize-Then-Process" framework: DBT skills widen the window of tolerance first; CBT interventions then restructure maladaptive beliefs and behaviors. |

*Participants learn to move fluidly between CBT's "Change" focus and DBT's "Acceptance" focus — addressing the overlapping avoidance and dysregulation mechanisms found across OCD, depression, anxiety, trauma, addiction, and chronic pain.*


SECOND EDITION
DBT Skills Training Manual
Marsha M. Linehan


Used by over 1,200,000 clinicians and clients
DBT Skills Training Handouts and Worksheets
Revised Edition
MARSHA M. LINEHAN

# Dialectical Behavior Therapy

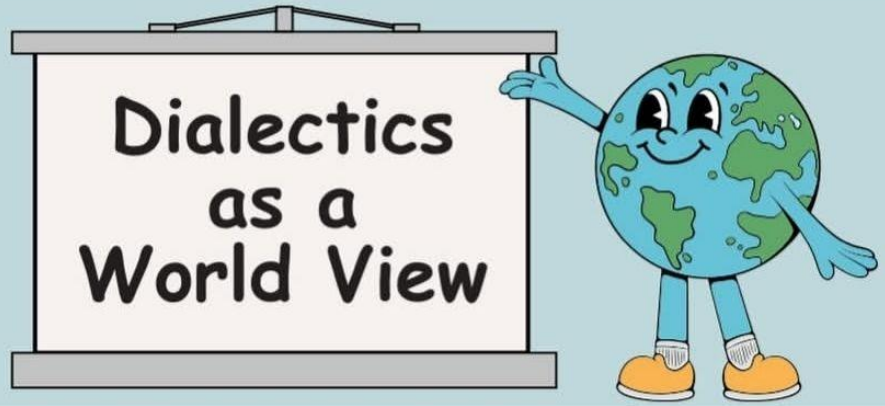
- Emotion dysregulation has been linked to a variety of mental health problems stemming from patterns of instability in emotion regulation, impulse control, interpersonal relationships, and self-image.
- The overall goal of DBT skills training is to help individuals change behavioral, emotional, thinking, and interpersonal patterns associated with problems in living.


Mindfulness
Emotional Regulation
DBT
Distress Tolerance
Interpersonal Effectiveness

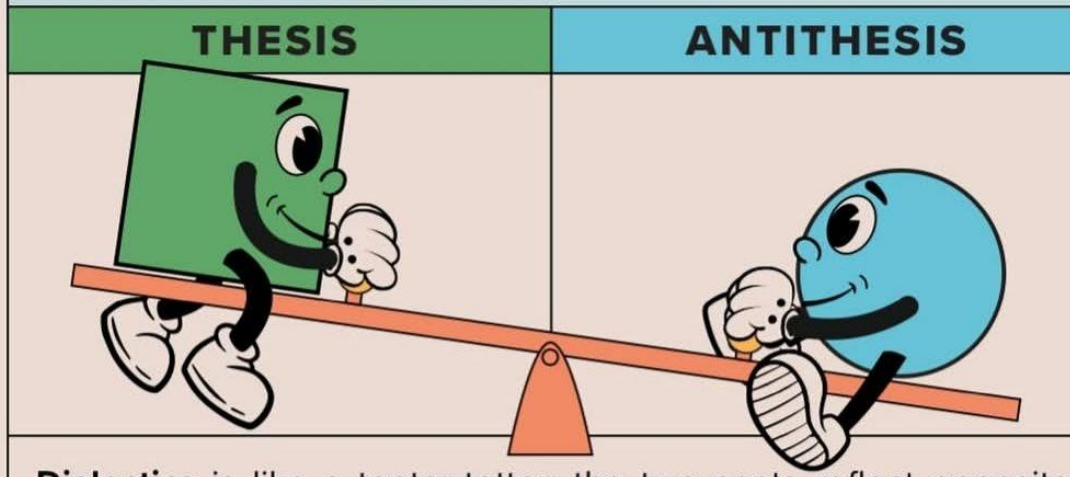
# Dialectical World View

- Views analysis of individual parts of a system (e.g. one specific behavior) as well as the interrelatedness of those parts (e.g. other behaviors, environment) and the larger whole (e.g. the culture, state of the world at the time)
- Learning one new set of skills is extremely difficult without learning other related skills simultaneously (e.g. the individual must learn not only self-regulation skills and skills for influencing his or her environment, but also when to regulate them.)

# UNDERSTANDING DIALECTICS IN DIALECTICAL BEHAVIOR THERAPY (DBT)




A **dialectical** philosophy guides **DBT**. It assumes that everything is interrelated, that tension is inevitable, and that change is constant. To adopt a dialectical worldview means to strive to embrace that seemingly opposite ideas can both be true and to accept change as a natural occurrence.




**Dialectics** is like a teeter-totter: the two seats reflect opposite sides or truths that can exist at the same time. These opposites sides are called **"thesis"** and **"antithesis."**



*Adapted from Linehan, M., M., (2015). DBT Skills Training Manual (2nd ed). Guilford Press.

# Polarities

1. The dialectic between the need for clients to accept themselves as they are in the moment and the need for them to change.
2. The tension between clients' getting what they need to become more competent, and losing what they need if they become more competent.
3. Maintaining personal integrity and validating their own views of their difficulties versus learning new skills that will help them emerge from their suffering.

Therapy does not focus on maintaining a stable, consistent environment, but rather aims to help the client become comfortable with change.

# Theory of Emotional Dysregulation

- Emotions are brief, involuntary, full-system, patterned responses to internal and external stimuli.
- Emotions are evolutionarily adaptive
- Suicidality is a response to extreme emotional suffering
- Emotion dysregulation is the inability, even when one's best efforts are applied, to change or regulate emotional cues, experiences, actions, verbal responses, and/or nonverbal expressions under normative conditions.

# Theory of Emotional Dysregulation

- Pervasive emotion dysregulation is due to vulnerability to high emotionality, together with an inability to regulate intense emotion-linked responses.
- Emotion dysregulation in general, as well as the dysregulation encountered in BPD specifically, is an outcome of biological disposition, environmental context, and the transaction between the two during development.
- Emotion regulation, in contrast, is the ability to (1) inhibit impulsive and inappropriate behavior related to strong negative or positive emotions; (2) organize oneself for coordinated action in the service of an external goal (i.e., act in a way that is not mood dependent when necessary); (3) self-soothe any physiological arousal that the strong emotion has induced; and (4) refocus attention in the presence of strong emotion.

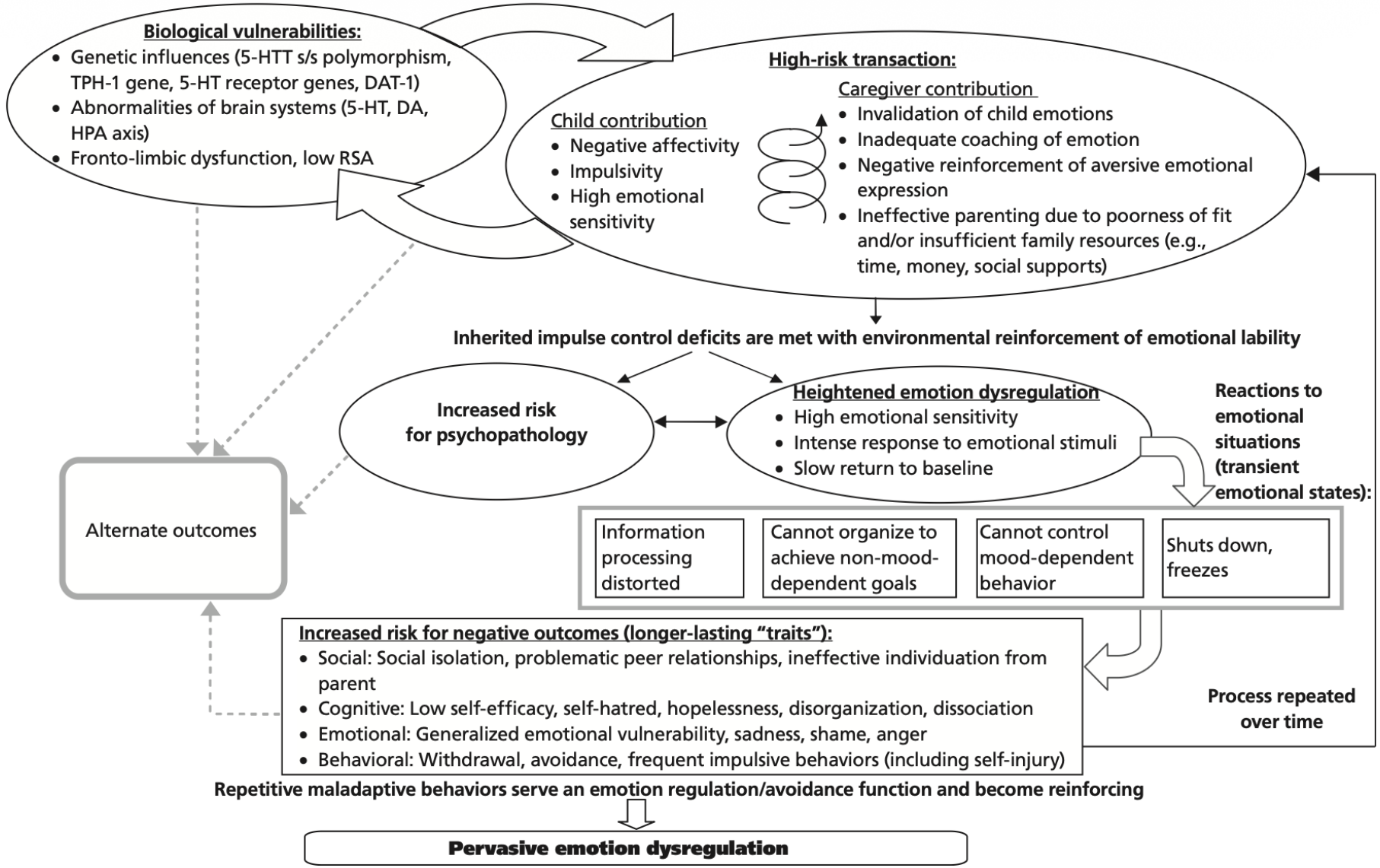



**FIGURE 1.1.** Illustration of the biosocial developmental model of BPD. 5-HT, serotonin; 5-HTT, serotonin transporter; TPH-1, tryptophan hydroxylase 1; DA, dopamine; DAT-1, dopamine transporter 1; HPA, hypothalamic–pituitary–adrenocortical; RSA, respiratory sinus arrhythmia. Adapted from Crowell, S. E., Beauchaine, T. P., & Lenzenweger, M. F. (2008). The development of borderline personality and self-injurious behavior. In T. P. Beauchaine & S. Hinshaw (Eds.), *Child psychopathology* (p. 528). Hoboken, NJ: Wiley. Copyright 2008 by John Wiley & Sons, Inc. Adapted by permission.

# Treatment

1. Synthesis of acceptance with change.
2. Inclusion of mindfulness as a practice for therapists and as a core skill for clients.
3. Emphasis on treating therapy- interfering behaviors of both client and therapist.
4. Emphasis on the therapeutic relationship and therapist self-disclosure as essential to therapy.
5. Emphasis on dialectical processes.

# Treatment

6. Emphasis on stages of treatment, and on targeting behaviors according to severity and threat.
7. Inclusion of a specific suicide risk assessment and management protocol.
8. Inclusion of behavioral skills drawn primarily from other evidence-based interventions.
9. The treatment team as an integral component of therapy.
10. Focus on continual assessment of multiple outcomes via diary cards.

# Skills Training in Non- DBT Programing/ Sessions

- Many non-DBT psychotherapists, counselors, case managers,, other mental health providers will find it useful at times to integrate DBT skills into their treatment of clients.
- What is important here is that providers know the skills and know what skills go with what problem or set of problems.
- Decide whether to use a handout and/or worksheet in teaching the skill, or to teach it orally without these materials.
- Practice the skill with the client if possible, and give an assignment or suggestion that the client practice the skill before the next visit.

