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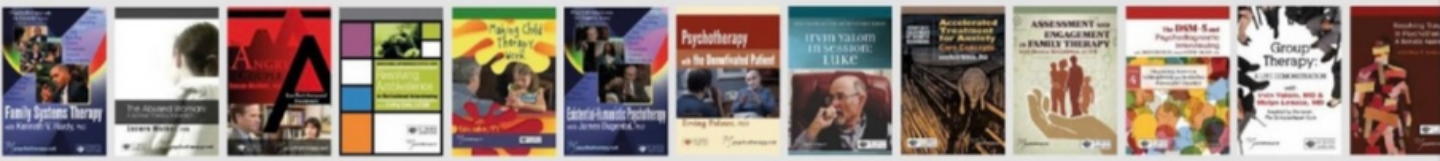

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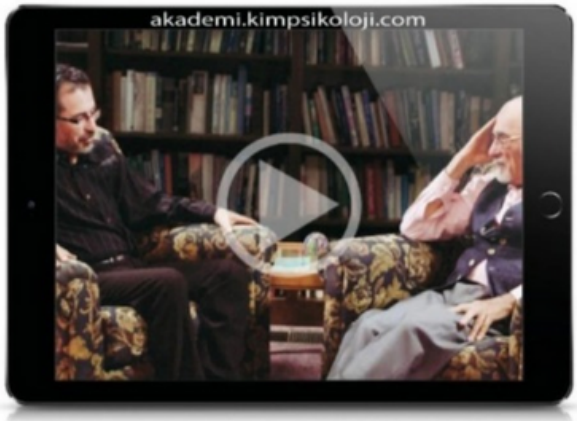

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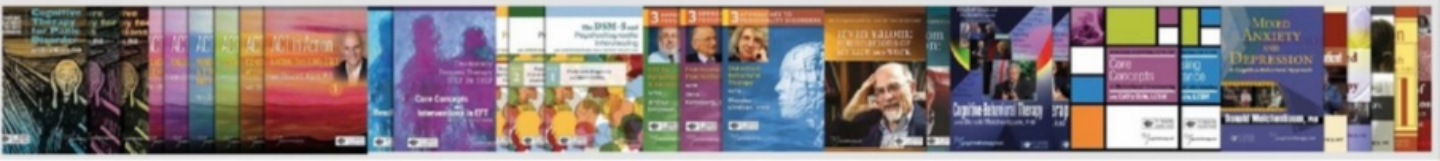

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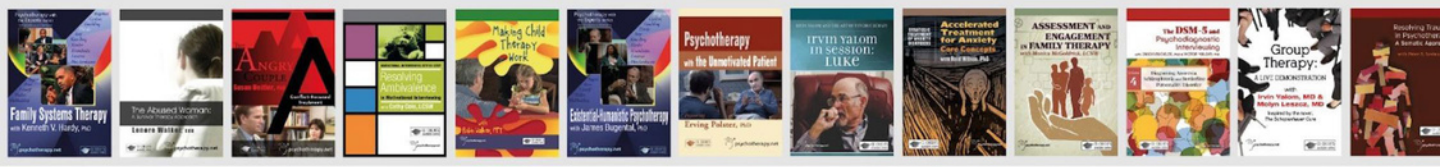

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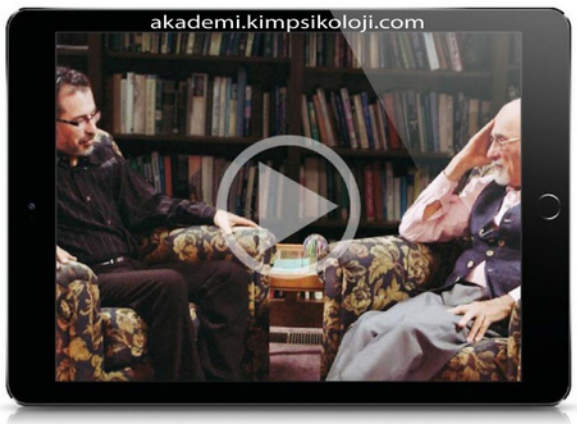

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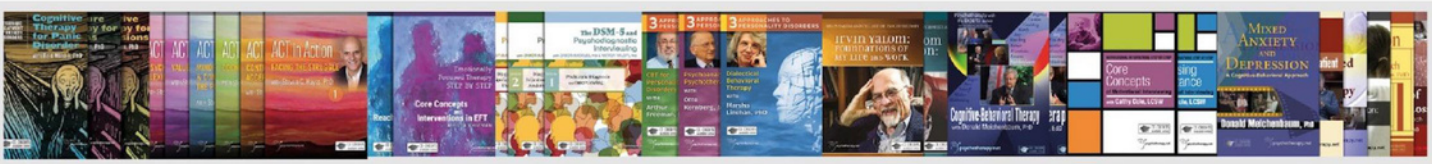

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Instructor's Manual

for

DIALECTICAL BEHAVIOR THERAPY

with

MARSHA LINEHAN, PH.D.

Manual by
Katie Read, MFT

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resources to inspire therapists

The *Instructor's Manual* accompanies the DVD *Dialectical Behavior Therapy with Marsha Linehan, Ph.D* (Institutional/Instructor's Version). Video available at www.psychotherapy.net.

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150 Shoreline Highway, Building A, Suite 1
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Email: contact@psychotherapy.net
Phone: (800) 577-4762 (US & Canada)/(415) 332-3232

Read, Katie, MFT

Instructor's Manual for Dialectical Behavior Therapy with Marsha Linehan, Ph.D.

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Instructor's Manual for

DIALECTICAL BEHAVIOR THERAPY WITH MARSHA LINEHAN, PH.D.

Table of Contents

Tips for Making the Best Use of the DVD

1. USE THE TRANSCRIPTS

Make notes in the video **Transcript** for future reference; the next time you show the video you will have them available. Highlight or notate key moments in the video to better facilitate discussion during and after the video.

2. FACILITATE DISCUSSION

Pause the video at different points to elicit viewers' observations and reactions to the concepts presented. The **Discussion Questions** section provides ideas about key points that can stimulate rich discussions and learning.

3. ENCOURAGE SHARING OF OPINIONS

Encourage viewers to voice their opinions; no therapy is perfect! What are viewers' impressions of what works and does not work in the sessions? We learn as much from our mistakes as our successes; it is crucial for students and therapists to develop the ability to effectively critique this work as well as their own.

4. CONDUCT A ROLE-PLAY

The Role-Play section guides you through exercises you can assign to your students in the classroom or training session.

5. HAVE STUDENTS OR TRAINEES WATCH OTHER TITLES IN THIS SERIES WITH SAME CLIENT

This video is part of a series, *Three Approaches to Personality Disorders*. Watch the other two videos featuring Otto Kernberg demonstrating a psychoanalytic approach (3 sessions), and Art Freeman demonstrating a cognitive therapy approach.

6. SUGGEST READINGS TO ENRICH VIDEO MATERIAL

Assign readings from Related Websites, Videos and Further Reading prior to or after viewing.

7. ASSIGN A REACTION PAPER

See suggestions in the Reaction Paper section.

PERSPECTIVE ON VIDEOS AND THE PERSONALITY OF THE THERAPIST

Psychotherapy portrayed in videos is less off-the-cuff than therapy in practice. Therapists may feel put on the spot to offer a good demonstration, and often move more quickly than they would in everyday practice to demonstrate a particular technique. Despite these factors, therapists and clients (or in the case of this video, actors portraying clients) on video can engage in a realistic session that conveys a wealth of information not contained in books or therapy transcripts: body language, tone of voice, facial expression, rhythm of the interaction, quality of the alliance—all aspects of the therapeutic relationship that are unique to an interpersonal encounter.

Psychotherapy is an intensely private matter. Unlike the training in other professions, students and practitioners rarely have an opportunity to see their mentors at work. But watching therapy on video is the next best thing.

One more note: The personal style of therapists is often as important as their techniques and theories. Therapists are usually drawn to approaches that mesh well with their own personality. Thus, while we can certainly pick up ideas from master therapists, students and trainees must make the best use of relevant theory, technique and research that fits their own personal style and the needs of their clients.

Dialectical Behavior Therapy: A Summary of Approach*

Developed by Marsha Linehan in the late 1980s and early 1990s, Dialectical Behavior Therapy (DBT) was originally created for suicidal and actively self-harming patients with a history of multiple psychiatric hospitalizations who met the criteria for Borderline Personality Disorder (BPD). For years, Linehan had used standard cognitive-behavioral therapy (CBT) approaches with this population but found certain aspects of CBT to be unsuitable for them. In particular, the unrelenting focus on change (changing one's thoughts, behaviors and beliefs) tended to be invalidating for clients and caused them to drop out of treatment at high rates. In addition, Linehan noticed that therapists working with this population had a tendency to burn out, since the demands these clients placed on them, including frequent suicide attempts, urges to self-harm, and threats to quit treatment were emotionally draining for those therapists.

Linehan realized that individual therapy was not adequate for treating high-risk clients and developed a multi-faceted approach that includes individual and group therapy, coaching and collateral contact between sessions, and group supervision and support for the therapists treating the clients. She hypothesized that a comprehensive psychotherapy needed to meet five critical functions:

1. It must enhance and maintain the client's motivation to change (clients work collaboratively with therapists and are given a clear set of guidelines and boundaries for their behavior);

2. It must enhance the client's capabilities (through skills groups, phone coaching, in vivo coaching and homework assignments);

3. It must encourage the generalization of the client's newly acquired capabilities;

4. It must enhance the therapist's motivation to continue therapy and also enhance their skills and abilities (e.g. through group consultation and "cheerleading" among co-therapists); and

5. It must structure the environment so that treatment can take

place (families may need to be drawn into treatment to ensure that they are also working therapeutically with the patient).

Linehan adopted some standard cognitive-behavioral techniques for emotion regulation and reality-testing. She then combined these with concepts derived from Buddhist meditative practice, including distress tolerance, acceptance, and mindful awareness. DBT may be the first therapy that has been experimentally demonstrated to be generally effective in treating BPD. Research indicates that DBT is also effective in treating patients who present varied symptoms and behaviors associated with spectrum mood disorders, including self-injury. Recent work suggests its effectiveness with sexual abuse survivors and chemical dependency.

Overview:

Linehan's first core insight was to recognize that the chronically suicidal patients she studied had been raised in profoundly invalidating environments. These environments might take the form of neglect or abuse, but might also take more benign forms, such as discouraging, punishing, or invalidating a child's emotional responses. These clients, therefore, required a climate of unconditional acceptance in which to develop a successful therapeutic alliance.

Linehan also believed that certain clients were born with a biological propensity towards stronger emotional responses than their peers. Because these children had stronger emotional responses, they were more likely to be invalidated by their environment, so dysfunction was the result of the interplay of child with environment.

Her second insight involved the need for a commitment from patients, who needed to be willing to accept their dire level of emotional dysfunction and engage in the treatment. Linehan observed that garnering this acceptance of reality and commitment to the treatment helped decrease therapist burnout when working with BDP and/or highly suicidal and demanding clients.

DBT strives to have the patient view the therapist as an ally rather than an adversary. Accordingly, the therapist aims to accept and validate the client's feelings at any given time, while, nonetheless, informing the client that some feelings and behaviors are maladaptive, and showing

them better alternatives.

Linehan defined a commitment to these core conditions of acceptance and change through the principle of dialectics. One example might be that a BPD patient with cutting behaviors must absolutely accept and commit to stop cutting, while concurrently understanding that if they cut again, they will be treated kindly and not viewed as a failure. This is not meant to excuse the behavior. Instead, it encourages flexible, dialectical thinking: “I will not cut again, and I will not be a failure if I do cut again.”

Linehan assembled an array of skills for emotional self-regulation drawn from Western psychological traditions, such as cognitive behavioral therapy and assertiveness training, and Eastern meditative traditions, such as Buddhist mindfulness meditation.

All DBT involves four components:

- **Individual**—The therapist and patient discuss issues that come up during the week (recorded on diary cards) and follow a treatment target hierarchy. Self-injurious and suicidal behaviors take first priority. Second in priority are behaviors which, while not directly harmful to self or others, interfere with the course of treatment. These behaviors are known as “therapy-interfering behaviors.” Third in priority are quality of life issues and working towards improving one’s life generally. During the individual therapy, the therapist and patient work towards improving skill use. Often, a skills group is discussed and obstacles to acting skillfully are addressed.

- **Group**—A group ordinarily meets once weekly for two to two-and-a-half hours and learns to use specific skills that are broken down into four skill modules: core mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance.

- **Phone Coaching**—As needed, clients may contact their therapists for additional support between sessions. This support is generally available 24/7, but DBT places certain restrictions to curtail abuse or overuse of the therapists’ availability, such as letting clients know that after a suicide attempt they will not have immediate contact with their therapist.

