Doctorate Program

3rd semester (2025 / 2026)

026801

Cognitive Behavioral Therapy(CPT) and Dialectical Behavioral Therapy(DPT)

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Objectives

At the end of this discussion each candidate will be able to:

- Define **Cognitive Behavioral Therapy (CBT)** and explain its core concepts.
- Describe the **historical development** of CBT.
- Explain the **theoretical foundations** of CBT (cognitive, behavioral, and social learning theories).
- Identify the **core principles and components** of CBT.
- Differentiate between **Beck's model and Ellis's REBT model**.
- Analyze **cognitive distortions, schemas, and automatic thoughts**.
- **Discuss the cognitive and behavioral techniques** .
- Evaluate the **application of CBT across psychiatric disorders**.

Objectives

At the end of this discussion each candidate will be able to:

- Explain the **mechanism of change** in CBT.
- Identify **practical tools and worksheets used in CBT**.
- Discuss the **role of psychiatric nurses in CBT implementation**.
- Analyze **challenges and barriers** to CBT in clinical settings.
- Identify the concept of **Dialectical Behavior Therapy (DBT)**.
- Explain the **principles and structure of Dialectical Behavior Therapy (DBT)**.
- Describe **DBT skills modules and treatment stages**.
- Evaluate the **effectiveness of DBT in managing borderline personality disorder and self-harm**.

Outlines:

- Definition of **Cognitive Behavioral Therapy (CBT)** .
- The **historical development** of CBT.
- **Theoretical foundations** of CBT (cognitive, behavioral, and social learning theories).
- **core principles and components** of CBT.
- **Beck's model and Ellis's REBT model**.
- **The cognitive and behavioral techniques** .
- **Application of CBT across psychiatric disorders**.

Outlines:

- The **mechanism of change** in CBT.
- **Practical tools and worksheets used in CBT**.
- The **role of psychiatric nurses in CBT implementation**.
- **The challenges and barriers** to CBT in clinical settings.
- **Definition of Dialectical Behavior Therapy (DBT)**.
- The **principles and structure of Dialectical Behavior Therapy (DBT)**.
- **DBT skills modules and treatment stages**.
- The **effectiveness of DBT in managing borderline personality disorder and self-harm..**

Introduction

Mental health care is no longer based on tradition or personal experience alone, but on scientifically proven approaches known as **Evidence-Based Practice (EBP)**.

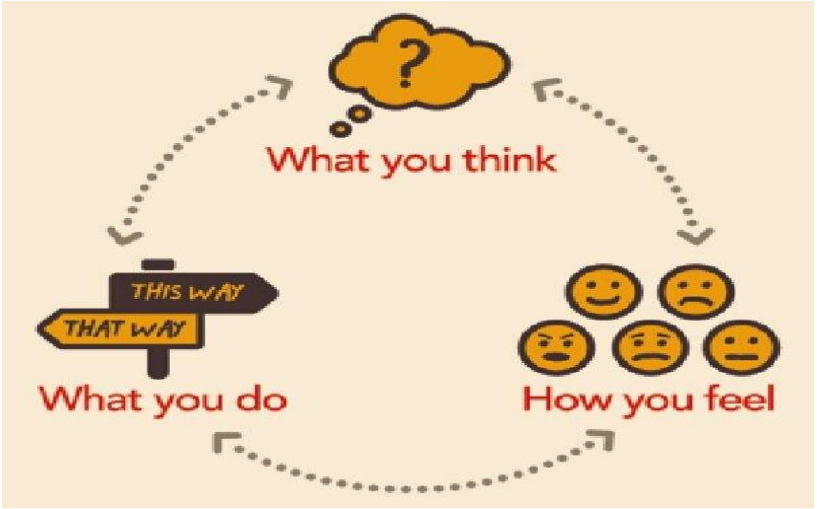
In psychiatric nursing, understanding the relationship between **thoughts, emotions, and behaviors** is essential for effective care.

Cognitive Behavioral Therapy (CBT) is one of the most widely used evidence-based approaches that helps patients identify and change maladaptive thinking patterns.

Cognitive behavioral therapy

(CBT) is a form of psychotherapy which used to treat people with a wide range of mental health problems.

CBT is based on the idea that our thoughts determine our feeling and our behavior



Cognitive behavioral therapy

- **CBT helps people learn how to identify and change the destructive or disturbing thought patterns that have a negative influence on their behavior and emotions.**

- **Thoughts: "They are making fun of me," "They don't like me."**
- **Feelings: Ashamed, upset, hurt.**
- **Behaviors: Dashing away and crying.**

Cognitive behavioral therapy

- CBT is defined as "psychotherapy that combines cognitive therapy with behavior therapy by identifying maladaptive patterns of thinking, emotional response, or behavior and substituting them with desirable patterns of thinking, emotional response, or behavior.

- Cognitive behavioral therapy (CBT) is a highly structured ,goal-oriented, time-based treatment**.**

Cognitive Behavioral Therapy (CBT)

- Cognitive Behavioral Therapy (CBT) is a widely used therapeutic approach that focuses on the **relationship between thoughts, feelings, and behaviors**. It is based on the premise that our thoughts influence our emotions and actions, and by changing our thought patterns, we can change how we feel and behave.

Cognitive Behavioral Therapy (CBT)

- In psychiatric nursing, CBT offers structured frameworks to address distorted cognitions and unhelpful behaviors. It bridges psychological theory with practical nursing care — empowering patients to take an active role in recovery.

Definition of Cognitive Behavioral Therapy (CBT)

- **A form of psychotherapy that focuses on the relationship between thoughts, feelings, and behaviors. It is based on the idea that our thoughts influence our emotions and actions, and by changing our thought patterns, we can change how we feel and behave.**
- In CBT, therapists work collaboratively with clients to **identify and challenge negative or distorted thinking patterns that contribute to emotional distress and behavioral problems**. By examining and restructuring these maladaptive thoughts, individuals can develop more adaptive ways of thinking and responding to situations.

Historical Background of (CBT)

Historical Development CBT emerged from a fusion of two separate therapeutic traditions in the 1950s-1970s:

- Behavior therapy (Pavlov, Watson, Skinner, Wolpe, Eysenck): Focus on conditioning principles and learned behaviors
- Cognitive therapy (Ellis's Rational Emotive Behavior Therapy, 1955; Beck's Cognitive Therapy, 1960s): Focus on conscious thoughts and information processing
- Aaron T. Beck is widely considered the father of CBT. Initially a psychoanalyst, he observed that his depressed patients had negative automatic thoughts that occurred spontaneously—not deep, unconscious conflicts. This led to the development of Cognitive Therapy, which later merged with behavioral techniques to form modern CBT.

Historical Background of (CBT)

1. Aaron T. Beck (1960s): Developed cognitive therapy for depression.
2. Albert Ellis (1950s): Rational Emotive Behavior Therapy (REBT).
3. Behaviorism Roots: Pavlov (classical conditioning), Skinner (operant conditioning).
4. Integration of cognitive and behavioral approaches → CBT.

Theoretical Base of (CBT)

- **Cognitive Theory (Beck)**
- Thoughts influence emotions and behaviors.
- Core schemas → Automatic thoughts → Emotional & behavioral reactions.
- Negative cognitive triad: self, world, future.
- Changing maladaptive thoughts improves mood and actions.

Theoretical Base of (CBT)

The Beck Model

- The predominant theoretical framework for CBT was developed by Aaron T. Beck. Beck's Cognitive Therapy (CT) model proposes that our emotions and behavior are influenced by the way we think and make sense of the world. According to this model, our interpretations and assumptions, developed from personal experience, often conflict with reality.

Theoretical Base of (CBT)

Key Theoretical Constructs:

- **Automatic Thoughts**: Beck encouraged patients to focus their attention on these spontaneous, reflexive cognitions that arise without deliberate effort. These thoughts are often negative and appear to arise unremittingly.

Theoretical Base of (CBT)

- **Key Theoretical Constructs:**
- **Cognitive Distortions**: Negative thoughts predominate a person's cognitions and reflect underlying themes about the self that can be identified as intermediate beliefs (conditional assumptions, attitudes, and rules) and core beliefs (fundamental, often global, and absolute rules).

