RO-DBT	DBT
Uses behavioral principles	**Uses behavioral principles**
Uses dialectical philosophy	**Uses dialectical philosophy**
Developed for over controlled clients Clusters A and C 'overcontrolled' personality styles e.g. avoidant, obsessive compulsive, paranoid and schizoid PD's, but also chronic depression and anorexia nervosa	**Developed for under controlled clients** Cluster B 'dramatic erratic' personality styles, mainly borderline and antisocial PD
Client has avoidant attachment style Does not seek attachment with therapist and abandons relationship easily, especially when there is conflict	**Client has anxious attachment style** Seeks attachment with therapist and fears abandonment
Core problem Social signalling deficits, low openness, and aloofness	**Core problem** Emotion dysregulation, poor impulse control
Suicide and self-harm Overcontrolled (OC) clients engage in self harm and suicide at high rates • OC client suicide and self-harm is usually planned • OC self-harming behavior is usually a well-kept secret • OC self-harm and/or suicidal behavior is more likely to be rule-governed rather than mood-governed—e.g., to restore their faith in a just world by punishing themselves for perceived wrongs	**Suicide and self-harm** Undercontrolled (UC)clients engage in self harm and suicide at high rates • UC client suicide and self-harm is usually mood-dependent and unplanned • UC clients do not keep their self-harming behavior a secret • UC self-harm and/or suicidal behavior is mood-dependent and impulsive
Therapist recognizes that clients characterized by over-control need to let-go of always striving to perform better or try harder	**Therapist recognizes that undercontrolled clients need to do better, try harder, and/or be more motivated to change**
Therapeutic stance Therapist is less directive, encourages independence of action and opinion, emphasizes self-enquiry and self-discovery	**Therapeutic stance** Therapist uses external contingencies, including mild aversives, takes a direct stance in order to stop dangerous, impulsive behavior

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Teaches the therapist How to use social-signaling to enhance client engagement and model vulnerability and connectedness	**Teaches the therapist** How to use external contingencies to help the client gain control and discover the reinforcing consequences of impulse control
Primary Therapeutic focus External - social-signaling, openness, and social connectedness skills	**Primary Therapeutic focus** Internal - emotion regulation skills, gaining behavioral control and distress tolerance
Teaches Clients to increase openness, flexible-responding, enhance social-connectedness, and vulnerable expression of emotion	**Teaches** How to avoid conflict, be more organized, restrain impulses, delay gratification and tolerate distress (skills already over learned or engaged in compulsively by most OC individuals)
Emphasis is on self-enquiry and self-discovery rather than impulse control	External contingencies, including mild aversives, help the client gain control and discover the reinforcing consequences of impulse control
Therapist encourages engagement if a conflict exists rather than automatic abandonment or avoidance	**Therapist may encourage brief disengagement from conflict** to reduce/avoid escalation
Therapist rewards Candid disclosure and uninhibited expression of emotion	**Therapist rewards** Regulated and measured expression of emotions and thoughts
Treatment Target Hierarchy 1. **Life-Threatening Behavior**—eg., suicide and self-harm behaviors. 2. **Therapeutic Alliance-Ruptures** 3. **Maladaptive OC social signalling** stemming from over control i.e. • Inhibited and disingenuous emotional expression • Hyper detailed focus and overly cautious behavior • Rigid and rule governed behavior • Aloof and distant style of relating • High social comparisons, envy and bitterness	**Treatment Target Hierarchy** 1. **Life-Threatening Behavior**—eg., suicide and self-harm behaviors. 2. **Therapy Interfering Behaviors** 3. **Quality of Life Interfering Behaviors** i.e. • Mental health related dysfunctional response pattern (e.g., other severe DSM Axis I & IV Disorders) • High risk or unprotected sexual behavior • Extreme financial difficulties • Criminal behaviors that may lead to jail • Seriously dysfunctional interpersonal behaviors

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	• Employment or school related dysfunctional behaviors • Physical health dysfunctional behaviors • Housing related dysfunctional behaviors
Prioritizes therapeutic alliance ruptures Positioned second in the treatment hierarchy, alliance ruptures are seen as opportunities for growth – thus are welcomed	**Prioritizes therapy interfering behaviors** Positioned second in the treatment hierarchy, therapy interfering behaviors are seen as problems necessitating change
Mindfulness Practices Informed by Malamati Sufism	**Mindfulness Practices Informed by Zen Buddhism**
Mindfulness • Emphasis on self enquiry, 'outing-oneself', participating without planning, and the cultivation of healthy self doubt • Encourages cultivation of Flexible-Mind responses that promote relaxation of rigid, rule-governed control efforts and an increase in context-appropriate disinhibition and/or emotional expression	**Mindfulness** • Emphasis on non-judgmental awareness of "what is" and intuitive knowing • Encourages cultivation of Wise Mind responses that focus on reducing mood-dependent impulsive responding and increasing abilities to delay immediate gratification in order to pursue distal goals
Emphasizes and Prioritises Radical Openness Radical Openness is actively seeking the things one wants to avoid in order to learn – challenging our perceptions of reality, modelling humility and a willingness to learn *"We don't see things as they are—we see things as we are."* (Lynch, 2017)	**Emphasises and Prioritises Radical Acceptance** Radical Acceptance is "letting go of fighting reality". *"It is the way to turn suffering that cannot be tolerated into pain that can be tolerated"* (Linehan, 1993; pg. 102)
Emphasizes our Tribal Nature and Social-Connectedness	**Emphasizes Internal Emotion Regulation and Non-Mood Dependent Actions**
Prioritizes interventions designed to take temperament into account Temperament (genetics for emotion) influences the perceptual and regulatory biases clients bring into social situations and needs to be accounted for when treating clients.	**Does not take temperament into account**
Targets bio-temperament With specific skills via activation of neural substrates	**Does not target bio-temperament**

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