• **Consultation Groups**—Therapists meet weekly to provide support, discuss cases, and practice DBT skills themselves. These groups increase motivation, improve therapist skills, provide support, and keep therapists in fidelity to the model. Linehan asserts that any therapist acting in isolation is not doing DBT.

No component is used by itself; the individual component is considered necessary to keep suicidal urges or uncontrolled emotional issues from disrupting group sessions, while the group sessions teach the skills unique to DBT, and also provide practice with regulating emotions and behavior in a social context.

DBT's Four Modules:

DBT basic skills are taught in four separate modules. Examples of each are provided below, but please note that this list is neither complete nor exhaustive, but rather a summary to give students an overview the skills each module is striving to teach.

Module One: Mindfulness

Mindfulness is one of the core concepts behind all elements of DBT. It is considered a foundation for the other skills taught in DBT, because it helps individuals accept and tolerate the powerful emotions they may feel when challenging their habits or exposing themselves to upsetting situations. The concept of mindfulness and the meditative exercises used to teach it are derived from traditional Buddhist practice, though the version taught in DBT does not involve any religious or metaphysical concepts. Within DBT mindfulness is the capacity to pay attention, non-judgmentally, to the present moment.

Mindfulness skills are divided into "What" and "How."

What skills teach participants to non-judgmentally observe their inner and outer environments. They are then taught to describe their experiences and observations without using judgmental statements or opinions. Further, they are taught skills to participate fully in the moment with focused attention, rather than moving distractedly through life.

How skills teach clients to act non-judgmentally, and focus the mind

on one thing at a time. Using these skills, clients learn to move more effectively through all of life, and not be as swayed by their emotional states.

Module Two: Distress Tolerance

Dialectical behavior therapy emphasizes learning to bear pain skillfully. Clients learn skills for accepting, finding meaning within, and tolerating distress.

Distress tolerance skills constitute a natural development from DBT mindfulness skills. They reinforce the ability to accept, in a non-evaluative and non-judgmental fashion, both oneself and the current situation. Since this is a nonjudgmental stance, this means that it is not one of approval or resignation. The goal is to become capable of calmly recognizing negative situations and their impact, rather than becoming overwhelmed or hiding from them. This allows individuals to make wise decisions about whether and how to take action, rather than falling into intense, desperate, or destructive emotional reactions.

DBT uses several acronyms to help clients remember these skills more easily. For example, the Distress Tolerance skill of Distraction is taught with the acronym ACCEPTS:

Distract with ACCEPTS

This is a skill used to distract oneself temporarily from unpleasant emotions.

- Activities—Engage in a positive activity that you enjoy.
- Contribute—Help out others or your community.
- Comparisons—Compare yourself either to people who are less fortunate, or to yourself when you were in a less fortunate situation.
- Emotions (other)—Cause yourself to feel something different by provoking your sense of humor or happiness.
- Push away—Put your situation on the back-burner for a while. Put something else temporarily first in your mind.
- Thoughts (other)—Force your mind to think about something

else.

• Sensations (other)—Do something that has an intense feeling other than what you are feeling, like a cold shower or a spicy candy.

Self-soothing is a basic Distress Tolerance skill, and involves helping participants behave kindly and gently to themselves, primarily by engaging in activities they find soothing, such as prayer, music, walks outdoors, etc.

Other skills taught include improving the moment, thinking about the pros and cons of tolerating this distress in the current moment, and being willing to do what is effective, rather than willfully doing that which is not.

All Distress Tolerance skills are taught within a framework Linehan termed “Radical Acceptance.” This means that clients must stop fighting reality, and must accept their current situations exactly as they are. This does not indicate surrendering to negative situations, but rather accepting all reality as it is so that clients can choose the most effective and competent ways to deal with it.

Module Three: Emotional Regulation

Individuals with BDP and suicidal individuals are often emotionally intense and labile. These clients can be angry, fearful, depressed, or anxious, and generally benefit by learning to regulate their emotions. Skills taught include identifying and labeling emotions, identifying obstacles to changing emotions, reducing vulnerability to acting out of “emotion mind,” taking the opposite action of what your emotions are encouraging, and engaging in distress tolerance. Clients are taught to do chain analyses of difficult situations, to better understand what triggers their emotions, how they experience those feelings in the mind and body, and how they might choose more productive outcomes in the future.

Clients are also taught basic self-management skills to limit vulnerability to emotion mind, such as sleeping enough, eating healthfully, and avoiding mood-altering chemicals.

Module Four: Interpersonal Effectiveness

Interpersonal response patterns taught in DBT are similar to those taught in many assertiveness groups. They include effective strategies for asking for what one needs, saying no, and coping with interpersonal conflict.

Individuals with BPD frequently possess good interpersonal skills in a general sense. The problems arise in the application of these skills to specific situations. A person may be able to instruct another on effective behaviors to cope with conflict, but may be incapable of generating or carrying out similar behaviors when analyzing his or her own situation.

The interpersonal effectiveness module focuses on situations where the objective is to change something (e.g., requesting that someone do something) or to resist changes someone else is trying to make (e.g., saying no). The skills taught are intended to maximize the chances that a person's goals in a specific situation will be met, while at the same time not damaging either the relationship or the person's self-respect.

DBT Tools

DBT uses a series of support tools, below:

Diary cards

Diary cards are used to track one's progress week by week. They track everything from which days clients chose to practice which skills, to therapy-interfering behaviors, to how many days each week clients remembered to fill out the card.

Diary cards have been modified slightly to better support various groups using DBT. For instance, chemical dependency clients with no suicidal ideations benefit from modified cards that better suit their specific treatment goals, while still maintaining fidelity to the model and the basic skills practiced.

Chain analysis

Chain analysis is a form of functional analysis of behavior but with increased focus on sequential events that form the behavior chain.

It has strong roots in behavioral psychology. A growing body of research supports the use of behavior chain analysis with multiple populations. In DBT, behavior chains are often used to examine how emotions predict our actions, and help clients understand where they might interrupt the chain to use more productive skills that move them towards their goals.

Milieu

The milieu, or the culture of the group involved, plays a key role in the effectiveness of DBT. The milieu provides support to therapists, as Skills Groups are generally conducted by two therapists together. It also provides gentle social pressure on clients to help them better meet their goals. A successful milieu creates positive accountability while still tolerating behavioral slips client might experience.

*Adapted from http://en.wikipedia.org/wiki/Dialectical_behavior_therapy

Discussion Questions

Professors, training directors and facilitators may use some or all of these discussion questions, depending on what aspects of the video are most relevant to the audience.

Seeking Information: What strikes you off the bat about Linehan's interpersonal style? Her level of directivity vs. listening? What did you make of Linehan's assertion that she was not particularly interested in the client's previous therapy experiences, or of how she changed the subject back to the present day? How does this compare with other training you've received on the early stages of building a therapeutic relationship? Do you see benefits to Linehan's style of information-gathering?

Choosing Not to Pursue: Linehan chooses not to pursue some provocative statements the client makes early on (the knife incident, "killing of our baby," client saying he would not come to therapy for himself but only for the relationship, not giving girlfriend enough space, prepared to give life for girlfriend in the first hour of knowing her, etc.). What are your opinions on the logic in not pursuing these early statements? Would you have done things differently? If so, how? Do you see benefit in Linehan's approach? Why? Where would your instincts naturally lead you when a new client dropped provocative statements such as these? What response do you believe the client is unconsciously (or consciously) trying to create in Linehan?

Cultural Differences: The client discusses believing in a marriage of souls, rather than traditional marriage. What do you think of Linehan's handling of this idea? Would you have pursued more cultural or personal information about the client at this point, or acted similarly to Linehan in expressing that this might be a cultural difference she did not know much about, and moving past it?

Suicidality: Throughout the session, notice how Linehan gathers information about this client's level of suicidality. How would you describe her style in this area (serious, casual, nonchalant, etc.)? What are your feelings about this style? Would it work for you, or

would your style be different when seeing a suicidal client whom you've just met? What do you think of how much time Linehan spends in session assessing for suicidality vs. learning about the client in general? Is there anything additional you would do regarding the client's suicidality (make a contract, create a safety plan, etc.)? DBT asserts that suicide and other extreme behaviors make sense when a person has a high level of emotional reactivity and is dealing with an invalidating environment. Do you feel that Linehan demonstrates this belief in the session? Why or why not?

Client Impressions: At about halfway through the interview, what are your diagnostic impressions of this client? How do your impressions change by the end of the session? Though we do not know enough to diagnose BDP with this client based on this session, do you see any evidence of this diagnosis? Do you see evidence to support a different diagnosis? What is your counter-transference towards this client? Do you believe you would work effectively with this client? Why or why not?

Domestic Violence: Do your thoughts and feelings about the client change as more information about his violent tendencies emerges? What do you make of the client's initial idea that his girlfriend was hiding from him out of guilt rather than fear? What do you make of the client's idea that in hiding things from him, his girlfriend was hitting him, just as he hit her physically? What in Linehan's interactional style works for you in this exchange with the client? Are there things that don't work, or that you might have done differently? Where do you see Linehan making accepting statements towards the client, and where do you see her drawing the line before fully validating his point of view?

Self-Disclosure: DBT therapists often use a more upfront and judiciously self-disclosing style. The client imagines that Linehan is judging him harshly for hitting his girlfriend. Linehan chooses a degree of self-disclosure in answer to this question. What choice might you have made? Do you think Linehan's choice was appropriate? Why or why not? How does this differ from other therapeutic styles you've learned about?

Goals: How does Linehan repeatedly return to and further define the client's goals? At what key moments do you see her returning the client to his goals, and how? Many therapeutic styles emphasize building alliance for the first few sessions. Linehan seems, at times, to work contrarily to this, by both challenging the client and relentlessly focusing on goal-definition. Why do you believe this works for this particular client? Might this backfire with other clients? How do you believe his suicidality influences Linehan's choices in this regard?

Use of Dialectics: Linehan points out one dialectic very clearly to the client: that he has to change and that it's not fair, and perhaps other people (not in the therapy room) need to change as well but might not. She points out the truth in both sides simultaneously (the dialectic). How could you see this being useful in sessions with your own clients? How might accepting both sides of a dialectic reduce tension and/or increase problem-solving in a client (or yourself)? Overall, do you find the concept of dialectics helpful?

Garnering Client Commitment: Linehan garners commitment from the client to engage in at least three sessions of therapy, to work on not hitting women, and to not commit suicide before the next session. She is also very blunt with him that therapy will be painful and he will see things about himself he must change. What do you think of these DBT strategies? Would you find them useful? If the client had refused on any of the points above, what other interventions might you (or a DBT therapist) use? What do you think of Linehan's "crossroads" dialogue with the client? About her response to his statement that he can always kill himself if it doesn't work? How would you assess this client's level of commitment to postpone suicide as he leaves the session? Is there anything you would choose to do differently?

Personal Reaction: How would you feel about having Linehan as your therapist? Do you think she could build a solid therapeutic alliance with you? Would she be effective with you? Why or why not?

Role Plays

After watching the video, divide class into groups of two, consisting of one therapist and one client. After each role-play, have the pair debrief with one another, then switch roles and do the role-play again in the opposite position. Let participants debrief again in their pairs, then come back to share insights and experiences with the whole group. These role-plays can also be done in groups of three, with one person acting as observer and offering their insights, then rotating into one of the active roles. You may also do role-plays in a fishbowl environment, with a pair working in front of the class, and the class offering feedback at the end, or suggestions to the therapist during the role-play itself.

1. Have one participant role-play that he or she is a client, while the other is a therapist conducting a behavioral assessment from a DBT perspective. Instructor may pre-determine what traits the client should demonstrate prior to the session (suicidal, defensive, high-risk, etc.).

2. Have one participant role-play that he or she is the client from the video, coming in for his second session. The therapist will practice using Linehan's interactional style with this client as she learns more about him and secures more commitment to treatment.

3. Have one participant role-play that he or she is the client from the video, but that there is more time allowed in the current therapy session for the therapist to explore issues of their choosing. The instructor might pick a moment from the session to stop the tape and have each group work further on this same moment, exploring alternate therapeutic interventions, or each pair might be allowed to choose their own moment to start from.

Reaction Paper for Classes and Training

Video: *Dialectical Behavior Therapy with Marsha Linehan, PHD*

• **Assignment:** Complete this reaction paper and return it by the date noted by the facilitator.

• **Suggestions for Viewers:** Take notes on these questions while viewing the video and complete the reaction paper afterwards. Respond to each question below.

• **Length and Style:** 2-4 pages double-spaced. Be brief and concise. Do NOT provide a full synopsis of the video. This is meant to be a brief reaction paper that you write soon after watching the video—we want your ideas and reactions.