Theoretical Base of (CBT)

- **Key Theoretical Constructs:**
- **Schema**: This refers to an integrated knowledge structure that influences what an individual remembers and how they process and store new experiences. Negative schema content remains latent during periods of normal mood but can be activated by external (environmental) stress carrying symbolic value or internal (physiologic) stress

Theoretical Base of (CBT)

- **Theoretical Distinctions: Beck vs. Ellis**
- Two main schools exist within cognitive behavioral therapies, both with scientific theories that have been tested:
- **Beck's Model:**
- Tests client assumptions for validity
- Focuses on treatment of symptoms in a protocol-driven manner
- Aims for symptom relief and return to normal functioning
- More cautious and offers a variety of problem-solving techniques

Theoretical Base of (CBT)

- **Theoretical Distinctions: Beck vs. Ellis**

Ellis's REBT Model:

- Assumes client beliefs are held as true to "cut to the chase" and identify unhealthy beliefs
- Aims for "profound philosophic change and a radically new outlook on life"
- More active and directive than CT
- Focuses on transforming deeply held core beliefs about self, others, and the world

Theoretical Base of (CBT)

- **Behavioral Theory (Pavlov, Skinner)**
- Behavior shaped by learning and reinforcement.
- Classical conditioning: associations create emotional responses.
- Operant conditioning: reinforcement and avoidance maintain maladaptive behavior.
- Exposure and behavioral activation break avoidance cycles.

Theoretical Base of (CBT)

Social Learning Theory (Bandura)

- Behavior learned through observation and modeling.
- Seeing others rewarded encourages imitation (vicarious learning).
- Self-efficacy—belief in one's ability—is key to change.
- Nurses can model adaptive coping and emotional regulation.

Theoretical Base of (CBT)

- CBT integrates these theories to create a holistic model of human behavior. While **cognitive** theory focuses on **changing thought patterns, behavioral theory targets learned responses through practice and reinforcement**. Social learning adds the understanding that people learn not only through experience but also by observing others. Together, these frameworks make CBT both practical and effective for promoting lasting change in mental health settings.

Cognitive Model Diagram

- .

Indication for CBT

Verywell / Daniel Fishel

Core Principles of CBT

- Based on the American Psychological Association's guidelines, CBT is built upon several core principles:
- **Psychological problems are based, in part, on faulty or unhelpful ways of thinking**
- **Psychological problems are based, in part, on learned patterns of unhelpful behavior**
- **People suffering from psychological problems can learn better ways of coping with them, thereby relieving their symptoms and becoming more effective in their lives**

The 3 basic principles of CBT

1. Core beliefs (irrational beliefs)

They are deeply rooted in how we view ourselves, our environment, and the future.

2. Dysfunctional assumptions

Humans tend to hold onto the negative more easily than the positive.

3. Automatic negative thoughts

These are thoughts or images which involuntarily ‘pop’ into our minds. They often appear in response to a trigger which can be an event, feeling, or another thought or memory. they are brief and cause negative emotions.

Cognitive Therapy

- **using confrontation of “irrational beliefs”**
- **It is both psycho educational & coping model therapy**
- **The client typically assigned homework is**
  - evaluation of thoughts
  - collection of evidence to test beliefs
  - behavioral activities like relaxation exercises

Cognitive Therapy

Aim

- **Remove negative thoughts which allow symptoms to persist**
- **Change the way clients think**

- **Clients are taught to detect their negative automatic thoughts**
- **Recognize the connection between cognition , affect and behavior**

- **Clients are then taught to subject these thoughts to reality testing to see whether thoughts realistic or not**

Cognitive Techniques

1- Cognitive Restructuring: This involves identifying catastrophic or unhelpful thoughts and using challenge questions to develop new perspectives. The learning goals include:

- Increasing awareness of catastrophic and unhelpful thoughts
- Learning to challenge catastrophic thoughts
- Increasing cognitive flexibility

CBT Cognitive Restructuring

1. Therapists use questions to probe a patient's assumptions, question the reasons and evidence for their beliefs, highlight other perspectives and probe implications.

For example
'What else could we assume?'
'What do you think causes …?'
'What alternative ways of looking at this are there?'

2. Ask the patient to provide evidence that supports/does not support this assumptions?

3. Thought records

CBT Cognitive Restructuring

Cognitive Restructuring

Cognitive Restructuring is a CBT technique that involves identifying, evaluating, and modifying maladaptive (unhelpful or distorted) thoughts to develop more balanced and realistic thinking patterns.

When is it used?

Anxiety disorders

Depression

Catastrophic thinking

Low self-esteem

Overthinking / rumination

CBT Cognitive Restructuring

Steps of Cognitive Restructuring

1) Identify the Automatic Thought

Ask:

“What was going through my mind at that moment?”

- Example:

“I’m going to fail the exam.”

2) Identify the Cognitive Distortion

Recognize the thinking error.

- Common distortions:

Catastrophizing → expecting the worst

Mind reading → assuming others’ thoughts

All-or-nothing thinking → black-and-white thinking

Overgeneralization → drawing broad conclusions

- Example:

“I’m going to fail” → **Catastrophizing**

CBT Cognitive Restructuring

Steps of Cognitive Restructuring

3) Challenge the Thought (Socratic Questioning)

Ask structured questions:

What evidence supports this thought?

What evidence contradicts it?

Is there an alternative explanation?

Am I exaggerating the situation?

What would I say to a friend in the same situation?

Is this a fact or just a feeling?

4) Generate a Balanced Thought

Replace the distorted thought with a realistic one.

- Instead of:

"I will fail"

- Use:

"The exam is difficult, but I have prepared and I might pass."

5) Re-evaluate Emotion

Measure emotional intensity before and after:

Before: Anxiety = 90%

After: Anxiety = 50%

Goal: Reduce intensity, not eliminate emotion completely

Cognitive Techniques

2-Decatastrophizing: A technique helping clients who anticipate unfavorable outcomes to sit down, relax, and think about their exaggerated thoughts and expected negative outcomes, then reconfigure how they think to determine actionable steps toward positive outcomes.

Decatastrophizing is a CBT technique used to help clients reduce catastrophic thinking. It helps the client examine whether the feared outcome is really as terrible, likely, or unmanageable as they believe.

- **Main idea:**
  The client learns to move from:
  "This will be a disaster."
  to:
  "This may be difficult, but I can handle it."
- **When it is used:**
  It is used when the client expects the worst possible outcome, especially in anxiety, panic, depression, low self-esteem, and stress.

Cognitive Techniques

Steps:

- **Identify the catastrophic thought**
  Example:
  "I will fail the exam and my whole future will be destroyed."
- **Estimate the likelihood**
  Ask:
  "How likely is this to happen from 0 to 100%?"
- **Examine the worst-case scenario**
  Ask:
  "What is the worst thing that could happen?"
- **Examine the best-case scenario**
  Ask:
  "What is the best possible outcome?"
- **Identify the most realistic outcome**
  Ask:
  "What is most likely to happen?"
- **Develop coping steps**
  Ask:
  "If the difficult outcome happened, what could you do?"

Cognitive Techniques

Example:

- **Situation:** The client has a presentation.
  Catastrophic thought: “I will forget everything and everyone will laugh at me.”
  Challenge:
- Has this happened before?
- Is it certain everyone will laugh?
- What would I do if I forgot one point?
  Balanced thought:
  “I may feel nervous, but I can use my notes, pause, and continue. One mistake does not mean failure.”
- **Goal:**
  To reduce fear, increase realistic thinking, and help the client feel more in control.

Cognitive Techniques

3-Guided Discovery: The therapist listens to the client's problems and viewpoints, then formulates questions that constructively challenge their viewpoints and beliefs. This involves asking clients to support their viewpoints with evidence and identify evidence that runs counter to their views.

:Guided Discovery is a CBT technique in which the therapist helps the client discover new perspectives through carefully structured questions rather than directly giving advice.

- **Main idea:**
  The therapist does not say:
  "You are wrong."
  Instead, the therapist asks questions that help the client examine the evidence and reach a more balanced conclusion.
- **Purpose:**
  To help clients question rigid beliefs, identify cognitive distortions, and develop cognitive flexibility.
- **Therapist role:**
  The therapist acts like a guide. They listen carefully, understand the client's viewpoint, then ask questions that gently challenge the belief

Cognitive Techniques

Guided Discovery

- **Common questions used (Socratic Questioning)**
- What evidence supports this belief?
- What evidence goes against it?
- Is there another way to understand this situation?
- What would you say to a friend who had this thought?
- Are you confusing feelings with facts?
- Is this thought helpful or harmful?
- What is a more balanced way to look at this?

Cognitive Techniques

Guided Discovery :(Socratic Questioning — Stages)

Definition

- Socratic questioning is a structured method of guided questioning used in CBT to help clients examine their thoughts, challenge assumptions, evaluate evidence, and develop more balanced and realistic thinking.

