PSYCHOTERAPIA 1 (204) 2023
PAGES: 15–25
DOI: 10.12740/PT/166069

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THE FIRST LEVEL OF CONCEPTUALIZATION IN DIALECTICAL BEHAVIOR THERAPY

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cognitive-behavioral therapy
case conceptualization
dialectical-behavior therapy

Summary

The ability to build a conceptualization of a patient's problem is a key competency of effective psychotherapists. Ways of understanding the patient and his or her problems vary between approaches in psychotherapy and depend on the theoretical framework within which the therapist operates. Even within such a coherent therapeutic approach as cognitive behavioral therapy (CBT), differences are discernible in the way in which the understanding of the patient is constructed, especially by therapists of the so-called third wave. In this article, the author introduces the philosophy of working in dialectical-behavior therapy, which is one of the approaches in the cognitive-behavioral therapies. He also makes a description of how conceptualization is carried out at the so-called first level – i.e., understanding the patient's reported problem in the context of the „here and now." The author also tries to outline the similarities and differences between the classical cognitive model used in CBT conceptualization and the models used in DBT therapy, namely the emotion model and the behavioral chain. Among the many similarities, the author points out areas where DBT conceptualization seems to go beyond the classical CBT conceptualization framework (e.g., the role of impulses accompanying emotional reactions).

Introduction

Cognitive behavioral therapy (CBT) is a therapeutic modality with a well-established position and importance among the many psychotherapeutic approaches used to treat people with mental disorders. The theoretical foundations of CBT derive from several different sources that have influenced each other over the years, resulting in the current integration of numerous theories from the humanities and natural sciences. The guiding principle of those developing this therapeutic approach has been to remain as close as possible to the empirical data flowing from scientific research (resulting in the development and con-

tinuous expansion of theoretical constructs useful in therapeutic work) and the ongoing evaluation of the effectiveness of therapeutic interventions undertaken. The marriage of CBT with empiricism and the philosophy of science inevitably led (and still leads) to the development of this approach and its progressive integration [1].

The form of psychotherapeutic work known today as CBT has undergone many changes and transformations over the years. Today's CBT deserves to be called a "family of cognitive-behavioral therapies" rather than a single therapeutic modality. This is reflected in the expanding array of approaches of the so-called "third wave of behavioral therapies," which includes Acceptance and Commitment Therapy (ACT), Mindfulness-Based Cognitive Therapy (MBCT) and Dialectical Behavior Therapy (DBT), among others. All of them, while remaining connected to the classical tenets of CBT, focus in their own specific way (from a simplified perspective) on conceptualizing and treating specific groups of patients (e.g., DBT – patients with borderline personality), place more emphasis on a specific therapeutic process (e.g., ACT — developing psychological flexibility) or incorporate specific methods of therapeutic work (e.g., MBCT — mindfulness techniques).

In Poland, dialectical behavior therapy has been gaining importance and popularity in recent years. The purpose of this paper is to present the first level of conceptualization within this modality and to introduce the reader to some of its assumptions. The author hopes to show the similarities (many) and differences (sometimes only apparent) between these two approaches in psychotherapy by placing them in the context of the theories underlying classical cognitive-behavioral therapy.

Levels of conceptualization in CBT

The primary task of a therapist of any modality is to understand the patient's problems. As new information about him or her emerges, hypotheses appear in the therapist's mind to provisionally explain and clarify the patient's reported difficulties. The set of emerging hypotheses is in close connection with the theoretical assumptions professed by the therapist and with the model of psychopathology through the prism of which the therapist seeks to understand what the patient is saying to him. The creation of such a hypothetical "map" is referred to as conceptualization or case conceptualization. In the practice of CBT, it is customary to distinguish so-called levels of conceptualization. In Poland, a division has become widespread that assumes two levels of conceptualization: the first — focused on describing "what happens" and "how it happens," and the second — centered around understanding the genesis of the patient's problems, taking into account a whole range of other factors, such as the patient's biological conditions and life history [2]. It can be said that at the first level of conceptualization, the therapist and patient narrow their focus to one specific moment or event and try, using the language of cognitive-behavioral therapy, to create as complete a description as possible of what happened. It is only through conceptualization at the second level that the patient with

the therapist create hypotheses about why the patient's way of thinking or reacting in a given situation was the way it was.