# Skill Building

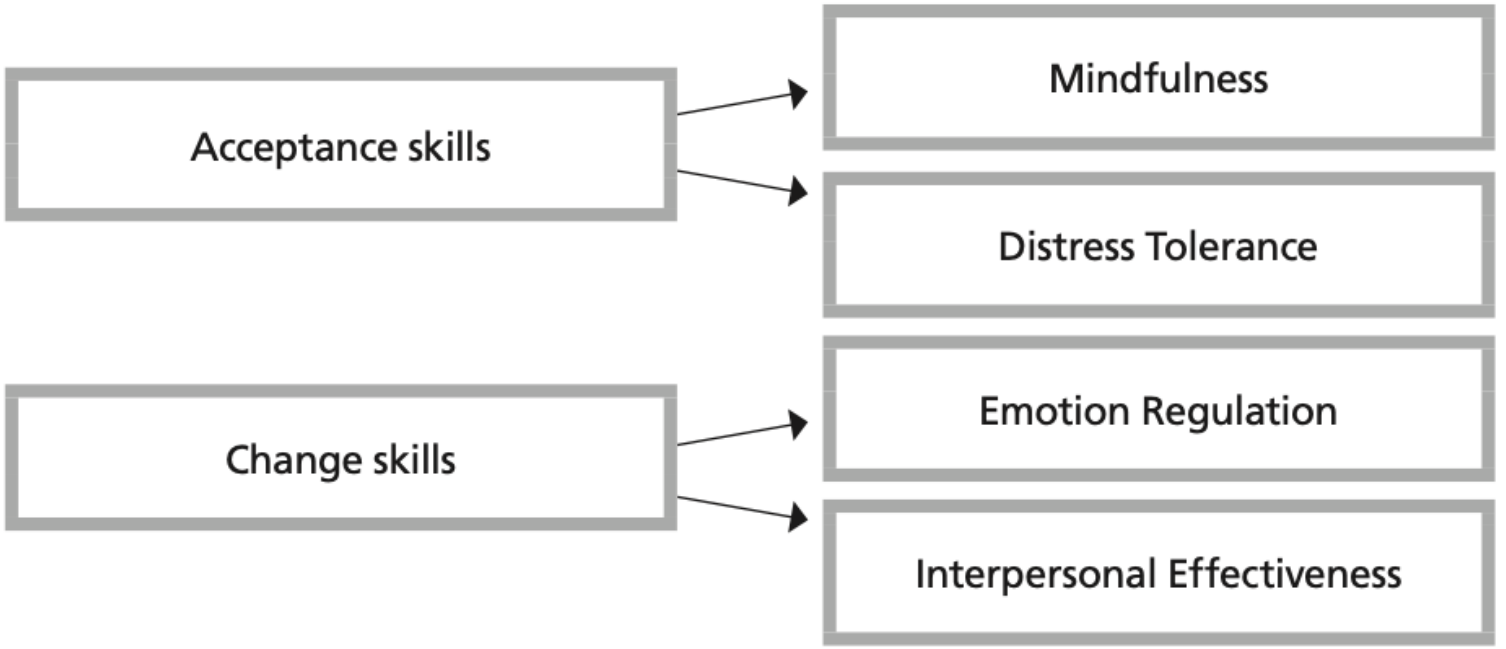


**TABLE 1.1. Overview of Specific DBT Skills by Module**

**Mindfulness Skills**

- Core mindfulness skills
  - Wise mind (states of mind)
  - "What" skills (observe, describe, participate)
  - "How" skills (nonjudgmentally, one-mindfully, effectively)
- Other Perspectives on Mindfulness
  - Mindfulness practice: A spiritual perspective (including wise mind and practicing loving kindness)
  - Skillful means: Balancing doing mind and being mind
  - Wise mind: Walking the middle path

**Interpersonal Effectiveness Skills**

- Obtaining objectives skillfully
  - Clarifying priorities
  - Objectives effectiveness
    - DEAR MAN (Describe, Express, Assert, Reinforce; stay Mindful, Appear confident, Negotiate)
  - Relationship effectiveness
    - GIVE (be Gentle, act Interested, Validate, use an Easy manner)
  - Self-respect effectiveness
    - FAST (be Fair, no Apologies, Stick to values, be Truthful)
  - Whether and how intensely to ask or say no
- Supplementary interpersonal effectiveness skills
  - Building relationships and ending destructive ones
    - Skills for finding potential friends
    - Mindfulness of others
    - How to end relationships
  - Walking the middle path skills
- Dialectics
- Validation
- Behavior change strategies

**Emotion Regulation Skills**

- Understanding and naming emotions
- Changing emotional responses
  - Checking the facts
  - Opposite action
  - Problem solving
- Reducing vulnerability to emotion mind
  - ABC PLEASE (Accumulate positive emotions, Build mastery, Cope ahead; treat PhysicaL illness, balance Eating, avoid mood-Altering substances, balance Sleep, get Exercise)
- Managing really difficult emotions
  - Mindfulness of current emotions
  - Managing extreme emotions

**Distress Tolerance Skills**

- Crisis survival skills
  - STOP skill
  - Pros and cons
  - TIP body chemistry
    - (Temperature, Intense exercise, Paced breathing, Paired muscle relaxation)
  - Distracting with wise mind ACCEPTS
    - (Activities, Contributing, Comparisons, Emotions, Pushing away, Thoughts, Sensations)
  - Self-soothing through the senses
    - (vision, hearing, smell, taste, touch; body scan)
  - IMPROVE the moment
    - (Imagery, Meaning, Prayer, Relaxation, One thing in the moment, Vacation, Encouragement)
- Reality acceptance skills
  - Radical acceptance
  - Turning the mind
  - Willingness
  - Half-smiling
  - Willing hands
  - Mindfulness of current thoughts
- Supplementary distress tolerance skills when the crisis is addiction:
  - Dialectical abstinence

| **Dialectical Behavior Therapy Diary Card** | Name: | Filled Out in Session?<br>Y N | How Often Did You Fill Out?<br>__ Daily __ 2–3×<br>__ 4–6x __ Once | Last Day Filled Out:<br>Month __ Year __<br>Day __ |
|---|---|---|---|---|

| Circle Start Day<br>**Day of week** | **Highest Urge To:** | | | **Highest Rating for Each Day** | | | **Drugs/Medications** | | | | | | | **Actions** | | | **Emotions** | | **Optional** | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Commit Suicide | Self-Harm | Use Drugs | Emotion Misery | Physical Misery | Joy | Alcohol | | Illegal Drugs | | Meds. as Prescribed | p.r.n./Over-the-Counter Meds. | | Self-Harm | Lied | Used Skills* | | | | |
| | 0–5 | 0–5 | 0–5 | 0–5 | 0–5 | 0–5 | # | What? | # | What? | Y/N | # | What? | Y/N | # | 0–7 | | | | |
| MON | | | | | | | | | | | | | | | | | | | | |
| TUE | | | | | | | | | | | | | | | | | | | | |
| WED | | | | | | | | | | | | | | | | | | | | |
| THUR | | | | | | | | | | | | | | | | | | | | |
| FRI | | | | | | | | | | | | | | | | | | | | |
| SAT | | | | | | | | | | | | | | | | | | | | |
| SUN | | | | | | | | | | | | | | | | | | | | |

Med. Change This Week

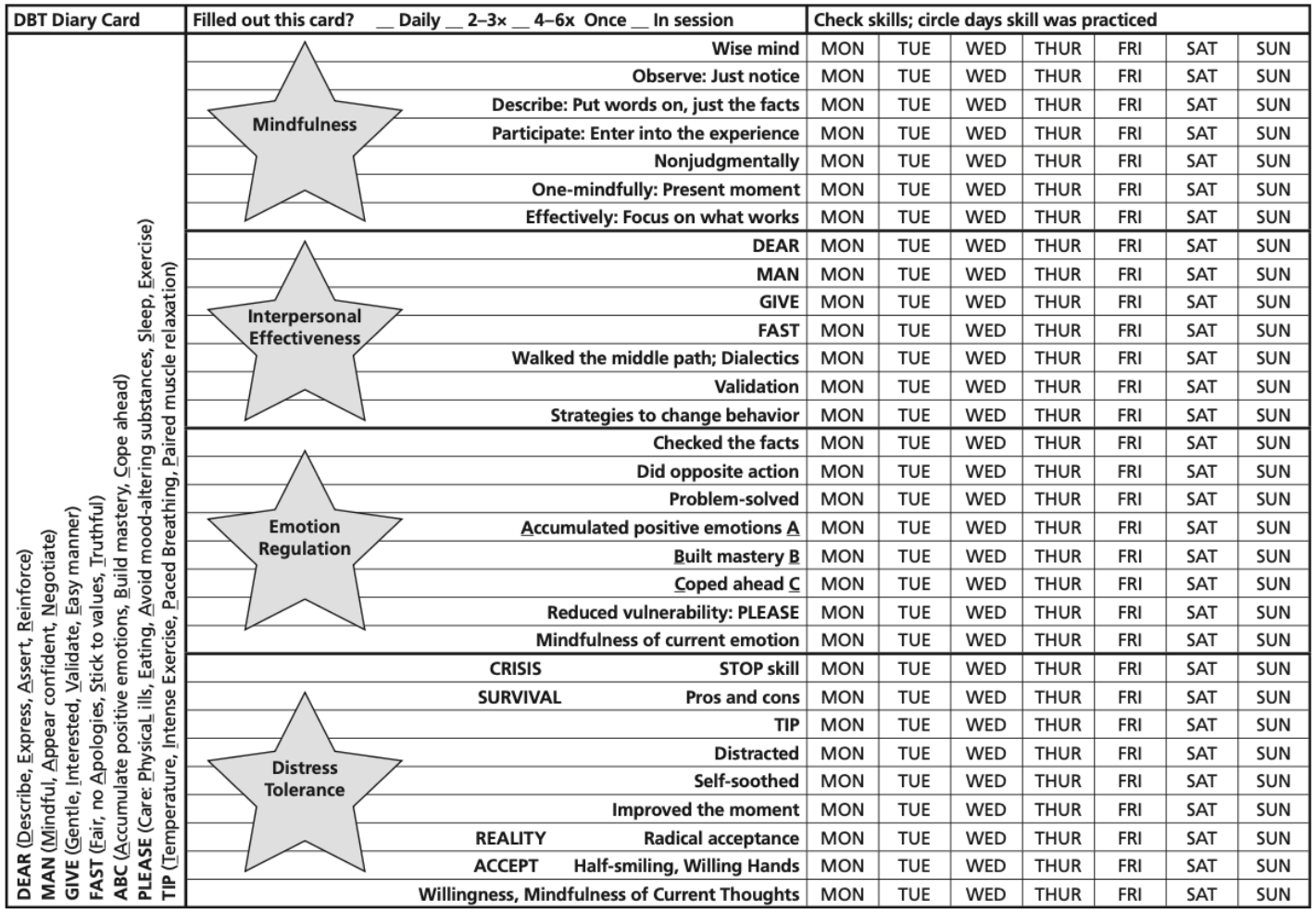
Homework Assigned and Results This Week:

***Used Skills**

0 = Not thought about or used
1 = Thought about, not used, didn't want to
2 = Thought about, not used, wanted to
3 = Tried but couldn't use them
4 = Tried, could do them but they didn't help
5 = Tried, could use them, helped
6 = Automatically used them, didn't help
7 = Automatically used them, helped

| **Urges to:** | **Coming into Session (0–5)** | **Belief I Can Change or Regulate My:** | **Coming into Session (0–5)** |
|---|---|---|---|
| Quit Therapy | | Emotions | |
| Use Drugs | | Actions | |
| Commit Suicide | | Thoughts | |

Skills Focus This Week:



| DBT Diary Card | Filled out this card? __ Daily __ 2–3× __ 4–6x Once __ In session | Check skills; circle days skill was practiced | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Wise mind | MON | TUE | WED | THUR | FRI | SAT | SUN |
| | Observe: Just notice | MON | TUE | WED | THUR | FRI | SAT | SUN |
| | Describe: Put words on, just the facts | MON | TUE | WED | THUR | FRI | SAT | SUN |
| | Participate: Enter into the experience | MON | TUE | WED | THUR | FRI | SAT | SUN |
| | Nonjudgmentally | MON | TUE | WED | THUR | FRI | SAT | SUN |
| | One-mindfully: Present moment | MON | TUE | WED | THUR | FRI | SAT | SUN |
| | Effectively: Focus on what works | MON | TUE | WED | THUR | FRI | SAT | SUN |
| | DEAR | MON | TUE | WED | THUR | FRI | SAT | SUN |
| | MAN | MON | TUE | WED | THUR | FRI | SAT | SUN |
| | GIVE | MON | TUE | WED | THUR | FRI | SAT | SUN |
| | FAST | MON | TUE | WED | THUR | FRI | SAT | SUN |
| | Walked the middle path; Dialectics | MON | TUE | WED | THUR | FRI | SAT | SUN |
| | Validation | MON | TUE | WED | THUR | FRI | SAT | SUN |
| | Strategies to change behavior | MON | TUE | WED | THUR | FRI | SAT | SUN |
| | Checked the facts | MON | TUE | WED | THUR | FRI | SAT | SUN |
| | Did opposite action | MON | TUE | WED | THUR | FRI | SAT | SUN |
| | Problem-solved | MON | TUE | WED | THUR | FRI | SAT | SUN |
| | Accumulated positive emotions A | MON | TUE | WED | THUR | FRI | SAT | SUN |
| | Built mastery B | MON | TUE | WED | THUR | FRI | SAT | SUN |
| | Coped ahead C | MON | TUE | WED | THUR | FRI | SAT | SUN |
| | Reduced vulnerability: PLEASE | MON | TUE | WED | THUR | FRI | SAT | SUN |
| | Mindfulness of current emotion | MON | TUE | WED | THUR | FRI | SAT | SUN |
| | CRISIS STOP skill | MON | TUE | WED | THUR | FRI | SAT | SUN |
| | SURVIVAL Pros and cons | MON | TUE | WED | THUR | FRI | SAT | SUN |
| | TIP | MON | TUE | WED | THUR | FRI | SAT | SUN |
| | Distracted | MON | TUE | WED | THUR | FRI | SAT | SUN |
| | Self-soothed | MON | TUE | WED | THUR | FRI | SAT | SUN |
| | Improved the moment | MON | TUE | WED | THUR | FRI | SAT | SUN |
| | REALITY Radical acceptance | MON | TUE | WED | THUR | FRI | SAT | SUN |
| | ACCEPT Half-smiling, Willing Hands | MON | TUE | WED | THUR | FRI | SAT | SUN |
| | Willingness, Mindfulness of Current Thoughts | MON | TUE | WED | THUR | FRI | SAT | SUN |



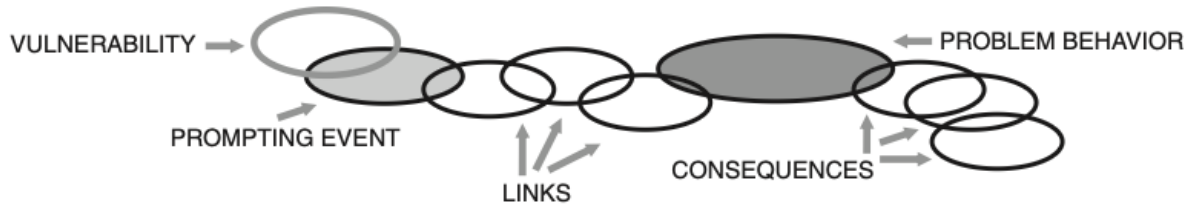
**FIGURE 4.1.** Front (top) and back (bottom) of a DBT diary card. The entire back half of the card is used in skills training sessions; the front half is used in individual therapy except for the "Used Skills" column, which is also employed in skills training. Should be printed on 4" × 6" card stock (front and back).