Stages

- **1) Clarification**
- **Purpose:** Understand the client's thought clearly.
- **Questions:**
- What do you mean by that?
- Can you explain that further?
- What exactly went through your mind?
- When does this thought occur?
- **Example:**
  Client: "I'm a failure."
  Therapist: "What makes you say that?"
- **2) Probing Assumptions**
- **Purpose:** Identify underlying beliefs or rules.
- **Questions:**
- What are you assuming here?
- Why do you think this must be true?
- What belief is behind this thought?
- **Example:**
  "If I fail once, it means I am a failure."

Cognitive Techniques

Guided Discovery :(Socratic Questioning — Stages

3) Examining Evidence

- **Purpose:** Test the thought against reality.
- **Questions:**
- What evidence supports this?
- What evidence contradicts it?
- Is this a fact or your interpretation?
- **Example:**
  "Have you succeeded in other situations?"

4) Exploring Alternative Perspectives

- **Purpose:** Generate different viewpoints.
- **Questions:**
- Is there another way to look at this?
- What would someone else say?
- Could there be another explanation?
- **Example:**
  "Could it be that the situation was difficult rather than you being a failure?"

Cognitive Techniques

Guided Discovery :(Socratic Questioning — Stages

5) Examining Consequences

- **Purpose:** Understand the impact of the thought.
- **Questions:**
- How does this thought make you feel?
- How does it affect your behavior?
- Is this thought helpful or harmful?
- **Example:**
  "This thought makes you avoid trying again, right?"

6) Challenging the Thought

- **Purpose:** Evaluate how realistic the thought is.
- **Questions:**
- How realistic is this belief?
- Are you exaggerating?
- What is the worst, best, and most likely outcome?

7) Developing a Balanced Thought

- **Purpose:** Replace the distorted thought with a realistic one.
- **Example:**
  "I didn't perform well this time, but that does not mean I am a failure. I can improve."

Cognitive Techniques

Guided Discovery :(Socratic Questioning — Stages

Full Example Flow

- Client: “Everyone thinks I’m stupid”
- Clarify → “Who exactly?”
- Assumption → “Do you believe everyone judges you?”
- Evidence → “What proof do you have?”
- Alternative → “Could there be another reason?”
- Consequence → “How does this affect you?”
- Challenge → “Is this 100% true?”
- Balanced → “Some people may not respond, but that doesn’t mean I’m stupid.”

Goals

- Increase awareness of thoughts
- Challenge cognitive distortions
- Promote independent thinking
- Improve cognitive flexibility

Cognitive Techniques

Example:

- **Client:** “Everyone thinks I am stupid.”
  Therapist:
- “What makes you think everyone believes that?”
- “Can you name specific people?”
- “Has anyone ever said the opposite?”
- “Could there be another reason they did not respond?”
- **New perspective:**
  “Some people may not respond because they are busy, not because they think I am stupid.”
- **Goal:**
  To help the client reach insight independently. This makes the new belief stronger because the client discovers it, instead of simply being told.

Cognitive Techniques

4-Journaling and Self-Monitoring: Clients record problems and responses between sessions, allowing therapists to identify patterns and counter negative thinking

- Journaling and Self-Monitoring are CBT techniques where clients record their thoughts, emotions, behaviors, triggers, and responses between therapy sessions.
- **Main idea:**

  The client becomes more aware of patterns that happen automatically in daily life.

Cognitive Techniques

Journaling and Self-Monitoring

- **Why it is important:**
  Many negative thoughts happen quickly and unconsciously. Writing them down helps the client slow down, observe them, and understand the connection between situations, thoughts, feelings, and behaviors.
- **What the client records:**
- Situation / trigger
- Automatic thought
- Emotion
- Emotion intensity
- Behavior
- Evidence for the thought
- Evidence against the thought
- Balanced thought
- Outcome

Cognitive Techniques

Example journal form:

Situation	**Thought**	**Emotion**	**Behavior**	**Balanced Thought**
Friend did not reply	"She is ignoring me"	Sad 80%	Avoided texting	"She may be busy; I do not have enough evidence"

Cognitive Techniques

Self-monitoring can track:
Anxiety level
Mood changes
Sleep
Eating
Panic attacks
Anger episodes
Compulsions
Avoidance behaviors
Self-harm urges
Substance use urges
Example:
A client with anxiety records when anxiety increases. After one week, the therapist notices that anxiety rises before social situations. This helps identify the trigger and plan intervention.
Goal:
To identify patterns, increase self-awareness, and provide real examples for therapy work

Cognitive Techniques

- **Thought Records:** Encourage clients to document automatic thoughts linked to emotional reactions (e.g., "I failed the test → I'm useless").
- **Cognitive Restructuring:** Challenge and replace distorted thinking with balanced alternatives (e.g., "One failure does not define my worth").
- **Identifying Cognitive Distortions:** Recognize patterns such as:
  - *All-or-nothing thinking* — "If I'm not perfect, I'm a failure."
  - *Catastrophizing* — "If I make a mistake, everything will go wrong."
  - *Overgeneralization* — "I was rejected once, so no one will ever like me."

Behavioral-Techniques

Cognitive Restructuring Approaches

Rational emotive behavior therapy (REBT)

involves identifying irrational beliefs, actively challenging these beliefs, and finally learning to recognize and change these thought patterns.

The ABC technique

When using this technique, you consider :

1. **the activating event (A)**
2. **your beliefs (B)**
3. **the consequences (C).**

- Bobby said something mean to me (A)
- He hate me (B)
- I feel annoyed and shame ,I responded by kicking him and I got into trouble at school (C)

The ABC technique

ABC Analysis

- This skill is solely focused on breaking down the behaviors that are related to depression, like snapping at people or sleeping all day.
- **The ABC model uses the following structure:**
- **The "Activating" event**
- **Your "Beliefs" about that event**
- The "Consequences" of the event, including your feelings and behaviors surrounding the event
- In analyzing Your triggers and consequences, you can explore the "consequential" behaviors and look to find common causes in your depressive triggers.

Ellis's A-B-C-D-E Paradigm

REBT follows Ellis's A-B-C-D-E paradigm:

- **activating event**
- **beliefs** are our interpretations about what those events mean
- **consequences** are emotional and behavioral reactions to those beliefs
- **dispute** irrational beliefs in therapy
- **emotional relief** follows recognition of irrationality of beliefs

Ellis's A-B-C-D-E Paradigm example

- **(A)** Someone passes you in the hallway and does not say hello.
- **(B)** she don't like me.
- **(C)**: I feel sad or disappointed ,I will avoid that person at work .
- **(D):** she must be busy today and didn't notice me
- **(E):** I will feel unfazed, and move on with the day Or, I will feel compassion toward her and offer help.

Rational emotive behavior therapy (REBT) techniques

- **Role-playing**
- **problem-solving skills**
- **Assertiveness training**
- **social skills**
- **decision-making skills**
- **conflict resolution skills**
- **Desensitization**
- **relaxation**
- **Meditation**
- **guided imagery and visualization**
- **Mindfulness**

Rational emotive behavior therapy (REBT) techniques

Assertiveness training

- **1. Basic Assertion (Simple "I" Statements)**
- Expressing your feelings, needs, or opinions without judging others.
- **Formula:** "I feel _____ when you _____ because _____."
- **Example:** "I feel anxious when you compare grades because I start doubting myself."

- **2. Empathic Assertion**
- Acknowledging the other person's feelings first, then stating your own.
- **Formula:** "I understand you feel _____, and I also feel _____."
- **Example:** "I understand you're stressed about the exam too, and I also feel overwhelmed when we only talk about grades."

Rational emotive behavior therapy (REBT) techniques

Assertiveness training

3. Escalating Assertion (Fogging + Repeated Assertion)

- Used when the other person ignores your first statement. You calmly repeat your point without getting defensive.
- **Step 1:** Say your assertion.
- **Step 2:** If ignored, repeat exactly or add a small consequence.
- **Example:**
  "I need to study alone now."
  "I hear you, but I really need to study alone."
  "I understand, and I still need to study alone. I'll talk to you after the exam."

4. Negative Assertion

- Accepting a valid criticism without becoming defensive or anxious.
- **Formula:** Acknowledge the true part of the criticism.
- **Example:** "Yes, I did get a bad grade on that quiz. That's true."