What to Write: Respond to the following questions in your reaction paper:

1. Key points: What important points did you learn about Linehan's DBT approach? What stands out to you about how Linehan works?

2. What I found most helpful: As a therapist, what was most beneficial to you about the model presented? What tools or perspectives did you find helpful and might you use in your own work? What challenged you to think about something in a new way?

3. What does not make sense: What principles/techniques/interventions did not make sense to you? Did anything push your buttons or bring about a sense of resistance in you, or just not fit with your own style of working?

4**. How I would do it differently:** What might you do differently from Linehan when working with clients? Be specific about what different approaches, interventions and techniques you would apply.

5. Other Questions/Reactions: What questions or reactions did you have as you viewed the therapy session with Linehan? Other comments, thoughts or feelings?

Related Websites, Videos and Further Reading

WEB RESOURCES

Behavioral Research and Therapy Clinics

http://blogs.uw.edu/brtc/

Psychcentral

http://psychcentral.com/lib/2007/an-overview-of-dialectical-behavior-therapy/all/1/

Behavioral Tech

http://behavioraltech.org/resources/

RELATED VIDEOS AVAILABLE AT WWW.PSYCHOTHERAPY.NET

Psychoanalytic Psychotherapy with Otto Kernberg

Cogntive Therapy with Art Freeman

The Abused Woman: A Survivor Therapy Approach with Lenore Walker

Suicide and Self Harm: Helping People at Risk with Linda Gask

RECOMMENDED READINGS

Linehan, M. (1993). *Skills Training Manual for Treating Borderline Personality Disorder,* 1st ed.: The Guilford Press

Linehan, M. (1993). *Cognitive Behavioral Treament of Borderline Personality Disorder*, 1st ed.: The Guilford Press

Dimeff, Linda A., ed. and Kelly Koener, ed. (2007) *Dialectical Behavior Therapy in Clinical Practice: Applications Across Disorders and Settings*, 1st ed.: The Guilford Press

Complete Transcript
Introduction

YALOM: Hello. I'm Victor Yalom, and I'm pleased to be here today with Dr. Marsha Linehan. She's the developer of Dialectical Behavior Therapy, a rigorous, evidence-based treatment which is best known for its use with suicidal patients and borderline personality disorder. Welcome, Marsha.

LINEHAN: Thank you.

YALOM: In a few minutes, we're going to have a chance to see you doing an initial assessment with a patient. But before we do that, I'd like to hear from you exactly what is Dialectical Behavior Therapy.

LINEHAN: Dialectical Behavior Therapy is a cognitive behavior therapy. So that's important to get—that it's actually behavior therapy, a version of it. And it's a comprehensive treatment that was originally developed for highly suicidal individuals, and then was expanded to highly dysregulated individuals who met criteria for borderline personality disorder.

But it's now expanded way beyond that and has become a comprehensive, multi-diagnostic treatment. And that's its real major asset, that it allows you to treat individuals with multiple disorders. So it's trans-diagnostic, which is a good quality.

The treatment started out as straight behavior therapy. And the patients that I recently was treating had severe suicidality, chronic self-injury, met criteria, for the most part, for borderline personality disorder, but also had extreme, out- of- control behavior and highly traumatic childhoods. So I walked into that with a straight behavior therapy, which, at that time in history, was a purely change-based treatment. So if that had worked, we would have had behavior therapy.

But it actually was a disaster and it blew up and the clients got upset, hid behind chairs, stormed out, quit therapy, did the whole thing. And it became clear that a change-based therapy was not going to work, that two things had to happen.

One, I had to develop treatment strategies for the therapists, teaching

therapists, how, in effect, to accept patients, and strategies that communicated acceptance, validation, et cetera. That's one side of things.

Two, it became utterly clear that simply teaching clients how to change was not going to work, either, and what I had to do was teach clients how to radically accept and tolerate distress. And although, that's all over the place in psychotherapy now, that was not all over the place in behavior therapy when I started.

YALOM: Which was when?

LINEHAN: I started developing Dialectical Behavior Therapy—I was funded in 1980. In reality, it was somewhat a progression through my whole career, which was focused on high suicide risk. And so it was really a progression from everything else.

But the funding for the development of a treatment for chronically suicidal, which is what I was funded to do, was started in 1980. The treatment manual was published in 1993, because I didn't want to publish a treatment manual when I didn't have a randomized clinical trial showing the treatment worked.

So the first clinical trial was published in 1991. Since then, there have been about 29 randomized clinical trials on DBT. DBT is short for Dialectical Behavior Therapy—about 29 randomized clinical trials, which is certainly more than any other treatment aimed at the populations DBT is aimed at.

Much more important than that, of course, is that there are 21 independent trials, meaning independent of my lab, where I had nothing to do with the trials. So that's really important.

The key characteristics for DBT are its emphasis, one, on assessment, and continuous assessment, and its emphasis on stages of treatment. So DBT is organized around stages of treatment. So stage one is the goal has to be to get action under control. So if we've got a client who's going to kill themselves, we've got to target, first, making them stay alive, because if they're dead, nothing works. So that's strategy one.

They also had to be able to participate in therapy, because there are really no treatments that work with clients who won't participate in

therapy. So you've got to get a client participating. And then, you have to have severe, out of control behaviors under control. In other words, if you've got a person who's a drug addict and is on drugs all the time, it's very hard to treat other things—or a person with alcohol or a person who's homeless, et cetera.

So that's stage one. Once you get stage one moving—and DBT is really very good at stage one, which is out of control behavior—then you move to stage two. Stage two is quiet desperation, which boils down to—you're now focused on, OK, so you've got your behavior under control, but you're really still miserable.

YALOM: OK. So just to be clear, if someone who's actively suicidal, cutting themselves—

LINEHAN: You would have to get that under control before you paid attention to making them happy.

YALOM: OK.

LINEHAN: OK? In other words, you can't be dead for us to work with you.

YALOM: It's a type of Maslow's Hierarchy of Needs.

LINEHAN: Well, it's either that or it's what you see in all treatments, which is, no matter what you're treating, a client walks in with a gun to the head—you don't say, "did you do your homework?"

YALOM: Right.

LINEHAN: You say, take the gun down.

YALOM: Right. It's a form of triage, in a sense.

LINEHAN: It's a form of triage, exactly. And so once you get quiet—so quiet desperation is where we treat PTSD, really severe PTSD. We treat maladaptive grieving. We're usually treating depression all along. We're treating other out of control behavior, like eating disorders all along.

And DBT is every bit as effective as any other treatment, say, for major depression, for eating disorders, et cetera. For a long time, it wasn't as effective at treating anxiety disorders like panic disorder and PTSD, et cetera. But now, we've made modifications to the treatment where

it's now effective, mainly because we brought in evidence-based treatments.

So DBT has multi-targets. You simply go through targets. Now, the third stage—once you've got misery out of the way—is you deal with ordinary problems in living. So a lot of borderline patients might come in with behavior under control with no severe Axis I disorder, but with a lot of problems in living. So that would be stage three. DBT does that.

And my original manual had only three stages. But now, we have stage four, which is "is this all there is?" stage. And that's more the spiritual end of DBT. And although I was very reluctant to ever really talk about that spiritual end of things, I switched over to discussing spirituality, because we discovered so many clients, spirituality is so important for them.

So our new version of skills, which will be coming out soon, has got a whole section now at looking at mindfulness from a spiritual point of view. And mindfulness was the core acceptance strategy taught to clients.

So DBT, for example, actually was the first psychotherapy that put mindfulness into psychotherapy. It was put into medical treatment before DBT by Jon Kabat-Zinn. But the first major treatment that it came into was actually DBT. And mindfulness is a core skill that both therapists have to practice and clients have to practice.

So you're going to see there's a big emphasis in DBT on what the therapist is doing as well as what you're actually teaching the client, which tells you another important factor about DBT. It's largely skills-based intervention. The basic idea is that clients are doing the best they can. That's one of core assumptions of DBT.

Clients are doing the best they can, and all people want to improve, which boils down to what the Dalai Lama said—everyone wants to be happy, including all of our clients. So we never sit around saying, you just don't want to be happy.

YALOM: So let me just interrupt for second. You said the behavior therapies, change-based therapies, with this population, blew up for you.

LINEHAN: Yeah.

YALOM: And so you had to add an acceptance piece.

LINEHAN: Yeah.

YALOM: So what exactly do you mean by that?

LINEHAN: What I meant was first that therapists had to learn to radically accept slow rate of progress, which is very different than what people were expecting in behavior therapy time. Behavior therapy was one of those things you came in 14 weeks—we still have a lot of 14-week treatments. So first, you had to accept slow rate of progress.

Second, you had to accept the tragic lives that many of our clients had. Many therapists never see these lives of just unbelievable childhood tragedies. And third, the therapist had to develop an ability to find the valid in the client's behavior and validate the valid, which is the most important acceptance-based strategy.

Now, a lot of people think, oh, you just validate and praise and say things about everything. No. You have to look for the valid. And therapists must find it in a session, or your adherence goes down—given the theory that it's always there if therapists look for it.

YALOM: And by adherence, you mean people continuing stay in treatment.

LINEHAN: No, adherence meaning the therapist has fidelity to the model, which, of course, we rate, because we have a fidelity measure. And we rate fidelity of therapists. And therapists have to keep their fidelity. There's a reason AT&T tapes those phone calls and looks at them. It's because it keeps you on the mark during treatment.

We know that therapists tend to drift out of treatments if fidelity's not monitored. So DBT, one of the—I sometimes think after I'm dead and they look back at what did I really contribute, they're going to say what she really contributed was a huge emphasis on therapists and taking care of therapists and making sure they don't get burned out, but also putting them on a team where the role of the team is to keep the therapist in the treatment model, because we know that evidence-based treatments work far better if therapists stay in the model of the

treatment—in other words, have fidelity.

There's a lot of research on that. And so my question was why is it that many therapies that work in a research setting don't work in the community? And I realized one of the main reasons is all research programs have a community of therapists who are helping each other stay on the treatment. But when you move it out into the community, that got lost.

So you can't say you're doing DBT if you don't have a treatment team.

You can't say you're doing DBT if you're not teaching skills. And one of the things that you're going to see in the tape coming up is an individual behavioral assessment first session. But individual therapy is not DBT.

And that's really important, because we've got data suggesting now that, maybe, it's not even the most important part of DBT. The most important part is actually systematic skills training.

YALOM: All right. So we're going to get to the session in a minute. But I'll ask you one more thing, which I'm sure you've been asked many times before. What is dialectical about DBT?

LINEHAN: Dialectical is the balance of opposites. It's the balance that you have to change and we have to accept the way you are. And so it's always looking for the balance, always looking for what's left out of our understanding, always looking for where's the truth in both ends of an opposition.

YALOM: And why is that important?

LINEHAN: Because first of all, it's incompatible with blame. Second, it's looking for truth. And in general, a lot of therapy mistakes are made because you start thinking either you're right or I'm right. And you don't look for how is it that we're both right in some ways and how can we come together and work together?

So dialectics has an emphasis on the nature of reality as change. It has an emphasis on the nature of reality is that all of us are connected, everything in the universe is connected. One of the biggest problems in borderline personality disorder, particularly those who are highly suicidal, is they have no experience whatsoever of connection to

others or to the universe as a whole. Dialectics always emphasizes how everything is connected, how even both sides of opposites are connected.

And so there's an emphasis on that, an emphasis on being comfortable with change. DBT therapists don't try to make everything stay the same so you feel more secure. They try to make sure that we program in change and teach you how to be comfortable with it because it's the nature of the world. So dialectics has a lot of characteristics that are very compatible with the behavioral approach, but it expands it.

YALOM: So the session we're about to see has an interesting history.

You and a number of other prominent therapists were at a conference in Holland some years ago. And they hired an actor—a very good actor, as we'll see—to play the role of a complex patient, presumably with some longstanding traits that many people would think of as characteristic of a personality disorder.

But we'll see how you approach it and do an introductory assessment session with that patient. And in this series, we're going to have a chance to see some other therapists—Otto Kernberg and Art Freeman—meet with the same patient. So that will be interesting to see how each of you work and what the similarities and differences are.

But it is just for a single session. So you've mentioned a behavioral assessment as being critical for DBT. Can you tell us what that is?

LINEHAN: A behavioral assessment is when you're trying to figure out, with an individual person who shows up for therapy, both what their problems are and what their goals are. Often, a client comes in and gives you goals. But you've got to figure out a way to translate a goal into a problem, because what therapy does is help you work on problems that you have. So that's really the first step—just to figure out what are the problems this person has. And that's a major issue in the assessment of this particular client.