# Dialectical Behavior Therapy DBT

Analyzing Behaviour

# Chain Analysis

**TO UNDERSTAND BEHAVIOR, DO A CHAIN ANALYSIS.**




**Step 1:** Describe the **PROBLEM BEHAVIOR.**

**Step 2:** Describe the **PROMPTING EVENT** that started the chain of events leading to the problem behavior.

**Step 3:** Describe the factors happening before the event that made you **VULNERABLE** to starting down the chain of events toward the problem behavior.

**Step 4:** Describe in excruciating detail the **CHAIN OF EVENTS** that led to the problem behavior.

**Step 5:** Describe the **CONSEQUENCES** of the problem behavior.

**To change behavior:**

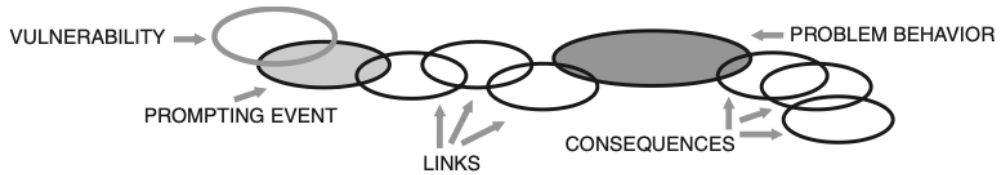
**Step 6:** Describe **SKILLFUL** behaviors to replace problem links in the chain of events.

**Step 7:** Develop **PREVENTION PLANS** to reduce vulnerability to stressful events.

**Step 8: REPAIR** important or significant consequences of the problem behavior.

# Chain Analysis of Problem Behavior

Due Date: _____ Name: _____ Date: _____




**1.** What exactly is the major **PROBLEM BEHAVIOR** that I am analyzing?

**2.** What **PROMPTING EVENT** in the environment started me on the chain to my problem behavior? Include what happened **RIGHT BEFORE** the urge or thought came into my mind.

Day prompting event occurred: _____

**3.** Describe what things in myself and in my environment made me **VULNERABLE.**

Day the events making me vulnerable started: _____

(***continued on next page***)

**LINKS IN THE CHAIN OF EVENTS:** Behaviors (Actions, Body sensations, Cognitions/Thoughts, Feelings) and Events (in the environment)

**Possible Types of Links**

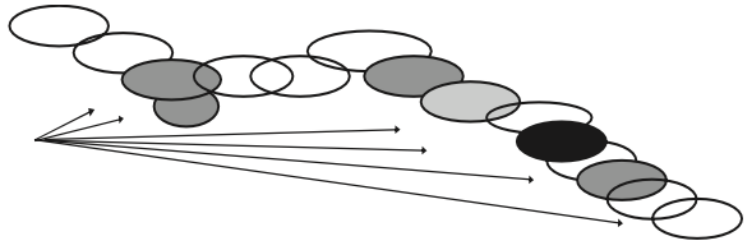
**A.** Actions

**B.** Body sensations

**C.** Cognitions/thoughts

**E.** Events

**F.** Feelings



**4.** List the ***chain of events*** (specific behaviors and environmental events that actually did happen). Use the ABC-EF list above.

**1st.** *I felt hurt and started sobbing on the phone with my sister and was angry with her.*

**2nd.** *I thought, "I can't stand it. No one loves me."*

**3rd.** *I felt very ashamed once I hung up from talking to my sister.*

**4th.** *I thought "My life is useless; no one will ever be here for me."*

**5th.** *Tried watching TV, but nothing was on I liked.*

**6th.** *I started feeling agitated and thought, "I can't stand this."*

**7th.** *I decided to drink a glass of wine to feel better, but ended up drinking two whole bottles.*

**8th.** *Got in my car to drive to a late-night concert.*

**9th.** *While I was bending down to pick up a piece of paper, car swerved. I was stopped by a cop and taken in on a DUI.*

**6.** List new, more ***skillful*** behaviors to replace ineffective behaviors. Use the ABC-EF list.

**1st.** *Listen to why my sister could not come.*

**2nd.** *Remember that my sister and my boyfriend love me.*

**3rd.** *Check the facts; is my sister going to reject me over this?*

**4th.** *Call my sister back and apologize for being angry (since I know she will validate how I feel).*

**5th.** *Download a movie, work on a puzzle, or call a friend instead.*

**6th.** *Try my TIP skills to bring down arousal.*

**7th.** *Walk down the street and have a dinner out, because I won't drink too much in public.*

**8th.** *Call my boyfriend and ask him to come over for a while.*

**9th.** *Take a long bath, try TIP skills again; Keep checking the facts; remember these emotions will pass; call my therapist for help.*

5. **What exactly were the *consequences* in the environment?**

*Short-term: I had to spend the night in jail.*

*Long-term: My boyfriend has less trust in me; my sister is upset about it.*

**And in myself?**

*Short-term: I am ashamed and furious with myself.*

*Long-term: I will have to pay more for car insurance and may have trouble getting a job.*

**What *harm* did my problem behavior cause?**

*It hurt me by giving me a DUI record. My sister feels guilty because she upset me.*

7. ***Prevention plans:***

**Ways to reduce my *vulnerability* in the future:**

*Make plans for how to cope whenever my boyfriend is out of town.*

**Ways to prevent *precipitating event* from happening again:**

*I can't keep the precipitating event from happening, so I need to practice coping ahead and have plans for how to manage when I am at home alone.*

8. **Plans to *repair,* correct, and overcorrect the harm:**

*Apologize to my sister and reassure her that she has a perfect right to change her plans. Work with her to plan a new time for a visit. Ask if it would be easier for her if I came to visit her.*

# Dialectical Behavior Therapy
# DBT

Mindfulness (1)

# Goals of Mindfulness Practice

## REDUCE SUFFERING AND INCREASE HAPPINESS

- ❑ Reduce pain, tension, and stress.
- ❑ Other: _____

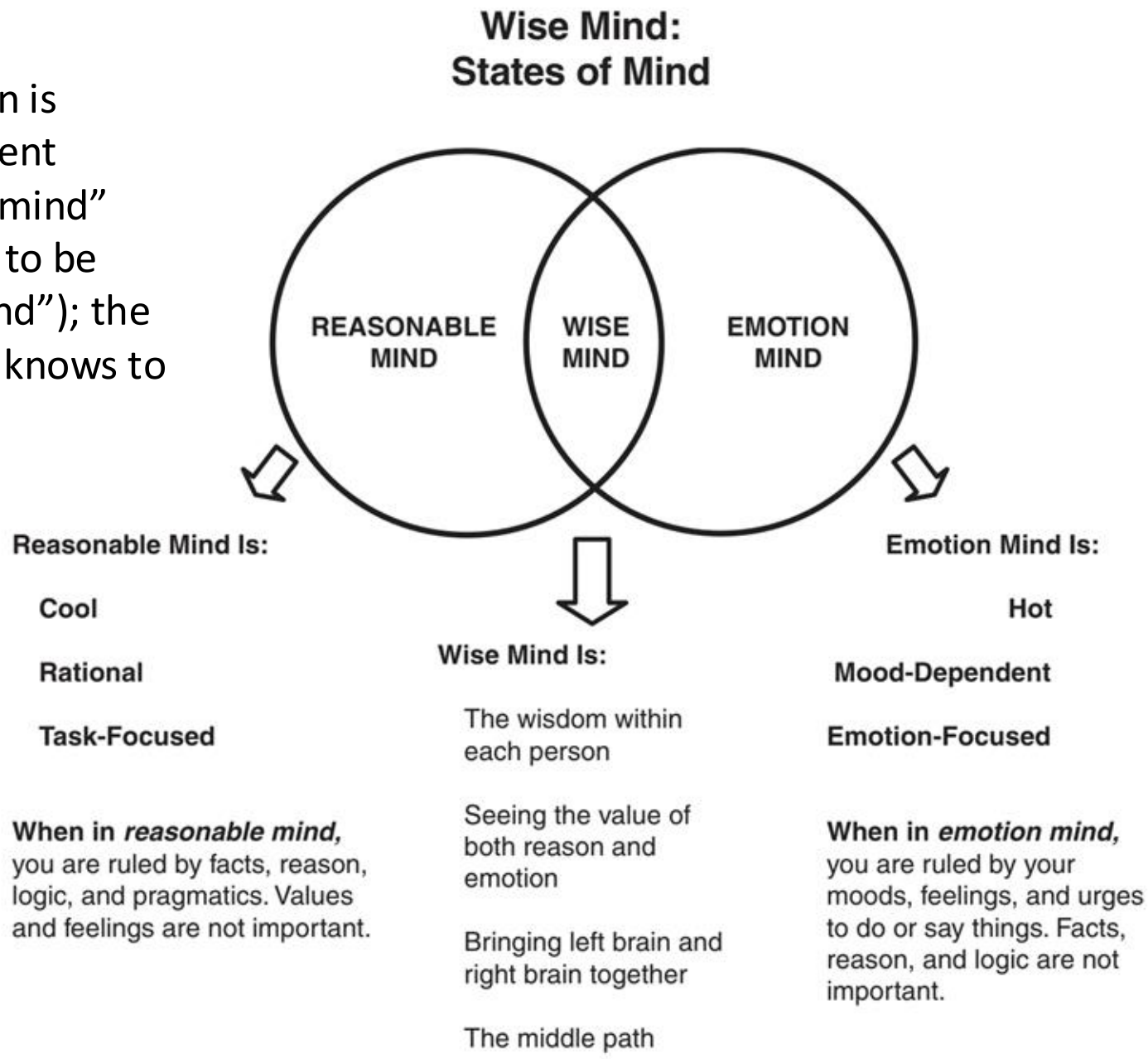
## INCREASE CONTROL OF YOUR MIND

- ❑ Stop letting your mind be in control of you.
- ❑ Other: _____

## EXPERIENCE REALITY AS IT IS

- ❑ Live life with your eyes wide open.
- ❑ Experience the reality of your . . .
  - connection to the universe.
  - essential "goodness."
  - essential validity.
- ❑ Other: _____

The dialectical tension is between what the client believes in “emotion mind” and what they thinks to be true (“reasonable mind”); the synthesis is what she knows to be true in wise mind.



# Mindfulness WHAT Skills

## ***What*** are the core mindfulness skills of DBT?

### OBSERVE

Pay attention to the present moment, observing both inside and outside yourself.

Notice your **body sensations** - what can you observe through your eyes, ears, nose, skin and tongue?