Rational emotive behavior therapy (REBT) techniques

Assertiveness training

- **5. Negative Inquiry**
- Asking for more information about a criticism to understand it better or to reduce fear of negative feedback.
- **Example:** "What exactly about my study method do you think is wrong?"

- **6. "I Want" Statement**
- Directly stating what you want, without apology or justification.
- **Formula:** "I want _____."
- **Example:** "I want to review the quiz mistakes by myself first."

- **7. Broken Record**
- Calmly repeating your request or refusal, word for word, no matter how the other person responds.
- **Example:**
  Friend: "Come study with us."
  You: "I prefer to study alone tonight."
  Friend: "But it's more fun together."
  You: "I prefer to study alone tonight."
  Friend: "You'll miss out."
  You: "I prefer to study alone tonight."

Rational emotive behavior therapy (REBT) techniques

Assertiveness training

- **8. Deflecting (Shifting Focus)**
- Redirecting a manipulative or intrusive question back to the original topic.
- **Example:**
  "Why are you so sensitive about your grade?"
  "Let's focus on how I can improve next time, not on my reaction."

- **9. Content-to-Process Shift**
- Commenting on what is happening in the conversation rather than answering the content.
- **Example:** "You keep asking me about my grade even after I said I don't want to discuss it."

- **10. Time-Out / Delay Assertion**
- Taking time to think before responding, instead of agreeing under pressure.
- **Example:** "I need to think about that. I'll get back to you in an hour."

Rational emotive behavior therapy (REBT) techniques

Assertiveness training

- **11. Assertive Refusal (Saying "No")**
- Politely but firmly declining a request without guilt.
- **Formula:** "No, I can't do that," or "Thank you for asking, but I have to say no."
- **Example:** "No, I can't share my notes right now. I'm still reviewing them."

- **12. Compromise Assertion**
- When your needs and another's needs conflict, you propose a middle ground – but only after trying a direct assertion first.
- **Example:** "I can't study with you for three hours, but I can do one hour."

Rational emotive behavior therapy (REBT) techniques

Assertiveness training

- **14. Scripting (Prepared Assertion)**
- Writing down and rehearsing an assertive statement before a difficult conversation.
- **Example:** Before talking to a professor about a bad grade: *"Professor, I got a low grade on the quiz. I want to understand my mistakes so I can do better on the final. Can we review it together?"*

- **15. Nonverbal Assertiveness**
- Using body language that matches assertive words:
- **Posture:** upright, relaxed, facing the person
- **Eye contact:** steady but not staring
- **Voice:** calm, firm, steady volume
- **Hands:** open, not clenched
- **Personal space:** appropriate distance

Rational emotive behavior therapy (REBT) techniques

Problem-solving skills

The Classic 6-Step Problem-Solving Model (D'Zurilla & Goldfried)

Step	Name	Action
1	**Define the problem clearly**	Write the problem in specific, objective terms. Avoid vague or emotional language.
2	**Generate all possible solutions**	Brainstorm without judging – quantity over quality.
3	**Evaluate each solution**	List pros and cons for each solution.
4	**Choose the best solution**	Select the one with the most pros and feasible cons.
5	**Plan implementation**	Break into small, concrete action steps.
6	**Evaluate the outcome**	Did it work? If not, go back to step 2 or 3.

SOLVED Technique

Letter	Meaning	Question to ask
S	**S**pecify the problem	What exactly is the problem?
O	**O**ptions	What are all possible solutions?
L	**L**ikely consequences	What will happen with each option?
V	**V**alidate a plan	Which plan is best?
E	**E**valuate and adjust	How did it work? What next?

The 5 Whys Technique

- **Go deep to find the root cause, not just the symptom.**

Example:

- Why did I get a bad grade? → I didn't understand the material.
- Why didn't I understand? → I studied alone without asking questions.
- Why didn't I ask questions? → I was afraid of looking stupid.
- Why afraid? → I think asking means I'm weak.
- Why do I think that? → Past teacher made fun of questions.
- **Root problem:** Fear of asking for help due to past shame.

  Solution now: Challenge that belief + ask professor anyway.

IDEAL Problem-Solving (Bransford & Stein)

Letter	Meaning
I	**I**dentify the problem
D	**D**efine goals and outcomes
E	**E**xplore possible strategies
A	**A**nticipate outcomes and act
L	**L**ook back and learn

The STAR Method (for interpersonal or work problems)

Letter	Meaning
S	**S**ituation – describe the context
T	**T**ask – what needs to be solved?
A	**A**ction – what steps were taken?
R	**R**esult – what happened? Then reflect.

Problem-Solving Worksheet (CBT Style)

Section	Fill in
1. What is the problem? (specific)	
2. What have I tried already?	
3. What are 3 new solutions?	
4. For each solution: pros and cons	
5. Which solution will I try first?	
6. When and how will I do it?	
7. How will I know it worked?	

Behavioral Techniques

1-Exposure Therapy: Clients are exposed to triggers for their fears, anxieties, or depressive responses. This may involve imaginal exposure (imagining the "worst case scenario" or feared outcome) or in vivo exposure. Therapeutic goals include:

- Learning to tolerate emotions associated with feared outcomes
- Facilitating cognitive reappraisal of feared outcomes
- Facilitating habituation to fear response (fear extinction)

Behavioral Techniques

2-Worry Scheduling and Worry Time: Scheduling specific times to worry and cycling through worrisome thoughts, based on stimulus control principles. Learning goals include:

- Associating worry with designated time and space
- Learning to delay worry until designated time
- Learning to tolerate worry without avoidance

Mindfulness

- **Mindfulness** is the practice of focusing attention on the present moment in a calm, non-judgmental way.

It helps reduce stress, anxiety, emotional reactivity, and impulsive behavior.

Mindfulness

l. Focused Attention (Concentration) Techniques

- These train the mind to stay on one object.

Technique	How to do it	Best for
Breath awareness	Focus on the sensation of breathing at nostrils, chest, or belly. When mind wanders, gently return.	Anxiety, racing thoughts
Counting breaths	Inhale 1, exhale 2 … up to 10, then repeat. Or count 1 on inhale, 2 on exhale up to 10.	Lack of focus, restlessness
Single word (mantra)	Repeat a neutral word silently (“one”, “peace”, “calm”) with each breath.	Intrusive negative thoughts
Sound meditation	Focus on a single sound (bell, fan, or ambient noise) without labeling it “good” or “bad”.	Overthinking, rumination
Candle flame or object	Gaze at a candle flame or a small object. When distracted, return gaze.	Visual distractions, low concentration
Body part focus	Move attention slowly from toes to head, holding each part for a few breaths.	Physical tension, insomnia

II. Open Monitoring (Vipassana / Insight) Techniques

- Observing whatever arises without getting caught in it.

Technique	How to do it	Best for
Note thoughts	As thoughts appear, silently label them “thinking” without judgment, then let them go.	Rumination, catastrophizing
Note emotions	Label emotion (“anger”, “fear”, “sadness”) as it arises. Stay with the physical sensation, not the story.	Emotional overwhelm
Note urges	When urge to avoid, procrastinate, or check phone arises, label “urge” and observe it fade.	Impulsive behavior, addiction
Open sky meditation	Imagine thoughts as clouds passing through a vast sky. You are the sky, not the clouds.	Identifying with negative thoughts
R.A.I.N. technique (see below)	Recognize, Allow, Investigate, Nurture.	Difficult emotions

III. Body-Based Mindfulness Techniques

- **Using physical sensations as anchors.**

Technique	How to do it	Best for
Body scan	Lying down, slowly move attention through each body part from toes to crown. 10–45 minutes.	Insomnia, chronic pain, dissociation
Mindful walking	Walk slowly, feeling each part of the step (lift, move, place). Notice sensations in feet and legs.	Restlessness, energy, anxiety
3-minute breathing space (DBT/ACT)	1 min: notice what's here (thoughts, feelings, body). 1 min: focus on breath. 1 min: expand to whole body.	Quick reset during stress
Mindful stretching / yoga	Slow, intentional movements while breathing and noticing sensations.	Tension, somatic symptoms
Hand on heart	Place hand over heart, breathe deeply, notice warmth and heartbeat.	Self-compassion, panic
Grounding through senses (5-4-3-2-1)	Name 5 things you see, 4 you feel (touch), 3 you hear, 2 you smell, 1 you taste.	Dissociation, panic, flashbacks

IV. Mindfulness of Daily Activities

- Bringing mindfulness into routine tasks

Activity	Mindful instruction
Eating	Look at food, smell it, take one small bite, chew slowly (20 times), notice taste and texture.
Brushing teeth	Feel the brush on gums, taste of paste, sound of bristles, movement of hand.
Showering	Feel water temperature on skin, smell soap, watch steam, listen to water sound.
Washing dishes	Feel warm water, sponge texture, sound of plates, sight of bubbles.
Waiting in line	Feel feet on floor, breath in belly, observe surroundings without judgment.
Listening to someone	Give full attention to their words without planning your response.
Typing / writing	Feel keys or pen, notice finger movements, sound of typing.