A slightly different division is proposed by Kuyken, Padesky and Dudley [3], who distinguished three levels of conceptualization. The first (descriptive) describes the patient's experience according to the language of cognitive-behavioral therapy, the second (cross-sectional) identifies typical cognitive and behavioral mechanisms that are, so to speak, the common denominator of the first level descriptions, and looks for triggers and sustaining factors of the patient's problems, and the third (longitudinal) attempts to understand the patient's problems taking into account the patient's life history and the development of the disorder.

In this paper, the author focuses on how to conduct first-level conceptualization, which regardless of the division (into two or three levels) follows the same principles and covers the same scope.

First level conceptualization in classical CBT

The matrix for conducting therapeutic work in the classical CBT approach is the so-called cognitive model, which describes the interdependence between the thinking process, physiological reactions of the body, emotional experiences, and human behavior.

The first conceptualizations derived from Ellis and his therapy, eventually named rational-emotive behavioral therapy [4, 5] presented the cognitive model in the form of the so-called "cognitive ABC", in which a specific event (A = activating event), is subject to a specific mental interpretation according to the individual's held beliefs (B = beliefs), leading to behavioral, emotional and physiological experiences (C = consequences) consistent with the interpretation (or understandable in its context). Despite Ellis' emphasis on the multidirectional relationships between the components of the model and its further development and nuancing, the model continues to be presented in its reductionist, simplified form and in such gets into the consciousness of psychotherapists. The model in this form emphasizes the most significant role of cognitive processes in understanding human emotions and behavior, and at the same time reinforces the assumption that cognitive processes (B) precede and, as it were, determine human emotions and behavior (C).

A slightly more complex way of representing the cognitive model is the five-factor model propagated by Christine Padesky [6], also known as the hot-cross bun, which consists of five components — thoughts, emotions, behavior, physiological sensations and environment — that are in bidirectional (reciprocal) relationships with each other. Looking at this model, it seems to indicate the circularity and complex interdependence between its five components. Cognitive processes (apparently) are no longer its "central" part, and it is difficult to consider them as "preceding" or "determining" the other components of the model. Its various components are presented as equivalent and mutually influencing each other. In a commentary on the presented model, the authors wrote: "just as changes

in any one of these areas can make you feel worse, changes in any one of these areas can also help you begin to feel better" [6]. Despite the declarations made, however, the detailed description of the model in the 1995 edition of the textbook "Mind over Mood" by Greenberger and Padesky [7] indicates the authors' claimed primacy of cognition over other components of the model, and their proposed methods of therapeutic work are mainly based on cognitive work. Thus, of the five factors listed by the authors, the starting point (and object of change) for them becomes the cognitive factor.

In the work aimed at changing this factor, one of the basic skills that the patient must acquire is the ability to recognize his automatic thoughts (i.e., involuntary, occurring at the border of conscious interpretations of reality). This allows patients to observe the impact of automatic thoughts (or the way they interpret events) on their emotions and behavior. If the patient is able to perceive that his or her cognitive processing of reality is distorted (or inadequate) then, with the help of the therapist, he or she will be able to revise his or her way of thinking (e.g., by assessing the validity of the automatic evaluation or by becoming aware of its distortion). The cognitive restructuring performed in this way translates into change in the other components of the model.

What is dialectical behavior therapy?

The origins of dialectical behavior therapy date back to the 1980s and relate to the work of Dr. Marsha Linehan and her research and clinical team treating patients diagnosed with borderline personality disorder (BPD). Therapists on this team initially used standard cognitive-behavioral therapy methods, only to realize after time that they did not work as well with this group of patients as expected. As they gained experience and analyzed the effectiveness of the interventions, the team supplemented them with additional techniques and created a slightly different philosophy of work to address the complex problems of BPD patients most optimally. The result of the work of Dr. Marsha Linehan and her team was a manual describing the working method, published in 1993 [8], with an accompanying manual of so-called "skills training" [9], which lived to see an update and a new second edition in 2014 [10]. The edition of the manual translated into Polish took place in 2007, and the skills training manual appeared on the Polish publishing market almost 10 years later, in 2016.

Dialectical behavior therapy is characterized by a high level of pragmatism. Its creators set themselves the goal of creating an effective support system for patients for whom other modes of therapeutic work had failed. This pragmatism led to DBT being based on numerous theoretical constructs, which together form a "strange hybrid" [11]. Its components are a set of those ways of understanding and acting that are effective in treating BPD patients.