### DESCRIBE

Label what you observe by putting words to the experience. Unglue interpretations and opinions and only **describe the facts.**

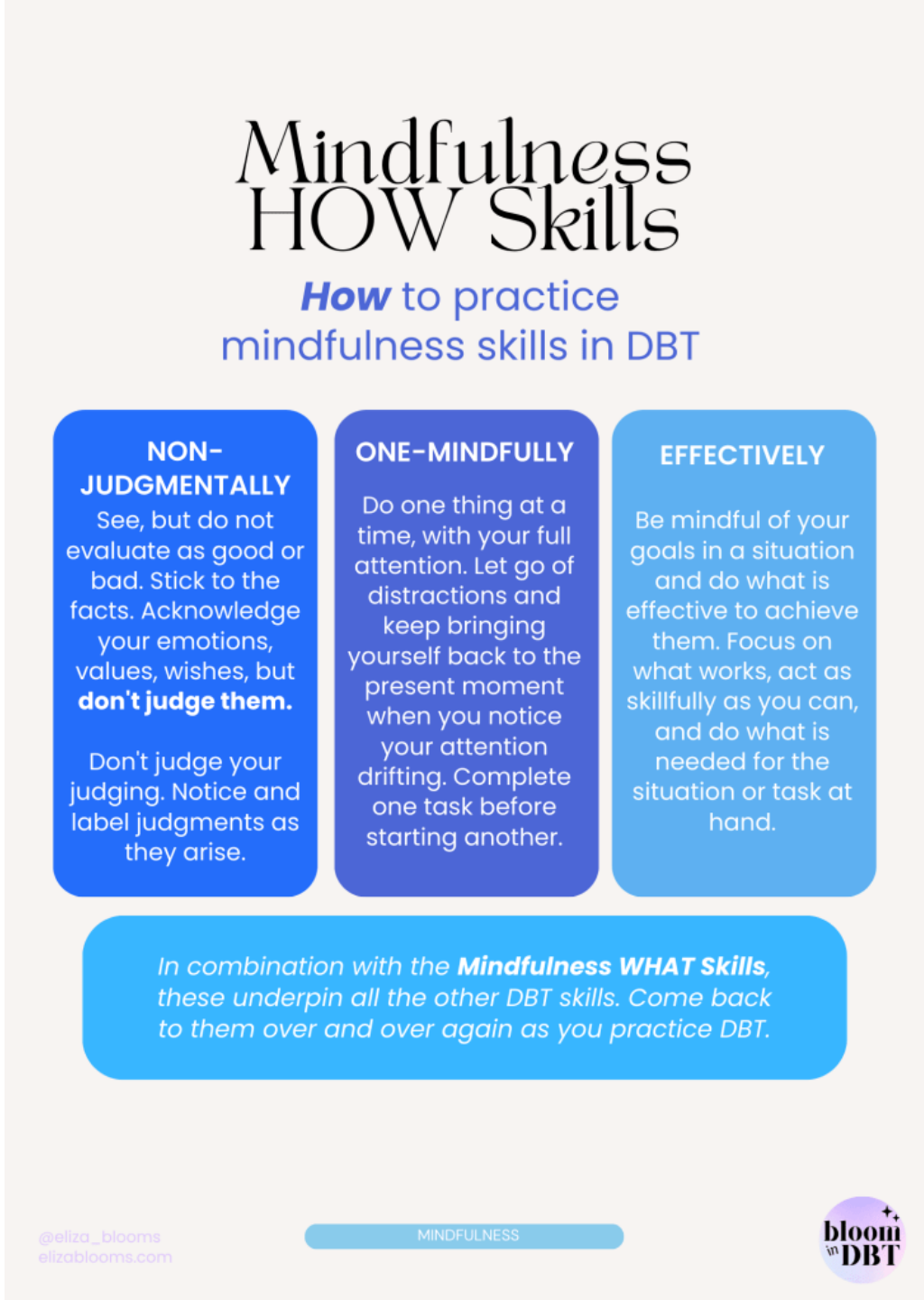
Remember: if you can't observe it through your senses, you can't describe it.

### PARTICIPATE

Completely throw yourself into the activity of the current moment, placing your attention fully whatever you are doing.

Act intuitively from a place of **wise mind**.

*In combination with the **Mindfulness HOW Skills**, these underpin all the other DBT skills. Come back to them over and over again as you practice DBT.*




Instead of judging, DBT stresses the consequences of behavior and events.

# Dialectical Behavior Therapy
# DBT

Distress Tolerance (2)

# Goals of Distress Tolerance

## SURVIVE CRISIS SITUATIONS

**Without Making Them Worse**

## ACCEPT REALITY

**Replace Suffering and Being "Stuck"**
**with Ordinary Pain and the Possibility of Moving Forward**

## BECOME FREE

**Of Having to Satisfy**
**the Demands of Your Own**
**Desires, Urges, and Intense Emotions**

**OTHER: _____**

# Overview:
# Crisis Survival Skills

**These are skills for tolerating painful events, urges, and emotions when you cannot make things better right away.**

**The STOP Skill**

**Pros and Cons**

**TIP Your Body Chemistry**

**Distract with Wise Mind ACCEPTS**

**Self-Soothe with the Five Senses**

**Improve the Moment**

# STOP Skill


| | |
|---|---|
| **S**top | Do not just react. Stop! Freeze! Do not move a muscle! Your emotions may try to make you act without thinking. Stay in control! |
| **T**ake a step back | Take a step back from the situation. Take a break. Let go. Take a deep breath. Do not let your feelings make you act impulsively. |
| **O**bserve | Notice what is going on inside and outside you. What is the situation? What are your thoughts and feelings? What are others saying or doing? |
| **P**roceed mindfully | Act with awareness. In deciding what to do, consider your thoughts and feelings, the situation, and other people's thoughts and feelings. Think about your goals. Ask Wise Mind: Which actions will make it better or worse? |

# TIP Skills: Changing Your Body Chemistry

**To reduce extreme emotion mind *fast*.**

Remember these as **TIP** skills:

**T**

**TIP THE TEMPERATURE of your face with COLD WATER***
**(to calm down fast)**

- Holding your breath, put your face in a bowl of cold water, or hold a cold pack (or zip-lock bag of cold water) on your eyes and cheeks.
- Hold for 30 seconds. Keep water above 50°F.

**I**

**INTENSE EXERCISE***
**(to calm down your body when it is revved up by emotion)**

- Engage in intense exercise, if only for a short while.
- Expend your body's stored up physical energy by running, walking fast, jumping, playing basketball, lifting weights, etc.

**P**

**PACED BREATHING**
**(pace your breathing by slowing it down)**

- Breathe deeply into your belly.
- Slow your pace of inhaling and exhaling way down (on average, five to six breaths per minute).
- Breathe *out* more slowly than you breathe *in* (for example, 5 seconds in and 7 seconds out).

**PAIRED MUSCLE RELAXATION**
**(to calm down by pairing muscle relaxation with breathing out)**

- While breathing into your belly deeply tense your body muscles (*not* so much as to cause a cramp).
- Notice the tension in your body.
- While breathing out, say the word "Relax" in your mind.
- Let go of the tension.
- Notice the difference in your body.

***Caution:** Very cold water decreases your heart rate rapidly. Intense exercise will increase heart rate. Consult your health care provider before using these skills if you have a heart or medical condition, a lowered base heart rate due to medications, take a beta-blocker, are allergic to cold, or have an eating disorder.

# The ACCEPTS Skill

**A** — Activities

Engaging in activities

**C** — Contributing

Doing something for someone else

**C** — Comparisons

Juxtaposing a previous worse period of your life with your current one

**E** — Emotions

Generating different emotions than the ones that you're feeling

**P** — Pushing away

Putting the problem on a shelf

**T** — Thoughts

Engaging in thoughts that compete with the ones present during the crisis

**S** — Sensations

Using the five senses in order to ground

Linehan, M. M. (2015). DBT® skills training manual (2nd ed.). New York, NY, US: Guilford Press.

Psychotherapy Academy

# IMPROVE

Imagery

Meaning

Prayer

Relaxation

One thing at a time

Vacation

Encouragement


- Linehan, M. M. (2015). *DBT skills training manual* (2nd ed.). Guilford Press.
- Reutter, K. (2019). *The dialectical behavior therapy skills workbook for PTSD: Practical exercises for overcoming trauma and post-traumatic stress disorder* (1st ed.). New Harbinger Publications.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| | Pros | Cons |
|---|---|---|
| Acting on crisis urges | Advantages | Disadvantages |
| Resisting crisis urges | Advantages | Disadvantages |

**FIGURE 10.1.** Pros and cons for acting versus not acting on urges.

# Dialectical Behavior Therapy
# DBT

Distress Tolerance (3)

# Overview:
# Reality Acceptance Skills

**These are skills for how to live a life that is not the life you want.**

**RADICAL ACCEPTANCE**

**TURNING THE MIND**

**WILLINGNESS**

**HALF-SMILING AND WILLING HANDS**

**ALLOWING THE MIND:
MINDFULNESS OF CURRENT THOUGHTS**


mindowl
RADICAL ACCEPTANCE COPING STATEMENTS
"This situation is only temporary."
"I can't change what has already happened."
"I won't stress over the things that I can't change."
"I've dealt with difficulties before and I can deal with this."
"This feeling will pass and I will be okay."
"I can't change the situation, but I can control how I respond to it."

## FIGURE OUT WHAT YOU NEED TO RADICALLY ACCEPT

1. Make a list of two **very important** things in your life right now that you need to radically accept. Then give each one a number indicating how much you accept this part of yourself or your life: from 0 (no acceptance, I am in complete denial and/or rebellion) to 5 (complete acceptance, I am at peace with this). *Note:* if you have already completed this section, you don't need to do it again unless things have changed.

   What I need to accept (Acceptance, 0–5)

   **1.** _____ (_____)

   **2.** _____ (_____)

2. Make a list of two **less important** things in your life you are having trouble accepting this week. Then rate your acceptance just as you did above.

   What I need to accept (Acceptance, 0–5)

   **1.** _____ (_____)

   **2.** _____ (_____)

1. **OBSERVE**

   Observe that you are questioning or fighting reality ("it shouldn't be this way")

2. **THE REALITY**

   Remind yourself that the unpleasant reality is just as it is and cannot be changed ("this is what happened")

3. **THE REASON**

   Remind yourself that there are causes for the reality ("this is how things happened")

4. **PRACTICE**

   Practice accepting with your whole self (mind, body, spirit) - Use accepting self-talk, relaxation techniques, mindfulness and/or imagery

5. **LIST**

   List all of the behaviors you would engage in if you did accept the facts and then engage in those behaviors as if you have already accepted the facts

**6** **IMAGINE**

Imagine, in your mind's eye, believing what you do not want to accept and rehearse in your mind what you would do if you accepted what seems unacceptable

**7** **ATTEND**

Attend to body sensations as you think about what you need to accept

**8** **ALLOW**

Allow disappointment, sadness or grief to arise within you

**9** **AKNOWLEDGE**

Aknowledge that life can be worth living even when there is pain

**10** **PROS & CONS**

Do pros and cons if you find yourself resisting practicing acceptance

# Dialectical Behavior Therapy
# DBT

Emotional Regulation (4)

## UNDERSTAND AND NAME YOUR OWN EMOTIONS

- ❑ Identify (observe and describe) your emotions.
- ❑ Know what emotions do for you.
- ❑ Other: _____

## DECREASE THE FREQUENCY OF UNWANTED EMOTIONS

- ❑ Stop unwanted emotions from starting in the first place.
- ❑ Change unwanted emotions once they start.
- ❑ Other: _____

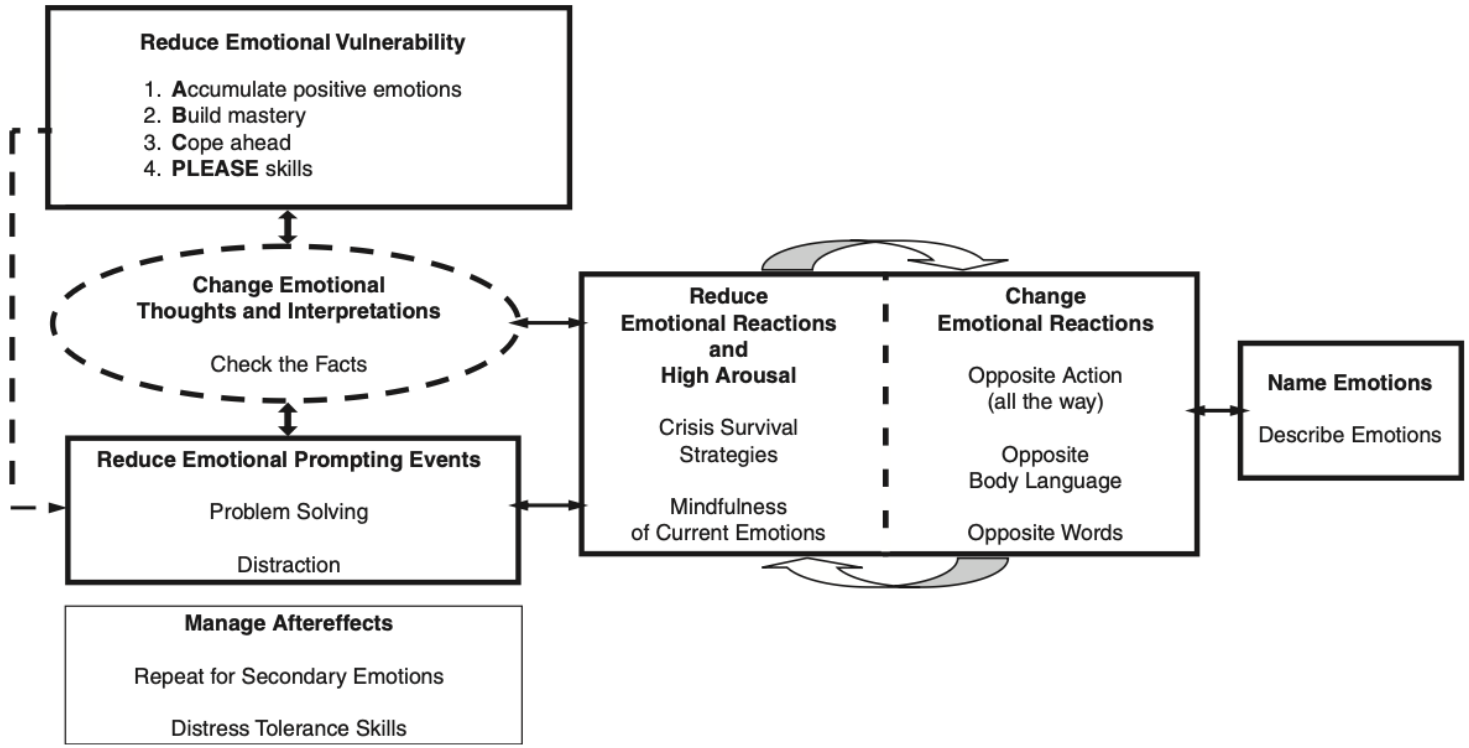
## DECREASE EMOTIONAL VULNERABILITY

- ❑ Decrease vulnerability to emotion mind.
- ❑ Increase resilience, your ability to cope with difficult things and positive emotions.
- ❑ Other: _____