And second, you're looking for what a behaviorist would call controlling variables. Controlling variables are what is it in the environment and what is it in the person's behavior patterns that

are controlling the problem, because you've got to figure out what's controlling it in order to change it. But a lot of what you're getting in a first session is more specificity on exactly what the problem is—in other words, what are the problem behaviors? We're looking for what is the frequency of the problem behavior? Is it a longstanding pattern or new behavior that's a problem?

We're looking for context. In other words, do you have the problem only in one situation but not in another situation? So it's a lot of this. You're looking for the client's goals, which is what I'm looking for in this session. And you're looking for whether the client is actually willing to change, because there's really not a whole lot of point in doing therapy—my goal as a therapist is not to try to make another person change or to convince them to change or do anything like that.

My goal at a session like this is to find out what are your goals? Do you have goals that I think I'm competent to treat? And do you have goals that I'm willing to treat? And I usually want to give them a little bit of taste of how I'm likely to interact with them, because I want them to be able to decide whether they want to have second session. So I have to do a little bit that somewhat gives them a flavor of who they're getting themselves into a relationship with.

YALOM: OK. So those are some of the things you're going to be doing this session.

LINEHAN: Yep.

YALOM: Anything else that the viewer should be watching for?

LINEHAN: Well, I don't really ever think of a first session as

Dialectical Behavior Therapy, to be honest. And the reason I don't think of it that way is if you haven't done an assessment, you don't know what treatment you're going to give. And you obviously have different treatments for different disorders, different treatments for different problems.

So I never walk into a first session with someone thinking I know what

treatment I'm going to give them. So I don't start giving a treatment without an assessment because that would make no sense to me. So I don't walk in thinking I'm doing anything.

What you'll see in it is some strategies a DBT therapist often uses. So one is assessment, which is central to DBT. It's really central to all behavior therapy. Secondly, you'll see some of our strategies. You see some validation in it. You see some irreverence.

You'll see a number of the dialectical strategies, but not really until I'm mostly at the end of the session. DBT strategies don't really show up at the beginning. It's more straight behavior therapy.

YALOM: OK, with some DBT, as we see, seeping in.

LINEHAN: Seeping in towards the end.

YALOM: Good. So let's go ahead and take a look at the session. And then throughout the session, you'll be adding your commentary—like what you were doing, what your thoughts were at the time.

LINEHAN: Yep.

YALOM: And then you and I will meet after the session to discuss it further.

Session

LINEHAN: OK.

LINEHAN: Did you have any trouble finding me?

ALFRED: Not very much, no.

LINEHAN: OK. Good. Well, I understand that when you called to make an appointment that your sister had referred you to me?

ALFRED: Yes.

LINEHAN: OK. And do you know why she referred to me in particular?

ALFRED: She had heard about you, and she has been very worried about me. And she said, that's a good one. You should try her. And she persuaded me to go. And to be honest, I was entering the building, and I was asking myself, why am I doing this? Why should I bother, because the last time—I've seen therapists before. The last time I had some meetings with a therapists, they were not very nice meetings.

And they ended in a bad way.

LINEHAN: So you've been in therapy before?

ALFRED: I've been with my girlfriend. Five months ago, we were together in therapy. We asked for help. And we had about three sessions. And after that, my girlfriend left me.

And already during the sessions, I had the impression that one of the therapists was biased against me. And I proved to be right, because they kind of brainwashed my girlfriend, and they kept on making big issues about small incidents.

LINEHAN: Well, why don't we go back to walking in here? OK.

ALFRED: Yeah.

LINEHAN: So when you came in here, why don't you tell me, from your point of view, why are you coming to see me?

ALFRED: Why I am coming—

COMMENTARY: I switched topics, mainly because I'm not that interested in his previous therapy except insofar as it is going to have an effect on our therapy if we do therapy together.

ALFRED: Perhaps it's—I'm doubting it. On one hand, I say I have to give myself another chance, because my life is a mess. A few months ago, I had a lot of hopes for the future. And everything has disappeared. Everything has changed. And I'm not even sure if I want to live.

And because of my sister—I've been living with my sister for two months because I couldn't live alone. And she was about the only person who really cared about me, who was prepared to take me in with her family, because I couldn't live alone—because I value her opinion, and she persuaded me to give myself another chance.

LINEHAN: OK. So you're feeling like your life is a mess or a wreck right now?

ALFRED: Yeah.

COMMENTARY: *OK. So what you just saw was me reflecting back to the client to check whether I heard correctly what the client was saying.*

And you're going to see this pattern all the way through. In general, I listen, then I reflect to check.

If my checking shows that I was correct in my listening, I keep going. If it turns out I was incorrect in what I heard, I continue to assess. And you're going to see that pattern all the way through the interview.

LINEHAN: And how old are you again?

ALFRED: 41.

LINEHAN: 41. OK.

ALFRED: Yeah.

LINEHAN: Have you always felt that your life was a wreck, or is this something new?

COMMENTARY: *What you see here is I'm looking to see if this is a long term pattern or a recent pattern. If it's recent, I want to find out what happened. And if it's long term, I'm going to be looking for what are behavioral patterns this client has that may be creating the problems that brought him into therapy*.

ALFRED: It's not something completely new. But the last few months, because there's so much difference between how it was before a half year ago—because we were expecting a baby. I was living with my girlfriend for more than four years.

We had high hopes. We had a future. And we were making plans. We were making plans about getting married. We were making plans about moving to a bigger house. And all of a sudden, without—till this day, I don't really understand why it had to be like this.

LINEHAN: Why it ended?

ALFRED: Why it ended.

LINEHAN: So from your point of view, it was very sudden?

ALFRED: Yes.

LINEHAN: OK. So you were just living along and were happy in the relationship?

ALFRED: Yeah.

LINEHAN: And then—you must have known you had some problems because you were in couples therapy.

ALFRED: Yes. We had some problems. But I wasn't prepared for this.

LINEHAN: For the ending.

ALFRED: No.

LINEHAN: OK.

ALFRED: Because we were trying to get help to improve our relationship so there will be room enough for the baby. And I still don't understand how she could make a decision like that.

LINEHAN: So she left you?

ALFRED: Yeah.

LINEHAN: OK. You didn't leave her?

ALFRED: No.

LINEHAN: OK. So when was that?

ALFRED: That was five months ago.

LINEHAN: Five months ago. OK.

ALFRED: And I wasn't even allowed to be in touch with her after that, because I was trying to find her and I couldn't. She went to some secret place, because they said that she was afraid of me.

COMMENTARY: *So what he just said is an alert. Mainly, it tells me there's more of a problem than he sees. I don't know what the problem is. And I'm certainly not going to make assumptions. I'm going to assess.*
Now, I have to find out what is he doing that results in her being afraid? That's the next question.

LINEHAN: What happened to the baby?

ALFRED: She had an abortion.

LINEHAN: Really?

ALFRED: Yes.

LINEHAN: Was that with your permission or without your permission?

ALFRED: Without my permission.

LINEHAN: Without, OK.

ALFRED: But during the sessions in the therapy, everyone thought it was very normal to discuss the killing of our baby.

LINEHAN: So that's how it seems to you?

ALFRED: Yeah.

LINEHAN: OK. So have things for you really gone downhill since that relationship ended?

ALFRED: Yeah.

LINEHAN: So what were you like before it ended? Would you have come to therapy? If you hadn't been having problems with her, would you have thought there was any value in you being in therapy or felt any need for it?

COMMENTARY: *So what I'm doing here is checking out to see if problems with this particular girlfriend are the critical factors that brought him into therapy, or if, in reality, there's a lot of other problems that have got him in here.*

ALFRED: Not for myself—perhaps for the relationship, because Saskia, my girlfriend, was feeling that she had not much space within the relationship, that I wasn't giving her enough space, which, in my opinion, wasn't true, because I was giving her a lot of space, I think. But she didn't know how to handle the space.

LINEHAN: I see. So from your point of view, the relationship was good.

ALFRED: Yes.

LINEHAN: From her point of view, it wasn't.

ALFRED: Yes.

LINEHAN: And she left.

ALFRED: But—yeah. But it's not as simple as you put it.

LINEHAN: Really?

ALFRED: No.

LINEHAN: Why not?

ALFRED: Because she wasn't telling me in my face that, in her opinion, the relationship wasn't good.

LINEHAN: OK.

ALFRED: She was making plans with me.

LINEHAN: OK.

ALFRED: She was as delighted as I was with her being pregnant, because for years, she was convinced that she wasn't able to be become pregnant.

LINEHAN: So from your point of view, not only were you happy, but she was happy. And then sort of all of a sudden, from your point of view, out of the blue—

COMMENTARY: *So what I'm doing here is checking out his perception of the problem. And what you're going to see from here for quite awhile now is that I am continuing to check out his perceptions and his experiences of the problem. So I'm just trying to get his point of view on what's going on.*

ALFRED: She had some problems. And she was insecure about a lot of things.

LINEHAN: Yeah. OK.

ALFRED: And maybe it's true. Maybe I didn't give her enough space for—but I was—how was I supposed to sit there and to listen to her just doubting about having the baby or not? But she was talking about me. The baby is a part of me as well.

LINEHAN: Yeah.

ALFRED: So at home, at one point, I gave her a knife and put it on my chest and said, you might as well stab me.

LINEHAN: Right. Yeah.

ALFRED: If you go on talking about maybe not having the baby—

LINEHAN: Do you have any other children?

ALFRED: No.

LINEHAN: OK. So this would have been your first child?

ALFRED: Yes.

LINEHAN: OK. And so were you happy when you found out she was pregnant?

ALFRED: I was delighted.

LINEHAN: OK.

ALFRED: I was delighted, because in my vision, it was as if life itself gave me a great gift—us. And for me, it was pure hope.

LINEHAN: Yeah, yeah. So you must have a terrible sense of loss now.

ALFRED: Yeah.

LINEHAN: OK. I want to get back to that, OK? So we're going to come back to how it feels right now. But let me just get a little bit of history just to understand things a little better.

If you're 41, let's see—you got involved or met her, started living with her when you were 37?

ALFRED: Yeah.

COMMENTARY: *I've gotten a reasonable idea of what his perception and experience of the problem are. And now, I want to stop getting more information on that and move to assess behavioral patterns from a historical point of view. So I'm going to be looking at, over time, what are the patterns of behavior that might have created the problem that he's coming into therapy for.*

LINEHAN: How long had you known her before that?

ALFRED: Very short.

LINEHAN: Very short.

ALFRED: Yes.

LINEHAN: OK.

ALFRED: Very short, yeah.

LINEHAN: How about other relationships? Have you been married?

ALFRED: I've not been married, but I've been living for two years with another girl when I was about 30, 31, when I was 31.

LINEHAN: And how'd that relationship end?

ALFRED: Well, apparently, I didn't see it coming, like I didn't see it coming this time, because she left me, and Saskia left me leaving a note. And Carla left me without leaving a note.

LINEHAN: So this is the second time this has happened?

ALFRED: Yeah.

LINEHAN: Now, has it happened before that?

ALFRED: Not in the same way, because I had a relationship when I was about 19, 20. And it ended, but in a different way, because—

LINEHAN: How'd it end?

ALFRED: She wasn't prepared to be in a steady relationship. We talked about it. In a way, I could understand it.

LINEHAN: So it made sense.

ALFRED: It made more sense than the other ones.

LINEHAN: But now, are those the only three relationships you've had?

ALFRED: Yeah.

LINEHAN: And all three of them, the partner left you?

ALFRED: Yeah.

COMMENTARY: *OK. So I've gotten a reasonable history of his relationships—mainly, that they've all been problematic. But now, I want to come back to that current relationship, because the current relationship is what's actually gotten him in therapy right now.*

LINEHAN: So you've never left anyone yourself?

ALFRED: No. No, because when I met Saskia, I knew from the very, very first moment—I saw her and we looked at each other and I knew—it's her. And it was almost the same for her. And from that moment, I committed myself.

LINEHAN: To her?

ALFRED: To her.

LINEHAN: Yeah.

ALFRED: And from the first hour, I knew, for this woman, I am prepared to give my life.

LINEHAN: Let me just ask you something. If that's true for you and true for her, how is it that you didn't get married?

ALFRED: Because I don't believe in that kind of marriage. I believe in a marriage of the souls, of the minds. And I don't need the paper. I don't need—

LINEHAN: OK. We're going to come back to that, too, because that could be a cultural difference. I from the—you probably know this. I'm a therapist trained in the United States.

ALFRED: Yeah.

LINEHAN: OK. You're from Holland, and I'm not sure about the differences here. OK, back to you again. All right. So you've had three relationships.

ALFRED: Yeah.

LINEHAN: They've all ended with the woman leaving you—two of them where they left you suddenly.

ALFRED: Yeah.

LINEHAN: And this one has been a major blow to have her leave.

ALFRED: Yeah.

LINEHAN: OK.

ALFRED: That's because she left with my child.

LINEHAN: Right. Hers also.