Behavioral Techniques

3-Progressive Muscle Relaxation: Tensing and releasing muscles with relaxation cues to increase awareness of tension, recognize the difference between tensed and relaxed muscles, and learn to reduce muscle tension.

4-Behavioral Activation: Particularly important for depression treatment, this technique focuses on engaging patients in reinforcing activities to break cycles of withdrawal and negative reinforcement.

5-Communication Training via Roleplaying: Therapist and client act out scenarios to teach assertiveness, confidence building, sociability, active listening, and conflict resolution.

Behavioral Techniques

- **Exposure Therapy:** Gradual confrontation with feared stimuli.
- **Behavioral Activation:** Scheduling rewarding activities to counter depression.
- **Relaxation Training:** Deep breathing, progressive muscle relaxation.

Behavioral strategies help break the avoidance cycle common in anxiety and depression. Nurses can coach and reinforce these behaviors in daily routines.

Behavioral Techniques

- **1. Exposure Therapy – Example**

A client with Obsessive–Compulsive Disorder (OCD) who constantly washes their hands due to fear of contamination.

Application:

Step 1: Touch a clean object (like a book) and delay hand washing for 2 minutes.

Step 2: Touch a doorknob and wait 5 minutes before washing.

Step 3: Progress to touching commonly shared items and waiting longer. Over time, anxiety decreases, and the urge to perform compulsions weakens.

Nurse's Role: Reassure the client during exposure, track anxiety levels, and reinforce progress — showing that anxiety naturally decreases without rituals.

Behavioral Techniques

- **2. Behavioral Activation – Example**

A client with postpartum depression who has lost interest in daily life and feels isolated.

Application: The nurse helps the client plan small, meaningful tasks: Sit outside in the sunlight with the baby for 10 minutes.

Listen to favorite music or cook a simple meal.

Schedule one social visit with a supportive friend per week.

Each completed activity provides positive reinforcement, improving mood and engagement.

Nurse's Role: Provide encouragement, monitor mood changes, and adjust activities to match energy levels and motivation.

Behavioral Techniques

- **3. Relaxation Training – Example**

A patient with post-traumatic stress disorder (PTSD) who experiences muscle tension and flashbacks when reminded of trauma.

Application: The nurse teaches progressive muscle relaxation (PMR):Tense and relax muscle groups while focusing on breathing.

Combine with grounding exercises like noticing objects in the room to stay in the present moment.

Regular practice reduces physiological arousal and increases the sense of control during triggers.

Nurse's Role: Guide sessions, provide a calm environment, and encourage daily practice. The nurse also evaluates which relaxation methods (breathing, PMR, visualization) work best for the individual.

Third-Wave CBT Approaches

- **Mindfulness-Based Cognitive Therapy (MBCT)** — awareness of thoughts without judgment.
- **Acceptance and Commitment Therapy (ACT)** — psychological flexibility, values-based action.
- **Dialectical Behavior Therapy (DBT)** — emotion regulation, distress tolerance, interpersonal effectiveness.
-

These “third-wave” therapies expand CBT’s scope to include mindfulness, acceptance, and emotion regulation — essential for complex psychiatric conditions like borderline personality disorder.

Third-Wave CBT Approaches

1. Mindfulness-Based Cognitive Therapy (MBCT): MBCT combines mindfulness (being aware of the present moment) with traditional CBT techniques.

It helps people notice their thoughts and feelings without judging or reacting to them. Instead of trying to stop negative thoughts, clients learn to observe them and let them pass.

Example: A client who feels “I’m worthless” learns to notice that thought, take a breath, and remind themselves that it’s just a thought — not reality. This reduces rumination and relapse in depression.

Third-Wave CBT Approaches

2. Acceptance and Commitment Therapy (ACT): ACT teaches clients to accept what they cannot control (like painful emotions) and commit to actions that reflect their values.

The focus is not on removing symptoms but on living a meaningful life despite them.

Example: Someone with social anxiety may still attend a family event because connecting with loved ones is important to their values — even if they feel anxious while doing so.

Third-Wave CBT Approaches

3. Dialectical Behavior Therapy (DBT): DBT was developed for people with intense emotions, especially those with borderline personality disorder.

It helps balance acceptance and change, teaching clients how to regulate emotions, tolerate distress, and build healthy relationships.

Example: When a client feels angry, instead of shouting or self-harming, they might use a DBT skill such as deep breathing, self-soothing, or calling a support person.

Third-Wave CBT Approaches

Approach	Core Focus	Example of Use	Nursing Role
MBCT	Mindful awareness, preventing relapse	Depression relapse prevention	Teach mindfulness, monitor mood awareness
ACT	Acceptance & values-based action	Chronic anxiety, pain, PTSD	Guide value-based goal setting
DBT	Emotion regulation & distress tolerance	Borderline Personality Disorder	Reinforce skills, model calm responses

CBT Applications to Psychiatric Disorders

- **Depression:** Cognitive restructuring, behavioral activation.

Anxiety: Exposure therapy, cognitive reframing.
PTSD: Trauma narrative, cognitive reappraisal.
OCD: Exposure and Response Prevention (ERP).
Bipolar Disorder: Relapse prevention, early warning signs.
Schizophrenia: Reality testing, coping with voices.
Substance Use Disorders: Trigger recognition, relapse prevention.
Eating Disorders: Body image correction, cognitive control.
Insomnia: Sleep hygiene, relaxation, stimulus control.

•

Each disorder demands tailored CBT techniques. Adapt strategies to patient readiness, culture, and cognitive level.

CBT Applications to Psychiatric Disorders, cont.

1. Depression

Goal: To reduce negative thinking, increase positive behaviors, and improve mood.

Applied: CBT focuses on identifying negative thoughts and encouraging engagement in rewarding activities.

Cognitive Technique: Cognitive restructuring helps the client challenge negative beliefs.

Example: A client thinks, "I'm worthless." helping find evidence against it and replace it with "I have value and strengths.

Behavioral Technique: Behavioral activation encourages participation in enjoyable or meaningful tasks.

Example: The client plans a daily walk or meets a friend for coffee to improve motivation and energy.

Cognitive behavioral therapy for depression

Cognitive behavioral therapy for depression is based on a theory that individuals with depression exhibit the "cognitive triad" of depression:

- A negative view of themselves
- A negative view of their environment
- A negative view of their future

Your therapist can help you break down reactions and thought patterns into several categories of self-defeating thought (also known as cognitive distortions).

- These may include:
- **all-or-nothing thinking:** viewing the world in absolute, black-and-white terms
- **disqualifying the positive:** rejecting positive experiences by insisting they “don’t count” for some reason
- **automatic negative reactions:** having habitual, scolding thoughts

Cognitive behavioral therapy for depression

- **magnifying or minimizing the importance of an event:** making a bigger deal about a specific event or moment
- **overgeneralization:** drawing overly broad conclusions from a single event
- **personalization:** taking things too personally or feeling actions are specifically directed at you
- **mental filter:** picking out a single negative detail and dwelling on it exclusively so that the vision of reality becomes darkened

You and your therapist can also use the journal to help replace negative thought patterns or perceptions with more constructive ones. This can be done through a series of well-practiced techniques, such as:

- learning to manage and modify distorted thoughts and reactions
- learning to accurately and comprehensively assess external situations and reactions or emotional behavior
- practicing self-talk that is accurate and balanced
- using self-evaluation to reflect and respond appropriately

Cognitive behavioral therapy for depression

- You can practice these coping methods on your own or with your therapist. Alternately, you can practice them in controlled settings in which you're confronted with challenges. You can use these settings to build on your ability to respond successfully.
- In relation to the cognitive triad, patients with depression have cognitive distortions that perpetuate these negative beliefs. With this in mind, cognitive behavioral therapy for depression often emphasizes specific behavioral strategies (such as scheduling activities) along with cognitive restructuring aimed at changing automatic negative thoughts.

CBT Applications to Psychiatric Disorders, cont.