DBT developed on the foundation of classical CBT. It is firmly rooted in the spirit of collaborative empiricism, uses self-observation tools, and the DBT therapist's attention during the session is most heavily placed on the "here and now." In conceptualizing and

planning interventions, the DBT therapist draws on theories about cognition, learning and behavioral concepts. DBT, to a greater extent than CBT, is based on behavioral rather than cognitive concepts. The DBT therapist places more emphasis on the role of classical and instrumental conditioning in the way he or she understands human functioning, patients participating in therapy are taught principles of effective behavior change, and their problem behaviors are analyzed in the context of reinforcement.

One of the basic tenets of therapy is that the therapist takes a "dialectical view of the nature of reality and human behavior" [8] and teaches it to the patient. The concept of "dialectical thinking" is quite nuanced and its explanation is beyond the scope of this paper. To put it in a nutshell: dialectical thinking is a third option alongside universalist ("there is absolute truth and ultimate order") and relativist ("truth is only in the eye of the beholder") thinking, and assumes that truth and order evolve and develop over time. This thinking requires "the abilities to transcend polarities and, instead, to see reality as complex and multifaceted; to entertain contradictory thoughts and points of view, and to unite and integrate them; to be comfortable within flux and inconsistency; and to recognize that any all-encompassing point of view contains its own contradictions. When one is stuck in considering a problem, a dialectical approach would be to consider what has been left out or how one has artificially narrowed the boundaries or simplified the problem" [8].

The dialectical view of the therapeutic process also prescribes the simultaneous use of two seemingly contradictory therapeutic strategies, such as acceptance (expressed in understanding and validating the patient's experience) and change (expressed in teaching the patient relevant skills and solving life's problems). The dialectical worldview emphasizes the importance of interconnectedness and wholeness of reality. This is a point of contact with the philosophy of Zen Buddhism, which is another pillar on which the therapeutic approach under discussion is based. Hence, the therapeutic program places great emphasis on developing mindfulness skills and acceptance of reality (e.g., the inevitability of death or the unchangeability of the past, including the traumatic past). These competencies become the patient's primary resource to help adopt a non-judgmental attitude toward reality, which is crucial in the process of regulating emotional arousal.

DBT also incorporates concepts from the psychology of emotions. It views emotions (along with reinforcement) as important factors controlling human behavior. This seems particularly relevant because BPD patients experience numerous simultaneous emotional arousals, which they themselves are often unable to adequately recognize. Therapists point to the importance of distinguishing between primary emotions, which are contextually understandable emotional responses (e.g., sadness in response to loss or anger in response to a need not being met), and secondary emotions, which are emotional responses to primary emotional responses (e.g., fear of anxiety or shame over anger).

First level of conceptualization in DBT

Behaviorism

First-level conceptualization in DBT therapy is conducted using behavioral language that describes the patient's actual behavior as if described by an outside observer witnessing the situation. Conducting the conceptualization in this way makes it difficult to make value judgments about the behavior and keeps assumptions or interpretations from being made about the motive or function of the behavior exhibited by the patient. DBT, in contrast to radical behaviorism, integrates the behavioral approach with various fields of psychology (cognitive, developmental, biological, personality) and conceptually approximates to psychological behaviorism as described by Arthur Staats [12]. This makes the behavioral language used in DBT also include a description of factors other than behavior, such as thoughts, feelings and physiological sensations. It thus approaches a phenomenological, non-evaluative description of phenomena that are the patient's reported experience.

In order to make a behavioral description, DBT therapists conduct what is known as behavioral chain analysis (BCA) with patients, which consists of identifying all possible components of a given behavior arranged in a temporal sequence (like links in a chain). In the hands of a DBT therapist, it is the primary tool for assessing human behavior. The primary goal of any single chain analysis is to obtain an exceptionally clear description of the sequence of events leading up to a single occurrence of a problem behavior and a description of the consequences that followed. Achieving this goal usually requires putting considerable effort into orienting the patient to this way of presenting events. In general, patients want to "tell a story" about something that happened, not necessarily in a linear fashion, and focus on elements they believe are important, regardless of their actual importance in contributing to the occurrence of the problem behavior. Chain analysis provides a structure for conducting an ongoing assessment that allows the therapist and patient to obtain relevant information to understand the causes and factors that sustain the occurrence of the problem behavior.

It should be noted that the behavioral chain analysis conducted within the framework of DBT distinguishes the same components as Christine Padesky's five-factor model, i.e., behavior (actions), physiological reactions (bodily sensations), thoughts (cognitive elements), feelings (emotions) and external events (environment), but also distinguishes additional ones (e.g., impulses to act or behaviors reflecting dialectical dilemmas). Each of these factors can be the content of a particular link in the chain, and in behavioral analysis will be considered behavior in a broad sense.