## DECREASE EMOTIONAL SUFFERING

- ❑ Reduce suffering when painful emotions overcome you.
- ❑ Manage extreme emotions so that you don't make things worse.
- ❑ Other: _____

# Review of Skills for Emotion Regulation



# What Emotions Do for You

## EMOTIONS MOTIVATE (AND ORGANIZE) US FOR ACTION

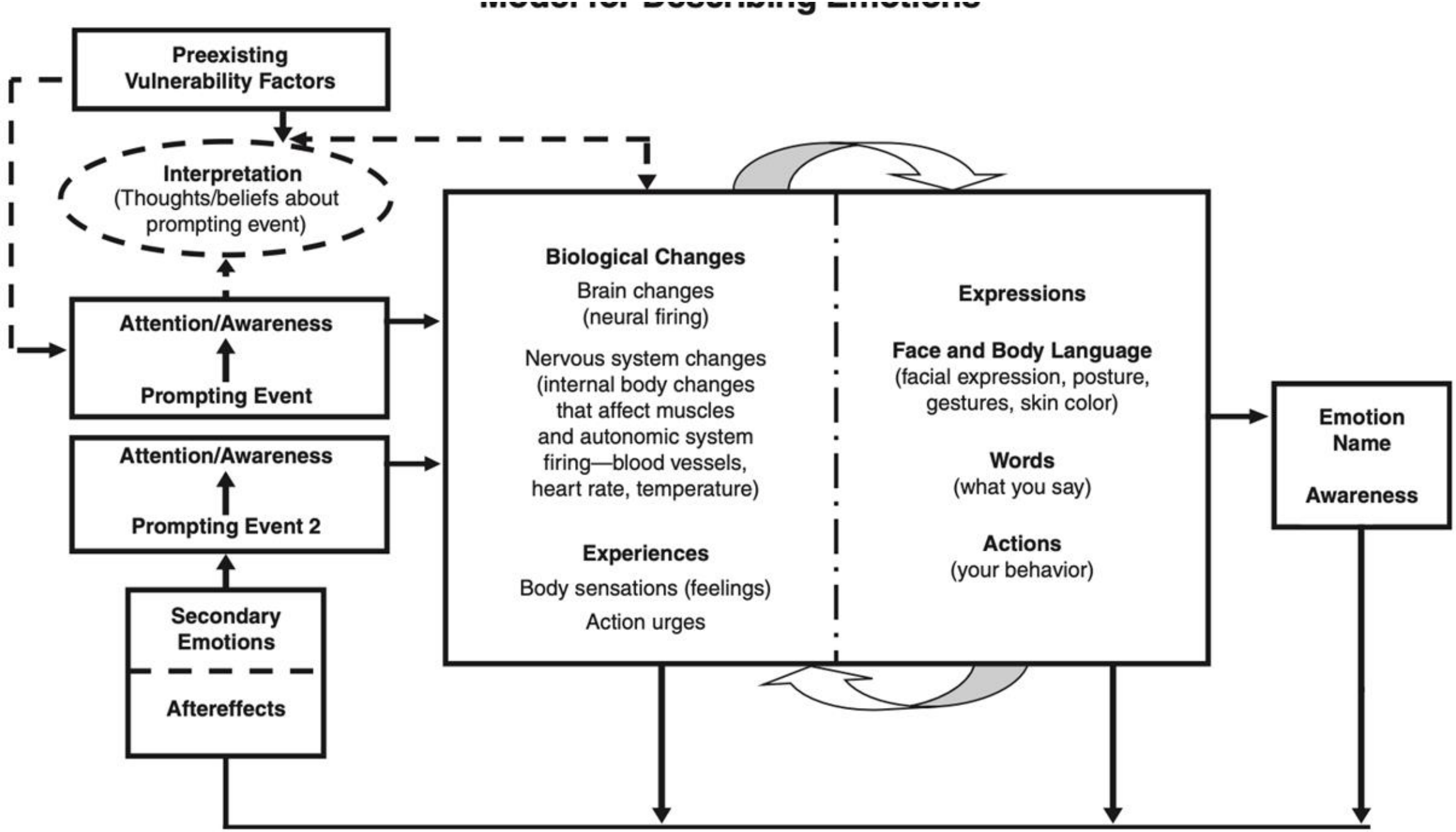
- Emotions motivate our behavior. Emotions prepare us for action.
  The action urge of specific emotions is often "hard-wired" in biology.
- Emotions save time in getting us to act in important situations.
  Emotions can be especially important when we don't have time to think things through.
- Strong emotions help us overcome obstacles—in our minds and in the environment.

## EMOTIONS COMMUNICATE TO (AND INFLUENCE) OTHERS

- Facial expressions are hard-wired aspects of emotions.
  Facial expressions communicate faster than words.
- Our body language and voice tone can also be hard-wired.
  Like it or not, they also communicate our emotions to others.
- When it is important to communicate to others, or send them a message,
  it can be very hard to change our emotions.
- Whether we intend it or not, our communication of emotions influences others.

## EMOTIONS COMMUNICATE TO OURSELVES

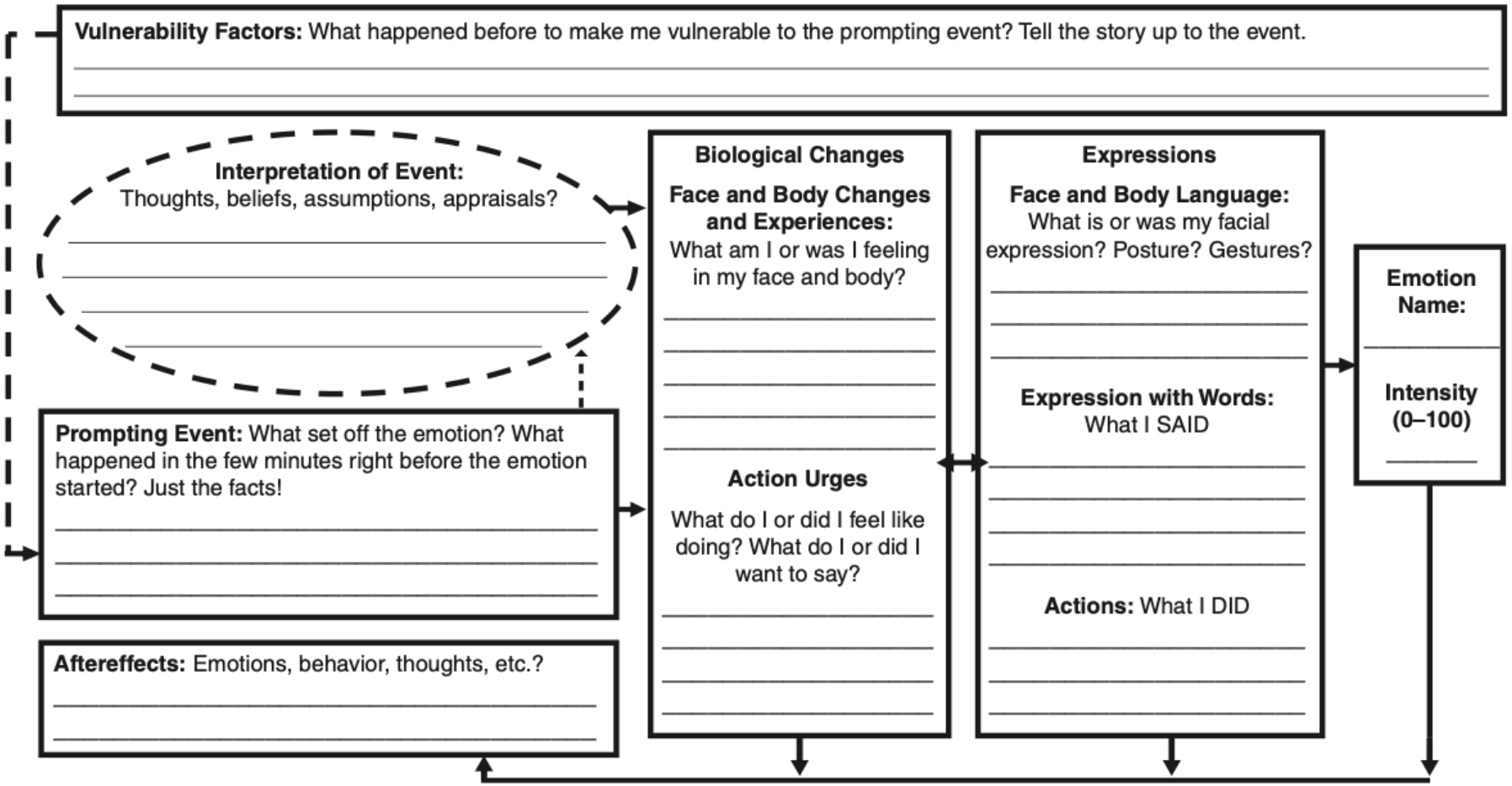
- Emotional reactions can give us important information about a situation.
  Emotions can be signals or alarms that something is happening.
- Gut feelings can be like intuition—a response to something important about the situation.
  This can be helpful if our emotions get us to check out the facts.
- **Caution:** Sometimes we treat emotions as if they are facts about the world: The stronger the emotion, the stronger our belief that the emotion is based on fact. (Examples: "If I feel unsure, I am incompetent," "If I get lonely when left alone, I shouldn't be left alone," "If I feel confident about something, it is right," "If I'm afraid, there must be danger," "I love him, so he must be OK.")
- If we assume that our emotions represent facts about the world, we may use them to justify our thoughts or our actions. This can be trouble if our emotions get us to ignore the facts.



# Observing and Describing Emotions

Due Date: _____ Name: _____ Week Starting: _____

Select a current or recent emotional reaction, and fill out as much of this sheet as you can. If the prompting event for the emotion you are working on is another emotion that occurred first (e.g., fear prompted anger at yourself), then fill out a second worksheet for the first emotion. Use Emotion Regulation Handout 6 for ideas. Write on the back of this sheet if you need more room.



# Dialectical Behavior Therapy
# DBT

Emotional Regulation (5)
Changing Unwanted Emotions

# Changing Unwanted Emotions

## CHECK THE FACTS

Check out whether your emotional reactions **fit the facts** of the situation.

Changing your beliefs and assumptions to fit the facts can help you change your emotional reactions to situations.

## OPPOSITE ACTION

When your emotions do not fit the facts,
**or** when acting on your emotions is not effective,
acting opposite (all the way)
will change your emotional reactions.

## PROBLEM SOLVING

When the facts themselves are the problem,
solving the problem
will reduce the frequency of negative emotions.

# How to Check the Facts

**What emotion do I want to change?**

**What is the prompting event for my emotional reaction?**

- Look for and challenge extremes and judgments as you are describing the prompting event

**What are my INTERPRETATIONS (thoughts, beliefs, etc.) about the facts?**

- What am I assuming?

**FACTS**

Many emotions and actions are set off by our thoughts and interpretations of events, not by the events themselves.

**Event → Thoughts → Emotions**

Our emotions can also have a big effect on our thoughts about events.

**Event → Emotion → Thoughts**

Examining our thoughts and *checking the facts* can help us change our emotions.

**Am I assuming a THREAT?**

- What is the threat? What worrisome consequences or outcomes am I expecting?