2. Anxiety Disorders

Goal: To reduce excessive worry, avoidance, and physical symptoms of fear.

Application: CBT teaches clients to face fears gradually and replace irrational thoughts with realistic ones.

Cognitive Technique: Cognitive reframing — identify and modify catastrophic thoughts. Example: Instead of "Everyone will think I'm stupid," the client learns to think, "Everyone makes mistakes when speaking — that's okay."

Behavioral Technique: Exposure therapy — gradual exposure to feared situations.

Example: A client with social anxiety starts by greeting one person, then speaking briefly in class.

CBT Applications to Psychiatric Disorders, cont.

- **3. Post-Traumatic Stress Disorder (PTSD)**
- **Goal:**
  To reduce trauma-related distress, avoidance, and negative beliefs about the self or world.
- **Application:** CBT helps clients process traumatic memories safely and change unhelpful meanings attached to the trauma.
- **Cognitive Technique:** Cognitive reappraisal — correcting distorted guilt or shame thoughts.
- Example : The client replaces “It was my fault” with “I did the best I could in a dangerous situation.”
- **Behavioral Technique:** Trauma narrative/exposure — gradually recounting the traumatic event to reduce emotional power.
- Example: A client writes or discusses their trauma in therapy to face memories safely.

CBT Applications to Psychiatric Disorders, cont.

- **4. Obsessive–Compulsive Disorder (OCD)**
- **Goal:** To weaken obsessive thoughts and stop compulsive behaviors.
- **Application:** CBT uses structured exposure exercises and prevention of ritual responses.
- **Cognitive Technique:** Cognitive restructuring to challenge exaggerated responsibility.
- Example: The client replaces “If I don’t wash, I’ll get sick and die” with “My body can handle small amounts of germs.”
- **Behavioral Technique:** Exposure and Response Prevention (ERP) to reduce anxiety without rituals.
- **Example:** A client touches a doorknob and delays washing hands. Over time, anxiety decreases naturally.

CBT Applications to Psychiatric Disorders, cont.

- **5. Bipolar Disorder**
- **Goal:** To prevent relapse, manage mood swings, and recognize early warning signs.
- **Application:** CBT helps patients monitor thoughts, behaviors, and triggers while promoting balanced daily routines.
- **Cognitive Technique:** Identifying early warning thoughts ("I can do anything!" during hypomania).
- Example: A client learns to challenge risky thoughts during mania ("I don't need sleep") with reality-based thinking ("Lack of sleep can trigger relapse").
- **Behavioral Technique:** Relapse prevention planning — maintaining sleep, structure, and support.
- Example: Behavioral: Using a daily mood chart and contacting the nurse when early signs appear.

CBT Applications to Psychiatric Disorders, cont.

- **7. Substance Use Disorders**
- **Goal:** To reduce cravings, prevent relapse, and promote healthy coping mechanisms.
- **How Applied:** CBT identifies triggers for substance use and teaches alternative responses.
- **Cognitive Technique:** Identifying and reframing craving-related thoughts.
- Example: The client challenges "I can't relax without drinking" by replacing it with "Relaxation can come from exercise or music."
- **Behavioral Technique:** Relapse prevention through coping plans and lifestyle change.
- Example**:** When craving occurs, the client calls a sponsor or practices deep breathing instead of using substances.

CBT Applications to Psychiatric Disorders, cont.

- **8. Eating Disorders**
- **Goal:** To change distorted body image and normalize eating patterns.
- **How Applied:** CBT challenges perfectionistic or distorted beliefs about food and body shape.
- **Cognitive Technique:** Cognitive restructuring — correcting distorted body thoughts.
- Example: The client replaces "I must be thin to be loved" with "My worth is not defined by my body."
- **Behavioral Technique:** Exposure and meal monitoring — eating with support to reduce anxiety.
- **Example:** Eating regular meals while practicing positive affirmations in front of a mirror.

Practical Tools and Worksheets

- CBT commonly utilizes worksheets to help clients practice skills and apply them to actual problems:
- **Decatastrophizing Worksheet**: Guides clients through identifying worries, evaluating likelihood, examining evidence, and identifying favorable outcomes
- **Self-Compassion Worksheet**: Builds self-esteem and self-worth by identifying personal strengths, support systems, and goals
- **Thoughts and Behaviors Journal**: Daily recording of triggers, thoughts, feelings, and responses to identify patterns
- **Automatic Thoughts Worksheet**: Identifies automatic negative thoughts and replaces them with realistic or positive alternatives
- **Personal Values Worksheet**: Lists personal values to examine whether negative patterns align with or counter important values

Mechanism of Change

Mechanism of Change

- **Experiential Disconfirmation**
- When patients disprove a negative cognition through the process of "experiential disconfirmation," the therapist helps them change that cognition. This mechanism is central to CBT's therapeutic action—patients learn through direct experience that their negative predictions are not accurate.
- **Bidirectional Relationships**
- CBT teaches patients the bidirectional relationship between thoughts, feelings, and behaviors, helping them understand that they can influence emotions by changing thoughts and behavior.
- **Learning to Become One's Own Therapist**
- The ultimate goal of CBT is to provide empiric tools that help patients explore the validity or usefulness of their thoughts and the impact of their behaviors, empowering them to continue this work independently after treatment ends

Factors Determining CBT Session Frequency and Duration

- Session frequency and duration in CBT depend on the **disorder's severity**, **client readiness**, **therapy goals**, **model used**, **setting**, and **progress rate**. Nurses and therapists must individualize the schedule to balance clinical effectiveness and client capacity.

Implementation Challenges in Nursing

- **Time constraints in busy wards** — limited opportunities for structured sessions.
- **Limited formal CBT training** among nurses.
- **High caseloads and heavy documentation** burden reduce therapeutic time.
- **Need for supervision and institutional support** to maintain quality and confidence.
- **Resource limitations** — lack of private space or digital tools for therapy.
- **Interdisciplinary coordination issues** — unclear role boundaries in mental health teams.
-

Despite proven benefits, practical barriers exist. Addressing these through training and policy support enhances CBT integration.

Ethical Considerations in CBT Practice

- **Informed consent & confidentiality** — ensure client understanding and privacy.
- **Avoiding coercion in behavior modification** — promote voluntary participation.
- **Cultural humility & respect for autonomy** — adapt interventions sensitively.
- **Maintain professional boundaries** in nurse–patient relationships.
- **Competence and supervision** — practice within training and seek guidance.

Role of the Nurse in CBT

- Psychiatric nurses play a vital role in addressing the interaction between a patient's thoughts, emotions, and behaviors. During assessment, nurses **identify negative automatic thoughts, emotional triggers, and maladaptive coping styles that contribute to psychological distress.**
- Provide psycho education through **explaining how thoughts influence emotions and behaviors**—and **teach practical skills such as thought monitoring and cognitive restructuring**. By supporting behavioral experiments, nurses help patients **test unhelpful beliefs in real-life situations, fostering insight and adaptive coping**.

Role of the Nurse in CBT

- Nurses also integrate CBT principles within the nursing process (ADPIE)—from assessing cognitive and behavioral patterns to planning interventions and evaluating outcomes. They use CBT-informed nursing diagnoses such as ineffective coping or distorted thought processes to guide care plans that target both psychological and behavioral change. Collaboration with psychologists and psychiatrists ensures that CBT interventions are consistent with broader treatment goals, such as medication management or crisis stabilization.
- Through education, support, and multidisciplinary teamwork, nurses could empowering clients to build healthier thought patterns and improve emotional well-being.

Nursing Process Integration

Step	CBT Application	Focus Points
Assessment	• Identify maladaptive thoughts & behaviors	• Explore thought–feeling–action links • Use thought records/interviews
Diagnosis	• Define cognitive-related problems	• Ineffective coping • Distorted thinking patterns
Planning	• Set collaborative goals	• Target specific thoughts or behaviors • Plan measurable outcomes
Implementation	• Apply CBT interventions	• Cognitive restructuring • Exposure & relaxation • Behavioral activation
Evaluation	• Review progress & outcomes	• Track symptom changes • Modify plan as needed

Dialectical Behavior Therapy (DBT)

- Dialectical Behavior Therapy (DBT) is an evidence-based, multimodal psychotherapy originally developed in the 1980s by Dr. Marsha Linehan (Professor Emeritus, University of Washington) .
- Dr. Linehan developed DBT specifically to address the limitations she observed when applying standard Cognitive Behavioral Therapy (CBT) to individuals with Borderline Personality Disorder (BPD)—particularly those struggling with chronic suicidal ideation and self-injurious behaviors .