ALFRED: Hers also, but also mine.

LINEHAN: Yes.

ALFRED: She had no right to make a decision like that.

LINEHAN: OK. A lot of people think that way. And I can see how you would think that way. But let me just get a few other—I just need a context to put all this in, OK?

ALFRED: Yes.

LINEHAN: So tell me a couple things. Are you employed?

ALFRED: I'm employed, yes.

LINEHAN: What kind of job do you have?

ALFRED: I work in a hotel as a night porter, night watch. And I've been doing that now for almost four years here. And before that, I've been a waiter and I've been a night watch in several cities in Europe in hotels. So I've been in Brussels. I've been in Basel, Switzerland, and Berlin. And I've worked in several places.

LINEHAN: You've always worked in hotels?

ALFRED: Yes.

LINEHAN: OK. Where were you born and brought up?

ALFRED: Here in Holland.

LINEHAN: In Holland.

ALFRED: Yes.

LINEHAN: OK. Did you go do—how much education do you have?

ALFRED: I didn't finish the school here before university. I didn't finish it.

LINEHAN: You didn't finish that.

ALFRED: No.

LINEHAN: OK.

ALFRED: I left before the exams.

LINEHAN: OK. Let me just ask you something.

ALFRED: And after—yeah.

LINEHAN: Do most people finish? Or is that typical?

ALFRED: Most people—no, it's not typical.

COMMENTARY: *So notice that this is second time I've asked a question about his culture. And what I'm trying to do here is figure out whether his behavior is normative in his culture. And the reason I'm asking about that is because he comes from a completely different culture than I do.*
And so I don't really understand his culture as well.

We have experience and training in Dialectical Behavior Therapy that, many of the skills that we teach, we have to make modifications across cultures so that the behaviors that we're teaching people fit the culture that they're in. So this is not a minor detail.

LINEHAN: It's not typical.

ALFRED: No.

LINEHAN: OK. Why didn't you finish?

ALFRED: Because I was seeing a future that we—everything was already prepared. You can predict precisely how your life would go. And I was seeing all the others doing exactly what their parents expected from them.

LINEHAN: Yeah, yeah.

ALFRED: And I wasn't prepared to do that.

LINEHAN: OK. OK. OK. So you were kind of a rebel?

ALFRED: Maybe, in a way. I'm trying to do it in my way.

LINEHAN: OK. All right. So do you regret that? Are you satisfied with that? Is that OK with you?

ALFRED: It's OK with me.

LINEHAN: OK. Are you happy in your job?

ALFRED: Yes.

LINEHAN: OK. So you like your work.

ALFRED: Yeah. I like to work at night because nobody bothers me.

No manager is around. I am my own boss at night, because I have—there are managers, but they sleep at night. And I can do—I'm my own boss at night.

LINEHAN: Yeah. OK. OK So you like your job.

ALFRED: Yeah.

LINEHAN: But earlier, you were saying that you can't live alone. So you're living with your sister, right?

COMMENTARY: *It's important to find out if he also has problems in his job as well as in relationships, because we're looking to see if he has a pervasive pattern across all contexts. But it appears to be, from the answers that he'd given me, is that this isn't as pervasive. In other words, his problem appears to be in relationships with women, but not in relationships at his job.*

ALFRED: Right now, I'm not living with my sister anymore. I've lived with her family for about three months. And the last two months, I'm living alone again.

LINEHAN: All right. In an apartment?

ALFRED: In the same apartment where I lived for four years with my girlfriend.

LINEHAN: OK. And so how does that feel to be back in that apartment?

ALFRED: Sometimes—sometimes, it's like hell, because all the places, all the objects, all the—I don't usually stay for hours in my own apartment, because I'm driving around a lot, going out, because I can't stand to be in my house for a long time.

LINEHAN: OK. So what? It's been four months?

ALFRED: Five months.

LINEHAN: Five months.

ALFRED: Yes.

LINEHAN: OK. So you're still grieving? Still sad?

ALFRED: Yeah, I'm still asking myself why—what have I done wrong? Why are there other people who saw it coming? And why didn't I see anything?

LINEHAN: Yeah, yeah. OK.

ALFRED: What's wrong with me? Am I not capable of being in

a relationship? Why should I—should I try again? Or will it end in the same way? Should I bother at all? Or should I just finish it? Sometimes, I'm thinking about it.

LINEHAN: Finish it, meaning what?

COMMENTARY: *Notice that when he said, should I bother at all or should I just finish it, I immediately go to asking what he means by that. So I'm checking for suicide ideation. Once I find out about that, I'm then going to start assessing for suicidality.*

The topics that have to be covered is one, to do at least a minimal risk assessment at this point, including questions about does he have a suicide plan, asking what are the consequences that he expects from the suicide. I want to look at whether he's got current urges to kill himself or are these just thoughts that go through his mind. You can have thoughts. Or you can have thoughts and an extreme desire to kill yourself right now. That's going to be very important.

I also want to find out about his social network. Does he have a supportive community that we're going to be able to count on to help him stay alive if he gets very suicidal? And then I'm going to want to find out about what's his willingness to work to stay alive? Is he willing to make one of the treatment goals that he'll stay alive at least while he's in treatment? So you can watch me cover each of these topics in the following sections.

ALFRED: Not live anymore.

LINEHAN: So you've been thinking about suicide?

ALFRED: Yes, I've been thinking about it.

LINEHAN: When you think about suicide, how do you think about doing it? Or have you thought about how to do it?

ALFRED: I think about when I do it, I do it in a radical way. And I think about trains. I think about my car. I can always have an accident—like that.

LINEHAN: When you think about it, is the thought just coming in and out of your mind? Or do you spend a lot of time thinking about it and planning it?

ALFRED: No.

LINEHAN: Have you been planning it or does it just come in and out?

ALFRED: No. When I don't know what to do, sometimes I think it would be a great relief for me and for a lot of other people, I think, when I'm no longer here. A lot of people will be relieved.

LINEHAN: OK. So the thought comes in that you'd be relieved. Then you start thinking about how other people would be relieved.

ALFRED: Yeah.

LINEHAN: OK. So when you're alone, sometimes, you start thinking about it. And when you think about it, you think about jumping in front of a train or having a car wreck, right?

ALFRED: Yeah.

LINEHAN: Right. OK. So what's the chance that you're going to do that? What do you think? Is there some chance—do you have an urge to do it, or is it just like thoughts that come through your mind?

ALFRED: Well, it's in the back of my mind, because if this doesn't work, I can always do it.

LINEHAN: OK. So it's like a safety valve.

ALFRED: Yeah.

LINEHAN: I'll either get my life worked out or I'll kill myself.

ALFRED: Yeah.

LINEHAN: All right. OK. I take it, then, that you would rather work things out. If you could figure out a way to solve your problems, you'd rather do that than kill yourself.

ALFRED: Yeah.

LINEHAN: OK.

ALFRED: But I don't see how that will go, because I've not much reason to think that it will work out this time.

LINEHAN: OK. That's because it hasn't worked yet.

ALFRED: No, because I'm already 41. And then, you should be

arranged.

LINEHAN: So you're feeling like you should already be in a relationship?

ALFRED: Yeah.

LINEHAN: OK. Do you have friends? Do you have a network of friends?

ALFRED: I have one friend from longer ago, from about when I was 16. And I don't see him very often. And I'm not sure if he's a real friend, because during the period that we had our problems, in a way, he was interfering with things in a way I didn't like.

LINEHAN: So you and your girlfriend didn't have a circle of friends,

people you did things with?

ALFRED: No. We had some acquaintances, but not real friends.

And because from the beginning, we didn't need much. We could be together for days without needing anyone else.

LINEHAN: Yeah. So you were happy with each other.

ALFRED: Yeah.

LINEHAN: OK. OK. But that's not true now, right?

ALFRED: No.

LINEHAN: OK. Let me just see if I'm clear on what the problem is.

COMMENTARY: *So you can see that I've done a brief assessment of suicidality. So when you're doing a behavioral assessment, you're going through, getting facts, checking facts, defining the problem, and trying to figure out goals. But what often happens in the middle of that is someone starts telling you they're suicidal.*

So you're doing your behavioral assessment, they say they're suicidal, so you put a halt to what you were doing, move over, assess suicide, suicide risk. Once you've completed that—and you don't want to take too long on that—you then come right back again, continuing on with your behavioral assessment. And that's what you're seeing me do.

And now, I move back again by summarizing what I've heard so far and

now asking more questions to better define the problem, and also for me
to figure out what are all the elements of this problem, or at least most of the elements?

LINEHAN: From your point of view, the real problem, it sounds to me that you're saying, is that—what I'm getting from you is that you want to be in a relationship that's stable, that you would like to have children. You would like to have a loving relationship.

ALFRED: Yes.

LINEHAN: Is this true?

ALFRED: Yes, of course.

LINEHAN: OK. You would like to have that.

ALFRED: Yeah.

LINEHAN: And so far, you're 41, and you haven't been able to manage it, except for short periods.

ALFRED: Yeah.

LINEHAN: And in two out of three, the woman has left you suddenly.

ALFRED: Yeah.

LINEHAN: And you haven't known what had happened.

ALFRED: No.

LINEHAN: So you're now afraid to try again, because you're figuring there must be—you're wondering what's going on here.

ALFRED: Maybe something terrible wrong with me.

LINEHAN: Right.

ALFRED: And that it's not for me in this life to have a relationship.

LINEHAN: Yeah. Those are two very different ideas. That there's something wrong with you is one idea. And that it's not for you—that's a different idea.

ALFRED: Yeah.

LINEHAN: Those are not the same idea.

ALFRED: And maybe it's difficult to find someone who's prepared to love me for 100%.

LINEHAN: I see. OK. Or at least to keep loving you. Because it sounds like the—what was the name of this—

ALFRED: Saskia.

LINEHAN: Saska?

ALFRED: Saskia.

LINEHAN: Saskia? OK. It sounds like you were actually very happy with Saskia and how much she loved you until she left you.

ALFRED: Yes.

LINEHAN: OK. So if she hadn't left you, from your point of view, it was a good relationship. OK. So the question would be, could you get another relationship that would also be good but that wouldn't end?

ALFRED: Yeah.

LINEHAN: OK. And now, the question that I have for you—OK. So that's an important question. That's an important problem. It seems a reasonable problem to me. And it seems clear that there's some problem someplace. So the question is, is that something you would like help with? You're here talking to me and telling me about it, but your sister's the one that sent you here because she was worried about you.

ALFRED: Yeah.

LINEHAN: So the question is would you like to work on that in therapy with someone—me or someone else? And we have to decide whether it would be me or not. So that's something you would like some help with?

ALFRED: Yes, and at the same time, I think I don't see it. I don't—I cannot imagine that it's possible to get help for that.

LINEHAN: Right. So it feels hopeless.

ALFRED: Yes.

LINEHAN: OK. And you feel that you're somehow fatally flawed

or something, that maybe you're fatally flawed or there's something terribly wrong with you?

ALFRED: There must be, because in the therapist's opinion, Saskia was right to make the choice she made. So if she was right, I must have been wrong all the time.

LINEHAN: OK.

ALFRED: And because I wasn't allowed even to get in touch with her, so I must be a monster, because why would she hide?

LINEHAN: That's a good question, actually. Why do you think she's hiding? If you really thought about it, what do you think? It's not that usual. I'll agree with that.

ALFRED: Because she knows by leaving me that she killed a part of me. She knows that. She must feel very guilty about it, I think. And perhaps she doesn't dare to have a confrontation again.

LINEHAN: You think she's afraid of you?

COMMENTARY: *Now, this is the second time the topic of his girlfriend being afraid of him has come up. So now that it's come up again, it's going to be important to figure out what behavior patterns does this guy have that lead to this girlfriend feeling afraid. And I'm also going to want to know did anyone else feel afraid of him in the past? Were there other parts of his life where he engages in behaviors that make other people afraid of him? So that's the next topic for the assessment. In other words, if she's afraid, there must be a reason.*

ALFRED: They told me that she's afraid of me, because she knows what she did to me.

LINEHAN: But what is she afraid of?

ALFRED: There's no reason for her to be afraid of me. I would not harm her or anything.

LINEHAN: Have you harmed her before? Hit her, pushed her, done anything like that?

ALFRED: There were some minor incidents. And maybe there was—well, the therapist talked about it a long time—a very long time—

about me being aggressive. But on the other hand, talking about killing your baby, isn't that aggressive as well? So who's aggressive? And they were expecting that I would sit there and listen, very calm, indifferent about her making plans about killing my baby and not losing my temper. Of course I lost my temper. And of course I did things that I regret.

LINEHAN: Like what?

ALFRED: Well, at one point, there had been a moment that she tried to—I held her, and she tried to run away. And by accident, her finger broke. But that was not on purpose, and it was not my intention to harm her.