**What's the CATASTROPHE, even if the outcome I am worry about does occur?**

# Does my emotion (or it's intensity or duration) FIT THE FACTS?

| | |
|---|---|
| **Fear** | 1. There is a threat to your life or that of someone you care about.<br>2. There is a threat to your health or that of someone you care about.<br>3. There is a threat to your well-being or that of someone you care about.<br>4. Other: _____ |
| **Anger** | 1. An important goal is blocked or a desired activity is interrupted or prevented.<br>2. You or someone you care about is attacked or hurt by others.<br>3. You or someone you care about is insulted or threatened by others.<br>4. The integrity or status of your social group is offended or threatened.<br>5. Other: _____ |
| **Disgust** | 1. Something you are in contact with could poison or contaminate you.<br>2. Somebody whom you deeply dislike is touching you or someone you care about.<br>3. You are around a person or group whose behavior or thinking could seriously damage or harmfully influence you or the group you are part of.<br>4. Other: _____ |
| **Envy** | 1. Another person or group gets or has things you don't have that you want or need.<br>2. Other: _____ |

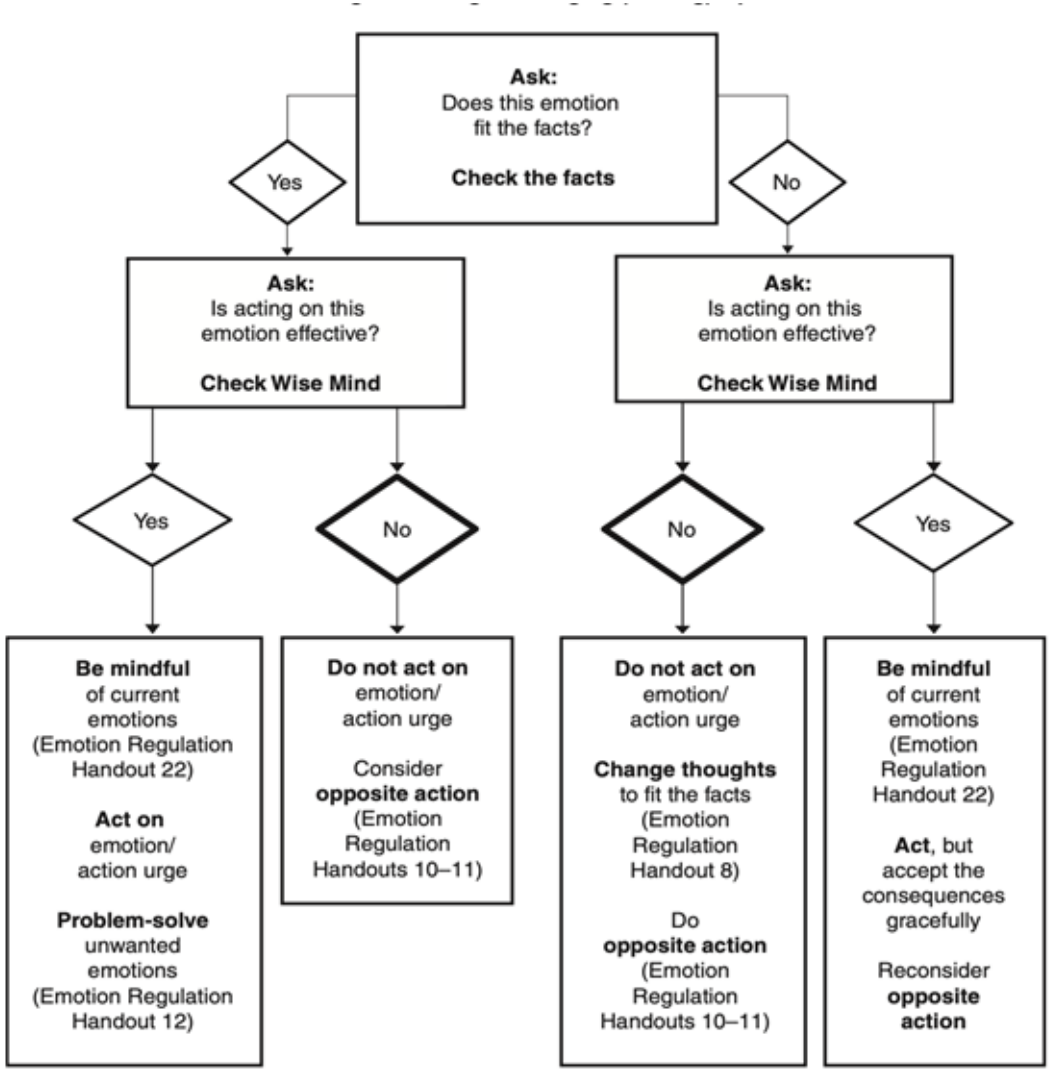
| | |
|---|---|
| **Jealousy** | 1. A very important and desired relationship or object in your life is in danger of being damaged or lost.<br>2. Someone is threatening to take a valued relationship or object away from you.<br>3. Other: _____ |
| **Love** | 1. Loving a person, animal, or object enhances quality of life for you or for those you care about.<br>2. Loving a person, animal, or object increases your chances of attaining your own personal goals.<br>3. Other: _____ |
| **Sadness** | 1. You have lost something or someone permanently.<br>2. Things are not the way you wanted or expected and hoped them to be.<br>3. Other: _____ |
| **Shame** | 1. You will be rejected by a person or group you care about if characteristics of yourself or of your behavior are made public.<br>2. Other: _____ |
| **Guilt** | 1. Your own behavior violates your own values or moral code.<br>2. Other: _____ |

Which to use:

# Opposite Action

or

# Problem Solving



# Opposite Action

## What is Opposite Action?

Acting opposite to the emotional urge to do or say something.

## Why act Opposite?

An effective way to change or reduce unwanted emotions when your emotion does not fit the facts.

## When Opposite Action Works Best

When Knowing the Facts about a Situation Does Not Work

When the Emotion (or Its Intensity or Duration) Is Not Justified by the Situation

When the Emotion (or Its Intensity or Duration) Is Not Effective for Meeting Goals in the Situation

When You Are Avoiding What Needs to Be Done

# Step-by- Step: How to do Opposite Action

1. Identify and Name the Emotion You Want to Change
2. Check the Facts
3. Identify and Describe Your Action Urges
4. Ask Wise Mind: Is Expressing or Acting on This Emotion Effective in This Situation?
5. Act Opposite to the Emotion's Urges
   - Do the Opposite of Your Actual Action Urges
   - Let Opposite Actions Do the Work; Do Not Suppress Emotions
6. Do Opposite Action All the Way
   - Opposite Words and Opposite Thinking
   - Opposite Facial Expression, Voice Tone, and Posture
   - Halfway Opposite Actions Don't Work
7. Continue Acting Opposite until the Emotion Goes Down

# Dialectical Behavior Therapy
# DBT

Interpersonal Effectiveness

# Goals of Interpersonal Effectiveness

## BE SKILLFUL IN GETTING WHAT YOU WANT AND NEED FROM OTHERS

- ❑ Get others to do things you would like them to do.
- ❑ Get others to take your opinions seriously.
- ❑ Say no to unwanted requests effectively.
- ❑ Other: _____

## BUILD RELATIONSHIPS AND END DESTRUCTIVE ONES

- ❑ Strengthen current relationships.
  - ❑ Don't let hurts and problems build up.
  - ❑ Use relationship skills to head off problems.
  - ❑ Repair relationships when needed.
  - ❑ Resolve conflicts before they get overwhelming.
- ❑ Find and build new relationships.
- ❑ End hopeless relationships.
- ❑ Other: _____

## WALK THE MIDDLE PATH

- ❑ Create and maintain balance in relationships.
- ❑ Balance acceptance and change in relationships.
- ❑ Other: _____

# Factors in the Way of Interpersonal Effectiveness

❑ **YOU DON'T HAVE THE INTERPERSONAL SKILLS YOU NEED**

**YOU DON'T KNOW WHAT YOU WANT**

- ❑ You have the skills, but can't decide what you really want from the other person.
- ❑ You can't figure out how to balance your needs versus the other person's needs:
  - ❑ Asking for too much versus not asking for anything.
  - ❑ Saying no to everything versus giving in to everything.

**YOUR EMOTIONS ARE GETTING IN THE WAY**

- ❑ You have the skills, but emotions (anger, pride, contempt, fear, shame, guilt) control what you do.

**YOU FORGET YOUR LONG-TERM GOALS FOR SHORT-TERM GOALS**

- ❑ You put your immediate urges and wants ahead of your long-term goals. The future vanishes from your mind.

**OTHER PEOPLE ARE GETTING IN YOUR WAY**

- ❑ You have the skills but other people get in the way.
- ❑ Other people are more powerful than you.
- ❑ Other people may be threatened or may not like you if you get what you want.
- ❑ Other people may not do what you want unless you sacrifice your self-respect, at least a little.

**YOUR THOUGHTS AND BELIEFS ARE GETTING IN THE WAY**

- ❑ Worries about negative consequences if you ask for what you want or say no to someone's request get in the way of acting effectively.
- ❑ Beliefs that you don't deserve what you want stop you in your tracks.
- ❑ Beliefs that others don't deserve what they want make you ineffective.

# Myths in the Way of Interpersonal Effectiveness

## Myths in the Way of Objectives Effectiveness

- ❑ 1. I don't deserve to get what I want or need.
- ❑ 2. If I make a request, this will show that I am a very weak person.
- ❑ 3. I have to know whether a person is going to say yes before I make a request.
- ❑ 4. If I ask for something or say no, I can't stand it if someone gets upset with me.
- ❑ 5. If they say no, it will kill me.
- ❑ 6. Making requests is a really pushy (bad, self-centered, selfish, etc.) thing to do.
- ❑ 7. Saying no to a request is always a selfish thing to do.
- ❑ 8. I should be willing to sacrifice my own needs for others.
- ❑ 9. I must be really inadequate if I can't fix this myself.
- ❑ 10. Obviously, the problem is just in my head. If I would just think differently I wouldn't have to bother everybody else.
- ❑ 11. If I don't have what I want or need, it doesn't make any difference; I don't care really.
- ❑ 12. Skillfulness is a sign of weakness.

Other myth: _____

Other myth: _____

## Myths in the Way of Relationship and Self-Respect Effectiveness

- ❑ 13. I shouldn't have to ask (say no); they should know what I want (and do it).
- ❑ 14. They should have known that their behavior would hurt my feelings; I shouldn't have to tell them.
- ❑ 15. I shouldn't have to negotiate or work at getting what I want.
- ❑ 16. Other people should be willing to do more for my needs.
- ❑ 17. Other people should like, approve of, and support me.
- ❑ 18. They don't deserve my being skillful or treating them well.
- ❑ 19. Getting what I want when I want it is most important.
- ❑ 20. I shouldn't be fair, kind, courteous, or respectful if others are not so toward me.
- ❑ 21. Revenge will feel so good; it will be worth any negative consequences.
- ❑ 22. Only wimps have values.
- ❑ 23. Everybody lies.
- ❑ 24. Getting what I want is more important than how I get it; the ends really do justify the means.

Other myth: _____

Other myth: _____

# Guidelines for Objectives Effectiveness: Getting What You Want (DEAR MAN)

A way to remember these skills is to remember the term **DEAR MAN:**

**D**escribe
**E**xpress
**A**ssert
**R**einforce
(Stay) **M**indful
**A**ppear Confident
**N**egotiate

## **D**escribe

Describe the current SITUATION (if necessary). Stick to the facts.
Tell the person exactly what you are reacting to.

"You told me you would be home by dinner but you didn't get here until 11."

## **E**xpress

Express your FEELINGS and OPINIONS about the situation.
Don't assume that the other person knows how you feel.

"When you come home so late, I start worrying about you."

Use phrases such as *"I want"* instead of *"You should," "I don't want"* instead of *"You shouldn't."*

## **A**ssert

Assert yourself by ASKING for what you want or SAYING NO clearly.
Do not assume that others will figure out what you want.
Remember that others cannot read your mind.

"I would really like it if you would call me when you are going to be late."

## **R**einforce

Reinforce (reward) the person ahead of time (so to speak)
by explaining positive effects of getting what you want or need.
If necessary, also clarify the negative consequences of not getting what you want or need.

*"I would be so relieved, and a lot easier to live with, if you do that."*

Remember also to reward desired behavior after the fact.

(Stay)

**M**indful — Keep your focus ON YOUR GOALS.
Maintain your position. Don't be distracted. Don't get off the topic.

"Broken record": Keep asking, saying no, or expressing your opinion over and over and over.
Just keep replaying the same thing again and again.

Ignore attacks: If another person attacks, threatens, or tries to change the subject,
ignore the threats, comments, or attempts to divert you.
Do not respond to attacks. Ignore distractions.
Just keep making your point.

"I would still like a call."

**A**ppear confident — Appear EFFECTIVE and competent.

Use a confident voice tone and physical manner;
make good eye contact.

No stammering, whispering, staring at the floor, retreating.

No saying, "I'm not sure," etc.

**N**egotiate — Be willing to GIVE TO GET.
Offer and ask for other solutions to the problem.
Reduce your request.
Say no, but offer to do something else or to solve the problem another way.
Focus on what will work.

"How about if you text me when you think you might be late?"

Turn the tables: Turn the problem over to the other person.
Ask for other solutions.

"What do you think we should do? . . . I can't just stop worrying about
you [or I'm not willing to]."

Other ideas:

# Guidelines for Relationship Effectiveness: Keeping the Relationship (GIVE)

A way to remember these skills is to remember the word **GIVE (DEAR MAN, GIVE):**

(Be) **G**entle
(Act) **I**nterested
**V**alidate
(Use an) **E**asy manner

(Be)
**Gentle**

BE NICE and respectful.

No attacks: No verbal or physical attacks. No hitting, clenching fists. No harassment of any kind. Express anger directly with words.

No threats: If you have to describe painful consequences for not getting what you want, describe them calmly and without exaggerating.
No "manipulative" statements, no hidden threats. No "I'll kill myself if you . . . "
Tolerate a "no." Stay in the discussion even if it gets painful. Exit gracefully.

No judging: No moralizing. No "If you were a good person, you would . . . "
No "You should . . . " or "You shouldn't . . . " Abandon blame.

No sneering: No smirking, eye rolling, sucking teeth. No cutting off or walking away.
No saying, "That's stupid, don't be sad," "I don't care what you say."

(Act)
**Interested**

LISTEN and APPEAR INTERESTED in the other person.
Listen to the other person's point of view.
Face the person; maintain eye contact; lean toward the person rather than away. Don't interrupt or talk over the person.
Be sensitive to the person's wish to have the discussion at a later time. Be patient.

**Validate**

With WORDS AND ACTIONS, show that you understand the other person's feelings and thoughts about the situation. See the world from the other person's point of view, and then say or act on what you see.