Dialectical Behavior Therapy (DBT)

- The core challenge Dr. Linehan identified was that many clients with severe emotion dysregulation experienced CBT's strong focus on **change** as invalidating. These clients felt that therapists were challenging their thoughts and emotions without first acknowledging their validity. In response, DBT was designed to balance change-oriented strategies with an equally powerful emphasis on **acceptance** and validation .
- Rooted in cognitive-behavioral theories and techniques, DBT integrates Eastern mindfulness practices with behavioral science. The ultimate goal is for clients to build **"a life worth living"** .

Dialectical Behavior Therapy (DBT)

What is DBT?

- **Dialectical Behavior Therapy (DBT)** is a structured, skills-based psychotherapy originally developed for people with **borderline personality disorder**, especially those with **chronic self-harm, suicidal behavior, severe emotional dysregulation, and unstable relationships**. NICE describes DBT as an intensive psychological treatment that helps the person build skills to regulate emotions and behavior, and notes that it usually runs for about **1 year** with **weekly individual and group sessions**.

Dialectical Behavior Therapy (DBT)

The word **dialectical** means working with two truths at the same time:

- **acceptance** of the patient as they are right now
- **change** in the behaviors that are causing harm
- That balance is the whole engine of DBT. It does not shame the patient for self-harm, and it does not excuse harmful behavior either. It says, in effect: *you are doing the best you can, and you still need to learn safer, more effective ways to cope*. This acceptance-plus-change framework is one of the reasons DBT is especially suitable for BPD.

Dialectical Behavior Therapy (DBT)

The term "dialectical" refers to the philosophical concept of resolving the tension between opposing forces. In DBT, the primary dialectic is the balance between **acceptance** and **change**

Acceptance-Oriented Strategies	**Change-Oriented Strategies**
Validation	Problem-solving
Mindfulness	Behavioral activation
Recognizing reality as it is	Skills training
Self-compassion	Exposure-based techniques
Reducing emotional suffering	Modifying maladaptive behaviors

Dialectical Behavior Therapy (DBT)

The therapist's task is to help clients hold two seemingly opposing truths simultaneously: "I am doing the best I can" **AND** "I need to change and do better." This dialectical stance prevents the polarization that often occurs in therapy (e.g., therapist pushing for change while client feels criticized)

Dialectical Behavior Therapy (DBT)

Main goals of DBT

- DBT usually aims to:
- reduce life-threatening behaviors, including suicide attempts and severe self-harm
- reduce therapy-interfering behaviors, such as dropping out, severe avoidance, or repeated non-engagement
- reduce quality-of-life-interfering behaviors, such as substance misuse, impulsivity, or destructive relationship patterns
- build behavioral skills for a more stable and meaningful life
- That hierarchy matters. In DBT, **safety comes first**. You do not start polishing abstract insight while the patient is actively bleeding emotionally or physically.

The Biosocial Theory: DBT's Model of Psychopathology

- DBT's understanding of emotion dysregulation is grounded in the **Biosocial Theory** . According to this model, pervasive emotional dysregulation arises from the transaction between two factors:
- **1. Biological Vulnerability**
- Heightened emotional sensitivity
- Greater reactivity to emotional stimuli
- Slower return to baseline emotional state
- A "sensitive nervous system" that responds intensely to environmental cues

The Biosocial Theory: DBT's Model of Psychopathology

2. Invalidating Environment

- Dismissal or trivialization of the individual's emotional experiences
- Punishment or criticism for emotional expression
- Inconsistent reinforcement of emotional communication
- Failure to teach effective emotion regulation skills
- Over-simplification of problem-solving ("Just get over it")
- When a biologically vulnerable individual grows up in an invalidating environment, they do not learn to label, tolerate, or regulate their emotional experiences. Instead, they may oscillate between emotional suppression (leading to numbness or dissociation) and overwhelming emotional expression (leading to self-harm, suicidal behavior, or interpersonal chaos) .

Comprehensive DBT: The Four Modes of Treatment

- **Comprehensive DBT** is not simply a set of techniques—it is a **full treatment system** consisting of four modes delivered concurrently . Each mode serves a specific function:
- **Mode 1: Individual Therapy (Weekly)**
- **Function:** Enhancing motivation and addressing specific target behaviors.
- The individual therapist is the client's primary therapist. Sessions are structured, goal-oriented, and focus on a pre-determined hierarchy of priorities. Two essential tools are used:
- **Diary Card:** A daily self-monitoring tool where clients track emotions, urges, behaviors (e.g., self-harm, substance use, suicidal ideation), and skills practiced. This guides session focus .
- **Chain Analysis:** A detailed behavioral analysis examining the sequence of events, thoughts, feelings, and body sensations leading to a target behavior (e.g., self-harm). The therapist and client identify "links" in the chain where different choices or skills could have been applied .

Dialectical Behavior Therapy (DBT)

Core components of DBT

- Standard DBT is not just one weekly chat. It is a **multicomponent treatment**. The classic model usually includes:
- **1) Individual therapy**
- This is where the therapist and patient work on:
- recent crises
- self-harm urges and incidents
- suicidal thoughts
- treatment goals
- applying DBT skills to real-life problems
- A major tool here is **behavioral chain analysis**, where the patient and therapist examine, step by step:
- what happened before the self-harm
- what thoughts, feelings, body sensations, and events built up
- what vulnerability factors were present
- what the short-term payoff of self-harm was
- what skills could have been used instead next time
- This makes self-harm understandable and treatable, not mysterious.

Comprehensive DBT: The Four Modes of Treatment

Mode 2: Skills Training Group (Weekly, 2-2.5 hours)

- **Function:** Teaching behavioral capabilities.
- Despite the name, this is more accurately described as a **class** rather than group therapy. The format is didactic, with a structured curriculum, handouts, homework assignments, and skill practice. Groups typically run for **6 months to one year** and are often repeated to ensure skill acquisition .

Dialectical Behavior Therapy (DBT) for Borderline Personality Disorder (BPD) and self-harm

2) Skills training group

- Patients are taught practical skills in a group format. These are the famous four DBT skill modules:
- **a) Mindfulness**
- This teaches the patient how to:
- notice thoughts and emotions without immediately reacting
- stay in the present moment
- reduce automatic, impulsive responding
- Mindfulness is foundational because many BPD crises escalate fast. If the patient cannot notice the emotion rising, they cannot intervene before self-harm becomes the default coping response. .

Dialectical Behavior Therapy (DBT) for Borderline Personality Disorder (BPD) and self-harm

- **b) Distress tolerance**
- These skills help the person survive a crisis **without making it worse**. They are used when emotions are too high for deeper processing.
- **Examples include:**

➢ **distraction strategies**

➢ **grounding**

➢ **self-soothing**

➢ **crisis survival methods**

➢ **urge management**

➢ **This is the module most directly relevant to self-harm because it gives the patient emergency alternatives when the urge hits hard.**

Dialectical Behavior Therapy (DBT) for Borderline Personality Disorder (BPD) and self-harm

c) Emotion regulation

- These skills help patients:
- identify emotions accurately
- reduce emotional vulnerability
- understand what triggers emotional escalation
- respond in ways that fit the situation
- This matters because BPD is often marked by **high emotional sensitivity**, **intense emotional responses**, and **slow return to baseline**. DBT aims to make emotions more manageable, not eliminate them.

Dialectical Behavior Therapy (DBT) for Borderline Personality Disorder (BPD) and self-harm

d) Interpersonal effectiveness

- These skills help with:
- setting boundaries
- asking for needs effectively
- saying no
- reducing relationship chaos
- maintaining self-respect in conflict
- Because many crises in BPD are triggered by perceived rejection, abandonment, or invalidation, interpersonal skills are not “extra”; they are relapse prevention.