The chain analysis distinguishes five types of components. In the first and most important stage of chain analysis, a component called problem behavior is identified (since patients do not always consider the analyzed behavior to be problem behavior, some therapists advocate using the phrase target behavior instead) and its clear definition is obtained [13]. In the next step, it is recommended to look for a component called a prompting event. This

is an event that appears to be the cause (or "spark") for the analyzed behavior (i.e., if the prompting event was missing, the problem behavior would not occur in the chain). In the third place, the vulnerability factors are analyzed, i.e., variables that may have made the patient more susceptible to the effects of the prompting event in that particular case (such vulnerability factors may be lack of sleep, hunger, symptoms of untreated physical illness, pain, failure to take medication). Life events that lead to overload or strain on the patient (such as a recent job loss or breakup) are also considered vulnerability factors. It can be helpful in determining vulnerability factors to ask the question: "Why did the behavior in question occur on that particular day, when the same triggering factor is present in the patient's life every day?".

The fourth type of component is the so-called "links", i.e., those parts of the chain that occur between the prompting event and the analyzed behavior. This is the place to look for any thoughts, impulses, emotions, covert behavior and other phenomena that are the patient's experience. This is also where the important "insight work" occurs, where the patient has a chance to see that his or her behavior occurs in a certain context and under the influence of certain phenomena. The final, fifth type of component is consequences of a given behavior. The analysis here is devoted to identifying factors that can act as reinforcers of a behavior, which consequently increases the likelihood that the behavior will occur again in the future. DBT therapists pay particular attention to those consequences that occur immediately after the problem behavior (e.g., the feeling of power and control that occurs after aggressive behavior is a greater reinforcer than the punishment that occurs later in the form of guilt).

Together, these five components make up a complete behavioral analysis of a patient's single problem behavior. The chain created with a patient may contain five links, or even more than a hundred in complex cases. The analysis can take anywhere from a few minutes to several hours. Such a way of looking at the patient's behavior fulfills at least several goals, the most important of which is to find solutions as efficiently as possible to reduce the likelihood of the behavior occurring in the future. At the same time, behavioral analysis is treated in DBT as a tool for insight and a way to improve competence in recognizing and naming emotions. It also makes it possible to identify those links in the chain that reinforce and sustain the occurrence of a given behavior.

Emotion model

DBT therapists, in conducting first-level conceptualization, use — in addition to behavioral analysis — an emotion model. Interestingly, this model is used less often in individual sessions, and patients learn it during skills training (i.e., group psychoeducational-training meetings during which patients are taught the DBT therapy skills needed to engage in treatment and make life changes). Knowing the emotion model and moving competently within it is considered one of the therapy skills taught in the "emotion regulation" module.

The emotion model in many of its aspects resembles the five-factor model (the hot-cross bun) described earlier, but is a bit more complicated. More attention is paid to emotions, which occupy a central place in the model.

The first-level conceptualization carried out within DBT specifically emphasizes the role of emotional arousal as a variable that plays a central role in understanding the phenomenology of the patient's experience. Unlike classical CBT, the model on which DBT therapists rely is somewhat more cautious about the antecedence of cognitive processes to the other components of the model, as postulated in classical CBT. According to the emotion model, the cognitive component (interpretations, automatic thoughts) need not always be captured as a mediating variable between the trigger and the emotion (as is the case, for example, in the fight-or-flight response or in the case of so-called conditioned emotions).

Cognitive processes in the DBT model of emotions are captured in two ways: (1) as a trigger for a given emotional response (e.g., interpretation of a situation leading to the experience of sadness; similar to the linear ABC model presented earlier), (2) but also as a cognitive component of the emotional response (i.e., assessments and judgments about reality that are consistent with the current emotional state and are generated by the patient in an emotionally arousing situation). DBT therapists recognize here an extremely problematic positive feedback loop that can lead to significant emotional dysregulation or mental crisis (i.e., the initial interpretation of reality triggers an emotional response, which reciprocally distorts cognitive processes, which in turn intensifies the emotional response, etc.)

DBT depicts emotional reactions as "integrated whole-system responses" involving multiple subsystems [8]. What Padesky's five-factor model conceptualizes separately (thoughts, emotions, physiology, behavior), Marsha Linehan sees as components of the body's emotional response: (1) biological/physiological changes in the body such as neurochemical changes within the nervous system, changes in blood flow or changes in muscle tension, (2) specific sensations involving the cognitive system such as feelings of "butterflies in the stomach" or "blushing," but also phenomenological "emotional experiences," (3) impulses to action accompanying these sensations that are specific and characteristic of a particular emotion (e.g., the impulse to flee in the case of fear and the impulse to hide in the case of shame), (4) nonverbal forms of emotional expression such as facial expressions, body language, voice timbre, and (5) behavior caused by the emotional response.