LINEHAN: Have you ever intended to harm her, though? Have you ever harmed her when you intended to?

ALFRED: No.

LINEHAN: OK. So you've never harmed her intentionally. Have you ever beat her? Have you ever gotten so angry that you hit her, beat her, did things like that?

ALFRED: Because I was giving her everything I had. I was not hiding anything.

LINEHAN: Yeah.

ALFRED: And sometimes, she was hiding.

LINEHAN: Yeah. And?

ALFRED: And that made me angry sometimes.

LINEHAN: Yeah. And what do you do when you're angry?

ALFRED: I did the same as she did.

LINEHAN: Which is what?

ALFRED: By hiding from me, she was hitting me as well.

LINEHAN: So what'd you do?

ALFRED: Hit her.

LINEHAN: Physically, though?

ALFRED: Yes.

LINEHAN: OK. So part of your relationship was that you were hitting her, physically.

ALFRED: And the other part was that she was hitting me.

LINEHAN: Psychologically.

ALFRED: Yeah.

LINEHAN: OK. Those are different, though. They feel the same—

ALFRED: Yeah, they feel the same.

LINEHAN: They may feel the same. I grant you, they may feel the same. But they are different. To physically hit someone is different than to hurt them psychologically.

ALFRED: If I had a choice, I would rather that she hit me than that she hit me in the way she did.

LINEHAN: Yeah.

ALFRED: So for me, there's a difference, but the other way around, as you put it.

LINEHAN: Yeah—that it hurts more to be hurt psychologically.

ALFRED: Yeah.

LINEHAN: Yeah. No. I think a lot of people probably feel the same way. It's probably not an uncommon way to feel. OK. So that makes sense. But the question is this. Let me just find out from you how bad was the physical hitting of her? How often would you say you hit her?

ALFRED: I didn't keep—I don't count that way.

LINEHAN: Yeah, yeah. But like once a week?

ALFRED: Why is it so important to know this? As I told you already, she was hitting me as well. Why should it be an issue?

LINEHAN: An issue with you?

ALFRED: Yeah.

LINEHAN: Well, OK. So let's talk for a moment. My—I don't have her in therapy. If I had her in therapy and you had left her, I might be

talking to her trying to help her figure out why you left her.

ALFRED: Yeah.

LINEHAN: But she's not here.

ALFRED: No.

LINEHAN: OK?

ALFRED: No, and the other therapist made an issue about this. And I told him—and I was honest about it.

LINEHAN: Yeah, yeah.

ALFRED: And they made abuse of it.

LINEHAN: Yeah. OK. And so you're worried I'm going to do the same thing?

COMMENTARY: *If you noticed, he had asked me previously why is it that I'm not talking more about her instead of just about him. And I told him that the reason was because he's the only one in therapy. So now, I'm going to continue talking about therapy and start discussing what therapy is and clarify his goals for treatment, to be sure that we're on the same page.*

ALFRED: I don't know you. You're a total stranger for me.

LINEHAN: Yeah, yeah.

ALFRED: Because I'm talking about my intimate life, about my life to a total stranger.

LINEHAN: Yeah, yeah.

ALFRED: I'm not sure what you are doing, what you are thinking.

LINEHAN: Right. Well, that's true. You're not. How could you be? OK So you're worried about what I'm thinking. Right?

ALFRED: Yeah.

COMMENTARY: *Now, you notice that I said, "right, well, that's true. You're not. How could you be?" In other words, I'm validating the client's point of view. It's very important in DBT to validate. But even more important than validation is you validate the valid. You don't validate*

the invalid. That's critical. You don't validate things that aren't true or that are dysfunctional. So you don't validate everything. But it's essential in DBT that a therapist find things to validate that can be validated. So you'll notice me doing that quite a bit in this session with this client.

LINEHAN: Well, let me tell you what I'm thinking about this particular thing, OK? One thing that you need to be clear is that if you were in a relationship right now, with a child or an older person, and you hit them, I might have to report it. So you could worry about that. OK?

If you're in a relationship with a woman your age and you're hitting her, your hitting her is going to stay confidential in here. But what I'm going to think about you hitting a woman is that that's probably going to create problems in the relationship. So listening to you talk and hearing that you've hit her, my opinion is that's probably going to cause a lot of problems.

And so if you decide you want to work with me, my guess is that one of things that you and I would have to work on is for me to work with you to help you not hit women, because there's almost no relationship that can tolerate physical hitting, no matter how good your reason is.

So just listening to you, I can tell you right off the bat that one of the things you and I would have to work on in therapy would be for me to help you find ways to relate to women that don't involve hitting them.

COMMENTARY: *So what you've noticed here is a very matter of fact approach to telling a client, one, I might have to report your behavior if it's serious and violent; and two, not fragilizing the client as I tell him that this is the behavior that's going to have to change if he wants to reach his goals. In other words, you can't really have a relationship with a woman if you keep hitting her. So it's very matter of fact. And this is very typical in DBT to both be matter of fact, but also not to fragilize clients.*

LINEHAN: And so does that make sense, what I just said?

ALFRED: Yes, that makes sense.

LINEHAN: OK.

ALFRED: Because on the other hand, I think that she could do

anything she wanted. She could hide from me. She could be silent.

LINEHAN: Yeah.

ALFRED: She could not speak. She was allowed to do anything.

LINEHAN: Yeah, yeah. Right. So one of things to do would be to learn how to be in a relationship with a person who does those things, given that you loved her and wanted to stay in it, right? Even though she did all that, you still wanted to be in the relationship, right?

So the question would be, if a person does that, how could you be in a relationship and react in such a way that they continue to want to stay with you, because that's really what you want, isn't it? For her to also want you?

ALFRED: Yeah.

LINEHAN: OK. So it seems like one of the things we would need to work on in therapy, if you wanted to do therapy, would be how to be in a relationship with someone and react to them in such a way that they want to stay with you. Is that something you want to work on?

ALFRED: Yeah.

LINEHAN: OK. Now, I can tell you right off the bat, just as a first step, hitting them would be a major task for us to stop. Now, the other—but I don't know what the other problems are. So we would have to figure them out, work on them, try to figure them out. But the important thing for you to recognize is that if you're in therapy, I can only help you change. If your girlfriend, she comes in, I'll help her change. But if you're here, it doesn't really make too much difference to me whether you're right or you're wrong.

All I can do is help you change so that you can get what you want. So that's what it would involve. What do you think about that? How do you feel about that?

ALFRED: In one way, it sounds reasonable. In the other way, it makes me feel some resentment, because—

LINEHAN: It's not fair.

ALFRED: No, it's not fair. Why should I change because the others

betrayed me?

LINEHAN: Right. Exactly. Yes.

ALFRED: It's not fair.

LINEHAN: Right. I totally understand that. So on the one hand, you feel like I need to change. There must be something wrong with me, because these women keep leaving me. And on the other hand, your every day view is that they're doing things that are very upsetting. And why should you change? Why shouldn't they change?

ALFRED: Yeah.

LINEHAN: Right. So you sort of think both ways.

ALFRED: Yeah.

LINEHAN: OK. So the trick would be to figure out the truth in both sides. There's probably some truth that you need to change and there's probably some truth that it's not fair. So I assume when you start thinking it's not fair, then you get angry, right?

COMMENTARY: *So up until that last statement, I've been clarifying goals, making sure we're on the same page. And then, as you see, I made a synthesizing statement, where I brought together two different points of view. So that would be a dialectical statement, which is also common in DBT. Now that I've done that, though, I'm going to go back to assessment, checking again for context. In other words, is the problem happening in more than one place?*

LINEHAN: It must be when you hit or things like that. OK. So have you—in here, you're seeming very sad and upset and worried. But I'm assuming, just from listening to you and the fact that you've hit your girlfriend, that in everyday life, you also have a lot of problems with anger. Is that true? Would you say?

ALFRED: Hmm. Sometimes I have to break something, because—perhaps I have a problem with that.

LINEHAN: So you have a problem with anger? Now, do people at your job think you have a problem with anger? Or is it just in relationships? Are you a person who has a problem across the board? Or is it just relationships?

ALFRED: Just in relationships.

LINEHAN: Just in relationships. So at work, you don't get angry?

ALFRED: No.

LINEHAN: Do other people think you get angry?

ALFRED: No.

LINEHAN: OK. So you don't break things at work?

ALFRED: Not in general, no.

LINEHAN: OK. And you haven't hit people at work?

ALFRED: No.

LINEHAN: OK.

ALFRED: No.

LINEHAN: So it's just in relationships. All right. So you have a problem with anger. So we'd have to work on that. And you want to work on it? You want to reduce it? You want to get less angry?

ALFRED: I could say yes, but I don't know what I'm—

LINEHAN: You're not sure?

ALFRED: No, I'm not sure.

LINEHAN: OK. OK So you're not sure if you want to be less angry. But you are sure that you want to figure out what's going wrong in relationships?

ALFRED: Yeah.

LINEHAN: OK. So now, if we figured out what was wrong in relationships and that turned out to be a problem with anger, would you then want to work on it?

ALFRED: It's not because—the relationship didn't break because of me being angry.

LINEHAN: I see.

ALFRED: That's not—I mean, it didn't start with hitting.

LINEHAN: Yeah, yeah. Right. I assume it didn't. I assume—let's hope

it didn't. Did you hit the woman that you related to before? The other one who left you, did you hit her?

ALFRED: We had fights. We argued a lot.

LINEHAN: And? Did you hit her?

ALFRED: Yeah, but she threw things at me.

LINEHAN: Yeah, yeah. OK. But you hit her?

ALFRED: Yeah.

LINEHAN: OK. OK. So listen. Here's the thing. I could work with you on relationships. You just have to know up front that one of the main things we'd have to agree to is that you're going to also work on not hitting women.

ALFRED: You told that already before.

LINEHAN: Yeah, I know.

ALFRED: I heard you.

LINEHAN: You did?

ALFRED: There's no need to repeat it every time.

LINEHAN: OK. You're right. So have you had therapy before?

ALFRED: Not—only the time five months ago with—

LINEHAN: Just with the girlfriend.

ALFRED: Yeah.

LINEHAN: OK. Do you have any thoughts about what therapy is?

ALFRED: Maybe I some prejudice about it.

LINEHAN: What are they?

ALFRED: Well, some people meddle with your life, and know what you should do and tell you how to behave and tell you what to think and what to feel. And already when you start seeking help—counseling or anything—you must start on your knees, because I'm wrong and I need help. And the other people know it all.

LINEHAN: So I've assessed context. And now, I'm going to go back

to assessing goals of therapy, and also talking with him about what therapy might be like with me.

LINEHAN: Yeah. Therapy's like that.

ALFRED: Yeah.

LINEHAN: I agree. So why'd you come?

ALFRED: Yeah. That's a good question. That's the question I ask myself a lot.

LINEHAN: So do I come across is that kind of therapist to you?

ALFRED: No. Perhaps not. Maybe just the way you kept going on about not hitting, I thought, well—I say something and you take it and go on about.

LINEHAN: Yeah, yeah.

ALFRED: So maybe I'm thinking—because when I tell something, you do something with it.

LINEHAN: Right—something you don't like.

ALFRED: Yeah.

LINEHAN: OK. And what are you afraid I might do?

ALFRED: Judge me.

LINEHAN: I think that's a reasonable fear. Do you think I'm judging you now?

ALFRED: I was thinking of before. Right now, I don't know.

LINEHAN: When we were talking about hitting women?

ALFRED: Yeah.

LINEHAN: OK. Well, you need to be clear that, obviously, I'm a female myself. So that is something that I'm going to have some feelings about—hitting women. So that's probably going to be true, though, I would think, of any woman therapist. And that might be an important thing for you to think about of whether you would feel more comfortable with a woman therapist or maybe more comfortable with a male therapist. Because the advantage, of course, of getting a

woman therapist is that I might be able to help you understand your girlfriend and understand all these women in your life. I might be able to see things more like they see things and help you see things that way, which seems to me it might be good for you, if you could see things more from their perspective. But on the other hand, a male therapist might see things more from your perspective. And so you might feel more understood. But you're probably going to have to choose, because I can't be female one week and male the next week. So you're going to have to jump this way or that way.

ALFRED: Yep.

LINEHAN: What do you think is more important? Do you think it's more important to get a therapist who will understand the women's point of view that you've been involved with? Or do you think it's more important to get a therapist who's going to more understand your point of view?

ALFRED: I think it's important to understand the women's point of view, but not if it means that I'm accused of a lot of things.

LINEHAN: A lot of things you haven't done?

ALFRED: Yeah.

LINEHAN: Yeah. Do you want a therapist who will help you see the things you are doing that you might not be aware of?

ALFRED: Yeah. Yes.