Comprehensive DBT: The Four Modes of Treatment

Mode 3: Phone Coaching (As-Needed)

- **Function:** Generalizing skills to the natural environment.
- Clients can call their individual therapist between sessions—typically for brief (5-10 minute) interactions—to receive **in-the-moment coaching** on applying DBT skills to real-life crises. This is not psychotherapy by phone; it is skills coaching. The rule is simple: **"Call me before you harm yourself, not after."**

Dialectical Behavior Therapy (DBT) for Borderline Personality Disorder (BPD) and self-harm

- **3) Between-session coaching**
- In standard DBT, patients may receive brief coaching to help them use DBT skills **in the moment**, before acting on self-harm urges. The goal is not dependency; it is real-time skill generalization. NICE's description of DBT as an intensive treatment is consistent with this broader, skills-focused structure. (NICE)
- **4) Therapist consultation team**
- DBT also includes support for therapists. This is important because work with chronic suicidality, self-harm, splitting, dropout risk, and emotional intensity can burn clinicians out. The consultation team helps maintain treatment fidelity and clinician effectiveness. This component is part of why DBT is more than generic supportive therapy. (PMC)

Comprehensive DBT: The Four Modes of Treatment

Mode 4: Therapist Consultation Team (Weekly)

- **Function:** Enhancing therapist motivation and competence.
- DBT can be emotionally demanding. Therapists treating clients with severe suicidality and self-harm risk burnout, vicarious trauma, and therapist drift. The consultation team is a weekly meeting where DBT therapists support each other, maintain treatment fidelity, and help each other stay dialectical. No therapist practices comprehensive DBT alone

The Five Functions of DBT Treatment

The Five Functions of DBT Treatment

- DBT is designed to address five critical functions that any effective treatment for complex, dysregulated patients must provide

Function	How It Is Addressed
1. Motivating commitment to change	Target hierarchy, commitment strategies, pre-treatment orientation
2. Teaching new skills	Skills training group, modules
3. Generalizing skills to natural environment	Phone coaching, homework assignments
4. Structuring the environment to reinforce adaptive behavior	Therapist structuring of sessions, contingency management
5. Enhancing therapist competence and motivation	Consultation team

The Four Skills Modules for (DBT)

The Four Skills Modules

- The skills training curriculum is organized into four modules :
- **Module 1: Core Mindfulness**
- **Purpose:** To develop the capacity for intentional, nonjudgmental awareness of the present moment.
- Mindfulness skills are considered the **foundation** of all other DBT skills. They teach clients to observe, describe, and participate in their experience without judgment or impulsive reaction.
- Key concepts include:
- **"Wise Mind"** : The synthesis of "Emotional Mind" (emotion-driven) and "Reasonable Mind" (logic-driven). Wise Mind integrates knowing with feeling.
- **"What" Skills:** Observe, Describe, Participate
- **"How" Skills:** Nonjudgmentally, One-mindfully, Effectively
- These skills are derived from contemplative practices but are presented in entirely secular, behavioral terms .

The Four Skills Modules for (DBT)

The Four Skills Modules

- **Module 2: Distress Tolerance**
- **Purpose:** To survive painful situations without making them worse.
- Distress tolerance skills are crisis survival strategies. They are **not** about solving problems or changing emotions—they are about getting through crises without resorting to self-harm, substance use, or other destructive behaviors.
- Key techniques include:
- **TIPP:** Temperature (cold water on face), Intense Exercise, Paced Breathing, Progressive Relaxation
- **ACCEPTS:** Activities, Contributing, Comparisons, Emotions (opposite), Pushing away, Thoughts, Sensations
- **IMPROVE:** Imagery, Meaning, Prayer, Relaxation, One thing in the moment, Vacation, Encouragement
- **Radical Acceptance:** Fully accepting reality as it is (not as it "should be") without fighting it
- **Turning the Mind:** Making a conscious choice to accept, again and again

The Four Skills Modules for (DBT)

The Four Skills Modules

- **Module 3: Emotion Regulation**
- **Purpose:** To understand, name, and change painful emotional states.
- Suicidal and self-harming behaviors are conceptualized in DBT as **maladaptive attempts to regulate overwhelming emotions**. This module teaches adaptive alternatives.
- Key skills include:
- **Model for Describing Emotions:** Identifying prompting events, interpretations, body sensations, urges, and expressions
- **PLEASE Master:** Treating Physical Illness, balancing Eating, avoiding mood-Altering drugs, balancing Sleep, getting Exercise, building Mastery
- **Opposite Action:** Acting opposite to the action urge of an unjustified emotion (e.g., approaching when afraid, being kind when angry)
- **ABC PLEASE:** Accumulating positives, Building mastery, Cope ahead, PLEASE

The Four Skills Modules for (DBT)

The Four Skills Modules

- **Module 4: Interpersonal Effectiveness**
- **Purpose:** To ask for what one needs, say no effectively, and maintain self-respect in relationships.
- This module draws on assertiveness training and social problem-solving. Clients learn to navigate the tension between getting what they want, maintaining the relationship, and keeping their self-respect.
- Key acronyms include:
- **DEAR MAN:** Describe, Express, Assert, Reinforce, stay Mindful, Appear confident, Negotiate (for getting objectives)
- **GIVE:** Gentle, Interested, Validate, Easy manner (for maintaining relationships)
- **FAST:** Fair, no Apologies, Stick to values, Truthful (for maintaining self-respect)

Stages of Treatment and Target Hierarchy

Stages of Treatment and Target Hierarchy

- DBT organizes treatment into discrete stages, each with specific goals. This staging prevents the common problem of treating "crisis of the week" without making deeper progress :
- **Pre-Treatment Stage**
- Orientation to DBT model and commitment to treatment
- Client and therapist agree on a contract specifying target behaviors
- Client must agree to attend regularly (missing 4 consecutive sessions results in discharge)

Stages of Treatment and Target Hierarchy

Stage 1: Achieving Behavioral Control

- **Primary Target Hierarchy (in strict order of priority):**
- **Life-threatening behaviors:** Suicidal ideation, suicide attempts, non-suicidal self-injury (NSSI). These are always the first priority.
- **Therapy-interfering behaviors:** Missing sessions, non-disclosure, non-compliance, rudeness to therapist.
- **Quality-of-life-interfering behaviors:** Substance use, disordered eating, severe relationship conflicts, housing or employment instability.
- Stage 1 is the most researched stage. The goal is to get the client out of hell—to reduce life-threatening and therapy-interfering behaviors so that deeper work can begin .

Stages of Treatment and Target Hierarchy

Stage 2: Experiencing Emotions Fully

- Focus on post-traumatic stress and emotional experiencing
- Address underlying trauma that was previously too destabilizing to explore
- DBT has specific protocols for PTSD, including **DBT Prolonged Exposure (DBT PE)**

Stage 3: Solving Ordinary Life Problems

- Enhance self-respect and achieve "ordinary happiness and unhappiness"
- Work on relationship goals, career development, and life meaning

Stage 4: Finding Freedom and Contentment

- Address feelings of incompleteness
- Work toward transcendence and ongoing contentment
-

Dialectical Behavior Therapy (DBT)

Why is DBT used in BPD?

- BPD is associated with:
- intense and rapidly shifting emotions
- impulsivity
- unstable self-image
- unstable relationships
- recurrent self-harm and suicidal behavior

Dialectical Behavior Therapy (DBT)

Why is DBT used in BPD?

- A recent clinical summary notes that psychotherapy is the **primary treatment modality** for BPD, and recent guideline synthesis says clinicians should optimize psychotherapy before moving toward unnecessary medication escalation.
- DBT is one of the best-known and most studied psychotherapies for this group. A 2024 systematic review reported that DBT **reduces suicidality and self-injurious behaviors** in patients with BPD. A 2024 comprehensive review also reported that DBT reduces **self-harm, suicidality, and depressive symptoms**, with benefits that may persist after treatment ends.

Dialectical Behavior Therapy (DBT)

Why is DBT especially useful for self-harm?

- Many patients with BPD do not self-harm “for attention,” despite the lazy myth that still floats around clinical settings like bad coffee. Self-harm is often used to:
- reduce unbearable emotional intensity
- escape dissociation or numbness
- express distress that feels impossible to verbalize
- regain a sense of control
- punish the self
- DBT directly targets these functions. Instead of only telling the patient to stop self-harming, it teaches **alternative coping skills** that can regulate distress more safely and effectively. The evidence base supports DBT for reducing both **non-suicidal self-injury** and **suicidal/self-directed violence** in BPD populations.

Dialectical Behavior Therapy (DBT) for Borderline Personality Disorder (BPD) and self-harm

- **How does DBT reduce self-harm?**
- DBT reduces self-harm through several linked mechanisms:

1-It teaches replacement behaviors

- Instead of cutting, overdosing, burning, or hitting walls, the patient learns concrete distress-tolerance skills that serve a similar short-term regulatory function with less harm. (PMC)

2-It identifies triggers and patterns

- Patients learn to map the sequence leading to self-harm, including:
- sleep deprivation
- conflict
- shame
- substance use
- abandonment fears
- invalidating encounters
- Once the pattern is visible, it becomes interruptible.

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Thank You!