"I realize this is hard for you, and . . . ", "I see that you are busy, and . . . "

Go to a private place when the person is uncomfortable talking in a public place.

(Use an)
**Easy manner**

Use a little humor.
SMILE. Ease the person along. Be light-hearted. Sweet-talk.
Use a "soft sell" over a "hard sell." Be "political."
Leave your attitude at the door.

Other ideas:

# Dialectical Behavior Therapy

- Originally developed for chronically suicidal individuals diagnosed with borderline personality disorder (BPD).
- Full protocol consists of combination of individual psychotherapy, group skills training, telephone coaching, and a therapist consultation team
- Skills training alone is a promising intervention for a variety of populations

# 01

# The Dialectical Framework

*Acceptance vs. Change*

# Why each modality needs the other

## Why CBT needs DBT

- Cognitive restructuring and exposure require a client who can stay in a workable emotional range.
- Without regulation skills, clients flee, dissociate, or shut restructuring down before it can take hold.
- DBT's distress-tolerance and mindfulness modules build that capacity first.

## Why DBT needs CBT

- Skills-focused stabilization can plateau without addressing the beliefs that generate distress.
- Chronic disorders are often maintained by specific maladaptive schemas and avoidance patterns.
- CBT's restructuring and behavioral tools give skills work a target to work toward.

*Integrated transdiagnostic protocols that combine CBT and DBT skills in a single manual let clinicians serve a broader range of presentations without switching frameworks between clients.*

# Three roots shared across disorders

### Intolerance of Uncertainty

A dispositional difficulty tolerating ambiguity, linked to anxiety, depression, and OCD symptoms alike.

### Emotional Avoidance

Escape and suppression strategies that provide short-term relief but maintain long-term symptoms.

### Cognitive Rigidity

Fixed, catastrophic interpretive patterns that resist updating even in the face of disconfirming evidence.

## .50–.57

**Mean correlation between intolerance of uncertainty and GAD, MDD, and OCD symptoms across the literature.**

**Why it matters clinically**

Because these mechanisms cut across diagnostic boundaries, a single transdiagnostic skill set can address multiple presenting problems at once, rather than requiring a new protocol per diagnosis.

*Gentes & Ruscio (2011), Clinical Psychology Review*

EVIDENCE SPOTLIGHT

# Intolerance of uncertainty as a shared engine of distress

**.57**

Mean correlation with generalized anxiety disorder symptoms

**.53**

Mean correlation with major depressive disorder symptoms

**.50**

Mean correlation with obsessive-compulsive symptoms

A meta-analysis synthesizing dozens of studies found that intolerance of uncertainty relates meaningfully to symptoms across generalized anxiety, depression, and OCD — evidence that a single underlying process can fuel very different-looking presentations.

*Gentes, E. L., & Ruscio, A. M. (2011). Clinical Psychology Review, 31(6), 923–933.*

# Skill deficit or performance deficit?

### Skill deficit

The client has never learned the regulation or cognitive skill in question. Start with direct skills training — psychoeducation, modeling, in-session practice.

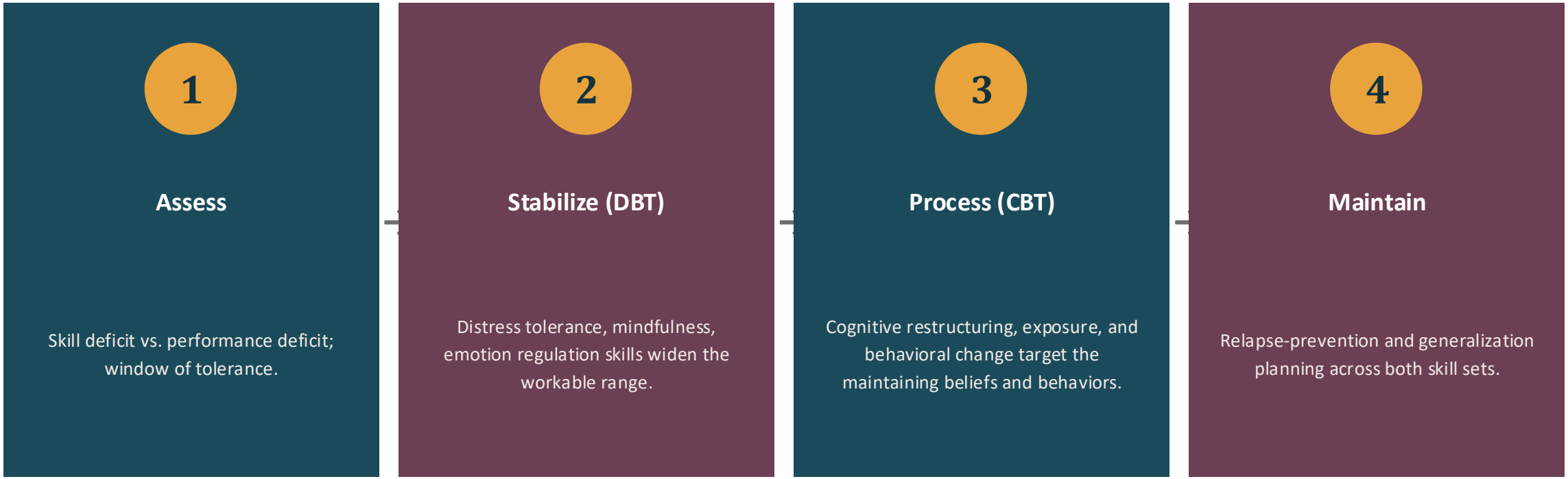
### Performance deficit

The client has the skill but cannot access it under emotional load. Start with distress tolerance and in-vivo coaching to close the gap between knowing and doing.

### Why this distinction matters

Misreading a performance deficit as a skill deficit leads to repetitive psychoeducation that never touches the real barrier: emotional intensity in the moment.

# Stabilize


1
Assess
Skill deficit vs. performance deficit; window of tolerance.
2
Stabilize (DBT)
Distress tolerance, mindfulness, emotion regulation skills widen the workable range.
3
Process (CBT)
Cognitive restructuring, exposure, and behavioral change target the maintaining beliefs and behaviors.
4
Maintain
Relapse-prevention and generalization planning across both skill sets.

# 02

# Stabilization & Safety

*Trauma & Addiction*

# Widening the window of tolerance

## The problem

In PTSD and addiction crises, physiological arousal outpaces the client's capacity for verbal, reflective processing

## The DBT answer

Distress-tolerance skills act on the body first, using fast physiological levers to bring arousal back into a workable range before any restructuring is attempted.

## The clinical payoff

Only once the nervous system is regulated does exposure, cognitive restructuring, or insight-oriented work have a realistic chance of being encoded rather than resisted.

### Phase-based treatment

Complex trauma protocols that place a stabilization and skills phase before trauma memory processing have shown gains in affect regulation, interpersonal functioning, and PTSD symptoms that are maintained at follow-up.

*Cloitre et al. (2002, 2010), Journal of Consulting and Clinical Psychology; American Journal of Psychiatry*

# T.I.P.P.: four fast physiological levers

### Temperature

Cold water on the face or an ice pack triggers the mammalian dive reflex, rapidly lowering heart rate and arousal.

### Intense exercise

Brief, vigorous movement burns off stress hormones and matches the body’s activation to something it can discharge.

### Paced breathing

Slowing the exhale relative to the inhale shifts the nervous system toward parasympathetic dominance.

### Paired muscle relaxation

Tensing and releasing muscle groups while breathing out reduces somatic tension that keeps arousal elevated.

# Stabilization skills before trauma-focused work

**2013**

First RCT of residential DBT-PTSD in survivors of childhood sexual abuse showed significant symptom reduction

**2020**

DBT-PTSD outperformed cognitive processing therapy on several outcomes in complex PTSD

**×2**

Adding a prolonged-exposure protocol to standard DBT roughly doubled reductions in PTSD severity versus DBT alone in a pilot RCT

A German research program led by Bohus and colleagues built and tested DBT-PTSD specifically for complex, childhood-abuse-related presentations, sequencing regulation skills ahead of trauma processing. A separate pilot trial found that once patients met behavioral stability criteria, adding a prolonged-exposure component to ongoing DBT produced meaningfully larger PTSD symptom reductions than DBT skills alone — direct support for the stabilize-then-process order taught in this module.

*Bohus et al. (2013), Psychotherapy and Psychosomatics; Bohus et al. (2020), JAMA Psychiatry; Harned, Korslund, & Linehan (2014), Behaviour Research and Therapy.*

ADDICTION & CRAVING

# Urge surfing: riding the wave without acting

## The core instruction

Clients are coached to observe a craving as a wave — rising, cresting, and passing — rather than fighting it or immediately obeying it.

## Why it works

Cravings are time-limited physiological events; mindful, non-reactive observation lets the urge peak and subside without reinforcing the substance-seeking behavior loop.

## Where it fits

Deployed at the moment of highest urge intensity, then paired with CBT relapse-prevention planning once the craving has passed.

**Origin**

Urge surfing was developed within relapse-prevention and mindfulness-based traditions as a way to shift clients from controlling the urge to observing the craving without acting on it.

*Marlatt & colleagues; adapted in Bowen & Marlatt (2009)*

# Mindfulness-based craving management, tested

## RCT

College smokers using a brief urge-surfing intervention showed reduced smoking relative to controls

## RCT

Mindfulness-based relapse prevention outperformed treatment-as-usual on substance-use days at 12-month follow-up

## RCT

Adolescents receiving urge surfing as aftercare showed improved outcomes for alcohol use

Across adult and adolescent samples, and across substances from tobacco to alcohol, mindfulness-based urge-surfing interventions have shown reductions in use and craving-related outcomes relative to standard relapse-prevention or usual-care comparisons in randomized trials.

*Bowen & Marlatt (2009), Psychology of Addictive Behaviors; Bowen et al. (2014), JAMA Psychiatry; Harris, Stewart, & Stanton (2017), Mindfulness.*

# Mapping the high-risk situation

### Identify the trigger chain

High-risk situations combine an environmental cue, an emotional state, and a habitual coping deficit that together raise relapse probability.

### Build a hierarchy

Clients and clinicians jointly rank situations from lowest to highest risk, informing where coping-skills rehearsal is prioritized.

### Rehearse the alternative response

Behavioral experiments test a coping response other than substance use in a graded, planned way — before the client faces the real trigger unprepared.

# Catching “permission-giving” thoughts

“Just one won’t hurt.” “I’ve earned this after the week I’ve had.” “I can stop whenever I want.”

## What they do

Permission-giving thoughts function as cognitive off-ramps that justify a return to use — often arriving just before the highest-risk moment.

## The intervention

Clients learn to flag these thoughts as a warning signal rather than a neutral observation, then apply cognitive restructuring or a rehearsed coping response in that exact moment.

INTEGRATION SNAPSHOT

# Sequencing DBT and CBT for trauma and addiction

*A client with a childhood-abuse history and active alcohol use disorder is flooded by shame and cravings whenever trauma material surfaces — relapse-prevention worksheets alone haven't held, because the underlying arousal spikes before any cognitive strategy can be deployed.*

- Phase 1: Teach T.I.P.P. and urge surfing so the client has body-based tools to lower arousal in the moment.
- Phase 2: Once stability criteria are met, layer in CBT relapse-prevention mapping and, where indicated, trauma-focused exposure work.
- Outcome target: fewer crisis-driven dropouts and a higher tolerance for the emotional intensity that trauma and addiction work both require.

*Consistent with phase-based and DBT-PTSD trial findings (Cloitre et al., 2002, 2010; Bohus et al., 2013, 2020).*

# 03

# The Anxiety & OCD Spectrum

*Facing the Fear*

DBT SKILL

# Check the Facts: reducing intensity before logic

## The sequence

Before challenging a thought's validity, clients first check whether their emotional response actually fits the facts of the situation — lowering intensity enough that reasoning becomes possible.

## Why order matters

Attempting cognitive restructuring while arousal is at its peak tends to fail; Check the Facts functions as a bridge between DBT's acceptance stance and CBT's change-oriented restructuring.

## Best fit

Especially useful for anxiety presentations where the emotion is proportionate to a distorted appraisal rather than to genuine, current threat.

# Exposure and response prevention: the gold standard

## The mechanism

Clients confront feared stimuli (exposure) while deliberately refraining from the compulsive ritual (response prevention), allowing anxiety to rise and naturally subside without the reinforcing relief of the ritual.

## Why it works

Repeated non-ritualized exposure disconfirms the belief that anxiety is intolerable or that the ritual is necessary to prevent harm.