LINEHAN: You realize that'll be painful. Do you realize that? Surely, you do, because it seems to me like this has been somewhat of a painful interaction itself. Has this been painful? Yeah. So that's one thing about therapy, I have to tell you. Therapy is usually very painful. One of the painful parts of therapy, among other parts, are that you often see things about yourself that you don't like. So you have to be ready for that before you go into it.

ALFRED: I think it couldn't be worse than the last few months.

LINEHAN: Yeah. OK. So one, you have to see things about yourself you don't like. And the other is, often in therapy, you have to work on changing things about yourself. Do you want to do that?

ALFRED: Again, my first reaction is why should I change?

LINEHAN: Right. So are you willing to change anyway?

COMMENTARY: *So you notice that he said, "why should I change"? And so you may wonder, why didn't I discuss that with him? The reason I didn't discuss it with him is, in my own mind, I'm thinking, this is irrelevant. The facts of the matter are you're going to have to change, and there's no point discussing why you have to change. For one, we've already discussed that you're the only one in therapy. And second, really, I'm thinking in my own mind, tough shit. You'll have to change. So I want to make sure he's on board. So I say, so are you willing to change anyway? In other words, I didn't get into any discussion on why should he change. I want to move him into agreeing that he will change.*

ALFRED: Apparently, I have to change, whether I like it or not.

LINEHAN: Oh, I don't know. You could stay. You could go have more relationships that break up. You could stay on the same track you're on. Why not? You don't have to be here today, do you?

ALFRED: No.

LINEHAN: No one made you come.

COMMENTARY: *So what you saw here was one of my all time favorite strategies. In fact, I would say it's one of the favorite strategies in most of our therapists. One of the reasons it's our favorite is because it actually works almost every time. I told him he needed to change, all right? Then what did he tell me? He said, well, I have to, whether I want to or not—meaning that he didn't have a sense freedom. But commitments are a lot better when you feel free. So what did I do? I gave him an illusion of freedom. The illusion of freedom is no, you don't have to change. Absolutely not. That's not required of you. But you have to add on the absence of alternatives, which is you don't have to change. You can stay miserable. I don't see any problem with that. These aren't the exact words I say, but that's the basic idea. All DBT therapists use this strategy.*

LINEHAN: So it seems to me, though, that you're at a crossroads in your life. That's what it seems to me like, and that at this point, at this crossroad, you have to choose. Even though it seems totally unfair to

you that you have to change, it seems like you're at a crossroads that either you change or you don't.

If you choose not to change, obviously, it doesn't make any sense to be in therapy. If you choose to change, to find out what has to change for your life to go better, then it makes sense to be in therapy. But you, obviously, have to choose. You don't have to like it. You just have to choose. Does that make sense?

ALFRED: That makes sense.

LINEHAN: So what do you want to do?

ALFRED: I can always give it a try.

LINEHAN: Yeah. Does that mean you're going to give it a try? You want to give it a try? You'd like to give it a try?

ALFRED: But if I don't like it, I can always stop.

LINEHAN: Right. True.

ALFRED: And if it doesn't work, I can always kill myself.

LINEHAN: Right. Exactly. Precisely. So you want to do it?

ALFRED: I have nothing to lose, because I've lost already everything.

LINEHAN: Yeah. So does that mean you're going to do it?

ALFRED: Yeah.

LINEHAN: OK. Here's my proposal. My proposal is that we spend today, next week, and the week after. We take maybe three sessions. And that now that you've made a commitment to really work on some change, that you and I spend a couple of sessions with me getting to know you better, you getting to know me better, and me talking about how I do therapy and what you think would be helpful to you so that we can make sure that we're the best match—that what we do is that we say you're committed to therapy and then we spend a couple of sessions deciding whether I'm the best person for you. OK?

ALFRED: Yeah.

LINEHAN: Because if I'm not, then what we should do is find someone else who would be better for you. OK? And I need to be sure

that I can help you, because there's no point in me starting therapy if I think someone else would be better. I don't have any doubts that you can change, because you seem genuine and that this was hard and you came and you've talked openly in this session about yourself. So we just have to be sure that you and I are the best match. OK?

And before we leave, does that sound OK to you?

ALFRED: Yeah.

COMMENTARY: *OK. You notice that I said, "I don't have any doubts that you can change." This is a statement of believing in the client. And believing in the client is acquired in DBT. In fact, you have to believe whether you believe or not. The basic idea here is that a therapist can choose to believe. One of the most common statements we get in DBT from clients is a statement to the therapist that we are the first people who've ever believed in them.*

LINEHAN: How do you feel about the fact that we're just going to explore it for a couple of weeks, you and me?

ALFRED: That sounds good to me.

LINEHAN: OK. All right. Now, what I want to do now is go back to something else. I want to find out how suicidal are you feeling right now? This minute?

ALFRED: This minute, I don't feel suicidal at all.

LINEHAN: OK, good. Now, what I want to do, at least, is have an agreement that although it is perfectly true that you could kill yourself later if the therapy doesn't work, that, at least for the moment, we could agree that you're not to kill yourself before we really give this treatment a chance. So can you agree not to kill yourself? If you kill yourself, this therapy will not work.

ALFRED: Obviously.

COMMENTARY: *Notice a slight irreverence here. The irreverent statement was if you kill yourself, this therapy won't work. This is not a statement that the average therapist says when they're talking about suicide. But DBT therapists use a lot of irreverence. So what do I mean by*
that? An irreverent statement is an unexpected statement. In other words,

it's something a person doesn't expect to hear. Now, why do we do that?

There's a lot of research data that suggests that clients and people in general will process more deeply any information they get that's unexpected more deeply than any information they get that's expected. So it can be a very effective strategy. Irreverence is required in DBT. A lot of therapists, though, are not naturally irreverent. So you may think, oh, I couldn't do that. But in fact, you could, because we teach our therapists to do it. One of the ways we teach, for example, is we do a lot of improv. And we do a lot of practice. Another major way to do it is to actually find out what a really irreverent therapist says and say the exact same thing they say. It turns out, if you imitate somebody else, it works just as well.

LINEHAN: So you've got to stay alive to give the therapy a chance.

OK? So what I want to know is if you've already agreed that you are willing to really try to make some changes, you're going to explore whether I'm the right person. What I want you to agree to now—I want us to agree. I'm perfectly willing to agree to stay alive myself. So I want to know whether you'll agree not to kill yourself before we give it a chance.

ALFRED: Yeah.

LINEHAN: You're not speaking.

ALFRED: No.

LINEHAN: Yeah. So speak.

ALFRED: What do I have to say after that?

LINEHAN: You have to—I want to find out whether you agree. Do you agree not to kill yourself before giving the therapy a chance?

COMMENTARY: *You noticed that I asked the client to commit to not killing himself before giving therapy a chance. This is really important that you ask clients for that commitment. But it's equally important to notice that DBT is not a suicide prevention program. It's a life worth living program.*

So the actual goal you're asking the client to commit to is the goal of trying to develop a life worth living, instead of killing themselves before they try to do that.

ALFRED: I could make an oath?

LINEHAN: No.

ALFRED: No?

LINEHAN: I'm just trying to find out whether you do agree. You just have to tell me what's going on in your mind. Either yes, I agree—no, I don't.

ALFRED: Yes, I agree.

LINEHAN: Thank you. OK. I'll stay around. You stay around. And we'll spend a couple of weeks looking at the problem. You can get to know me. You have to make sure I'm a good therapist for you. That's very important for you, to make sure you think you can work with me.

ALFRED: Yeah.

LINEHAN: And I need to get to know you. And I need to make sure I think I can work with you.

ALFRED: Yeah.

LINEHAN: So we'll spend a couple of weeks on that. If we can work together, in these couple weeks, we'll try to figure out a treatment plan—a plan that seems to me and to you, to both of us, like it would work.

ALFRED: Yeah.

LINEHAN: All right?

ALFRED: Yeah.

LINEHAN: OK. Anything else you want to say before we start?

ALFRED: No, it sounds like a good idea to explore.

LINEHAN: OK. So my secretary will make an appointment with you. You can make an appointment with her on the way out for next week.

ALFRED: Yeah.

LINEHAN: All right. So I look forward to seeing you next week. And also, my secretary, she will give you—I have some forms, like questionnaires, things to get background information. And she'll give

you some. If you could work on starting to fill those out.

ALFRED: Yeah.

LINEHAN: And you can either bring them with you next session or you could mail them back to me.

ALFRED: Yeah.

LINEHAN: If there's anything you don't want to answer in questionnaires, just don't answer them.

ALFRED: OK.

LINEHAN: OK? All right. OK.

DISCUSSION

YALOM: I thought that was an interesting session. There was a lot in there. There was why he was coming in for treatment, violence, suicidality, and whether he was going to enter therapy or not with you to address any of these. What was your overall reaction to watching it?

LINEHAN: My overall reaction, actually, is I thought it was a reasonably decent behavioral assessment.

YALOM: So let's take some of those one at a time. In doing a behavioral assessment, you really are quite thorough in terms of extracting information and data. What are the principles from your point of view? What are you trying to accomplish?

LINEHAN: Well, I'm trying to find out, first, what are his goals for therapy. That's number one, because the job of a therapist is to help a client with their goals. The job is not to tell them what their goals should be. So first, I needed to know his goals. Once you know the goals, you have to figure out how to translate that into what are the problems. In other words, what's the problem behavior that you want to change, since you have to figure out what the problem behaviors are, which I tried to do.

He started out with his problem behaviors, to a certain extent, were not only his behavior, but his girlfriend's. So I had to clarify that therapy could not change the girlfriend. We could only work on

changing him.

So he was pretty adaptable to that, I thought. And then it was just to go through as various things came up. So suicidality came up, so I assessed that. And then it came up that the girlfriend was afraid of him, which said, well, wait a second. Hold the phone here. There's more than just afraid girlfriend. We had to figure out what exactly do you do that gets a girlfriend to be afraid, at which point we discover that he hit his girlfriend or had a pattern of hitting girlfriends, actually.

So it's clear, OK, that had to change. Then you have to find out was this guy abusive across all of his relationships—work, here, there? In other words, does he have a major anger problem everywhere? It doesn't look that way. It might be. I might find out later that it's true. But in the assessment, it sounded like OK, no, I don't have this problem at work. So it looks like maybe it's only an intimate or close relationships, et cetera. So I just went through, one after another, as things came up to try to get a feel for the overall issues that he was dealing with.

YALOM: Yeah. And I think you were quite methodical about that. And it's easy when you have all these red flags. This is not a run of the mill therapy case where someone's coming in for being anxious or depressed because a girlfriend broke up. When you have suicidality, you've got to stop, as you said, and assess that. Is that typical of a suicide assessment that you do?

LINEHAN: It's typical of a suicide assessment where it doesn't look like the person's got imminent risk. If I thought there was imminent risk, I would've asked a lot more. I would have focused a lot more on it. But it didn't appear to be imminent risk, which means anything in the next 24 to 48 hours.

YALOM: Right. And obviously, you're used to working with patients often who are a lot greater risk.

LINEHAN: Yeah.

YALOM: Yeah. And in those cases—

LINEHAN: In those cases, I do a lot more assessment. And then I have to move from assessment to either crisis intervention or some sort of intervention—to crisis planning, to planning for what are you going to do before you see me next, et cetera, et cetera, et cetera. So this is a suicide ideation case, but not as severe as it could be. But it's important to find out what you can find out. And it would be important, before ending the session, to talk to the person about what are you going to do if you get more suicidal before I see you next time?

YALOM: And in terms of the violence, I think, you did a nice job of being very clear with him in a neutral way of what you saw the problems of him being violent with women were, and that that was going to be a goal that you felt he had to work on if he was going to be in therapy with you.

LINEHAN: Well, actually, it was more a goal he had to work on if he wanted to have a relationship with women. It was not so much you have to do this to be in therapy with me. It's more if your goal is to have good relationships with women, this behavior will have to stop, because it's not compatible with good relationships.

I think of my job as not to tell them what their goals are. But definitely, my job is to tell them what they have to do to get to their goals. That's what I'm paid for. It's to actually know what they have to change to get what they want.

YALOM: And then in terms of—even though this was an assessment, there were, as you indicated earlier, some aspects of dialectical behavior therapy that emerged in the session. For example, this part about him saying it wasn't fair, and yet he needed to change. Any thoughts about that or other aspects of DBT that you saw in the session at all?

LINEHAN: Well, Dialectical Behavior Therapy has a large range of strategies. One set of strategies is dialectical strategies, which is looking how to bring together opposites. So that was a dialectical strategy, which is you don't want to change but you have to change anyway. There were a number of others—DBT-type strategies. All the behavioral assessment, of course, is a DBT problem solving strategy, because step one in problem solving is assessment. And so you saw

a few. But there's very little DBT in here, mainly because DBT is so much broader than an individual assessment.