This view of emotional reactions makes it possible to implement a variety of emotion-regulating strategies such as influencing by means of temperature, breathing or exercise the physiological component of an emotion in order to reduce its intensity, distracting from emotional experience in order not to aggravate one's situation, deliberately changing posture and body language in order to induce a change in the felt emotion, carefully separating the impulse to act from the action itself to emphasize that they are not the same, and deliberately acting in a way opposite to the felt impulse. Also used, of course, are cognitive techniques supported by mindfulness techniques to check the facts and change the emotional mindset to a more balanced one.

An extremely important concept in DBT therapy is that which distinguishes between primary emotions and secondary emotions, in which primary emotions are defined as "initial reactions to what is happening (...) strong feelings that come on quickly, that don't involve having to think about what's happening" [14, p. 145] and secondary emotions as "emotional reactions to your primary emotions. Or to put it another way, secondary emotions are feelings about your feelings" [14, p. 145]. In the face of this, the joint task of the therapist and patient is to direct therapeutic attention to the valid primary emotion and support the expression of primary emotions in place of the expression of secondary emotions.

Differences between CBT and DBT

The work of CBT therapists revolves around extracting patients' automatic thoughts, evaluating them together, and implementing changes in patients' thinking that translate into changes in emotional and behavioral functioning. One of the basic skills (besides recognizing automatic thoughts) is spotting their distortion — that is, the way in which thinking deviates from facts.

DBT therapists, on the other hand, are careful not to view patients' thinking as "erroneous," "distorted" or "maladaptive" [15], but to make an ongoing effort to find the "grain of truth" in their thinking [8]. They devote a great deal of attention to "validating" the patient's experience, that is, communicating to the patient that his or her way of thinking, feeling and behaving is understandable if placed in the right context, or if given enough attention and uncovering previously unseen aspects of the whole. Empowerment then contrasts sharply with the patients' self-invalidation and the invalidation they experience from their immediate environment, which deems the patient's reactions inappropriate or incomprehensible [16]. This does not mean, of course, that DBT therapists have abandoned the interventions involving cognitive restructuring typical of CBT; nevertheless, this only occurs when the patient's experience is first presented as understandable and meaningful.

The model of emotions taught in DBT pays attention to the role of impulses accompanying emotional sensations, while classical CBT seems to omit analysis of this phenomenon. According to the premise of the emotion model, each emotional sensation is accompanied by impulses typical of that sensation, which, in light of the function of the emotion and evolutionary justifications, have a deep meaning (e.g., the impulse to attack in the case of anger or the impulse to hide in the case of shame). An important emphasis made by therapists is the distinction between the impulse to behave and the behavior itself, which makes it possible to effectively legitimize the patient's experience and implement skills such as not reacting on impulse or counter reacting to the impulse.

In DBT therapy, the social function of emotions is also reflected upon. Emotions, according to the theories espoused by this therapeutic modality, are viewed as forms of expression, containing within them information that is read by the environment. It there-

fore becomes important to analyze this expression and the reaction of the environment to it — whether the expression is adequate or inadequate, and whether it is met with validation or invalidation.

Finally, it is also worth mentioning that DBT is referred to as principle-driven therapy, while CBT customarily takes the form of protocol-driven therapy. This means that the course of a DBT therapy session is not predetermined by some specific scenario, and the therapy is often compared to a dance, in which every move made by one person depends on the moves made by another person. Therapeutic work, therefore, involves the implementation of certain strategies and rules, which are adapted to the therapeutic situation on an ongoing basis.

Conclusion

Dialectical behavior therapy is conceptually derived from classical cognitive-behavioral therapy, but places more emphasis on behavioral concepts than cognitive ones. In addition to many similarities with classical cognitive-behavioral therapy, dialectical behavior therapy additionally weaves in ideas and practices drawn from dialectical philosophy and Zen Buddhism. An in-depth analysis of the way the first level of DBT therapy is conceptualized shows a high level of consistency with the way it is conceptualized in classical CBT. However, it is characterized by a greater emphasis on the legitimization of the patient's experience (which, of course, does not mean that CBT therapists do not legitimize their patients' experiences), includes a greater number of factors taken into account during the analysis (e.g., impulses to act or the social dimension of emotional expression), and is presented in a linear (though still taking into account circular processes) form.

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