## The barrier

Many clients disengage or dissociate mid-exposure when distress tolerance is low — exactly the gap DBT skills are positioned to close.

| Hierarchy Item (without washing) | SUDS |
|---|---|
| Visit someone ill, delay hand wiping for 30 minutes | 30 |
| Visit someone ill, no hand wiping | 40 |
| Visit someone ill, no hand wiping or hand washing | 45 |
| Visit someone ill, no hand wiping, washing, or changing/washing clothes | 50 |
| Wear clothes (unwashed) day after visiting someone ill | 55 |
| Visit someone ill, husband shakes their hand, Caroline shakes husband's hand, no wiping or washing (ritual prevention by both husband and Caroline) | 65 |
| Visit someone ill, husband shakes their hand, Caroline shakes husband's hand + complete ritual prevention (no wiping, washing, cleaning, showering) | 70 |
| Visit someone ill, Caroline shakes their hand, + complete ritual prevention (no wiping, washing, cleaning, showering) | 75 |
| Visit someone ill, Caroline shakes their hand, no wiping or washing or changing clothes | 80 |
| Visit someone ill, Caroline shakes their hand, + complete ritual prevention (no wiping, washing, cleaning, showering) | 90 |
| Visit someone ill, Caroline shakes their hand, + imagine they get cancer and die + complete ritual prevention (no wiping, washing, cleaning, showering) | 95 |
| Visit someone ill, Caroline shakes their hand, + shake another person's hand (i.e., purposely "spread cancer") + complete ritual prevention (no wiping, washing, cleaning, showering) | 100 |

**How To:**

- create list of feared situations
- rate anxiety level (0-100) for each item

**Include:**

- 10-15 items
- items with varying SUDS rating
- different types of exposures
- SUDS rating 20-30 and above
- changes to proximity and duration

# Exposure and response prevention, meta-analyzed

**24**

Studies (1,134 patients) included in a meta-analysis comparing ERP to control and active-treatment conditions

**g = 0.97**

Effect size for ERP versus placebo comparisons on OCD symptom reduction

**g = 0.59**

Effect size for ERP versus medication-only comparisons

A systematic review and meta-analysis found that ERP produced significantly greater reductions in Yale-Brown Obsessive Compulsive Scale scores than both neutral and active comparison conditions, reinforcing ERP's status as the front-line psychotherapeutic treatment for OCD — provided clients can tolerate the exposure process itself.

*Ferrando, C., & Selai, C. (2021). Journal of Obsessive-Compulsive and Related Disorders, 31, 100684.*

MERGING THE TWO

# Mindfulness “tethers” during high-intensity exposure

## The risk

High-intensity exposure can tip vulnerable clients into dissociation rather than productive habituation — particularly those with trauma histories.

## The DBT contribution

Brief mindfulness anchors (grounding on breath, senses, or a physical object) are woven into the exposure hierarchy to keep the client present and engaged rather than checked out.

## The clinical rule of thumb

The exposure needs to be felt to be effective — tethers keep the client in contact with the experience without letting distress escalate into avoidance-by-dissociation.

THE SHARED DRIVER

# Intolerance of uncertainty across anxiety and OCD

### A common thread

Both generalized anxiety and OCD are strongly associated with difficulty tolerating ambiguous, unresolved situations — the compulsion or the worry functions as an attempt to manufacture certainty.

### The treatment implication

Interventions that build tolerance for not knowing — rather than only targeting the content of specific fears — can generalize across anxiety and OCD presentations.

### DBT plus CBT

Distress tolerance builds the capacity to sit with uncertainty; ERP provides the structured practice of doing so on purpose.

**r ≈ .5–.6**

**Mean association between intolerance of uncertainty and GAD/OCD symptom measures.**

*Gentes & Ruscio (2011), Clinical Psychology Review*

CLINICAL DECISION FLOW

# When to stabilize first vs. move straight to exposure

**Low baseline distress tolerance**

History of dissociation, trauma, or crisis behavior

→

**Route: Stabilize first**

Teach Check the Facts and mindfulness tethers before hierarchy exposure begins

**Route: Begin ERP directly**

Adequate distress tolerance already present — start graded exposure with standard pacing

*Both routes converge on the same goal: durable habituation without dissociation, using ERP as the change engine and DBT skills as the regulation scaffold.*

INTEGRATION SNAPSHOT

# Contamination OCD with a trauma history

*A client with contamination-based OCD and a history of medical trauma dissociates roughly ten minutes into every exposure attempt, leaving prior ERP treatment incomplete and symptoms unchanged.*

- Add brief mindfulness tethers at fixed intervals throughout the exposure hierarchy to keep the client oriented to the present.
- Use Check the Facts before each exposure step to separate the feared catastrophe from the actual, current level of risk.
- Maintain full response prevention throughout — the DBT additions support engagement, they do not replace the exposure itself.

*Consistent with ERP efficacy evidence (Ferrando & Selai, 2021) and IU research (Gentes & Ruscio, 2011).*

# 04

# Depression

*Moving from Inertia to Action*

# Behavioral activation: jumpstarting the reward system

## The core idea

Depression is maintained partly by a shrinking contact with rewarding activity; scheduling mastery and pleasure activities directly re-opens that contact.

## How it’s delivered

Structured activity scheduling and self-monitoring increase overt engagement with the environment, ahead of — or alongside — any cognitive work.

## Why it’s first-line

It is behaviorally concrete, easy to teach, and does not require the client to already have insight into their thought patterns.

# As effective as cognitive therapy — and medication

## ≈

Behavioral activation performed comparably to full cognitive therapy across meta-analyses of adult depression

## ≥

In severely depressed patients, BA outperformed cognitive therapy and matched antidepressant medication in a landmark RCT

## ↓ dropout

BA showed a lower dropout rate than antidepressant medication in the same trial

A large randomized trial found behavioral activation was more effective than cognitive therapy for severely depressed patients and performed comparably to antidepressant medication, with better retention. Subsequent meta-analyses spanning dozens of trials have confirmed BA as an effective, low-cost, and easy-to-disseminate treatment for adult depression.

*Dimidjian et al. (2006), Journal of Consulting and Clinical Psychology; Ekers et al. (2014), PLOS ONE; Cuijpers et al. (2023), Psychotherapy Research.*

# Opposite action: acting against the urge

"My depression wants me to isolate, so I will go to the coffee shop."

## The mechanism

When an emotion doesn't fit the facts of the situation, deliberately acting opposite to its behavioral urge can reduce the emotion's intensity over repeated practice.

## How it differs from behavioral activation

Opposite action is emotion-first: it starts by naming the specific emotion and urge, then selects the opposing behavior — a more granular, moment-to-moment tool than a standing activity schedule.

# Effective — but emotion-specific

✓

Acting opposite to sadness and guilt/shame produced short-term reductions in emotional intensity

✗

Acting opposite to anxiety and anger did not show the same short-term reduction in this laboratory study

**n=16**

Adults with borderline personality disorder in a single-case alternating-treatment design isolating the skill

A laboratory-based study isolating opposite action from the rest of DBT found it reduced emotional intensity for sadness and guilt/shame — the emotions most central to depressive presentations — but not for anxiety or anger in the short term. For a depression-focused module, this is reassuring: the skill's strongest evidence lines up precisely with the emotions depression most often produces.

*Sauer-Zavala, Wilner, Cassiello-Robbins, Saraff, & Pagan (2019). Behaviour Research and Therapy, 117, 79–86.*

# Identifying the negative triad

### Self

"I am worthless / inadequate / a failure." Automatic negative appraisals of one's own worth and competence.

### World

"Nothing works out. Everything is against me." A distorted, uniformly hostile reading of ongoing experience.

### Future

"It will always be this way." Pervasive hopelessness about what lies ahead.

**Beck's cognitive theory of depression**

Beck proposed that depressive disorders are maintained by these three interlocking negative belief domains — self, world, and future — which together generate and sustain automatic negative thoughts.

*Beck (1967); Beck, Rush, Shaw, & Emery (1979)*

# Socratic questioning as the restructuring engine

### What is the evidence?

For and against the automatic thought — slowing the client down enough to notice they are inferring, not observing.

### Is there another way to see this?

Generating alternative, equally plausible explanations widens a rigid interpretive frame.

### What would I tell a friend?

Perspective-taking questions often surface a more balanced appraisal than direct self-questioning alone.

### What’s the effect of believing this thought?

Shifts the focus from “is it true” to “is it workable,” which is often more motivating for a depressed client.

INTEGRATION SNAPSHOT

# Severe depression with anxious rumination

*A client with major depression spends most waking hours in bed, ruminating on perceived failures, and reports that behavioral activation homework "feels impossible" most mornings.*

- Start with opposite action on the specific urge to isolate — a single, small, opposite behavior rather than a full activity schedule.
- Layer in behavioral activation once early wins build some momentum and self-efficacy.
- Use Socratic questioning on the negative triad content that emerges once behavior — and mood — begin to shift.

*Consistent with BA (Dimidjian et al., 2006) and opposite-action (Sauer-Zavala et al., 2019) findings.*

# 05

# Chronic Pain

*A Special Application*

# Suffering = Pain × Resistance

*Pain and suffering are not the same thing.*

### Pain

The physical sensation itself — often chronic, often not fully modifiable by psychological treatment alone.

### Resistance

The fight against the reality of the pain: catastrophizing, avoidance, and the wish that it were otherwise.

### Suffering

The multiplied, amplified distress that results when resistance is high, even at a constant level of physical pain.

# Radical acceptance and psychological flexibility

## ↓ disability

Increases in pain acceptance predicted decreases in pain-related disability, depression, and anxiety

## ↑ function

Values-based action and acceptance predicted better physical and psychosocial functioning independent of pain intensity

## 24+ yrs

Research program tracking psychological flexibility as a mechanism of change across chronic pain treatment

Radical acceptance — acknowledging the reality of a diagnosis rather than exhausting oneself fighting it — is not passive resignation. In the chronic pain literature, increases in acceptance and psychological flexibility have consistently predicted improved functioning and reduced disability, even when pain intensity itself does not change.

*McCracken & Velleman (2010), Pain; Vowles & McCracken (2008), Journal of Consulting and Clinical Psychology; Scott & McCracken (2015), Current Opinion in Psychology; McCracken (2024), Annual Review of Psychology.*

# Pacing: breaking the boom-and-bust cycle

## The pattern

On a good day, clients overdo it (boom); the resulting flare forces days of enforced rest (bust) — and the cycle repeats, with function trending downward over time.

## The pacing alternative

Activity is planned in advance and matched to a sustainable baseline, rather than being driven by how good or bad the client feels in the moment.

## The behavior change

Pacing modifies both excessive persistence and excessive avoidance — replacing both with steady, planned engagement.

### What the research shows

Clinicians and patients consistently describe pacing as reducing fear of activity-triggered flares while improving cumulative activity levels over time, though stopping only once symptoms appear can itself perpetuate the boom-bust pattern.

*Antcliff et al. (2019), Musculoskeletal Care*

# How avoidance becomes disability

### Catastrophic interpretation

An injury or pain flare is interpreted as more dangerous than it is, triggering pain-related fear.

### Avoidance

Movement and activity are avoided to prevent re-injury — which feels protective in the short term.

### Deconditioning & disability

Avoidance leads to physical deconditioning, which increases pain and disability, reinforcing the original fear in a self-sustaining loop.

### The exit ramp

Graded exposure to feared movements breaks the cycle by directly disconfirming the belief that movement equals harm.

# Reducing kinesiophobia through movement

## RCT

Graded in-vivo exposure outperformed operant graded activity on pain-related fear in chronic low back pain

## ↓ fear

Individualized exposure hierarchies produced greater reductions in fear of movement than usual activity-based care

## Replicated

Findings replicated across single-case and randomized designs in chronic low back pain populations

Randomized and single-case studies converge on the same finding: exposing patients to a graded hierarchy of feared movements — built around their specific fears rather than generic exercise — reduces pain-related fear and disability more effectively than activity programs that don't directly target the fear itself.

*Vlaeyen et al. (2002), The Clinical Journal of Pain; Leeuw et al. (2008), Pain; Leeuw et al. (2007), Journal of Behavioral Medicine.*

# Reducing the fear of movement itself

## What it is

An excessive, often irrational fear of physical movement or activity stemming from a felt vulnerability to re-injury — distinct from the pain itself.

## Why it persists

Well-meaning avoidance of “making it worse” can outlast any tissue-level reason for caution, becoming the primary driver of disability.

## The combined approach

Radical acceptance reduces the fight against the diagnosis; graded exposure and pacing rebuild a working relationship with movement — acceptance and change, side by side.

INTEGRATION SNAPSHOT

# Fibromyalgia with activity avoidance

*A client with fibromyalgia alternates between pushing through pain on "good days" and being bed-bound for days afterward, has stopped most physical activity out of fear of flares, and reports the pain has come to dominate every plan she makes.*

- Introduce radical acceptance and the pain-versus-suffering distinction to loosen the fight against the diagnosis itself.
- Build a pacing plan based on a sustainable baseline rather than symptom-contingent stopping, to interrupt the boom-bust cycle.
- Layer in a graded exposure hierarchy for specifically avoided movements, directly targeting kinesiophobia.

*Consistent with McCracken & Velleman (2010), Antcliff et al. (2019), and Vlaeyen et al. (2002).*

# 06

# Complex Case Synthesis

*Treatment Mapping & Q&A*

TREATMENT MAPPING

# One roadmap, applied across every module

| | |
|---|---|
| **Assess** | Skill deficit vs. performance deficit; window of tolerance; which transdiagnostic drivers are active (uncertainty, avoidance, rigidity). |
| **Stabilize** | T.I.P.P., urge surfing, Check the Facts, mindfulness tethers — selected to match the presenting arousal pattern. |
| **Process** | Cognitive restructuring, ERP, behavioral activation, opposite action, graded exposure, pacing — matched to the target disorder(s). |
| **Weave, don't stack** | Skills are interleaved across sessions, not delivered as two separate unrelated protocols back to back. |
| **Maintain** | Relapse-prevention planning and generalization across all symptom domains addressed in treatment. |

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