YALOM: Yeah. Let's talk about that. So what else did you see? You did validation. Can you say a bit about that?

LINEHAN: Well, validation is a required strategy in DBT. It's required in every session. And you have to find the valid and validate it. And so I did that several times, which I think I pointed out as you go through the session. There's not an enormous amount of validation. The main validation strategy is paying attention, which happens to be a valid thing to do. In other words, if you pay attention to someone, you communicate to them that they're worth paying attention to, that they're a valid person, that their problems are valid, that they have a right to be heard. So actually, paying attention is the first and foremost validation strategy.

YALOM: And you were rather—you didn't get triggered by him. And you certainly didn't rush in to try to save him. Your therapist role persona was pretty neutral. Now, is that something that's typical of you? Or is that typical of DBT?

LINEHAN: DBT has a stance where you have to validate, which is sort of running in a little bit. But being very matter of fact is also a strategy. We have matter of fact. And then we have irreverence on the other side. And so it's matter of fact. DBT therapists pay a lot of attention to trying to get therapists not to fragilize the patient.

YALOM: And by fragilize, meaning—

LINEHAN: As treating them like they're fragile, where you don't say things, where you try to remove cues. You don't want to say anything that's distressing. DBT puts distressing things out there and actually acts like any client could actually take it. And then if they can't, you move in and do something about that.

YALOM: And the rationale for that is? It sounds—

LINEHAN: When you treat people as fragile, they start acting like they're fragile. You, of course, can't ignore real fragility either. But the assumption that a person's fragile is where the problem is. If they are fragile, you have to be careful.

YALOM: If this was a real client, he entered therapy with you, what would you see happening?

LINEHAN: Well, first of all, I'd have to be sure he should enter therapy with me.

VICTOR YALOM: OK.

LINEHAN: So first, I'd do a diagnostic assessment.

YALOM: OK.

LINEHAN: OK. Because what do you—

YALOM: So this was not a diagnostic assessment?

LINEHAN: No, this was not a diagnostic—this was a behavioral assessment.

YALOM: So what's the difference?

LINEHAN: A behavioral assessment's looking at what are your problem behaviors. A diagnostic assessment is looking at does the pattern of your behavior fit criteria for specific diagnosis. So what we always do in our lab is go through an Axis I disorder diagnosis. And we do Axis II. And we want to be sure that we're not ignoring or missing key things that might actually require different therapy. DBT is a multi-component treatment that can treat and is very effective for most Axis I disorders. But if all you've got is an Axis I disorder of some sort, usually, there's a lot simpler therapies than DBT.

DBT is for complex, multi-diagnostic patients who have complex problems across multiple disorders. And then, it's a really effective treatment. It's one of the only treatments that does that. But if you have just one disorder—let's say his only problem was anger, that the problem was excessive anger and therefore, anger and acting angry.

One could treat that without treating a million other things. If anger's one problem and he has five other problems, then DBT might be the right treatment. But you've got to know the whole picture.

YALOM: All right. So even though you didn't do a diagnostic assessment, do you have any sense of how you would think about him diagnostically?

LINEHAN: I don't think in those terms most of the time. I think behaviorally. I might have brought him into behavior therapy. I could have easily treated him. I just don't know if I would have treated him with DBT. But I could have easily treated him for is problems.

And as I looked, I would have looked for multi-problems across areas. The key thing that would have made the difference for DBT is does the guy need skills training? And DBT, of course, is not DBT if you don't have skills training. So individual therapy is not DBT.

YALOM: OK. So—

LINEHAN: So I would have had to figure out what were his skills deficits. That, I don't know.

YALOM: Hypothetically, if you decided he did need DBT—just so we can fill out the picture a bit—what are some of the other components of DBT?

LINEHAN: So there are four components to DBT. Component one is skills training, which is often done in a group setting, but can be done individually. You'd want to do it individually if a person has social phobia plus other things.

Skills training has four modules. Module one is teaching mindfulness skills, which really is taking mindful meditation and practices and breaking them down into specific behavioral components that you can teach. So that's module one.

Module two is interpersonal skills, which is how to interact effectively with other people, particularly when you want something or want to say no. The third is emotion regulation skills. This is a very comprehensive approach to teaching how to regulate emotions.

YALOM: So just give me an example. How do you teach that, for example?

LINEHAN: Well, the first is how do you name emotions. Figuring out how do you know what emotion you feel is actually very good evidence that learning how to name emotion has an effect on the amygdala, which is very important in emotion regulation. It turns out, being able to name your emotions actually regulates them. So that's

the first strategy you have to get. The second strategy is there's a set of three for how do you change your emotions, which is how to check the facts. That's similar to cognitive therapy. You have to know what the facts are.

The second one is problem solving. When the facts are that the situation is the problem, you have to problem solve. Often, though, the situation's not the problem. You're afraid, for example, of something not, in reality, dangerous. So then you do what's called opposite action, which you have to act opposite to your urge. It's one of the principal skills in DBT. It's probably one of the most effective skills.

So we have those. Then we have how do you reduce vulnerability emotion, which boils down to how do you build a life worth living. So we teach things like how do you get—the idea here is that if you have a life with more positives in it, you'd be less vulnerable to negative emotions. So we teach things like how do you get a lot of positive events into your life. We look at what are your values—how do you build on goals to reach a life that fits your values? But we also have skills in there of cope ahead, which is another one of our best skills, which is that whole research now that imaginal practice of new behaviors actually carries over. So we have a lot of skills that are focused on getting clients to practice imaginally in their mind—coping with things, with problems, with catastrophes, et cetera. And so those are emotional regulations.

We have more mindfulness of current emotions, which is the idea if you try to suppress or push down emotions, they bump back up even worse. So you have to learn how to be mindful of your emotions. You have to put that at the end with most of our clients, because if you try to get them to be mindful at the beginning, they fall apart and you can't really do anything else.

YALOM: Hard for people to be mindful when they're so dysregulated and upset?

LINEHAN: Well, they get dysregulated if they're mindful at the beginning. Then we have a new set of skills called our tip skills, which are what do you do when you're so dysregulated that you can't cognitively use other skills, that they take too much thought on your

part? So we have psychological skills to bring arousal down extremely rapidly, something like paced breathing and a number of other skills that fit in.

And then we have—the next other module is distress tolerance. So the first half of distress tolerance is how do you get through a crisis without making it worse? So there, we have things like how to distract, how to self-soothe, how to do a lot of different things. How you get through without taking drugs, without harming yourself, without killing yourself, without quitting the job impulsively, without all the impulsive behaviors people engage in—how to cope with a crisis. And those have to be temporary. Unfortunately, many of my clients use crisis survival all the time. So we have to remind them life is not a crisis. And then, the second half is how do you live a life that's not the life that you want? How do you deal with the fact that you didn't have a childhood? How do you radically accept that you can't go home for Christmas because you don't have a home to go to? Or that you're not going to be able to have a baby, or you can't have the job that you want or you're not going to be promoted or accept all the things that all of us have to deal with, which is how do you do radical acceptance?

And most people don't realize if I had to ask clients what their most used skills, like for example, obviously, the action of radical acceptance. It's amazing that clients will say radical acceptance. So we give them a lot of strategies. Clients love it because it—now, if you ever told someone to accept, it's very invalidating. That's like implying that you could just accept this. But you can't make yourself accept anything, really. People can't do that. All you can do is practice acceptance. But the miracle of life is if you practice accepting something long enough, one day, you will discover you actually have accepted it. It's sort of like a miracle.

So we teach that. Clients love it. They love the skills period. And that's the one thing clients love. So that's a component. That's skills training. The other component's individual. The focus of individual is to strengthen skills, teach skills ahead of time if clients need them. The individual therapist also does phone coaching. With skills, the basic idea in DBT is that if you make phone calls contingent on a person

being suicidal, you have a huge risk of reinforcing that behavior and increasing it.

And so what you have to do—what a lot of therapists say is OK, so we won't take any calls. But there's a real ethical problem not taking calls from highly suicidal people, frankly. So the strategy is instead to flood them with calls. In other words, let them call whether they're suicidal or not so there's no contingency at all. And of course, the rule in DBT is if you harm yourself, you can't call for 24 hours, which turns out to be quite effective.

And the final part of DBT is the DBT team. So if there's not a team, there is not DBT. And the function of the team is for therapists to hold each other in compliance or at fidelity with the treatment. So it's like peer therapy. The goal is what is in the way of me doing effective therapy? What is in the way of me doing DBT?

YALOM: Oftentimes, the person doing the skills training may be different from the individual therapist?

LINEHAN: Yeah, almost always. Not always, but often. So you have your skills training. You have all your individual therapists. And the goal there is to reduce burnout. I would say almost everyone developing treatment for suicide now has added this in as a component of treatment, which is you have to have this group. Because with highly suicidal people, particularly ones who are constantly on the edge—and there's no evidence whatsoever that hospitalizing anybody keeps them alive, so often, you're the person who's dealing with very high risk. Therapists have to accept high risk to deal with it. But you also need support so you don't get burned out. And therapists can get burned out easily by doing too much, sometimes, because they're afraid. You can, when you have a high risk person, you get afraid and then you get angry. So you start attacking the patient. That's pretty common. Or you can get so afraid that you get compassionate and you fall into the pool of despair with the client. That's pretty common, too.

YALOM: And that's not helpful, either.

LINEHAN: None of these are helpful. The thing that's helpful is to keep your equilibrium and stick with the model and get a lot of

consultation from your colleagues.

YALOM: That's interesting, because I don't recall hearing any model or approach to therapy where a central component of the approach is not the clinical work and not the patient, but what the therapist needs to be effective.

LINEHAN: Right.

YALOM: And that's what you're saying this is what you found is important for a therapist dealing with this population.

LINEHAN: This actually came from the fact I started trying to figure out why is it that a lot of therapies really work, and at clinical trial, and then they don't work when people go out to the environment? Now, what all the therapists in the environment would say, most the time, was well, you're not treating the same kind of patients as I am.

But the facts of the matter are, I have to admit, nobody says that about me, because my clients are actually worse than most of those people out there. But the problem is what is the difference? In other words, why is it?

So I started looking at what goes on in clinical trials. And what I realized was a really important part of clinical trials is there's a really big emphasis on keeping therapists at fidelity with the treatment that's being studied. And so that's a part of it.

Then what happens is when you go out into the environment, that part's dropped as if it wasn't important, because everybody acts like that wasn't important in the therapy. So I just said, what if that's really important in therapy? And so what I did was I simply made it a component of therapy.

YALOM: And one of the things that helps them keep fidelity with the treatment is having a supportive team of therapists.

LINEHAN: A support group, because it's very easy to fall out of it for a lot of reasons. One, we know in almost every evidence-based treatment when you put people out by themselves there's a drift. That's not just that. AT&T knows the same thing. You put a bunch of people answering phones, you don't monitor them, they drift out, too.

Humans drift. So what you have to do is do something to keep the grip. That's why they have checklists in hospitals now, because it has really improved treatment. Why? It's a lot harder to drift if you have to do a checklist. And so DBT also has checklists therapists have to fill out, particularly for the management of suicide. So it's one of the more important aspects. The suicide people are now putting it into their treatment also. So I'm not alone anymore. I used to be, but I'm not now.

And you know, I've said a lot of times, I thought, when I'm dead and gone and people look back, what did I contribute? There are probably two things. One, I brought mindfulness into psychotherapy. But the other thing—they'll probably forget all the unique stuff about DBT and say, she paid attention to the therapist. So I think it's important.

We've never done a study, though, where we checked it out to find out for sure. So I have to say it's expert opinion and you've got to be careful with expert opinion, and that's because it's not data.

YALOM: Yeah. Well, you've consistently, throughout your career, shown an adherence to your research background and to data. And you've made a great contribution. And I want to thank you for sharing this session with us and sharing your thoughts about your work.

LINEHAN: Thank you.

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About the Contributors

VIDEO PARTICIPANTS

Marsha Linehan, PhD, is best known for creating DBT. She has published numerous books and scholarly articles on her system. She is currently Director of the Behavioral Research and Therapy Clinics at the University of Washington.

MANUAL AUTHORS

Katie Read, MFT, is a writer for Psychotherapy.net as well as a psychotherapist in private practice in Roseville, CA. She works with individuals, couples, and families and focuses on helping moms and couples through the transition to new parenthood. You can learn more about her practice at www.katiereadtherapy.com.

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Experts

Ellyn Bader
Judith Beck
Insoo Kim Berg
James Bugental
Albert Ellis
Kenneth Hardy
Sue Johnson
Monica McGoldrick
Donald Meichenbaum
Salvador Minuchin
William Miller
Jacob & Zerka Moreno
John Norcross
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Otto Kernberg
Arnold Lazarus
Peter Levine
Rollo May
…..and more

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